

# Transference-Focused Psychotherapy: Structural Diagnosis as the Basis for Case Formulation

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Case formulation in transference-focused psychotherapy (TFP) is based on the severity of the patient's personality pathology, also referred to as Personality Organization, which is mainly determined by the patient's capacity for reality testing, predominant defence mechanisms, and consolidation of identity. In TFP, the patient's level of personality organization or structure is evaluated at the beginning of treatment using the structural interview, which is a clinical psychiatric/psychological interview developed and articulated by [Otto Kernberg \(1984\)](#). That evaluation then serves as the basis for case formulation and treatment planning. The structural interview, and TFP more broadly, are theoretically rooted in the psychodynamic object relations theory ([Kernberg, 1984](#)).

## REVIEW OF OBJECT RELATIONS THEORY IN RELATION TO AN UNDERSTANDING OF PERSONALITY DISORDERS IN TERMS OF PSYCHOLOGICAL STRUCTURE

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Central to our thinking about personality is how to understand identity and, in the case of severe personality disorder, identity diffusion. This latter term refers to an identity that is fragmented, without a clear and

coherent sense of self. To better understand this fragmentation, we refer to the concept of the object relations dyad in the development of psychological structure. A dyad consists of a very specific and narrow mental image, or representation, of the self in relation to a corresponding very specific image, or representation, of another (the object of the self's emotion) linked by an intense affect. The object relations dyad thus brings together affects with cognitive representations. These cognitive/affective dyads are first internalized in the mind in the course of a person's early development but are also subject to continued modification throughout life. They become the building blocks of psychological structure, understood as the matrix through which the individual perceives self and the world.

In the course of early development, the newborn experiences both moments of total satisfaction when the caretaker responds perfectly to its needs and also moments of fear, abandonment, and suffering when the caretaker is not available or, even worse, is neglectful or abusive. In this early phase of development, before object constancy is achieved, the self and the world are perceived through equally extreme and unrealistic lenses of all-good or all-bad. Libidinal (loving and affectionate) and aggressive (hateful and destructive) affects become organized around these extreme representations of self and others. This split state is sometimes referred to as the 'paranoid-schizoid' organization: schizoid because it is split and paranoid because the part of the mind characterized by aggressive affects is not experienced as part of the self but is projected and experienced as coming from others. Individuals whose subjective experience is mainly organized in this way tend to experience anxiety in relations to others since closeness is associated with danger and the risk of abandonment or attack.

In most individuals, identity diffusion is an early stage of psychological development that resolves as they develop more complex and realistic images of self and others. However, identity diffusion persists in those with a borderline level of psychological organization and, in fact, defines that condition. In the state of identity diffusion, the dyads imbued with very specific affects (love, trust, hate, fear) are not brought together in a more coherent representation of a whole and complex self-characterized by nuanced emotions in relation to a complex sense of others. Instead of this, there is no ambivalence – one either totally loves or hates, one is totally fearful or trusting.

In terms of subjective experience, identity diffusion is characterized by rapid changes in the sense of self in relation to other that correspond to the activation of a specific dyad by a 'trigger event'. For example, a patient in a therapy session might abruptly shift from experiencing the therapist as a concerned caregiver to experiencing him as uncaring and hateful if the therapist glances at the clock. While a person with an integrated sense of self and others might think 'my therapist can be concerned about me and also need to know when to end the session', a person with identity diffusion might think 'If my therapist doesn't care for me totally and without

limits, he hates me and wants to get rid of me'. A core feature of identity diffusion is the ongoing segregation of the cognitive and affective mental elements into a segment of purely positive affect and the opposing segment of exclusively negative affect. This split psychological structure is considered the basis of primitive defence mechanisms such as splitting itself, idealization/devaluation, and projective identification.

In successful psychological development, life experience and learning lead individuals to move beyond the split paranoid-schizoid position and to achieve a mature psychological organization in which, for example, they can continue to love someone even when frustrated by that person rather than believe that frustration equals total rejection and abandonment.

It is important to appreciate the impact of the level of psychological organization on: (1) the perception of oneself, (2) the perception of others, (3) the experience of affects/emotions, and (4) the expression of affects/emotions. A split internal world corresponds to extreme emotional states while an integrated self facilitates balance and modulation of emotions. Emotional complexity does not exist in the split internal world of identity diffusion; what the person experiences in the immediate moment determines their experience of *all* of reality at that moment, without taking into account what they may have experienced at other times. This has an impact on reality testing. Without experiencing a total break from reality testing, the extreme and simplistic internal representations that are projected onto everyday experiences can distort perception according to the exaggerated images of the internal world. The combination of these distortions and the projection of aggressive affects hinders an individual's capacity to adapt to the complexity of the world.

## THE STRUCTURAL INTERVIEW AS A CLINICAL INSTRUMENT

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Structural interviewing consists of a mental status examination that has been adapted for assessing personality disorders. Kernberg called the interview 'structural' because it tries to evaluate the basic structures of the mind. It is not structured in terms of a decision tree for interview like the SCID or the ADIS or even the IPDE. The structures that it tries to evaluate are, first, the presence or level of identity diffusion (sense of self, coherence and commitment to goals, representation of others); Second, the degree of reality testing (differentiation of self vs. non-self, distinguishing internal vs. external, and social tact and empathy for social criteria of reality), and third, in that context, also, a secondary element, the diagnosis of the dominant defensive operations that characterize the individual (splitting, projective identification vs. repression). The defensive operations in what we call neurotic personality organization (milder cases), usually

don't show up in the interview, while defensive operations in severe personality disorder usually show up and reinforce diagnosis (particularly what we call primitive or immature defences, in contrast to neurotic or mature defences). Mature defences as articulated by Kernberg (1984), Vaillant (1994), and A. Freud (1965) include repression, intellectualization, isolation, rationalization, displacement, projection. Immature defences include splitting, primitive idealization, projective identification, omnipotent control, and denial. In the structural interview the therapist is assessing these areas in order to make a decision about the patient's level of personality organization. This task is of utmost importance because it will dictate how therapists proceed with treatment. However, it is important to note that case conceptualization in TFP, while occurring mostly during the structural interview, is almost always a dynamic process that continues and develops throughout treatment, as the therapist's understanding of the patient and their difficulties is modified based on information obtained in the process of therapy and becomes increasingly nuanced and accurate.

