

The poor ego has a still harder time of it; it has to serve three harsh masters, and it has to do its best to reconcile the claims and demands of all three. . . . The three tyrants are the external world, the superego, and the id

—Sigmund Freud (1856–1939)

Having touched upon the history of the consultation process, we will now make a brief sojourn to a number of psychological theories and the factors that influenced their development. These theories will guide the consulting psychiatrist's approach to the patient (Chap. 3), the family (Chap. 4), and the treatment team (Chap. 5). Herein, we will provide the background for our approach to the complex psychiatric case, which we hope will help the reader and psychiatric consultant gain insight into the way human behaviors and relationships can be intertwined. Integrating what have historically been viewed as conflicting approaches and theoretical orientations, we aim to diffuse the tension that exists between the classic drive-based, conflict-based, object-relations, and one-person psychology theories and the contemporary relational, intersubjective, co-constructive, and two-person psychology theories, believing, as we do, that all of these have much to offer the psychiatric consultant facing complex psychiatric cases. The consultant will likely be familiar with terminology from classic and object-relations theories—learned during psychiatric training and/or routinely used in understanding patients and families—however, the reader will also recognize in this chapter that the interventions typically made in consultation-liaison work are more aligned with and guided by contemporary, family-systems, and two-person psychological approaches defined as a relational theory of mind, giving importance to both persons, co-constructing a narrative influenced by the here and now (Aron 1990). The reader will also become acquainted with the practical aspects of both classic and contemporary theories as they apply to complex psychiatric patients and how they may be used in developing interventions that promote stability and facilitate cooperation among the patient, family, and treatment-team members.

Certainly, any attempt to discuss psychodynamic theory in a book like this does a disservice to the many clinicians and theorists who have been instrumental in developing these theories. Nonetheless, for practical purposes, we will briefly review psychodynamic theories, and in doing so will highlight important concepts and processes that are particularly relevant to difficult consultations. Importantly, we will not address the controversies surrounding the process of psychodynamic formulations using classic, one-person psychology and contemporary relational, two-person psychologies. Instead, we refer the reader to contemporary sources that present these controversies in a balanced manner (BPCG 2010; Fonagy et al. 2002; Greenberg 2003; Mitchell 2003; Wachtel 2011).

Before we begin our discussion proper of psychodynamic theory and its genesis, we should note that we have organized this chapter around what is often referred to as “one-person” and “two-person” psychologies. The astute reader will already be aware that these terms fail to capture the complexities of each psychotherapeutic approach. At the most basic level, one-person psychology tends to focus on the patient’s understanding, within the therapeutic encounter, of his or her past experiences as they relate to intrapsychic processes transferred onto the therapist. By contrast, two-person psychology may be seen as focusing symmetrically on both players (i.e., the therapist and the patient), and the treatment is considered to occur through a relational here-and-now constructivism rather than through intrapsychic shifts based on the patient’s experience as perceived by a neutral therapist. In many cases, the therapist employing a two-person psychology may be less reticent, less neutral, more likely to use implicit and explicit disclosure, and may welcome enactments in the treatment of his or her patients.

2.1 Classic Psychanalytic Theories: One-Person Psychology

Drive Theory

Classic psychoanalytic theory was developed by Sigmund Freud (1856–1939), who based his theories on his psychoanalytic work with adult patients. In his efforts to understand the human mind, Freud proposed several hypotheses. First, the *topographic model* (Fig. 2.1) posits that most mental life occurs in the *unconscious*, and that *preconscious* and *conscious* life is rather limited. Later, in revising the *topographic model*, Freud developed the *structural model* (Fig. 2.2). In this model the unconscious is comprised of several intrapsychic agencies: (1) the *id*, which embodies the instinctual sexual and aggressive drives; (2) the *superego*, which consists of the cultural and societal norms that have been incorporated into the person’s psyche; and (3) the *ego*, which moderates conflict between the *id* (which desires free reign) and the *superego* (which urges civility). Still later Freud wrote about the importance of the sexual drive theory in the form of psychosexual developmental phases determined by the organ of predominant interest to the

Fig. 2.1 Sigmund Freud’s topographic model of the mind

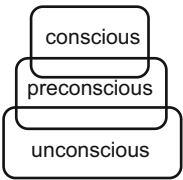


Fig. 2.2 Sigmund Freud’s topographic and structural model of the mind

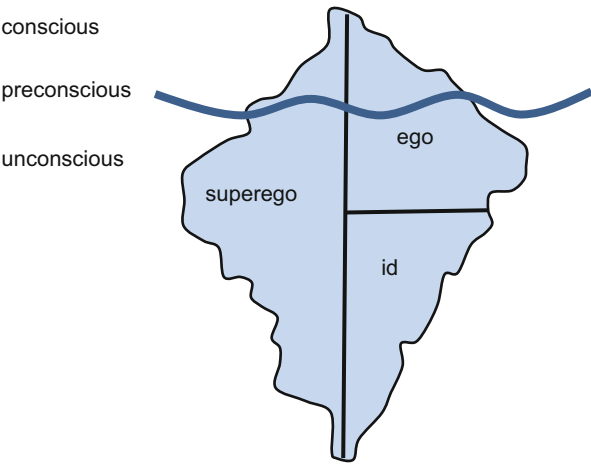


Table 2.1 Sigmund Freud’s model of psychosexual development

Psychosexual stage	Oral		Anal	Oedipal	Genital	Latency	Adolescence
Age	0–6 months	18 months	24 months	4 years	4–6 years	7–11 years	

infant/child for pleasure. Freud posited that the key developmental task of children involved “taming the instinctual drives” of the id through the development of the superego and ego (Freud 1916–1917). As can be seen in Table 2.1, there are three phases (oral, anal, and phallic) of the developmental process—often referred to as *psychosexual development*—and each requires that conflicts from the previous phase be successfully resolved. Freud emphasized that during the phallic phase, between the ages of 4 through 6 years, the intrapsychic conflict centers on the important oedipal complex, part of a longitudinal process of psychosexual development. When the anxieties of the oedipal complex are resolved, the person achieves the healthy psychological genital phase of normal heterosexuality (Freud 1924). According to Freud, pleasurable heterosexual intercourse was the goal of his psychosexual theories: “the subordination of all the component sexual instincts under the primacy of the genitals” (Freud 1905).

For Freud, unresolved conflicts of the oral, anal, or oedipal phase lead the person to have a neurotic fixation that, when he or she is under stress, manifests in a regression of ego functions to behaviors of the phase fixated in. Additionally, classic Freudian theory posits that a given personality is determined (or defined) by the ego functions that he or she utilizes and is continually influenced by the superego, which inhibits the unconscious drives' press for gratification.

A summary of Freud's theories and their importance to psychoanalysis can be found in *An Elementary Textbook of Psychoanalysis* by Charles Brenner (1974) and in the more recent work, *Freud and Beyond*, by Mitchell and Black (1995).

Ego Psychology

Heinz Hartman (1894–1970), a psychiatrist and psychoanalyst, often described as one of Freud's favorite students, developed the school of ego psychology. Holding that the ego has a biological substrate that includes perception, memory, concentration, motor coordination, and learning, he believed these innate ego capacities had autonomy from the sexual and aggressive drives of the id and were not products of frustration or conflict. Hartman coined the term "autonomous ego functions" (Hartman 1958), and his ideas share much with recent concepts concerning implicit memory systems and internal working schema stored in non-declarative memory systems (Mancia 2006).

