**CHAPTER 3**

# A Psychoanalytic Theory of Personality Disorders

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The fundamental premise of psychoanalytic theories of personality disorders is that the observable behaviors (personality traits) and subjective disturbances that characterize a particular personality disorder reflect specific pathological features of underlying psychological structures. As a result, treatments that alter psychological structures and mental organization will result in changes in pathological personality traits and subjective disturbances. The psychoanalytic theory of personality disorders that we present is intimately linked with models of treatment. Empirical studies of the treatments derived from our theory of personality pathology (Clarkin et al., 2001; Clarkin, Levy, Lenzenweger, & Kernberg, 2004) enable us to study the utility of the underlying model of mental organization.

In this chapter, we make an effort to formulate an integrated psychoanalytic view of the etiology, structural characteristics, and mutual relations of the personality disorders. Our model is based on advances in the psychoanalytic understanding of particular types of personality disorders and their diagnosis, treatment, and prognosis. The study of patients with personality disorders undergoing psychoanalytic treatment provides a unique opportunity. Specifically, psychoanalytic research allows us to observe the relationships (1) among pathological personality traits, (2) between surface behavior and underlying psychological structures, (3) between various constellations of pathological behavior patterns as they change in the course of treatment, (4) between motivation of behavior and psychological structure, and (5) between changes in behavior and shifts in

dominant transference patterns. The model we present in this chapter is to a large degree derived from clinical data acquired from psychoanalytic treatment of patients with personality disorders. We attempt to integrate these data with empirical data from psychoanalytic research and relevant scientific developments in the fields of psychiatry, developmental psychology, cognitive science, neurophysiology, genetics, and infant observation.

The theory we present has led to the development of specific treatments that deal with the clinical features presented by patients with personality disorders (Clarkin, Yeomans, & Kernberg, 1999; Bateman & Fonagy, 2004). Specifically, we have developed a psychotherapeutic treatment for patients with severe personality disorders (Clarkin et al., 1999), a psychotherapeutic treatment for patients with higher-level, or "neurotic," personality disorders (Caligor, Clarkin, & Kernberg, 2004) and a psychotherapeutic approach to treatment of patients with narcissistic personality disorders (Kernberg, 1984, 1992). Ongoing research efforts open the possibility of developing a broad array of treatments, finely tuned to address the clinical demands presented by the different personality disorders. In addition, psychoanalytic approaches to psychopathology facilitate differential diagnosis of subtle aspects of personality disorders, which can be used to establish prognostic indicators and to guide differential treatment planning. In this regard, the differentiation between the narcissistic personality disorder, the malignant narcissism syndrome, and the antisocial personality proper (Bursten, 1989; Hare, 1986; Kernberg, 1989, 1992; Stone, 1990) has been especially influential.

In this chapter, we present a model of mental organization and of mental functioning that accounts for the descriptive features of personality disorders. By "descriptive features" we refer both to the observable behaviors and to the subjective states that characterize a particular personality disorder. After presenting our model of mental organization we look to this model of mind, as it interacts with other factors, to address questions about the etiology of personality disorders, developmental continuities among the personality disorders, and implications for treatment. Our model classifies personality disorders first using a dimensional approach, based on severity of pathology, and makes a second-order diagnosis using a prototypical, or categorical, classification system. We believe that any model of classification that is going to be of use in a clinical setting must combine dimensional and categorical approaches.

## PSYCHOANALYTIC OBJECT RELATIONS THEORY AND PSYCHOLOGICAL STRUCTURES

The model we present emerges from contemporary psychoanalytic object relations theory as it has been developed by Otto Kernberg (1975, 1976,

1980, 1984, 1992). This model looks to the organization of psychological structures, derived from the interaction of constitutional and environmental factors early in life, to account for descriptive phenomena. In essence, personality traits and the relationships among pathological personality traits are seen as reflecting specific features of underlying psychological organizations. In this sense, our model is predominantly intrapsychic in its orientation.

The term "structure" as we use it here refers to an organization of related functions or processes that is relatively stable and enduring over time. Structures can be integrated and hierarchically organized to form new structures, organized at increasing levels of complexity. The term "organization" is often used to refer to the structures that are the result of this process. A "psychological structure" is a stable and enduring configuration of mental functions or processes that organize the individual's behavior and subjective experience. In psychoanalytic theories of personality, personality traits and subjective disturbances (i.e., the descriptive aspects of personality) are conceptualized as structures that are observable, sometimes referred to as "surface" structures. Surface structures, in turn, reflect the nature of underlying psychological structures, along with the degree of integration and organization of these structures. These underlying psychological structures, sometimes referred to as "deep" structures, cannot be directly observed. Rather, the presence and organization of deep structures is inferred from the observable features of personality, which are understood as organized by, and reflecting of, underlying deep structures.

## Internal Object Relations

In psychoanalytic object relations theory, "internal object relations" are the basic building blocks of psychological structures and are the organizers of motivations and related behavioral patterns. An internalized object relation consists of a particular affect state linked to an image of a specific interaction between the self and another person (e.g., fear, linked to the image of a small, terrified self and a powerful, threatening authority figure). From the first days of life, internal object relations are derived from the integration of inborn affect dispositions and interactions with caretakers. When an affect is repeatedly experienced in the context of a particular kind of interaction, affective memories are organized to form enduring, affectively charged representations or memory structures, which we refer to as internal object relations. Internal object relations have a complex relationship to their developmental origins, reflecting a combination of actual and fantasied interactions with others as well as defenses in relation to both. The most basic internal object relations are dyadic, by which we mean they consist of two representations, a representation of the self, and the representation of

another person, in interaction. As internal object relations become more highly integrated and organized in relation to one another, they may become triadic, or triangular. Triadic internal object relations consist of a self- representation interacting with two object representations. The prototype of the triadic internal object relation is an image of a sexual or loving couple and a third party who is excluded.

### Identity Consolidation and Internal Object Relations

Internal object relations are integrated and hierarchically organized to form the higher-order structures that organize personality and psychological functioning. At the core of our model of personality and personality disorders is the psychological structure or organization we refer to as "identity." A normal, consolidated identity corresponds with the subjective experience of a stable and realistic sense of self and others. In contrast, pathological identity formation corresponds with an unstable, polarized, and unrealistic sense of self and others. From the perspective of motivational systems, normal identity is associated with a broad array of affect dispositions, with the predominance of positive affect states, reflecting the preponderance of loving, affiliative motivations, and the predominance of defensive operations based on repression. In contrast, pathological identity formation is associated with affects that are crude, intense, and poorly modulated, with the predominance of negative affect states, reflecting the preponderance of pathological aggression and the predominance of defensive operations based on primitive dissociation, or splitting.

Fully consolidated identity is the hallmark of the normal personality, as well as the higher-level (or "neurotic") personality disorders (the hysterical, obsessive, and depressive–masochistic personalities). Pathology of identity formation is the hallmark of the severe personality disorders. (We include here all the DSM-IV personality disorders, save the obsessive–compulsive personality). This approach has been developed by Kernberg (1976), incorporating significant contributions from other psychoanalytic researchers and theoreticians, notably, Akhtar (1989, 1992), Krause (1988; Krause & Lutolf, 1988), Stone (1980, 1990, 1993a), and Volkan (1976, 1987).

## PROBLEMS WITH EXISTING APPROACHES TO CLASSIFICATION OF PERSONALITY DISORDERS

A major question in personality disorder theory and research is how the various behavioral characteristics of any particular personality disorder relate to each another and to their particular predisposing and causative factors. Research efforts have repeatedly found that multiple factors appear

to combine in the background of any particular personality disorder, without a clear answer to how these factors relate to each other in codetermining a specific type of psychopathology (Marziali, 1992; Paris, 1994; Steinberg, Trestman, & Siever, 1994; Stone, 1993a, 1993b).

Researchers proceeding with a dimensional model usually carry out complex factor analyses of a great number of behavioral traits. These studies lead to specific factors or a few overriding behavioral characteristics that, in different combinations, would seem to characterize the particular personality disorders described by clinicians (Benjamin 1992, 19936 Clark, 1993; Cloninger, Svrakic, & Przybeck, 1993; Costa & Widiger, 1994, 2002; Widiger & Frances, 1994; Widiger, Trull, Clarkin, Sanderson, & Costa, 1994; Livesley, 1998; Millon, 1981; Wiggins, 1982). This approach links particular behaviors and lends itself to establishing a general theory that could integrate the major dimensions arrived at by statistical analyses. These dimensions, however, tend to have only a rather general relation to any specific personality disorder, thus limiting their clinical utility. The clinical utility of this approach is further limited by failure to account for the specific contexts within which a given trait is expressed. (One notable exception may prove to be Benjamin's [1992, 1996] "Structural Analysis of Social Behavior [SASB]," a model strongly influenced by contemporary psychoanalytic thinking.)

A currently well-known dimensional model, the five-factor model, has proposed that neuroticism, extroversion, openness, agreeableness, and conscientiousness constitute basic factors that describe the core dimensions of normal personality, and that personality disorders may be seen as extremes of these basic dimensions (Costa & Widiger, 1994; Widiger et al., 1994). However, there are limited data to substantiate that these five dimensions developed in studies of normal personality can be meaningfully applied to classification of personality disorders. From the perspective of the clinical treatment of personality disorders, it is difficult to imagine that these five general traits can capture the subtleties of the clinical features of specific personality constellations.