During the structural interview, the therapist observes and obtains information through three channels: (1) the patient's verbal communication; (2) the patient's nonverbal communication (e.g., behaviour, affect); and (3) the therapist's countertransference. Diagnoses and case formulation from the structural interview are based on an integration of clinical symptoms (both reported and observed), the assessment of intrapsychic structures (inferred from the patient's narrative and experienced through countertransference), and quality of the therapeutic relationship (observed and experienced through countertransference).

During the structural interview, therapists should get the following information: mental status, a complete symptom picture, the patient's current functioning, and the patient's sense of self and others, and, toward the end of the interview, their response to trial interpretations. In addition, the therapist provides the patient with feedback regarding their initial formulations and uses this feedback to assess the patients' willingness to engage in treatment. Figure 2.1 illustrates how the therapist moves through the structural interview.

As the therapist carries out the structural interview, he is constantly aware of the attitude of both the clinician and the patient. The therapist's attitude should be one of concern but without siding with either side of the patient's conflicts. Kernberg referred to this attitude as technical neutrality. In referring to the attitude as technical neutrality he was trying to differentiate it from the more traditional psychoanalytic concept of neutrality. By technical neutrality, we do not mean taking a bland, cool, and aloof attitude but rather a nonjudgmental stance that allows for all aspects of the patient's experience to be considered.

It is also important to note the patient's attitude. Are they concerned? Are they cavalier?

It is very important for rapport building that the therapist convey their understanding of the patient's difficulties. This can be done without overt support, reassurance, or validation. Instead, a genuinely concerned attitude, an attentive stance, and staying close to the patient's phenomenological experience all convey understanding, especially when embedded in warmth. It is important to remember two things about validation: (1) It can be invalidating; and (2) it can support distortions. For instance, reassuring the patient that you are confident in their ability to do something or that you value them can be experienced as invalidating of their concerns even if the reassurance is authentic to the therapist. It is also important to remember that a good interpretation can have a holding quality and be experienced as both very accepting and validating of the patient. For example, when working with a patient that expresses doubts about his ability to complete college despite being very intelligent, instead of providing direct reassurance, the therapist could say: 'Despite being very smart and creative, it is difficult for you to imagine that you could achieve the goals you are aspiring toward. I, like others in your life, could tell you that I think you could complete college, but I imagine that at some level you might still doubt that it is possible'. Rather than overt reassurance this kind of comment captures the complexity of the patient's experience.

Also, maintaining technical neutrality can be very validating and filled with empathic regard. Nonjudgmental, noncritical stance provides patients with sense of safety that allows exploration of previously avoided memories, thoughts, and feelings. In TFP, empathy is defined as being able to connect with the entirety of the patient's internal experience – even parts that they are not aware of (Yeomans, Clarkin, & Kernberg, 2015).

By the end of the structural interview, the therapist should be able to provide the patient with their *initial* diagnostic impressions or understanding and be ready to move onto getting more history and to the contract-setting phase. The contract-setting phase sets the frame for the treatment. It makes explicit conditions for treatment and what the role and responsibilities are for both the patient and the therapist.

During the course of the interview, the therapist should also assess attitude, attention, orientation, consciousness, comprehension, judgement, memory, and intelligence. The therapist begins the interview by providing some context: what they know about the patient, the purpose of the meeting, and what they are interested in finding out. We usually begin with the following four questions, which both facilitates the collection of important information as well as mental status:

1. I would like to know what brings you here?
2. What is your understanding of the nature of your difficulties?
3. What do you expect from treatment?
4. Where are you now?

Often, after their initial answer, a patient will ask whether they answered all the questions and may state something like 'I don't know if that answers all of your questions'. This is a good opportunity to assess mental status. The therapist can say: 'Do you think you answered all the questions?'; 'What do think?'; 'What is your sense?' The therapist can follow by respectfully asking, 'Did you understand what I was asking?'

The four questions begin concretely and become more abstract. The first one is very concrete: What brought you here? The patient may answer concretely and say 'my mother brought me' or 'I came by bus'. What's the nature of your difficulties? That's somewhat more abstract. What do you expect from treatment? That's quite abstract. Where are you now? That's totally unstructured. These questions at the same time have a progressive degree of unstructured nature to test the reality testing.

The patient's answers to these questions provide some cursory evidence for their level of personality organization because, for example, schizophrenic patients usually cannot answer these questions. In addition, although formally assessed only later in the interview, with these first four questions, the therapist immediately tests the patient's sensorium: capacity for attention, degree of consciousness, intelligence and capacity to realistically provide appropriate answers.

1. The therapist challenges the patient's memory – whether they can remember those four questions.
2. The therapist tests intelligence – whether the patient can provide intelligent answers to the questions or not.
3. The therapist also observes the patient's behaviour with them.
4. The therapist observes the patient's affect.
5. The therapist observes the patient's thoughts, both regarding content and process.

