

Solitude and Personality Disorders

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The experience of aloneness is central to our human experience. Solitude researchers distinguish *aloneness* from negative subjective states, such as loneliness or depression, or defensive behaviors, such as isolation or withdrawal (Katz & Buchholz, 1999). Solitude-seeking behaviors are not necessarily pathological or adaptive; abundant research suggests that aloneness is neither a necessary nor sufficient condition for the feeling of loneliness (Buchholz & Catton, 1999; Long & Averill, 2003; Richman & Sokolove, 1992; Suedfeld, 1982). People who seek solitude are not necessarily withdrawn or asocial; many people pursue solitary activities because of a specific desire for solitude (Leary, Herbst, & McCrary, 2003). When individuals enter the state of solitude, whether they are able to benefit or suffer from the experience depends upon their unique personality facets elaborated throughout development. In particular, the quality of one's internal resources is central in determining whether one is able to endure and benefit from the experience of being alone.

Individuals with personality disorders, despite differing greatly in terms of their manifest presentation, often have a conflictual relationship toward a desire for closeness and relatedness on the one hand and distressing experiences of isolation on the other (Blatt, 1995). Further, a number of the personality disorders are characterized by painful experiences of loneliness. Despite the conflictual relationship toward aloneness within personality disorders, there have been surprisingly few links made between these disorders and solitude research.

In this chapter, we will integrate the literatures on solitude and personality disorders through the more robust literatures linking each to the development of secure and reliable mental representations. Classic and recent psychological theories and research on personality development emphasize the quality of one's internal representations as central in determining whether one benefits from the

experience of being alone. Individuals with personality disorders may struggle with the capacity to be alone due to disruptions in the internalization of representations of consistently present and reliable others.

First, we will discuss personality and the nature of personality disorders. We will then discuss personality development and the central role of internalizing secure mental representations in achieving the capacity for aloneness (Winnicott, 1958). Theory and research illustrating how individuals with personality disorders struggle to consistently evoke secure mental representations will be presented (Blatt, 1995). We will then discuss how solitude is experienced and behaviorally expressed in a variety of personality disorders based on that disorder's core deficits in identity and relatedness. Finally, we will discuss future directions for theory and research.

Personality and Personality Disorders

Personality, an umbrella concept that encompasses the dynamic organization of psychological functioning, refers to enduring patterns of thoughts, feelings, and behaviors that are expressed in a variety of circumstances (Mischel & Shoda, 1995). Our personalities are a complex interaction of temperament, internalized experiences, and evolved behavioral patterns shaped by our interpretation of these attributes and the consequences of our life choices. Personality is dynamic in that it is in constant interaction with biological predispositions, schemas of oneself and others, evolved affective and behavioral patterns, and the demands of the external world. Central to how we experience our personality is the organization of our internal representations (Blatt, 1995; Kernberg, 1975). At the beginning of life, all experiences are relatively undifferentiated, unintegrated, and unorganized. Over time, with development and maturation of cognitive and affective systems, there is an increasing differentiation, integration, and hierarchical organization of our schemas of self and our world. The quality and organization of our personality structure strongly influences our capacity to access, retrieve, and flexibly use pertinent schematic information. The more quickly and flexibly that we can retrieve and utilize internal schemas to make sense of our world, the better we are able to regulate our emotions and maintain a coherent self-experience. Healthy individuals flexibly react to different circumstances in context-appropriate ways, paving the way for the capacity to create, enjoy life, develop intimacy, and invest in goals and relationships. In contrast, when internal representations are limited in breadth and rigidly applied, the more difficult it becomes to regulate our emotions and maintain a coherent self-experience. In the absence of a capacity to adaptively process and respond to affectively valenced information, we are likely to feel unmoored by novel contexts and respond to them as if they are old ones.

Personality disorders involve chronic, long-standing traits and patterns of responding to distress that are often limited in variability and rigidly applied regardless of appropriateness to context (Bender & Skodol, 2007; Shedler &

Westen, 2004). Because such personality patterns tend to enact the very experiences trying to be avoided by the individual, these patterns come to define that individual's experience (Wachtel, 1997). Thus, in personality disorders, the ways the individual thinks, feels, acts, and relates to others directly restrict the capacity to work, pursue goals, and enjoy intimate relationships.