Those researchers who are inclined to maintain a categorical approach to personality disorders, usually clinical psychiatrists motivated to find specific disease entities, tend to proceed differently. They study the clinically prevalent constellations of pathological personality traits, carry out empirical research regarding the validity and reliability of the corresponding clinical diagnoses, and attempt to achieve a clear differentiation between personality disorders, keeping in mind the clinical relevance of their approaches (Akhtar, 1992; Stone, 1993a; Westen & Schedler, 1999a, 1999b). This approach, pursued in DSM-III (American Psychiatri Association, 1980) and DSM-IV (American Psychiatric Association, 1994), has had the benefits of better acquainting clinical psychiatrist with some fre-

quently seen personality disorders and facilitating psychiatric research in the area of the personality disorders. However, this approach has been plagued by the high degree of comorbidity among the severe personality disorders (Livesley, 2001 ) as well as low test–retest reliability (Perry, 1992; Zimmerman, 1994) and, in some instances, poor stability over time (Zanarini, Frankenburg, Hennen, & Silk, 2003). In addition, the DSM system has omitted the less severe personality disorders, which are those most commonly seen in clinical practice, and it is perhaps for this reason that the DSM-IV Axis II system is rarely seen as useful by clinicians (Westen & Arkowitz-Westen, 1998).

Many of these problems with DSM classification reflect the weaknesses of a categorical system in which the "menu" of listed criteria include a mixture of symptoms, behaviors, subjective experiences, and affective states, all of which are equally weighted. Thus, for example, in the diagnosis of borderline personality disorder, suicidal behavior (behaviors that are often episodic) and chronic feelings of emptiness (a subjective inner state that is characteristic of the individual) are both included as criteria and equally weighted. To further complicate matters, in the absence of sufficient empirical data to guide decision making, political factors have unduly influenced decisions about what personality disorders to include and exclude in the official DSM system and under what labels (Jonas & Pope, 1992; Kernberg, 1992; Oldham, 1994). In this setting, the hysterical personality disorder, a common personality disorder with a long historical tradition, has remained excluded. Similarly, the depressive–masochistic personality disorder, excluded under DSM-III, has now reemerged under the heading "depressive personality disorder" in the appendix of DSM-IV, shorn of controversial references to "masochism" (Kernberg, 1992).

A major factor underlying problematic aspects of both existing classification systems, be they categorical or dimensional, is the tendency to anchor diagnostic criteria and, as a result, empirical research predominantly in reference to observable behaviors. The problem here is that the same behaviors can serve very different functions depending on the underlying personality structure. For example, behaviors related to what is seen as social timidity or inhibition may contribute to a diagnosis of either a schizoid or an avoidant personality. However, these same behaviors may in fact reflect the cautiousness of a deeply paranoid individual, or the fear of exposure of a narcissistically grandiose individual, or a reaction formation against exhibitionistic tendencies in a hysterical individual. A related problem is the necessary dependence, in large-scale research efforts, on standardized inquiries or questionnaires, assessment instruments that are known to be relatively poor measures of personality pathology (Torgerson & Ainaeus, 1990). Patients with personality disorders may not be sufficiently aware of certain pathological personality traits to report on them.

Further, even when patients are aware of their personality traits, responses to questionnaires and standard interviews will be influenced by the social desirability of particular traits.

## PERSONALITY: CONSTITUTIONAL FACTORS, CHARACTER, AND INTERNALIZED VALUE SYSTEMS

From a psychoanalytic perspective, personality represents the dynamic integration of behavior patterns derived from temperament, constitutionally determined cognitive capacities, character (and its subjective correlate, identity), and internalized value systems (Kernberg, 1976, 1980). Though we discuss them separately, from both a developmental and a functional perspective, these four dimensions of personality are intricately intertwined with one another.

Temperament refers to the constitutionally given and largely genetically determined, inborn disposition to particular reactions to environmental stimuli, particularly the intensity, rhythm, and thresholds of affective responses. In our model, affective responses, particularly affective responses under conditions of peak affect arousal, are crucial determinants of the organization of the personality. Thus, inborn thresholds for activation of both positive, pleasurable, and rewarding affects and negative, painful, and aggressive affects represent the most important bridge between biological and psychological determinants of the personality (Kernberg, 1994). In addition to affect disposition, temperament also includes inborn dispositions to perceptual organization, to motor reactivity, and to control over motor reactivity.

Constitutionally determined aspects of cognition, especially as they interact with affect dispositions, also pay an important role in personality. At the most basic level, cognitive processes play a crucial role in the development and modulation of affective responses by providing the representational aspects of affect activation. It is by way of representation that primitive affect states are transformed into complex emotional experiences. At a higher level of integration, the capacity for “effortful control” is closely linked to constitutionally determined aspects of cognition. Here we refer to the individual’s capacity to focus on certain cognitively relevant stimuli in the face of distracting affective stimulation, as well as the capacity to establish priority among various affective stimuli (Posner & Rothbart, 2000; Posner et al., 2002). Effortful control appears to play an important role in the severe personality disorders (Depue & Lenzenweger, 2001; Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001; Posner et al., 2002).

Character refers to the dynamic organization of enduring behavior patterns, including ways of perceiving and relating to the world, that are characteristic of the individual. A description of character includes the level

of organization of these patterns of behavior, the degree of flexibility or rigidity with which the observed behaviors are activated across situations, and the extent to which the observed behaviors are adaptive or interfere with psychosocial functioning. From a psychoanalytic perspective, the structured behaviors constituting character traits, and their overall organization into what is referred to as "character," reflect the organization of underlying psychological structures. In particular, "character" refers to the behavioral manifestations of identity. Conversely, the subjective aspects of identity, notably an integrated and crystalized self-concept and concept of significant others (or the lack thereof), are the psychological structures that determine the dynamic organization of character.

The third determinant of personality within a psychoanalytic frame of reference is the system of internalized values. The degree of integration of value systems, in essence, the moral and ethical dimension of the personality, is an important component of the total personality.

## Normal Personality: Descriptive Features

The normal personality is characterized, first of all, by an integrated concept of the self and an integrated concept of significant others. These structural characteristics, jointly referred to as identity or "ego identity" (Erikson, 1950, 1956; Jacobson, 1964), are reflected in an internal sense and an external appearance of self-coherence and are a fundamental precondition for normal self-esteem, self-enjoyment, the capacity to derive pleasure from work and values, and an overall zest for life. An integrated view of one's self ensures the capacity for a realization of one's desires, capacities, and long-range commitments. An integrated view of significant others guarantees the capacity for an appropriate evaluation of others, empathy, and social tact. An integrated view of self and others implies the capacity for mature dependency—that is, the capacity to make an emotional investment in others while maintaining a consistent sense of autonomy, as well the capacity to experience concern for others.

A second structural characteristic of the normal personality, largely derived from and an expression of an integrated identity, is the presence of a capacity for a broad spectrum of affect dispositions. In the normal personality affects are complex and well modulated, and even relatively intense affective experiences do not lead to loss of impulse control. Consistency, persistence, and creativity in work and interpersonal relations are also largely derived from normal ego identity, as are the capacity for trust, reciprocity, and commitment to others, which are codetermined by internalized value systems (Kernberg, 1975).

A third aspect of the normal personality is an integrated and mature system of internalized values. Though the system of internalized values is

developmentally derived from parental prohibitions and values, in the normal personality moral behaviors and values are no longer closely connected to parental prohibitions. Rather, the mature system of internalized values associated with the normal personality is stable, "depersonified," relatively independent of external relations with others, and individualized. Such a mature system of internalized values is reflected in a sense of personal responsibility, a capacity for realistic self-criticism, integrity as well as flexibility in dealing with the ethical aspects of decision making, and a commitment to standards, values, and ideals.

A fourth structural aspect of the normal personality is an appropriate and satisfactory management of sexual, dependent, and aggressive motivations, which may be experienced subjectively as needs, fears, wishes, or impulses. Appropriate expression of sexual, dependent, and aggressive strivings are fully integrated with normal ego identity. In the sexual sphere, we see the capacity for a full expression of sensual and sexual needs integrated with tenderness and emotional commitment to a loved other. With regard to dependency needs, the normal integration of dependent motivations is expressed in the capacity for interdependence and enjoyment of both caretaking and dependent roles. Finally, a normal personality structure includes the capacity to successfully channel aggressive impulses into expressions of healthy self-assertion, to withstand attacks without excessive reaction, to react protectively, and to avoid turning aggression against the self. Internalized value systems contribute to the normal integration and successful management of the motivational structures we describe.

## Normal Personality: Structural and Developmental Factors

The structural conditions that characterize normal identity represent the completion of a series of successive steps leading to progressive integration and organization of internalized object relations. The steps we describe represent a hypothesized (but yet to be validated) developmental model. At the same time, this model corresponds closely with clinical observations emerging from the psychodynamic treatments of patients with severe personality disorders and atypical psychoses.

A basic assumption of our developmental model is that psychological structures derived from interactions associated with high affect activation will have different characteristics from those derived from interactions under conditions of low affect activation. Under conditions of low affect activation, reality-oriented, perception-controlled cognitive learning takes place, leading to the formation of differentiated, gradually evolving definitions of self and others. These definitions start out from the perception of bodily functions, the position of the self in space and time, and the permanent characteristics of others. As these perceptions are integrated and

become more complex, and interactions with others are cognitively registered and evaluated, working models of the self in relation to others are established. Inborn capacities to differentiate self from nonself and the capacity for cross-modal transfer of sensorial experience play an important part in the construction of the model of self and the surrounding world.

In contrast, interactions associated with high affect arousal lead to the establishment of specific affective memory structures, framed by the nature of the interaction between baby and caretaker. These structures, which we have referred to as internal object relations, are constituted, essentially, by a representation of the self interacting with a representation of a significant other under the dominance of a peak affect state. The importance of these affective memory structures lies in their constituting the basis of the primary psychological motivational system, directing efforts to approach, maintain, or increase the conditions that generate peak positive affect states and to decrease, avoid, and escape from conditions of peak negative affect states.

In the early organization of these affective memory structures, the structures associated with positive affects and affiliative behaviors are built up separately from those associated with negative affects and aversive behaviors. With time, positive and negatively charged affective experiences come to be actively dissociated from each other. The result is the development of two major domains of early psychological experience. An idealized, or "all good," sector is characterized by purely positive representations of self and other associated with positive affect states. A persecutory or "all bad" sector is characterized by purely negative representations of other and threatened representations of self associated with negative affect states. These representations of negatively charged, painful, and dangerous relationships tend to be projected, leading to a fear of painful and dangerous relationships with people in the environment.