Next, the therapist asks symptoms and very completely so, and whenever there is a symptom that needs a differential diagnosis, they go into it. It is our experience that therapists often do not pay sufficient attention to descriptive symptoms. Research suggests that there are a number of important comorbidities to assess for and differential diagnoses to make with regard to BPD. These include: psychotic disorders, mood disorders, anxiety disorders, stress related disorders, attentional disorders, substance use disorders and eating disorders, and other personality disorders. A full discussion of the shared characteristics and the differential diagnosis of these disorders is beyond the scope of this chapter (see [Kernberg & Yeomans, 2013](#)).

The next step is to assess the patient's present life. The therapist can say to the patient, 'I'd like to know about your present life, so to get to know you as you are, as a person. Can you tell me about your work, your studies, your family, your parents, your girlfriend or boyfriend, your children,

what do you do in your free time?’ The goal is to get a complete picture of the patient’s present life circumstances. This allows the therapist to assess problems in the areas of: love and sex, in work and profession, in social life, in recreation, in creativity, in functioning.

Once information about the patient’s current life has been obtained, the therapist asks about and assesses identity. There are two questions for assessing identity. First, the therapist selects one or two of individuals that the patient mentioned as important in their life and asks them to describe that person (s) to them, so that the therapist gets a live picture of them: ‘What makes this person unique? What makes them different from everybody else?’ With normal identity it is possible for a person to provide a live description and a sense of the person. It’s not something easy to do, but it evokes a thought process by which the therapist can see how a person reconstructs what’s essential. In contrast to a thoughtless, some kind of standard, canned, or stereotyped answer (e.g., ‘Oh, that’s a lovely person, great, very sensitive, lovely, beautiful person’). The therapist obtained others’ descriptions until they have a clear sense, and then asks the patient: ‘Now that you’ve described somebody else to me, could you describe yourself? What makes you different from everybody else? What makes you a unique person?’ Of course, by that point the therapist already has an impression of the person and can already contrast that description with what they are observing, but also can evaluate to what extent there is a capacity for an assessment in depth. The therapist assesses the capacity for an integrated view of significant others and of self, in which contradictions may exist, but are described in an integrated, satisfactory way. Identify diffusion is an important indicator of a severe personality disorder and strongly suggest further exploration of personality disorder features.

The next step is assessment of reality testing and is carried out only with patients who, during the interview, give the therapist a sense of something strange. The therapist focuses on those inappropriate aspects in the patient’s affect, thought, or behaviour. The therapist describes these aspects to the patient and then asks: ‘I noticed X – affect, thought, or behaviour – that seems strange to me. Can you see that?’ If the patient provides a conceivable explanation, reality testing is maintained. If that question disorganizes the patient, it indicates impairments in reality testing, which likely suggest a psychotic disorder rather than a personality disorder. If strong evidence exists for impaired reality testing early in the interview (e.g., patient falls asleep while at the same time talking with the therapist; or patient is unable to remember the therapist’s questions), the therapist can skip the previous parts and move immediately to evaluate the sensorium. If there are alterations of thought, affect, or behaviour, the therapist evaluated psychotic symptoms (hallucinations or delusions), that have to be distinguished from obsessive ideas, overvalued ideas, illusions, pseudohallucinations, hallucinosis, hypnogogic experiences, and

faked hallucinations. If the therapist is unsure of the information obtained and how best to evaluate it, they can return again through the cycle in Fig. 2.1. If the patient seems confused and disoriented (i.e., an alteration of the sensorium), they may have acute organic mental illness that requires immediate psychiatric attention. If the sensorium is intact, the therapist moves to assessing alright memory, by ordinary memory tests, and intelligence. The similarities subtest of the WAIS is a very nice and easy way to get a gross assessment and compare it with the patient's educational background.

After that, the therapist obtains a thorough history from the patient. For example, 'What I would like to do now (or in our next meeting) is to get a very complete history about your parents, what they were like, your childhood, the major influences on you, your sexual history, your school and work history, your prior therapy (or therapies), and so forth. This will give me a context to understand what we talked about today and what we continue to discuss in therapy'.

After obtaining the history the therapist acknowledges that they have completed the task and asks the patient if there was anything that should have been asked that was not or if there is anything else that they feel the therapist should know in order to be helpful to them.

