

Shrink Rap Radio #376
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**A Psychodynamic Understanding of Personality Structure
with Nancy McWilliams**

David Van Nuys, Ph.D., aka “Dr. Dave” interviews Nancy McWilliams, Ph.D.

Dr. Dave: On today’s show I’ll be speaking with noted psychoanalyst and author Dr. Nancy McWilliams. We’ll be speaking about understanding personality structure and its role in psychoanalytic diagnosis and therapy. Nancy McWilliams, who teaches at the Graduate School of Applied and Professional Psychology at Rutgers, the State University of New Jersey, is author of *Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process* that was published 1994 and revised in 2011. She is also the author of *Psychoanalytic Case Formulation* and *Psychoanalytic Psychotherapy: A Practitioner’s Guide*, and she’s also the associate editor of the *Psychodynamic Diagnostic Manual*.

She’s past president of the Division of Psychoanalysis of the American Psychological Association and is on the editorial board of *Psychoanalytic Psychology*. Recipient of many awards, Dr. McWilliams specializes in psychoanalytic psychotherapy and supervision, the relationship between psychodiagnosis and treatment, alternatives to the *DSM* diagnostic conventions, integration of feminist theory and psychoanalytic knowledge, the application of psychoanalytic understanding to the problems of diverse clinical populations, altruism, narcissism, and trauma, and dissociative disorders. Now here’s the interview.

Dr. Dave: Dr. Nancy McWilliams, welcome to Shrink Rap Radio.

McWilliams: Thanks very much. Glad to be here.

Dr. Dave: Well, I’m glad to have you on, which is the result of urging from Philip Brooks, who teaches at the California Institute of Integral Studies and who also is an ardent fan of Shrink Rap Radio, and he strongly suggested that I have you on the show.

McWilliams: Well, please thank him for me.

Dr. Dave: Yeah, I will. I wasn’t sure if he had any particular connection to you or not. Have you done some teaching out at the California Institute?

McWilliams: Yes, I have been there. It’s an interesting program out there.

Dr. Dave: Yeah. Where are you based?

McWilliams: I'm in Western New Jersey, but I teach at Rutgers University in the Graduate School of Applied and Professional Psychology, so I teach in a Psy.D. program that prepares therapists.

Dr. Dave: Okay. Well, I see from your resume that you're also a board certified psychoanalyst, but also that your B.A. was in political science, so I'm wondering how you got from polisci to psychoanalysis.

McWilliams: Well, it was actually more the other direction. I was always interested in people and in the deeper meanings of why they behaved the way they did, and in individual differences. And when I went to Oberlin College in the early '60s to be a psych major, you couldn't take their intro course until your sophomore year, and it was a strict two semester, four hour course of rat-running, and then so it was your junior year before you could talk about people. And in the Political Science Department they were talking about people from the get-go, so I thought that would be a better general major.

Dr. Dave: Interesting. I ran into the same thing as an undergraduate myself, thinking I might major in psychology. It turned out it was all about running rats, and the guy started out the semester announcing to the class if you're here to find out about your own personal quirks and those of your friends, you're in the wrong place; psychology is the science of animal behavior and humans. [*Laughs.*]

McWilliams: Yeah, that was the party line back then.

Dr. Dave: Yeah, yeah. Thankfully it's evolved a bit.

McWilliams: So I studied political theory because they were talking about human motivation in political theories. And my junior year my professor handed me Freud's *Civilization and Its Discontents* and said, you know, for your honors thesis you might be interested in trying to sort of deduce Freud's political theory, and that was the first time I'd ever read anything psychoanalytic, and I was captured.

Dr. Dave: So the hook was set, so to speak.

McWilliams: Yep, yep.

Dr. Dave: Now, I think there are many therapists out there who are not trained as psychoanalysts, per se, and who perhaps who don't even consider themselves as practicing psychoanalytic psychotherapy, but who nevertheless value the psychoanalytic understanding of personality structure. Does that fit with your perception?

McWilliams: Absolutely. That's certainly been my experience.

Dr. Dave: How do you account for the persistence of the psychodynamic understanding of personality?

McWilliams: Well, I think first of all it's an understanding of personality that tries to make meaning out of things, it doesn't just list traits. It tries to understand what are the central preoccupations of different people. And human beings are meaning-makers and meaning seekers. I think it's also intuitively resonant.

People respond to psychoanalytic descriptions of personality differences and they have "aha" experiences that make sense of friends and of themselves. And—but I think this isn't really a big part of the answer, but there's a tremendous amount of empirical support for the personality differences that emerged from people closely observing individual differences from a psychoanalytic perspective.

Dr. Dave: Well, that kind of leads into my next question. Did you have a follow-on thought you wanted to complete there?

