



Personality Structures and Chronic Childhood Relational Trauma: Psychodynamic and Attachment based Perspectives that Challenge the Restricted Diagnosis of Personality Disorder

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Abstract

With the imminent publication of DSM V growing ever closer, the author suggests that *headline* diagnostic categories, such as narcissistic personality, histrionic personality or the ubiquitous borderline personality may actually be unhelpful to the clinician, who wishes to reach a deeper understanding of the factors shaping character pathology. The proposed revision of diagnostic criteria for personality disorder, in the forthcoming DSM V, to further emphasise traits within nosographical personality categories, appears to remain limited in conceptual scope.

The psychoanalytic concept of personality structure is considered more malleable, from a conceptual perspective, in that it may enable the clinician to both describe and situate current psychological conflicts more appropriately, within a developmental context. It is suggested, in this paper, that such a conceptual progression is necessary in order to accommodate the rich seam of object relations, and attachment based approaches that have further shaped our understanding of personality development and personality difficulties, over the last two decades.

Keywords: Personality; Disorder; Structure; Attachment; Psychodynamic

Introduction

Clinicians working in the broad field of psychological medicine are intimately familiar with patients who present for assessment, urgently seeking relief from painful, distressing, and often debilitating symptoms. These symptoms may include those on the continuum of depressive anxiety, persistent and disturbing distortions of thinking, or what appear to be the somatised representatives of psychological conflicts which have been, through the process of conversion, rendered at a bodily physiological level. In many cases, brief and focused interventions may provide symptomatic relief, for instance, in the case of cognitive behavioural therapy deployed to treat a simple and specifiable phobia. Other distressing conditions, for instance

many of the dysomnias, may also remit when the underlying anxiety, connected to the disturbance in functioning is traced, explored, and then felt to be more appropriately contained, at a psychological level. Of course, the psychotherapeutic relationship, when it is working well, provides a prototype for this psychological containment, prior to individual psychological internalisation, of the containing function, in the case of the patient. It might even be recognised that for the clinician, in treating such relatively straightforward cases, the gains made by these patients, when they are consolidated, provide a degree of healthy narcissistic satisfaction for the clinician that enriches the reserves and capacities required by the therapist, in the treatment of the more demanding cases that psychotherapists accept for treatment.

Amongst the many difficulties encountered by psychiatrists, psychologists and psychotherapists, the personality disorders present particular challenges, both conceptually, and in terms of the practicalities of psychological treatment. We are all familiar with the categories of personality disorder listed in DSM-IV (r) and in ICD-10, and the general sense of therapeutic caution that pervades the whole area of characterological difficulty. Many of us, perhaps too readily, employ the well worn diagnostic terms associated with disorders of personality, for example by describing a patient as borderline or, at times, psychopathic, narcissistic, schizoid, obsessional, histrionic or paranoid. In what follows it is suggested that a more nuanced view of personality difficulties might focus on the concept of personality structures, rather than disorders. These structures evidence a range and depth of affects, defences, and object representations. The latter, it will be argued, require exploration at both the inter and intra-psychological levels, if the realistic evaluation of psychotherapeutic treatment and its potential efficacy is to proceed. In this sense, one can imagine a continuum of severity in terms of symptoms indicative of personality difficulties, across the three distinct groupings described in DSM IV (r) i.e., paranoid, flamboyant and avoidant types.

For example, to take an individual evidencing an apparently paranoid personality structure. Typically such patients will be suspicious and mistrustful of others, evidence heightened levels of affective anxiety in relation to perceived threats and deploy primitive defensive mechanisms, often based on a repertoire of splitting of the ego, and the object and deployment of both projection and projective identification. It should be borne in mind, however, that the range of affective disturbance, defensive organisation and structural personality instability has a very wide compass of variability, and that in assessing as accurately as possible the global personality the clinician will require both time, and, most likely, high levels of patience. In the case of an ingrained paranoid personality structure, time must be taken in developing the differential diagnosis, in order to establish that the paranoid personality traits do not occur during the course of a schizophrenic illness, a mood disorder with psychotic features, or another psychotic disorder. The clinician must also satisfy herself that paranoid ideation is not due to the direct physiological effects of another medical condition [1].

Psychodynamic approaches to personality structure

Interestingly, from the point of view of classical psychoanalytic theory, analysts came relatively late to the question of character

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disturbance [2-4]. Perhaps, this reflected Freud's emphasis on the drive and his rather late attention to splitting of the ego, and the fate of the internal object [5,6]. Be that as it may the period from the 1950's to the 1980's saw a dramatic expansion of interest in disturbances of personality. Robert Knight, in the United States, was a pioneer who applied ego psychological thinking to his conceptualisation and treatment approach, particularly with individuals considered to exhibit borderline states. These states were thought to indicate weak ego integration, and the borderline description followed Adolph Stern's earlier use of the term to describe patients, who appeared to evidence character pathology somewhere between the psychotic and the neurotic ranges of functioning [3].

