Severe Personality Disorders:
Psychotherapeutic Strategies

OTTO KERNBERG

Yale University Press *New Haven and London*

1984

with chronic schizophrenic illness, the diagnosis of borderline personality organization (in contrast to psychotic structure) during periods of remission indicates the possibility of psychoanalytic psychotherapy and, implicitly, the possibility of fundamentally improving the personality structure and thus affording the patient additional protection against psychotic breakdown.

CHAPTER 2: *The Structural Interview*

My principal objective in this chapter is to illustrate the clinical usefulness of structural interviewing, particularly in the differential diagnosis of borderline conditions. The detailed clinical descriptions of different patterns emerging during structural interviews should also illustrate the limits of the usefulness of structural interviewing. To put it briefly, the more a clear-cut psychotic or organic syndrome emerges, the more the structural interviewing resembles the traditional mental-status examination. But for patients within the borderline or neurotic spectrum of psychopathology, the advantages of structural interviewing quickly become apparent. The structural interview not only sharpens the differential diagnosis but also reveals information with important prognostic and therapeutic implications. It tells us about the patient's motivation, his capacity for introspection and for collaboration in psychotherapeutic treatment, and his potential for acting out and for psychotic decompensation.

An important question is whether a standard psychiatric history should be taken before a structural interview, which, under these conditions, then replaces the traditional mental-status examination; or whether both the standard history-taking and the traditional mental-status examination should be replaced by a structural interview, which may end up with selective history-taking in the light of the findings of the interview itself.

The advantages of starting out with classical history-taking are that this method conforms more easily to psychiatric residents' training in medical history-taking and examination, it permits the psychiatrist quickly to diagnose obvious psychotic and organic psychopathology (where structural interviewing is much less important), and, because this approach is more traditional, it decreases the initial anxiety for the

patient by fitting into the ordinary expectations of the patient/doctor interaction. To start with taking a history also avoids the consequences of a severe premature flare-up of primitive defenses (with activation of intensely negativistic or oppositional developments, particularly in the case of paranoid patients).

The disadvantages of starting with a traditional history-taking before structural interviewing are that it allows the patient's predominant defensive operations to go underground, and, especially with borderline and neurotic personality structures, makes it easier for the patient to "adapt" protectively to the interview, which decreases anxiety while obscuring areas of current conflicts and early transference developments.

In weighing these advantages and disadvantages, I think that the less time the interviewer has for a full evaluation of the patient, and the less experience the interviewer has had in structural interviewing, the greater is the advantage in beginning with a standard history and then shifting to structural interviewing. In contrast, the more time available, the more experienced the interviewer, and the more the differential diagnosis focuses on the boundaries between neurotic and borderline, and between borderline and psychotic structure, the more useful it is to start with a structural interview, with the understanding that the historical information required in individual cases will fit naturally into the advanced phases of the structural interview.

The interviewer begins by asking the patient to present a brief summary of his reasons for coming to treatment, his expectations of treatment, and the nature of his predominant symptoms, problems, or difficulties. While the search pattern that follows the initial opening questions may vary in different approaches to structural interviewing (Stone, 1980; Selzer, 1981), my preference is to follow the initial inquiry with a systematic search, surveying the cycle of "anchoring symptoms" of key psychopathology indicated on the perimeter of the circle in Figure 1.

The survey completed, the interviewer focuses on the significant symptoms that have emerged in its course, exploring them as they appear in the here-and-now interaction of the interview, followed by clarification, confrontation, and tentative interpretation, with careful attention given to the patient's reactions to these interventions. The patient's capacity to empathize with the interviewer's query, to further clarify issues regarding his ego identity, object relations, reality testing, and current defense–impulse configurations, gives an indication of his capacity for introspection. The structural diagnosis depends heavily upon how the patient handles clarifications, confrontations, and interpretations.