McWilliams: Yeah, I was just going to add that it's useful, that even if you are cognitive behavioral in your orientation or you're a substance abuse disorders person, it helps to know something about the personality of the person you're trying to help.

Dr. Dave: Yeah, I certainly agree, and I certainly have observed, over the years, that people who are trained in some other modality, for example Gestalt therapy or maybe CBT, as they got deeper into their practice, they developed a hunger for more depth, for some kind of more complex understand of people, and so they gravitated towards psychodynamic training of some sort or another.

McWilliams: Yes, yes. I know many people that that description applies to.

Dr. Dave: Yeah. Now, in your recently updated book on psychodynamic diagnoses, you note that many of the psychoanalytic concepts are difficult to pin down empirically, so I'm wondering how that plays with the current interest in the APA with everything having to be evidence-based.

McWilliams: Well, in APA there's a group of very influential psychologists who use the term evidence-based in an incredibly narrow way. What they mean is have there been randomized controlled studies of a particular technique. And these are the same people who tend to define the psychoanalytic tradition as if it's all about a particular technique. And it's really not. In fact, I don't know of a single psychoanalyst who would say that what defines psychoanalysis is that we put people on the couch and ask them to free associate, and that that should be good for everybody. It's much more a sensibility or a knowledge base.

And if you define evidence very narrowly like that, that there have to be randomized, controlled trials on the technique that you're studying, it's not very applicable to the psychoanalytic tradition, which is more about listening and listening for uniqueness and for underlying meanings. We don't see ourselves as

applying a technique. So although there are randomized, controlled trials of some psychoanalytic approaches, more narrowly defined, like Kernberg's transference focused therapy, there aren't a lot of randomized, controlled trials of specific psychoanalytic techniques.

But what there is is a vast literature on personality differences, on neuroscience, on development, on attachment, on all kinds of areas that bear on what you do as a therapist. I would say my work is always evidence-based. And I don't think any psychoanalytic therapist would say that we should not base our work on evidence. We also tend to base it on supervisor recommendations, on what was helpful to us in our therapy, clinical anecdote and so forth. But we do read some empirical literature very assiduously.

Dr. Dave: Yeah. I've been interviewing some people that are involved in what has been called neuropsychanalysis, so there are people out there.

McWilliams: I heard a piece of your interview with Jaak Panksepp, who I think has discovered some things of enormous relevance to psychotherapy.

Dr. Dave: Mm-hmm, yeah.

McWilliams: I mean, I love his research. So again, that's a kind of evidence-based. But there's been an odd development in psychology where a lot of the researchers don't have a clinical practice and don't have much empathy with what it's like to do a clinical practice. They're good at running very good research trials of very limited phenomena, and then they get upset that therapists aren't using the outcome of their research to apply to much more complex real world phenomena. And without the experience of having been therapists themselves, they often treat practicing therapists contemptuously, as if we are not interested in science.

Dr. Dave: Somehow that's almost reminiscent of the rat-running days that we were talking about earlier.

McWilliams: Yes, I'm afraid so.

Dr. Dave: Yeah, there is that sort of narrow understanding of science that seems to persist in the field of psychology, and particularly in the APA.

McWilliams: Yeah. It's not a majority of APA, I don't think, because actually APA as a total organization put out a press release a little over a year ago saying that what matters in psychotherapy is not so much the particular technique as the relationship. And by the way, there's enormous research attesting to that.

Dr. Dave: Sure.

McWilliams: Something like 85% of the variance in outcome relates not to the particular brand name of the technique, but to the quality of the person of the

therapist, to their skill at getting people to talk about themselves, to the relationship. So it's a small group in APA, but it's a very loud group, and they are talking to the media saying these contemporary therapists, they're not reading the important literature, namely their randomized controlled trials.

Dr. Dave: Well, I actually read, in, I think, the most recent *American Psychologist*, a report by a committee, I guess, that was set up to look at training in psychology, both at the undergraduate and the graduate level, and to try to revamp the whole enterprise. And the words "science" and "evidence-based" kept reoccurring throughout, and it seemed like in that very, very narrow way.

McWilliams: Yes, and when I hear enough of that kind of stuff, I find myself having the fantasy that a whole bunch of therapists should descend upon the academic laboratories and say that we are the ones that should be defining what they do, because the idea that research scientists should come into clinical training programs and tell us that what we've been doing for decades is all wrong is enormously smug, at best.

Dr. Dave: Yeah. And it's also striking because, the last time I heard, clinical psychologists outnumber the other specialties in the APA. Isn't that the case, that more than 50% are therapists?

McWilliams: I think that's right. But speaking of personality, I think therapists often are of a somewhat depressive psychology themselves, and find themselves worrying that maybe anybody who criticizes them is right.

Dr. Dave: Uh-huh. [Laughs.]

