Psychodynamic Psychotherapies

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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

reliability of diagnosis. However, a side effect of this approach has been to increase the number of Axis II diagnoses per patient. From the phenomenological vantage point of DSM-IV-TR (American Psychiatric Association 2000), there are 10 different and supposedly distinct personality disorders. We do not think it is conceptually valid to describe psychodynamic treatments for each of the 10 personality disorders as though they are separate and distinct. Many patients who appear for evaluation with personality disorder have multiple personality disorders according to DSM-IV-TR, Axis II. Thus, in most cases, it is not clinically relevant to think of assessment and treatment for one of the 10 personality disorders. It is more fruitful to consider the underlying psychological structures that subtend many of the personality disorders and to discuss the therapeutic approach to these pathological structures.

Psychodynamic Perspectives on the Nature of the Personality Pathology

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 (Lenzenweger and Clarkin 1996). 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); 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 determinism"); 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 transference: the unconscious reexperiencing of past relationships, as registered in the individual's mind, in a present relationship); and 4) the goal of deep change in the personality that goes beyond symptomatic improvement to improve the overall quality of the patient's life experience. Beyond these commonalities, the various schools of psychodynamic thinking lend different emphases to libidinal/affiliative 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 1923/1961). 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 strives for their 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 mature and successful, whereas others are more primitive and provide inadequate reduction in anxiety at the expense of successful adaptation to life. If the defense mechanism is "mature"—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, tend to result in psychological symptoms, such as anxiety, or in impaired functioning, as in compulsive behaviors. The most primitive defenses—such as splitting or projective identification—characterize the rigid and distortion-prone psychological structures found in severe personality disorders. The *superego* is the largely unconscious set of rules (a combination of ideals and prohibitions) that often oppose the strivings of the id for drive satisfaction. Broadly speaking, ego psychology addresses the question of what are the individual's psychological resources—ego functions and defenses—for adapting to internal and external demands. It views character pathology as the result of the habitual use of maladaptive defense mechanisms, with corresponding problems in functioning such as impulsive behavior, poor affect control, and an impaired capacity for accurate self-reflection.