If, for example, the initial survey has revealed some evidence of identity diffusion and defects in reality testing, the interviewer first attempts to amplify the expression of these characteristics in the here-and-

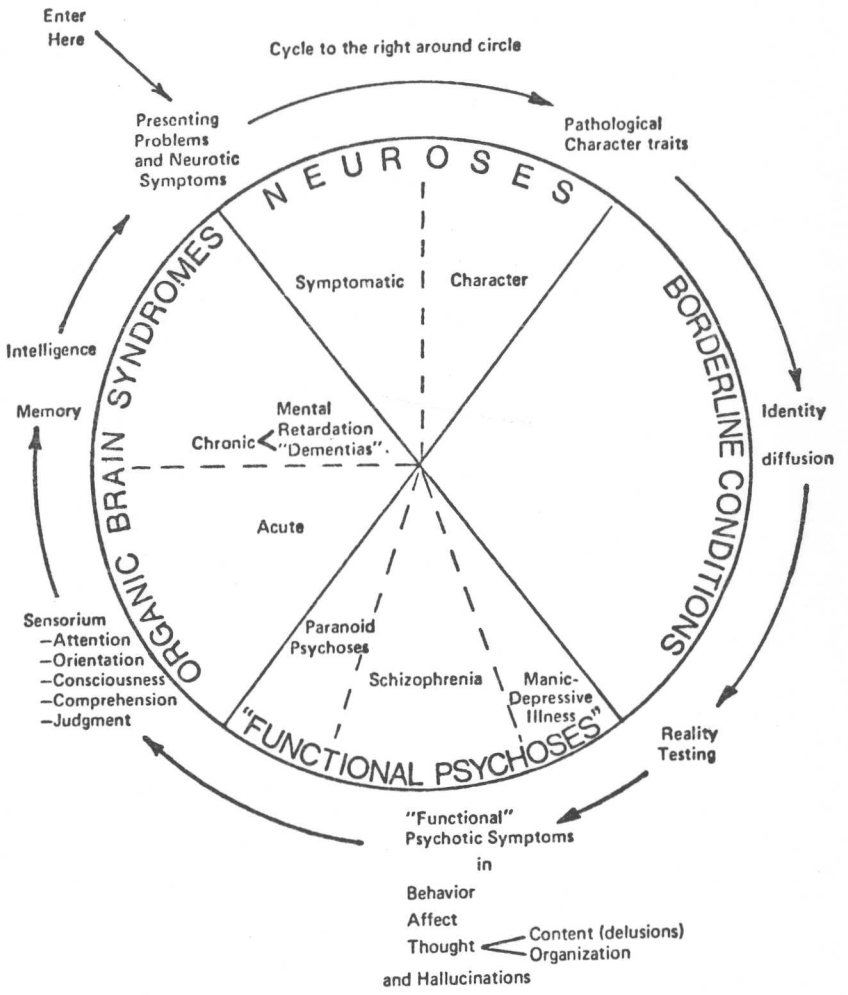

Figure 1. *Cycling of Anchoring Symptoms.*

now interaction of the interview. Then he confronts the patient by calling attention to discrepancies in what the patient has said or to other incongruities that indicate the possible defensive nature of his behavior. In addition, the interviewer tentatively interprets the possible significance of the discrepancies, which further challenges the patient to explore his behavior and motivations. The patient is asked how he sees these inconsistencies, how he feels about them, and what other information might clarify what has been occurring.

The patient's responses are of primary importance in differentiating neurotic, borderline, and psychotic structures. Given their intact capacity for reality testing, borderline patients reveal an often surprising reorganization and improvement in functioning with these clarifications, confrontations, and interpretations. They are able to empathize with the interviewer's "confusions," to clarify and correct their perceptions, and to use these corrections constructively in subsequent phases of the interview. In addition, borderline patients demonstrate some capacity for introspection and insight concerning the basis for the incongruities. As noted earlier, patients with psychotic structures lack this ability to empathize with ordinary social criteria of reality, and attempts to clarify may therefore reveal further distortions in reality testing. Neurotic patients, unlike the borderline cases, emerge with an integrated concept of themselves, which, in turn, tends to increase the interviewer's empathy with various aspects of their conflicts and reality and with their integrated concepts of significant others. The latter give the interpersonal reality and past history of these patients a sharp presence. Whereas borderline patients may increase their realistic behavior during the interview, they simultaneously make plain the emptiness, chaos, and confusion in their life situation and object relations.

