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A FREUDIAN CONSTRUCT LOST AND RECLAIMED

The Psychodynamics of Personality Pathology

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Although many early 20th-century descriptions of personality pathology were unabashedly psychoanalytic, recent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) have attempted to frame personality disorders (PDs) in atheoretical terms. This article discusses the continuing relevance of psychoanalytic theory for PD diagnosis, research, and treatment. After reviewing the evolution of the PD concept since Freud's time, 3 psychodynamic constructs central to a contemporary understanding of personality pathology are described: ego strength, defense style, and mental representations of self and others. Research in each area is briefly reviewed, the heuristic value of the psychodynamic perspective is discussed, and unresolved questions and future directions in the psychodynamics of personality pathology are addressed.

Keywords: personality disorder, psychoanalysis, *DSM*, Axis II

Although every personality disorder (PD) has a unique origin and history, 2 sources had a particularly strong influence on modern conceptualizations of personality pathology during the late 19th and early 20th centuries. First, diagnosticians such as Ribot (1890) and Kraepelin (1913) described in detail the surface behaviors characteristic of various dysfunctional personality styles and the interrelationships of different personality-based syndromes. Although the nosologies of Ribot, Kraepelin, and others were based on unique assumptions and descriptive terminologies, these models generally conceptualized personality pathology in terms of more basic, underlying traits that combined to form recognizable patterns of dysfunctional interpersonal behavior (see Leary, 1957, and Costa & Widiger, 2002, for more recent perspectives on the underlying trait structure of PDs).

The 2nd major early influence on PD theory and research came from Freud and other psychoanalysts (e.g., Abraham, 1927; Fenichel, 1945; Horney, 1937), who focused

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primarily on the internal dynamics of problematic personality styles. Freud's (1905/1953) *Three Essays on the Theory of Sexuality* represents a turning point in psychoanalytic theorizing regarding this issue; in it Freud articulated in detail his hypothesis that variations in early childhood experiences may lead to "fixation," to continued preoccupation with the conflicts and issues characteristic of a particular developmental phase, and to the formation of a "character type" that represents an indirect expression of these conflicts and issues later in life. Freud (1908/1961, p. 167) formalized this hypothesis in memorable terms, noting that "one very often meets with a type of character in which certain traits are very strongly marked while at the same time one's attention is arrested by the behavior of these persons in regard to certain bodily functions."

Freud focused largely on narcissism, obsessiveness, and dependency in his early speculations regarding problematic personality functioning (see Auerbach, 1993; Bornstein, 1996; Gabbard, 2001), and it was not until the development of object relations theory and self psychology that psychodynamic principles were extended to other forms of personality pathology (e.g., borderline, histrionic, avoidant). By the time Axis II appeared in the *DSM–III* (APA, 1980), psychoanalytic thinking had been applied to every formalized personality disorder. Now, nearly 3 decades later, psychodynamic theorists and researchers use several different frameworks—including classical psychoanalytic theory, object relations theory, and self psychology—to examine the etiology and dynamics of *DSM–IV* (APA, 1994) PDs (see Bornstein, 2005a for a review).

This article describes the psychoanalytic perspective on contemporary PDs. I begin by reviewing the evolution of PDs in the *DSM* series, from early psychodynamic descriptions to the more atheoretical language used in recent editions of the manual. I then outline a psychodynamic perspective on personality pathology, describing distinctive psychodynamic constructs and research relevant to these constructs. Next, I discuss the implications of the psychodynamic perspective for PD diagnosis, research, and treatment. Finally, I offer suggestions for future research on PDs that will enhance psychologists' understanding of the psychodynamics of personality pathology and help integrate psychoanalytic thinking with ideas and findings from other theoretical perspectives.

A Freudian Construct Lost: PDs in the *DSM* Series

The influence of psychoanalytic theory on *DSM–I* (APA, 1952) conceptualizations of personality pathology is unmistakable. For example, the *DSM–I* description of the emotionally unstable personality notes that the patient's relationship to other people "is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety" (APA, 1952, p. 36). The *DSM–I* description of the compulsive personality describes such individuals as "rigid and [lacking] a normal capacity for relaxation. . . . This reaction may appear as a persistence of an adolescent pattern of behavior, or as a regression from more mature functioning as a result of stress" (APA, 1952, p. 37). The *DSM–I* description of the passive-dependent personality as "characterized by helplessness, indecisiveness, and a tendency to cling to others as a dependent child to a supporting parent" (APA, 1952, p. 37)—though less obviously psychodynamic than these other descriptions—is taken almost verbatim from Sullivan's (1947) description of the overdependent patient.