McWilliams: A lot of therapists have sort of drunk the Kool-Aid that, gee, maybe I'm doing something wrong, the academics are telling me I should have been able to fix this complex problem in six sessions.

Dr. Dave: Uh-huh. Interesting, yeah. I can resonate to that. Now, I guess the *DSM-5* has recently come out amidst a fair amount of criticism. What's your own response to *DSM-5*?

McWilliams: Well, I was very critical even back in 1980, when *DSM-III* came out, and I think *DSM-5* is...it's sort of...it's taken categorical, non-inferential, non-contextual, non-dimensional diagnosis, or the so-called Neo-Kraepelinian diagnosis, where things are present versus absent, there or not, here are the criteria, to its logical extreme, and finally there is a reaction against it. To be fair, the *DSM* was never intended as a guide to clinical practice—it was intended to make it easier for researchers to do a particular kind of research, so it didn't initially identify itself as any kind of Bible of mental health.

But when the drug companies started claiming that their drugs alleviated these categorical disorders, then some psychologists began doing experiments—and

I'm grateful to them for it—that eventually demonstrated that psychotherapy helps with those disorders as fast as the drugs do. But in the process they kind of bought into the drug companies' preferable definition of the problem, in other words, that [these were] discrete disorders, that, you know, we don't all have everything, that we're not all vulnerable and so forth.

Dr. Dave: And of course the other major institution or industry that's helping to drive things is the insurance industry and reimbursement, and that certainly has reified the *DSM* as the ultimate authority.

McWilliams: Yes, it's certainly in their interest to do that. I mean, they marketed their policies to corporations saying that they gave comprehensive mental health services, and as soon as the corporations signed up with them, they kind of said, whoops, we didn't mean the personality disorders, that's not comprehensive mental health service.

But we have research showing that more than 50% of people who come for psychotherapy have some kind of personality issue that goes along with their symptomatic issue. So the insurance companies, you know, would like to... I mean, I don't think that they're evil people. I think that they're in a system where they're just trying to save as much money as possible.

Dr. Dave: Right, right.

McWilliams: So it's in their interest to see it a certain way.

Dr. Dave: Yeah. Now, some therapists are skeptical of the whole diagnostic enterprise and wouldn't concern themselves with it at all were it not necessary for insurance reimbursements, so let me put to you the question that you raise in the very first chapter of your book, which is why diagnose?

McWilliams: Well, I actually think that even therapists who say that they hate diagnosis or don't diagnose, they do diagnose in an intuitive way, if they're any good. They get a feel for which kinds of people are more comfortable if you say very little and give them a lot of space versus which kinds of people really want you to be engaged with them and will feel abandoned if you leave too many gaps in the conversation.

So I'm actually sympathetic to the idea that the diagnostic categories that are most common now don't tell us very much about what's really important to know about people. But I do think if you think about the term diagnosis in its original Greek meaning, to understand or to know thoroughly, that any good therapist tries to have a feel for his or her patient.

Dr. Dave: Mm-hmm. An interesting point that you make in this regard is that diagnosis can play a role in the communication of empathy, I guess, to the patient. Tell us about that.

McWilliams: Well, if you pick up that a patient has what, in the psychoanalytic literature, has been generally referred to as schizoid, or the Jungian literature would say introverted, if you get the sense that you're talking to somebody who has a very sensitive sensorium, is much more comfortable with distance than with closeness, then you might even just be sure you're not leaning over too far into that person's space, and they'll feel it as more empathic if you just give them a lot of room to tell their story. Whereas someone with a more depressive tendency, who seeks comfort in closeness and feels easily abandoned, is going to be able to tell their story much better, and feel you as empathic, if you get that about them and draw them out explicitly.

The more schizoid person is likely to feel you're impinging on him or her if you try to draw them out. The depressive person might feel you're just not interested if you're not asking questions. And again, I think we do this very intuitively. And I would have done it intuitively and not written a book about it except that I was trying to train therapists in personality differences because I think that's the most important thing to know.

Dr. Dave: Mm-hmm. Now, would you ever tell the patient what the diagnosis is that you have come up with as a way of creating empathy, to kind of say here's what I think is going on with you and here's what we know about this?

McWilliams: Oh, yeah. In fact I can't imagine not doing that with a person. First of all, if they need a diagnosis for insurance purposes, I generally share with them what the options are that pretty much match what their complaint is, and we make a collaborative decision about how they want it represented, because sometimes it's a kind of close call—is it dysthymic disorder, is it major depression, is it a posttraumatic condition? It might meet all those criteria. And there are different implications of them.

I had a paranoid woman once, very early in what was then peer review process, where there was starting to be insurance company concern that therapies not go on too long. She was paranoid to the core, and I knew that therapy with her would take literally years. And when we were sitting there in the first session, I said to her, well, you know, you and I can see what you're talking about goes way back in your history, and it goes very deep, and so I'm going to have to give you a personality disorder diagnosis because that's at least a diagnosis that your insurance company will be willing to reimburse for a long enough period of time.

