Psychodynamic theoreticians and clinicians have given increasing attention to the nature and treatment of personality disorders. In this chapter, we explore the psychodynamic models most relevant to understanding these disorders and then describe the application of these models in treatment. The psychodynamic literature has traditionally focused more on describing the underlying dynamics of personality disorders than on describing treatment techniques in detail. Following the psychoanalytic model, therapists tended to avoid setting a specific agenda, followed the patient's associations, and kept the treatment open-ended with little attention to specific treatment goals. However, psychodynamic therapists have increasingly realized that effective treatment of personality disorders requires specific treatment modifications. This awareness has come both from clinical experience and from the role of empirical research.

Early psychodynamic literature often assumed that an understanding of the characteristic unconscious conflicts in a given personality disorder allowed the therapist to use the traditional psychoanalytic method of free association and interpretation to treat the disorder. More recently, there has been increased emphasis on clear explanation of techniques, including the development of treatment manuals. This trend began with the detailed description of psychodynamic treatments for patients with interpersonal difficulties (Luborsky 1984; Strupp 1984) and recently has been expanded with descriptions of psychodynamic treatments for those with severe personality disorders (Bateman and Fonagy 2003; Clarkin et al. 1999).

Psychoanalytic explorations of character pathology not only predate but also attempt to go beyond the phenomenological approach of DSM-III (American Psychiatric Association 1980) and its successors. In fact, DSM-III started the trend of taking the American Psychiatric Association's diagnostic system away from descriptions based on a psychoanalytic understanding of psychiatric illnesses toward a system based on phenomenological considerations, with the goal of increasing the
Psychodynamic Psychotherapies

The psychodynamic models of psychological development most relevant to the treatment of character pathology are ego psychology, object relations theory, self psychology, and attachment theory (see also Chapter 2, "Theories of Personality and Personality Disorders"). These psychodynamic models can be contrasted with and complemented by other models of pathology, such as the cognitive, interpersonal, evolutionary, and neurocognitive models (Lorenzwegger and Charlin, 1994). Psychodynamic approaches do not espouse a purely "psychological" model at the expense of a biological understanding of psychopathology. Psychodynamic concepts such as affects and drives have a clear grounding in biology (Valzelli, 1981). What distinguishes a psychodynamic approach is the further elaboration of mental functioning that focuses on both the conscious and unconscious meanings of experience as biological forces interact with interpersonal (social, cultural), and linguistic influences.

The elements that link psychodynamic models are:

1. an emphasis on the role of unconscious mental forces (e.g., drives, wishes, prohibitions); and
2. the notion that the individual's conscious mind is only a partial slice of his mental activity and that unconscious forces influence his feelings, thoughts, and actions in ways that are not known to him (referred to as "psychic de
termination");
3. an emphasis, to varying degrees, on the past—as filtered through and registered in the mind—as determining the individual's experience of the present (this third tenet includes the concept of transferrence: the unconscious experiencing of past relationships, as registered in the individual's mind, as a present relationship); and
4. the goal of deep psychological change in the personality that goes beyond symptomatic improvement to improve the overall quality of the patient's life experience. Beyond these commonalties, the various schools of psychodynamic thinking lend different emphasis to id/dialectal drives or to aggressive drives, to drives as a whole or to defenses, and to the role of conflict among intrapsychic forces versus deficits in the development of psychic structures. Most of these are not "either/or" debates but rather "degree of emphasis" debates.