Object Relations Theory

Object relations theory brought psychoanalysis from a one-person system concerned primarily with drive forces and prohibitions against them to a more complex system considering the drives in relation to their objects (Fairbairn 1954; Jacobson 1964; Kernberg 1975, 1980, 1995; Klein 1946/1975). Within this model, internalized representations of relationships are referred to as *object relation dyads*. Each dyad is composed of a particular representation of the self as it experiences an affect (related to a libidinal or aggressive drive) in relation to a particular representation of the other. An example is the contented, satisfied self in relation to a nurturing other linked by an affect of warmth and love. An opposite example is the abandoned self in relation to the neglectful other linked by an affect of fear and anger. These dyads become the building blocks of psychic structure that guide the individual's perceptions of the world and, in particular, of relationships. 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 (1984), the degree of differentiation and integration of these representations of self and other, along with affective valence, constitutes personality organization. He distinguished between three levels of personality organization: neurotic, borderline, and psychotic. Borderline organization is based on simplistic 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, projective identification, dissociation), identity diffusion (an inconsistent view of self and others), and unstable reality testing. The borderline level of organization includes the paranoid, schizoid, schizotypal, borderline, narcissistic, antisocial, histrionic, and dependent personality disorders of DSM-IV-TR as well as the sadomasochistic, hypochondriacal, cyclothymic, and hypomanic 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 devolve from the split psychic structure: splitting, idealization/devaluation, primitive denial, projective identification, and omnipotent control. 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/affectionate 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 and then experiencing an awareness of them as though they originated in 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 most 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 (Ornstein 1998). Adler and Buie (Adler 1985; Buie and Adler 1982) 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 imago*, which are considered the archaic but healthy nuclei of the "bipolar self" that is the normal product of the evolution of these two nuclei. In the development of the bipolar self, the grandiose self evolves into self-assertive ambitions and involves self-esteem regulation, goal-directedness, and the capacity to enjoy physical and mental activities. The idealized parental imago becomes the individual's internalized values and ideals that function as self-soothing, self-calming, affect-containing 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, anhedonia, and malaise. Inadequate development of the idealized parental imago results in difficulty regulating tension and the many behaviors that can attempt to achieve this function (e.g., addictions, 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 structures 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 disillusionment in the idealized imago. 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 (1971, 1977) introduced the concept of *self-object*: 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 cohesion 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 psychopathology, the unextinguished hopes and needs of the patient have to be perceived in order to allow the patient a chance to belatedly 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 affectional 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 1987; Shaver et al. 1996). 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 lies at the center of disordered personality traits, and he tied 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 affectionless and psychopathic personalities" (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. 1995; 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 *mentalization*, 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 proposed that a secure attachment relationship with the caregiver gives the child a chance to explore his or her own mind and the mind of the caregiver. In this way the caregiver has the child's mind in mind, and the caregiver's thinking of the child contributes to the child's understanding of himself or herself as a thinker. This model includes an understanding of the relationship between personality disorders and childhood abuse. Individuals who experience early trauma may defensively inhibit their capacity to mentalize to avoid having to think about their caregiver's wish to harm them. This inhibition of mentalizing is associated with an absence of adequate symbolic representations of self-states and creates a continuous and intense desire for understanding what is experienced as internal chaos. Some characteristics of severe BPD may be rooted in developmental pathology associated with this inhibition. Even in cases of maltreatment, the child internalizes the self-directed attitudes of the attachment figure into the self-structure. In this case, however, the internalized other remains alien and unconnected to the structure of the self. Although lodged within the self, this "alien" representation is projected outside—both because it does not match the rest of the self and because, in the worst cases, it is persecutory. This projection and attempt to control the object of the projection underlie many BPD symptoms.

Indications for Psychodynamic Treatment

In general, patients with the less severe personality disorders, such as obsessive-compulsive, hysterical, narcissistic,[1] avoidant, and dependent, are suited for psychodynamic treatment (Gabbard 2000, 2001). These patients would be seen as neurotically organized, as compared with the more severe personality disorders with borderline organization (Kernberg 1984). The decision to recommend dynamic therapy rather than psychoanalysis for these disorders can be difficult. One major consideration entering into this decision is the patient's motivation for deep change influencing all areas of his or her life versus more specific relief from anxiety or resolution of problems in certain areas. Other considerations include psychological-mindedness, capacity for transference work,[2] propensity to regress, impulse control, frustration tolerance, and financial resources.

Patients with the more severe personality disorders are seen as potentially responsive to a modified, more highly structured psychodynamic treatment (Bateman and Fonagy 2003, 2004; Clarkin et al. 1999; Kernberg 1984), and there is empirical evidence to support this notion (Bateman and Fonagy 1999, 2001; Clarkin et al. 2001). Kernberg (1984) suggested that borderline patients with a high level of narcissistic, paranoid, and antisocial traits, a syndrome termed *malignant narcissism*, are the most challenging to treat and that even with a highly structured treatment have a poorer prognosis than other patients organized at the borderline level. Patients with antisocial personality disorder (those with no capacity for remorse or for nonexploitive relationships) may be beyond the reach of psychodynamic, or any, psychotherapy.

Across the spectrum of the personality disorders, psychodynamic clinicians utilize nondiagnostic patient variables as indicators of psychodynamic treatment, such as quality of object relations, degree of psychopathy, nature of attachment status, capacity for mentalization, level of secondary gain, and capacity for reflection and insight. In general, the presence and capacity for meaningful relationships and attachments to others, investment in work at the level of one's capacities and training, the capacity to reflect on one's experience, relatively good impulse control, and intact reality testing would be positive signs for psychodynamic psychotherapy (Gabbard 2001). Those patients with low intelligence, those who lack psychological-mindedness, and those who have significant secondary gain of illness (i.e., whose illness results in practical benefits such as disability payments) may be referred to a psychodynamically informed supportive treatment (Rockland 1989, 1992).