Although conceptualizations of personality disorders are diverse and have evolved over time, most models conceptualize these pathologies as primarily disorders of self and relatedness (e.g., Blatt, 1995; Fonagy, Gergely, Jurist, & Target, 2002; Kernberg, 1984). In fact, the criteria specified for each of the personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; American Psychiatric Association [APA], 2000) centrally describe problems with sense of identity and/or interpersonal problems. For example, impoverished interpersonal relationships are a cardinal feature of both schizoid and avoidant personality disorders; such individuals prefer to be alone and often seek solitude. Central to both dependent and borderline personality disorders are difficulties with aloneness as well as preoccupation with fears of abandonment and the dissolution of close relationships (Gunderson, 1996; Zanarini et al., 2007). Histrionic and narcissistic individuals often need to be the center of attention and have difficulty not being admired by others.

In the *DSM-5* (2013) "Alternative Model for Personality Disorders", self and relatedness have become core aspects of the proposed definition of a personality disorder, with symptoms organized along these two domains. For example, the proposed criteria for borderline personality disorder (BPD) evaluate problems in self-functioning – particularly identity diffusion feelings of emptiness – and interpersonal functioning. It is important to note that these problems of self and relatedness are not separate but rather highly interdependent and have a cyclical relationship with one another (Blatt, 1995; Kernberg, 1984). For example, chronic feelings of emptiness and uncertainty about oneself may lead individuals with BPD to look to their relationships to define who they are. Given the affective lability associated with this disorder, how such individuals see themselves in relation to others may then be highly dependent on the affective context – "I feel good because the person I love is good," and conversely "I feel bad because this person is bad to me." Further, with a sense of self so centrally tethered to others, when there is a threat to that relationship ending, one comes to feel that the self is also threatened – "If I am not her boyfriend, then who am I?" This may lead to intense fears of abandonment as well as desperate and impulsive attempts to pull the person back. Thus, as can be seen in this illustration, one's sense of relatedness cannot be understood in the absence of the one's sense of self.

Development of Mental Representations as Related to Solitude

Winnicott's (1958) conception of the "capacity to be alone," or one's ability to endure, even prosper, in solitude, has become the theoretical touchstone for many solitude theorists and researchers (e.g., Burger, 1995; Larson & Lee, 1996; Long &

Averill, 2003; Suedfeld, 1982). In Winnicott's view, this achievement is understood as the product of having internalized stable and secure representations of self with others, a notion that has been advanced by attachment and object relations theory and research (Blatt & Levy, 2003; Levy & Blatt, 1999). These theories posit that in normal personality development, representations of self in relation to others become increasingly more differentiated and integrated (Blatt, 1995; Kernberg, 1975). The infant's experiences, initially organized around moments of pain and pleasure, become increasingly differentiated and integrated representations of self and other.

Through the experience of being regulated, the child comes to internalize a representation of self in relation to a regulating other such that at a later stage of personality development, the child is able to draw internally upon this integrated *self being soothed by a regulating other* representation. Although at an earlier stage of development external contact with the primary caregiver was necessary in regulating affect, the child may now internally evoke a regulating representation, and concrete contact with caregivers becomes a less immediate need. This capacity has been termed *evocative constancy* – the capacity to retain and recall an object that is no longer immediately present (Blatt, 1995). Evocative constancy is central to the capacity to be alone and prosper in solitude because it allows for the individual's internal experience to be *populated* with loving and caring others, even when no one else is present. Thus, the internalization of a consistently present and reliable other is what paves the way for the capacity to be alone.

In the absence of an assuredness of the presence of a regulating other, considerable resources must be directed both outward toward monitoring the presence or absence of the caregiver and inward in order to reestablish homeostasis. This allocation of resources significantly impinges on the child's experience, as the child must direct a great deal of attention on short-term strategies for securing resources from caregivers (Tuber, 2008; Winnicott, 1958). The experience of aloneness is no longer one of safety, but rather one of danger and unmet needs. Such experiences impinge on the child internalizing a representation of self being consistently and reliably regulated by another.