The window into a personality style can be created through the study and understanding of the ego defense mechanisms an individual employs in coping with daily-life anxiety and threats to self-esteem from intrapsychic conflicts. Though Sigmund Freud was the first to describe such defense mechanisms, our contemporary understanding of these processes comes from his daughter, Anna Freud (1895–1982), who systematically classified these defenses, compiling a comprehensive catalog in her classic work *The Ego and the Mechanisms of Defense* (Freud 1937/1966). Sometimes we might consciously know which defense mechanisms we use in relation to others—as in humor to manage family conflict or denying or overlooking a colleague's negative comments—but in most cases they occur unconsciously. Defense mechanisms usually are adaptive and can have a salutary effect, allowing an individual to function normally. Importantly, however, when used in a repetitive fashion, defense mechanisms can become maladaptive and induce further anxiety. In this regard, a diabetic patient who unconsciously and routinely uses denial may avoid following through with the treatment team's recommendations regarding monitoring blood sugar and administering insulin, and thus his or her diabetes may be poorly controlled. This distinction between adaptive and maladaptive defense mechanisms was thoroughly evaluated by George Vaillant, MD (1934–) in his seminal work *Ego Mechanisms of Defense: A Guide for Clinicians and Researchers* (Vaillant 1992), in which he hierarchically categorizes defense mechanisms as mature, neurotic, immature, and pathological

Table 2.2 Common defense mechanisms

Category	Defense mechanism	Description
Immature and pathological	Acting out	Unhealthy behavioral responses to an intolerable wish that bring partial relief
	Denial	Reality is not accepted as it is too painful
	Projection	Attributing unacceptable thoughts or feelings to someone or something else
	Projective identification	An individual's projections exert interpersonal pressure which induces the other person to unconsciously identify with what has been projected
	Splitting	Others are experienced as "all good" or "all bad" and ambivalence is not tolerated.
Neurotic	Regression	Reverting to an earlier, less mature way of managing conflicted feelings and stress
	Repression	Burying a painful feeling or thought from awareness, though it may resurface in symbolic form
	Isolation of affect	Detaching the affect from an unpleasant thought or behavior
	Displacement	Channeling a feeling or thought from its actual source to something or someone that is more acceptable
	Reaction formation	Adopting beliefs, attitudes, and feelings that are contrary to an unacceptable wish
	Rationalization	Justifying unacceptable behaviors and motivations by "good" and acceptable rational explanations
Mature	Altruism	Placing the needs of others before the needs of oneself
	Humor	An unpleasant thought or experience is viewed as comedic to buffer the unpleasant affect
	Sublimation	Redirecting unacceptable, instinctual drives into healthy and socially acceptable channels
	Suppression	The act of consciously setting aside and controlling unacceptable thoughts or feelings

(Table 2.2). More recently, these defense mechanisms have been categorized dichotomously into mature and immature based on the degree to which they are considered pathologic.

Having briefly discussed Freud's psychoanalytic models and related ego-psychological models, which will be of practical relevance to the psychiatrist working with difficult consultations, we will now discuss three important concepts: *introjection*, *transference*, *countertransference*. These concepts subtend classical psychodynamic and contemporary psychodynamic theories and are central to approaching the consultation with complex psychiatric patients.

Introjection

Vignette: Healthy Introjection

A sibling with parental healthy introjections reassures her hospitalized brother, who is receiving treatment for newly diagnosed diabetes, stating, “Everything will be ok. I will help you feel better.”

Vignette: Unhealthy Introjection

An adolescent patient with cystic fibrosis refuses to complete respiratory treatments and accuses the treatment-team members of being “mean and stupid like my parents.” Her reaction is based on unhealthy introjected parents, confirmed as the parents do not provide emotional support during the adolescent’s hospital stay and yell that, if she does not improve, it is her fault.

Introjection refers to the internalization of psychological characteristics that a child attributes to caregiving, parental figures, yet that are filtered by the child’s internal wishes and needs (Delgado and Songer 2009). As an example, introjection of positive early childhood experiences is evinced when psychologically healthy children and adults who experience an acute medical problem (see vignette) allow for an also healthy loved one to reassure them, providing in an empathic manner their support to continue with the medical course recommended by the treatment team. On the flip side, when the patient has been a victim of neglect or abuse, they may unconsciously be loyal to the introjection of bad-object (negative experience) representations and, unable to psychologically access a healthier internal experience to interpret the situations, are likely to recreate/repeat early experiences in which they were criticized for “being bad.” In the clinical setting, this individual is inclined to believe that members of a treatment team dislike him or her, particularly when the team attempts to set limits on the use of medications for pain or the number of visitors allowed. Further, these patients frequently see the treatment team as inflicting pain, which sets the stage for a pattern of refusing treatment recommendations and of misinterpreting good intentions.

Transference

Vignette: Transference

A patient with history of being passive and dependent, who was raised by critical and demanding parents whom he feared, is unable to make crucial decisions to continue with the treatment recommendations. The patient feels pressured by the requests of the treatment-team members for decisions by him or her, and the perception of their authority leads to passivity and indecision in spite of efforts to reassure the patient of the likely good outcome from the treatment.

For much of the twentieth century, Sigmund Freud's process of transference, considered central to psychoanalysis and psychodynamic psychotherapy, was felt to be a critical element for psychotherapeutic change to occur. In short, the phenomenon involves the transferring of early, unresolved wishes and feelings toward parents or caregivers onto the therapist or another who has attributes that remind the patient of these early unconscious experiences. By remembering and repeating with the therapist these unhealthy patterns, the patient's conflicts are "worked through" in the psychotherapeutic process (Freud 1914). Upon experiencing improvement in the symptoms that brought him or her to treatment, the patient starts making more mature life choices. Through the "interpretation" of transference, the individual's previously unconscious conflicts and maladaptive experiences are brought to consciousness, resulting in the patient developing insight and improving symptomatically. Currently, an understanding of transference is helpful for the psychiatric consultant in assessing the back-and-forth interactions between patients and treatment-team members during difficult psychiatric consultations.

Countertransference

Vignette: Countertransference

A 40-year-old man hospitalized with asthma responds in an angry manner to his physician at the need to take maintenance medication for his condition. The physician has a history of difficulties with conflict when working with patients, as these current experiences resonate with past discord with siblings. The physician begins to round in the early morning, when the patient has just awoken, to limit interaction and avoid conflict. Thus his countertransference is being acted out.

Countertransference occurs when the therapist unwittingly participates in the patient's transference. His or her unconscious reactions to the patient guide the therapist's responses, which are rooted in the therapist's own unresolved

intrapsychic conflicts evoked by the patient. The issue of countertransference has direct relevance to the psychiatric consultant and has been well described in the extant literature. In his classic paper “Taking care of the hateful patient,” Groves notes, “admitted or not, the fact remains that a few patients kindle aversion, fear, despair or even downright malice in their doctors” (Groves 1978). Groves believes that the negative feelings some physicians have for hateful patients are the result of countertransference. If the physician’s actions are influenced by these negative reactions, a countertransference enactment ensues by which the physician gratifies the transference wishes of the patient. In such cases, the clinician may find that recognizing his or her countertransference reactions will help to avoid many clinical pitfalls, as discussed in Chap. 5.