Ego Psychology

Ego psychology stems directly from the Freudian "structural model" (Freud 1933/1961). This model provides many basic concepts incorporated into other psychoanalytically based therapies, but it also provides the least specific formulation of personality disorders. In this model the id, ego, and superego are the key psychic structures that interact in ways that lead either to successful or unsuccessful resolution of competing interests. Unsuccessful resolution results in psychopathology. The id is the seat of the drives and desires for immediate satisfaction. The ego is the more largely conscious system that mediates contact with the constraints of reality, involving perception and the use of reason, judgment, and other "ego functions." The ego also includes defense mechanisms, which are unconscious ways of attempting to resolve or deal with anxiety stemming from the conflicts between the competing psychic agencies. Certain defense mechanisms are more successful at enabling the individual to adapt to life, whereas others are more primitive and provide inadequate reduction in anxiety at the expense of successful adaptation to life. If the defense mechanisms are "ma
ture"—such as humor or sublimation—the conflict may be dealt with in a way that does not interfere with the individual's functioning or feeling state. However, less mature, or neurotic, defense mechanisms, such as repression or reaction formation, are more likely to result in psychological symptoms, such as anxiety, or in impaired functioning, as in compulsive behavior. The most primitive defenses—such as splitting or projection—are those that are most likely to remain and appear in the personality. In normal psychological development, representations of self and others become increasingly more differentiated and integrated. These mature, integrated representations allow for the realistic blending of good and bad, positive and negative, and the tolerance of ambivalence, difference, and contradiction in oneself and others.

For Kernberg (1964), the degree of differentiation and integration of these representations of self and other, along with anxiety and defense, constitutes personality organization. He distinguishes between three levels of personality organization: prototypical, borderline, and histrionic. Prototypical organization is based on stable representations of self and other, in contrast to more integrated and complex ones. It is characterized by the use of primitive defense mechanisms (e.g., splitting, projectional identification, identification, identity diffusion, animosity toward self). The borderline level of organization includes the paranoid, schizoid, borderline, narcissistic, antisocial, histrionic, and dependent personality disorders of DSM-IV-TR as well as the sadomasochistic, hypochondriacal, cyclothymic, and histrionic personality disorders (Kernberg 1996). In this system of classification, the obsessive-compulsive, hysterical, and depressive-masochistic personality disorders are at the neurotic level. This classification system has treatment implications, because the therapeutic approach is guided by the level of personality organization.

We can understand how psychic structure leads to symptoms by considering the primitive defense mechanisms that derive from the split psychic structure: splitting, idealization/idealization, primitive denial, and omnipotence. These defense mechanisms are attempts to wall off intense feelings, affects, and impulses that the individual has difficulty accepting in him- or herself. This "walling off" does not eliminate awareness of these feelings but leads to experiencing/dealing with them in ways that interfere with functioning. For instance, because the split prevents the integration of aggressive feelings and libidinal/affectioonal feelings into a more complex whole, the individual may alternate abruptly between extremely positive and extremely negative feelings toward other people in his or her life. This defensive split underlies the instability in interpersonal relations seen in many personality disorders. Alternatively, an individual may deal with split-off feelings by subtly inducing them in another person in order then experiencing an awareness of them as though they belonged to the other person (projective identification). This process of projective identification leads to chaos and confusion in relationships as well as in one's ability to deal with one's own feelings.

Self Psychology

The self psychology model, developed by Kohut (1971, 1977, 1984), is distinguished by an emphasis on the centrality of the self as the fundamental psychic structure and by the view of narcissistic and other character pathologies as resulting exclusively from a deficit in the structure of the self without giving a role to conflict among structures within the psyche (Orenstein 1998). Adler and Buš (Adler 1985; Buš and Adler 1983) applied this model specifically to patients with borderline personality. Self psychology focuses on the cohesiveness and vitality versus weakness and fragmentation of the self and on the role that external relationships play in helping maintain the cohesion of the self. It posits that primary infantile narcissism, or love of self, is disturbed in the course of development by inadequacies in caregiving. In an effort to safe-
guard a primitive experience of perfection, the infant places the sense of perfection both in an image of a grandiose self and in an idealized parent image, which are considered the archaic but healthy nuclei of the "bipolar self" that is the normal product of the evolution of the two nuclei. In the development of the bipolar self, the grandiose self evolves into self-affirming ambitions and involves self-esteem regulation, goal-directedness, and the capacity to enjoy physical and mental activities. The idealized parental image becomes the individual's internalized values and ideals that function as self-soothing, self-calming, affectcontaining structures that maintain internal psychological balance. Problems in either of these evolutions lead to psychopathology. Inadequate development of the grandiose self results in low self-esteem, lack of motivation, anxiety, and malaise. Inadequate development of the idealized parental image results in difficulty regulating tension and the many behaviors that can attempt to achieve this function (e.g., addiction, promiscuity) as well as a sense of emptiness, depression, and chronic despair. Pathology stems from deficits in the development of the bipolar self. The individual responds to these deficits in psychic structure by developing defensive strategies that attempt to fill that gap and lead to the manifest pathology. The anger and rage that often accompany narcissistic pathology are seen as reactions either to attacks on the grandiose self or to dissatisfaction in the idealized image. Because the rage is not considered a primary part of the psyche, the therapeutic focus is not on the rage itself but on the circumstances that occasioned it.

