An Object-Relations Based Model for the Assessment of Borderline Psychopathology

Barry L. Stern, PhD[a,*], Eve Caligor, MD[a],
Susanne Hörz-Sagstetter, PhD[b], John F. Clarkin, PhD[a]

KEYWORDS

• Psychoanalytic psychotherapy • Borderline • Borderline personality disorder
• Personality organization • Assessment

KEY POINTS

- The authors describe an object-relations based model drawing on the work of Kernberg and colleagues for the assessment of borderline pathology.
- The substrate of internal object relations that constitutes borderline pathology internally or structurally is described and a model for assessing such pathology in a clinical interview format focusing on identity, defensive style, and quality of object relations is presented.
- Two clinical examples illustrate how these data can be compiled for purposes of psychodynamic case formulation and decisions about psychodynamic treatment.

Psychodynamic clinicians have long been troubled by the disconnect between the official psychiatric diagnostic classification codified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM),[1,2] and the underlying, internal characteristics of disordered personality, our understanding of what is pathologic in personality disorders, and how personality disorders are treated therapeutically. This disconnect has diminished somewhat in the past several years, with the development of both the *Psychodynamic Diagnostic Manual* (PDM)[3,4] and the Alternate Model for Personality Disorders in Section III of the DSM-5 (AMPD),[2] both of which move beyond assessment of symptoms to the acknowledgment of core psychological features of a patient's personality, specifically, the patient's experience of the self and the relation of that experience to others, that lies at the heart of personality disorders.

Disclosure statement: Work on the STIPO-R, which is a significant focus on this paper, has been provided by the American Psychoanalytic Association, and the International Psychoanalytic Association.
[a] Columbia University Medical Center, 122 East 42nd Street, Suite 3200, New York, NY 10168, USA; [b] Psychologische Hochschule Berlin, Clinical Psychology and Psychotherapy, Am Köllnischen Park 2, 10179 Berlin, Germany
* Corresponding author. Columbia University Medical Center, 122 East 42nd Street, Suite 3200, New York, NY 10168.
E-mail address: bs2137@cumc.columbia.edu

Psychiatr Clin N Am 41 (2018) 595–611
https://doi.org/10.1016/j.psc.2018.07.007
psych.theclinics.com

Abbreviations	
BPO	Borderline personality organization
STIPO	Structured Interview of Personality Organization

The psychodynamic assessment of borderline pathology unfolds in the initial meetings with a patient according to the particular therapist's frame of reference as well as the level of acuity with which the patient presents. Along with providing appropriate containment of affect and assessments of risk and safety, the therapist's questions in the initial sessions allow the therapist to develop a map of the patient's internal world and how this internal experience in turn fits with the therapist's model of health and pathology. Part of this assessment involves the patient's capacities, for example, for reflection, interpersonal relatedness, reality testing, coherence of self, impulse control, and anxiety tolerance, all features related to borderline symptoms as well as dynamic conceptions of personality disorder.[5,6] The patient's primary defensive style can also be ascertained in these initial meetings; is there flexibility and openness, or clear "no-go" areas of inquiry that would suggest the patient's need for control and the operation of splitting-based defenses. An assessment process that conveys at the outset an interest in the person through which maladaptive behaviors and symptoms are expressed, in his or her capacities, proclivities, and defenses, frames a treatment focused on this broader conception of personality, proposing that a better understanding of this person is intimately related to the success and durability of the treatment.

Before elaborating further our particular psychodynamic model of personality disorder assessment, we need to frame this discussion in the context of a major shift in the empirical, theoretic, and clinical classification of personality disorders. Criticism of the DSM's categorical classification system, for the lack of any empirical support for distinct personality disorders, for the significant criterion overlap and the associated, clinically meaningless comorbidity of diagnosis, and for the lack of reliability for individual personality disorder diagnoses, has been long and well-documented.[7–10] Furthermore, the current present or absent, 10-category diagnostic system provides no information about severity of illness, prognosis, or likely course of treatment. The broad chorus echoing these complaints, along with scores of empirical studies, has led to a groundswell of support for a reconceptualization of personality disorder diagnosis based on a dimensional approach,[11–15] a shift that has been expressed to varying degrees in the revisions of each of several major diagnostic systems, including the PDM 2,[4] the Alternative Model for Personality Disorders in the DSM-5,[2] and the still in-process *International Classification of Diseases*, 11the edition.[11]

Despite clear consensus that a shift to dimensional thinking better fits the empirical data and is more clinically useful, 2 questions remain somewhat less clear: what definition of personality are we considering when we say "a dimensional approach to personality assessment" and, then, what specific variables or domains related to personality health and pathology ought we assess in this dimensional manner? One definition or conceptual model for personality with a long tradition of empirical research across cultures involves dispositional traits (ie, The Big Five).[16–20] An approach to personality assessment based on dispositional traits has been lobbied effectively for inclusion in personality disorder diagnostic systems, in part owing to their recognizability, replicated links to personality disorders, and biological and evolutionary underpinnings. For many dynamic clinicians, however, an individual's trait signature (eg, extraverted, antagonistic, open to experience, self-conscious, vulnerable) provides little information about the person's "characteristic adaptations,"[21]

the psychosocial and interpersonal context of the person over time, and his or her motivations, interests, characteristic tendencies, conflicts, and overall adaptation. Although the assessment model we elaborate is a specific psychodynamic model of personality within this latter category of "characteristic adaptations," and with specific domains of functioning, surveyed dimensionally, it is notable that both the DSM-5, the AMPD, and to some extent the PDM 2 are hybrid models in which both dispositional traits and styles of characteristic adaptation are assessed.