In the 1960's, Otto Kernberg further developed the pioneering work of Stern and Knight by formalizing, from the psychoanalytic perspective, the diagnostic categories of neurotic, borderline and psychotic personality types, in his approach to a range of mental health difficulties. Kernberg and Horowitz [7-9], employing a mixed model approach based on contributions from both ego psychological drive theorists [10], and object relations approaches add immensely to our understanding of the underlying structures of personality [10-12]. Kernberg considers individuals to repeat and replay in their relationships with others, including the psychotherapist, early affective states, based on primitive intra-psychic self and object representations. Assessing configurations of the self representation, the object representation and the affective state, which appears as a change in relation to these representations is fundamental to the analysis of the transference and, importantly in work with severe character pathology, the counter-transference, as these emerge with dynamic force, in the therapeutic relationship.

Koenigsberg et al. [13] at the Personality Disorder Institute, New York Presbyterian Hospital, Westchester Division have been instrumental in attempting to extend the range of psychotherapeutic treatability for personality disorders, with modifications of classical technique, including face to face time limited psychotherapy, a more active interventionist approach and a reduction in weekly treatment sessions.

Two other approaches to borderline personality disorder that should be mentioned here are the Dialectical Behaviour Therapy (DBT) model developed by Linehan [14], and the mentalization based approach developed in London by Bateman et al. [15]. These models convey, respectively, the black and white polarised thinking that underscores borderline functioning, on the one hand, and the role of the early attachment relationship, with regards to the later emergence of the borderline personality. Crucially, Linehan, Bateman and Fonagy, having the courage of their theoretical convictions, build their treatment approaches on the basis of their conceptualization of the factors that aetiologically influence borderline pathology. This is a point that I will return to in the consideration below of psychodynamic and attachment based treatment approaches to personality structures.

The approaches of clinicians such as Kernberg and colleagues, Linehan, Bateman and Fonagy, specifically in relation to borderline personalities, have sharply focused clinical attention in such key areas as intra-psychic structure and transference dynamics, the polarity of thinking, and the associated acting out of primitive emotional conflicts. The status of attachment and its effects on the evolution of personality difficulties has also received considerable attention.

Similarly, Kohut's [16,17] work with narcissistic personalities led him to develop self psychology, based on his understanding of the central role of self-objects during the formative years of development and the sense in which the child may develop narcissistic character pathology, when the healthy relinquishment of the self-object is forestalled, or becomes blurred.

Most recently, in the last twenty years, those psychoanalytic theorists and clinicians interested in furthering our understanding of personality development, structure and disorder have refined their understanding of specific defensive types, in the context of the therapeutic relationship, expanded our understanding of malignant and invasive objects and their deleterious effects on personality functioning, and explored sealed over personality states that are based on dissociative defences following exposure to pronounced early childhood trauma [18-22]. This latter area, focusing on the links between chronic relational trauma and dissociative defensive character constellations, based on the early attachment environment, has proven particularly helpful in extending both our conceptual understanding of enduring personality problems and their therapeutic treatment.

Chronic relational trauma, automata states and black holes in the personality structure

Howell and Blizard [19] propose a new diagnostic scheme that would replace the term borderline personality with that of *chronic relational trauma disorder*. In turn, they see the spectrum of dissociative disorders as being intimately related to chronic relational trauma, and suggest a re-conceptualisation of this continuum of dissociative phenomena, stressing the role of early attachment disturbances in the ontogenesis of dissociative personality states. Howell and Blizard draw the obvious comparisons between many of the primary symptoms of borderline personality disorder and dissociative disorders and observe that:

Borderline personality may best be understood, and its aetiology most accurately described, as a disorder of trauma, attachment and dissociation. Dissociated self states underlie the stable instability (i.e. the affect dysregulation), unstable identity, and sudden changes in relationship, that characterize BPD [19].

The authors, quite rightly in my view, contend that BPD is so often misunderstood as a diagnostic category, and *pari passu* employed as a psychiatric catch all, due to the potpourri of symptoms that cover a wide range of severity in the DSM IV classification. Though, this is particularly true of borderline personality disorder a similar point could I think, be made across the range of personality disorders classified within DSM IV (r). Howell and Blizard demonstrate that symptoms of BPD can be understood, from another perspective, as signs of dissociated self-states, making reference to: unstable relationships, affective instability, fears of abandonment, transient psychotic symptoms, substance abuse to self-medicate overwhelming affects, and sexual impulsivity which may reify, through acting out, earlier experiences of sexual abuse.

They trace these later symptoms to early environments of relational trauma in which it is hypothesised, they have their origins. Borderline personality structure is considered to develop, to a large degree, as a result of the internalisation of dissociated self representational states, following disorganised attachments and intra-familial abuse, and/or neglect that is of early onset. Disorganised

attachment may include bizarre or frightening parental behaviours, unpredictability, exploitation of the child for parental satisfaction, periods of absence or emotional unavailability, in the case of the proposed caregivers, as well as direct emotional, physical, and/or sexual abuse of the child [23,24]. Crucially, in the evolution of the borderline personality structure, it is the dialectical swings within the caregiver, often rapidly vacillating, that leads to the internalisation of disorganised attachment working models and defensive dissociative self states, within the infant/child. In practice, this means that the very person, upon whom the child depends, for both security and protection, is also the person who threatens and frustrates these core psycho-physical and emotional needs.