The active dissociation of positive and negatively charged experiences we have described is referred to as splitting. Splitting of positive and negative sectors of experience is a motivated mental operation, often described as a "defensive operation," representing an effort to maintain an ideal domain of experience characterized by the gratifying and pleasurable relation between self and others, while escaping from the frightening experiences of negative affect states. Splitting of experience into "all-good" and "all-bad" sectors protects the idealized experiences from "contamination" with bad ones, until a time when a higher degree of tolerance of pain and a more realistic assessment of external reality under painful conditions have evolved. Defensive operations based on splitting are sometimes referred to as primitive defenses.

This rudimentary stage of development of mental representations of self and other, with primary motivational implications of "move toward

pleasure and away from pain," eventually evolves toward the integration of the positive and negative sectors of experience. An important outcome of this process is that the intensity of negative affects and persecutory experiences is significantly diminished, as a result of integration with more positive affective relational experience. Integration is facilitated by the development of cognitive capacities and ongoing learning regarding realistic aspects of the interactions between self and others under circumstances of low affect activation. In simple terms, during this stage of psychological development, the child recognizes that he has both "good' and "bad" aspects, and he also recognizes that so does mother, and so do the significant others in the immediate family circle. It is the predominance of "good," pleasurable affective experiences, intimately linked with positive interactions with mother and other caretakers, that makes it possible to tolerate and organize an integrated view of self and others. That is, the normal predominance of positively charged or "idealized" experiences with caretakers is a prerequisite for the normal integration of positively and negatively charged sectors of mental experience.

The better integrated (neither "all-good" nor "all-bad"), more realistic, and affectively toned down representations of self are organized to form a complex and realistic self-concept that includes a view of the self as potentially imbued with both loving and hating impulses. A parallel integration occurs in the representations of significant others. These developments correspond to the consolidation of normal identity and determine the capacity for experiencing stable, coherent, and ambivalent relationships with others. Identity consolidation, associated with the capacity for ambivalent relations with others, thus marks the stage of "whole" (in contrast to "split") or total internalized object relations.

Erik Erikson (1950, 1956) first formulated the concept of normal ego identity and pathological identity formation, which he referred to as identity diffusion. Erikson proposed that normal ego identity is derived, developmentally, from early internalizations of affectively invested representations of significant others as they are integrated with later identifications that take into account the status and roles of the various members of the family. Erikson stressed that ego identity develops gradually, until a final consolidation of its structure in adolescence. For Erikson, identity included identification with aspects of significant others along with an integration of the individual's view of his position in society and his awareness of society's acknowledgment of his characteristics. Insofar as Erikson considered the confirmation of the self by the representations of significant others as an aspect of normal identity, he already stressed the intimate link between the self-concept and the concept of significant others. However, it was the work of Edith Jacobson (1964) in the United States, powerfully influencing Margaret Mahler's conceptualizations, and the work of Ronald Fairbairn

(1954) in Great Britain, that pointed to the dyadic nature of early internalizations and created the basis for contemporary psychoanalytic object relations theory.

The stage of identity consolidation, corresponding with the integration and crystalization of the experience of self and others, is equivalent to the phase of "object constancy" described by Mahler (Mahler & Furer, 1968; Mahler, Pine, & Bergman, 1975), characterized by the child's developing capacity to maintain a continuous and integrated (in terms of "bad" aspects being part of an overall, integrated, predominantly positive) mental representation of mother, even in the face of frustration and/or physical separation. In Mahler's developmental framework, the achievement of object constancy is hypothesized to take place somewhere between the end of the first year of life and the end of the third year of life.

Mahler's research points to the gradual nature of the integration of the experience of self in relation to others over the first 3 years of life, a process she referred to as "separation–individuation." In this regard, Mahler's framework is consistent with current developmental research. However, Mahler also assumed the existence of earlier phases of development marked by a mental organization corresponding to a "symbiotic" state in which the boundaries between self and other were not clearly established. This assumption is not consistent with more recent infant research, which suggests that infants have the capacity to distinguish self from other from the earliest days of life. As a result, rather than a symbiotic phase, we hypothesize a tendency very early in life to experience "symbiotic" moments of fantasized fusion between self-representation and object representation under peak affect conditions. These momentary fusions are counteracted by the inborn capacity to differentiate self from nonself, and the real and fantasized experience of third parties disrupting the states of momentary symbiotic unity between infant and mother.

The achievement of object constancy coincides with two additional changes in mental organization, the formation of an integrated system of internalized values and the formation of an unconscious system of highly affectively charged motivational structures.

Coinciding with identity formation, the mental structures derived from early prohibitions and later internalized value systems are organized into an integrated system of internalized morals and values, often referred to as the "superego." The superego is seen as constituted by successive layers of internalized self and object representations (Jacobson, 1964; Kernberg, 1984). A first layer of negatively affectively charged, persecutory split representations reflects a demanding and prohibitive, primitive morality as experienced by the child when environmental demands and prohibitions run against the expression of aggressive, dependent, and sexual impulses. A second layer of organization is constituted by ideal representations of self

and others reflecting early childhood ideals that promise the assurance of love and dependency if the child lives up to them. The integration of the earliest, persecutory and the later, idealizing representations tones down and modulates the intensity of both. In this process, a new level of organization is introduced into the system of internalized values, corresponding with decrease in the tendency to reproject these representations. This level of organization also brings about the capacity for internalizing more realistic, toned-down demands and prohibitions from the parental figures, leading to a third layer of integration of internalized value systems. This final stage corresponds with the formation of normal identity. Integration and consolidation of the structures that comprise identity facilitate this parallel development in the system of internalized values.

Finally, as part of the process of identity formation and formation of an internalized value system, those representations that are least well integrated and most highly affectively charged are dissociated from the representations that comprise the integrated, conscious sense of self and are eliminated from consciousness. These "high affect" mental structures are often referred to as a group as the dynamic unconscious or the id. The mental structures of the dynamic unconscious serve as an unconscious motivational system, corresponding with extreme manifestations of sexual, aggressive, and dependent impulses, needs, and wishes. The internalized system of values, in conjunction with the dominant sense of self that crystalizes with identity formation, is responsible for rejecting these highly charged and relatively poorly integrated mental structures from the conscious sense of self.

The capacity to reject threatening, painful, or anxiety-provoking aspects of mental experience and to eliminate them from consciousness is referred to as repression. The capacity for repression both reflects and facilitates the progressive integration and organization of psychological structures. As we have described, defensive operations based on splitting involve mutual dissociation of positive and negative sectors of experience to avoid anxiety, and, as a result, splitting-based defenses interfere with the normal integration of these sectors. In contrast, defenses based on repression ("neurotic defenses") do not interfere with the integration of persecutory and idealized structures. As a result, the emergence of defensive operations based on repression reflects some degree of integration of persecutory and idealized sectors and, at the same time, facilitates further integration of persecutory and idealized structures. Repressive defenses do, however, introduce a degree of rigidity into personality organization that is not seen in the normal personality.

Thus far we have focused on the shift from defenses based on splitting to those based on repression from the perspective of psychological structures and personality organization. We would like at this point to comment

briefly on this shift from the perspective of the psychological anxieties that motivate defense. We have already described how splitting is motivated by the need to protect the idealized sector of experience from contamination or destruction by the persecutory sector. Further, when splitting predominates, persecutory aspects of experience tend to be projected, leading to typically paranoid fears associated with the predominance of splitting-based defenses. In contrast, with repression, threatening aspects of the inner world are less likely to be projected and are more likely to be experienced as potentially dangerous or destructive aspects *of* the self, rather than dangers coming *toward* the self. In this setting, the dominant sources of anxiety are of doing harm and of being unable to protect the loved and vulnerable parts of the self and others from harm. Kleinian psychoanalysts refer to this dynamic situation as depressive anxiety (Klein, 1935). It is depressive anxiety that motivates repression of threatening internal object relations, relegating them to the dynamic unconscious. Depressive anxieties typically become organized around internal object relations that are derivatives of sexual, dependent, or aggressive needs and wishes.

## MOTIVATIONAL ASPECTS OF PERSONALITY ORGANIZATION: AFFECTS AND INTERNAL OBJECT RELATIONS

At the core of our model of personality and personality disorders is the development, progressive integration, and hierarchical organization of motivational systems. We stress the importance of the structural organization of motivational systems because the exploration of severe personality disorders consistently finds the presence of pathological aggression predominating. In contrast, a key dynamic feature of the normal personality is the full integration of erotic, dependent, and aggressive needs and wishes, under the dominance of loving, affiliative strivings. Finally, it is predominantly sexual conflicts, in the setting of failure to complete the normal integration of erotic, dependent, and aggressive strivings, that underlie the psychopathological features of the higher-level, neurotic personality disorders.

The developmental sequence of motivational structures begins with affects, which we consider to be the primary motivational system. Affects are instinctive components of human behavior common to all individuals of the human species. Affects are inborn, constitutionally and genetically determined modes of reaction triggered first by physiological and bodily experiences. Almost immediately, affects are activated in relation to, regulated by, and cognitively linked to interactions with caretakers. As we have described, over time, early interactions between children and their caretak-

ers are internalized and gradually organized to form internal object relations. Internal object relations are psychological structures with motivational implications. Because internal object relations are the basic building blocks of all psychological structures, in our model, affects, motivational systems, and psychological structures are intricately related.

Our model is consistent with the work of Krause (1988), who has proposed that affects constitute a phylogenetically recent biological system evolved in mammals to signal the infant animal's emergency needs to its mother. Further, Krause proposes that there exists a corresponding inborn capacity in mother to read and respond to the infant's affective signals, thus protecting the early development of the dependent infant mammal. Using videotapes, Beebe (Beebe & Lachman 2002) has studied the ways in which the baby's affects are shaped by early interactions with mother. In her interactions with her baby and her reactions to baby's affect states, mother helps to regulate and organize the baby's affect arousal. Beebe demonstrates how mother's acknowledgement of the infant's affect state can function to modulate the baby's affects and organize baby's behavior, whereas interactions in which mother fails to acknowledge the baby's affect state can lead to the disorganization of the baby's affective experience and behavior.