The remainder of this article addresses the question of which specific domains of adaptation or functioning related to personality we assess, why these particular domains, and how they are assessed. It is notable that we are speaking of several domains, each sampled dimensionally, and that, taken together, form a full picture of the individual's personality functioning, one into which the individual's symptoms and clinical problems can be contextualized, for example, one's sense of self over time, stability versus instability in experience of others, coping and defensive style, aggression and hostility, and moral functioning. They provide the clinician with both an index of severity of illness, as well as a sense of the patient's competence and resiliencies, all of which help to contextualize the patient's difficulties in the language of the therapist's theory of technique, clinical experience, and his or her own personality.

The assessment model that follows is born of the belief that the symptoms of borderline personality disorder, as well as most of the other personality disorders cataloged in the DSM IV and 5, share certain core or "structural" features forming a syndrome called borderline personality organization (BPO). Derived from modern object relations theory,[5,6] we conceptualize a personality disorder as a pathology of "internal object relations," in which the integration of positively and negatively charged representations of self and others, required for a realistic and stable sense of self across time and situations, is not attained. This lack of integration of positive and negative aspects of the self is referred to as identity diffusion. It is from this internal structure that the various symptomatic expressions of personality disorder in the borderline range (eg, borderline proper, schizoid, narcissistic, paranoid) derive and that the experience of borderline symptomatology, at various levels of severity follows.

BORDERLINE PERSONALITY ORGANIZATION AS A PATHOLOGY OF INTERNAL OBJECT RELATIONS

Of the several features that come to a clinician's mind when thinking of borderline personality, problems with identity and splitting as a defensive posture are among the more prominent and defining. Almost indistinguishable empirically,[22–24] identity pathology and splitting-based defenses also work hand-in-glove psychically and together constitute the core of the internal world of the borderline patient. Splitting-based defenses such as primitive denial, omnipotent control, idealization/devaluation, and black-and-white thinking, operate intrapsychically and interpersonally to divide the full experience of the self, splitting off experiences and representations that are undesirable, disturbing, or incongruent with a desired self-image and assigning, or projecting them, onto others. The result of this process is the internally segmented world that we term "identity diffused," meaning that the self is experienced as discontinuous over time and across situation as different aspects of the self, dissociated from one another, are experienced in a back-and-forth and abruptly shifting manner. When representations of self and other fail to consolidate to form an integrated sense of self and others, and the good and desirable qualities never touch and thus modulate the bad or undesirable qualities and vice versa, and the result is a brittle, rigid caricature of a self, and a correspondingly brittle caricature of others, one lacking in the depth, nuance,

and realistic feel of an integrated, healthier personality. This internal split leaves the individual vulnerable to typical borderline symptoms such as mood lability, idealization/devaluation, instability, and a lack of coherence in the sense of self, with corresponding difficulties in the steady, realistic experience of others.

ASSESSMENT OF BORDERLINE PERSONALITY ORGANIZATION

Our evaluation approach begins with a discussion of presenting symptomatology and allows for the determination of both phenomenological (DSM) and structural diagnoses. Our approach follows the form and content of Kernberg's Structural Interview,[5] a free-form clinical interview that typically might take 60 to 90 minutes over 1 or 2 evaluation sessions, and that queries all aspects of the patient's difficulties—cognitive, emotional, physical, and interpersonal, both their history and current manifestation. The Structural Interview is typically conceived in 3 phases: an initial phase focusing on the specific presenting complaint and symptom inquiry, a middle phase explicitly oriented to the assessment of personality disorder features and structural diagnosis, and a concluding phase seeking information on the patient's family history and current life situation, sharing with the patient a diagnostic formulation, and outlining a framework for treatment if psychotherapy is indeed recommended.

The interview begins with an initial probe to the effect of, "Please tell me what problem or problems bring you here today, any other difficulties—emotional, cognitive, or physical—that you may have, how you understand your problems, and what you hope to gain from therapy?" The initial phase focuses in turn on each of the presenting difficulties identified by the patient, querying their history and the extent of associated impairment. This initial phase of symptom inquiry constitutes a concurrent mini mental status examination and initial test of the patient's personality organization and overall mental and emotional functioning: Can the patient hold the questions in mind? Are the responses coherent and logical? Are they realistic, suggesting an appropriate matching of verbal content to emotional valence? And what is the patient's reflective capacity? Throughout its various stages, the method of the interview itself constitutes an in vivo test of the patient's defensive system and reality testing through a focus on how the patient is functioning in the here-and-now interaction with the interviewer. Are the patient's responses open or guarded or evasive, agreeable or defensive or argumentative, realistic or superficial or caricature-like? The operation of splitting-based defenses can be discerned in various ways: when we sit with a patient whose hostility is palpable and by whom we feel controlled during the interview; when, after an hour of examination we feel confused, as though we have learned nothing of the patient, where information seems to have no substance or cannot attach to anything in the clinician's model of health and pathology. In such cases, it is not the content but rather interview process itself, our experience and feeling about the same, which suggests the influence of splitting-based defensive operations and the presence of borderline pathology.

The middle phase of the structural interview serves 2 functions:

1. To elicit information related to the structural diagnosis and the assessment of acuity within the borderline range, ie, as described, is the patient's sense of identity unintegrated, supported by splitting-based or "primitive" defenses, or is the internal structure integrated, and coherent, supported by more adaptive, higher-level defenses; and
2. To inquire more directly around the symptoms of DSM-5 borderline personality disorder.

In this middle phase of the interview, we further assess the patient's defensive system by gauging his or her response to gentle inquiries into contradictions in his or her responses, contradictions within the verbal report, between the patient's verbal report and his or her behavior, and between the patient's report and collateral information. Does this "confrontation" of discrepant information lead to an increase in hostility, paranoia, and control, or is the patient relaxed in response, openly providing information that clarifies what had seemed to be contradictory? Whereas the former suggests the operation of splitting-based defenses leaning toward a borderline diagnosis, the latter suggests some initial guardedness or anxiety that dissipates, and the associated flexibility and trust associated with greater openness in the interview.