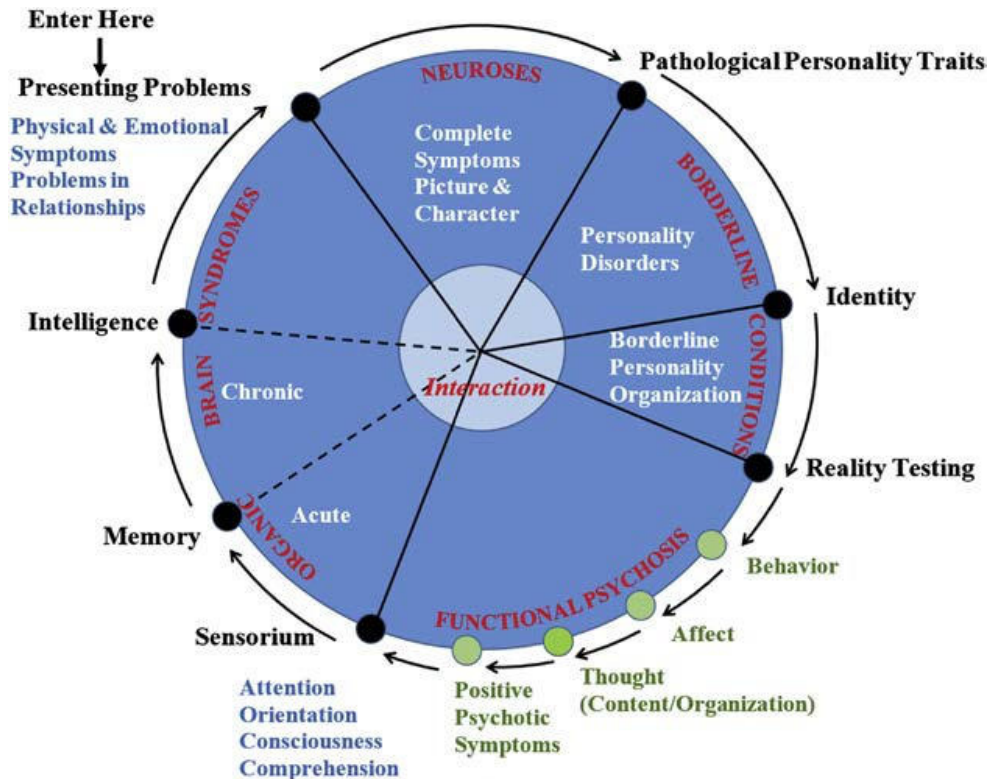


FIGURE 2.1 Cycling Through The Structural Interview



The therapist can conclude the interview when he/she feels he has adequate information to support to have a clear diagnostic impression and sufficient information to set the treatment frame with the patient. The patient's description of self and others, along with continuity or discontinuity/contradictions in his discourse and narrative, have provided the therapist with information about his level of identity diffusion versus integration. The patient's understanding of his condition and problems add to what has been learned about his level of defensive operations from the presence or absence of split views of self and others: a tendency to externalize responsibility for problems within seeing any contribution on his part supports the presence of projection as a primitive defence. The therapist's sense of the patient's capacity to have a nuanced and rich experience of others versus a superficial one is an indication of the degree to which the patient is unknowingly trapped in his own internal world of object representations in contrast to being engaged in deep and genuine relations with others. The structural interview will also have provided information about the consistency/inconsistency/lack of the patient's internal value system and about the level of aggressive affects and if they are egosyntonic or egodystonic. Finally, any questions about reality testing will have determined if the patient may be subject to distortions based on the power of simplistic internal representations or if the patient may be frankly psychotic.

If the structural interview has provided evidence of identity diffusion, primitive defence mechanisms, and shaky but intact reality testing, the therapist will consider the patient to have a psychological structure organized at the borderline level (BPO). The next question is whether the patient is situated at the higher or lower level of BPO; this is determined mostly with regard to whether aggressive drives and affects are stronger than affiliative ones and whether the patient has some degree of meaningful involvement with others and with life activities. This distinction is important to guide the therapist in establishing an adequate treatment contract and frame.

The next question is if the patient's identity diffusion is manifest as such, as in prototypic BPD, or whether it is masked by the pathological grandiose structure (PGS) that distinguishes patients with narcissistic personality disorder (NPD) from other personality disorders in the BPO range. The PGS is a brittle and fundamentally hollow self structure present in the mind of those with NPD that appropriates all that is good to the self and projects all that is negative onto others. This can be seen in self-descriptions that are relatively intact and differentiated compared to those with BPD but also characterized by pathological grandiosity. The description of others, in contrast to the description of self in those with narcissistic personality is characterized by a poverty of detail and richness. The presence of this structure requires certain modifications of the

techniques of TFP (see [Diamond et al., submitted](#); [Diamond, Yeomans, & Levy, 2011](#); [Levy, 2012](#)).

Finally, the therapist decides if the patient falls within a more specific PD category (BPD proper, paranoid PD, schizoid PD, avoidant PD, etc.). The latter distinction has less bearing on the next step treatment (the discussion of diagnosis and of the treatment contract and frame) than the triage into the higher versus lower level of BPO and presence/absence of the PGS that subtends NPD. Fundamental to the discussion of the diagnostic impression is the explanation to the patient that his symptomatic picture, which, of course, must be addressed, is best understood and ultimately best treated by considered a fundamental underlying difficulty in the sense of self.

## **DISCUSSION OF THE DIAGNOSTIC IMPRESSION/ FORMULATION WITH THE PATIENT**

The structural interview is not only important in establishing a diagnosis and case formulation with personality-disordered patients but it is useful in gathering information that can be shared with the patient when providing feedback and in developing collaborate goals for the psychotherapy. Often therapists are reluctant to provide diagnostic feedback/case formulation to the patient because of concerns such as upsetting or stigmatizing the patient. Some therapists view the diagnosis of a personality disorder as pejorative, stigmatizing, or are afraid of the patient's reaction. However, providing diagnostic feedback is important because patients have a right to know how the therapist conceptualizes their difficulties and importantly, one cannot begin the treatment in earnest if there is no explicit agreement about what the problems are that the patient is in treatment for (e.g., it makes no sense to propose a psychological treatment to a patient who insists his problems are exclusively biological). Additionally, the frame, its rationale, and the treatment approach and techniques are related to the diagnosis/case formulation. Patients often conceptualize their difficulties as depression, anxiety, bipolar disorder, PTSD, ADHD, substance abuse, or as the victim of other people's impositions and malevolence. Thus it is important to collect the necessary information to assess and make the differential diagnoses that will be helpful for the patient in understanding how the therapist understands their difficulties. A poorly conducted structural interview, will likely result in difficulty convincingly providing feedback to the patient. Having the information acquired in the structural interview allows the therapist to present feedback that can resonate with the patient's experience without unnecessarily stigmatizing or upsetting them. In doing so, the therapist should stay phenomenologically close to the patient's conscious experience and take their time

in bringing disparate information into the patients awareness. Providing feedback obviously has to be done sensitively and rather than leaving the patient feeling labelled it should leave them feeling understood and hopeful. In sharing this information with the patient, they should feel understood and helped rather than stigmatized and judged. However, despite the best efforts, because the patient is identity diffused, they may have very disparate and unintegrated experiences of the feedback. On the one hand, they may feel the therapist is taking their concerns seriously, being thoughtful in their deliberations and phrasing, and on the other hand feel attacked and judged, not necessarily because of anything the therapist has said but because of their own judgements or experiences of others judgements. Also, this ambivalence can lead the patient to feel hopeful about the treatment with the therapist during the session, but afterwards, contradictory feelings may fester. It is important for the therapist to be vigilant for any ambivalence and gently address it.