Winnicott's (1958) theory of the capacity to be alone – that of a developmental milestone and sign of mental health resulting from a child's early experiences of comfortably *sharing* aloneness with the mother – is widely accepted among solitude theorists and researchers (e.g., Burger, 1995; Larson & Lee, 1996). Despite this, there is only a small body of research supporting the link between internalized representations and the capacity to be alone (Richman & Sokolove, 1992). In a recent study, Detrixhe, Samstag, Penn, and Wong (2011) evaluated the quality of object relations and internal resources in predicting attitudes toward solitude and mental well-being. Using the *Object Relations Inventory* (ORI; Blatt, Wein, Chevron, & Quinlan, 1979), they found in a nonclinical sample that one's attitude toward solitude and sociability mediated the positive relationship between loneliness and the complexity of representations of oneself and attachment figures. This finding

suggests that, consistent with Winnicott's conceptualization of the capacity to be alone, one's quality of object relations strongly influences one's attitude toward solitude and experience of loneliness.

Theory on Mental Representations and Personality Pathology

Attachment and object relations theory and research have linked problems in the internalization of representations of *self being soothed by a regulating other* to the subsequent development of personality pathology. Fonagy et al. (2002) contend that many features of personality pathology can be understood as originating in a failure to internalize representations of one's affect states that are accurately mirrored by caregivers. They note that such representations are established through a mirroring of the child's affective experience from caregivers that is both congruent with the child's internal experience and *marked* or playfully exaggerated in a manner that modulates the affect and protects the child from a *too real* reflection of the emotion. For example, children who fall down are often comforted by an affected expression of *oh no! do you have a boo boo?!* but may become even more upset if caregivers look truly panicked by the injury.

Fonagy et al. (2002) note that without an experience of marked and congruent mirroring, the child may experience a lack of differentiation between the caregiver's affect state and his/her own internal state. This may manifest in individuals with personality pathology through impairment in the ability to read and interpret the minds of others and view self and others as separate and whole beings. Further, if a child does not receive contingent mirroring, he/she will nonetheless take in the caregiver's reflections, even if the affect state of the caregiver does not map onto the child's own affective experience. The child comes to internalize the caregiver's incongruent affect states and projections, which creates in the child an alien experience of self. These distorted representations may include identifications of the self as bad, aggressive, malevolent, destructive, or deserving of harsh punishment. As a result, there is a discontinuity between the child's affect states and the alien representations of the self. Only by projecting the alien aspects of self onto the other can the child achieve a sense of continuity within the self. Therefore, such an individual may behave in a way that induces anger and frustration in the other in order to locate the alien experience in that person. Conversely, such an individual may need to withdraw from those in whom the alien aspect of self has been located, leading to a cycle of intense engagement and withdrawal into painful solitude.

Blatt, Zohar, Quinlan, Zuroff, and Mongrain (1995; Blatt & Shichman, 1983) conceptualize personality development as involving two fundamental parallel developmental lines – (i) an anaclitic or relatedness line that involves the development of the capacity to establish increasingly mature and mutually satisfying interpersonal relationships and (ii) an introjective or self-definitional line that involves the development of a consolidated, realistic, essentially positive, differentiated, and integrated

self-identity. These two developmental lines normally evolve throughout life in a reciprocal, dialectic, and mutually facilitating transaction. Blatt (1995) and colleagues (e.g., Blatt & Levy, 2003; Blatt & Shichman, 1983; Levy & Blatt, 1999) conceptualize various forms of psychopathology as an exaggeration of one of these developmental lines at the expense of development of the other line, each with distinct disordered behavior. Anaclitic psychopathologies are those disorders in which patients are primarily preoccupied with issues of relatedness and use primarily avoidant defenses (e.g., withdrawal, denial, repression) to cope with psychological conflict and stress. These disorders include BPD, dependent personality disorder (DPD), anaclitic depression, and histrionic personality disorder (HPD). Individuals with such disorders tend to fear abandonment and have difficulty tolerating aloneness.

In contrast, introjective psychopathology includes patients primarily concerned with establishing and maintaining a viable sense of self, with concerns about autonomy and control as well as conflict around self-worth. These patients use primarily counteractive defenses (e.g., projection, rationalization, intellectualization, reaction formation) to cope with conflict and stress. Introjective patients are more ideational and concerned with establishing, protecting, and maintaining a viable self-concept than they are with the quality of their interpersonal relations. Issues of anger and aggression, directed toward the self or others, are usually central to their difficulties. Examples of introjective disorders include paranoid personality disorder (PPD), obsessive-compulsive personality disorders, introjective (guilt-ridden) depression, and overt narcissism. Individuals with such disorders tend to seek isolation, although not usually in the service of productively utilizing solitude toward personal growth.