Fonagy and Target (Target & Fonagy, 1996; Fonagy & Target, 2003), have taken a similar approach, emphasizing the role of mother–child interactions in the child's developing capacity to reflect on his own emotional states and on the emotional states of others. Specifically, Fonagy and Target suggest that mother, in activating her normal capacity to respond to her infant and young child by "marking" (i.e., signaling that she can empathize with the child's affect state without sharing it), permits the child to internalize her contingent, accurate, and differentiated emotional experience. The child thus becomes able to reflect on his own affective experience. Mother's incapacity to mark her responses to the young child and her incapacity to accurately mirror her child's affective state are hypothesized to increase the dominance of the negative segment of experience for the child.

As we described, in the early life of the human baby, two series of mental structures are developed, one associated with highly charged positive affect states motivating "approach" behaviors and another associated with highly charged negative affect states motivating aversive behaviors. This level of mental organization corresponds with the predominance of two central motivational systems, one associated with positive affective reinforcement and motivating affiliative behaviors and the other associated with negative affective reinforcement and motivating aversive behaviors. Psychoanalysts often refer to these two, overarching motivational systems as the drives, libido, and aggression, respectively.

Rage represents the core affect of aggressive internal object relations, and the vicissitudes of rage explain the origins of hatred and envy, the dom-

inant affects in severe personality disorders. Similarly, the affect of sexual excitement constitutes the core affect of the sexual series of internal object relations. Sensual responses to intimate bodily contact dominate the development of the erotic impulses, and sexual excitement slowly and gradually crystalizes from the primitive affect of elation. Early experiences of pleasurable gratification crystalize to organize dependency needs, which evolve from infantile demands for perfect caretaking to longings for mutually dependent relations.

As mental development leads to the progressive integration of idealized and persecutory internal object relations, affect dispositions become increasingly complex and well modulated. These relatively well-integrated structures, associated with relatively well-modulated affect dispositions, are organized to form conscious motivational systems. With identity formation, these motivational systems are further integrated and become part of normal identity and the mature system of internalized values. At the same time, a subgroup of internal object relations, as a result of constitutional and environmental factors, remains poorly integrated and highly affectively charged. With the achievement of identity formation, object constancy, and the capacity for repression, these psychological structures and associated affect dispositions are repressed and become part of the dynamic unconscious, or the id. The dynamic unconscious contains internal object relations that are relatively extreme manifestations of erotic, dependent, and aggressive impulses.

Ultimately, what emerges from the initial series of mental structures associated with highly charged positive affect states motivating "approach" behaviors on the one hand and highly charged negative affect states motivating aversive behaviors on the other are three distinct motivational systems associated with erotic, dependent, and aggressive strivings, respectively. The erotic and the dependent motivational systems both emerge from the initial series of positively charged mental structures, sharing a common origin in highly charged wishes for physical closeness and fusion, and subsequently differentiate from one another. The aggressive motivational system emerges from the initial series of highly negatively charged mental structures. Each motivational system is associated with specific wishes and fears, organized as fantasies, some of which are conscious and some of which are unconscious. In the normal personality, the three motivational systems are flexibly integrated with one another and with the conscious sense of self, allowing for appropriate and satisfying expression of sexual, dependent, and aggressive needs, wishes, and impulses. In the higher-level, or neurotic, personality disorders we see the predominance of pathology of sexual motivations, in conjunction with anxiety pertaining to integrating sexual, dependent, and aggressive strivings. In contrast, in

severe personality disorders, we see the predominance of a very intense, poorly integrated, and poorly modulated form of aggression.

## Aggression and the Severe Personality Disorders

We propose that the pathology of aggression seen in patients with severe personality disorders reflects the confluence of constitutional and environmental factors. The theory of development we have presented permits us to account for the concept of inborn dispositions to excessive or inadequate affect activation, thereby doing justice to the genetic and constitutional variations in the intensity, rhythm, and thresholds of activation of aggression. This theory equally permits us to incorporate the role of physical pain, psychic trauma, and severe disturbances in early interactions with caretakers in intensifying aggression as a motivational system by triggering intense negative affects.

A review of the recent literature on alteration in neurotransmitter systems in severe personality disorders, particularly in the borderline and antisocial personality disorders, although still tentative, points to the possibility that neurotransmitters are related to specific distortions in affect activation associated with severe personality disorders (Stone, 1993a, 1993b). Abnormalities in the adrenergic and cholinergic systems, for example, may be related to general affective instability. Deficits in the dopaminergic system may be related to a disposition toward transient psychotic symptoms in borderline patients. Impulsive, aggressive, self-destructive behavior may be facilitated by a lowered function of the serotonergic system (deVagvar, Siever, & Trestman, 1994; Steinberg, Trestman, & Siever, 1994; Stone, 1993a, 1993b; van Reekum, Links, & Federov, 1994; Yehuda et al., 1994). In general, genetic dispositions to temperamental variations in affect activation would seem to be mediated by alterations in neurotransmitter systems, providing a potential link between the biological determinants of affective response and the psychological triggers of specific affects.

The genetic disposition to affect activation, at the level of serotonergic, noradrenergic, and dopaminergic neurotransmitter systems, may determine an organismic hyperreactivity to painful stimuli. This hyperreactivity may be expressed first in an inborn vulnerability to the development of excessive aggressive affect and, secondarily, to the development of severe personality disorders. Genetically determined hyperactivity of the areas of the brain that involve affect activation, particularly hyperactivity of the amygdala in relation to negative affect activation, presumably also play a role in this process. A genetic disposition to the development of severe personality disorders may also involve inborn inhibition of areas of the brain involved in cognitive control, particularly the prefrontal and preorbital cortex and the anterior portion of the cingulum, the areas involved in determining the capacity for "effortful control" (Posner & Rothbart, 2000; Posner et al.,

2002). Silbersweig et al. (2001), in a collaborative neuroimaging study with our Personality Disorders Institute, found that patients with borderline personality disorder presented decreased activity in dorsolateral prefrontal and orbitofrontal cortex when compared with normal control subjects during inhibitory conditions. In addition, these patients demonstrated an inappropriate increase in amygdalar activity in neutral word conditions relative to controls. These genetic and constitutional dispositions to excessive aggressive affect activation and lack of cognitive control would result in an inborn, temperamentally given predominance of the negative domain of early experience.

These findings with regard to inborn dispositions to the activation of aggressive affect states are complemented by well-established findings relating structured aggressive behavior in infants to early experience. Specifically, early, severe, chronic physical pain in the first year of life (Grossman, 1991; Zanarini, 2000) and habitual aggressive teasing interactions with mother (Galenson, 1986; Fraiberg, 1983) are related to the accentuation of aggressive behaviors of infants. Grossman's (1986, 1991) convincing arguments in favor of the direct transformation of chronic intense pain into aggression provides a theoretical context for the earlier observations of the battered-child syndrome. The impressive findings of the prevalence of physical and sexual abuse in the history of borderline patients, confirmed by investigators both here and abroad, (Marziali, 1992; Perry & Herman, 1993; Stone, 1993a; van der Kolk, Hostetler, Herron, & Fisler, 1994; Zanarini, 2000) provide additional evidence of the influence of trauma on the development of severe manifestations of aggression.

Further, even in less extreme circumstances, early experiences with caretakers appear to play a crucial function in facilitating affect modulation and regulating the domain of negative affective experience. In particular, Wilfred Bion (1962, 1967, 1970) and after him Fonagy and Target (Target & Fonagy, 1996; Fonagy & Target, 2003) have stressed the function of mother in transforming the infant's poorly defined and highly charged affect states into more highly integrated levels of experience. Conversely, mother's failure to function in this way will intensify the child's anxiety and anger, perhaps functioning as a risk factor for the development of pathological aggression.

Regardless of etiology, we propose that it is the developmental impact of pathological aggression that is responsible for the formation and perpetuation of the personality organization characteristic of patients with severe personality disorders and for the familiar constellation of personality traits that characterize the severe personality disorders. The predominance of pathological aggression reinforces splitting and related defensive operations and interferes with the normal integration of idealized and persecutory mental structures. Failure to integrate the rudimentary psychological structures (i.e., to integrate aggression and transform idealization into reality assessment) fixes personality organization at a stage preceding normal

identity formation. This fixation of psychological structures and affects at a relatively poorly integrated level of organization is sometimes referred to as identity diffusion.

## Sexuality and the Personality Disorders

While the central motivational feature of the severe personality disorders is the development of pathological aggression, the dominant pathology of the higher-level, or "neurotic," personality disorders (Kernberg, 1975, 1976, 1980, 1984, 1995) is pathology of sexuality. The group of neurotic personality disorders includes particularly the hysterical, the obsessive–compulsive, and the depressive–masochistic personalities, although the centrality of sexual conflicts is most evident in the hysterical personality disorder (Kernberg, 1984). These disorders all present with some form of sexual inhibition related to Oedipal conflicts, and pathological personality traits are dominated by acting out of unconscious guilt over childhood sexual impulses. These Oedipal dynamics reflect the activation of internal object relations unconsciously linked to childhood fantasies of sexual conquest and triumph in relation to one or both parents. Sexual impulses directed toward the parents of childhood, along with related wishes and fantasies, are considered unacceptable and so remain repressed, introducing both sexual inhibition and character rigidity into the neurotic personality. Because, for the neurotic, enjoying sexual pleasure with a partner who is loved (combining erotic and loving strivings) is unconsciously linked to these repressed object relations and related fantasies, neurotics in one way or another avoid the integration of passion and tenderness. Primary conflicts in relation to sexuality are often associated with conflicts around dependency and/or expression of aggression in the neurotic personality.