Object Relations Theory

From the 1940s to the 1960s, psychoanalytic theorists increasingly recognized the importance of the patient’s early interactions with parents and caregivers, given that these developmental experiences were crucial to the formation of the individual’s ego. As a result, in the 1940s a natural transition from *ego psychology* to *object-relations theory* evolved. Melanie Klein (1882–1960), a student of Freud, is thought to be the first object-relations theorist, noting that object relations were at the center of a person’s emotional life (Klein 1932). Object relations refers to the capacity to have a stable and rewarding relationships based on the internalization (a process closely related to introjection as described above) of the early childhood representations of others in the form of “objects.” However, internalization of these objects is not a mere imitation. Filtered by the child’s wishes and needs (Delgado and Songer 2009), these objects are attributed an individualized significance. The variability in what an infant innately happens to internalize from his or her parents as “objects” supported later psychodynamic theories that incorporated temperament and attachment styles into what has recently been termed “intersubjectivity.” Clinically, this concept—intersubjectivity—has been defined as “the capacity to share, know, understand, empathize with, feel, participate in, resonate with, enter into the lived subjective experience of another” and “interpreting overt behaviors such as posture, tone of voice, speech rhythm and facial expression, as well as verbal content . . . which assumes that [the therapist] can come to share, know, and feel what is in the mind of the patient and the sense of what the patient is experiencing” (Stern 2004).

Melanie Klein posits that the infant, as part of a normative developmental phase, from 0 to 4 months of age, possesses a primitive fear. During this period, which Klein refers to as the *paranoid position*, internalized representations of caregivers are experienced as part objects that are split into “good” and “bad” objects (e.g., the loving mother, nurturing mother, and the depriving mother). In the early stages, the child maintains the self and object split to avoid the distress in recognizing that there are aggressive and depriving aspects of the self as well as the other. Then, from 4 to 12 months of age, the child learns to integrate and tolerate that a person

has both “good” and “bad” parts and enters a healthy phase that Klein describes as *the depressive position* (Klein 1932). Having psychologically achieved the depressive position, the child proceeds to develop a capacity of concern for others and guilt about one’s actions and thoughts about others, with desire for reparation (Winnicott 1965). Klein believed that individuals who are unable to work through the depressive position in their childhood continue to struggle to relate to others in adult life. More recently, the contemporary object relations theorist and psychoanalyst Otto Kernberg, MD (1928–), has suggested that when the patient’s internal representation of others remains “split,” they primarily use low-level defense mechanisms including splitting, projection, and projective identification (Kernberg 1976). According to Kernberg, these patients were best understood as exhibiting a borderline level of organization, with poor capacity for affect regulation, and are prone to impulsive actions, including suicide (Kernberg 2000). Those with borderline-level organization have tumultuous relationships with others, unconsciously experiencing them as “bad objects” that evoke early internalized frightening and chaotic experiences, usually at the hands of a critical parent or caregiver. They often display maladaptive defense mechanisms—splitting, projection and projective identification, and these are commonly linked to patients with longstanding patterns of difficult/feisty temperaments, poor cognitive and affective flexibility (see Chap. 3), and insecure attachment styles (described below). In turn, these patients are unable to navigate the back-and-forth complex adjustments to different affective states of the other. Further, they have a limited capacity to have genuine concern for others and little or no guilt about their thoughts and interactions with them.

It would be beyond the scope of this book to provide a full description of all the object-relation processes of individuals with character pathology. We focus instead on the theory’s most relevant clinical contributions in working with difficult psychiatric consultations. To this end, we define splitting, projection and projective identification.

Projection

Projection refers to the ego defense mechanism whereby an individual reduces the anxiety in recognizing some of his or her own negative attributes, desires, and emotions by unconsciously ascribing them onto another person (Akhtar 2009). At first glance, the process may seem much like Freud’s transference. However, projection occurs when a person projects his or her own state of mind onto a new object (e.g., therapist or treatment-team member), whereas in transference the past parental experiences are being repeated with the therapist or treatment-team member standing in for the parental object.

Projective Identification

Projective identification involves two components: (1) projection as described above, in which the person blames the other by projecting onto him or her the individual’s own unconscious object representations of the self, which they cannot tolerate as being their own, and (2) the negative reactions by the “recipient” of the

person's projections which "exerts interpersonal pressure that nudges the other person to. . .[unconsciously identify with that which has been projected]" (Gabbard 2010). Importantly, though the recipient's behaviors are generally not considered "in character" but rather are a reaction to the feelings that belong to the person projecting, these very reactions, inability to contain and tolerate the affective states evoked by the projections, he or she will identify with the projections and uncharacteristic negative behaviors ensue. Sadly they confirm what the patient believed to be the case all along. An example in a clinical setting: a physician who is well-liked has a pleasant temperament and is generally able to connect with others, attends a family meeting, and is accused by the patient's family of not treating the patient or family fairly and of dismissing their feelings. Initially, the physician recognizes this is not the case and, with compassion, attempts to explain to the patient and family that they are being treated fairly and that their feelings are important to him and to his treatment team. Yet the physician's explanation infuriates the patient and his family, who feel that their experience is being further rejected. They continue with the projections, and at some point, without being consciously aware; the treating physician incorporates the projected attributes and begins to react in an uncharacteristic way. He becomes overly firm, insisting on strict boundaries and defending himself and his treatment team. In short, the physician has now manifested what the patient and family accused him of; he is dismissive and treats them in a harsh manner. It is common for a person caught up in identifying with a patient's projections to end meetings abruptly and later ask the team, "What just happened?" Typically team members say, "The patient got under your skin. It's not like you."

As with many psychodynamic or psychoanalytic theoretical concepts, projective identification and countertransference remain subjects of controversy. Certainly, both represent the reactions of the healthcare provider when he or she is the recipient of a displaced conflict or projections from a patient, and they may share other psychological facets as well. As American psychiatrist and psychoanalyst Glen Gabbard (1949–) notes, "the similarities between projective identification as used in contemporary psychoanalytic writing, role-responsiveness, and countertransference enactment have been observed by a number of authors" (Gabbard and Wilkinson 1994). For many, the difference between the two related concepts derives from the theoretical school that spawned them. The classic drive-theory school positions countertransference in relation to the unconscious conflicts with early objects, conflicts that are repeated when the patient transfers/displaces past experiences onto the recipient. In the school of object relations, projective identification is a primitive phenomenon in which the patient psychologically forces the disavowed bad self-object onto a recipient who unconsciously returns the foreign bad self-object back to the patient as if the recipient had owned it. Some contemporary authors believe these two mechanisms are, for practical purposes, one and the same (Renik 2004).

Splitting

The phenomenon commonly referred to as "splitting" is categorized, in the hierarchy of defense mechanisms, as pathological. There are some difficulties in defining and understanding splitting when the origin of this concept is studied. There is

splitting of the ego, which Freud described in his early work (Freud 1938), although the predominant view is Klein's splitting of the self as a part of the developmental stage in infants. Splitting, therefore, is a metapsychological concept with many interpretations in object-relations theory. Put simply, we define splitting as the inability to hold in mind that the person in a relationship is a whole entity with both positive and negative attributes. When it becomes unconsciously intolerable for a patient to accept that the person he or she experiences as depriving or abusive also has positive characteristics, splitting occurs. In order to modulate his or her inability to integrate and view himself and others as a whole objects with strengths and weakness, the patient resorts to the use of primitive ego defense mechanisms and, like the infant, "splits their self and other object representation into good and bad, self and other objects" (Delgado and Songer 2009). This process prevents any form of closeness, as the relationship is now distorted and no longer bound by reality.