With patients who are inarticulate and communicate poorly, information from sources other than the interview must be brought to bear on the diagnostic process. Inferences about anchoring symptoms can be made from such information. Then the focus on the symptoms in the here-and-now and clarification, confrontation, and interpretation can be attempted. This more detailed investigation may be carried out for several of the presenting anchoring symptoms until the interviewer feels comfortable with the structural diagnosis.

The structural diagnostic interview, then, combines a psychoanalytic focus on the patient–interviewer interaction with a psychoanalytic technique for interpreting conflictual issues and defensive operations in this interaction in order to highlight simultaneously the classical anchoring symptoms of descriptive psychopathology and the underlying personality structure.

A significant feature of the proposed model for structural interviewing is its cyclical nature. The concept of the anchoring symptoms as located on the perimeter of a circle makes it possible for the interviewer, as he proceeds from one cardinal symptom to the next, to return eventually to the starting point and reinitiate a new cycle of inquiry, in sharp contrast to a "decision tree" model of inquiry, which has a fixed pattern of progression. "Recycling" along the anchoring symptoms permits the interviewer to return as often as is necessary to the same issues in different contexts, retesting preliminary findings at later stages of the interview. As will be seen, it is not intended that the anchoring symptoms invariably be explored systematically, one by one. Depending upon early findings, different approaches to this cycling of inquiry are recommended.

The Initial Phase of Structural Interviewing

It is useful to start the interview with several questions (direct or indirect) presented in sequence, thus providing both a clear idea of what you expect from the patient and several possible ways for him to answer. In addition, the patient's very capacity to understand a series of questions and to remember them tests his functioning on several key anchoring symptoms. A typical initial inquiry might go as follows: "I am interested to hear what brought you here, what is the nature of your difficulties or problems, what you expect from treatment, and where you are now in this regard." If the interview occurs in the context of a hospital consultation or a research setting, or if the interviewer has previous information about the patient from other sources, he might add an explanatory comment such as: "I have had the opportunity of hearing something about your difficulties, but I am very interested to learn from you directly how you see all of this," or "I should like to tell you that although I shall have opportunity to learn about your difficulties from the members of the staff [or the person who referred you for a consultation, etc.] at this point I have no information about you at all."

This opening permits the patient to talk about his symptoms and the main reasons for his coming to treatment, as well as to expand on the nature of other difficulties. It permits the interviewer to evaluate indirectly the patient's awareness of his illness and of the need for treatment and the realistic or unrealistic nature of his expectations from treatment and reactions to already suggested treatment recommendations.

In response to these questions, patients without psychotic or organic psychopathology may talk freely about neurotic symptoms and difficulties in the psychological aspects of their social life that would point to pathological character traits; thus, indirectly, they give the first sign of good reality testing. The capacity to remember these questions, to respond to them in a cohesive, well-integrated way, also indicates a clear sensorium, good memory, and probably normal or even high intelligence. It represents, therefore, an automatic first "cycling" along the entire perimeter of anchoring symptoms.

In contrast, patients with alterations in the sensorium (decreased attention, orientation, consciousness, comprehension, or judgment) may have difficulties in responding to such questions, and the same is true for patients with memory or intellectual deficits (particularly, limited capacity for abstraction)—that is, patients with acute or chronic organic brain syndromes.

Patients may also be excessively concrete, vague, confused, or evasive in their responses to these questions. The interviewer can then tactfully clarify the discrepancy between the questions and the responses. It is helpful to inquire whether the patient feels he has responded fully to what he was asked or believes that the questions have not been clear enough, or perhaps are overwhelming. If the patient now acknowledges difficulties in following or understanding the interviewer, the questions should be repeated, worded somewhat differently, and the interviewer should then explore whether the patient still has difficulty in understanding. If this is the case, he should explore next what the nature of the difficulty is. In this fashion, often "entering" the diagnostic cycle through evaluation of symptoms, the interview may now lead rapidly to clarification, confrontation, and interpretation of the difficulty, which permits the interviewer to differentiate confusion stemming from intense anxiety and from psychotic misinterpretation of the total situation, negativism, and alteration of the sensorium, or serious memory or intelligence deficits.