Assessment

Clinicians should be alert not only to symptoms but also to the long-standing character of the patient as manifested in the typical ways the patient conceptual-

[1] The reader should distinguish between the higher-level narcissistic personality disorder, per se, and the more challenging BPD with narcissistic features or with malignant narcissism.

[2] Assessing patients for psychological-mindedness and capacity for transference work may require a period of working with the patient, because apparent lack of these capacities may serve as an initial defense against insight and may change with interpretation.

izes self and others and relates to others in work, friendship, family, and intimate relationships. Experienced clinicians do not limit assessment for character pathology to reviewing the criteria in Axis II but explore the nature of relationships with others and observe the patient's behavior with the interviewer as the core of their assessment (Westen 1997). The clinical interview is a time-honored approach to the assessment of character pathology. However, a number of more structured assessments of character pathology can enrich the clinical evaluation. In addition to the International Personality Disorder Examination (Loranger et al. 1997) and the Structured Clinical Interview for DSM-III-R Personality Disorders (First et al. 1995) that assess each diagnostic criterion, there are the Diagnostic Interview for Borderlines (Zanarini et al. 1989), Kernberg's (1981) structural interview (so-called because it investigates the patient's psychological structure), and the Structured Interview of Personality Organization (Clarkin JF, Caligor E, Stern B, et al.: "Structured Interview of Personality Organization (STIPO)," unpublished manuscript, 2004).

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 1971), borderline (Fonagy et al. 1995, 2003; 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. At 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 Leibling 2003). Most research to date has focused on a mix of personality disorders, avoidant personality disorder, or BPD. This situation makes it difficult to address treatment of the specific DSM-IV-TR Axis II diagnoses separately. Therefore, the therapist should have both an understanding of the basic psychological structure that underlies severe 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 stability 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 transference; 4) use of clarification and confrontation to discourage self-destructive behaviors and render them ego-dystonic and ungratifying; 5) use of interpretation to help the patient establish bridges between actions and feelings; 6) blocking acting-out behaviors by setting limits on actions that endanger the patient, others, or the treatment; 7) focusing early 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 technique, 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 (TFP) (Clarkin et al. 1999; Kernberg et al. 1989, Koenigsberg et al. 2000; Yeomans et al. 1992, 2002). Emerging data support this treatment (Clarkin et al. 2001; Levy KN, Clarkin JF, Foelsch 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). TFP 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 between therapist and patient before beginning 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 TFP, 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 may elicit angry and hostile feelings, it is felt to create a fuller 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, to unwittingly signal that the patient's negative feelings are not welcome in the therapeutic arena.

Mutative Techniques

TFP advocates early interpretation of transference as well as the interpretation of both the positive and negative transference. This strategy is based on the immediacy of the affect in the relationship with the therapist, whereas early interpretation of the patient's past often becomes an exercise in intellectualization. However, because poorly delivered interpretations, particularly of aggressive feelings, may result in patients feeling attacked, the ground for interpretation is set by clarification of the patient's feeling states and by exploring any contradictions in the patient's discourse or actions. These contradictions are considered reflections of the split, unintegrated internal world underlying borderline pathology.