Kohut (1977, 1979) introduced the concept of selfobject: the other seen as the "self's object." It includes the individual's intrapsychic experience of the other and emphasizes the role that the other serves in the development and structuralization of the self (the attainment and maintenance of the coexistence of the self and the unfolding of its capacities). In the course of treatment, selfobject transferences represent the revival of infantile and childhood developmental needs that were never adequately met. Behind the manifestations of psychodynamic pathology, the unattenuated hopes and needs of the patient have to be perceived in order to allow the patient a chance to be more closely build up the faulty structures and attain fulfillment.

Attachment Theory

Attachment theory, first formulated by John Bowlby (1969, 1973, 1980), emerged from the object relations tradition. However, in contrast to object relations theorists who retained much of Freud's emphasis on sexual and aggressive drives and fantasies, Bowlby stressed the centrality of the affective bond developed in close interpersonal relationships. Although his work fell within the framework of psychoanalysis, he also turned to other scientific disciplines, including ethology, cognitive psychology, and developmental psychology, to explain affective bonding between infants and their caregivers and the long-term effects of early attachment experiences on personality development and psychopathology.

Central to attachment theory is the concept of internal working models or mental representations that are formed through repeated transactions with attachment figures (Bretherton 1997, Slavin et al. 1998). These working models subsequently act as heuristic guides in relationships, organizing personality development and the regulation of affect. They include expectations, beliefs, emotional appraisals, and rules for processing or excluding information. These working models can be partly conscious and partly unconscious and need not be completely consistent or coherent. Bowlby postulated that insecure attachment styles at the center of personality traits, and led to the overt expression of felt insecurity to specific characterological disorders. For instance, he connected anxious ambivalent attachment to "a tendency to make excessive demands on others and to be anxious and clingy when they are not met, such as is present in dependent and hysterical personalities, and avoidant attachment to "a blockage in the capacity to make deep relationships, such as is present in phobic and schizoid psychopathologies" (Bowlby 1973, p. 14).

Many of the symptoms of borderline personality disorder (BPD), such as the unstable, intense interpersonal relationships, feelings of emptiness, chronic fears of abandonment, and intolerance of aloneness, have been reinterpreted as sequelae of insecure internal working models of attachment (Blatt and Levy 2003; Diamond et al. 1999; Fonagy et al. 1999; Gunderson 1996; Levy and Blatt 1999).

A recent development within attachment theory has been the work of Fonagy and colleagues (Fonagy and Target 1998; Fonagy et al. 2003), who have outlined the concept of reflective function or mentalisation, defined as the capacity to think about mental states in oneself and in others. Their evidence suggests that the capacity for reflective awareness in a child's caregiver increases the likelihood of the child's secure attachment, which in turn facilitates the development of mentalization in the child. They further propose that a secure attachment relationship with the care-
Descriptions of Psychodynamic Treatments of Personality Disorders