Following the diagnostic feedback, the therapist sets the frame for treatment. When working with personality-disordered patients it is important to have a clear discussion of the treatment frame or what is called the treatment contract in a TFP model (Yeomans, Selzer, & Clarkin, 1992). As described earlier, the contract-setting phase has multiple purposes. First, it educates the patient to psychotherapy. This is important for not only the therapy naïve patients but also therapy experienced ones because even those patients who have been in multiple treatments may have only minimal understanding of this particular type of therapy, in part because they may have been in therapies that utilized very different stances (e.g., supportive treatment, medication management, or CBT) or because all too frequently therapists are not explicit with patients about the structure and rationale for a treatment.

A second goal of the contract-setting phase is to establish a clear treatment frame that allows the patient and therapist to address and reflect on the material that arises in treatment, including feelings both in and out of session. The treatment contract creates a safe environment for patients that allow their dynamics to unfold with the therapist. By providing structure and clear expectations, it also provides a safe environment for the therapist to work within. Having an explicit agreement of the tasks and responsibilities of each party also provides an avenue for discussing and understanding deviations from the frame or contract. As Diamond et al. (2013) outline more fully, the contract-setting phase is more difficult with narcissistic patients because the expectations and responsibilities confront and limit the patient's grandiosity and omnipotent control and often results in their perceiving the therapist as controlling and imposing. The frame or contract is often initially rejected or tested in ways that may threaten the treatment. It is important when setting the treatment frame with personality disorder patients that the therapist utilize patients' past

treatment experiences and relationship patterns to predict the kind of difficulties they might experience in the treatment. It is also important for the therapist to examine a patient's responses to the treatment frame to ensure that he or she is not simply acquiescing to the goals proposed by the therapist but is making a true commitment. The frame is established before beginning the therapy per se through negotiation of the treatment contract. The process is a collaborative one in which the therapist presents the rationale for elements of the therapy and the patient discusses any concerns that they may have. The therapist's stance is collaborative not imposing, to avoid acquiescence of the patient. The therapist observes and monitors how the patient is responding and verbally checks-in with them about how they are feeling. The therapist combines flexibility and openness to discussion with adherence to essential aspects of the treatment. In addition to defining the responsibilities of patient and therapist, the structure provided by the contract protects the therapist's ability to think clearly and reflect, provides a safe place for the patient's dynamics to unfold, and sets the stage for exploring and interpreting the meaning of deviations from the contract. When there are deviations from the frame, referring back to the contract supports the patient's capacity to step outside of the moment and to view their behaviour from alternate perspectives. An implicit message in the establishment of the contract is that all feelings can be experienced and reflected on, in contrast to the patient's felt need to manage threatening aspects of affective experience through acting out and projection. This verbal agreement is often referred to as the treatment contract; it establishes the conditions or frame of the therapy in a way that emphasizes the experience of emotions within the therapy and curbs the expression of emotions in the form of acting out (cutting, taking overdoses, substance abuse, unsafe sex, etc.)

### **USING THE DIAGNOSTIC IMPRESSION/CASE FORMULATION TO CHOOSE A THERAPY**

Ultimately the diagnostic data from the structural interview is used to choose and guide therapy. In the broadest sense, knowing if the patient is organized at the neurotic, borderline, or psychotic level allows the therapist to make a choice about treatment intervention. Neurotically organized individuals can utilize a range of therapies across cognitive-behavioural and psychodynamic treatments. The particular therapy is a function of the patient's difficulties and the patient's interests. Some patients are interested in working on specific concerns or symptoms whereas others on broader issues such as capacity for intimacy and self-actualization. For those with focal interests and/or needs, short-term treatments are appropriate, such as cognitive-behavioural therapy, interpersonal therapy, and

short-term psychodynamic therapy, especially for those with depression. For patients with panic disorder, in addition, to a number of CBT based treatments, panic-focused psychodynamic psychotherapy can be used. When the patient is interested, psychoanalysis can be appropriate.

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## CASE EXAMPLE

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The case below is adapted from [Levy \(2012\)](#).

### Presenting Problem and Client Description

Anne was referred by a friend of hers in the field to a colleague who referred her to the therapist for treatment. Her chief complaints were feelings of chronic depression and diffuse anxiety. The colleague who referred her had also indicated that she was prone to angry outbursts, which a number of times resulted in having the police being called. These outbursts occurred in places of business, when travelling, with friends, family, lovers, and with neighbours.

Anne was a tall, attractive, married woman in her mid-thirties with three children, who looked slightly younger than her chronological age. She was the older of two children. Growing up, her father was an extremely successful businessman who had left her with a substantial inheritance. He was a self-made man who was 'all business', hostile and very derogating of her, and generally too busy for his children. After her father's death, her mother remarried. Her mother was both physically absent and emotionally distant while Anne was growing up; although she provided for basic and nonemotional needs, Anne's mother tended to use this support to coerce her children to do as she desired. This pattern of behaviour continued into her children's adulthood. Anne's mother often provided the patient with loans and helped her with her finances as much of her inheritance was unavailable (e.g., in the form of stocks). Because of the unavailability of these funds, Anne had difficulty managing her money and often relied on her mother to organize her finances. In return, her mother often put pressure on Anne about where to live, where the children should go to school, and other major decisions in her life.