In contrast to the situation we describe in relation to the neurotic personality disorders, in the severe personality disorders where primary conflicts are in relation to pathological aggression, sexuality is usually "coopted" by aggression. For the severe personality disorders, sexual behavior is intimately condensed with aggressive aims, a situation that severely limits or distorts sexual intimacy and love relations. In addition, it is common to see the development of paraphilias, which invariably reflect the condensation of sexual and aggressive aims.

## Higher-Order Organization of Motivational Systems

The construct of the "drives," aggression and libido, viewed as the basic motivational systems in classical psychoanalysis, has had a long and problematic history. In presenting our model, we have focused on affects and motivational structures, sidestepping the question of whether or not to retain the term "drive." The motivational systems we have described are

fundamentally different from the original construct of drives, insofar as drives were considered to be inborn motivational systems, whereas we view affects as the inborn component of motivation. In our view, internal object relations, derived from the interplay of affects and interactions with caretakers, serve as the fundamental structures in the psychological development of motivational systems. However, we remain consistent with classical psychoanalytic approaches to motivation insofar as we do maintain that a theory of motivation based on affects or even on internal object relations alone is not sufficient.

It is our position that despite the problematic nature of the "drives" as a construct, a superordinate integration of motivational structures, organized around particular impulses, fears, and wishes, and associated with specific fantasies, is needed to account for clinical observations and to facilitate clinical work. There are always multiple positive and negative affects expressed toward the same significant other. What emerge in treatment, however, are organized psychological motivational systems, each with its own developmental history and associated with specific wishes, fears, and fantasies, that are characteristic of the individual. A psychological theory that links motives to affects only, without linking affects to integrated motivational systems, does not account for the organized series of mental structures associated with expression of a particular impulse that consistently emerge in the clinical setting. Specifically, hierarchically organized motivational systems corresponding to sexual, dependent, and aggressive strivings consistently emerge in the clinical setting, especially in the treatments of better integrated patients. These motivational systems are organized as integrated systems of internal object relations and are subjectively experienced as conscious and unconscious needs and wishes, linked to unconscious fantasies, that can be seen to have organized the patient's history of past internal object relations. In sum, although we do not retain the original psychoanalytic theory with regard to the origin of the drives, we do endorse a higher-order organization of motivations around aggressive, dependent and sexual strivings.[1] These motivational systems are not inborn but crystalize during psychological development as a result of the interaction of temperamental factors and experiences with significant others. In essence, within a contemporary psychoanalytic frame of reference, drives are the organizational consequence of the activation of inborn affective dispositions under the influence of environmental stimuli.

## A PSYCHOANALYTIC MODEL OF NOSOLOGY

The classification of personality disorders we describe in this section was first presented by Kernberg, in 1976. This classification system is organized around the dimension of severity, paying particular attention to identity

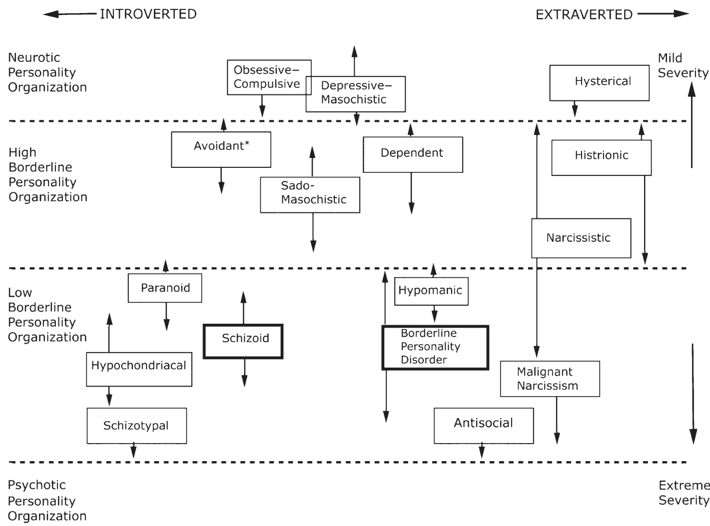


**FIGURE 3.1.** Relationship between familiar, prototypic personality types and structural diagnosis. Severity ranges from mildest, at the top of the page, to extremely severe at the bottom. Arrows indicate range of severity. *We include avoidant personality disorder in deference to the DSM. However, in our clinical experience, patients who have been diagnosed with avoidant personality disorder ultimately prove to have another personality disorder that accounts for avoidant pathology. As a result, we question the existence of avoidant personality as a clinical entity. This is a controversial question deserving further study.

consolidation, defensive operations, and reality testing. Severity ranges from (1) psychotic personality organization, through (2) borderline personality organization, to (3) neurotic personality organization (see Figure 3.1).

## Psychotic Personality Organization

"Psychotic personality organization" is characterized by lack of integration of the concept of self and significant others, that is, failure to attain normal identity formation ("identity diffusion"), a predominance of defensive operations centering around splitting ("primitive defenses"), and loss of reality testing. Within a psychoanalytic frame of reference, reality testing refers to the capacity to differentiate self from nonself, to distinguish intrapsychic from external sources of stimuli, and to maintain empathy with ordinary social criteria of reality. All these functions are typically lost in the psychoses and are manifested particularly in hallucinations and delu-

sions (Kernberg 1976, 1984). The loss of reality testing reflects the loss of differentiation between representations of self and other, especially under conditions of peak affect activation. All patients with psychotic personality organization really represent atypical forms of psychosis. Therefore, strictly speaking, psychotic personality organization represents an exclusion criterion for the personality disorders in the clinical setting.

## Borderline Personality Organization

"Borderline personality organization" is characterized by pathological identity formation (identity diffusion), primitive defensive operations, and varying degrees of pathology of internalized value systems in the setting of maintained but somewhat reduced reality testing marked by a decreased capacity for subtle and tactful evaluation of interpersonal processes, particularly in the setting of more intimate relations. This level of personality organization includes all the severe personality disorders seen in clinical practice. Typical personality disorders included here are the borderline personality disorder, the schizoid and schizotypal personality disorders, the paranoid personality disorder, the hypomanic personality disorder, hypochondriasis (a syndrome which has many characteristics of a personality disorder proper), the narcissistic personality disorder (including the malignant narcissism syndrome [Kernberg, 1992]), and the antisocial personality disorder. The antisocial personality, the syndrome of malignant narcissism, and many of the narcissistic personalities are characterized in addition by significant pathology of internalized value systems (Kernberg, 1989, 1992).

From a clinical standpoint, the syndrome of identity diffusion represents the dominant characteristic of borderline personality organization and, thus, of the severe personality disorders as a group. In particular, in the context of pathological aggression we see a poorly integrated, superficial, and unstable sense of self and others and limited affect dispositions marked by a combination of intensity and superficiality in the setting of the predominance of negative affects. These core features of the severe personality disorders reflect the splitting of the idealized segment of experience from the paranoid. Splitting mechanisms are naturally reinforced by other primitive defensive operations intimately connected with splitting (projective identification, denial, primitive idealization, devaluation, omnipotence, and omnipotent control). This entire constellation of defensive operations serves to distort interpersonal interactions, to create chronic disturbances in interpersonal relations, and to interfere with the capacity to assess other people's behavior and motivations in depth, particularly under the impact of intense affect activation. The lack of integration of the concept of the self interferes with a comprehensive integration of one's past and present into a capacity to predict one's future behavior and decreases the capacity for

commitment to professional goals, personal interests, work and social functions, and intimate relationships.

The lack of integration of the concept of significant others interferes with the capacity for realistic assessment of others, for selecting partners harmonious with the individual's actual expectations, and for investment in others. The predominance of negative affect dispositions leads to an infiltration of sexual intimacy by excessive aggressive components. The outcome is, frequently, an exaggerated and chaotic interest in polymorphous perverse sexual practices as part of the individual's sexual repertoire. In more severe cases, we see a primary inhibition of the capacity for sensual responsiveness and erotic enjoyment. Under these latter circumstances, overwhelming negative affect states eliminate the very capacity for erotic response, leading to the severe types of sexual inhibition that are to be found in the most severe personality disorders.

The lack of integration of the concept of self and of significant others also interferes with the internalization of the early layers of the system of internalized values. This leads to a particularly exaggerated quality of the idealization of positive values and ideals, and to an extremely persecutory quality of prohibitions. These developments lead, in turn, to a predominance of splitting mechanisms at the level of internalized value systems, with excessive projection of internalized prohibitions. At the same time, excessive, idealized demands for perfection further interfere with the integration of a normal superego. Under these conditions, antisocial behavior may emerge as an important aspect of severe personality disorders, particularly in the syndrome of malignant narcissism and in the antisocial personality. Of note, the antisocial personality, the most severe of the personality disorders, is characterized not only by the lack of any internalized system of values but also by the greatest severity of identity diffusion seen among the personality disorders (Kernberg, 1984, 1992). In general, consolidation of a normal system of internalized morals and values is a consequence of identity integration, and, in turn, protects normal identity. Severe disorganization of the system of internalized values, in contrast, worsens the effects of identity diffusion.

A particular group of personality disorders presents the characteristics of borderline personality organization while maintaining more satisfactory social adaptation, including the capacity to obtain some degree of intimacy and some degree of satisfaction from work. These patients have relatively good impulse control, relatively little overtly aggressive behavior, some capacity for a benign cycle of intimate involvements along with a capacity for dependency gratification, and a better adaptation to work. These features clearly differentiate this group from the group presenting with more severe pathology. This group constitutes "high borderline" level of personality organization. The high-borderline group includes the cyclothymic per-

sonality, the sadomasochistic personality, the histrionic or infantile personality, and the dependent personalities, as well as some better-functioning narcissistic personality disorders.

### Neurotic Personality Organization

The next level of personality disorder, "neurotic personality organization," is characterized by normal identity consolidation, the predominance of defenses based on repression, and stable reality testing. This level of psychological organization is associated with a capacity for deep and caring relationships with others and a fully integrated system of internal values. The neurotic personality organization is associated with good anxiety tolerance, impulse control, effectiveness and creativity in work, and a capacity for sexual love and emotional intimacy disrupted only by unconscious guilt feelings reflected in specific pathological patterns of interaction in relation to sexual intimacy. The neurotic personality organization includes the hysterical personality, the depressive–masochistic personality, the obsessive personality, and many so-called avoidant personality disorders, in other words, the "phobic character" of psychoanalytic literature (which, in our view, remains a problematic entity).

