

Diagnosis of Personality Organization: A theoretical-empirical update of Otto F. Kernberg's proposal.

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Personality Organization Diagnosis, proposed by Dr. Otto F. Kernberg and his team from the Personality Disorder Institute in New York, has been an important contribution to the understanding and treatment of personality disorders. The aim of this article is to make an updated review of this approach, addressing a general understanding of what is personality is, and subsequently deepening the differential diagnosis of the neurotic and borderline personality organization. Furthermore, within of borderline spectrum, those high, medium, and low functioning will be distinguished, considering its severity and prognosis. Finally, a synthesis of the personality assessment process will be carried out, which consists of the Structural Interview

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INTRODUCTION

Otto Kernberg and his team of the Personality Disorder Institute in New York have made significant contributions to literature on understanding and treatment of personality disorders, which marked its beginning with the book on “Severe personality disorders”¹. From then on progress has been made, both in diagnosis, integrating neurobiological progress, operationalize concepts for developing diagnostic assessment scientific instruments, and developing a therapy empirically validated for the treatment of this population: Transference-Focused Psychotherapy (TFP)². In this review, we mean to make to summary

of the main updates of Dr. Kernberg's team, regarding understanding personality disorders, and next to deepen on differential diagnosis among the neurotic-borderline structures.

¿What is Personality?

Even though there is no agreed definition on personality, some theorists have proposed a way to understand it as a complex pattern of psychological characteristics expresses in almost any area of psychological functioning³. Dr. Kernberg's proposal points out to a dynamic integration of the subjective experience and or behavior of an individual. The foregoing involves an integrated/organized association of multiple traits and experiences influencing each

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other, being much more sophisticated than the summation of all parts^{4,5}. In this way, Kernberg proposes 5 systems making up personality⁶:

1- Temper:

It is a fundamental structure of personality which represents the psychological reaction of affective/cognitive/psychomotor systems, and is strongly influenced by the genetic predisposition^{6,7}. There are various affective systems and neurotransmitters connected to the latter, which organize subjective/behavior experiences, shaping biological systems that make part of our human species: attachment, eroticism, affiliation, fight/escape/panic, etc.^{6,7,8}.

The foregoing is related to the object relationships theory, as from the beginning the notion of ourselves, of others, and of the relation itself is configured in our minds, where the prevailing affection in such interaction is going to be the milestone of development in our personality, which along with the physiological systems (limbic system, the cortex, the hippocampus, and the hypothalamus), will process thoughts and will store affective memories.^{6,9}

2- Character

In this dynamic interaction, where repeated activation, both on extremely pleasant/unpleasant affections, and also traumatic events will determine primary motivations. In this way, temper reflects motivation of behavior activation, but internalized objects will determine development of character and identity, being character a goal aspect of behavior patterns, and identity as a subjective corresponding of the character⁶. Character traits will depend, mostly, on temperamental predisposition, which will be influenced by how the needs of a subject -in the context of significant relationships with others- have been gratified or frustrated.

3- Normal Identity and identity diffusion

The concept of identity has become more relevant in the study of personality disorders. The 5th version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has included the assessment of this construct in the alternative proposal¹⁰. Additionally, the

discussion of the 11^o version of the International Classification of Diseases (ICD-11) deepens more on the identity assessment, both of the self as from others for personality disorders diagnosis¹¹.

The development of a normal identity involves gradual integration of the representations of one self and of significant others, in such a way that it is a long lasting/stable/realistic conception. This process facilitates the capacity of concern and curiosity of our own experience and that of others^{6,12}. On the other hand, the Syndrome of Identity Diffusion, which will be further discussed, involves severe complications in those who suffer it, consequently in their behavior, character, etc.

4- Integrated Values System

Founding of a moral structure reflecting the capacity to commit oneself with universally accepted values. Under normal conditions, this will allow an empathetic concern for others, and to be able to distinguish good from evil. However, under pathological conditions, a lower self control and higher level of persecutory anxiety may arise, which unleash less concern for others, and consequences of the his/her own acts (for instance, Psychopathic behavior)^{2,6,13,14}.