Despite her overt perception that she had superior intelligence and abilities, Anne reported constant difficulties doing well in school and in sticking with any one of her multiple hobbies (e.g., horseback riding, acting, and singing). She generally blamed her parents for not encouraging her or helping her develop her talents. She perceived herself as having difficulty concentrating or at least following through on tasks. She felt easily bored or frustrated with whatever she was doing. Despite her difficulties with money, she tended to hire assistants to carry out the more mundane

aspects of her work and hobbies (e.g., she hired someone to take her horseback riding for exercise because she found having to do so boring and an imposition). Her difficulties sticking with hobbies were sometimes made worse due to angry outbursts she would have with friends, colleagues, or others involved in these activities. She would frequently change her mind with regard to which hobbies were most important to and where she wanted to invest her time and efforts. She once sold a horse she owned because she had not ridden it in years, and then a few days later bought another after she saw a new horse she admired. The result of these patterns was that as she entered her 30s she had not yet developed expertise in any one area nor did she have a stable sense of what she wanted to do with her life.

To gain the approval of her parents, she married a man who, while supportive of her and tolerant of her rages, was unable to provide sufficiently for the family, in part because he was disproportionately responsible for the children, and in part because he was probably identity diffused himself. Her inheritance and support from her mother provided for the family and allowed both her and her husband to live comfortably but without steady career investments. She felt terribly put out by having children, found them to be quite a burden, yet needed them as an excuse for not having invested in a career path nor achieved tangible successes.

In addition to depressed mood and diffuse anxiety, the patient reported angry outbursts, significant alcohol and marijuana use, fleeting concerns about rapidly shifting interests, and unhappiness with the lack of success in her life. Upon detailed questioning the therapist determined that she was heavily involved with drinking and marijuana use. She felt considerably activated by routine situations and demands and saw the alcohol and drug use as ways of dampening her internal experience. She shared that her husband was concerned that she was too disconnected from the children and overly frustrated with them – frequently losing her temper with them over rather developmentally normal stresses. By all appearances, she was quite brittle and needed much support. In addition, to her mother's financial and logistical support, she had a housekeeper, gardener, au pair, and a number of babysitters to help her maintain the household and take care of the children. Additionally, her husband did not work regularly and was the primary caregiver who not only took care of the children's emotional needs but also brought them to all their lessons.

At times Anne believed that her children and 'unsupportive' husband were responsible for her 'not making it' or becoming famous and she had frequent fantasies of leaving her family and 'making it big'. She attended acting workshops and sang in a series of local bands, occasionally developing crushes on fellow actors or band members, particularly younger men. Sometimes these crushes resulted in affairs, sometimes in unrequited love relationships. She often fantasized about leaving her family and touring

Europe with a younger man who would produce her music and help her achieve fame and fortune.

## Case Formulation

The case formulation for this patient was derived over a number of sessions using Kernberg's structural interview. From the data that emerged, it became clear that despite her complaints Anne did not meet criteria for any axis I disorder. Although there were some somatic symptoms, she did not have any of the neurovegetative symptoms of depression, nor did she report feelings of worthlessness or excessive or inappropriate guilt or recurrent thoughts about death. She did report depressed mood and occasional loss of interest in activities, but these states were variable, fleeting, and typically in response to a perceived interpersonal slight or some other failure. In fact, rather than being anhedonic, she was particularly self-indulgent and pleasure seeking. Likewise, she did not meet criteria for dysthymia or depressive personality disorder, bipolar disorder, or an anxiety disorder.

Although at times she displayed elevated, expansive, and irritable moods, they never lasted at least a week (or even four days for a hypomanic mood); instead, these symptoms tended to be quite labile, reactive to environmental triggers, quickly vacillating with depressed mood states or irritability as is more characteristic of personality disorders (Henry et al., 2001; Koenigsberg et al., 2002). This pattern was chronic as opposed to being present in discrete episodes as is the case with bipolar disorders. With regard to Generalized Anxiety Disorder (GAD), her anxiety was diffuse, free-floating, and variable. Her anxiety was also imbued with irritability and impulsivity and the GAD diagnosis was contradicted by a variable presence of anxiety and long periods of lack of any anxiety, even in the face of anxiety-provoking situations. Although she had described an occasional panic attack, she did not meet criteria for the disorder.

Her reality testing and sensorium were mostly intact, but as she discussed her functioning, she described situation after situation in which she flew into rages and made outrageous verbal attacks on those she was close to as well as strangers she encountered. She would fly into rages against her parents, her husband, her children, the au pair, her auto mechanic, her singing and acting coaches, lovers, and countless others. No one was safe from her wrath. On the section in which patients are asked to describe themselves and others, consistent with Kernberg's theory, Anne was able to provide a relatively intact and coherent, albeit grandiose, description of herself, whereas her descriptions of others were quite impoverished and in terms of need gratification and frustration. In terms of NPD, she clearly displayed a pervasive pattern of grandiosity in her fantasy and behaviour, a need for admiration, and described instances of clear lack of empathy

for others. With regard to specific criteria, she (1) displayed a sense of self-importance that was exaggerated in terms of her achievements and talents and she certainly expected to be recognized as superior without commensurate achievements; (2) described being preoccupied with fantasies of unlimited success, power, beauty, and ideal love; (3) indicated that she considered herself to be special and should associate with other special or high-status people; (4) described a clear need for excessive admiration; (5) displayed a sense of entitlement; (6) periodically was interpersonally exploitive; (7) had difficulty recognizing feelings and needs of others; (8) was often envious of others and believed that others were envious of her; and (9) at times behaved or displayed an arrogant, haughty attitude.