The neurotic personality organization is distinguished from the normal personality on the basis of character rigidity. Character rigidity can be defined as the automatic activation of organized constellations of personality traits that are more or less maladaptive and not subject to voluntary control. In the neurotic personality disorders, internal object relations that are threatening are split off from the integrated representations that comprise normal identity. The repression-based defensive operations that ensure that these particular internal object relations remain apart from the dominant, conscious sense of self introduce rigidity into the neurotic personality organization and are responsible ultimately, for neurotic character traits. As we have already described, internal object relations that are rejected from the dominant sense of self are especially highly charged and poorly integrated manifestations of sexual, dependent, and aggressive impulses, wishes, and fears, with conflicts over sexuality predominating.

## DEVELOPMENTAL, STRUCTURAL, AND MOTIVATIONAL CONTINUITIES

Having thus classified personality disorders in terms of their severity, we now examine particular continuities that establish a psychopathologically linked network of apparently related personality disorders (see Figure 3.1).

## The Borderline and Schizoid Personality Disorders

The borderline personality disorder and the schizoid personality disorder may be described as the simplest forms of severe personality disorders. These disorders reflect identity diffusion in the setting of the predominance of splitting mechanisms and can be seen as the "purest" expression of the general characteristics of borderline personality organization.

Fairbairn (1954) described the schizoid personality as the prototype of all personality disorders and provided an understanding of the psychodynamics of these patients unsurpassed to this day. He described the splitting operations separating "good" and "bad" internalized object relations, the motivated self and object representations that comprise the split-off object relations, the consequent impoverishment of interpersonal relations, and their replacement by a defensive hypertrophy of fantasy life. In fact, in the course of psychoanalytic exploration, the apparent lack of affect display seen in the schizoid personality turns out to reflect severe splitting operations; extreme splitting leads to a fragmentation of affective experience, which "empties out" interpersonal experience. At the same time, the internalized object relations of the schizoid personality have the split, persecutory, and idealized characteristics typical of the borderline personality disorder (Kernberg, 1975). While the schizotypal personality disorder as listed in DSM-IV appears to be a more severe form of schizoid personality, it appears increasingly likely that schizotypal personality is not a personality disorder at all but, rather, a variant of schizophrenia, characterized by a mild thought disorder and a family history of psychotic illness (Lenzenweger, 1998).

The borderline personality disorder presents structural and dynamic features similar to those seen in the schizoid personality, but in the borderline personality we see expression of this pathology predominantly in impulsive interactions in the interpersonal field (Akhtar, 1992; Stone, 1994). In contrast to the schizoid personality, where internal object relations are expressed in conscious fantasy life in the setting of social withdrawal, in the borderline personality disorder the same widely split, internalized object relations are enacted in the interpersonal field. In fact, in the borderline personality disorder, repetitive, powerfully motivated interpersonal behaviors often replace self-awareness. Episodic, intense, overwhelming affect states ("affect storms") and poor impulse control in the setting of identity diffusion are typical of the borderline personality disorder, in marked contrast with the schizoid personality where we see apparent lack of affect and good impulse control.

It may well be that the descriptive differences between the schizoid and borderline disorders reflect temperamental differences. In particular, the borderline and schizoid personalities appear to differ across the dimension

of extroversion and introversion, one of the important temperamental factors that emerges under different names in various models of classification.

## Pathology of Aggression and the Personality Disorders

Extreme pathology of aggression is characteristic of the paranoid personality disorder, the syndrome of hypochondriasis, the sadomasochistic personality disorder, the syndrome of malignant narcissism, and the antisocial personality. The paranoid personality reflects an increase of aggression relative to the schizoid personality disorder. In the paranoid personality, the projection of aggressive internal object relations creates an external world populated by persecutory figures. Defensive idealization of the self is related to efforts to control this overwhelmingly dangerous external world. Thus, where splitting per se predominates in the borderline and schizoid personality disorders, in the paranoid personality we see the predominance of defenses related to splitting but that rely heavily on the projection of persecutory experiences while trying to control them as they are embodied in the external world. The hypochondriacal syndrome reflects a projection of persecutory objects onto the interior of the body; hypochondriacal personalities usually also show strong paranoid and schizoid characteristics.

## Affect Regulation and the Personality Disorders

The intensity of affect activation and the lack of affect control seen in the borderline personality, along with the high incidence of affective illness that characterizes this group, suggest the presence of a temperamental factor relating to affect regulation as a predisposing factor for development of borderline personality disorder. At the same time, it is impressive the degree to which the integration of negative and positive affect states obtained in the course of psychodynamic treatments brings about a marked toning down and modulation of affect response. The increase of impulse control and affect tolerance in the borderline personality seen as a result of successful treatment illustrates that splitting mechanisms play a central role in the pathology of affects seen in borderline personality. In contrast, in the hypomanic and cyclothymic personalities, pathology of affect activation appears to reflect a temperamental disposition in the area of affect regulation.

The borderline personality disorder, when characterized by especially prominent and intense aggression, may evolve into the sadomasochistic personality disorder. With the achievement of identity consolidation, the disposition to strong sadomasochism may become incorporated into or controlled by a relatively well integrated superego structure, establishing the conditions for the depressive masochistic personality disorder. The

depressive–masochistic personality may be considered the highest level of two lines that go from the borderline personality through the sadomasochistic to the depressive masochistic on the one hand, and from the hypomanic to the depressive masochistic, on the other. This entire spectrum of personality disorders appears to reflect the internalization of object relations under conditions of abnormal affective development or affect control.

## Pathological Identity Formation and the Personality Disorders

In contrast to the clear indication of identity pathology seen in all the other personality disorders included in borderline personality organization, in the narcissistic personality a lack of integration of the concept of significant others goes hand in hand with an integrated, but pathological, sense of self. This structure is sometimes referred to as a pathological grandiose self or pathological identity formation. The pathological grandiose self replaces the underlying lack of integration of a normal self and is responsible for the appearance of better surface adaptation seen in the narcissistic personality disorders relative to the other severe personality disorders (Akhtar, 1989; Plakun, 1989; Ronningstam & Gunderson, 1989). In the course of psychodynamic treatment we may observe the dissolution of this pathological grandiose self and the reemergence of the typical structure of identity diffusion of borderline personality organization before a new integration of normal identity can take place.

In the narcissistic personality the pathological self absorbs both real and idealized self and object representations into an unrealistically idealized concept of self. This structural development leads to a parallel impoverishment of the system of internalized values, where we see a predominance of persecutory superego precursors over idealized structures. In this setting, persecutory structures tend to be projected, interfering with the later development of more integrated superego functions (Kernberg, 1975, 1984, 1992). As a result, the narcissistic personality often presents some degree of antisocial behavior.

When intense pathology of aggression dominates in a narcissistic personality structure we see the development of especially malignant forms of psychopathology. In this setting, the pathological sense of self becomes infiltrated by aggression in such a way that expression of aggression in various forms is perfectly acceptable (“ego syntonic”) and also pleasurable. The result is the development of grandiosity combined with ruthlessness, sadism, or hatred. The constellation of narcissistic personality, antisocial behavior, ego syntonic aggression, and paranoid tendencies constitutes the syndrome of malignant narcissism. Kernberg (1992) has proposed that this syndrome is intermediate between the narcissistic personality disorder and

the antisocial personality disorder proper, in which a total absence or deterioration of superego functioning has occurred.

The antisocial personality disorder (Akhtar, 1992; Bursten, 1989; Hare, 1986; Kernberg, 1984) usually reveals, in psychoanalytic exploration, severe underlying paranoid trends together with a total incapacity for any nonexploitive investment in significant others. The total absence of a capacity for guilt feelings, or of any concern for self and others, an incapacity to identify with any moral or ethical value in self or others, and an incapacity to project a dimension of personal future characterize the antisocial personality disorder. The less severe syndrome of malignant narcissism is distinguished from the antisocial personality insofar as there is some capacity for commitment to others and for experiencing authentic feelings of guilt. The most important prognostic indicators for any psychotherapeutic approach to the personality disorders are the capacity for nonexploitive object relations (i.e., the capacity for significant investment in others) and the extent to which antisocial behaviors predominate (Kernberg, 1975; Stone, 1990).

## The Higher-Level or Neurotic Personality Disorders

At a higher level of personality organization we see the “neurotic” personality disorders, the obsessive–compulsive, hysterical, and depressive–masochistic personalities. The obsessive–compulsive personality can be characterized by the absorption of aggression into a well-integrated but excessively demanding and self-critical superego. This internal situation is expressed in the familiar features of perfectionism, self-doubts, and chronic need to control the environment and the self that are characteristic of this personality disorder.

While the histrionic, or infantile, personality is a milder form of the borderline personality disorder, though still within the borderline spectrum, the hysterical personality disorder represents a higher level of personality, falling in the neurotic spectrum of personality organization. In the hysterical personality, emotional lability, extroversion, and dependent and exhibitionistic traits of the histrionic personality are restricted to the sexual realm. In contrast to the histrionic personality, the hysteric is able to have normally deep, mature, committed, and differentiated relationships outside the sexual realm. Further, in contrast to the sexual “freedom” of the typical infantile personality, the hysterical personality often presents a combination of pseudo-hypersexuality and sexual inhibition.