We described the principal psychodynamic models of personality pathology earlier in this chapter in order of their historical development. In this section, we describe some specific treatments that have derived from these models and the more eclectic expressive-supportive model of therapy. The most fully articulated treatments include a clinical description, a treatment manual, and empirical research. However, although there are differences in these treatments, they have many commonalities. Psychodynamic thinking about character pathology and its treatment has historically centered on narcissistic (Kernberg 1975, 1984; Kohut 1977), borderline (Fonagy et al. 1995, 2002; Gunderson 1984; Kernberg 1975, 1984), hysterical (Kernberg 1975; Zetzel 1968), obsessive-compulsive (Reich 1972), and schizoid (Fairbairn 1954) character pathology. Others (Gabbard 2000) have more specifically addressed the individual personality disorders as defined by DSM-IV-TR (American Psychiatric Association 2000), sometimes gearing treatment techniques to the Clusters A, B, and C groupings of the disorders. Present there are few controlled studies of psychotherapy for personality disorders, although there are many case reports and a number of uncontrolled trials. Overall, there is evidence for the effectiveness of psychodynamic therapy (American Psychiatric Association 2001; Leichsenring and Leibing 2003). Most recent to date has focused on a mix of personality disorders, avoidant personality disorder, and BPD. This situation makes it difficult to address treatment of the specific DSM-IV-TR Axis II diagnoses separately. Therefore, this chapter should have both an understanding of the basic psychological structure that underlies many personality disorders (based on primitive defense mechanisms) and of the particular dynamic issues that distinguish the different disorders.

Waldinger (1987) described a set of common characteristics of dynamic therapies for patients with BPD that generalize to those with borderline organization or Axis II Cluster B disorders other than antisocial personality disorder: 1) an emphasis on the setting of the frame of the treatment; 2) an increase in the therapist’s participation during sessions as compared with therapy with neurotic patients; 3) tolerance of the patient’s hostility as manifested in the negative transfer; 4) use of clarification and confrontation to discourage self-destructive behaviors and render them ego-dystonic and unacceptable; 5) use of interpretation to help the patient establish bridges between actions and feelings; 6) blocking acting-out behavior by setting limits on actions that endanger the patient, others, or the treatment; 7) focusing early on therapeutic work and interpretations on the here-and-now rather than on material from the past; and 8) careful monitoring of countertransference feelings.

Within these common modifications to general psychodynamic techniques, we now review how different models address the treatment of personality disorders. We provide a vignette typical of each model and follow with a series of more general clinical vignettes. We take this approach for pedagogical and research reasons, knowing that many clinicians will creatively combine theory and techniques across these models.

Object Relations Models of Therapy

Among object relations models of therapy (Gabbard 2000; Strupp 1984), the most fully manualized is transference-focused psychotherapy (TFT) (Clarkin et al. 1999; Kernberg 1989, 2001; Koopman et al. 2001; Levenson et al. 2002). Emerging data support this treatment (Clarkin et al. 2001; Levy KN, Clarkin JF, Fuechsl PA, Kernberg OF, "Transference-Focused Psychotherapy for Borderline Personality Disorder: A Comparison With a Treatment-as-Usual Cohort," unpublished data 2004, and it is the only object relations model currently being tested in a randomized, controlled study (Clarkin et al. 2004). TFT considers an explicit contract, a clear set of therapeutic tactics and techniques, a focus on a hierarchy of acting-out behaviors, and a highly engaged therapeutic relationship as prerequisites for transference analysis with patients with severe character disorders. Because patients with character pathology have chronic difficulties in their relationships with others, including the therapist, this model emphasizes the need for a clear understanding of the conditions of treatment to be established both before therapy begins and after the patient begins the actual therapy. The verbal contract is the foundation both for containing acting-out and for interpreting deviations from the contract and distortions of it that will inevitably be introduced in the interaction between patient and therapist.