The patient may respond in ways that have little or no apparent relation to the initial question. A severely disorganized schizophrenic patient, one with a hypomanic syndrome or with severe character pathology, may make use of the initial inquiry to express, for example, paranoid evasiveness or obsessive perfectionism by clarifying every one of the interviewer's statements. A masochistic patient may start to cry as if presented with an excessively burdensome task. All these responses may be tactfully explored, clarifying the questions once again while attempting to elicit more information about the nature of the difficulty the questions evoked. In this way, early manifestations of loss of reality testing, psychotic symptoms, and acute or chronic organic symptoms may be elicited, together with premature transference developments characteristic of patients with severe character pathology.

If a patient first responds appropriately to the initial questions but then gets lost in details in attempting to clarify them further, the interviewer should again explore for various symptom complexes. Within the realm of neurotic symptoms, is the patient getting lost in details because of obsessive tendencies? Is he vague and cautious in expressing paranoid tendencies? Within the realm of loss of reality testing and psychotic symptoms, is the patient evasive because of underlying paranoid delusions or other psychotic interpretations of the present interaction? Does he get lost in details because of problems in his cognitive functions, either because of alteration in the sensorium or because of chronic loss of memory and intelligence? Again, tactful clarification, exploration with the patient of his difficulty in responding (confrontation), and tentative exploration of the reasons for the difficulty in communication (interpretation) may focus attention on one or another of the major anchoring

symptoms and provide early clues to the patient's descriptive and structural characteristics.

If the patient is able to understand and respond fully and clearly to the initial questions, and at the same time to present a coherent picture of the major symptom that brought him to consult and of other problems and difficulties as well, the interviewer may then raise subsidiary questions derived from the information already presented. For example, he may ask about more precise aspects of symptoms, the approximate date of their appearance and their development, and additional related symptoms; this may complete the information regarding neurotic symptoms and at the same time indirectly indicate that the patient has a normal sensorium, no major memory deficits, and at least a normal level of intelligence functioning. Nevertheless, if in the course of the patient's description of his difficulties he refers specifically to concentration, memory, and his cognitive functions in general, the interviewer would now have good reason to focus further on symptoms of acute and chronic organic brain syndromes, but with a preliminary understanding that reality testing is maintained (and the patient, therefore, even if organic, is not demented).

When the patient's responses do not lead in an "organic" direction but convey information indicating an excellent level of functioning in terms of sensorium, memory, and intelligence, it may be assumed that the most important information regarding neurotic symptoms has been obtained. The focus of the interview may now shift along the perimeter to the investigation of pathological character traits (see Figure 1).

The investigation of pathological character traits, fundamental in evaluating not only the type of character or personality pathology but also its severity (and, by the same token, the presence or absence of borderline personality organization, with its key anchoring symptom of identity diffusion), is a crucial focus of the structural interview. The first question, once this point of inquiry has been reached, may be formulated as follows: "You have told me about your difficulties, and I would now like to hear more about you as a person. Could you describe yourself, your personality, what you think is important for me to know so that I can get a real feeling for you as a person?" This question represents a new challenge, a deeper level of inquiry which, under optimal circumstances, may lead a patient to a self-reflective mood. He may then describe feelings about himself, the important areas of his life (studies or work, family, social life, sex, cultural and political interests, leisure time), and particularly, his key relations with significant others.