The goal of psychotherapy for borderline personality organization is the change from a state of identity diffusion to an integrated identity. The therapist perceives the patient's principal representations of self and of others as they unfold in the transference. The 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 violently accusing the therapist of being an uncaring tyrant whose only interest is in sadistically 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 "repertoire" 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 (2003), 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). Identi-

fying 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)[3] to guide the therapist's understanding, interpretations, and other interventions; 3) maintaining mental closeness, especially by the use of interventions that are "contingent" and "marked";[4] 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 thus 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" (Batman and Fonagy 2003, p. 200). Wary that direct transference interpretation is at too high a level of abstraction for borderline patients, the authors recommend using transference tracers, 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 reactions 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 see me as frightening today." The patient replied, in a challenging way: "What makes you say that?" The therapist provided the immediate evidence: "You had your head down and avoided looking at me," to which the patient responded, "Well, I thought that you were cross with me." 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 we think about why you were concerned that I was" (Bateman and Fonagy 2003, pp. 198–199).

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 eventual 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 neurotic 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.

Mutative Techniques

The self psychology model emphasizes the role of therapist empathy in facilitating selfobject transferences that can lead to developing a more adequate sense of self. These transferences are the *mirror transference* and the *idealizing transference*. The former involves experiencing the therapist as an affirming, approving, validating, and admiring presence and is believed to provide a "psychic glue" that holds the patient's fragile self together. The therapist helps the patient analyze his reactions to inevitable empathic failures on the therapist's part. These failures can lead to disruptions in this transference that result in the fragmenting of the self and the return of symptomatology. In the idealizing transference, the therapist is put on a pedestal so that the patient may borrow some of the therapist's "perfectness." This transference also provides some cohesiveness to the patient's experience of self. Again, therapeutic attention is focused on inevitable disappointments and the rage and symptomatology that may follow.

Mechanisms of Change

The selfobject's responsiveness (in the case of treatment, the therapist's) catalyzes this transformation by activating the individual's innate potential. Empathy is at the center of the therapeutic process. The patient's transference is seen as including a positive striving for a new beginning (Ornstein 1998) in addition to the repetition and distortion based on past experiences. Therapy proceeds not by challenging or focusing on the specific features of the patient's psychopathology but by focusing on the matrix, the vulnerable self, from which it emerged. The therapist's role is seen as that of facilitating the therapeutic reactivation of the patient's original need for appropriate selfobject responses. The therapist generally empathizes with the patient's need for resistances rather than interpreting them. The therapist addresses defenses by helping to see what function the defense/defensive behavior serves in maintaining some degree of cohesiveness in the fragile, fragmentation-prone self. After experiencing appropriate selfobject responses, the patient will be able to end therapy and establish appropriate selfobjects in life outside therapy.

The following example illustrates limit setting, confrontation, and interpretation as they might be carried out in a self psychology model. The therapist's intervention follows a patient's report of dangerous acting-out:

> "[Y]ou must not allow yourself to take such risks again. You felt so intensely because you believed I did not care. Anytime you feel this way and are in danger of acting on it, contact me instead. It would be much better, much safer, to talk with me on the phone.... See that I exist and that this relationship is real." (Adler 1985, p. 137)

Expressive-Supportive Therapy

The most widely practiced version of psychodynamic psychotherapy for personality disorders is probably expressive-supportive therapy (Gabbard 2000; Gunderson 2001; Luborsky 1984). Wallerstein (1986), in analyzing the Menninger Foundation Psychotherapy Research Project, concluded that most therapy included a mix of the more formal elements of psychoanalysis, termed *expressive* (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 more 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 modulate 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 changing to 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. 1980). Therefore, the central task, especially early in therapy, is primarily supportive and relationship building, with the fostering of positive or even idealiz-

ing aspects of the transference (Buie and Adler 1982; Chessick 1974). Alliance building takes precedence over focusing on the contract and conditions of treatment out of concern that emphasis on these might elicit negative transference or too quickly challenge the patient's defenses. Luborsky's (1984) manual for expressive-supportive therapy summarizes many aspects of the treatment.

Mutative Techniques

Depending on the relative expressiveness versus supportiveness of the therapy, the therapist would either directly offer interpretations to the patient (addressing transference, defenses, impulses, and/or the patient's past) or use the therapist's own awareness to guide an understanding of the patient while avoiding interpretation. Similarly, a more expressive approach to resistance is to interpret and help the patient understand its function, whereas a supportive approach might call for bolstering resistances in the service of reinforcing weak defensive structures in the patient.