Although the *DSM–II* (APA, 1968) retained some references to internal need states and underlying dynamics, it is clear (at least in retrospect) that by the late 1960s a paradigmatic shift was underway in mental health professionals' conceptualization of PD

pathology. By the time the *DSM–III* appeared in 1980, virtually all psychodynamic language had been excised from the manual. PD descriptions and symptoms now focused almost exclusively on expressed behaviors, and in those instances where underlying psychological processes were discussed, they were framed in decidedly atheoretical terms.

The evolution of the *DSM* description of schizoid PD illustrates nicely this paradigmatic shift. The *DSM–I* description of schizoid personality emphasizes the schizoid individual's "inability to express directly hostility or even ordinary aggressive feelings . . . . These qualities result early in coldness, aloofness, emotional detachment, fearfulness, avoidance of competition, and day dreams revolving around the need for omnipotence" (APA, 1952, p. 35). In the *DSM–II*, the parallel passage notes that in the schizoid person, "autistic thinking without loss of capacity to recognize reality is common, as are daydreaming and the inability to express hostile and ordinary aggressive feelings" (APA, 1968, p. 42). In the *DSM–III*, internal dynamics are barely mentioned, and the schizoid person is described as "reserved, withdrawn, and seclusive. . . . Individuals with this disorder are usually humorless and dull and without affect in situations in which an emotional response would be appropriate" (APA, 1980, p. 310).

Without question, the evolution of PD descriptions in successive editions of the *DSM* reflects a broader effort on the part of the mental health community to construct a diagnostic system not tied directly to any particular theoretical framework. Nonetheless, the fact remains that a diagnostic nomenclature once dominated by psychoanalytic thinking is now only modestly influenced by it. In the span of a few decades the official psychiatric diagnostic system shifted from being predominantly psychoanalytic to being determinedly atheoretical and nonanalytic (Bornstein, 1998b, 2001).

A Freudian Construct Reclaimed: The Psychodynamics of Personality Pathology

Paradigmatic shifts notwithstanding, 3 psychodynamic constructs—ego strength, defense style, and mental representations of self and other people—are key in understanding the intra- and interpersonal dynamics of different forms of personality pathology. In the following sections I discuss these 3 constructs and outline a tripartite severity model that makes explicit the relationship of PDs to other forms of psychopathology.

Ego Strength

A central tenet of classical psychoanalytic theory is that 3 mental structures—id, ego, and superego—play a major role in normal and pathological personality development. Traditionally, the id has been conceptualized as the source of drives and impulses, whereas the superego represents both the idealized self and conscience (or moral code), and the ego is responsible for rational, reality-oriented thought. Early experiences help determine the developing child's ego strength–the degree to which the ego carries out reality testing functions and deals effectively with impulses (Brenner, 1973; Eagle, 1984). Adequate parenting and minimal trauma or disruption enable the child to devote considerable psychic energy to developing good reality testing skills and acquiring effective self-control strategies. Inadequate parenting and/or significant disruption in the child-caregiver relationship divert psychic energy from these adaptation-enhancing ego functions because at least some of the child's psychological resources must be used to cope with various stressful and hurtful experiences. Studies indicate that ego strength in adolescents and adults varies to some degree as a function of situational factors (e.g., mood, anxiety level),

but these studies also suggest that 2 key elements of ego strength—reality testing and impulse control—are relatively consistent over time, with enduring, trait-like qualities (Block & Kremen, 1996; Hoffman, Granhag, See, & Loftus, 2001; Nestor, 2002).

