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Epilogue and Prologue: Continuing Discussions with Israeli Colleagues

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I am deeply honored and moved to have a volume of the Israel Journal of Psychiatry dedicated to my work. Though I have continued to live in the Diaspora for complicated personal reasons, Israel has always been an important part of my life since early in my adolescence. My attitudes about Israel were shaped during early adolescence watching my maternal grandmother weep each evening as she listened to radio reports of what was happening to Jewish communities throughout Europe shortly before and during World War II, followed later by the exhilaration in the founding of the State of Israel. So as my career developed, I decided, whenever possible, to make professional contributions to colleagues in Israel. Thus, I have been actively involved with Israeli academics and clinicians for many years as a research collaborator and consultant as well as facilitating visits of Israeli scholars to the United States, particularly to Yale University. I have made a number of trips to Israel (13 in all), beginning in 1973, and have lived in Israel for a year in 1988–89 when I was the Freud Professor of Psychoanalysis and the Ayala and Sam Zacks Professor of the History of Art at the Hebrew University of Jerusalem and a senior Fulbright Foundation research fellow. And I most recently returned to Israel for two weeks in May 2006 as a Fulbright Senior Specialist, lecturing and consulting at Bar-Ilan University and the Ben-Gurion University of the Negev. I have lectured at least once at every university in Israel except the Weizmann Institute and collaborated extensively with Israeli colleagues. Some of my major publications, in fact, have been written in collaboration with Israeli colleagues including, in alphabetical order, Avi Besser, Rachel Blass, Omri Cohen, Shmuel Erhlich, Eva Eshkol, Benni Feldman, Ruth Feldman, Irit Felsen, Chaim Gatt, Ilan Harpaz-Rotem, Esther Kalnitzki, Celine Maroudas, Etta Prince-Gibson, Golan Shahar, Shula Shichman, Shmuel Shulman, Sophie Walsh, Hadas Wiseman and Ada Zohar. And based on two extended visits I made to Ben-Gurion University as visiting professor, Beatriz Priel and her students have conducted extensive and creative research derived from my theoretical formulations, using several research procedures that colleagues and I developed here at Yale University. I have also tried to assist Israeli scholars, investigators and clinicians establish professional contacts in the United States as well as world-wide. So Israel and Israeli colleagues have a special place in my heart and mind, both personally and professionally, and thus it is a source of considerable personal satisfaction and pride to be honored by a special edition of the Israel Journal of Psychiatry.

In my theoretical, clinical, and research efforts over the past 40 or more years, I have often felt out of the mainstream in clinical and research matters here in the United States because of the increasing emphasis in clinical psychology on behavioral approaches and on biological and pharmaceutical approaches in psychiatry. For reasons which I do not fully comprehend, a number of Israeli scholars, clinicians and investigators, over many years, have resonated with my contributions. This response of talented and sophisticated Israeli colleagues has been professionally reassuring and has enabled me not to feel like a lone voice in the wilderness. It has been especially meaningful that these colleagues found my contributions of value long before my work began to receive recognition here in the United States. And some of these Israeli colleagues have been gracious and generous of their time, preparing

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papers for this volume. I am deeply indebted to them and to the editors of this volume, Golan Shahar, Ada Zohar and Alan Apter, for their efforts in preparing this volume, and to David Greenberg, the editor of the Israel Journal of Psychiatry, for his support of this effort.

The papers in this volume are broad ranging and address three aspects of my work. Two papers, those by Lilly Dimitrovsky and Ada Zohar, present my basic approach to matters theoretical and clinical. The second set of papers, by Hadas Wiseman and by Beatriz Priel and their respective colleagues, address issues of interpersonal relationships. Hadas Wiseman and colleagues, using the Depressive Experiences Questionnaire (DEQ; 1, 2), investigated the impact of three central personality dimensions: Dependency, Self-Criticism, and Efficacy on interpersonal relationships in young adults. Beatriz Priel and colleagues, using another methodology that colleagues and I developed to assess aspects of interpersonal relatedness, the Object Relations Inventory (ORI; 3) studied mental representations and processes of internalization of interpersonal experiences in children, and the relative contribution of interpersonal and intrapersonal factors in children's construction of a representational world. The third set of papers is directed toward more clinical issues. Israel Orbach addresses factors, including the role of introjective personality dimensions (i.e., Self-critical perfectionism), that contribute to self-destructive tendencies and suicide, and Nirit Soffer and Golan Shahar address the role of patient's pretreatment anaclitic and introjective personality characteristics on treatment outcome in three different studies.