And knowing that she was paranoid, I didn't want to just drop a diagnosis on her and make her feel like I was humiliating her or attacking her, so I just handed her the *DSM* and said here are the known personality disorders that have been accepted by the American Psychiatric Association, why don't you find the one that feels most like you? And she looked through and she said, "Oh, there I am, paranoid personality."

Dr. Dave: Wow.

McWilliams: Suspicious, mistrustful. And it was a whole different experience when she was collaborating on this.

Dr. Dave: Oh, I love that story. By the way, feel free to throw in any stories or anecdotes that come to mind. It always enlivens these interviews.

McWilliams: Well, I have a lot of them. You may be sorry you asked.

Dr. Dave: I'll bet you do. No, I don't think I'll be sorry. So what are some of the limits to the utility of diagnosing?

McWilliams: Well, of course first of all you can always be wrong. You can go down the wrong path. And I don't think you should ever be confident in your diagnosis. I know Anna Freud said that treatment terminates, but diagnosis goes on forever, because we're always learning unexpected things about people. And people are unique, and none of those categories really capture people. Nobody matches up to all of the...

Dr. Dave: Yeah, that's—

McWilliams: Also—

Dr. Dave: Yeah, that's very—

McWilliams: Sorry, I keep going on a roll and...

Dr. Dave: No, that's good. You keep rolling. I was just going to say, you know, going back to the days when I practiced, that was always such a challenge. I mean, people aren't like what's in the textbook or the *DSM*. I mean, they're like it, but they don't fit it exactly.

McWilliams: Absolutely. And often the diagnosis doesn't necessarily suggest a particular treatment, too. It's not like medicine, where, if you get the diagnosis right, generally there's an agreed upon treatment for it. Often that's not quite true in psychotherapy, even if you get it right.

Let's say you diagnose someone with a substance use disorder. You don't know right away whether they're going to be responsive to detox, and rehab, and AA, or whether they should go into another kind of program, or whether you're going to have to work with them a while until you get them motivated to do that. So, you know, I think it's important for understanding, but it's very limited in terms of what it means you can do, at least right away.

Dr. Dave: In your book you also refer to what you call the fringe benefits of diagnosing. What is it that you have in mind there?

McWilliams: Well, in my own experience—and there are a couple of exceptions to this—but in general people really appreciate feeling listened to with an effort not

to try to match them to a prototype in the *DSM*, but an interest in really understanding what it's like to be them. I think also if you really get what your patient struggles with in a deep way, you get realistic—you and the patient get realistic about what is expectable.

I mean, is what they're complaining about—for example, let's take a really shy person who wants to be the belle of the ball. If you really get a feel that their shyness is part of a deep temperamental sensitivity and tendency toward withdrawing, you can kind of reframe things together as, you know, I don't think you're ever going to be the belle of the ball, but I do think that together we can help you use your sensitivity to better advantage, and not be so withdrawing in social situations.

Or let's...just specifically, you wanted examples. If you're diagnosed with bulimia in the *DSM*, it doesn't give you very much. There's a huge difference between the college freshman or first year who comes to the college counseling center saying, "I began putting on weight because this is a new environment, I'm starting to purge, I'm worried about it, I think I should talk to somebody."

That's a completely different kind of clinical experience from someone who gets pulled to the college counseling center kicking and screaming because her roommates heard her vomiting in the bathroom, and they think she has a problem, and she sits there in front of you and says, "I don't get what I'm here for. This is not really a problem. This is how my mother taught me to control my weight. I've been doing it since I was seven. What's your problem?"

Dr. Dave: Wow. [Laughs.]

McWilliams: They will meet exactly the same *DSM* criteria for bulimia. But the first one you can probably help in a few sessions and the second one may take a year and a half before she separates enough from the craziness in her family of origin to see that she has a problem at all.

Dr. Dave: Uh-huh, yeah. You say there's been a tilt from classical Freudian drive theory toward a more developmental point of view. Take us through the highlights of that, if you will. It's kind of a huge question, I know.

McWilliams: Yeah, it is really huge. Well, Freud was trying to make a grand theory based on drive, and he came up with, originally, the erotic, libidinal drive. He tried to base everything on that. And then he was so struck by what happened in World War I and in some of the disappointments in his life that he decided that aggression and the death drive were as important as the life drive.

And, you know, that's...I kind of love grand theories, but it doesn't help you much with what any person's individual story is. And over the course of his career, he changed his theory a lot, and he became very interested in the

relationship and the specifics of the person's early experiences and how those replayed into the therapy, and subsequent analysts sort of took it from there.