Research on Mental Representations and Personality Pathology

A number of clinical theorists and researchers (Adler, 1985; Adler & Buie, 1979; Bender & Skodol, 2007; Blatt, 1995; Kernberg, 1975; Levy, 2005) have suggested that those with personality disorders such as BPD are vulnerable to feeling rejected, abandoned, and alone due to impairments in evocative constancy. Whereas healthy, integrated individuals are able to evoke representations of soothing experiences of others when stressed or alone, those with BPD struggle to do so and are therefore dependent on the actual presence of others (Adler & Buie, 1979; Blatt & Auerbach, 1988; Blatt & Shichman, 1983).

Consistent with this clinical theory, research suggests that those with personality disorders have less differentiated and integrated representations of self and others. Westen and colleagues (Segal, Westen, Lohr, & Silk, 1993; Westen, Ludolph, Lerner, Ruffins, & Wiss, 1990), using various social cognitive measures, have consistently found that patients with BPD show deficits in a range of social cognitive capacities such as the complexity of representations of people, capacity for emotional investment, and understanding of social causality. Wilkinson-Ryan and Westen (2000) also found using a clinician-rated scale that the factor *painful incoherence* best

distinguished BPD patients from non-BPD patients; one of the strongest items loading on this factor was *feelings of emptiness*. Patients with BPD also provide less coherent representations of significant others (Barone, 2003; Diamond et al., 2003; Fischer-Kern et al., 2010; Fonagy et al., 1996) and are less able to reflect on their mental states and the mental states of others (Diamond et al., 2003; Levy et al., 2006) on the *Adult Attachment Interview* (AAI; George, Kaplan, & Main, 1985). Levy et al. (2002) and Benedik (2009) each found that those with BPD showed less differentiated representations than healthy controls on the ORI (Blatt et al., 1979).

Richman and Sokolove (1992), comparing 20 patients with BPD with 20 neurotically organized individuals, found that the BPD patients reported a more pervasive experience of aloneness than those organized at a neurotic level. BPD patients also showed less developed representations and less capacity for evocative memory for affectively charged representations. Esplen, Garfinkle, and Gallop (2000) similarly found a reduced capacity for evocative memory for affectively charged representations on the UCLA-LS to be linked to the capacity to self-soothe in their study of patients with bulimia nervosa. Thus, impairments in evocative constancy may be strongly related to the capacity to be alone in psychopathologies with conflictual relationships to closeness and dependency.

Clinical theories of depression in BPD may be particularly relevant to understanding the experience of aloneness and behavioral solitude in BPD. Several authors (Grinker, Werble, & Drye, 1968; Gunderson, 1996; Masterson, 1976) have described depression in borderline patients as characterized by chronic, empty loneliness and boredom, as opposed to guilt, remorse, and a sense of failure in non-borderline depressed patients. Indeed, a number of studies have found this phenomenological difference in borderline versus non-borderline depression (Levy, Edell, & McGlashan, 2007; Rogers, Widiger, & Krupp, 1995; Westen, Moses, & Silk, 1992; Wixom, Ludolph, & Westen, 1993).

Clinical theorists (Beck, 1983; Blatt & Shichman, 1983) have distinguished between self-critical (or autonomous) and dependent (or sociotropic) depressions. Blatt et al. (1995) found that the dependent factor was made up of two dimensions: one characterized by interpersonally based depressions involving the loss of a real relationship and another called anaclitic neediness that is characterized by anxiety related to feelings of helplessness, fear of separation and rejection, and emptiness. Those with BPD, regardless of depressive symptoms, scored higher than those with depression on anaclitic neediness, which was significantly associated with interpersonal distress, self-destructive behaviors, and impulsivity, whereas self-critical and interpersonal depression was not.