An example of splitting is when a patient experiences a physician as being the best they have ever met and several days later, following a perceived transgression (being late to bedside rounds, encountering a treatment complication, etc.), sees the same physician as inattentive to his or her needs. In such cases, the patient is unable to reconcile the situation and thus unable to forgive the physician for his transgression (Horwitz 2005). The patient experiences the physician as becoming identical to his or her unconsciously held bad object and, as such, the patient may escalate his or her negative behavior, impeding psychological proximity for fear of retaliation. Unfortunately, the term splitting in the colloquial sense is commonly misused by psychiatrists, physicians, and other healthcare providers to describe situations in which patients are pleasant with one physician and angry or belligerent toward another. Although this occurs often in hospital settings, which we will discuss throughout this book, this is actually a process of projection, as described earlier, rather than splitting.

Let us clarify this distinction by way of everyday examples. We often see sports fans boasting that their team is the best (in other words, the team is "all good"), and this sense may be accentuated if the fan has a particular personal connection to the team (e.g., if they have a child or friend playing on it). In this example, the opposing team is disliked and thought of as "bad." We see here all of the elements of *projection*: idealized positive aspects of the self are projected onto the home-team players, and negative aspects of the self are projected onto the opposing team. We now use a similar example to illustrate *splitting*. Say during the sports event, a fan notices his or her team-making mistakes. The fan experiences the mistakes as personal and begins to distort the situation, believing the coaches should be listening to what he or she has been yelling regarding plays. He feels frustrated when the plays he's calling are not adopted and is suddenly unable to view the matter realistically. Moreover, the fan may be unable to see that the opposing team, at that time, is actually playing better. Thus, the home team is now viewed as a depriving the fan, in not giving the fan the win he deserves, and is therefore not worthy of the fan's support. In this instance, it is necessary for the fan, who is splitting, to have history of employing primitive defense mechanisms with

projections of the depriving early parental objects, without being able to experience healthy ambivalence about others. This type of fan—as we often see in the news media—is prone to acting out against the players and coaches, may yell obscenities, throw objects, and unfortunately at times resort to violence. In contrast, the “healthy” fan who is upset if their team plays poorly does not experience the loss as personal and merely hopes for a better game next time. This healthy fan has the capacity to hold in mind that teams normally have good and bad games, and he or she is able to integrate the team as a “whole object.”

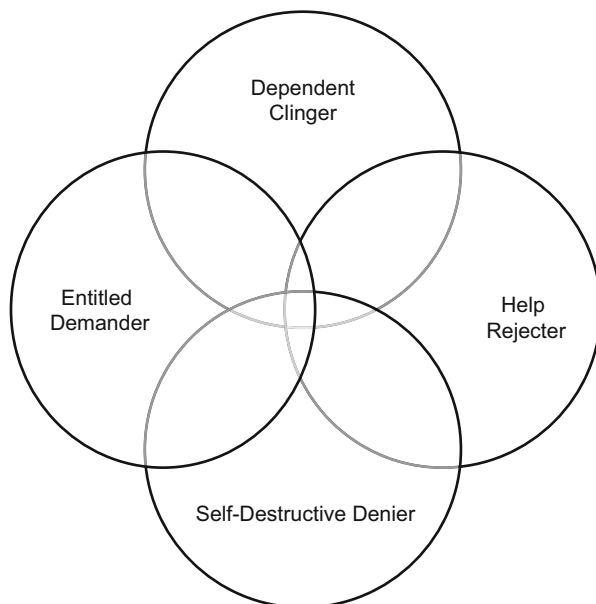
A similar everyday example, likely more familiar to those who have treated patients with psychodynamic psychotherapy, is when a person develops a crush on a friend at a social event. First, the person excitedly admires the positive attributes of the friend—polite, funny, and serious about succeeding in their career. When the feelings of excitement influence their perception of the friend, the person begins to project internal good-object representations. The projections are made with the idyllic hope/belief that the friend will have attributes similar to their own—love the same type of music, social causes, food, etc.—thus, the belief is that the friend seems to have the makings of a soul mate. This is typical of the early phase of romantic friendships, which are influenced by both the real attributes of the people involved as well as the hoped-for attributes, which are projected. Weeks later, the person, who also loves pets, finds that the possible soul mate actually strongly dislikes all pets. If the person is psychologically healthy and not prone to splitting, he or she will recognize that, as a whole, their friend is not perfect and the positive qualities of altruism and humor outweigh their flaw in the lack of interest for pets, which will be negotiated over time. When the person is prone to such primitive defense mechanisms as splitting, the discovery that the friend dislikes pets results in sudden anger, and he or she may state, “I knew it couldn’t be true, and you are a stupid jerk. If you don’t like pets, you don’t know anything about love.” They feel personally rejected and proceed to end the relationship. They have been unable to hold in mind their friend as a “whole object” with good and bad characteristics.

While we have attempted to introduce the reader to the nuances of splitting and projection, we recognize that, at times, splitting is a very complex intrapsychic process. While a full discussion of its subtleties is beyond the scope of this book, we refer the reader to several important and detailed descriptions of this concept by many object-relations theorists (i.e., Otto Kernberg 2000; James Masterson 2005; Donald Rinsley 1982).

Self Psychology

Like Freud, the American psychoanalyst Heinz Kohut (1913–1981) based his theory of self-psychology on inferences made during the treatment of adult patients. He hypothesized that narcissistic disorders of the self were due to childhood parental empathic failures (Kohut 1971). Kohut proposed that there were healthy and unhealthy forms of narcissism, in contrast to Freud, who considered narcissism a pathological investment of the ego by the sexual drive (Freud 1920). Kohut believed that treating disorders of the self, required a therapeutic empathic

Fig. 2.3 Common personality types of difficult patients according to Groves (1978)



reparation by the analyst of the patient's maladaptive (idealizing, mirroring, and twinship "self-object") functions. "Empathic failure" is the term used to describe a situation in which a patient feels misunderstood by the therapist, as is seen in the case of Jason in Chap. 3 (McLean 2007).

Personality Types

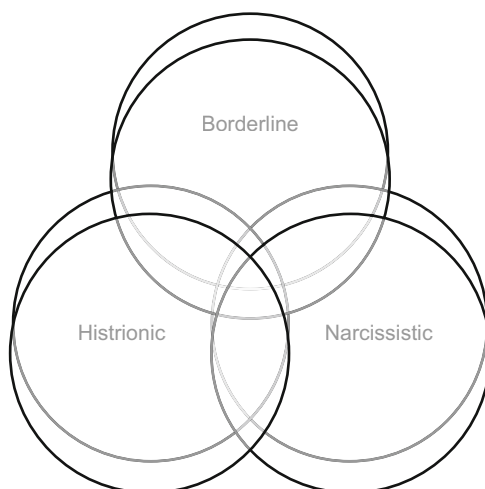
In two controversial papers, Groves (1978) and Strous et al. (2006) posit that the "difficult" and/or "hateful patients" encountered in medical centers may be categorized into four personality subtypes: (1) dependent clingers, (2) entitled demanders, (3) manipulative help-rejecters, and (4) self-destructive deniers (Fig. 2.3). They further suggest interventions for the physician in helping the patients in each of the four categories, to mitigate negative countertransference reactions. Strous et al. conclude "understanding of this "hateful" patient will lead to improved physician well-being and satisfaction, less self-destructive patient behavior, improved treatment compliance, and a lower risk of litigation." These personality types derive from observable traits to the general physician and do not represent the classification of personality disorders described in the *Diagnostic and Statistical Manual of Mental Disorders* 5th Edition (American Psychiatric Association 2013), where the traits must be part of enduring patterns that emerge under a wide range of situations and not only in the hospital setting. Using the concept of personality types may help the consulting psychiatrist to discuss with the treatment team patterns of behavior and thinking of patients who fit one of the above categories.