People like Erikson looked at the first six years, as Freud had, but also the whole life span, and talked about what was going on developmentally. People like René Spitz noticed that it's not really about what drives get met, like whether you feed the child, as it is about what kind of relationship the child has. I think John Bowlby's work on attachment was a kind of game-changer, as was the work of W.R.D. Fairbairn, who argued that people need a connection more than they need a drive satisfied. And that was just very persuasive in the clinical community.

Let me give you an example. If you're a strict Freudian and somebody's got a lot of compulsiveness in their personality, you tend to think about it as anal fixation. They're fixated on the developmental problem of control and lack of control and so forth.

But when we started thinking more about what kind of family was the kid in, what were their full experiences, we found that the idea of a controlling family, or its opposite, a family that was so out of control that the child had to exert all the control, the whole issue of control and the environment had much more explanatory power than just what psychosexual phase the kid was fixated on, to use the old Freudian terms.

And that has just continued to evolve, so that contemporary psychoanalysts are always thinking in relational terms, and always...to the extent that they will think as much about what they are contributing to what's going on with the patient as what the patient is understanding them to be like.

In other words, the Freudian idea is the patient is going to transfer stuff onto you, and you try to be fairly blank so that you can see what they're transferring. If they're saying you're like my critical mother, and you haven't said anything critical, then you're knowing that there's something important here.

But in contemporary psychoanalytic work, most people agree that there's always something going on between both people, and the therapist has to look at what they're bringing to the dyad as well. So it's been a long, long evolution of that.

Dr. Dave: Yeah.

McWilliams: I think a lot of what people criticize about psychoanalysis is the medicalization of early Freudianism that was popular in the country circa 1950, and they know very little about contemporary psychoanalytic thinking.

Dr. Dave: Right, right. And the whole role of attachment theory seems to have had a huge impact across a...you know, I think for psychoanalysis, for Jungian analysis. I mean, a lot of people are looking through that lens now.

McWilliams: Yes. And I guess we can thank Bowlby for that, because he set up a research program. I mean, I think psychoanalysts have ourselves to blame, in large part, for the attacks that we aren't paying attention to evidence, because there are a lot of psychoanalytic ideas that could have been researched much better than they have been. But attachment theory really has, and it's very valuable.

Dr. Dave: Yeah. You referred to the neurotic-borderline-psychotic spectrum in a way that sort of surprised me, because I'm interested in the borderline and how that's in the middle, because I used to think of borderline—oh, that's the borderline between neurotic and psychotic. It's somebody who's almost psychotic, but isn't. But then later it seemed like as the category of borderline became more fleshed out, it didn't seem like it was that anymore.

McWilliams: Yeah, and we had the problem, as we've always had in clinical writing, that people use terms in different ways. Some people did use the term borderline in the way you just described. But I think it was mostly Otto Kernberg's work in the early 1970s that sort of helped us focus around the idea of there being a kind of stable instability in some people. It wasn't that they were going to become schizophrenic, but they were somehow too disordered, or too chaotic internally, too intense, had too much difficulty with regulating their emotions to be considered just neurotic. And they behaved differently in therapy.

With the neurotic range, somebody who feels that the therapist is critical sort of notices it and notices that the therapist hasn't really behaved that way, and will come in and say, "You know, you've been very supportive to me, but I keep having this fantasy that you're critical." Whereas the person in the borderline range, they're not psychotic, they're not deluded, they're not hallucinating, but they'll come in and they'll say, "Bitch, I'm sick of your criticizing me."

Dr. Dave: [Laughs.]

McWilliams: And if you say to them, well, you know, is it possible that you're experiencing me as like your critical mother, they don't go to, "Well, gee, yeah, maybe I am transferring that." Where they go to is, "Yeah, it's just my bad luck that I found a shrink exactly like my mother."

Dr. Dave: [Laughs.]

McWilliams: And it was that phenomenon that therapists were trying to understand and work with. *DSM* has a sort of category, but that's not how it emerged.

Dr. Dave: I'm wondering if borderline is a bad word for it.

McWilliams: I think so.

Dr. Dave: You do think so?

McWilliams: I do think so. But, you know, we're stuck with a lot of bad words that have sort of emerged over clinical experience.

Dr. Dave: I'd hate to have somebody tell me that I'm borderline. [*Laughs.*] If you handed me the *DSM* and I had to find myself and borderline was one of the...it sounds terribly pejorative.

McWilliams: I know, it's like borderline to what?

Dr. Dave: Yeah. It also just feels very pejorative. Now, you make a distinction between primary and secondary defense processes. What are you getting at there, and how do they play into your diagnostic schema?

McWilliams: Well, they are part of what people in my field tend to try to be formulating, either intuitively or specifically, about whether the patient tends to use fairly primitive ways of defending themselves against pain, anxiety, shame, humiliation, fear and the negative feeling states.