Although some researchers use free-response tests (Meyer, 2000) or Q-sort methods (Block & Kremen, 1996) to assess ego strength, most recent investigations have used the MMPI-derived Barron (1953) Ego Strength (ES) scale. Studies support the utility of ES scores in predicting important features of psychological adjustment and treatment-related behavior. For example, Balge and Milner (2000) found that high ES scores in mothers were associated with more accurate recognition of their child's emotional state, and with decreased risk for child abuse. Similarly, Schatz, Schatz, Harden, Chilingar, Fox, and Hoffman (2000) found that mothers with high ES scores had infants who made more rapid progress through early developmental milestones.

Other investigations have focused on ego strength in adolescents and adults. Using a longitudinal design, Janson and Stattin (2003) found that low ES scores predicted increased likelihood of adolescent delinquency and antisocial behaviors in a community sample of Swedish men. Also using a longitudinal design, Roberts and Helson (1997) found that high ES scores were associated with increased autonomy in early and middle adulthood in a community sample of American women. These findings are echoed by data indicating that high ES scores were associated with increased probability of being classified in the category of identity achievement (vs. identity diffusion or moratorium) in separate samples of American and Japanese adolescents (Markstrom, Sabino, Turner, & Berman, 1997; Nagao, 1999).

Defense Style

As children move through adolescence into adulthood they gradually develop a stable defense style–a characteristic way of managing anxiety and coping with external threat (Cramer, 2000). Positive early experiences are associated with a flexible, adaptive defense style wherein mature defenses (e.g., sublimation, intellectualization) predominate (Vaillant, 1994). Negative early experiences lead to a less mature—and less effective—defense style characterized by coping strategies that entail greater distortion of internal and external events (e.g., repression, projection). Psychodynamic researchers have conceptualized defense style in myriad ways, but evidence from different research programs confirms that well-validated measures of defense style predict adjustment and functioning in a range of psychological domains (Cramer, 2000; Ihilevich & Gleser, 1986, 1991; Perry, 1991).

A broad array of defense style measures are available today, including Rorschach- and TAT-based indices (Cramer, 2000; Lerner, 2005), Gleser and Ihilevich's (1969) Defense Mechanisms Inventory (DMI), and Bond, Gardner, Christian, and Sigall's (1983) Defense Style Questionnaire (DSQ). Findings confirm that regardless of how they are derived, defense style scores predict important dimensions of personality and adjustment. For example, maladaptive defenses are associated with increased suicide risk (Corruble, Bronnec, Falissard, & Hardy, 2004), and with impairment in social functioning and academic performance in adolescents and adults (Sandstrom & Cramer, 2003). Longitudinal investigations have shown that children shift from reliance on primitive defenses (e.g., denial) to more mature defenses (e.g., identification) as they move through adolescence (Cramer, 2000). Other studies confirm that long-term psychodynamic psychotherapy is associated with a shift from maladaptive to adaptive defense configurations during a 3–5 year course of treatment (Bond, 2004; Bond & Perry, 2004).

Although data support the utility of widely used defense style measures in predicting adjustment and social behavior, findings regarding the defense style-PD relationship are more mixed. Some investigations have documented links between theoretically related defense styles and specific PD syndromes (Cramer, 1999), and between defense style and various forms of PD-related behavior (e.g., frequency of dissociation in borderline patients; see Simeon, Nelson, Elias, Greenberg, & Hollander, 2003). However, other investigations have failed to obtain predictable defense style-PD links, finding instead that the presence of clinically significant personality pathology (in general) is associated with reliance on immature and maladaptive defenses, with no consistent differences in defense style across PD categories (Mulder, Joyce, Sullivan, Bulik, & Carter, 1999; Holi, Sammallathi, & Aalberg, 1999; Kennedy, Schwab, & Hyde, 2001).

Mental Representations of Self and Others

Early in life the child internalizes mental representations of self and significant others (e.g., parents, siblings). These object representations (sometimes called *introjects*) evolve over time, but they also have enduring qualities that are relatively resistant to change. Studies by Blatt (1991) and others (e.g., Bornstein & O'Neill, 1992) confirm that qualitative and structural dimensions of an individual's object representations help determine interpersonal functioning and psychological adjustment throughout life: The person who has internalized introjects that are conceptually sophisticated and affectively positive is unlikely to develop severe, chronic psychopathology whereas the person who has internalized introjects that are conceptually primitive and affectively negative is at increased pathology risk (see Bornstein, 2003b).