Adler (1985) posits that depression in borderline individuals may be characterized by feelings of *aloneness* due to an inability to maintain stable representations of significant others. What remains unclear is how to best to understand the representational deficits seen in BPD. Theorists such as Adler (1985), Fonagy et al. (2002), Gunderson (1996), Kohut and Wolf (1978), and, to various degrees, have proposed deficit models to explain the unintegrated representations of patients

with BPD, contending that during development those with BPD failed to sufficiently internalize representations of self being reliably regulated by another. In contrast, Kernberg (1975, 1984) contends that the difficulties experienced by those with BPD are a result of defensive processes. Although Kernberg acknowledges that representational deficits may play a role in BPD pathology, he argues that problems with evocative constancy are related to defensive splitting – the dividing of people into all-good or all-bad representations. For Kernberg, splitting is a normal developmental process common to children who do not have the cognitive capacity to integrate ambivalent ideas and feelings. In adults, who are capable of integrating ambivalence, positive and negative mental images are defensively kept apart in order to protect one view from the other. Often this defensive splitting takes the form of seeing oneself as *all good* and the other as *all bad* or vice versa. Thus, borderline patients may not see their own aggression toward others and yet are acutely aware of indications of another's aggression (even if not present) as it maintains the "I am good–they are mean" split. This may vacillate back and forth quickly – in one moment seeing oneself in an all-good light and the other all bad and then seconds later the roles may reverse. This often leads those with BPD to feel overwhelmed by another's presence, leading them to push people away. However, moments later the individual may feel alone and abandoned, leading them to desperately seek contact with others. This dynamic has led to the popular characterization of patients with BPD, expressed in a book title, *I hate you – Don't leave me* (Kreisman & Strauss, 2010). Thus, defensive splitting may be a process that is centrally responsible for the painful experience of loneliness felt by these patients.

Kernberg (1975, 1984) further contends that individuals with BPD struggle to be emotionally intimate with others due to its potential to evoke feelings of fear and vulnerability. Opening up and allowing for desire of another person can be scary to anyone. Individuals with secure representations grapple with those feelings by considering a range of information about past experiences, such as times they might have been hurt as well as loved by others. They consider how this person and situation are similar and different from the past, how one might have grown since past experiences, and how best to address these concerns with an integrated and fully considered response. However, the person with BPD might instead defensively split off (or exclude from awareness) their dependent longings, thus protecting them from their fears. Experientially, this defensive process leaves the person only aware of the dangers of the relationship and not the potential benefits; behaviorally this might be expressed through withdrawal and expressed anger toward the love interest. As is the nature of personality disorders, this dynamic is often experienced across multiple relationships, such as friendships, romantic relationships, and therapeutic relationships. It is not uncommon for such patients to drop out of psychotherapy after a so-called good session in which feelings of closeness are aroused by the therapist being particularly empathic or responsive.

Although there is a wealth of clinical data on splitting in patients with BPD, empirical evidence is less abundant though suggestive of its merit. Baker, Silk,

Westen, Nigg, and Lohr (1992) found that those with BPD had a greater tendency to view others as malevolent rather than to split their representations. In contrast, Greene (1993) found that those with BPD were more likely to use image-distorting defenses such as splitting in which they saw themselves as both “omnipotent” and “bad.” Gould, Prentice, and Aisnlie (1996) found validity for a self-report measure of splitting that was related to borderline and narcissistic personality disorders as well as measures of self-image stability, self-esteem, negative affectivity, and lower levels of cognitive complexity. Linville, as well as Showers and colleagues (Linville, 1985; Zeigler-Hill & Showers, 2007) found using a card-sorting task that those higher in self-complexity and lower in integration reported more stable emotional states (Campbell, Chew, & Stratchley, 1991; Linville, 1987; Rafaeli-Mor & Steinberg, 2002) and became less distressed in response to negative feedback and less excited in response to positive feedback (Linville, 1985; Niedenthal, Setterlund, & Wherry, 1992). Low integration was significantly related to having unstable self-esteem (Zeigler-Hill & Showers, 2007). Consistent with the concept of splitting, those low in complexity and integration displayed a *spillover effect* in which negative evaluations in one area of their lives spill over into unrelated aspects of their lives (McConnell et al., 2005; McConnell, Strain, Brown, & Rydell, 2009).