As we proceed to discuss this middle section of the Structural Interview, the domains of functioning to assess and the specific questions one might ask to clarify a structural diagnosis, we must note several problems with the Structural Interview method. First, the ability to conduct the Structural Interview requires significant clinical tact and skill, coupled with a deep understanding of the structural features of personality disorder. Further, the method suffers from a lack of clinical "reliability"; two theoretic interviewers assessing the same theoretic patient would conduct the interview in the exact same way, and thus might not arrive at the same diagnosis. Further, each interviewer is subject to biases and blind spots within any given interview (a positive or negative halo effect, for example) that might lead the interviewer to omit content essential to determining a BPO diagnosis.

It was with the goal of developing a reliable and valid research tool, as well as the desire to provide language for clinicians assessing personality disorders in patients, that we developed the Structured Interview of Personality Organization (STIPO, Clakin, Caligor, Stern, & Kernberg, 2004, unpublished manuscript, Personality Disorders Institute, Weill Cornell Medical College, New York), an interview that provides coverage of the content domains sampled in the Structural Interview in a semistructured interview format familiar to personality disorder researchers. The STIPO has proved instrumental in our training of medical residents, psychology interns, analytical candidates, and transference-focused therapy trainees alike, providing language that operationalizes the structural features of personality disorder. In addition to items that tap identity and defenses (a spectrum including adaptive and primitive defenses), the domains central to making a structural diagnosis, the STIPO also assesses quality of object relations, aggression, and moral values, domains essential for determining the level of severity within the borderline range.

The items for the original STIPO and its recent revision were drawn from the experience of clinicians who for years practiced and studied psychodynamic psychotherapy with borderline patients. The original STIPO was tested in 2 separate clinical samples with empirical results supporting the reliability and validity of the various domains,[22,24] and the more focused, revised interview (Clarkin JF, Caligor E, Stern B, et al. Structured interview of personality organization-revised [STIPO-R]. Unpublished manuscript, Personality Disorders Institute, Weill Cornell Medical College, New York, 2016) which can be found in English online at www.istfp.org/measures/stipo-r, is also available in German, Italian, Spanish, French, and Turkish translations. This discussion weaves some of the language of the STIPO-R and its content domains into our discussion of the middle phase of the more free-form Structural Interview, during which our task as clinicians is to form a map in our clinical minds of the patient's sense of self, defensive and relational capacities, and overall life situation.

IDENTITY

Healthy identity is marked by a sense of coherence and continuity in the sense of self across time and situation, and in a correspondingly stable and coherent representation of significant others. To allow for a sense of the feel of the STIPO-R interview items, several sample items that reflect coherence and continuity of the identity domain are listed.

- Consistent sense of self in present
  - Would you say that you come across like a different person to different people in your life so that each of them get a different sense of who you are as a person?
  - Do you act in ways that appear to others as unpredictable and erratic (…or do people generally know what to expect from you)?
- Sense of self: Intimate relationships
  - In the course of an intimate relationship (your marriage), or as one begins to develop, are you afraid of losing a sense of yourself, of what's important to you?
- Self-esteem: Stability
  - Would you say that your self-esteem alternates, with you seeing yourself at times as special or unique, and at other times as small, boring, or defective?
  - If yes, would you say that the shifts in your self-esteem are quite severe, that they happen frequently, or that they are upsetting you?

For each item queried in the STIPO-R we typically ask follow-up probes designed to determine, for affirmative responses, the severity, frequency, and pervasiveness of the problem across various relationships and/or situations.

Open-ended self-descriptions are also elicited, assessing the patient's capacity to provide a coherent, ambivalent (freely accessing and tolerating positive and negative attributes), realistic, and on balance, positive, description of self that is a hallmark of consolidated, integrated, identity: "Tell me about yourself, what are you like as a person? Let's say that you wanted me to get to know you as quickly as possible, in just a few minutes—how would you describe yourself to me so that I get a live and full of picture of the kind of person you are?" Our objective in this exercise is to determine whether the description is realistic and nuanced versus superficial, and integrated and balanced realistically between positive and negative qualities, or whether the description tends toward split idealization or devaluation. In assessing the capacity to form stable, integrated representations of others, we ask the patient to describe a significant person in his or her life, following this same open-ended format, as well as specific questions related to the patient's confidence and stability in his or her experience of significant others. One can also develop impressions related to narcissistic pathology to the extent that the descriptions of others tends toward excessive idealization or devaluation, lacks depth and differentiation, and/or is largely self-referential.

One primary manifestation of a consolidated identity is the ability to direct oneself effectively, with purpose and pleasure, toward one's primary role, whether that be academic or occupational, and similarly, the capacity to "invest" the self in recreational pursuits. We ask how effective the patient is in his or her primary role, probing for grade reports, the ability to meet deadlines, promotions/raises/performance reviews, and the patient's subjective sense of effectiveness. We ask about the consistency of their engagement over time (significant absences, periods when not working), whether their goals have been consistent or shifting, and whether they experience a sense of

pleasure in doing the work, rather than a mere sense of obligation. We similarly ask about the presence of significant recreational pursuits with a demonstrated "investment" in learning or growing their involvement in the activity, probing the consistency of involvement over time and the sense of pleasure/satisfaction derived from the activity.

DEFENSES

If we conceive of identity as an ego function that reflects the organization of disparate internal object relations into either a coherent, integrated stable whole, or a chaotic, unintegrated and unstable internal world, it is the patient's defensive style that determines this quality of identity. During our interview, and in the STIPO-R, we assess healthy defenses such as suppression, proactive coping, and flexibility to determine whether they work effectively or in an overly rigid and less adaptive manner. We also assess the use of splitting-based defenses because these strategies, operating largely outside conscious awareness, serve to maintain splits in the experience of the self and others that, were they to break down, would lead to intense anxiety. Externalization helps patients to maintain largely favorable representations of self by deflecting responsibility for any adverse experience onto others. Projective identification involves the assignment of that which is undesirable in the self to others, while the patient him or herself is concurrently expressing, either in thought or behavior and at varying levels of awareness, that very same quality—that is, he or she remains identified with that undesirable quality, even if only in behavior—while also projecting it. Omnipotent control, whether it be through the subtle threat of hostility or otherwise, operates to shut off areas of uncomfortable dialogue or interaction with others, including the therapist, whereas idealization/devaluation works to split up the fullness of the self, dividing good from bad, positive from negative, and splitting these valences between self and other.