I will address, in turn, these three sets of papers devoted to 1) my basic theoretical and clinical orientation, 2) the study of interpersonal processes and 3) the investigation of personality factors in the clinical process.

Basic Theoretical and Clinical Orientation

I am delighted that Professor Lilly Dimitrovsky contributed to this volume the interview she conducted with me over a decade ago, as part of a series of interviews with individuals she defined as distinguished clinicians from a variety of theoretical orientations. As Lilly notes, the interview was very casual and informal, and it was only with Lilly's comments to this volume that I realized that she had a fixed interview schedule. The meeting with Lilly was spontaneous and free-flowing, and I had no sense that she was following a fixed set series of questions. Rather, I found that Lilly's genuine interest in my thoughts and feelings as a therapist facilitated my communicating fully and openly. Though this interview was conducted over a decade ago, it is an accurate presentation of my current views about the treatment process and the personal meanings and satisfactions I have derived from being a therapist.

The paper by Ada Zohar is a thoughtful rendition of my theoretical position on personality development, psychopathology, and the therapeutic process. I am grateful to Ada for preparing a succinct presentation of my position and for contrasting it with a more medically-oriented psychiatric position of Robert Cloninger. Ada's comparisons helped me become more fully aware that my approach to clinical matters has been a *bottom-up approach* in which I attempt to understand various forms of psychopathology as deviations and disruptions of normal developmental processes. I have found considerable advantage in this approach, as compared to the *top-down approach* so frequent in psychiatry that starts with the identification of a disease and then tries to construct the processes that contribute to these disruptions. There are clear limitations to this after-the-fact, top-down approach of starting with the disease or disorder and trying to understand the processes that contributed to its formation. In contrast, we know a great deal about normal personality development from extensive longitudinal investigations on the unfolding of developmental processes that enables us, from a bottom-up approach, to examine variations in normal developmental processes and how they are expressed in broad differences in personality organization within the normal range, as well as in more profound and extensive deviations that occur in clinical disorders. This approach allows for the identification of continuities among normal development, natural variations in personality organization, and two major configurations of psychopathology (4, 5).

These first two contributions to this volume are clear and comprehensive presentations of my per-

sonal and professional views, attitudes, and philosophy as a clinical psychologist with a psychodynamic and psychoanalytic perspective. The contributions by Dimitrovsky and Zohar express my views that the essence of personality development involves a complex, hierarchically organized, life-long, dialectic interaction of two fundamental developmental processes (6–8) — the development of interpersonal relatedness (what I call the *anaclitic* dimension) and the development of a differentiated, integrated, realistic and essentially positive sense of self (what I call the *introjective* dimension). Mild emphasis on one or the other of these developmental dimensions, define two broad personality types — a differentiation supported by extensive research (see summaries in 5, 9, 10). And many forms of psychopathology are defensive compensations for severe disruptions of this fundamental dialectic developmental process in an intense preoccupation with one of these two developmental dimensions, interpersonal relatedness or self-definition, to the neglect of the development of the other (8). Thus, the contributions by Dimitrovsky and Zohar provide the theoretical basis for the next four papers in this volume, contributions directed toward illustrating research applications of some of those views about personality development, personality organization and psychopathology.

Interpersonal Processes

Hadas Wiseman and her colleagues, Alon Raz and Ruth Sharabany, examine the factors that interfere with the development of long-term romantic relationships in Israeli young adults. In a well designed and carefully controlled study, they found that preoccupation with issues of interpersonal relatedness — dependency (the anaclitic dimension) and with issues of self-definition — self-criticism (the introjective dimension) both contributed, in different ways, to experiences of interpersonal distress. They evaluated the nature of these disruptions of interpersonal relatedness using the Depressive Experiences Questionnaire (DEQ; 1, 2) to measure three central personality dimensions: concerns about interpersonal relatedness (dependency) and self-definition (self-criticism) as well as feelings of efficacy. They also used the Inventory of Interpersonal Problems (IIP; 11) to explore two major dimensions of interpersonal relations: Affiliation and Dominance.