If the patient can spontaneously present such information about himself, he thus provides one indication of good reality testing. Psychotic patients with the capacity to maintain a certain semblance of an appropriate relation to reality may have arrived at this point in the inter-

view without showing major disturbances. For them to answer such an open-ended question satisfactorily, however, is virtually impossible since this requires the capacity for maintaining empathy with ordinary aspects of social reality (such as the interviewer's interest in the patient's personality). A patient's ability to explore his personality in depth may now indicate that he has probably maintained reality testing. The interviewer can therefore discard psychotic illness (in addition to the previously discarded acute and organic brain syndromes) from the spectrum of diagnostic possibilities.

Sometimes a patient has great difficulty talking about himself in such an unstructured way because of cultural as well as personality factors. The interviewer may then suggest that the patient describe his relations with the people who are most important to him and tell about his life, studies or work, family, sex life, social relations, how he spends his leisure time. Patients with severe character pathology, especially those with severely repressive or paranoid traits, may find it hard to provide even this more concrete, circumscribed information. Failure to respond to this more direct question would be a first indication of severe character pathology. The interviewer would then investigate identity diffusion for the differential diagnosis of borderline personality organization) and even reevaluate reality testing.

The procedure in this instance would be for the diagnostician to point out to the patient that he seems to have difficulty talking about himself as a person. The interviewer may then ask to what extent the patient believes that this difficulty is due to the circumstances of the interview itself, apprehensions about being interviewed in general, or specific fears about the interviewer or the diagnostic situation (thus probing for possible paranoid features), or whether the difficulty reflects a general problem the patient has in clarifying to himself who he is or what his relations with the surrounding world and others are (which probes for possible schizoid features). As a response to this probing, patients with borderline personality organization may present primitive defensive operations, such as projective identification, splitting, primitive dissociation of contradictory aspects of the self experience, denial, grandiosity, fragmentation of affects, omnipotence, or devaluation. The interview has now become focused on a specific segment of the perimeter of anchoring symptoms, namely, that extending from pathological character traits through identity diffusion to reality testing.

I described in chapter 1 how to recognize clinically the maintenance of reality testing. If the patient's affect, behavior, or thought content in the early stages of the interview is clearly inappropriate, indicating the possibility of a major organic or psychotic illness, the existence of hallucinations or delusions may be explored more directly. (This aspect of the interview is discussed more fully below.) If, however, no gross evidence

of psychosis has yet been obtained in the interview and the patient's information has given the interviewer no reason to think that he has had hallucinations or delusions in the past or, if he has had them, that they are still with him, the interviewer may now focus sharply on what seems most inappropriate, strange, or bizarre in the patient's affect, thought content, or behavior.

As mentioned before, encouraging the patient to talk about himself freely, particularly patients with borderline personality organization or psychotic syndromes that have so far gone undetected, may activate primitive defensive operations and the interpersonal features of these defenses that are manifest in the immediate patient/interviewer interaction. The diagnostician may at first experience this distortion as a sense of stress or strain; his internal sense of freedom in interacting with the patient diminishes. He may eventually find that a specific, regressive object relation has been activated and superimposed on the appropriate, reality-oriented one of the interview.

If, at this point, the interviewer, focusing on the patient's affect, thought content, and behavior, shares with the patient what seems to him most unusual in any of these aspects and asks the patient whether he can explain the interviewer's sense that the patient's presentation has a strange or puzzling aspect, the patient's reponse may shed light on his reality testing. Reality testing is reflected in the patient's capacity to empathize with the interviewer's perception of these characteristics of the interaction and, in a subtler way, in his capacity to empathize with the interviewer's perception of the patient in a broader sense.

For example, the interviewer may say: "As I asked you to tell me more about yourself, you first seemed puzzled and then began talking about the way your husband treats you. A little later, when I asked you whether you had any problem in relating to your husband under such circumstances and why you were mentioning this particular example, you responded by telling me about other aspects of your husband's behavior. It is as if, when I asked you to talk about yourself, you seemed to be obliged to talk about how you are treated by your husband. I find this puzzling. Can you see that I have difficulties with your attitude?" The patient may understand what puzzles the interviewer and explain, for example, that she feels so overwhelmed by her husband that it is as if she did not have the right to examine how she feels about herself (thus indicating reality testing in this situation). Or she may say, in a fearful and suspicious tone, that she is trying to point out that her husband is treating her badly and ask whether the interviewer is insinuating that these difficulties are all her fault (thus raising doubts about her reality testing, in addition to pointing to paranoid trends).