5- Intelligence

There are many ways to understand intelligence. From this point of view it involves cognitive capacity, genetically determined through development of the brain areas, which, in turn, participate actively in affective modulation process, and on the other hand it depends on the stimulation, receiving a subject from early childhood, based on his/her life experience^{2,15}.

Structural Aspects

Initially, Kernberg proposes a descriptive/structural/genetic-dynamic analysis for patients with a borderline organization of personality (OLP), which today may be considered as unspecific clinical manifestations^{1,16}.

1. Alterations on reality test and deviation towards the primary process thought.

2. Unspecific demonstrations of weakness of the self (intolerance to anxiety, impulse decontrol, and failure on sublimatory channels).

3. Defense operations, based on excision mechanism.

Today, some modifications are considered which allow to provide a guide when making an assessment of the personality organization^{2,6,17,18}. For the foregoing we can consider the following mnemonics: RADIOS; (1) reality test, (2) aggression infiltration on identity and conduct, (3) defense mechanisms, (4) identity formation, and (5) Quality of the object relationships, and (6) System of Values.

Reality Test

A Reality Test involves to differentiate the intrapsychic from the external origins of perception and other stimuli. The capacity to realistically assess our affections, behavior, and thoughts, according to regular social rules. The latter involves absence of hallucinations and delirium; absence of emotions, thoughts and/or bizarre and improper behavior and/or to be able to empathize and to clarify observations made by others, which could be interpreted as weird or bizarre. Loss of Reality testing steady in time is not no part of personality disorders, but rather these are others diagnosis which must be first considered, for instance, endogenous psychosis.

However, there are some provisional reality testing losses, which are usually compromised in severe personality disorders, in highly distressing situations. In such circumstances the patient could have highly concrete experiences of the subjective experiences which cannot be properly processed, which are then led toward mechanisms based on the excision². On the other hand, what we will frequently find in patients with borderline personality organization is failure in the sense and appreciation of reality. In this way, patient's perspectives become vivid as if they are "truths", with high difficulty to mentalize and reflect, however this must not be confused with loss of reality or Psychosis^{2,19}.

Infiltration degree of aggression on Identity and Conduct

Aggression is a drive in our species, and as long as there is an adequate modulation and assertive expression of this, along with our demands, this will allow us to adapt ourselves²⁰. On the other hand, the more severe the pathology is, the

more severe the aggressive impulses will be to even lead to sadism and siege mentality, which will be translated into self aggressive conducts, or else in severe psychopathic conduct^{s21,22}.

Defense Mechanisms

The main concept in psychoanalytic literature and on character diagnosis, in general terms, are strategies used to face reality complexities (external and psychic), which use the concept of "defense" to (1) avoid or confront feelings and/or anguish which may be intolerable, such as shame, loss, envy, etc., and (2) to keep our self esteem before complexities we have to face²³.

There are some pathological mechanisms and others healthier/mature ones, where all people have these mechanisms, as a sort of confrontation repertoire. Therefore, the more pathological the structure is, the more primitive domains there will be. That same logics may be applied for healthier structures, where healthier/adaptative mechanisms prevail^{18,23,24}. In turn, despite of having healthier mechanisms, the subject is expected to have a wide repertoire of defenses in order to adapt himself/herself to the reality, as if a subject uses only one mechanism all the time, in an inflexible and rigid manner, even though he/she is very healthy, this action will not allow him/her to adapt to the wide variety of problems during his/her life²³. The foregoing is typical of neurotic personality organizations (ONP)²⁵.

Identity Formation

From his first writings, Kernberg made a difference between an integrated identity of a Syndrome of Identity Diffusion, where the degree of integration both on of the concept of one self, of significant others, and the organization of the subjective experience 1,2 is assessed.

An integrated identity involves a real and integrated vision of oneself and of others, which matches the subjective emotional/complex/realistic experiences continuous in time in within the various contexts. It involves capacity to invest, in time, in work, in deep relationships, leisure interests, principles, feelings and beliefs. It is coherent with a healthy self esteem, and with emotional experiences that are modulated and proportional to the stimuli, and even

though they have intense affections there is no loss of control of the impulses, and there is no compromise of the reality test^{2,6,12}.