Dr. Dave: When you say primitive, such as?

McWilliams: Let's say denial. It's a pretty primitive defense. The way that—again, it's pretty arbitrary how we divide things—but the way that analysts tend to talk about primitive versus higher order defenses is that the more primitive ones distort reality in some important way, and they also tend to be unsure about the difference between what's inside and what's outside. So if I am afraid I'm gay, and I imagine that the cashier where I'm checking out my clothing is wondering if I'm gay and critical of me because I look gay, I'm sort of confused about what's inside and what's outside. Is this my worry or is she doing this to me?

And we assume that, you know, in babies there's a time before it's quite as clear to them what's inside and what's outside. We know now that they know a lot more than we used to think they did, but presumably when an infant is upset they just feel a sort of global distress, and the world feels bad and the self feels bad. So being a little confused about that is part of primitive defenses.

Or distorting reality. Denial is considered a more primitive defense. Denial is like it didn't happen, or it's not true, as opposed to it happened and I prefer to forget it, which is repression, or it happened and I will just intellectualize about it, but not feel it, which is intellectualization, or other ways that you kind of acknowledge reality, but treat it somewhat defensively. Does that make sense?

Dr. Dave: Yeah. Yeah, it does. Now, part two of your book focuses on types of character organization. And years ago I remember learning a distinction between neuroses on the one hand and character disorders on the other. Has that distinction gone away?

McWilliams: No, actually it's very instantiated up through *DSM-IV* in the difference between Axis I and Axis II. That's really what that difference is. They call Axis I disorder rather than neurosis now. And they did that in 1980 because they were trying to get rid of psychoanalytic taint in the *DSM*. And what they call personality disorders is what used to be called character neuroses or character problems.

But it's a useful discrimination to figure out whether a person is, let's say, has an obsessive compulsive disorder versus are they obsessive compulsive about everything, because an obsessive compulsive disorder might be that you have to do a particular ritual in one phase of your life, but if you're a completely ritualized person to the extent that you could be described as kind of a living machine, that's something more grave. So I think that distinction still does exist, and it's a kind of intuitively resonant distinction.

Dr. Dave: And it plays a strong role in your book. You have chapters on nine different character organizations. I won't have you take us through all nine, but perhaps you could take us through two or three of your favorites to illustrate—

McWilliams: [*Laughs.*]

Dr. Dave: —to illustrate the usefulness of understanding personality structure in the clinical process.

McWilliams: Let me see which ones I would pick. Well, first of all let me say that in those chapters I'm not implying that if you have a personality type you have a personality disorder. I think we all have a type of personality or a combination of types of personality. So I can describe myself as depressive and hysterical and I wouldn't be saying that I'm sick, necessarily. But if my personality tendencies kept getting in my way or I was completely inflexible, then they would dimensionally move down toward a personality disorder.

So I just want to say at the outset to talk about these differences doesn't necessarily mean that you're saying people have a problem, they're just talking about observable differences in people's ways of defending against pain, of coping with life, of understanding the world, of regulating their emotion and so forth.

Dr. Dave: Now when you say you can describe yourself as depressive and hysterical, hysterical is kind of a difficult word because it has different meanings. What is it that you mean when you say hysterical?

McWilliams: There is a kind of preoccupation, that is not at all uncommon, that got called hysterical in the old days and then histrionic later, which I think is an even worse word because it's more pathologizing. But it organizes experience very much along the lines of being sensitive to issues of gender and sexuality and power. So that's what I mean.

And Freud talked about it being symbolized in penis envy. I think he way overgeneralized about that. But I do think there are a lot of people who, because of their own history, inferred from life that one sex was the powerful sex and the other was the weak sex, and they kind of organized their thinking about how to deal with that. A lot of people who have been molested have that psychology.

That's not the source of my own, but I did have a somewhat scary father, and so I am inclined to worry about whether I have enough power in a situation vis-à-vis a male. And that's a recurrent theme in my dreams and I have to kind of watch that I don't over experience things in that way. An obsessive-compulsive person would be organized around issues of control-dyscontrol; a schizoid person around issues of closeness and distance; a paranoid person around trust-distrust; a psychopathic person around power or the lack of power.

One of the ways that the *DSM* gets personality really wrong is they try to make a—and again, I probably sound too confident there in my view—is that they try to talk about personality in terms of present versus absent traits. But people aren't really organized around traits. In fact, if you see one trait, you often see the opposite trait. Every fanatically neat person I've ever known has a dirty drawer somewhere. Every person I've known who shrinks from relationship because they're kind of schizoid has moments of incredible connection with other people. This is something that Jung was really onto.