Recent studies using intensive repeated measurement techniques have also found evidence for splitting and its relationship to BPD and dysregulated affect. Coifman, Berenson, Rafaeli, and Downey (2012) found using experience-sampling diaries over the course of 21 days that those with BPD as compared to healthy controls showed greater polarity in the experience of affective and relational experiences. Consistent with Kernberg’s (1984) contention that splitting is more likely to occur during intense affect, these investigators found that heightened interpersonal stress increased the likelihood of such polarities in experience.

Despite this evidence, it is important to note that whether the problems in evocative constancy seen in patients with BPD are the product of a deficit or defense is not mutually exclusive. Deficits in representational capacities could leave one vulnerable to defensive splitting due to the lack of integration needed to resolve a split. Further, by not considering multiple sides to an issue, defensive splitting may deny individuals the opportunity for integration and representational development, which repeated over many interactions may leave the individual with a deficit (Levy, 2005).

Expression of Behavioral Solitude in Personality Disorders

Although the various personality disorders differ greatly in terms of their manifest presentation, each can be understood in the context of core conflicts around closeness and relatedness on the one hand and distressing experiences of isolation on the other. For example, such deficits may manifest in isolation and a denied desire for closeness (schizoid personality disorder (SPD)), isolation despite a desire for closeness (avoidant personality disorder (APD)), seeking relationships despite a

denied desire for closeness (narcissistic personality disorder (NPD)), or seeking relationships with a strong desire for closeness (DPD). In BPD, individuals are particularly known to struggle with loneliness and fears of abandonment (Choi-Kain, Zanarini, Frankenburg, Fitzmaurice, & Reich, 2010; Gunderson, 1996; Klonsky, 2008; Zanarini et al., 2007).

BPD

As noted earlier, the developmental experiences of individuals with BPD may contribute to difficulties internalizing representations of others as caring (and the self as cared for), particularly in times of distress. Due to difficulty evoking these types of representations, they often require the tangible and immediate presence of another person in order to feel soothed and contained. Accordingly, the experience of aloneness is often very difficult to tolerate for these individuals. Gunderson (1996) argues that this intolerance to aloneness should be considered the *essential feature* of BPD insofar as it discriminates BPD from other disorders and also provides a coherent framework for conceptually linking the characteristic difficulties observed in BPD. For instance, fear of abandonment may be observed as a precipitant of self-destructive behavior, affective instability, and angry outbursts; similarly, the negative affective consequences of aloneness may lead to impulsivity and transient psychotic symptoms (Gunderson, 1996). Relatedly, Klonsky (2008) found that the BPD criterion of chronic emptiness was strongly correlated with feelings of isolation and loneliness preceding and following episodes of self-injury.

Studies of symptom course in BPD patients over a 10-year period have provided additional evidence that intolerance to aloneness, along with chronic dysphoria, represent the more enduring, stable aspects of the disorder (Choi-Kain et al., 2010; Zanarini et al., 2007). In particular, intolerance to aloneness, abandonment concerns, and dependency were among the features that were the slowest to remit over time (Zanarini et al.); among interpersonal symptoms in particular, affective dysphoria (i.e., anxiety, depression, emptiness, or anger) when alone was the last feature to remit – taking 10 years to reach a remission rate of 50% – even though this feature was endorsed by most of the patients at baseline (Choi-Kain et al.). Taken together, these findings suggest that intolerance to aloneness is a highly characteristic and enduring feature of BPD consistent with etiological models of the disorder.

NPD

Patients with NPD are characterized by grandiose self-assessments, strong needs for admiration, and difficulty empathically relating to others who see things differently (APA, 2000). Those with NPD have a complex relationship to aloneness, in that such individuals often deny or dismiss their needs for closeness and yet depend on others for admiration and validation of a positive self-appraisal. This apparent contradiction can be best understood in the context of this disorder's etiology. NPD, in

Kernberg's (1975, 1984) view, develops as a consequence of parental rejection, devaluation, and an emotionally invalidating environment. The child copes with parents who are inconsistent or who only relate in order to satisfy their own needs by defensively withdrawing and forming a pathologically grandiose self-representation. By combining aspects of the real self with fantasized aspects of what the child wants to be, as well as fantasized aspects of an ideal, loving parent, the grandiose self serves as an internal refuge from the harsh and depriving environment. The negative self-representation is disavowed and not integrated into the grandiose representation, but can be seen in the emptiness, chronic hunger for admiration and excitement, and shame that also characterize the narcissist's experience (Akhtar & Thomson, 1982). Thus, dismissiveness and feelings of emptiness go hand in hand with needs for contact with others that involves admiration and validation.