The Syndrome of Identity Diffusion involves a higher level of pathology in this area, and it is typical of personality disorders. It is initially defined as a poorly integrated concept of one self and of others, along with a subjective experience of chronic void, internal contradictions¹. It is featured, because it has a lack of coherence of the sense of one self and of significant others, in time and in various contexts^{2,6,18}. In turn, scarce and difficult investment on professional/recreation/interpersonal/sexual projects is observed, along with inconsistent/unstable values which dramatically change, according to current stimuli^{2,12}.

Quality of Object Relationships

Today, the theory of Object Relationships (OR) combines temper with early affective experiences of the subject with his/her caretakers. These are internalized in our mind, and thus generate a representation on how the world is, how dangerous it is or how containing it could be. Quality of Object Relationships (OR) will mostly depend on the first affective experiences between the care taker and the child, and will be manifested in beliefs, expectations, and capabilities of the subject to organize his/her interpersonal relationships, and also the capacity to establish a stable/mutual/intimate relationship. The healthier the personality is, the higher the capacity to depend and give up to others reciprocally will be, and also how to appreciate and understand the needs of others. The foregoing will allow that a depressive position is predominant in our mind, this is usual in normal organizations and ONP, and it is deeply manifested in relationships, in sexuality, and also as the capacity to enjoy intimacy⁶. However, if negative experiences are predominant, our own internal representations and those of others will be overburden with split internal experience, and with more intense and more destructive affections (anger, abandonment, envy, etc.), so paranoid-schizoid position will be predominant, which is usual on personalities with OLP^{1,2,18}. The foregoing involves a tendency to see others as objects to be used for our purposes, until reaching

an extreme case of exploitation and lack of consideration for the needs of others, as it is in the case of antisocial personality disorder^{2,6,18}.

System of Values

This aspect of personality is, in general terms, the Freud's concept of "superego", whose degree of integration and pathology are a severity/prognosis indicator in personality disorders.

The greater the integration of the superego is, the bigger the compromise with certain values e ideals will be, which would be consistent. Difficulties of integration in the superego may be witnessed in two ways; in one end, it is an excessive rigidity and guilt feelings before an unreachable ideal of the self; on the other hand the development of an antisocial/psychopathic conduct. Antisocial conduct is defined actively to cause damage, or to have an aggressive behavior against other people, a group, generally expressed with no guilty feelings, which may be featured as a parasitic passive behavior (for instance to lie, to rob, exploitation, to live on others, etc.), or simply aggressive (for instance to destroy objects, physical/sexual aggression, etc.)⁶. The maximum failure when integrating superego would lead to a dissocial personality disorder¹⁴.

PERSONALITY ORGANIZATION

Now that updated about structural components aimed to perform a diagnosis of personality organization have been reviewed, the next step is to understand the various structural levels. It is important to highlight that within the spectrum of borderline organization there are other sublevels; high, medium, and low functioning. Here we will mainly discuss neurotic organization and borderline organization.

Neurotic Personality Organization

Based on the previous mnemonics(RADIO), we can summarize this level of as follows; (R) an intact reality test is appreciated. There is proper empathy with reality social criteria, and it is possible to identify them and to consider them in the interaction with others²⁵. (TO) There are aggressive impulses, and even though they are controlled and are not expressed in

fully impulsive conducts, these are close to the excessive self criticism, with difficulties in assertive expression and a tendency to avoid confrontation. (D) There is predominance of defenses based on the repression, thus generating a rather rigid and inflexible functioning. (I) There is a coherent and continuous sense of one self and of others. However, when facing intense/conflictive affections, these are excluded from the conscious experience. The foregoing generates less distortions in the experience of one self and of others^{16,25}. (OR) are integrated, thus getting deep to intimate relationships with significant others, with a good functioning, en general, in various areas, except in those having conflicts. (S) Just like the defensive system, it is rather rigid where guilt and self criticism^{2,25} are predominant.