The expressive-supportive therapist gears interventions to the particular defensive structure of the patient. For instance, when treating a patient with paranoid personality disorder (Gabbard 2000), the therapist would be informed by an awareness of the patient's tendency to perceive attack from the therapist and thus to evoke the therapist's defensive responses. Resisting such responses, the therapist would leave the patient's suspicious accusations and projections "hanging," neither denying nor interpreting them. In this way, the projections of hatred and badness are contained by the therapist. As this lack of defensiveness, combined with empathy for the patient's subjective state, creates a sense of alliance, the patient will (it is hoped) become more open and revealing. In this process, the therapist helps the patient label feelings and better distinguish between emotions and reality (Meissner 1976). Therapists also guide the patient's perceptions of reality by questioning assumptions ("You assumed that when your friend didn't wave back from the other side of the theater that he was trying to avoid you. But are you sure that he saw you in that crowd?").

The fact that the therapist does not respond in the way anticipated, and provoked, by the patient is meant to lead the patient to a "creative doubt" (Meissner 1986) about the way the patient perceives the world. This questioning of his or her own way of thinking will help the patient develop a better capacity to accurately reflect on and perceive him- or herself in relation to others.

Mechanisms of Change

The traditional psychoanalytic principle of bringing subconscious aspects of the patient's mind into consciousness still holds. However, the expressive-supportive model emphasizes both the role of increasing the patient's understanding through interpretation *and* the role of the experience of a new type of relationship with the therapist as mechanisms of change.

Illustrative Vignettes

Any single vignette of a psychodynamic therapy must be understood as part of a more 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, through 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., Clarkin et al. 1999; Gabbard 2000; Yeomans et al. 2002).

Addressing Omnipotent Control in a Patient With Obsessive-Compulsive Personality Disorder

An obsessive-compulsive patient, typically anxious about experiencing intense affect, filled each session with lengthy monologues full of obsessive details. A main theme was having to submit to his aggressive boss. The therapist's attempts to intervene were overridden with comments such as, "But I haven't told you..." that led to more obsessive details. After many such sessions, the therapist commented on the overall process (seeing the patient's behavior as a character defense):

> Therapist: I have a thought about what's going on here that may help explain some of the problems you've had getting close to people, keeping jobs, and so on. It's striking how you fill our sessions with talk.
> Patient: But you told me to say whatever comes to mind.
> Therapist: That's true, and yet, even with that arrangement, therapy usually has the feeling of an exchange, a dialogue. The feeling here is that you need to keep control and can't let me exist independently in the room. It is interesting because what you are doing could be seen as a domination of me, similar to the domination you complain about from your boss. Yet I don't think you have any awareness of this. It may be that your fear of your own aggressive and domineering strivings leaves you unaware of them and thus unable to deal with them. This in turn could explain the stiffness, rigidity, and distance in your relations with others.

Addressing Narcissistic Defenses

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

> Therapist: So 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 frustrated because you haven't succeeded in getting married?
> Patient: That's not really going so badly. I've had a lot of dates lately.
> Therapist [somewhat confused, but thinking of his diagnostic 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 your problems have gone away, it may also be that you feel I am judging you critically when I state your problems...seeing you as less than perfect, and you may feel you have to present 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 relationships, 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 behaviors. She began therapy saying, "I don't want to be here. I just need help with my stupid symptoms so I can be independent and go live by myself. People are no good and I hate everyone."

The first months of therapy were stormy, with continued self-destructive behaviors outside the sessions and much anger and devaluing of the therapist 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 stormy. 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 these moments are followed by reinforcement of your angry 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 very 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 guarantee that your underlying longings will not be satisfied."

The patient's initial response was "bullshit." 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 do 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 herself that she had previously kept 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-

ture 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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