Subtype distinctions in the expression of NPD have been noted that have implications for this disorder's relationship to solitude. Kohut and Wolf (1978) described three subtypes of NPD based on how the conflict around distance versus closeness is negotiated. *Merger-hungry* individuals must continually attach and define themselves through others; *contact-shunning* individuals avoid social contact because of fear that their behaviors will not be admired or accepted; and *mirror-hungry individuals* tend to display themselves in front of others. Regardless of subtype, each shows a dearth of true intimacy, with relationships used in the service of validation of a positive self-appraisal. Further, each subtype uses solitude as a respite from threats to one's grandiose self-representation rather than utilizing aloneness in the service of internal growth.

HPD

Patients with HPD are characterized by dramatic emotionality that functions to bring attention toward oneself. These individuals share many features with BPD, in that each requires the concrete presence of another person in order to feel contained. They also share many features with NPD, in that each may seek an *audience* from which recognition arises. More unique to HPD is conflict and shame around sexuality, which may be either unconsciously repressed and converted to physical symptoms or counterphobically expressed with sexually seductive and provocative behaviors (Psychodynamic Diagnostic Manual Task Force [PDMTF], 2006). Individuals with HPD struggle to be alone and often seek interpersonal contexts that will provide a desperately needed attention, but this style of relating is often superficial and at the expense of deeper intimacy.

SPD

Patients with SPD are in many ways characterized by their aloneness and apparent indifference toward relationships (APA, 2000). Such individuals are thought to not desire intimacy and closeness and shun family, friend, and romantic relationships as a result. Further, individuals with SPD appear to be indifferent to the kinds of

praise and criticism that can be powerfully motivating for others. As a result, such individuals appear emotionally detached in social interactions, although recent research has begun to challenge the notion of absent desire underlying this manifest disinterest. Shedler and Westen (2004; Westen & Shedler, 2007) used a large sample of clinicians characterizing their own patients as well as prototypical patients on a wide range of personality descriptors to create empirically derived typologies. Their prototype of SPD goes beyond interpersonal avoidance to describe an inner experience of fear of embarrassment and humiliation. Thus, the internal experience of an individual with SPD may actually be highly vigilant of and intolerably pained by difficulty in engaging the social world, which is defended against by isolation and an apparent indifference toward relationships. Therefore, while patients with SPD may prefer behavioral solitude, this research challenges the assumption that a dearth of intimacy is their desired state.

PPD

Patients with PPD are characterized by a pervasive suspiciousness that leads to attacks on the fidelity and trustworthiness of others (APA, 2000). Unlike psychotic-level paranoia in which suspicions are beyond the bounds of reality testing, those with PPD may have actual relationships within which they fear being deceived or maligned. Kernberg's (1984) notion of defensive splitting is particularly relevant for understanding this disorder, in that such individuals do not see their own aggression toward others (i.e., hostile accusations) and yet are acutely aware of indications of another person's aggression. Accusations of distrust are likely to be made without sufficient basis or may be evoked by the paranoid person's behavior, which could lead others to withhold or hide information that may in turn be misconstrued as evidence of distrust. It is important to note that for defensive splitting to successfully protect the all-good image of the self, there needs to be another on whom the all-bad image can be projected. Thus, while individuals with PPD may isolate themselves by either pushing others away by their hostile accusations or retreating into solitude to seek respite from a world perceived as unsafe, the need to locate the experience of danger in others may pull them back toward relational experiences.