In addition to findings that dependency and self-criticism were related to interpersonal dissatisfaction, they found that high levels of personal efficacy were associated with interpersonal satisfaction and with tendencies toward affiliation and dominance in interpersonal relationships. Furthermore, efficacy moderated the disruptive effects of low levels of investment in interpersonal concerns (dependency) and the disruptive effects of high levels of self-criticism on relationship satisfaction. These findings are consistent with earlier conclusions by Kuperminc and colleagues (12) and Shahar and colleagues (13) about the important moderating effect of efficacy on the impact of dependency and self-criticism on psychological functioning in non-clinical samples. In addition, Wiseman and colleagues found that the tendency toward affiliation in interpersonal relatedness is enhanced by feelings of dependency but reduced by feelings of self-criticism. But again, feelings of efficacy moderated the negative effects of self-criticism on tendencies toward affiliation.

Beatriz Priel and her colleagues (Avi Besser, Ariela Waniel, Michal Yonas-Segal and Gabriel Kuperminc) approached issues of the quality of interpersonal relatedness through an assessment of the content and structural organization of mental representation. They present research findings that support the distinction between the structural organization and the thematic (or qualitative) dimensions of mental representations of self and significant others as well as the assumption that the structural dimensions express the level of basic cognitive organization and that thematic dimensions express more the experiential dimensions of interpersonal experiences (3, 14). Priel and colleagues found that the *Conceptual Level* (3, 14, 15) with which individuals described significant figures was an effective measure of the structural organization of mental representations (cognitive-affective schemas) of self and significant others. In late adolescence and adulthood, the Differentiation-Relatedness scale (16, 17) provides yet another method for assessing structural dimensions of mental representation. This distinction between the structural cognitive organization and the thematic content of mental representations is vital (18). Priel and col-

leagues point out that this distinction facilitates the investigation of the interaction between "rules of organization of interpersonal knowledge" and "actual interpersonal experiences" that contribute to the formation of mental representations or, as colleagues and I (3, 5, 19) have recently noted, between more procedural (implicit) and episodic (explicit) dimensions of interpersonal knowledge. The three studies presented by Priel et al. demonstrate that the structural and thematic dimensions of mental representations or cognitive-affective schemas of self and others (the procedural or implicit and the thematic, episodic or explicit) provide important insight into the role of mental representations in psychological functioning. Priel and her colleagues call for further investigation of factors that contribute to the formation and growth of mental representations in studies of normal development and of the therapeutic process.

Personality Factors in the Clinical Process

Israel Orbach presents an extensive and systematic review of self-destructive processes that result from three major sources: 1) a motivated need or wish, 2) a failure to protect the self, and 3) distorted cognitions and personality traits. Orbach considers suicide potential from this broad theoretical perspective and stresses the importance of life-long self-destructive processes that create experiences of unbearable mental pain that result in suicide as an attempt to escape this intense psychological anguish. In the latter half of his paper, Orbach presents 12 brief, very informative, vignettes of suicidal patients that enable us to elaborate on the personality factors that contribute to suicide. It is impressive that the concerns and preoccupations of 10 of these 12 vignettes are focused around introjective issues of self-worth and self-esteem (e.g., success-failure, guilt). Only two of the 12 patients have concerns and preoccupations that were focused around anaclitic issues of feeling accepted and loved (e.g., neglect, abandonment and loss).

The 10 patients focused on introjective issues are: 1) Dina, a suicidal woman had difficulty completing her dissertation and feelings of guilt; 2) a 20-year-old woman who stressed that she was so bad that she did not deserve to live; 3) a soldier whose failure of an important training course in the army was experienced as only the most recent of a life-long series of failure; 4) a young Israeli adolescent who was frightened of being in the army; 5) a young man who was upset because of his inability to contain his obesity that interfered with his life-long ambition to be a dancer; 6) a young woman tormented by a secret of which she was deeply ashamed; 7) a woman who felt guilty and worthless; 8) a creative and beautiful woman who felt she was disgusting, smelly, dirty, a failure and lazy — that there "is nothing good about me"; 9) an adolescent girl who felt that she was not valued by her parents; and 10) Dora, a 28-year-old high achieving physician who was always fearful of being a failure and a disappointment. The two self-destructive and suicidal patients whose issues seemed more focused around anaclitic issues were: 1) a 35-year-old angry, frustrated, demanding woman who felt deprived of supplies provided by others; and 2) a middle-aged man who felt he never received enough love from his mother and had profound experiences of loss and abandonment with his migration to Israel and when his son became non-observant.