Such dynamics as they emerge in the early parent child relationship have been linked by Fonagy et al. [25] to the impingement of the child's reflective function and, consequently, to a failure or restriction in symbolising capacities. Though Howell and Blizard acknowledge Fonagy's emphasis on restricted reflective function and symbolizing capacity, they assert that their conceptualisation of borderline personality structure, and their suggestion that it more accurately be defined as chronic relational trauma disorder, is based primarily on the influence of dissociated self-states.

However, it might be suggested that more unites Howell, Blizard and Fonagy, in their conceptualisation of developmental factors, critical to the development of borderline functioning, than divides them. By this I refer to the attention that all these authors pay to the interrelated dual aspects of the early attachment environment and the conditions that either encourage or impinge upon the development of an intentional, containing and reflective capacity, for both thoughts and emotions. Returning from the rather dominant position held by borderline personality in the wider field of personality structures, we might even extend these findings to a re-consideration of the personality disorders, per se.

In two recent papers, Sweet explored the idea of personality structures that evolve along a trait-state continuum, in these papers the emphasis being on what was termed automata states and the Automaton Self [21,22]. It was suggested that the Automaton Self emerges to defend individuals from unbearable thoughts, feelings and emotions, when a catastrophic failure of containment during early childhood has inhibited the internalisation of the capacity to organise and make sense of experience. The descriptive emphasis was on the severe and consistent intra-psychic splitting that leads to internalised dissociative self and object representations that become organised as a more permanent personality structure, in opposition to the experience of chronic early relational trauma. Subsequently, Sweet has also offered, as an analogy to the destructive core of the Automaton Self, the image of the cosmological black hole and its powerful distorting qualities [26].

Challenging the diagnosis of personality disorder by recourse to symptom criteria

The approaches referred to above, in the clinical evaluation of personality structure, share many commonalities, though one I think stands out in particular. This is the refusal to assess or to evaluate the global personality structure of the individual on the basis, simply of a defined symptom criteria menu, contextualised within a temporal framework. It may be that clinicians approaching an understanding of personality difficulties from a psychoanalytic vantage point are influenced by their experiences in lengthy therapeutic relationships.

During these extended periods of clinical contact, the clinician notes both the subtle, and sometimes more overt and dramatic changes that occur within the patient. In this sense, the mutability of the personality structure is perhaps more apparent over time than it may appear to the assessing psychiatrist or clinical psychologist, who may have severely restricted and limited access to the patient.

Taking the time to explore the developmental history, as fully as possible, and to attempt a more detailed understanding of the infantile and childhood attachment milieu, management of emotional affects, abilities to manage separations and adaptations into group situations, as these progressively evolve developmentally can further inform the assessing clinician of the range and extent of personality variables, or the relative paucity of these. Patients who are emotionally fragile and prone to rapid affective dysregulation, including self-harmers, may require in depth individual therapy before moving into a small group and subsequently on to a larger one [27].

Of course, it is difficult in this debate not to challenge the very nature of the term disorder, not least because it suggests a gold standard for normal personality against which disordered individuals should somehow be measured or evaluated. More perniciously, the term disorder often wholly fails to convey the sense in which the only viable defensive structures available to our patients were the ones they adopted and developed, in the midst of chronic and enduring inter-relational hardship.

Another frequently encountered problem in the assessment, evaluation and treatment of longer-term personality problems is the way in which the types are compressed into the three dominant categories: paranoid, flamboyant and avoidant. Obviously, the crossover between the paranoid and avoidant type strikes one as self-evident, though it should also be remembered that the predominantly narcissistic or histrionic personality structure may also exhibit both avoidant and paranoid tendencies. The classificatory system, from a psychodynamic perspective, becomes all the more abstruse when the clinician assesses a narcissistic patient as deploying omnipotent and omniscient defences, in order to combat profound fears that are paranoid-schizoid in origin and that may have led to the deployment of typical primitive defensive mechanisms, including, for example, splitting, denial and projective identification.

Summary and Conclusion

In this brief paper, it has been suggested that research carried out within the psychoanalytic field of therapeutic investigation has assisted, in considerable measure, our understanding and conceptualisation of those conditions referred to as disorders of personality. However, the author has suggested that a more appropriate approach to evaluation of individual character and character difficulties might utilise the term personality structure. This term is suggested in order to convey the sense in which the personality evolves over time and is, generally, still in an evolutionary process during the course and duration of psychotherapeutic treatment. The diagnosis of personality disorder has also been challenged on the basis that symptom, and sub-symptom criteria tend to present a simplistic picture, or ready headline snapshot, of the deeper personality structure.

Following reference to the work of contemporary psychodynamic theorists in the field of personality research [7-9,15,19,22,26], it has been suggested that a fuller exploration of the individual personality structure should be based on, amongst other considerations, the

investigation of the early attachment matrix, the internalisation and range of symbolising capacities, and the current defensive repertoire of the patient under examination. In addition, these parameters of experience and ability should be reviewed as treatment progresses.

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