The identification of identity diffusion as described elsewhere in this article, and the experience or manifestation of primitive defensive operations during the interview confirms the diagnosis of BPO. Several factors help to determine the severity and prognosis for patients in the borderline range. The first of these involves the quality of the patient's object relations[a]: How isolated is the patient, socially and romantically? What is the quality of his or her relationships? The second involves aggression, the severity of aggression or hostility, how frequently expressed or well-controlled it is, and whether it is directed primarily at the self, others, or both. Last, we assess the patient's capacity for concern over his or her actions, the capacity for guilt and remorse, and the extent to which such feelings provide a check on the patient's impulsive aggression. The greater the extent of the aggression, as described, the less concern and remorse related to that aggression, and the poorer the state of the patient's interpersonal relationships, the lower in the BPO spectrum the patient falls, and the poorer the patient's prognosis in psychodynamic treatment. Each of these 3 areas is elaborated further.

QUALITY OF OBJECT RELATIONS

This section of the structural interview and STIPO-R involves an assessment of the patient's social connectedness, socially and romantically, and the quality of those

[a] Object relations refers to both the relation between internal representations of self and other within the mind, and also to the person's interpersonal relations, both of which are assessed in the Quality of Object Relations section of the STIPO-R and the Structural Interview.

connections. We ask who the patient's friends are, assessing both the breadth and depth of his or her social network. We ask about the duration of close friendships, the frequency and mode of contact, and the extent of tension and volatility in the friendship as well as the level of reciprocity, support, and mutual dependency. In terms of romantic and sexual relationships, we inquire as to the presence of romantic and sexual partners at the current time and in the recent past, and the duration, depth, and quality of those relationships: Are they brief, superficial, and volatile or chaotic? or, are they deep, mutually dependent, reciprocal, loving relationships? We ask about the patient's sexual functioning: Do they have sex? With whom? How frequently? and is the sex in the context of an ongoing relationship or not? Are they satisfied with the sexual aspect of their relationships? and What do they mean by "satisfied?"

The final section of the Quality of Object Relations domain is termed Investment in Others, a set of questions that essentially assesses narcissistic object relations. Among the aspects we assess in this section are the capacity for empathy, the patient's attitude toward lending support and nurturance to others, the extent of the patient's preoccupation with fairness or equality in relationships, and the tendency toward boredom in friendships and romantic relationships.

AGGRESSION

The extent of a patient's aggression, against the self in the form of severe neglect, self-injury, and suicidality, as well as aggression felt and/or enacted against others, is central to the determination of the acuity and treatability of patients in the borderline range. In the Structural Interview, we inquire as to the number of suicide attempts, their mode, state of intent, and lethality. We also ask about various modes of self-injury, their frequency, and severity, because these behaviors need to be contained in some stable manner for the effective conduct of any dynamic treatment (see, eg, our writings on treatment contracting in transference-focused therapy).[25,26] The assessment of hostility, resentment, and enacted aggression against others is also a crucial prognostic factor. In the Structural Interview and STIPO-R, we ask about the frequency and extent of rage manifest through tantrums and verbal dyscontrol, as well as tendencies toward physical altercations and assault.

MORAL VALUES

Closely related to the assessment of aggression is the patient's moral functioning. In addition to asking about any frank antisocial behaviors, criminal history, and legal involvement, we also attempt to assess the patient's capacity for remorse and guilt, as well as the patient's capacity for genuine concern for another, and how that concern might influence his or her aggressive inclinations. When focusing during the Structural Interview on acts of interpersonal aggression in a patient's presentation and history, the interviewer attempts to determine whether that aggression is ego syntonic or dystonic: Does the patient feel entitled to or justified in his or her expressions of hostility, that the injury to the target is deserved and just, or does the patient express any regret for such behavior based on a sense that it has violated some internal moral code or out of concern for the hurt or damage done to another? In the STIPO-R, we are interested in examples in which the patient behaved in ways that either hurt others, were patently immoral, or that violated his or her internal moral code. We ask how the patient felt about his or her behavior, probing for feelings of guilt and/or remorse, and we ask what the patient did in response to his or her behavior? Did he attempt to avoid getting caught, avoid the target person, or seek that person out for purposes of apology and repair?

NARCISSISM

Throughout the structural interview, we pay attention to manifestations of narcissistic pathology, which often co-occur with a diagnosis of borderline personality disorder,[27] including features such as grandiosity, the signature feature of narcissistic personality disorder, and a corresponding devaluation of others, including the interviewer and/or treatment team; feelings of entitlement; an excessive need for admiration; expressions of envy; and statements reflecting a preoccupation with one's social standing (looks, job status and finances, sexual exploits, etc) and self-esteem. In addition to items in the content domains described that address features of narcissism (eg, boredom in, and an economic or quid pro quo view of interpersonal relationships, idealization/devaluation), the STIPO-R also includes several items specifically related to the assessment of narcissistic features, including the patient's need for admiration and reaction to a withdrawal of attention/admiration, and his or her experience of envy.

THE STRUCTURAL INTERVIEW: CONCLUDING PHASE

Having covered the patient's presenting problems and conducted a thorough assessment of symptomatology (phase I), and evaluating (by testing, challenging) the patient's defensive system while assessing the extent of personality symptoms and structural features (phase II), the concluding phase of the interview involves a discussion of the patient's motivation for treatment, of factors that may interfere with the safe and effective conduct of psychodynamic treatment (assessment of acute danger to self, and the presence of treatment-interfering behavior), and as well as a discussion of the patient's family and personal history as related to current difficulties, recognizing that these are subject to distortions of memory and motivation, but are yet useful as an expression of the patient's representations of significant others. At the conclusion of the interview, diagnostic formulations, both structural and phenomenological, are shared with the patient, along with the outline of a proposed treatment.