As was true of defense style, a broad array of instruments is available to assess internalized mental representations. Among the most widely used are Blatt, Chevron, Quinlan, Schaffer, and Wein's (1988) measure of Qualitative and Structural Dimensions of Object Representations (QSDOR), Westen's (1995) TAT-based Social Cognition and Object Relations Scale (SCORS), the Bell (1991) Object Relations and Reality Testing Inventory (BORRTI), and various Rorschach indices of mental representations and introjects (see Levy, Meehan, Auerbach, & Blatt, 2005). Studies in this area have utilized a wide range of outcome measures, generally producing results consistent with the psychoanalytic hypothesis that malevolent introjects are associated with increased psychopathology (including personality pathology).

For example, Weise and Tuber (2004) found that SCORS profiles differentiated narcissistic from well-adjusted latency-age children; the object relations of narcissistic children were more negatively toned and conceptually primitive. Other researchers have shown that introject quality can differentiate abused from nonabused children (Ornduff, 1997), and predict aspects of children's interpersonal functioning and social adjustment (Niec & Russ, 2002). In this latter investigation SCORS data predicted teacher ratings of empathy, helpfulness, and quality of fantasy play in a mixed-sex sample of 86 8–10 year olds. In adults, SCORS data differentiated borderline from nonborderline psychiatric patients (Tramantano, Javier, & Colon, 2003), and distinguished patients with different Cluster B and Cluster C PDs (Ackerman, Clemence, Weatherill, & Hilsenroth, 1999). Some studies suggest that affective dimensions of internalized object representations may be more effective than cognitive dimensions of object representations in predicting level and type of psychopathology (Hibbard, Hilsenroth, & Hibbard, 1995; Porcerelli, Cogan, & Hibbard, 1998), but additional studies are needed to contrast the predictive validities of these 2 categories of data.

A Tripartite Severity Model

Psychoanalytic theory classifies psychological disorders into 3 levels of severity, with each level characterized by differences in ego strength, ego defenses, and introjects (see, e.g., Bornstein, 2003b; Trimboli & Farr, 2000). Table 1 summarizes this tripartite model. The least severe level of psychopathology in the psychoanalytic model—neurosis—is characterized by high levels of ego strength, mature defenses, and relatively benign introjects. The middle level—personality pathology (sometimes called *character pathology* by psychoanalysts)—is characterized by less adequate ego strength, immature defenses, and introjects that are structurally flawed and/or malevolent. The most severe form of psychopathology in the psychoanalytic model—psychosis—is characterized by low levels of ego strength (with concomitant impairment in reality testing), immature (or even nonexistent) defenses, and primitive, malevolent introjects.

In theory, the 3 key constructs in the psychodynamic model should covary in predictable ways: High levels of ego strength should be associated with mature defenses and healthy introjects whereas low levels of ego strength should be associated with comparatively immature defenses and malevolent introjects. Although relatively few investigations have addressed this issue directly, extant data generally support the psychodynamic "covariation hypothesis" (e.g., Auerbach & Blatt, 2002; Gordon, 2001; Shahar, Blatt, & Ford, 2003; Sugarman, 2000).

Heuristic Value of the Psychodynamic Perspective: Implications for Research, Diagnosis, and Treatment

Although the influence of psychoanalytic theory in *DSM* descriptions of personality pathology has declined in recent years, studies confirm that psychodynamic constructs remain relevant for conceptualizing, classifying, and treating PDs. In the following sections I describe the heuristic value of the psychodynamic perspective with respect to research, diagnosis, and treatment.

Research

There have been numerous investigations examining the epidemiology and comorbidity of different PDs (e.g., Robins & Regier, 1991), and the impact of personality pathology on psychotherapy process and outcome (e.g., Hembree, Cahill, & Foa, 2004), but relatively few studies have assessed directly the intra- and interpersonal dynamics of PDs. These

Table 1
Levels of Psychopathology in Psychodynamic Theory

Level	Ego strength	Ego defenses	Introjects
Neurosis	High	Adaptive/mature (displacement, sublimation)	Articulated/differentiated and benign
Personality disorder	Variable	Maladaptive/immature (denial, projection)	Quasi-articulated and/or malevolent
Psychosis	Low	Maladaptive/immature or nonexistent	Unarticulated/Undifferentiated and malevolent