Personality Disorders

The psychiatric consultant is best prepared when understanding personality disorders and personality patterns mitigating the negative effects in difficult psychiatric consultations. It has been estimated that 20 % of patients seen by a psychiatric consultant have a personality disorder (Laugharne 2013). A patient with a personality disorder typically has difficulties providing a reliable and accurate timeline in terms of the symptom presentation.

In the *Diagnostic and Statistical Manual of Mental Disorders 4th Edition, Text-Revision (DSM-IV-TR*, American Psychiatric Association 2000), personality disorders were included in Axis II of the multiaxial diagnostic approach. Additionally, personality disorders are described as having “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (American Psychiatric Association 2000). In the *DSM-IV-TR*, ten personality disorders are outlined and categorized in three clusters: A, B, and C. In consultation psychiatry, we have found that patients with three personality disorders from cluster B (borderline personality disorder, histrionic personality disorder, and narcissistic personality disorder) are the most difficult for treatment teams to understand and to engage effectively. Despite the challenges of working with those who exhibit a personality disorder, however, it is important to recognize that these patients may also have brief periods of lucidity and tempered social engagement, seen when they interact with certain persons (e.g., individuals in distress, those who are experiencing vulnerability). A patient with a predominant personality disorder may also evince characteristics of the other personality disorders types (Fig. 2.4) or may have an amalgam of several types of each personality. We should note that in the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5* 2013) personality disorders are captured in the same categorical model and criteria for the ten personality disorders included in *DSM-IV-TR*, although there was a removal of the multiaxial system and the documentation of diagnosis is in a non-axial format, combining the former Axes I, II, and III with what have often been considered primary disorders (e.g., major depressive disorder, generalized anxiety disorder, etc.). Though it is too early to know what the implications of this change are on the level of diagnosis and treatment, the psychiatric consultant is nevertheless best prepared when understanding the personality disorders and patterns that can be helpful in mitigating negative effects during consultations.

Fig. 2.4 Overlap between “normal” and “disordered” personality patterns. Importantly, there are shared features, common internal experiences, and common patterns of relating among the “classic” personality disorders, wherein even the “borderline” patient may occasionally struggle with “narcissistic” or “histrionic” difficulties and may also—at times—relate in a more “normal” manner



Mentalization

Vignette: Mentalization

A 2 1/2 year old girl is playing a simple board game and attempts to win by jumping several spaces ahead. She sheepishly looks at her mother to see if this has been noticed. Her mother returns a “hmmm” disapproving look. The child infers her mother’s intent, desire and feelings and begins to laugh as she retraces the path of her game character on the board and says “Oh dear,” indicating her awareness that this was “not right.”

Contemporary theorists believe that the central problem of patients with personality disorders is their difficulty with the ability to mentalize (Allen et al. 2008). This process involves the ability to interpret behavior as meaningful and as based on the mental states and psychological makeup of both the self and others, such as desires, needs, beliefs, reasons, and feelings. Some have said this is akin to “holding mind in mind” (Allen et al. 2008). It is accepted that persons with a history of being securely attached have good mentalizing abilities, while a person who grew insecurely attached has difficulty mentalizing and makes use of maladaptive defense mechanisms. Mentalization-based treatment (MBT) is becoming widely recognized as helpful for patients with personality disorders in both adolescents (Rossouw and Fonagy 2012) and adults (Bateman and Fonagy 2008, 2009). Yet the idea of a mentalization-focused treatment is “the least novel therapeutic approach imaginable, simply because it revolves around a fundamental human capacity—indeed, the capacity that makes us human” (Allen and Fonagy 2006).

2.2 Relational Theories: Two-Person Psychology

Although the work by two-person theorists or “relationalists” has been frowned upon by some, it has served to provide clarity about the application of attachment-theory tenets in psychotherapy and psychoanalysis. We find that these principles are very useful for our day-to-day clinical work in the hospital setting, especially in navigating impasses in complex psychiatric cases. Below we will provide brief reviews of the relevant concepts from each theory followed by examples in which they are utilized in difficult psychiatric consultations. We will again cherry pick the main concepts of contemporary theories to give the reader a basic understanding of their importance and applicability.

Attachment Theory

John Bowlby (1907–1990), a British psychiatrist and psychoanalyst, is best known for his contributions to our understanding of the process of attachment. As such, he is considered the “father of attachment theory”—though Bowlby may have preferred to be known as the “the primary caregiver of attachment theory,” which would reflect his belief that an infant needs to develop a relationship with at least one primary caregiver, regardless of gender, for healthy psychological development to occur. Bowlby departed from traditional psychoanalytic school of thought when he discovered through his work that infants have an evolutionary, innate wish for close, shared experiences with their primary caregivers for survival, growth, and development (Bowlby 1999). He felt this urge was biologically rooted and divorced from Freud’s drive theory, which placed emphasis on sexuality and aggression as innate drives (Freud 1916-1917). Bowlby notes that early in life, the infant creates attachment behavioral systems that help it assess whether its caregiver is available not only physically but emotionally. He further suggests that the quality of the attachment between the infant and the parent or primary caregiver is a powerful predictor of a child’s later social and emotional facility (Benoit 2004). The caregiver strongly influences how the infant develops the capacity for emotional regulation of their feelings, creating an “internal working model of social relationships” that serves as a template when relating to others (Bowlby 1999). Attachment theory subsequently provided a longitudinal view on how early dyadic relationships, with mother or primary caregivers, shape the quality of emotional relationships the child has with others throughout its lifespan.

During the 1960s and 1970s, developmental psychologist Mary Ainsworth (1913–1999), influenced by her communication with John Bowlby, began to experimentally evaluate his basic formulations through studies of infant–parent pairs in Scotland and Uganda (Ainsworth et al. 1978). Her work led to the foundation of different descriptions of patterns of attachment between infants and caregivers based on observable traits of the mother and the infant during times of separation and reunification: (1) secure attachment, (2) avoidant attachment, and (3) anxious attachment (Ainsworth et al. 1978). Ainsworth’s work was later expanded by Mary Main (1943–), a researcher who introduced the concept of “disorganized attachment,” which was instrumental in understanding the experiences of children

exposed to chaotic and unpredictable environments had and their tendency to seek the same type of interactions (Main 2000).

Attachment Styles

The four attachment styles described above warrant further discussion, given the central role they play in determining the patient's ability to interact with the treatment team and with regard to the ways they can be used to guide the interventions the psychiatric consultant may chose, as discussed later in this book (Table 2.3).

Secure Attachment

The first type of attachment, secure attachment, occurs when the infant is cared for by a person who provides a sense of safety and reciprocity. The caregiver also exhibits empathic attunement and helps the infant handle normal periods of distress with actions such as holding, soothing with touch, rocking rhythmically, or singing with a melodic voice. The child develops with a coherent discourse over time, values attachments whether pleasant or temporarily unpleasant, and is able to provide others a sense of reciprocity.

Ambivalent Attachment (Anxious)

The ambivalent type of attachment occurs when the infant feels anxious because the caregiver's availability is unpredictable and inconsistent. The infant develops patterns of relationships based on superficiality. The ambivalent infant grows to be a child and adult that wishes for closeness with others, but often fails to convey a sense of reciprocity and as a result is frequently rejected, repeating the original pattern established with caregiver.