Should the latter be the case, the interviewer may now ask the patient why his asking if she might be making any contribution to the dif-

ficulties with her husband suggested the insinuation that the difficulties were all her fault. He thus follows the technique of carrying out cycles of clarification, confrontation, and interpretation around an area of disturbance in the interaction that may provide further information about the patient's personality, at the same time clarifying the patient's ability to test reality.

It is important first to clarify whether the patient has a psychotic structure—that is, absence of reality testing (which, by definition, would indicate that the patient is not a borderline patient)—before investigating identity diffusion. The patient's sense of identity differentiates borderline character pathology (characterized by identity diffusion) from nonborderline character pathology (where identity integration is intact).

If, in the course of exploring the patient's personality characteristics or pathological character traits, the question of loss of reality testing never arises (or is rapidly answered satisfactorily in the sense that reality testing is maintained), the interview then enters the middle phase, in which the evaluation of identity diffusion (and therefore the differential diagnosis of borderline personality organization) becomes the major objective. But if, in evaluating the patient's personality, it clearly emerges that reality testing is lost, the interview then focuses on the nature of the patient's psychosis.

It should be clear by now that, although the interview begins in standard ways in all cases, the nature of the questions, the interaction, and the entire quality of the interview will vary considerably according to the nature of the patient's psychopathology. In structural interviewing, this is a desirable effect, a consequence of the interviewer's systematic connection of the patient's information with the nature of the patient/diagnostician interaction.

The Middle Phase of Structural Interviewing

Neurotic Personality Organization

Patients with symptomatic neuroses and nonborderline character pathology are those who are able to respond in the initial phase of the structural interview with a pertinent summary of what brought them to treatment, what their main difficulties are, what they expect from treatment, and where they are at this point. These are also patients who give no evidence of bizarre, strange, or absurd behavior, affects, or thoughts. Their ability to test reality permits the interviewer to rule out the possibility of psychotic illness, and they present an obviously normal sensorium, normal memory, and at least normal intelligence, thus ruling out an organic brain syndrome as well. These patients are able, when the interviewer asks for further information, to expand on their presenting symptoms or difficulties in meaningful ways. They clearly understand not only the manifest content of the interviewer's questions but the subtler implications of these questions.

Such an interview may appear to an outside observer remarkably similar to a traditional or standard psychiatric interview. Now, the interviewer's main area of focus along the perimeter of the circle of anchoring symptoms is the area of pathological character traits. The questions should now focus on the patient's difficulties in interpersonal relations, in adjusting to the environment, as well as on his internally perceived psychological needs.

Whatever cues the patient provided earlier about difficulties in any of these areas should now be explored, and this exploration should be followed with a more general question such as: "I would now like to learn more about you as a person, the way you perceive yourself, the way you feel other people perceive you, whatever you think might help me to form a picture of you in depth within this limited time." This question probes for further information regarding characterological problems and leads to a more specific diagnosis regarding the predominant type of pathological character traits, the dominant pathological character constellation. At the same time, the question also makes possible an evaluation of identity diffusion.

If the patient now conveys information that the interviewer cannot put together in his mind, particularly contradictory data that do not fit with the internal image of the patient that the interviewer is building up, a tactful probing of such potential or apparent contradictions is indicated. The interviewer's aim is to evaluate the extent to which contradictory self representations are present (an indication of identity diffusion) or the extent to which the patient presents a solid, well-integrated conception of himself. Quite frequently there are peripheral areas of self experience that are contradictory to a well-integrated, central area of subjective self experience, peripheral areas that the patient himself experiences as ego-alien or ego-dystonic, not fitting into his otherwise integrated picture of himself. These isolated areas may be an important source of intrapsychic conflicts or interpersonal difficulties but should not be equated with identity diffusion. In other words, we do not expect total harmony in neurotic patients, but there should be central subjective integration of the self concept on the basis of which the interviewer can construct a mental image of the patient.