In TFT, building the therapeutic alliance comes first through the collaboration in discussing the treatment contract and then through the therapist’s empathy with the entire range of the patient’s affective responses, including the negative transference as soon as it arises. Although addressing the negative transference early on can elicit angry and hostile feelings, it is felt to create a better alliance with the patient by indicating that the therapist welcomes and can tolerate the full expression of the patient’s most difficult internal feeling states. To avoid the negative transference would be to participate in supporting the split internal world and, perhaps, unwittingly signal that the patient’s negative feelings are not welcome in the therapeutic scene.


therapist brings these dyads more fully into the patient’s awareness and explores the unconscious motivations for keeping distinctly different, often opposite, dyads separated. Key moments in therapy occur when the patient becomes aware of an aspect of himself that, up to now, he had only expressed in behavior, with no awareness, and/or had projected and seen in others. For example, at a time when the patient is visibly accusing the therapist of being an uncarrying parent whom his only interest is in satisfactorily controlling her, the therapist might say: "I see the conviction with which you hold your ideas, but I’d like to suggest that you think of someone looking in on this scene. They would see you getting up out of your chair and gesturing at me in a menacing fashion. With that in mind, could you consider that you may be capable within yourself of some of the harsh, aggressive feelings that you are attributing to me?"

The working through consists of repeatedly analyzing the dyads that appear first in the transference and then as they appear in the patient’s life outside the therapy and in the patient’s past. In the course of this process, transference interpretations are consistently linked with material regarding the patient’s relationships, behavior control, work functioning, and sense of self.

Mechanisms of Change

Change comes both from interpretations that increase the patient’s awareness of aspects of him- or herself that are split off rather than integrated—and from the patient’s eventual ability to experience the relationship with the therapist as different from his or her earlier "reparenting" of relations and to generalize this awareness to other relationships outside the therapeutic setting.

Attachment-Based Treatment

Attachment-based treatment has been developed for Cluster B personality disorders. The emotional instability of these disorders is seen as secondary to the instability in the self-structure. Therefore, the goal, as described by Bateman and Fonagy (2005), is to "stabilize the self-structure through the development of stable internal representations, formation of a coherent sense of self, and capacity to form secure relationships" (p. 195). To achieve this goal, the therapist must help the patient "move from a disorganized attachment in which affects are volatile and unpredictable toward a more secure attachment in which they are less capricious and more stable" (pp. 195–196). Identifi-
flying and fostering appropriate expression of affect is integral to this process. Anger and aggression are seen as responses to neglect and abuse rather than primary affects.

**Mutative Techniques**

The key therapy tactics are 1) agreeing clearly on the purpose and expectations of therapy; 2) using the therapist's appreciation of how the patient is stabilizing self-structure (e.g., through self-harm or substance abuse) to guide the therapist's understanding, interpretations, and other interventions; 3) maintaining mental closeness, especially by the use of interventions that are "co-egorical" and "matched"; 4) accepting aspects of the "alien self" (through projection and countertransference); and 5) using brief here-and-now statements recognizing the patient's current absence of symbolic representation.

**Mechanisms of Change**

The mechanism of therapeutic action is based on developing the patient's ability to evolve an awareness of mental states and then find meaning in his or her own and other people's behavior. The transference is seen as the emergence of latent meanings and beliefs that are evoked by the therapeutic relationship. "It [transference] is a new experience influenced by the past rather than a repetition of an earlier one" (Bateman and Fonagy 2003, p. 200). Watt that direct transference interpretation is at too high a level of abstraction for borderline patients, the authors recommend using transference truces, comments that predict likely future action based on the patient's previous experience in a way that heightens the patient's ability to begin to see transference patterns. In this sense, one difference between this approach and the TFP approach described earlier is that the therapist following this model would tend to "hold the projection" within him- or herself longer before directly interpreting it to the patient.

The core of the work is helping patients understand their intense emotional reactivity in the context of the treatment relationship. The patient is urged to consider who engendered the feeling and how and to ask: "What feeling may I have engendered in someone else, even if I am not conscious of it, that may have made him behave that way toward me?" An important part of this process is focusing the patient's attention on the therapist's experience, with the goal of the exploration of a mind by a mind within an interpersonal context. This interpersonal focusing involves mental closeness, which is "to represent accurately the feeling state of the patient and its accompanying internal representations, to distinguish the state of mind of self and other to mark the difference, and to demonstrate this distinction to the patient" (Bateman and Fonagy 2003, p. 202).