Note. Originally published as Table 5.5 in Psychodynamic Models of Personality, pp. 117–134, by Robert F. Bornstein, in *Personality and Social Psychology,* T. Millon & M. J. Lerner, Eds., 2003, Vol. 5 in I. B. Weiner (Editor in Chief), *Handbook of Psychology;* Hoboken, NJ: John Wiley & Sons. Reprinted with permission.

limitations in the focus of contemporary PD research are due primarily to limitations in method: A recent review of the PD literature (Bornstein, 2003a) revealed that the vast majority of published studies employ correlational designs (91% overall) and rely solely on self-report outcome criteria (82% overall). Researchers' near-exclusive use of correlational methods and self-report measures reflects an implicit (but unjustified) assumption that accurate self-reports can routinely be obtained from individuals with significant personality pathology.

Not surprisingly, those studies that assess PD dynamics in lieu of questionnaire-based self-reports come primarily from the psychoanalytic perspective, and results of these investigations indicate that many PD-related symptoms and behaviors are shaped by unconscious thoughts, motives, and emotional responses. For example, Bornstein, Ng, Gallagher, Kloss, and Regier (2005) found that subliminal priming of the dependent person's "helpless" self-representation led to increased efforts to cultivate ties to potential protectors and caregivers. Other data suggest that high levels of unconscious dependency needs coupled with low levels of conscious dependency needs are associated with histrionic PD traits and symptoms, whereas high levels of both types of dependency needs are associated with dependent PD symptoms (Bornstein, 1998a). Using different methods, Morf and Rhodewalt (2001) found that subtle alterations of narcissistic individuals' perceptions of their status relative to others led to predictable changes in defense mechanism use, with use of immature defenses increasing following negative status feedback and decreasing following positive feedback. Clearly, the psychodynamic perspective has the potential to enrich PD research by going beyond correlational methods and self-report measures, elucidating underlying processes and subtle intra- and interpersonal dynamics.

Diagnosis

Research on PD comorbidity and diagnostic reliability confirms that in their current form, PD categories lack discriminant validity: Our ability to describe different PDs in an abstract sense has outstripped our ability to diagnose them accurately in real-world clinical settings (see Bornstein, 1998b, 2003a, for evidence bearing on this issue). The traditional strategy for resolving these diagnostic quandaries has been to add, remove, or revise PD symptom criteria to decrease overlap between categories (Widiger & Clark, 2000). However, two alternative strategies have been proposed in recent years. Westen and Shedler (1999) argued for replacing existing PD categories with categories that reflect more accurately clinicians' understanding of PD symptom clusters, in effect classifying patients based on clinician "prototypes" rather than preexisting diagnostic descriptors. Along somewhat similar lines, Bornstein (1998b) suggested that—given their high comorbidity and low reliability—discrete PD syndromes and diagnostic thresholds should be replaced with dimensional ratings of PD intensity, idiographic descriptors of prominent PD-related behaviors, and a listing of those contexts and settings wherein PD symptoms are particularly problematic for a given patient.

Though these strategies are not without merit, they emphasize classification of PDs based primarily on surface characteristics. A truly heuristic and clinically useful PD diagnostic system must include indices of underlying dynamics in addition to expressed behaviors, and the psychoanalytic model provides a useful starting point in this regard. By supplementing traditional PD symptom criteria with ratings of ego strength, defense style, and introject quality, it may be possible to enhance the utility of Axis II in future versions of the *DSM*. Of these 3 domains, only defense style has received serious consideration for

possible inclusion as a separate axis in the *DSM–V*, with detailed coding criteria and a provisional *Defensive Functioning Scale* included as an appendix in the *DSM–IV–TR* (APA, 2000, pp. 807–813). It might also be useful to include indices of introject quality and ego strength on this axis in future versions of the manual, using rating schemes modeled on the current Axis V *Global Assessment of Functioning* scale.