The predominance of introjective issues among the vignettes presented by Orbach is consistent with the research literature on suicidality (e.g., 15, 20–23) that stresses the central role of introjective personality characteristics, especially self-critical perfectionism (e.g., 24), in suicide. The distinction between anaclitic and introjective issues in suicidality is important because it identifies some of the predominant motivational factors in suicide and the issues that are likely to be focal concerns in the treatment process. An important aspect of the vulnerability to suicide of introjective patients is the tendency toward social isolation among introjective patients (9, 21).

Nirit Soffer and Golan Shahar examine the impact of patients' pretreatment personality characteristics on the treatment process in three different treatment studies. Similar to the noting by Orbach of the association of introjective personality characteristics with suicidiality, Soffer and Shahar discuss how these introjective personality characteristics limit patients' response to brief outpatient treatment of depression. They note that introjective personality

characteristics have this negative impact on the treatment process because of the patient's tendency toward social isolation that is expressed in a reduction of involvement in the treatment process (25) and in their social network external to treatment (26). Soffer and Shahar also report on findings from further analyses of data from the Menninger Psychotherapy Research Project (MPRP) that examined the differential response of anaclitic and introjective patients to long-term psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP) and how the emotionally detached, interpersonally isolated introjective patients were responsive primarily to the intensity of the involvement in PSA (27, 28). Soffer and Shahar also reported on the finding (29) that patients with more constructive representations of interpersonal relations, especially introjective patients, made significantly greater therapeutic gain in both PSA and SEP. These findings by Shahar and colleagues are also consistent with findings in the paper in this volume by Priel and colleagues about the value of assessing the content and structure of mental representations. Soffer and Shahar, in addition, stress the importance of the social context on psychological functioning in their summary of findings of a third study that examined the impact of different types of social support networks on patients with severe mental illness. Severely mentally ill patients with high self-esteem did substantially better if their social network involved a healthy person whereas severely mentally ill patients with low self-esteem did significantly better if they met with another patient.

Summary

The findings reported in the third set of papers addressing personality factors in the clinical process (the papers by Orbach and by Soffer and Shahar), consistent with the finding reported in the papers in the second section (papers by Wiseman et al. and Priel et al.), stress the importance of interpersonal relationships in psychological functioning. As Soffer and Shahar note in their comments on the move toward empirically supported treatments in the mental health networks in Israel, it is vital in planning for mental health services to acknowledge that the nature of the patients' pretreatment characteristics and the quality of the therapeutic alliance are among the important factors determining treatment outcome, much more than the type of treatment provided (i.e., medication or two forms of brief, manual directed psychotherapy — Cognitive-behavioral or Interpersonal Psychotherapy). These findings suggest that clinicians must have basic understanding of personality development and organization if they are to provide effective clinical care to a wide range of patients (30). Another commonality among the papers on research on interpersonal processes (papers by Wiseman et al. and by Priel et al.) and those on the clinical process (by Orbach and by Soffer and Shaher) is the emphasis on the centrality of mental representation (or cognitive-affective interpersonal schemas) in psychological development and personality organization. These central psychological processes express both the quality of an individual's past and current interpersonal experiences as well as the level of their cognitive organization and, therefore, they are invaluable in studying normal psychological development and psychological development in the therapeutic process.

In closing, I want to express my deep appreciation for the honor that the Israel Journal of Psychiatry has bestowed on me and to the contributors and editors of this issue demonstrating clearly some of the implications of two configurations model of personality development and psychopathology (6–8) and the value of focusing on the development of interpersonal relatedness and of self-definition as the fundamental developmental processes of this theoretical model (5).

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