Generally, main conflicts are around sexuality, dependence, more integrated forms of aggression, and narcissist needs. Within this environment, we can find obsessive, depressive, masochist, hysterical personalities. Its pathology level is moderate, so, they use to have a good prognosis in less structured treatments²

Borderline Organization of Personality

As general clinical features, there is (1) an oscillating/instable/hyperactive mood before stimuli, which may even unleash disproportionate emotional responses, because of the poor defense mechanisms they have. (2) The foregoing explains low self control and tendency to the impulsive behavior. (3) There is a significant disrupt in RO quality manifested in difficulties to establish interpersonal/intimate/deep/long lasting relationships. (4) There is identity diffusion whose severity depends on the individual functioning degree, characterized by a chronic void feeling or a diffused anguish, with limited capabilities to enjoy, feel pleasure, or to feel containment. (5) Finally, there is a lack of integration of the superego, thus showing a permissive rules system^{1,2,6,13,26,27}.

High Borderline Organization:

(R) Intact Reality Test, but with significant social deficits before affective conflicts. (TO) A moderate pathology regarding aggression expressions, usually inhibit the latter. A self

destructive and negligent behavior with one self is predominant, a controlling interpersonal style, but there may be some occasional outbursts. (D) Predominant defenses regarding excision and repression. (I) Slight to moderate identity diffusion; poor and shallow integration of the self and object, which evidences incoherence and instability, and clear difficulties to invest in work/study and other projects. (OR) Predominant paranoid-schizoid and depressive conflicts, where the links are present, but in a shallow manner. These are not satisfactory, even in the sexual area, and despite there is some empathic capacity and concern, there is a tendency to deem relationships in terms of needs satisfaction; (S) inconsistent moral functioning, where there may be some areas functioning responsibly and coherent, but in others their values system is permissive².

Main conflicts are related to dependency/narcissist needs, along with fears associated to sexuality and aggression. In this way, symptoms existing in this level are histrionic, dependent, and the evitative traits.

Regarding prognosis, here there are less severe symptoms within the borderline spectrum. Even so, these work poorly in less structured treatments, but not in those that are well structured.

Medium Borderline Organization:

(R) Reality test is vulnerable to conflictive/affective states, where there are transitions to micro psychotic episodes, specially in transference status. (TO) A poor control on aggression whether if it is self directed, in terms of a more active behavior and marked by episodes which may be even lethal (for instance Cuts and suicidal attempts), or else hetero directed, manifested as verbal aggressive episodes, threats to wound others or oneself, and intimidation. (D) Predominant defenses around excision, with marled oscillation on perception of one self or others, affecting functioning of the subject. (I) Moderate to severe identity diffusion with little capacity to invest in work/studies, personal projects, etc. (OR) Predominance of paranoid-schizoid conflicts that make establishment of intimate/deep relationships hard, where the links are just a few and shallow, and are mostly considered

as a transactional, with little empathy capacity. (S) Weak/inconsistent/corruptible system, with presence of psychopathic conducts, generally undercovered by other areas, although other more violent or impulsive signs may show up as well and they are not aforethought; there is egosyntonic exploitation, and certain goals are achieved at the expense of others.^{2,27,20}

Main conflicts are caused by a poorly integrated aggression, where perception of a threatening world is predominant, along with paranoid anxiety. In this spectrum we can see limit symptoms, such as paranoid, schizoid, and narcissist symptoms.

Regarding forecasts, despite severe symptomatology, they use to have a rather positive prognosis as long as they are under highly structured treatments and a clearly defined contract/framework, although acts and threats to the contract during initial phases of the treatment are expectable

Low Borderline Organization:

(R) Reality Test is highly vulnerable to stress, where we can also see some very intense micro psychotic episodes in the transference. (TO) High miscontrol of the aggression, revealing in this aspect a severe pathology regarding highly lethal conducts for for one self and for others, where the outburst of anger are frequent, with un low threshold of activation. (D) Excision is predominant, with significant oscillations in the perception of one self and of others, thus severely interfering on functioning. (I) Extreme identity pathology, along with establishing a one self that is magnificent/pathological and severely disturbed. (OR) RO highly loaded with with paranoid-schizo anxieties, which shows a lack of of deep links and dependence, and could become a highly isolated individual, with no empathy capacity or desire of intimacy. His/her few relationships are exclusively aimed to satisfy his/her own needs that are aimed to exploit others. (S) There is no notion of moral values, which is expressed in a violent/antisocial/psychopathic behavior with no sense of guilt or remorse^{2,14,20,27}.