The depressive–masochistic personality disorder (Kernberg, 1992), the highest-level outcome of the pathology of depressive affect as well as that of sadomasochism, presents not only a well-integrated superego (as do all other personalities with neurotic personality organization) but also an

extremely punitive set of internal values. This predisposes the patient to self-defeating behavior, reflecting an unconscious need to suffer as an expiation for guilt feelings or as a precondition for sexual pleasure, reflecting the Oedipal dynamics characterizing the neurotic spectrum of personality disorders. The excessive dependency and easy sense of frustration seen in these patients goes hand in hand with their "faulty metabolism" of aggression. Where an aggressive response is called for, the depressive–masochistic personality is more likely to feel depressed. As a result, a typically excessively aggressive response to the frustration of dependency needs may rapidly turn into a renewed depressive response, as a consequence of excessive guilt feelings over aggression.

### Implications of This Classification System

The classification system we have outlined combines structural and developmental approaches to psychological organization, based on a theory of internal object relations. Personality disorders are classified, first and foremost, according to severity of pathology, which mirrors the presence or absence and also the severity of pathology of identity. Level of personality organization is the most powerful "first pass" predictor of prognosis and will guide treatment planning as well. A combined analysis of reality testing, identity, the predominant level of defensive operations, the system of internalized values, quality of object relations, and the degree of integration and organization of motivational structures, as well as their accessibility to consciousness, permits us to characterize severity of psychopathology. In addition, at any level of severity or level of personality organization, we can distinguish among the personality disorders across several dimensions. Specifically, we consider the extent to which pathology is dominated by aggression, the extent to which pathological affective dispositions influence personality development, the effect of the development of a pathological grandiose self, and the potential influence of a temperamental disposition to extroversion/introversion distinguish among the various personality disorders. This classification illustrates the advantages of combining categorical and dimensional criteria for classifying personality disorders.

There are clinically observable affective–developmental lines that link several of the personality disorders to one another, particularly along an axis of severity. Figure 3.2 summarizes the relationships we have outlined that can be seen among the various personality disorders.

## PSYCHOANALYTIC AND PSYCHOTHERAPEUTIC TREAMENTS FOR PERSONALITY DISORDERS

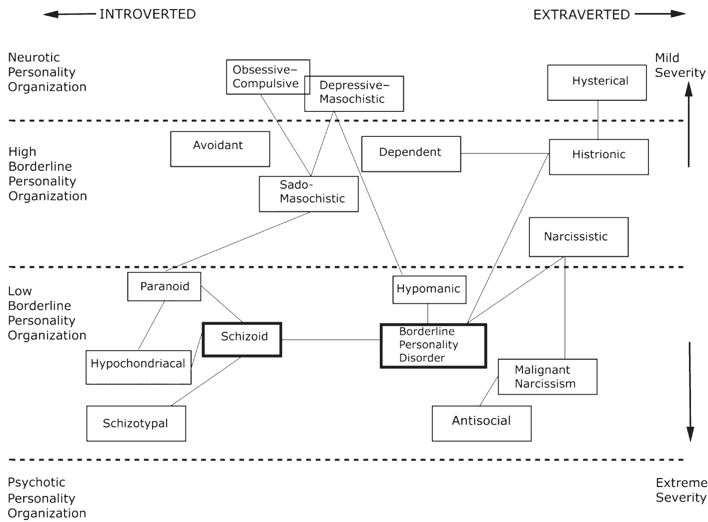


**FIGURE 3.2.** Continuities and clinically relevant relationships among the personality disorders. Connecting lines indicate clinically relevant relationships among disorders.

## A General Therapeutic Frame

The treatments we describe here are long-term psychodynamic psychotherapies and psychoanalytic treatments designed to treat personality disorders. Psychotherapy sessions meet twice weekly and treatments typically last between 2 and 4 years. Psychoanalysands attend sessions three or four times a week, and treatment typically lasts between 4 and 6 years. The amount of time and effort required reflects the ambitious nature of these treatments. The goals of psychoanalytic psychotherapy and psychoanalysis are to modify personality organization and the quality of the internal object relations associated with symptoms and pathological character traits.

For patients organized at a borderline level, treatment is organized around the goal of resolving or ameliorating identity diffusion and promoting normal identity consolidation. For patients organized at a neurotic level, treatment is organized around the goal of reducing character rigidity. Our therapeutic approach reflects our understanding of the structural and dynamic features underlying identity diffusion and character rigidity. To resolve identity diffusion, we promote integration of split, mutually dissociated idealized and persecutory internal object relations. To resolve character rigidity, we promote integration of conflictual, unconscious internal

object relations into the dominant sense of self. These changes in personality organization correspond with changes in the maladaptive character traits and subjective disturbances characteristic of the various personality disorders.

With all the personality disorders, our technical approach is organized around exploration of the patient's internal object relations. Predictably, conflictual, or pathogenic, internal object relations tend to be played out, and in the process to distort current interpersonal relationships. As a result, in the psychotherapeutic treatment of patients with personality disorders we focus on the patient's internal object relations as they are played out in the patient's current relationships; in our approach, the patient's current interpersonal relationships serve as a window into the patient's inner world. In psychotherapy and psychoanalysis the patient's relationship with the therapist offers a special opportunity for the patient and therapist to explore, in their immediate here-and-now interactions, the ways in which the patient's conflictual internal object relations are enacted in his interpersonal relationships. The tendency for patients in psychodynamic therapies to experience and enact aspects of their pathogenic, conflictual, internal object relations in their interactions with the therapist is referred to as transference. Transference manifestations differ according to the nature of the patient's psychopathology and, in particular, the patient's level of personality organization.

In patients with neurotic level of personality organization, transferences tend to be relatively stable, well organized, and realistic and are associated with complex, relatively well modulated affect states. These internal object relations can be relatively easily understood in terms of an unconscious relationship between the patient's childhood self and the parents of the past. When activated in the transference, these unconscious relationships can be interpreted as reflections of both realistic and fantasied aspects of childhood relationships with the parents, as well as defenses against the reactivation of these unconscious relationships in the present. Neurotic transferences emerge gradually and evolve slowly during the course of treatment, and the internal object relations activated in the transference unfold systematically.

The situation is quite different when it comes to the treatment of patients with severe personality disorders. When treating patients with poorly consolidated identity (borderline level of personality organization), transferences are poorly organized, unstable, and unrealistic. They are associated with affects that are intense, poorly differentiated, and poorly modulated. Although derived from aspects of past relationships, these internal object relations cannot be easily linked to actual or fantasied relationships with the parents of the past. In treatment, internal object relations

of this kind are typically activated in the transference immediately and chaotically, often during the first contact between patient and therapist. An additional complication, adding further confusion and instability to the treatment situation, is that in borderline transferences, we see not only shifts among different internal object relations activated in the transference, but also typically rapid shifting of roles within any given internal object relation. Thus, we see a rapid interchange of roles, such as that at one moment the patient will identify with one half of an object relational dyad and, at the next moment, with the other half of the dyad, while attributing the complementary role to the therapist.

Our model of personality disorders, embedded in an object relational frame of reference, permits the therapist to understand and to work therapeutically with what often appears to be complete chaos in the treatment of patients organized at a borderline level. At the same time, our model guides the clinician treating the neurotic patient, helping the therapist to negotiate the different challenges presented by this patient population.

## The Treatment of Patients with Borderline Personality Organization

The treatment approach we present has been designed specifically to treat patients with severe personality disorders. This treatment, "transference-focused psychotherapy" for patients with borderline personality organization (TFP-B), is a twice-weekly psychodynamic treatment based on principles derived from psychoanalysis. TFP-B has been systematically described in a treatment manual (Clarkin et al., 1999) and is the basis of an empirical research program that is presently in progress (Clarkin et al., 2001; Clarkin et al., 2004). The treatment is organized around the goals of promoting identity consolidation while containing the destructive acting out that typically characterizes the treatments of patients organized at a borderline level. The basic strategy of TFP-B is to promote integration of "split" persecutory and idealized internal object relations to form better-integrated representations of self and other, while decreasing reliance on splitting-based defenses.

### *Strategies of Transference-Focused Psychotherapy for Patients with Borderline Level of Personality Organization*

The overall psychotherapeutic strategy of TFP for the treatment of patients with severe personality disorders can be conceptualized in terms of three sequential tasks:

*Step 1* is to diagnose the idealized or persecutory internal object rela-

tion that is apparently dominant within the overall chaotic transference situation and to describe in as much detail and as accurately as possible the representations involved. For example, the therapist might point out to the patient that their momentary relationship resembles that of a sadistic prison guard with a paralyzed, frightened victim.

*Step 2* of this strategy is to clarify which is the self-representation and which is the object representation in this internal object relation at the moment and what is the dominant affect linking them. For example, the therapist might point out, in expanding the previous intervention, that it is as if the patient experienced himself as a frightened, paralyzed victim while attributing to the therapist the behavior of a sadistic prison guard. Because of the typical oscillating or alternating attribution of self and object representations seen in the borderline patient, the patient's identification with either half of the dyad is unstable. As a result, later in the same session the therapist might point out to the patient that, now, the situation has become reversed in that the patient behaves like a sadistic prison guard while the therapist has been placed in the role of the frightened victim.

*Step 3* of this interpretive strategy is to link the particular internal object relation currently dominant in the transference with the entirely opposite transference, activated at other times in the treatment, that constitutes the split-off counterpart to the object relation currently active. For example, the therapist might remind the patient that even though he presently feels himself to be in the hands of a sadistic prison guard, at other times the patient has experienced the therapist as a perfect, all-giving mother. The therapist would go on to point out that this other experience of the therapist is associated with the patient's experiencing himself as a satisfied, happy, loved baby who is the exclusive object of mother's attention. The therapist might, in addition, suggest that the persecutory prison guard is in fact a frustrating, teasing, and rejecting mother, while the victim is an enraged baby who wants to take revenge but is afraid of being destroyed if he does so. The therapist might further add that this terrible mother–infant relationship is kept completely separate from the idealized relationship. A complete interpretation would also establish a hypothesis as to the meaning of or motivation for the patient's dissociating the persecutory and idealized transferences. For example, the therapist might interpret that the patient feels he needs to do this out of fear that if he allows the idealized relationship with the therapist to be contaminated by the persecutory relationship, the ideal relationship might be permanently destroyed, taking with it all hope.