STRUCTURAL ASSESSMENT: CLINICAL VIGNETTES

The evaluation of a patient's character pathology in clinical settings does not generally follow a structured protocol such as the STIPO-R. Rather, the therapist's idiosyncratic adaptation of the more free form Structural Interview, covering the content domains outlined herein and perhaps using or informed by the language of the STIPO-R, allows for the collection of relevant clinical information but in a manner that allows for clinical flexibility and the building of rapport.[28] A thorough evaluation typically requires a minimum of 90 minutes; more extended evaluation sessions in some cases are warranted, allowing for the collection of information from collateral sources (past treaters, family members) that can then be fed back into the ongoing consultation process when that information conflicts with the patient's direct report. Information obtained in this manner, particularly related to the nature of the patient's expressed aggression, moral functioning, and secondary gain, are, again, crucial for determining acuity within the borderline range, and helping the therapist to ascertain whether a viable treatment can be established.

These clinical vignettes summarize the results of structural interviews of patients with 2 different levels of borderline pathology.

Case 1. Shelly

Shelly, a 45-year-old married woman, mother of 2 teenage children, was referred by a colleague, a cognitive–behavioral therapist whom she had seen for 3 years owing to

"anxiety." The colleague stated that she had "exhausted her bag of tricks," that is, strategies to help Shelly calm herself under stress, regulate her emotions, and manage interpersonal challenges, and that she felt a more dynamic approach might help the patient to grow further.[b] The colleague acknowledged that the patient, rather than becoming more independent and stable as a result of their work, had become increasingly unstable, acute, and unmanageable in recent months, related in part to her use of the therapist for emotional support outside the treatment sessions, throwing verbal tantrums and threatening her when she was not sufficiently available or helpful to her via phone or text.

Shelly was intolerant of the new clinician's evaluation process, rolling her eyes, angry and impatient—she wanted to get going already, why did she have to talk about herself again to someone new??!! She agreed with his impression that her sense of omnipotence gets activated when her immediate needs are not met, and that others' needs, including the new clinician's needs with regard to starting a treatment, should not matter when the issue of her discomfort or desire is at play. Further, despite her eagerness, Shelly repeatedly pushed back the clinician's lines of questioning, his sense of what was important, and the overall interventional stance of the treatment, that is, exploratory rather than overtly supportive, protesting that such a treatment felt like an abandonment, leaving her to "suck it up" on her own. At the end of each evaluation session, Shelly underscored that she felt unhelped and was reluctant to leave. Further, upon return to the next session she stressed how difficult the session had been and how emotionally draining she experienced the days in between our meetings. Upon inquiry, it was quite difficult for Shelly to articulate the nature of her upset; instead, she would describe her focus on one thing the clinician had said, or had not said in the prior session, and how angry the perceived lack of tact or callous omission made her feel.

In terms of her identity, Shelly demonstrated the capacity to invest herself quite fully and with pleasure in multiple areas of functioning, including her job as an attorney at her own boutique law firm, her role as a mother, and 2 serious recreational pursuits (tennis and choral singing), both of which were activities that she deeply enjoyed, studied, and had engaged in at a very high level (the latter semiprofessionally), consistently, for many years. Her sense of self in the present was stable, although her description of self was highly superficial, as was her ability to think in depth about her emotional states and motivations and those of others. She described herself largely through the lens of her neediness, and the sense of being the victim of an unjust world that did not understand or support her. Shelly's self-esteem was labile, up and down depending on interpersonal setbacks and disappointments in her recreational and professional pursuits; she alternated between thinking extremely highly of herself, and also feeling as though there were things deeply wrong with and lacking in herself.

Shelly displayed the capacity for significant healthy defenses, including her ability to plan effectively and proactively, and to work to a high standard in many areas of her life without the tyranny of rigid perfectionism. At the same time, when emotionally stressed, her capacity for suppression and flexibility were compromised, and splitting-based defenses became activated. Shelly had a tendency to be rejecting of support and help when it could not magically solve her problems or discomforts, while

[b] The authors frequently have the experience of receiving referrals of this nature, wherein the patient, consistent with the current climate in psychiatry and mental health treatment, was evaluated for symptoms and Axis I diagnoses, but not for features of personality disorder. This unfortunate and all too common experience often leads unnecessarily to years of symptom-chasing treatments that provide little relief.

concurrently feeling rejected and abandoned by others who failed to meet such an unrealistic, idealized standard. This tendency toward projective identification was profound, causing considerable tension in her close interpersonal relationships, including the one with her previous therapist. Externalization was evidenced through a brittle, unrealistic idealization of the new clinician and the treatment, along with a superficial sense of hopefulness—"I really hope this will work"—a sense devoid of any personal responsibility or agency for change.

Shelly had a largely good relationship with a quiet, emotionally reserved husband, whom she experienced as dedicated and loving, but also devalued as ineffectual. Her description of her best friend was highly idealized and superficial—"She's the best… I don't know….I mean I just love her, our kids grew up together, we've shared so much. I don't know what to say, she's always there for me, whatever I need, whenever….you know what I mean…. I don't know what you want." When asked to elaborate further on her friend, she could describe her beauty and intelligence, but little in terms of an example or story between the 2 of them that could bring any quality of her friend's to life. Other friendships were long-standing and durable, with some ups and downs, but few ruptures. The clinician's sense was that Shelly was able to maintain relational stability, but only to a minimal depth and at the price of true intimacy and dependency. The lack of depth and openness with others resulted in a predominance of superficial relationships, wherein the lack of true intimacy protected her from exposing her poor self-esteem and tendency to break down under emotional stress, whereupon she would withdraw into extended periods of angry depression.