Main conflicts in this spectrum are focused on perception of a highly aggressive/threatening world, from which he/she has to defend himself/herself at all cost. In this way, envy and hatred

are highly predominant. Traits within this spectrum are malignant narcissism syndrome and antisocial personality disorder.

The prognosis is ominous, with high risk of a treatment for (self) destructive behavior, full of sadism. Minimum conditions for treatment must be secured, with an extense/rigorous contract, involving third parties. In case of antisocial personality disorder, due to its null capacity to have affective dependence and to invest libidinally on others, this has no treatment.

STRUCTURAL INTERVIEW

The structural interview is a assessment methodology designed to perform a differential diagnosis not only about the psychiatric pathology, but also on personality organization. It has 6 clearly defined phases, which are performed by means of 90-minute interviews, ideally. It is important to consider not only the content, but it is also more important the how is it that the person transmits the information, and what happens while doing it^{1,2,18}.

The interview is started with 4 initial questions: (1) Why have you come to ask for assistance?, (2) What are your difficulties and problems? (here difficulties that were not necessarily mentioned by the patient, at the beginning are investigated), (3) What do you think is the nature of your difficulties?, and (4) How do you expect us to help you? (Yeomans et al., 2015). The question “¿How are you doing now?” has also been proposed to be added, in order to assess current functioning of the individual, beyond previous conflicts which may not be directly currently impacting him/her¹⁸ (OR. F. Kernberg, personal communication, 2020)

The 6 phases of the structural interview are: (1) reason for asking for help, symptoms, and psychiatric background, (2) functioning of the personality (work/studies, interpersonal relationships, couple, sexuality, and leisure), (3) identity formation, (4) past history (remote anamnesia), and (5) pending issues and to solve doubts. Only once the current patient's functioning has been explored in all areas, it is possible to take time to investigate the past history, including the presence of traumas or

other adverse experiences^{2,18}.

In order to make the Structural Interview to the empiric investigation sustainable, in 2006 Dr. Kernberg and his team designed The structural interview for personality organization (STIPO) which consists of an interview with 87 items, which assesses 6 domains of personality (identity, object relationships, defenses, aggression, and values system). Additionally, the domains are combined to assess the personality functioning and the level of the pathology²⁸.

STIPO has been validated in USA, Germany and Chile, among others^{28,29,30}. In Chile an investigation was also made which took the Identity Dimension of the STIPO in order to compare it with the diagnosis type DSM-5³¹. The new version of the STIPO (STIPO-R), which consists of an interview with 55 items, will be a more effective and brief way for assessing personality organization, and it also includes exploration of the narcissist domain³². The STIPO, has also been used as a concurrent validity instrument for the axis IV of "Structure" for the Operationalized Psychodynamic Diagnosis (OPD-2)³³

DISCUSSION

Scientific contribution made by Dr. Kernberg and his team are a significant contribution to the scientific and academic world. This was an amazing contribution in terms of knowledge and deep understanding of severe personality disorders. When exploring the foregoing aspects, and going beyond the reason to be assisted, it allows to have a deeper knowledge about the internal world of the patient, and in turn, to boost development of proper/specific techniques and strategies to anticipate and to face early difficulties in a potential treatment.

Severity of personality disorders may be very variable, therefore it is necessary to make a comprehensive assessment on current functioning of the subject, going through all the areas, even though it is not considered as problematic. In this way we can hypothesize about the prognosis and lines of intervention from the beginning that match with the conflicts of the patient, even though they are not conscious about these yet.

Another contribution of the personality organization diagnosis is that it facilitates the dialogue among treating professionals; and there may be various assumptions about the conflict of an individual, and each one may be correct up to a certain point. However, it is necessary to use a common language which allows to match on the conflict, functioning, pathology level, prognosis, and potential treatment strategies. We believe that the structural diagnosis of personality allows to reach such agreement point.