This approach will lead to the gradual integration of persecutory and idealized internal object relations to form the more realistic transferences typical of patients organized at a neurotic level. The successful integration of mutually dissociated idealized and persecutory internal object relations

in the transference results in the integration not only of the corresponding self and object representations but also of primitive affects. The integration of intense, polarized affects leads, over time, to affect modulation, an increase in the capacity for affect control, and a corresponding decrease in impulsive behaviors, as well as a heightened capacity for empathy with both self and others and a corresponding deepening and maturing of interpersonal relations.

The three-part strategy we have outlined relies on three basic tools of psychoanalytic technique, all modified to meet the clinical demands of patients with severe personality disorders. We refer to interpretation of unconscious conflict, systematic transference analysis, and technical neutrality. We define each of these terms and then explain how each has been modified for TFP-B.

*Interpretation.* Interpretation is a three-step process, beginning with clarification, followed by confrontation, and leading finally to interpretation proper. Clarification entails systematic exploration of the details of the patient's subjective experience. Confrontation involves pointing out contradictions, inconsistencies, and omissions in the patient's verbal and nonverbal communications. Interpretation entails establishing hypotheses about the unconscious determinants of the patient's behavior. In contrast to standard psychoanalysis, in TFP the emphasis is on clarification and confrontation rather than on interpretation proper. To the degree that unconscious meanings are interpreted in TFP, this is done in a restricted fashion, limited largely to the unconscious meanings of the patient's behavior in the "here and now."

*Systematic Transference Analysis.* In TFP-B, as in psychoanalysis, the therapist focuses his attention on the patient's internal object relations as they are activated in the treatment. However, in TFP-B the therapist cannot afford to focus his attention entirely on transference developments. Instead, in each session, the therapist must also maintain ongoing attention to the patient's long-range treatment goals and to the dominant, current conflicts in the patient's life outside the sessions. This is necessary because when borderline patients are in psychotherapy they tend to lose sight of treatment goals and to neglect the demands of external reality. This propensity on the part of borderline patients reflects the activation of defensive operations that lead to dissociation between external reality and treatment hours.

*Technical Neutrality.* Technical neutrality is central to the strategy of TFP-B. When we describe the TFP therapist as maintaining a "neutral" stance, we mean that he or she makes an effort to avoid taking sides in the patient's inner struggles. This does not imply that neutral therapist is in any

way detached from the patient. Rather, the neutral therapist is actively engaged with the patient and maintains an attitude of concern for the patient's best interests. The hallmark of the neutral therapist is his or her capacity to reflect on the ways in which the patient is affecting the therapist and to use his or her reactions to the patient to deepen understanding of the patient's conflicts. In contrast to treatments for neurotic patients, in which the therapist can maintain a neutral stance relatively consistently throughout the treatment, in TFP-B, technical neutrality is an ideal position from which the therapist repeatedly deviates and then returns. The impossibility of consistently maintaining technical neutrality reflects the severe acting-out characteristic of borderline patients, inside and outside the treatment hours, which often requires limit setting and structuring of the treatment situation. Every time the therapist intervenes in this way he or she is deviating from technical neutrality. After doing so, the therapist will reinstate technical neutrality by reviewing and interpreting the reasons for having moved away from a position of technical neutrality.

Given the strong tendencies toward acting out on the part of borderline patients, dangerous complications of treatment are common and pose a chronic threat to the treatment. Specifically, characterologically based (i.e., not linked to affective illness) suicide attempts, drug abuse, self-mutilation and other self-destructive behaviors, and aggressive behaviors that may be life threatening to the patient and to others are all typical features of the psychotherapeutic treatments of many patients with severe personality disorders. As a result, the assessment of whether there are emergency situations that require immediate intervention is an important aspect of each session. On the basis of our general treatment strategy and experience in the treatment of severely ill borderline patients, we have constructed the following set of priorities of intervention that reflect the need to assess, diagnose, and treat these and other complications.

A threat of imminent suicidal or homicidal behavior has the highest priority in each session. If there seem to be immediate threats to the continuity of the treatment, these constitute the second highest priority that needs to be taken up by the therapist. If the patient appears to be communicating in deceptive or dishonest ways, this constitutes the third highest priority; psychodynamic psychotherapy demands honest communication between patient and therapist and the meanings that underlie the patient's dishonesty or deceptiveness must be interpreted. Acting out in the sessions as well as outside the session constitutes the next highest priority. With these priorities considered, the therapist is free to concentrate fully on the analysis of the patient's internal object relations as they are being enacted in his current life, with special attention to the transference.

## The Treatment of Patients with Neurotic Personality Organization

Transference-focused psychotherapy for patients with neurotic personality organization (TFP-N) has been designed specifically to treat patients with neurotic personality organization (Caligor, Clarkin, & Kernberg, 2004). In contrast to TFP-B, the clinical technique of TFP-N is very similar to the technique employed in psychoanalysis, with few modifications. The main difference between TFP-N and psychoanalysis is that TFP-N is more focal and less ambitious in its goals. The goal of psychoanalysis is reduction of character rigidity across all affected areas of functioning. In contrast, the goal of TFP-N is reduction of character rigidity in a specific area of functioning, manifested in the patient's presenting complaints and designated in the mutually agreed on treatment goals. In keeping with the more limited goals of TFP-N relative to psychoanalysis, in developing TFP-B, we have modified analytic technique to focus on particular areas of conflict rather than endorsing the less selective attitude of "evenly hovering attention" assumed by the psychoanalyst. The basic strategies of TFP-N and psychoanalysis are to promote integration into the dominant sense of self of conflictual internal object relations that have been split off and repressed, while decreasing reliance on neurotic defenses relative to healthy or mature defenses. The overall approach is to bring repressed and dissociated internal object relations into consciousness where the underlying conflicts can be explored and worked through. The outcome of this process is that previously conflictual internal object relations become better integrated and less affectively charged and, as a result, are assimilated into the dominant sense of self.

### *Strategies of Transference-Focused Psychotherapy for Patients with Neurotic Level of Personality Organization*

The overall psychotherapeutic strategy of TFP for the treatment of patients with neurotic personality organization can be conceptualized in terms of five sequential tasks, described below. In TFP-N, implementation of these tasks is restricted to circumscribed areas of character rigidity. Specifically, the treatment focuses on areas of character rigidity tied to the patient's dominant symptoms and the problems that have been agreed upon as the targets of the treatment, as well as on those character defenses that interfere with exploration of these specific areas.

*Step 1* is to facilitate activation of conflictual representations of self and others and associated affects in the treatment. This is accomplished by the therapist's maintaining a neutral stance while systematically exploring the internal object relations enacted in the session, beginning with defen-

sively activated representations and moving toward those more closely associated with impulse expression. The process of clarifying, exploring, and ultimately interpreting the functions of the patient's defensively activated internal object relations is referred to as analysis of resistance.

*Step 2* of this strategy is to diagnose the affectively dominant internal object relation that is being enacted in the treatment and to describe in as much detail and as accurately as possible the representations involved. For example, the therapist might point out to the patient that his discomfort with regard to speaking openly with the therapist appears connected to an experience of himself as a self-conscious child in the presence of an admired but potentially disapproving parent.

*Step 3* of this strategy is to clarify and ultimately interpret the conflict embedded in the affectively dominant object relation activated in the treatment. For example, the therapist might point out, in expanding the previous intervention, that it is as if the patient experienced himself as entirely free of disapproving and critical impulses, feeling only self-conscious and admiring. The therapist would suggest that it might make the patient feel anxious to experience himself as at all critical of the therapist or of the other important people in his life. This is an example of analysis of resistance, in which the patient's defensively activated internal object relations are identified, explored, and ultimately interpreted. In this example, the therapist's interpreting, over time, the patient's defensive use of attributing all critical feeling to an object representation while dissociating himself from these feelings will pave the way to uncovering the impulse underlying the patient's defensive self-representation, along with the anxiety associated with expression of that impulse.

*Step 4* of this interpretive strategy is to explore the repressed and dissociated, impulsive, internal object relations that underlie the defensively activated internal object relations, along with the anxiety associated with impulse expression. For example what might emerge in the foregoing example is that the self-conscious child self and the admired but potentially disapproving parent defends against activation of the experience of a hurt and angry child who wants revenge in relation to a critical, derisive, and rejecting parent. The patient avoids consciously experiencing this internal object relation because feeling angry and vengeful, as well as critical and derisive, are unacceptable feelings, associated with guilt, depression, anxiety, and fear. During the course of the treatment, the patient will become aware of his unconscious identification with both halves of the impulsive dyad, both the angry and vengeful child and the critical, derisive, and rejecting parent.

*Step 5* is to work through the guilt and regret associated with acknowledging and taking responsibility for formerly unconscious impulses, represented as affectively charged internal object relations. In this process, the

patient will make amends, in fantasy and reality, for the potential harm to others associated with the expression of his conflictual impulses. For example, the patient we have been describing, now aware of his potential hostility and derision as well as his anger and wishes for revenge, might experience a new level of concern for the important people in his life. He might pay special attention to the needs of his employees or his children or his parents, and he might demonstrate similar feelings and efforts in relation to the therapist in the transference. The outcome of this process of uncovering unacceptable impulses, taking responsibility for them and making reparation, repeated over time, is that representations associated with expression of hostile, derisive impulses become more complex and differentiated and associated affects become less intense and less anxiety provoking. As the internal object relations associated with expression of hostile and derisive impulses become better integrated, they will become part of the patient's dominant sense of self. These changes in psychological structures correspond with a decrease in character rigidity in relation to the expression of hostility and greater freedom to enjoy intimacy and interdependence.

The strategy we have outlined relies on the same three basic tools of psychoanalytic technique—interpretation, systematic transference analysis, and technical neutrality—described in relation to TFP-B but without the modifications introduced for the severe personality disorders.

## NOTE

1. These strivings are best synthesized in the concepts of libido and aggression: the intimate connection between sexual and dependent strivings warrants their condensation as libido.

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