Shelly's hostility was well-controlled. She did not injure herself and took good care of herself physically. Although she did not lose verbal or physical control with others, she harbored considerable feelings of resentment toward others whom she felt did not accord her the respect, attention, or support she deserved. Last, Shelly, had good moral functioning; there was no evidence of antisocial or exploitive behaviors, and a clear capacity for guilt and remorse over her actions, an awareness when pressed that her behaviors and emotional immaturity hurt others, and a tendency to make reparation to others, particularly her husband and children, after having behaved poorly.

These were the data the clinician gathered from Shelly over a 90-minute initial session, one 45-minute follow-up session, and a brief discussion with the referring therapist. Shelly met the DSM diagnostic criteria for borderline personality disorder, characterized by difficulties with her sense of identity, mood lability, feelings of abandonment, difficulties with intense anger, tendencies toward idealization or devaluation, and difficulties in her interpersonal relationships. Structurally, Shelly falls within the range of BPO with prominent narcissistic features, including identification with both a grandiose and vulnerable self, feelings of entitlement and a tendency toward devaluing others who do not meet her expectations, and significant difficulties in her interpersonal relationships characterized by a lack of depth and mutual dependency. The ability to largely control the expression of her hostility and aggression, and her concern over the same, place Shelly in the high borderline range, and her motivation for treatment and historical dedication to the same, despite her difficulty using a more supportive treatment to develop emotionally, suggested that she would be a good candidate for an exploratory psychodynamic treatment.

Case 2: Mark

At the first meeting, Mark, a 23-year-old college dropout, described the circumstances of his referral, namely, his dismissal from a therapeutic residential community for repeated violations of its rules of sexual conduct. His disregard and disdain for the

rules, lack of any guilt or remorse, and retributive attacks on the community's staff and therapists, including his well-organized attempts to rally other residents against the staff, resulted in Mark and his hostility coming to be seen as too toxic and destructive to the community to sustain his residence therein.

Mark detailed his sense of mistreatment by the staff, stating that they were "just all over me," for infractions that he felt ridiculous and unhealthy for people whose problems involve difficulties in relationships: "How ridiculous is that??!! To ban being in a relationship while being in treatment for difficulties in relationships?" This statement condenses Mark's intelligence with his oppositionality and expresses a disingenuousness with highly perverse and destructive elements that left no room to "submitting" himself to others for his own potential benefit.

Mark described a repeated pattern since his high school years of doing well for brief periods of time in school before becoming engaged in some dramatic acting out in which administrators and fellow students were aligned against him. His self-righteousness and clever arguments left no room for an alternate view of the circumstances. When, in the first session, the evaluating clinician confronted him with the fact that his repeated attempts to "just find a place to learn and share the good I have inside with others" had not worked out for him, following a familiar pattern of subversion, sowing conflict, and eventual dismissal, the clinician was breezily dismissed without a shred of reflection or remorse. Mark had held several jobs, obtained for him through connections with his influential family, each of which he had left after brief periods of time, citing either a lack of interest, a change in life plan, or a good opportunity to travel that had arisen and to which he "could not say no." In fact, Mark had demonstrated no ability to invest in school, work, or recreation, no consistent sense of what appealed to him, and no track record of consistent engagement or achievement anywhere.

Mark's open-ended self-description focused solely on how misunderstood and mistreated he was. Said differently, he used the probe of asking him to describe himself as an opportunity to demonstrate the defense of projective identification, that is, how others have treated him with a dismissive, uncaring attitude, while demonstrating that very same dismissive, uncaring attitude toward himself and toward the clinician during the interview. When prompted to describe further his personality, he provided positive, idealized adjectives with superficial elaboration, and when confronted with the ways in which those adjectives contradicted data from collateral sources (the referring therapist), these were again met with no evidence of reflection but only with angry disbelief that the clinician would challenge his narrative, and that a view other than his own might actually have any merit.

Mark described no relationships of any significant duration, and none that were free of conflict. He described his closest friend as someone he had met at the hospital several months earlier and with whom he had partied on several occasions since, meaning, binged for several days on cocaine and alcohol. Many of his male friends from high school had, for reasons difficult to discern in the interview, dropped out of touch with him in the ensuing years. Similarly, Mark had never been in a serious romantic relationship of any duration, or one that was free of chronic conflict and involved any mutuality or dependency.

Mark's defensive style was characterized significantly by splitting-based, primitive defenses, including denial, projective identification, idealization (of self) and devaluation (of others), and omnipotent control. There was no demonstration of adaptive, higher level defenses, perhaps because Mark had never committed to any circumstance wherein such defenses would have been required for success (proactive coping, flexibility, suppression), or perhaps because he avoided any deeper

professional or academic commitments owing to some awareness that he was not equipped for the associated challenges to his coping capacities.

The varied expressions of Mark's aggression was impressive: binge drug and alcohol use; illegal procurement of sedative medication; impulsive sex with strangers without protection; gleeful, deliberate revenge against staff who had confronted and set limits on his behavior and against friends who, in his view, had "betrayed him"; repeated self-injury; and, finally, his blithe and highly provocative affirmation of his plan to kill himself by his 26th birthday if he had not completed college and found a girlfriend. Mark's discussion of the foregoing was triumphant; he beamed when discussing it, while completely denying his pleasure in the same when it was pointed out to him. His lack of concern for himself was demonstrated by the grandiose triumph of his destructiveness, his proof that it was stronger than anyone's "therapeutic" or helpful influence, even stronger than the weakened part of himself that might want a better life, which he too had vanquished.