The next question deals with significant others in the patient's life. Once the interviewer has tentatively answered in his own mind the question regarding integration of the self concept, he may then explore the patient's integration of the concepts of significant others. Patients with borderline personality organization and the corresponding syn-

drome of identity diffusion typically present an incapacity to integrate the representations of significant others in depth. These patients have more trouble presenting a picture endowed with life of people who are important to them than they do of people they know only casually. A lead question here might be: "I would like to ask you to tell me something about the people who are now most important in your life. Could you tell me something about them so that, given our limited time here, I might form a clear impression of them?" Now the extent of integration of object representations versus lack of integration may be explored and, in this context, the degree of pathology of the patient's interpersonal life. Both identity integration or diffusion (a cross-sectional structural criterion) and the nature of the patient's object relations (a longitudinal, historical-structural criterion) may become clarified in the process.

Again, whenever internal contradictions emerge in the patient's narrative, the interviewer may clarify these first, then tactfully confront the patient with these apparent or potential contradictions and evaluate the patient's capacity to reflect on the interviewer's observations. The interviewer can thus study the patient's capacity for introspection. Finally, if obvious conflictual issues emerge in the exploration of such contradictory areas—within either the self concept or the concept of significant others—clarification and confrontation may be followed by a tentative interpretation, in the here-and-now only, of potentially dynamic or conflictual implications of these issues.

While this part of the interview with a typical neurotic patient is proceeding, the interviewer should focus on the effects the exploration is having on the actual interaction between himself and the patient. Exploration of areas of confusion, internal contradictions, and potential conflicts may increase the patient's anxiety as well as mobilize his predominant defensive operations. Characteristically, in the neurotic patient, these defenses will be fairly unobtrusive, so that in practice it is often quite difficult to diagnose the existence of repression, displacement, rationalization, or intellectualization in evaluating the patient's early interaction with the interviewer. Only reaction formations and inhibitory character traits that assume immediately defensive functions and pathological character traits in general (which, of course, always assume defensive functions) may be detected early in the interaction with neurotic patients. High-level defenses may be inferred indirectly from the content of what is being discussed but rarely show directly in the early interviews.

As noted, with borderline personality organization the exploration of identity diffusion (along the lines of dissociation of the self concept and of the concepts of significant others) typically activates primitive defensive operations which emerge in the interaction with the diagnostician rather than simply in the content of verbal communications. The more the immediate interaction between patient and diagnostician becomes transformed, altered, or distorted by such defensive processes, the more likely it is that primitive defensive operations are predominating. Thus a significant structural criterion for the diagnosis of borderline personality organization is confirmed.

In the case of patients who show no indication of identity diffusion or primitive defensive operations, dominant areas of conflict, emotional inhibitions, or symptomatic development may then be explored to the point where the limits of the patient's conscious or preconscious awareness are reached—in other words, to the limits of his repressive barriers. In these cases, the diagnostician may formulate dynamic hypotheses regarding unconscious intrapsychic conflicts. Often those are strengthened by the natural continuity between the patient's current experiences and his recall of past experiences, but such dynamic hypotheses must remain highly speculative. The healthier the patient, the easier it is for the diagnostician in early interviews to hypothesize connections between the conscious past and the present but, paradoxically, the harder it is for the patient to link present and past because these links are repressed.

With neurotic personality organization, the careful exploration of presenting symptoms, overall personality, and the interactional aspects in the interview that enrich or complement other information practically coincides with a systematic history-taking. In these cases the information gathered by structural interviewing is usually much more complete, richer, and more immediately relevant for treatment considerations than the standard approach. The relevant information regarding the patient's past follows naturally from the investigation of his current personality. In all cases with neurotic personality structure, after completing the information regarding the current illness, it is helpful to obtain a brief history of the past. In the context of such data gathering, it is often possible to link findings regarding the patient's personality tentatively with information regarding his past, a linkage intended not to test dynamic hypotheses but to test the limits of the patient's spontaneous understanding and integration of his past and present.