BIBLIOGRAPHY

- 1.- Kernberg, O. F. Severe personality disorders: Estrategias Psicoterapéuticas. Mexico: Manual Moderno; 1984.
- 2.- Caligor, E., Kernberg, O. F., Clarkin, J. F., & Yeomans, F. E. Psychodynamic Therapy for Personality Pathology, Treating Self and Interpersonal Functioning. Washington, DC: American Psychiatric Association, 2018
- 3.- Millon, T., Grossman, S., Millon, C., Meagher, S., & Ramnath, R. Personality Disorders in Modern Life (2nd ed.). New Jersey: John Wiley & Son, 2004
- 4.- Kernberg, O. F., & Caligor, E. A Psychoanalytic Theory of Personality Disorders. In M. F. Lenzenweger & J. F. Clarkin (Eds.), Major Theories of Personality Disorder. 2nd ed. New York: Guilford Press; 2005, p. 114–156
- 5.- Posner, M. I., Rothbart, M. K., Vizueta, N., Thomas, K. M., Levy, K. N., Fossella, J., et al An approach to the psychobiology of personality disorders. *Development and Psychopathology*, 2003; 15: 1093–1106. [https://doi.org/10.1017.S0954579403000506](https://doi.org/10.1017/S0954579403000506)
- 6.- Kernberg, O. F. Treatment of Severe Personality Disorders: Resolution of Agression and Recovery of Eroticism. Washington, DC: American Psychiatric Association, 2018
- 7.- Panksepp, J. Affective Neuroscience, the Foundations of Human and Animal Emotions. New York: Oxford University Press, 1998

- 8.- Wright, J. S., & Panksepp, J. P. An Evolutionary Framework to Understand Foraging, Wanting, and Desire: The Neuropsychology of the SEEKING System. *Neuropsychoanalysis*, 2012; 14; 5–39. <https://doi.org/10.1080/15294145.2012.10773683>
- 9.- Kernberg, O. F. Neurobiological correlates of object relations theory: The relationship between neurobiological and psychodynamic development. *International Forum of Psychoanalysis*; 2014; 24, 37–41. <https://doi.org/10.1080/0803706X.2014.912352>
- 10.- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)* Washington, DC; London, England: American Psychiatric Publishing, 2013.
- 11.- Bach, B., & First, M. B. Application of the ICD-11 classification of personality disorders. *BMC Psychiatry*, 2018; 18; 1–14.
- 12.- Kernberg, O. F. Identity: Recent findings and clinical implications. *Psychoanalytic Quarterly*, 2006; 75; 969–1004. Retrieved from <http://dialnet.unirioja.es/servlet/articulo?codigo=2282066>
- 13.- Jacobson, E. *The Self and the Object World*. New York: International Universities Press, 1964
- 14.- Kernberg, O. F. The Almost Untreatable Narcissistic Patient. *Journal of American Psychoanalysis Association*, 2007; 55; 503–539. <https://doi.org/10.1177/0003065107055020701>
- 15.- Silbersweig, D., Clarkin, J. F., Goldstein, M., Kernberg, O. F., Tiescher, O., Levy, K. N., et al. Failure of Frontolimbic Inhibitory Function in the Context of Negative Emotion in Borderline Personality Disorder. *American Journal of Psychiatry*, 2007; 164; 1832–1841.
- 16.- Kernberg, O. F. Borderline personality organization. In *Journal of the American Psychoanalytic Association*, 1967; 15. <https://doi.org/10.1177/000306516701500309>
- 17.- Valenciano, L. M., Rosique, P. D., & González, P. M. Los preliminares de la psicoterapia focalizada en la transferencia. *Psicopatología y Salud Mental Del Niño y Del Adolescente*, 2015; 26; 61–72.
- 18.- Yeomans, F. E., Clarkin, J. F., & Kernberg, O. F. *Transference-Focused Psychotherapy for Borderline Personality Disorder, A Clinical Guide (2nd ed.)*. Washington, DC; London, England: American Psychiatric Publishing, 2015
- 19.- Capponi, R. M. *Psicopatología y Semiología Psiquiátrica (Universita)*. Santiago, Chile, 2006
- 20.- Kernberg, O. F. Aggressivity, Narcissism and Self-Destructiveness in the Psychotherapeutic Relationship. In *Journal of Chemical Information and Modeling*, 2004a; 53 <https://doi.org/10.1017/CBO9781107415324.004>
- 21.- Fertuck, E. A., Makhija, N., & Stanley, B. The nature of suicidality in borderline personality disorder. *Primary Psychiatry*, 2007; 14; 40–47. Retrieved from <http://ovidsp.ovid.com/ovidweb. GE=fulltext&D=psyc5&AN=2008-18300-008>
- 22.- Kernberg, O. F. (1988). Clinical dimensions of masochism. *Journal of the American Psychoanalytic Association*, 36(4), 1005–1029. <https://doi.org/10.1177/000306518803600407>
- 23.- McWilliams, N. *Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process (2nd Ed.)*. New York, London: The Guilford Press, 2011
- 24.- Lingiardi, V., & McWilliams, N. *Psychodynamic Diagnostic Manual (PDM-2)*. New York, London: The Guilford Press, 2017
- 25.- Caligor, E., Kernberg, O. F., & Clarkin, J. F. *Handbook of Dynamic Psychotherapy for Higher Level Personality Pathology*. Washington, DC; London, England: American Psychiatric Publishing, 2007