Treatment

In addition to aiding in research and diagnosis, the 3 psychodynamic constructs discussed earlier provide potential treatment foci—points of entry that can help patient and therapist gain insight and effect positive change. Virtually all contemporary psychodynamic treatment methods emphasize analysis and exploration of introjects, defenses, and ego strength, with varying emphases in different treatment models (see Blatt, Auerbach, & Aryan, 1998; Gassner & Bush, 1998). Moreover, many nonpsychodynamic treatment approaches also focus on these 3 domains of functioning. For example, cognitive interventions for PD symptoms aim to make explicit (and ultimately alter) biased self-perceptions and self-defeating coping strategies (Ball, 1998; Young, 1994). Like psychodynamic treatment techniques, many humanistic and existential interventions focus on conscious and unconscious distortions in the patient's self-concept (Bornstein, 2005c; Elliott, 2002).

Beyond providing potential treatment foci, these 3 constructs also provide a framework within which the therapist may anticipate potential treatment obstacles, including problematic transference and countertransference responses (see Luborsky & Crits-Christoph, 1990). Moreover, as Trimboli and Farr (2000) noted, these constructs provide a foundation for identifying and building upon patient strengths, and delineating treatment goals (i.e., increased reality-testing, use of more mature defense mechanisms, adaptation-enhancing changes in perceptions of self, others, and self-other interactions).

Finally, defenses, introjects, and ego strength represent 3 dimensions along which therapists may assess and quantify therapeutic change. As Finn (2003) noted, periodic reassessment of patient functioning during therapy can help the therapist understand which interventions are most effective, and which areas of functioning are most strongly affected by these interventions. Some studies further suggest that periodic reassessment has therapeutic value in and of itself, providing the patient with feedback regarding areas of positive change, and identifying potentially fruitful areas for further discussion and exploration (Finn & Tonsager, 2002). Blatt and Ford (1994); Cramer (2000); Hilsenroth (2004), and Huprich and Greenberg (2003) provided recommendations for well-validated instruments that may be useful for assessing changes in defense style, reality testing, and perceptions of self and others during the course of treatment.

Unresolved Questions and Future Directions

One hundred years after Freud (1905/1953) published his seminal hypotheses regarding the psychodynamics of personality pathology, it is clear that psychoanalytic theory remains central to the investigation, classification, and treatment of PDs. This ongoing psychodynamic influence has gone unacknowledged in many quarters, however, and an odd discontinuity characterizes contemporary PD theory and research with respect to this issue. On the one hand, cognitive models dominate the literature, and mainstream theorizing on PDs emphasizes biological and behavioral influences. At the same time, in informal discussions with PD researchers—even those whose thinking is based primarily

on these other frameworks—it is common to hear our colleagues acknowledge (albeit in hushed tones) the impact of psychodynamic concepts on their clinical and empirical work.

A close reading of the cognitive and behavioral literature on PDS reveals two things. First, with some exceptions (e.g., Turkat, 1994), even those theoretical frameworks and treatment models that are derived from other theoretical perspectives draw upon psychoanalytic concepts (see, e.g., Linehan, 1993). Second, even those treatment models that make little reference to psychodynamic principles often use Freudian ideas. Examining Beck's (1976) construct of *dichotomous thinking*, for example, one cannot help but wonder why he did not simply use the existing psychodynamic label of *splitting*, which describes much the same phenomenon (see Bornstein, 2005b, for a discussion of psychodynamic concepts that have been "reinvented" in other fields).

In the following sections three unresolved issues regarding the psychodynamics of personality pathology are discussed. As clinicians, theorists, and researchers grapple with these issues they will help set the stage for a renewed psychoanalytic conceptualization of PDs during the 21st century.

Primary and Secondary PD Psychodynamics

Psychodynamic processes affect all PDs, but they do not affect all PDs equally. For certain syndromes psychodynamic elements play a central role; for others psychodynamics are subsidiary to other variables. It is useful to divide PDs into 2 broad categories with respect to psychodynamic relevance. Six *DSM–IV–TR* PDs are strongly affected by psychodynamic processes. These PDs—which form what may be termed a *primary psychodynamic cluster*—include dependent, narcissistic, histrionic, obsessive-compulsive, paranoid, and borderline. Each of these PDs can be traced to problematic early relationships that lead to impairments in ego functioning, dysfunctional introjects, and an ineffective defense style. Although other factors (e.g., inherited neurological variations, conditioning and modeling effects) also play a role in the etiology of these syndromes, psychodynamic processes are central to each (see Bornstein, 2005a).