An example from this model involves a patient who came into a session looking agitated and frightened and remained silent. The therapist proposed, "You appear to me as frightening today." The patient replied, "I'm not frightened, it's hard for me to think about you." The therapist then proposed to explore a bit more deeply within the patient, saying, "I am not aware of being cross with you, so it may help if I think about why you were concerned that I was" (Bateman and Fonagy 2003, pp. 196-199).

**Self Psychology**

Self psychology is described (Kohut 1971, Ornstein 1998) as a form of psychoanalysis whose principles can be applied to therapy as well. The main emphasis at the beginning of therapy is facilitating the development of the selfobject transference, which creates the precursors of a therapeutic alliance. This model sees the patient's potential capacity for a true therapeutic alliance as evidence that he or she has resolved a borderline or narcissistic personality disorder and has advanced to a core level of difficulty (Adler 1985). The model does not emphasize establishing the treatment frame through contracting as a separate process, but in the case of acting-out borderline patients, it describes the therapist's need to set limits and participate in protecting the patient.

3 In accordance with the primitive defense mechanisms, self-destructive acting-out can stabilize the self-structure by satisfying intense and poorly integrated aggressive affects rather than dealing with them in more mature ways.

4 "Marking" involves reflecting back to the patient that you understand his affect but also indicating that your affect is distinct from it.

**Expressive-Supportive Therapy**

The most widely practiced version of psychodynamic psychotherapy for personality disorders is probably expressive-supportive therapy (Gabbard 2000, Gunderson 2001, Luborsky et al. 1983, Wileman 1986), in analyzing the Menninger Foundation Psychotherapy Research Project, concluded that this therapy involved a mix of the more formal elements of psychoanalysis, termed repressive (e.g., the therapist's neutrality and use of interpretation), and of elements described as supportive (e.g., the therapist at times supporting rather than interpreting the patient's current defenses). Expressive-supportive therapy refers to an eclectic therapeutic stance of selecting interventions from any of the more specific theoretical models according to what seems to be the best fit with a given patient at a given moment in the treatment. Therapeutic goals can vary from mere analytic (e.g., gaining insight and achieving resolution of internal psychological conflict, increasing the cohesiveness of the self, improving the quality of interpersonal relationships) to more supportive (e.g., helping the patient to adapt to stresses while not directly addressing unconscious wishes and defenses). This form of therapy proposes the "expressive-supportive continuum of interventions" (Gabbard 2000, p. 96): Interpretation → Confrontation → Clarification → Encouragement to elaborate → Empathic validation → Advice and praise → Affirmation.

The expressive-supportive approach has the advantage of allowing the therapist to mediate between more analytic exploration and more supportive involvement. Yet there is a risk of countertransference enactments as the therapist shifts between an analytic focus and a supportive one. For example, the therapist could deviate from the analytic objective if he or she regularly responds to the patient's anxiety about internal conflicts by giving a more supportive mode. Awareness of this risk and appropriate supervision are the best guarantees against countertransference enactments.

Expressive-supportive therapy emphasizes establishing the alliance as the sine qua non of the therapeutic process, a view that is supported by research (Luborsky et al. 1983). Therefore, the central task, especially early in therapy, is primarily supportive and relationship building, with the fostering of positive or even idealizing
Mechanisms of Change

The traditional psychodynamic principle of bringing unconscious aspects of the patient's mind into consciousness still holds. However, the expressive-supportive model emphasizes the role of the therapist's understanding through interpretation and the role of the patient's unique style of relating with the therapist as mechanisms of change.