Avoidant Attachment (Dismissive)

The avoidant type of attachment occurs when the infant is in constant fear due to the unpredictability of the quality of the relationship with the caregiver and cannot develop a stable internal working model of social relationships (Bowlby 1999). As the infant grows, he or she shows a tendency toward passivity and avoids the expression of affect with others to prevent feelings of rejection and to protect against the hurt of being ignored. The avoidant infant as a child and adult develops patterns of self-sufficiency and independence and consequently has difficulties with closeness.

Disorganized Attachment

Disorganized attachment occurs when the infant experiences caregivers lack of coherent attachment patterns and relate with a poor sense of reciprocity. There is common history of abandonment or trauma in these children, who grow to be frightened of commitment and have significant vulnerabilities that prevent them from sustaining stable relationships, causing a repeating cycle of their incoherent life discourse. As adults they are prone to trauma and dissociative experiences. Some believe this an early precursor of borderline personality disorders.

Table 2.3 Attachment patterns in children and their caregivers' responses

Attachment pattern	Child's behaviors	Caregiver behaviors
<i>Secure</i>	<ul style="list-style-type: none">• Uses caregiver as a secure base for exploration.• Protests caregiver's departure and seeks proximity and is comforted on return, returning to exploration.• May be comforted by a stranger, although shows clear preference for the caregiver.	<ul style="list-style-type: none">• Responds appropriately, promptly and consistently to child's needs.• Caregiver has successfully formed a secure parental attachment bond to the child.
<i>Ambivalent(anxious)</i>	<ul style="list-style-type: none">• Unable to use caregiver as a secure base.• Distressed on separation with ambivalence, anger, and on return of caregiver, has reluctance to warm and return to play.• Preoccupied with caregiver's availability, seeking contact but resisting angrily when it is achieved.• Not easily calmed by stranger. In this relationship, the child feels anxious as the caregiver's availability has not been consistent.	<ul style="list-style-type: none">• Inconsistent between appropriate and anxious responses.• Generally will only respond after increased attachment behavior from the infant.• Caregiver is reluctant to warm and return to play with child.
<i>Avoidant (dismissive)</i>	<ul style="list-style-type: none">• During play there is little affective sharing.• Little or no distress on departure, little or no visible response to return, ignoring or turning away with no effort to maintain contact if picked up.• Treats the stranger similarly to the caregiver.• The child behaves in a rebellious manner and grows to have a lower self-image and self-esteem.	<ul style="list-style-type: none">• During play there is little affective sharing• Little or no response to distressed child.• Discourages crying and encourages independence.
<i>Disorganized</i>	<ul style="list-style-type: none">• Stereotypes on return such as freezing or rocking.• Lack of coherent attachment strategy shown by contradictory, disoriented behaviors such as approaching but with the back turned.	<ul style="list-style-type: none">• Frightened or frightening behavior, intrusiveness, withdrawal, negativity, role confusion, affective communication errors and at times maltreatment.

Summary regarding patterns infants have in strange situation and corresponding patterns of Adult Attachment classification
Descriptions are adapted from Main et al. (1985), Main and Goldwyn (1984, 1998), Ainsworth et al. (1978) and Main and Solomon (1990)

Attachment Theory Across Lifespan

Attachment theory has contributed to the understanding of how early childhood experiences contribute to, not just child attachment patterns, but to attachment patterns of adults across their life spans. Shaver and Hazan (1988) eloquently describe the connection between early attachment patterns and characteristics of later romantic relationships. These studies suggest that adults who describe themselves as having secure, avoidant, or ambivalent styles of attachment in their current relationships had similar patterns as children in their families of origin. Moreover, attachment research has recently broadened its focus; these approaches are now being used to inform novel psychotherapeutic treatments and to enhance our understanding of interpersonal dynamics in marital relationships, among middle-aged adults and among the elderly (Cicirelli 1991, 1998; Weiss 1982, 1991).

For Parkes et al. (1991), the scope is broader yet. According to him, a healthy society depends on factors that (1) minimize disruptive events, (2) protect each child's attachment experience with caregivers from harm, and (3) support families in coping with obstacles in their lives. In addition, Parkes emphasizes the importance of social context on the growth of the infant and suggests that safeguarding the infant's dyadic relationships can have further implications in public health: "valuing of attachment relations thus has public policy and moral implications for society, not just psychological implications for attachment dyads" (Bretherton 1992).

Attachment Theory in the Medical Setting

Having described how the bidirectional attachment process involving the infant or child and the caregiver sets the stage for "lifelong patterns of stress-response, receptivity to social support and vulnerability to illness" (Maunder and Hunter 2001), we turn our attention to its role in the difficult psychiatric consultation. Patients in the medical setting with a history of secure attachment will have a sense of safety about the services provided by their treatment team (Sullivan et al. 2009), whereas those with insecure attachment styles will exhibit mistrust toward the treatment team and may be hesitant to follow its recommendations. Encountering this mistrust, team members may in turn engage in negative interactions with the patient based on their counter-transference reactions (Miller and Katz 1989). Understanding attachment theory can help the psychiatric consultant in this setting address the behaviors of all parties involved. And by providing the treatment-team members with a useful framework for assessment—giving them the understanding that the quality of the patient's early attachment has established patterns that will be repeated in their encounters with medical providers—the clinician and the team can more ably effect the patient's adherence to treatment (Hooper et al. 2011). Hooper et al further add that "Attachment theory may provide a blueprint for attachment-based practice in the context of medical settings. This blueprint or guide can help physicians better understand and respond to the ways in which patients' presenting

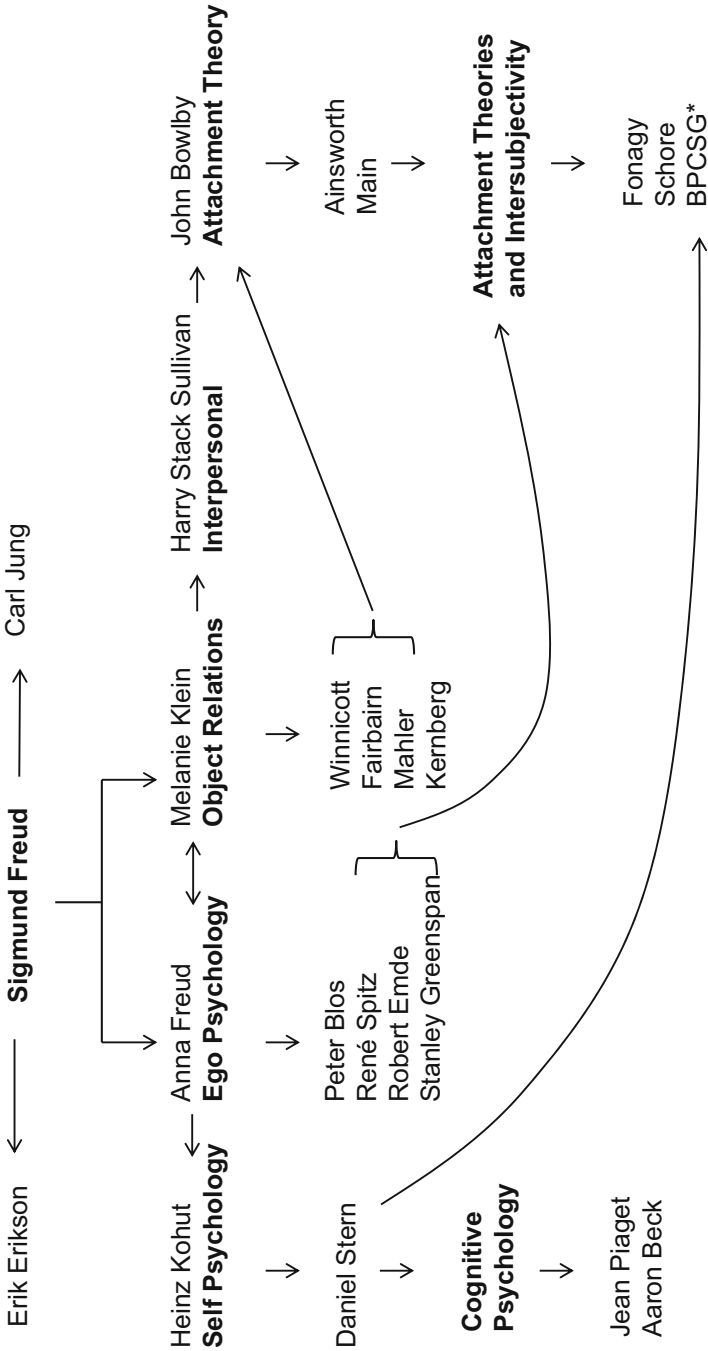
symptomatology are described and discussed, and the manner in which patients form relationships and interact with other significant persons, including healthcare providers (e.g., primary care physicians, nurses, psychologists, psychiatrists)” (2011).