Based on her symptom picture, her functioning in work and love, and inferred psychological organization based on the quality of the narrative descriptions of self and others as well as the quality of her relatedness to others, it was determined that the panoply of symptoms she presented with could best be understood as occurring in the context of an NPD diagnosis, with a borderline personality organization. This is a woman who aggressively defended against feeling small and inconsequential to her parents – one of whom was hostile and derogating and the other who was cold and disengaged. Understandably, she deeply wanted to be with her parents, to be valued by them, and to be nurtured by them. She was angry with them and others, sensitive to any indication that she was being devalued, and prone to distort benign situations so as to feel belittled. In these situations, she quickly responded with extreme rage that often resulted in her being removed from a situation and/or the dissolution of previously established relationships.

The therapist could tell from the onset that he was about to begin a challenging treatment. Anne's opening volley to the therapist showed both her aggression and her neediness. The very first thing she said to the therapist, referring to his office, was 'Gee, this is the nicest broom closet I have ever seen', which was quickly followed by reprimands for a series of perceived failures on his part: The therapist had no water cooler in his faculty office, his office was too far from where she had to park, the weather did not suit her. Each of these comments was embedded in an angry 'put-out' affect and resulted in the therapist feeling both criticized and sympathetic toward her. She was hostile but the therapist hypothesized that part of her wanted him to care for her. She wanted him to provide nourishment, intimacy, and atmospheric comfort. And even before the therapist said anything more than 'come in', she was angry at him for her own desires of wanting these things from him. Her comments invited interpretations but to do so would have been too early, too exposing, and too penetrating. Consistent with the therapist's countertransference, she would feel attacked without any good options. Immediately, the therapist had a sense of the link between her neediness and her feelings of abandonment with



her aggressiveness and superiority. The therapist felt she wanted these things from him and she was sad that he could not provide them, but she was also angry at him that he had not provided them and that the therapist evoked such desire in her. The therapist also sensed that she took great pleasure in knowing that he was incapable of making a water cooler appear or move the parking garage. And, even if he could get her some water and find her a closer parking spot, he could not change the weather. Thus, it was the therapist who was incapable not her.

This dynamic continued, for as the therapist explained his practice to her, she dismissed everything he said as if he was telling her things she already knew (despite the fact that this was her first therapy). When the therapist told her his fee, she told him that he 'would never get rich charging so little'. She followed this comment with stories of all the people who wanted a piece of her financially as if she was made of money and others were corrupt users who wanted nothing more than to have what was rightfully hers. Infused in these comments were the therapists presumed greed (i.e., that he was using her for his financial gain) but also its opposite: that he was not charging as much as he could and therefore, maybe he was not a greedy money-hungry user. Additionally, she was scoffing at his fee as if it was inconsequential to someone with her money maintaining her superiority to him but at the same time expressing her concern that the therapist didn't really care about her besides the money. Early on, it was clear that her communications were complicated and represented a condensation of overt and covert narcissistic concerns.

Despite the therapist's experience of the patient as critical of him, she also spoke very glowingly about him and it became apparent that her experience of him was very different than the way she spoke to him. Anne described multiple situations in which she was hostile, disparaging, and rude toward others and the therapist experienced her as that way toward him too, despite the intermittent idealizations. However, she saw herself as someone others attacked, derogated, coerced, imposed upon, and controlled. She could not acknowledge it but it seemed to him from her affect and the content of what she was saying that she found him and his questions a terrible imposition. Someone was being imposed upon and controlled and someone was imposing and controlling, but it was unclear to her who had what roles. She and the therapist in the consultation room and others outside it vacillated back and forth in her scenarios.

As the therapist continued the structural interview and he gathered information about her relationships and experience of others, she frequently talked about people in her life that she thought were narcissists or had a personality disorder. She often spoke to the therapist as if the two of them were colleagues discussing her family members who were patients two colleagues might consult one another about. The therapist began to experience dread about sharing his diagnostic impressions

with her. He fretted how she was going to take it and imagined that she might lash out at him and end the treatment (part fear, part wish upon reflection). This was an unusual feeling for the therapist. Although it can be difficult to share a personality disorder diagnosis with patients, it is important that therapists convey diagnostic impressions to collaboratively set the treatment frame. The therapist not only advocates the sharing of diagnoses with patients but usually feels quite at ease and skilled when doing so. Despite the therapist's apprehension, he knew what he needed to do and dutifully did so. The therapist did his best to be tactful and precise in his language and to utilize the material she shared in ways that he thought would resonate with her. To his surprise she initially took the news very well. His descriptions of her experience and the psychological rationales he described resonated with her but, most importantly, despite her disparagement of those she perceived as narcissistic in her circle of family and friends, she disclosed that she had long suspected that she herself could be diagnosed with NPD (in fact, she reported that she wondered about this for almost 10 years!). This was an important moment of both reflection and connection between them. They had a shared experience that the therapist could now refer back to as needed. It was not just the therapist who thought she was narcissistic; she too believed this.

The discussion of the treatment frame was easier now that both were on the same page about the problems and they discussed each of their roles and responsibilities in the treatment as well as the rationale behind them. She was less defensive but the therapist realized that this state was most likely only temporary. With Anne, the therapist stated that although she felt what they were suggesting was reasonable right now, we might predict that at some later time she might feel differently and that it would be important to discuss those feelings as they arise.