Illustrative Vignettes

Any single vignette of a psychotherapy must be understood as part of a complex whole involving a process between patient and therapist. Maintaining a flexible approach is crucial, and it is often the case that a therapist will draw on different psychodynamic models of treatment at different times. This process extends from the evaluation phase, through the setting of the treatment frame, to the development of the therapeutic alliance, into the interpretation and working through of conflicts, and into the termination phase. The following vignettes provide a small sample of interventions with patients with personality disorder. Fuller clinical illustrations can be found in other texts (e.g., Chodin et al. 1999; Gabbard 2000; Yeomans et al. 2002).

Addressing Narcissistic Defenses

A narcissistic patient, typically preoccupied with and defending against an inadequate sense of self, presents with a chief complaint of feeling depressed and anxious because he believes he should be married at age 30 but had not succeeded in finding a wife. In the next session, the therapist summarized the complaints:

Therapist: You've been depressed and anxious?

Patient: No, not really... maybe a little, but not more than anyone feels at times.

Therapist [attempting to find his bearings]: You said you've been frightened because you haven't succeeded in getting married?

Patient: That's not really going on today. I'm feeling lonely.

Therapist [somewhat confused, but thinking of his didactic impression of narcissism, offers a therapeutic confrontation and interpretation]: Something seems to be going on right here that may be central to the problems you have described. After telling me about some problems, you have taken them back. While one possibility is that these problems have gone away, it may also be that you feel I'm judging you critically when I state your problems... seeing you as less than perfect, and you may feel you have to pretend with me with a positive image of yourself. Yet, if we look further, we may find that the harsh judge and the demand for perfection are in you and make it impossible to ever feel good about yourself. This could be part of your difficulty in relating, because it is very difficult to get close to someone if you feel a constant pressure to be perfect. The question is where this pressure is coming from.

Addressing Splitting in a Borderline Patient

A patient, typically torn between desperately needing others and attacking them, presented with a history of violent destructive and self-destructive behavior. She began by asking, "I don't want it to be true. I just need help with my stupid symptoms so I can be independent and get along with myself. People are not good and I hate everyone."

The first months of therapy were stormy, with continued self-destructive behavior outside the sessions and much anger and devaluing of the therapist by the patient in sessions. However, the therapist noted moments when the patient would calm down, and there would be a sense of being together with a modicum of peace and harmony. Inevitably, the following session would be very disturbed. The therapist pointed out this pattern and said, "As unpleasant as it may be, it seems as though you feel relatively comfortable and safe here when you are angry and dismiss me as useless and meaningless to you. Even so, moments emerge when you give in to what appears to be a natural tendency to relate to me in a positive way but those moments are followed by reinforcement of your anger and devaluing attitude toward me. It seems as though that attitude serves a purpose (pointing out the defense) of protecting you from the positive, attached feelings that make you feel uncomfortable (beginning to address the conflict). A big part of our job here is to understand what it is about your positive feelings toward others, your longings, that makes you so uncomfortable that you replace them with the angry and violent feelings that are what people see and that governs that your underlying longing will not be satisfied."

The patient's initial response was "puzzling." However, after more cycles in which the therapist pointed out the pattern of the patient's relating to him positively and then becoming violently angry and rejecting, the patient said, "I've been thinking, and I think you're right. I really want to be close to people, but that scares me so much I can't stand those feelings." This freed the patient to experience an important part of her unconscious longing and fear out of consciousness and to explore why it was difficult for her to experience and express those feelings.

SUMMARY

Psychodynamic therapy has a long tradition of addressing our understanding of personality disorders and how to treat them. Psychodynamic models may differ in certain areas, such as the degree to which personality disorders are considered the result of intrapsychic conflict or of a deficit in psychic structure or self-structure. According to the model's position on this issue, the technical approach may put more emphasis on interpretation versus empathy. Nevertheless, it is important to keep in mind a common theme: the role of early development in combination with the individual's temperament in creating a psychic struc-
tute that does not adapt well to dealing with the complexities of the real world and the need to integrate or complete that psychic structure to help the individual replace failure and frustration in life with a realistic measure of satisfaction and achievement.

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