2.3 Social Referencing, Affective Attunement, and Intersubjectivity

In recent years, neurodevelopmentally informed research has extended the works by Bowlby, Ainsworth, and Main and has helped to refine our understanding of how internal working models are formed. It is now recognized that there are significant underpinning neurobiological factors influencing the quality of attachment between the child and caregiver. In fact, given the recent advances, particularly regarding the importance of neurophysiology and neurocircuitry to these processes, we see Sigmund Freud’s dreams beginning to be realized. In Freud’s early writings, he expressed eagerness for the day when his psychoanalytic concepts could be understood through biological process. Miller and Katz (1989) state “Freud’s eventual theories of psychoanalysis rested on his insistence on a topographical approach to the unconscious that was derived from the structural concepts he borrowed from neurology. He thus formed the foundations for his later theories of psychoanalysis when he studied hysteria as a neurologist.”

The Shift from One-Person to Two-Person Psychology

Earlier in this chapter we laid the groundwork for distinguishing between one- and two-person psychologies. In the former, symptomatic improvement occurs through remembering the conflicted past parental relationships with the use of free associations, which involve repeating early neurotic maladaptive patterns with the analyst through transference. Once a transference neurosis is apprehended [with help from the analyst’s interpretations to make the unconscious conscious: “where id is, there shall ego be” (Freud 1920)], the patient can work through it. During the early 1990s, traditional theorists struggled to openly embrace the emerging theoretical formulations of a two-person psychology. In the psychoanalytic world of the time, two-person psychology was negatively perceived and believed to be a form of “wild analysis” (Schafer 1985). The idea of a two-person, relationally based psychoanalysis and psychotherapy shook the foundations of traditional psychoanalytic theory in positing that the patient’s healing would come about with the active presence of the “real person” in the analyst or therapist, who would cocreate a new “corrective emotional experience” (Alexander et al. 1946; Hoffman 1992; Mitchell 2003). Alexander et al coined the term *corrective emotional experience* holding that it is the fundamental therapeutic principle of psychotherapy: “to re-expose the patient, under more favorable circumstances, to emotional situations which he could not handle in the past” (Alexander et al. 1946). They added that “intellectual



*The Boston Process and Change Study Group

Fig. 2.5 Lineage of psychodynamic theories and theorists

insight alone is not sufficient,” a sentiment with which most psychotherapists agree. In short, the patient, in order to be helped, must undergo an engineered, participatory emotional experience to repair the traumatic influence of actual past experiences. This idea was initially dismissed from psychoanalytic circles, and it was not until the 1990s that the concept was reintroduced, with two-person psychology theorists recognizing its relevance to psychoanalysis and psychotherapy. Among the leading empirically based psychoanalytic relational theorists over the last 20 years are Stephen Mitchell, Irwin Hoffman, Jessica Benjamin, Lewis Aron, Jay Greenberg, Emmanuel Ghent, Philip Bromberg, Charles Spezzano, Adrienne Harris, Owen Renik, Donnel Stern, Jeremy Holmes, and Paul Wachtel.

The principal neurodevelopmental (and relational) theorists of the past 40 years include René Spitz, Robert Emde, Peter Fonagy, Daniel Stern, and Allan Schore (Fig. 2.5). They all had intimate knowledge of traditional psychoanalytic theories and theoreticians, from which their work derived (Palombo et al. 2012). Among these theorists, René Spitz (1887–1974) was the first to base his research on direct infant observation with video recordings that allowed his research team to carefully analyze the details of interactions and communications between infant and caregiver. Early on, Spitz noted the impact of severe maternal deprivation in the failure-to-thrive syndrome in infants (Spitz 1965). Robert Emde (1935–), a student of Spitz, is known for his infant research studies on social referencing, which the caregiver must provide the infant to promote a sense of security to explore and analyze the world: “the self is a social self to begin with” (Emde 2009). Recapitulating this concept, Emde emphasized the importance of the “we-go,” a play on the “ego” that had dominated one-person psychology for the half-century prior to Emde’s infant studies. The use of his term in the seminal paper “From Ego to ‘We-Go’: Neurobiology and Questions for Psychoanalysis” underscored that from “infancy, innately given brain processes support social reciprocity and the development of “we-ness”” (Emde 2009).

In a parallel, the British psychologist and psychoanalyst Peter Fonagy (1952–) theorized that infants can learn to regulate internal affective states when the caregiver promotes their capacity to “mentalize” (see mentalization, this Chapter). Later, Allan Schore (1943–), a developmental psychologist, began to formulate a regulatory theory that emphasized the role of the experience-dependent emotional-processing neurocircuitry. His work centers on a relational unconscious that becomes active when the infant’s unconscious affective state resonates with the caregiver’s experience-dependent maturation of the emotion-processing system, allowing the infant to develop internal working models of the attachment (Schore 2003, 2009). He further believes that these internal working models are stored in non-declarative memory systems in the right cerebral cortex. Similarly, Daniel Stern (1934–2012) is known for his contributions to the emerging concept of *intersubjectivity*, a psychodynamic term that refers to a person’s capacity to share and participate in the subjective experience of another. Stern et al. liken this phenomenon to “the oxygen we breathe but never see or think of” and emphasizes that the experience of two persons interacting is determined by the here and now,

“present moments” within the intersubjective space cocreated by both, a meeting of the minds that create a mutually shared encounter (Stern et al. 1998).

Intersubjectivity and the Exasperated Family of a Psychiatrically-Hospitalized

Adolescent

A 12-year-old girl, originally from Honduras, was adopted when she was two by midwestern parents who were both professionals and were happy in their marriage. Her adoptive parents had good cognitive flexibility, easy/flexible temperaments (Chap. 3), a good capacity to mentalize, and a history of secure attachment. Their adoptive daughter was the opposite; she had many explosive and aggressive episodes that at times led the parents to hold her down to prevent her from hurting herself or them. They shared their frustration with medical providers, concerned that their daughter did not show “any remorse” after these violent outbursts. The episodes were increasing in frequency and intensity, with minimal improvement in spite of regular outpatient psychiatric services that included individual, family, and pharmacological therapies. Feeling hopeless about her progress and fearing for their well-being, the adoptive parents had begun to consider calling social services for the removal of their adopted daughter from the home. When she was admitted to her third inpatient psychiatric hospitalization, the parents felt validated, stating, “Medications and therapy do not work on her. She is not fixable.” It was immediately apparent to the inpatient psychiatrist, in the first interview, that the child had cognitive deficits as evidenced by her concrete thinking, poor procedural memory, and limited cognitive flexibility in processing emotions. This was confirmed by a full battery of psychological testing. She also presented as having the difficult/feisty temperament style using the criteria set forth by Thomas and Chess (Chap. 3).