Four *DSM–IV–TR* PDs are influenced by psychodynamic processes, although for these syndromes psychodynamics are secondary to other variables. Antisocial, avoidant, schizoid, and schizotypal PDs may be grouped into this *secondary psychodynamic cluster*. All 4 syndromes are characterized by maladaptive perceptions of self and other people, problems in reality-testing, and defense styles that impair interpersonal functioning and/or impulse control. However, in all 4 syndromes identifiable neurophysiological diatheses pay a central role in PD etiology, and precursors of dysfunctional interpersonal behavior are observable early in life as temperament differences. These temperament differences precede the psychodynamic processes that help shape subsequent intra- and interpersonal functioning (see, e.g., Alden, Laposa, Taylor, & Ryder, 2002; Lenzenweger, 2001).

Evolution of Personality Pathology Across the Life Span

The vast majority of PD studies to date have focused on adolescents and younger adults, with few investigations exploring the changing expression of PD traits and symptoms in later adulthood. Some data suggest that the prevalence rates of most PDs diminish after age 50 (Abrams & Horowitz, 1996; Morse & Lynch, 2004), though the causes of this decline remain unclear. It is possible that certain PD symptoms diminish with age as

activity levels decline in middle and later adulthood. Alternatively, it may be that PD symptoms persist through late life, but that the manner in which they are expressed changes over time.

Continued exploration of the evolution of personality pathology across the life span is particularly important because the current *DSM* PD symptom criteria—like the symptom criteria for many Axis I disorders—apply most directly to younger adults. Accurate diagnosis of late-life PDs will require revision of the existing *DSM* symptoms along with greater attention to the psychodynamics of personality pathology in older adults. A complete understanding of personality pathology across the life span will also require more extensive integration of psychodynamic and neurophysiological PD models. Researchers have shown that the changing expression of some PD-related traits in later adulthood can be explained in terms of the interaction of psychodynamic and biological processes (e.g., the indirect expression of late-life dependency in terms of *pseudodementia*—"false dementia"—reflects a combination of underlying dependency needs and disinhibition resulting from loss of neurological control mechanisms; see Brink, 1986). The degree to which age-based changes in other PD syndromes may be explained in terms of similar psychodynamic-neurophysiological interactions is unknown.

The Behavioral Psychoanalyst

Three decades ago, Wachtel (1977) argued that integration of psychodynamic principles and behavioral treatment techniques was not only possible, but desirable. Since Wachtel's pioneering contribution numerous clinicians and clinical researchers have attempted to integrate psychodynamic and behavioral intervention strategies (e.g., Linehan, 1993; Overholser, 1987), and evidence suggests that an integrated psychodynamic-behavioral treatment framework can be effective in clinical work with personality-disordered patients (Stricker & Gold, 1993). In recent years clinicians have delineated models to optimize the effectiveness of integrated treatment techniques, and although these models differ in the details, they typically advocate starting treatment with a single overarching theoretical framework that guides therapists' initial exploration efforts and provides patients with a language to understand and describe their difficulties. Once this initial exploration/engagement has occurred, interventions derived from other theoretical perspectives are introduced to enhance insight and facilitate behavior change in vivo (Beitman, 1992; Gold, 1994).

An integration process similar to that taking place in the clinic is underway in the laboratory. Psychodynamic researchers are increasingly investigating basic psychoanalytic concepts and the efficacy of psychoanalytic treatment techniques using behavioral manipulations and outcome measures (see Bornstein & Masling, 1998; Masling & Bornstein, 1994). As researchers continue to move beyond self-report outcome measures and analyses of therapeutic interchanges, complementing these methods with indices of observable, measurable behavior, evidence regarding the efficacy of psychodynamic therapy will be further enhanced. This expanded approach to assessing treatment process and outcome will be especially important in studies of personality-disordered patients, whose ability to report accurately on internal states and in vivo behaviors is limited. It is ironic, to be sure, but continued growth of the psychodynamic perspective on PDs requires that we incorporate into our research studies and clinical efforts ideas and techniques from outside psychoanalysis—even those ideas and techniques that come from theoretical frameworks ostensibly inconsistent with our own.

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