APD and DPD

APD and DPD fall into the *anxious or fearful* cluster of personality disorders (APA, 2000). Patients with APD are characterized by intense fears of criticism, humiliation, and embarrassment that lead to withdrawal from the social world to avoid this feared outcome. Patients with DPD are characterized by fears of their own lack of competence and capability to function autonomously, leading to clingy, submissive, and dependent relationship patterns. Thus, the manifest presentation of these disorders is quite different; those with DPD desperately approach relationships and, as a result, are rarely alone, while those with APD desperately avoid relationships

and are often alone. However, Shedler and Westen's (2004; Westen & Shedler, 2007) empirically derived prototypes of avoidant and dependent personality disorders were found to share many key features, at times making it difficult to distinguish between the two. These patients were found to share what they termed a depressive core (i.e., "tends to feel inadequate, inferior, a failure," "helpless, powerless," and "will be rejected/abandoned") from which different coping strategies related to behavioral solitude arise (i.e., excessively avoiding vs. needing people).

Future Directions

As can be seen, the possible combinations of manifest presentations in the personality disorders are great, but each reflects underlying core conflicts around closeness and relatedness. Despite the conflictual relationship toward experiences of aloneness in the personality disorders detailed earlier, there have been surprisingly few links made between these disorders and solitude research. Yet there are ways in which each literature could clearly benefit from integrating knowledge from the other.

Solitude research has consistently demonstrated that those with the capacity to be alone have better mental health outcomes than those without (Katz & Buchholz, 1999; Larson, 1997; Larson & Lee, 1996; Suedfeld, 1982). However, surprisingly few researchers have evaluated solitude in the context of patient populations who are characterized by loneliness and poor mental health outcomes. Our review of the literature identified only one empirical study (Richman & Sokolove, 1992) that evaluated a personality-disordered sample with a widely used measure of solitude (UCLA-LS; Russell, 1996). While research has begun to evaluate the quality of object relations in predicting attitudes toward solitude and mental well-being in nonclinical samples (Detrixhe et al., 2011), future research should seek to extend these findings in clinical samples for whom loneliness is a distinctive feature (e.g., BPD). One of the strengths of the work of Detrixhe et al. was the use of a well-validated measure of quality of object relations (ORI; Blatt et al., 1979) that has been widely used in personality-disordered samples (Benedik, 2009; Levy et al., 2002). Building on the work of Richman and Sokolove, future research could extend their findings with a more rigorous measure of quality of object relations, such as the ORI. This work could also be built upon by assessing solitude from a variety of domains; in addition to utilizing a solitude-related well-being measure such as the UCLA-LS (Russell), personality-disordered groups could also be evaluated with measures of behavior (e.g., hours spent in solitude), attitudes toward solitude (e.g., the Capacity to Be Alone Scale (CBAS); Larson & Lee), and attitudes toward social experiences (e.g., the Sociability Scale (SS); Cheek & Buss, 1981).

The personality disorder literature could similarly benefit from a greater integration of the solitude literature. Although clinical theorists and researchers have noted the central role of loneliness for understanding BPD, relatively little attention has been paid to understanding the experience of solitude for other

personality disorders. Future editions of the *DSM* should continue to move beyond overt descriptions of signs and symptoms of personality pathology to include a greater focus on the function of isolation and intimacy. Such assessment would include the many domains of functioning impacted by deficits in self and relatedness— affect, behavior, cognitions, and interpersonal functioning (PDMTF, 2006). Further, a conceptualization of personality pathology should include not just deficits in these domains but also the presence of internal resources that might buffer against the impact of symptoms (i.e., the capacity for intimacy and healthy object relations).

Further, a conceptualization of personality disorders that emphasizes descriptions of overt signs and symptoms may present barriers to treatment. For example, a strikingly low number of schizoid adults present for outpatient treatment (APA, 2000), which may reflect not only the disorder's characteristic tendency to isolate but also a complacency on the part of the mental health community who assumes such individuals prefer isolation and "don't want treatment anyway." An understanding of the disorder that includes a greater focus on object relations, underlying need states, and the capacity to be alone may be essential in reconceptualizing how to welcome such patients into therapy.

Lastly, it is notable that the *DSM-IV-TR* (APA, 2000) treats *social isolation* as a particularly problematic behavior, seeing it as symptomatic of not only personality disorders but also a variety of symptom disorders. Clearly, solitary behaviors that cross a certain threshold in duration and intensity may place a person at risk for mental illness. However, little is known about that threshold or whether an optimal, normative balance between alone time and together time actually exists. Future study might investigate possible personality variables that determine whether solitude-seeking is a source of well-being or a sign of pathological isolation.

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