Due to her biological mother’s active use of illicit drugs during pregnancy, the child had a history of poor prenatal care. Born at 35 weeks, she spent her first 2 years of life in Honduran foster homes. This clearly had a negative influence in her cognitive, psychological, and social-development milestones. At age 10 she had been diagnosed as having an oppositional defiant disorder, reactive attachment disorder, and generalized anxiety disorder.

During an early treatment-team meeting, after the members had met with the patient and family on several occasions, the team social worker expressed a strong empathy for both the child in her limitations and for the parents in their difficulties parenting her. She also shared that “there is something about the parents I don’t like. They don’t seem to show any empathy toward their daughter when they visit her. They don’t give the child any smiles or hugs, so sad.” Fortunately, before the treatment-team meeting, the attending child psychiatrist had interviewed the girl in her room. Due to her disruptive behavior, she had been sent to her room from the treatment milieu group. Having knowledge of her cognitive deficits and temperamental difficulties, the child psychiatrist tried to engage her by showing interest in her favorite games and music. During the interview, the intersubjective experience the child psychiatrist was co-creating with the patient was very similar to the one the treatment team social worker had described in relation to her parents: “They do not seem to show any empathy.” The patient made no effort to connect with the child psychiatrist, in spite of his attempts to play and draw with markers to

capitalize on her strengths with visual spatial skills. She refused to participate and withdrew into her angry affective state, blaming the unit staff, with no hint of remorse for disrupting the milieu group. The child psychiatrist's subjective experience was that of wanting to be removed from the interaction to avoid having the feelings of hopelessness about the patient's future. He, like the parents, subjectively felt "What is the point in giving her hugs and smiles?" and noted experiencing sadness that the child was not able to relate to him. The intersubjective experience had been co-created though both the child psychiatrist's wishes to "help" the patient and the patient's inability to mentalize the experience as a corrective one. Her internal regulatory system had neurological deficits which left her unaware that her subjective implicit self was that of a primitive child with minimal reciprocity. She was unable to hold in mind the experience of the other person and was bound to seek gratification of her unregulated needs. The child psychiatrist shared with the treatment team his understanding of the interaction and wondered whether his feelings lent insight into the parents': a sense of hopelessness about the future of the child due to her neuro-cognitive deficits, which prevented her from engaging in relationships. The child psychiatrist worked with the nursing staff and psychiatric treatment team to see things from the parents' point of view: 10 years of caring for a difficult child who was unable to provide them with emotional reciprocity and joy. The treatment team agreed and conveyed to the parents that they better grasped their dilemma in caring for their daughter. When the social worker shared in an empathic manner that the treatment team now recognized how they—adoptive parents—must have felt, exhausting themselves by providing affection to a child that had difficulty reciprocating their kindness, the parents, in tears, expressed that they finally felt understood and not blamed.

They openly shared that initially they had felt that the treatment team considered them a bad fit for their child because they did not provide affection to her "in front of the unit staff." They explained that after many years of effort in providing affection to their daughter, they had begun to resent that she was unable to value their love and, still weeping, added, "We now know that it is not her fault. She has neurological deficits."

As this case demonstrates, understanding a person takes more than just listening. The interactions between the patient and members of the treatment team are co-created, shared experience. It is impossible for any person to know in advance how another will relate to them. How the members of a treatment team approach a patient will invariably affect how the patient responds. For example, when treatment-team members approach a patient in a friendly and jovial manner, the patient usually responds similarly. By contrast, if team members approach the patient in a professional and distant manner, the patient will likely feel talked down to, which may evoke implicit memories of early negative experiences, causing the patient to respond in a defensive and distancing manner. This first relational moment will shape the many other moments that are to emerge from their interactions.

Poor social competence that stems from cognitive deficits, temperamental traits, and disorganized attachment schemas will not dissipate with age or educational achievement.

Thus, the psychiatric consultant, like the child psychiatrist described above, will need to keep in mind that his interventions and recommendations will result from the interplay of multiple “subjectivities” that will focus on the “here and now” experiences of all involved parties. In short, intersubjectivity will be forever present in the work with patients, their families, and treatment teams, and the psychiatric consultant, knowingly or unknowingly, will use intersubjectivity in guiding his or her recommendations.

Mentalization and Intersubjectivity: Are They Different?

The reader, at this point, may wonder whether there are differences between mentalization and intersubjectivity. We suggest that mentalization-based theories contain aspects of both one-person and two-person psychologies, whereas intersubjectivity is exclusively a two-person psychology. We recognize that both concepts are “theories of mind,” and both are relational theories. Regarding mentalization, Allen et al. (2008) note, “the concept of mentalizing first emerged in psychoanalysis: Freud implicitly employed the concept of mentalizing in his initial neurobiological theory of the development of the mind.” They later add, “It is no accident that within psychoanalysis, object relations theory has been especially compatible with focusing on mentalizing in treatment.” He further clarifies that mentalizing in clinical practice “might be viewed as equidistant between psychodynamic psychotherapy and cognitive therapy.” By contrast, Wallin (2007) notes that intersubjectivity “is the permeability or ‘interpenetrability’ of personal boundaries that allow us to participate in the subjective experience of other people.” He adds that intersubjectivity may be “seen as a matter not just of communication but . . . ‘interpersonal communion’” (Wallin 2007). The concept of interpersonal communion is best described by Stern: “it is a form of nonmagical mindreading via interpreting overt behaviors such as posture, tone of voice, speech rhythm, and facial expression, as well as verbal content” (Stern 2005). These contemporary controversies are far from over, and we refer the reader to recent reviews that address them (Wachtel 2010). These unique clinical concepts, mentalization, and intersubjectivity will be used when applicable—and not interchangeably—throughout the book when discussing clinical material.

2.4 Summary

In this chapter, we have provided a foundation to better comprehend the importance that innate biological and genetic processes have in forming a patient’s unique core sense of self, as well as their intrapsychic and interpersonal psychological functioning. With a greater grasp of these concepts, the consulting psychiatrist can begin to use the psychodynamic tenets to understand the patient’s personality style and may develop a psychodynamic formulation, regardless of his or her theoretical orientation, to facilitate the implementation of practical treatment interventions in difficult consultations.

Some readers may feel that this chapter is heavy-handed with psychodynamic theory and not attachment theory, while others may consider there is not sufficient emphasis of classic psychodynamic theory and too much on contemporary attachment theory. It is not our aim in this book to provide an in-depth analysis of the similarities and differences between each very useful theory. Rather, we hope to provide an easy way to employ, in a practical sense, each theory as it pertains to the patient, family, and treatment-team members psychodynamically. When the interaction between patient and others is approached in a psychodynamic way, a balanced framework results—a framework that can be easily explored within the short time period that the consulting psychiatrist or child psychiatrist usually has to devote to his or her cases, whether or not they are difficult consultations. For those wanting a more in-depth study of psychodynamic and attachment theories, we provide references for the detailed review of the interested student.

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