In terms of structural diagnosis, Mark would fall in the low borderline range, with a severe narcissistic personality disorder, demonstrated by his substantial grandiosity, his complete inability to consider others for their own sake, independent of his needs, and his thorough use of splitting-based defenses to assign all the negative, weak qualities in himself to others. The severity and pervasiveness of Mark's perverse aggression, as well as his complete lack of remorse, accounts for his placement in the low range of BPO. Mark's poor prognosis was signaled through his proudly stated commitment to self-destructiveness and by the sense of pleasure and triumph that accompanied that.

ALTERNATIVE MODELS

Having outlined in detail our approach to the psychodynamic assessment of personality disorders, it is worthwhile to comment briefly on 2 alternative models to the assessment of borderline pathology that clinicians will likely encounter.

The Diagnostic and Statistical Manual of Mental Disorders

Although the narrative portions of the personality disorders section of the last 2 versions of the DSM have discussed difficulties in the sense of self or identity, and difficulties in the realm of self-regulation and interpersonal relationships, these features have not been systematically included in the diagnostic system proper. Although the most recent revision of the DSM (the DSM-5)[2] did not include major changes to the official 10-disorder classification system for personality disorders, the AMPD brings these core features into the actual diagnostic system. Whereas one aspect of the AMPD involves the assessment of specific maladaptive traits that vary or combine according to specific personality disorder styles, the criteria also elaborate "impairment in self and interpersonal functioning," defined further as difficulties in the areas of identity and self-direction (self) and empathy and intimacy (interpersonal relations). Scales have been developed to operationalize both aspects of the AMPD: The Levels of Personality Functioning Scale for the self and interpersonal functioning criteria,[29–32] for which there has also been developed a diagnostic interview to specifically provide the clinical data to inform a Levels of Personality Functioning Scale rating[33,34]; and, for the maladaptive personality traits, the *Personality Inventory for DSM-5*,[35] for which there is also a significant and growing body of empirical support (see Refs.[36,37] for a recent review). The authors are of the view that these aspects captured in the AMPD are indeed the domains central to the diagnosis of BPO, the group of personality disorders characterized structurally, internally, by a pathology

of internal object relations described elsewhere in this article in our model of borderline pathology and assessment.

The Psychiatric Diagnostic Manual

The PDM[3] was developed to provide a more clinically meaningful and useful diagnostic alternative to the DSM and *International Classification of Diseases*, 10th edition. The PDM and its recent revision, the PDM-2, reflect a psychodynamic tradition that conceptualizes personality disorder in terms of personality traits and styles and also the psychological functions that underlie healthy/normal and pathologic personality. The PDM-2 is integrative, with aspects related to personality reflected in all 3 axes of its diagnostic system for adults, which in combination constitute a multidimensional approach that describes the patient's overall functioning, symptoms, psychological capacities, and modes in which he or she is likely to engage the therapeutic process. Said differently, the manual attempts to provide a comprehensive and clinically useful taxonomy of the person, rather than a taxonomy of disorders.

Personality disorder features are folded into 3 axes of the PDM-2. The P axis, of personality patterns and disorders, is explicitly grounded in the object-relations model elaborated elsewhere in this article. The focus is on identifying both a level of personality organization (neurotic, borderline, psychotic as elaborated in the work of Kernberg),[5,6] as well as a determination of which personality style best fits the person. The personality styles are drawn largely from the personality disorders listed in the DSM 5, but considered less as disorders than prototypic themes or organizing principles that characterize the person and his or her conflicts, and without a resulting cut-off for disorder status but rather an impression of the patient's rigidity, dysfunction, impairment, and subjective suffering.

The M axis yields a profile of mental functioning that also integrates much of our thinking as to the structural factors related to the diagnosis of BPO. The M profile assesses psychological capacities in 4 areas:

1. Cognitive and affective processes (eg, ability to communicate and understand, mentalization, and attentional capacities);
2. Identity and relationships (capacities for differentiation and integration, for relationships and intimacy, and for self-esteem regulation);
3. Defensive style and coping (including impulse control and regulation, primary defensive style [splitting based vs higher level], and overall adaptation and resiliency); and
4. Self-awareness and self-direction (including the capacity for self-observation and to develop and use an internal moral code).

Finally, the S axis incorporates much of DSM Axis I, with a focus on present symptomatology, with a recognition that individual with similar symptoms patters may present in different ways and with differing degrees of subjective distress and impairment owing to the nature of their person (Axes P and M). Although integrative and clinically rich, the PDM-2 does not provide a categorical diagnosis of any personality disorder. Methods for organizing the PDM-2 data are currently under development and investigation (see the Psychodiagnostic Chart[38]), and these will in time speak to the usefulness of PDM-2 formulations in clinical settings and discussions of subtypes of patients on dimensions of personality.

SUMMARY

The landscape of personality disorder assessment is experiencing a generational shift. The move from a categorical diagnostic system to one combining a trait focus with a