- 26.- Yeomans, F. E., Clarkin, J. F., & Kernberg, O. F. *A Primer of Transference-Focused Psychotherapy for the Borderline Patient*. Northvale, New Jersey, London: Jason Aronson Inc, 2002
- 27.- Kernberg, O. F. *Narcissism, and self-destructiveness in the psychotherapeutic relationship*. Yale University Press. 2004b
- 28.- Stern, B. L., Caligor, E., Clarkin, J. F., Critchfield, K. L., Horz, S., MacCornack, V., et al. Structured Interview of Personality Organization (STIPO): preliminary psychometrics in a clinical sample. *Journal of Personality Assessment*, 2010; 92; 35–44. <https://doi.org/10.1080/00223890903379308>
- 29.- Balbontin, A. M., Isaac, A., & Pollak, H. *Instrumento Structured interview of personality organization (STIPO): Dimensión Identidad*. Tesis para optar al grado académico de magíster. Universidad del Desarrollo, 2008
- 30.- Doering, S., Burgmer, M., Heuft, G., Menke, D., Bäumer, B., Lübking, M., et al. Reliability and validity of the German version of the Structured Interview of Personality Organization (STIPO). *BMC Psychiatry*, 2013; 13; 1–13. <https://doi.org/10.1186/1471-244X-13-210>
- 31.- Castillo, R. T., & Arias, H. Z. Aplicación de la dimensión identidad de la entrevista STIPO para diagnosticar difusión de identidad en pacientes con diagnóstico previo de trastornos severos de la personalidad. *Estudio clínico cuantitativo*. *Revista Chilena de Neuro-Psiquiatria*, 2018; 56; 9–17. Retrieved from www.sonepsyn.cl
- 32.- Clarkin, J. F., Caligor, E., Stern, B. L., & Kernberg, O. F. *Structured Interview of Personality Organization – Revised (STIPO-R)*. 2016, Retrieved January 27, 2020, from www.borderlinedisorders.com
- 33.- Grupo de Trabajo OPD Diagnóstico psicodinámico operacionalizado (opd-2). *Manual para el Diagnóstico, Indicación, y PLANIFICACIÓN de la Psicoterapia*. Barcelona: Herder, 2008
- 34.- Lenzenweger, M. F., Clarkin, J. F., Kernberg, O. F., & Foelsch, P. A. The Inventory of Personality Organization : Psychometric Properties , Factorial Composition , and Criterion Relations With Affect , Aggressive Dyscontrol , Psychosis Proneness , and Self-Domains in a Nonclinical Sample. *Psychological Assessment*, 2001; 13; 577–591. <https://doi.org/10.1037//1040-3590.13.4.577>

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