And what differentiates people is it's not a trait at the end of that spectrum, it's the spectrum itself. It's being organized around that issue. So a paranoid person is organized around trust and distrust. And you'll see both. They'll be very distrustful, but some paranoid people will think that their cult leader is flawless, so they're like pathologically over trusting in some area. But the whole area of trust itself is the issue.

Or narcissistic people who appear so inflated in their self-esteem also have very low self-esteem in some way. You can't say that they have a present versus absent trait of self-esteem. They use inflated self-esteem to defend against low self-esteem, and the whole issue of managing their self-esteem is what organizes them.

Dr. Dave: I love that dynamic that you just painted for us.

McWilliams: Well, thank you. I'm not the only one who thinks that way.

Dr. Dave: [*Laughs.*]

McWilliams: That is sort of essential to a psychoanalytic understanding of people, that they don't... There are traits in people, and there's a huge psychological literature on the big five traits which are very reliable and valid, but they're not clinically very relevant. When I sit with people I don't tend to think about those traits of agreeableness and conscientiousness and so forth.

I'm thinking what is their preoccupation here? What do they understand the world to be about? How are they experiencing their relationship with me? Are they organized around the fact that I'm a woman? Are they organized around the fact that I have power? Are they organized around the fact that I might impinge on them? Are they afraid I might abandon them? Those are different kinds of personality orientations.

Dr. Dave: Mm-hmm. And I can see how those would, in fact, structure the clinical process, how you will relate to them.

McWilliams: Yeah. I'll give you an example. With paranoid patients, there are a lot of people who have a pretty significant paranoid streak who will never be psychotic, or maybe at some point they had a breakdown, but they've been nonpsychotic for years, but they have a significant paranoid streak. And if you know that about somebody that you're with, you know that they are very vulnerable to the experience of humiliation and attack, so you tend not to be trying to give them information about themselves the way you might to somebody who's hungry for your ideas about them because they'll experience it as a humiliating—if they think you're right, it's a humiliation that they didn't know this, and they may very well experience it as an attack on them.

The literature about working about paranoid people often mentions that the therapist should be quite self-disclosing because that kind of evens the playing field. If my patient comes in, and let's say he's a paranoid person and he's all critical of himself for something—let's say he says, “Oh, I lost it with my teenage daughter,” instead of just exploring that, which makes him feel even more humiliated, because he's going to have to tell you all the details, it's probably more helpful to him to get safe in the first place to explore the details if you say something like, “Oh, tell me about it. When my kids were that age, I wanted to strangle them twice a day. What happened?” Now, you wouldn't do that with most other types of personality, you wouldn't have to.

Dr. Dave: Boy, that self-disclosure really flies in the face of the image that most people would have about psychoanalysis, psychoanalysts being the blank screen.

McWilliams: Yes, and first of all, I always thought that that was a perversion of Freudian ideas. Freud didn't act like that himself. People started emphasizing the blank screen when they were trying to make psychoanalysis a medical specialty so that they could explicate the technique. But secondly, to the extent that that became the image of classical analysis, it has certainly changed. The relational movement in psychoanalysis has pretty much wiped out the idea of the completely sanitary, sort of...or sanitized idea of being blank.

Dr. Dave: I don't know if the word's gotten out yet. [*Laughs.*]

McWilliams: Maybe not. But there's a huge literature on self-disclosure.

Dr. Dave: Well, I think my listeners will feel heartened by that knowledge. Hey, to switch focus just a bit, you mentioned penis envy. I see that one of your specializations has been in the integration of feminist theory and psychoanalytic knowledge, and perhaps you can give us an overview of that, especially since I recall that it was feminists who were particularly upset with psychoanalytic theory.

McWilliams: Yeah, well, I don't think you can be a woman of my age and be ambitious and not be a feminist. It would be very unusual. Because when I came up—I'm 68—the voice of authority was always male, and there were very few examples of women living full, rich lives in which they both worked and had a domestic role. As I remember what was the sort of mindless sexism of the era that I went to high school with, it's kind of appalling, in retrospect. So of course I'm a feminist, like almost every other ambitious woman my age.

But I also...I understood what the objections were to psychoanalysis. I think Freud was wrong in several ways about women. But on the other hand, I didn't think he was toxic in the way that some of them felt. I suspected that many of the women, such as Kate Millett, for example, who really went on the attack towards psychoanalysis, had very bad analysts or psychiatrists that had tried to tell them that they should be happy living in the suburbs and having two and a half kids, and that any unhappiness with that meant that they had something horrible called penis envy, which is a very different way than I experienced Freud's comments on it.

My experience of his comments on it were, well, yeah, of course. One sex has the power and the other one notices that they also have a penis, and of course that envy of the power of the sex that's running the world could be symbolized that way. And in his actual behavior, Freud did more to encourage women to be fully equal partners in a profession than any other profession I knew of. I mean, he encouraged his daughter into it, he invited women into his little "in" group at a certain point.