concurrent focus on capacities and tendencies related to the experience of the self, and the self in relation to others, is monumental. This shift promises to lend greater validity to personality disorder diagnostics and to yield a diagnostic language that is of greater usefulness to clinicians, who must determine the nature and severity of an individual's pathology, as well as that individual's suitability for treatment.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th edition. Washington, DC: Author; 2000. text rev.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edition. Washington, DC: Author; 2013.
3. PDM Task Force. Psychodynamic diagnostic manual. Silver Spring (MD): Alliance of Psychoanalytic Organizations; 2006.
4. Lingiardi V, McWilliams N. Psychodynamic diagnostic manual, version 2 (PDM-2). New York: Guilford Press; 2017.
5. Kernberg OF. Severe personality disorders. New Haven (CT): Yale; 1984.
6. Kernberg OF, Caligor E. A psychoanalytic theory of personality disorders. In: Lenzenweger M, Clarkin J, editors. Major theories of personality disorder. New York: Guilford; 2005.
7. Trull T, Durrett C. Categorical and dimensional models of personality disorder. Annu Rev Clin Psychol 2005;1:355–80.
8. Verheul R. Clinical utility of dimensional models for personality pathology. In: Widiger TA, Simonsen E, Sirovatka PJ, et al, editors. Dimensional models of personality disorders: refining the research agenda for DSM-V, 203-218. Washington, DC: American Psychiatric Association; 2006.
9. Westen D, Arkowitz-Westen L. Limitations of Axis II in diagnosing personality pathology in clinical practice. Am J Psychiatry 1998;155:1767–71.
10. Widiger T, Samuel DB. Evidence-based assessment of personality disorders. Psychol Assess 2005;17(3):278–87.
11. Hopwood CJ, Kotov R, Krueger RF, et al. The time has come for dimensional personality disorder diagnosis. Personal Ment Health 2018;12:82–6.
12. Krueger RF, Markon KE. The role of the DSM-5 personality trait model in moving toward a quantitative and empirically based approach to classifying personality and psychopathology. Annu Rev Clin Psychol 2014;10:477–501.
13. Markon K, Kreuger RF, Watson D. Delineating the structure of normal and abnormal personality: an integrative hierarchical approach. J Pers Soc Psychol 2005;88(1):139–57.
14. Morey LC, Hopwood CJ, Gunderson JG, et al. Comparison of alternative models for personality disorders. Psych Medicine 2007;37(3):983–94.
15. Widiger TA, Livesley WJ, Clark LA. An integrative dimensional classification of personality disorder, Psychological assessment 2009;21(3):243–55.
16. Costa PT, Widiger TA, editors. Personality disorders and the five factor model of personality. Washington, DC: American Psychological Association; 1994.
17. Digman JM. Higher-order factors of the big five. J Pers Soc Psychol 1997;73: 1246–56.
18. John OP. The "Big Five" factor taxonomy: dimensions of personality in the natural language and in questionnaires. In: Pervin LA, editor. Handbook of personality: theory and research. New York: Guilford; 1990. p. 66–100.

19. McCrae RR, Costa PT Jr. Toward a new generation of personality theories: theoretical contexts for the five-factor model. In: Wiggins JS, editor. The five-factor model of personality: theoretical perspectives. New York: Guilford; 1996. p. 51–87.
20. Widiger TA, Trull TJ. Plate tectonics in the classification of personality disorder: shifting to a dimensional model. Am Psychol 2007;62:71–83.
21. McAdams DP, Pals JL. A new Big Five: Fundamental principles for an integrative science of personality. American Psychologist 2006;61(3):204–17.
22. Doering S, Burgmer M, Heuft G, et al. Reliability and validity of the German version of the Structured Interview of Personality Organization (STIPO). BMC Psychiatry 2013;13:210.
23. Lenzenweger MF, Clarkin JF, Kernberg OF, et al. The Inventory of Personality Organization: psychometric properties, factorial composition, and criterion relations with affect, aggressive dyscontrol, psychosis proneness, and self-domains in a nonclinical sample. Psychol Assess 2001;13:577–91.
24. Stern B, Caligor E, Clarkin JF, et al. The Structured Interview of Personality Organization (STIPO): preliminary psychometrics in a clinical sample. J Pers Assess 2010;91:35–44.
25. Yeomans FE, Clarkin JF, Kernberg OF. Transference-focused psychotherapy for borderline personality disorder: a clinical guide. Washington, DC: American Psychiatric Publishing; 2015.
26. Yeomans FE, Delaney J, Levy K. Behavior action in TFP: the role of the treatment contract in transference-focused psychotherapy. Psychotherapy 2017;54(3): 260–6.
27. Diamond D, Levy K, Clarkin J, et al. Attachment and mentalization in female patients with comorbid narcissistic and borderline personality disorder. Personal Disord 2014;5:428–33.
28. Hörz-Sagstetter S, Caligor E, Preti E, et al. Clinician-guided assessment of personality using the structural interview and the Structured Interview of Personality Organization (STIPO). J Pers Assess 2018;100:30–42.
29. Bender DS, Morey LC, Skodol A. Towards a model for assessing level of personality functioning in DSM-5, Part I: a review of theory and methods. J Pers Assess 2011;93(4):332–46.
30. Hutsebaut J, Feenstra DJ, Kamphuis JH. Development and preliminary psychometric evaluation of a brief self-report questionnaire for the assessment of the DSM-5 level of personality functioning scale: the LPFS Brief Form (LPFS-BF). Personal Disord 2016;7(2):192–7.
31. Morey LC, Berghuis H, Bender DS, et al. Towards a model for assessing level of personality functioning in DSM-5, Part II: empirical articulation of a core dimension of personality pathology. J Pers Assess 2011;93(4):347–53.
32. Rockland LH. Supportive therapy for borderline patients: a psychodynamic approach. New York: Guilford; 1992.
33. Bender DS, Skodol AE, First MB, et al. Module I: structured clinical interview for the level of personality functioning scale. In: First MB, Skodol AE, Bender DS, et al, editors. Structured clinical interview for the DSM-5 alternative model for personality disorders (SCID-AMPD). New York: New York State Psychiatric Institute; 2016.
34. Hutsebaut J, Kamphuis JH, Feenstra DJ, et al. Assessing DSM–5-oriented level of personality functioning: development and psychometric evaluation of the Semi-Structured Interview for Personality Functioning DSM–5 (STiP-5.1). Personal Disord 2017;8(1):94–101.
35. Krueger RF, Derringer J, Markon KE, et al. Initial construction of a maladaptive personality trait model and inventory for DSM-5. Psychol Med 2012;42:1879–90.

36. Al-Dajani N, Gralnick TM, Bagby RM. A psychometric review of the Personality Inventory for DSM-5 (PID-5): current status and future directions. J Pers Assess 2016;98(1):62–81.
37. Bagby, 2016.
38. Gordon RM, Bornstein RF. Construct validity of the psychodiagnostic chart: a transdiagnostic measure of personality organization, personality syndromes, mental functioning, and symptomatology. Psychoanal Psychol 2017. https://doi.org/10.1037/pap0000142.