It is not uncommon for NPD patients to begin therapy with either a haughty devaluing attitude toward the therapist or conversely with an idealization of the therapist as one who can magically provide solutions to all problems. Both these stances result from the need to sustain the grandiose sense of self and from the envy the patient experiences in relation to others. In both cases the patient envies the therapist's functioning and psychological health. This conflict often leads the patient to devalue the therapist or aspects of the therapy and to either subtly or explicitly reject the therapist's interventions. In Anne's case, she prefaced every acceptance of what the therapist offered by stating 'Of course'. At other times, she made small tweaks to the therapist wording. At still other times, she would reject what the therapist said, only to come in the next week or sometime later and share with him her newfound understanding that was exactly what the therapist had offered earlier but which she had rejected.

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## REVIEW OF RESEARCH

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Empirical support for the reliability, validity, and clinical utility of the structural interview comes from two main lines of research: studies on the traditional structural interview, and studies on the Structured Interview of Personality Organization (STIPO), a semistructured interview derived from the structural interview.

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### RESEARCH ON THE STRUCTURAL INTERVIEW

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#### Reliability of the Structural Interview

Several studies have now established the interrater reliability of structural diagnosis based on the structural interview (e.g., [Armelius, Sundbom, Fransson, & Kullgren, 1990](#); [Bauer, Hunt, Gould, & Goldstein, 1980](#); [Carr, Goldstein, Hunt, & Kernberg, 1979](#); [Derksen, Hummelen, & Bouwens, 1994](#); [Ingenhoven et al., 2009](#); [Kullgren, 1987](#); [Lewis & Harder, 1991](#)). These studies show that, regardless of whether clinicians provide global impression or dimensional ratings, high rates of agreements are achieved on structural diagnosis using the structural interview.

#### Validity and Clinical Utility of the Structural Interview

The convergent validity of the structural diagnosis has been supported in studies that show that measures of the structural diagnosis from the structural interview are positively correlated with related constructs such as DSM personality disorders diagnoses, personality pathology, and use of primitive defence mechanisms, as assessed by a variety of methods, such as structured interviews, batteries of psychological testing and self-report questionnaires ([Armelius et al., 1990](#); [Bauer et al., 1980](#); [Carr et al., 1979](#); [Kernberg et al., 1981](#); [Kullgren, 1987](#); [Lewis & Harder, 1991](#); [Reich & Frances, 1984](#)).

#### Research on the Structured Interview of Personality Organization (STIPO)

The STIPO ([Clarkin, Caligor, Stern, & Kernberg, 2004](#)), and its revised version the STIPO-R ([Clarkin, Caligor, Stern, & Kernberg, 2015](#)) is a semistructured interview based on the structural interview that was developed for use in clinical and research settings. The 55-item STIPO-R consists of standard questions along with additional clarification probes. Ratings are then used to compute five subscales: identity; object relations; defences; aggression; and moral values. In addition, a narcissism dimension can be

scored from items that are included in the other subscales. It is possible to also classify patients into categories of neurotic, high borderline and low borderline personality organization (Hörz et al., 2009).

### Reliability of the Structured Interview of Personality Organization (STIPO)

The interrater reliability of the STIPO is well-established, with estimates of excellent intraclass correlations (ICCs) as well as good-to-excellent internal consistency coefficients, except for the reality testing subscale for which internal consistency is just short of satisfactory (0.69), possibly due to small number of items (Doering et al., 2013; Preti, Prunas, Sarno, & De Panfilis, 2012; Stern et al., 2010).

### Validity and Clinical Utility of the Structured Interview of Personality Organization (STIPO)

The STIPO has been shown to differentiate between various DSM disorders in theoretically meaningful ways and to correlate with self-report measures of personality organization, as well as other theoretically relevant constructs such as attachment style, coping, anger, dissociation, and temperament (Doering et al., 2013; Stern et al., 2010).

Studies have also shown that the STIPO is sensitive to improvements in personality organization during successful treatments of borderline personality disorder, including TFP (Doering et al., 2010). In addition, higher STIPO scores also predicted greater likelihood of dropout among dual-diagnosis patients in a residential treatment for substance abuse (Preti et al., 2015).

In sum, research on the traditional and semistructured versions of the structural interview shows that trained clinicians can achieve adequate agreement on the structural diagnosis based on either a global clinical judgement or dimensional ratings. In addition, the structural interview is successful in capturing the construct of structural diagnosis, and, more broadly, various dimensions of personality pathology, in theoretically and clinically meaningful ways.

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## CONCLUDING REMARKS

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The structural interview is a clinical psychiatric/psychological interview developed by Otto Kernberg (1984) that is central to the case formulation in TFP. Through structural interviewing the therapist is able to assess the severity of the patient's personality pathology conceptualized both in terms of personality organization and the specific PD diagnosis.

Assessment of personality organization provides an understanding of the patient's capacity for reality testing, predominant defence mechanisms employed, and the patients level of identity consolidation. Based on the structural interview, the therapist derives a complete picture of the patients presenting symptoms, pathological personality traits, identity, and mental status needed to make the differential between levels of personality organization and various diagnoses such as major depression, bipolar disorder, panic disorder and borderline and narcissistic personality disorders. The information gathered during the structural interview allows the therapist to confidently provide feedback to the patient that resonates with both parties and thus contributes to the collaborative development of a treatment frame and plan. Additionally, the information obtained allows the therapist to discuss threats to the treatment (e.g., coming late, missing sessions, etc) and how those threats can be protected against in advance and addressed if they arise.

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Select details of the case description were changed so as to protect client privacy.

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