In psychoanalysis, there are many very important women, and have been since at least the 1930s, who were not just practitioners, but were major theorists. And Freud certainly supported that. So I always felt that it was an oversimplification to tar all psychoanalysis and all of Freud's ideas with the same brush of his having misunderstood some things about women.

Dr. Dave: Have you drawn any fire yourself for taking that position?

McWilliams: Not that I know about. I suspect at the time, in the early '70s, when there was an awful lot of controversy within the feminist community, that there were feminists at that time that thought that I was sleeping with the enemy to say anything good about psychoanalysis. But I think most female analysts of roughly my era would describe themselves as feminists, and always did. And there have

been major feminist theorists—Nancy Chodorow comes to mind—who have really contributed a lot more to psychoanalysis and to the larger culture.

Dr. Dave: Well, as we start to wind down here, I wonder if there are any final points that you'd like to make.

McWilliams: Well, I guess the reason that you were urged to interview me is the success of a book that has surprised me, actually, in its success, that I originally wrote because my students got sick of hearing me complain that there should be a book like this. And I suppose one thing we haven't talked about is...I wasn't entirely surprised that the book did well in the United States because I knew there was a need for it, and I knew that I wrote fairly well, which is not that common in the psychoanalytic tradition, I have to say, from observation.

Dr. Dave: Yeah, really.

McWilliams: But what has completely floored me is the international reception. It's in 15 languages now, and some other languages informally, and I get invited all over the world. And all over the world people recognize these personality differences, and even though they say that their own culture is somewhat different and that the personality types distribute differently, they resonate to this.

So I guess I've been sort of emboldened by this and have been trying to put pressure on my own field, namely psychology, to look more at personality variables than at these randomized controlled trials that target a particular symptom, because I think there's just much more value for psychotherapy in trying to understand the person you're talking to than in figuring out what criteria for this particular disorder are present or absent.

Dr. Dave: Well, I have to say that I really wish that your book had been around when I was in a Ph.D. clinical program at the University of Michigan, which was very psychoanalytic at the time—I don't know if it still is or not. And the book that we read, my first—I mean, I went into this program sort of naively—and the book that we were given was by Otto Fenichel. I can't remember the exact title.

McWilliams: Oh, yeah.

Dr. Dave: A totally impenetrable and pathologizing tome that just really turned me off in a major way. If I had been given your book instead, oh, it would have been so much better an introduction.

McWilliams: Well, that's very kind of you, though I do worry that over time what I might say in a perfectly egalitarian way may be read with a tinge of pathologization later, because words tend to shift. The word "retarded" was originally thought a much better word than lunatic or idiot, and then it got changed to developmentally disabled, or challenged. We keep changing the terms of things.

I suspect, from what I know about Otto Fenichel, he actually was a very humane, egalitarian, loving person, not particularly pathologizing in his actual practice, but the words were absolutely impenetrable by the time I was assigned that book, and it sounded very much like the doctor looking at all the rest of us and saying that we were sick. I'm not sure that was the tone in which it was written. So I do worry that no matter how careful I am to say, about my own writing, that, listen, I'm one of the people I'm writing about, I worry that in some future era it will sound not just quaint, but hostile.

Dr. Dave: Well, it's certainly very well tuned for this era.

McWilliams: Well, thank you.

Dr. Dave: And so I want to encourage students out there, or others who are interested in learning more about a contemporary psychoanalytic perspective, to read this book.

McWilliams: Oh, thank you very much.

Dr. Dave: Well, Dr. Nancy McWilliams, I want to thank you for being my guest on Shrink Rap Radio.

McWilliams: Thank you very much for having me.

Dr. Dave: Well, my thanks go out to listener and therapist Philip Brooks for recommending this interview with Dr. Nancy McWilliams. I really appreciate her combination of expertise and humility and the down-to-earth nature of her presentation. I also appreciate her willingness to engage in appropriate self-disclosure, which she illustrated in this interview, especially in her observation about her own personality structure, and that it might tend a bit toward the depressive and hysteric. Her explanation of the meaning of hysterical was enlightening to me, and I'm sure to many listeners as well.

She certainly has exploded the stereotypic myth of the psychoanalyst as a blank screen, bringing us up-to-date with contemporary psychoanalytic therapy practice. As you heard me say, I wish her book on psychoanalytic diagnosis had been my first exposure rather than Otto Fenichel's 1945 *The Psychoanalytic Theory of Neurosis*. [Laughs.] It was dated then. Nancy's book is the epitome of clarity, and I recommend it to all who wish to better understand psychodynamic personality theory. As always, you can use the Amazon widget on our site should you decide to order it, and a few pennies will fall into our tin cup.