Borderline Personality Organization

I have already stressed the extent to which patients with borderline personality organization usually contaminate information about the past with current personality difficulties. Such contamination is even more extreme in the case of functional psychotic illness. A careful exploration of the borderline patient's current life, with particular emphasis on the syndrome of identity diffusion—and, in this context, the nature of his object relations—usually proves a rich source of data for clarifying the

type and severity of his character pathology. This information should be complemented by an exhaustive investigation of currently manifest neurotic symptoms. In these cases it is preferable to explore the past only very generally and not attempt to clarify, confront, or interpret the patient's characterization of his past experiences; rather, information about the past should be registered as it is presented.

Patients with borderline personality organization typically present identity diffusion, but narcissistic personalities present an important complication in this respect. The narcissistic personality usually has an integrated self concept, but the concept is pathological and grandiose. However, the narcissistic personality clearly presents a lack of integration of the concept of significant others—thus facilitating the diagnosis of identity diffusion and a predominance of primitive defensive operations, particularly omnipotence and devaluation.

The structural characteristics of the narcissistic personality tend to emerge more slowly in structural interviewing than those of non-narcissistic borderline pathology. It is usually in the middle phase of the interview, with a patient who clearly presents good reality testing and no initial evidence of lack of integration of the self concept, that a strange superficiality or unavailability of descriptions in depth of significant others gradually emerges, together with a subtle yet pervasive expression of self-aggrandizement and often a subtle or not so subtle derogatory attitude toward the interviewer. At times, in better-functioning narcissistic personalities, the diagnosis emerges first in these patients' descriptions of their relations with others rather than in the interactions with the interviewer proper.

In contrast, in non-narcissistic borderline pathology, the initial inquiry regarding patients' motives for the consultation and expectations from treatment may immediately bring forth an apparently thoughtless, chaotic jumble of information about themselves, their unrealistic expectations of treatment, and strange or inappropriate ideas, behavior, or affects in relation to the diagnostician, which require evaluation of their reality testing. For example, a patient may start to cry in presenting her reasons for consultation, and when the diagnostician explores with her what makes her cry (particularly the possibility of acute or severe depression), the immediate response may be that she cries because she knows nobody is going to pay attention to what she says, and everybody, and therefore also this psychiatrist, will agree with her mother, with whom she has severe conflicts. In contrast, crying as a manifestation of emotional lability in an essentially neurotic personality structure (for example, in a hysterical personality) may easily disappear under exploration. The patient will acknowledge her quick change of moods and the inappropriate nature of that affect, and she will maintain a spontaneous, immediate empathy with the reality of the present social interaction.

Whenever the immediate emotional interaction of the session becomes deeply intensified in the early phase of structural interviewing (by the expression of behavior, affects, or thoughts that strongly affect that interaction), an exploration is indicated, after completing the exploration of the patient's responses to the initial inquiry, of these manifestations in the here-and-now. A delicate decision now has to be made: Where the severity of the patient's interpersonal disturbances in the immediate interaction raises the question in the interviewer's mind of whether reality testing is being maintained, an immediate exploration of these disturbances is warranted. Under these circumstances, clarification and confrontation in the here-and-now of these interactional disturbances may clarify the existence of reality testing and assure the interviewer that he is not in the presence of a psychotic structure. He can then return to the exploration of the patient's character pathology in terms of other aspects of the patient's life and at the same time focus further on primitive defensive operations manifested in the interview.

But where reality testing is not in question, there may be an advantage in following the first inquiry with a second set of questions investigating further the patient's current life and relations with others. The purpose here is to search for confirmation of indications of identity diffusion in the patient's information about himself and his social life. Only later would the interviewer return to the manifestations of primitive defensive operations and pathological object relations in the here-and-now. Here the key question is: "What you have told me about your life makes me think of something I have observed here, in this hour, and reminds me of these difficulties you mentioned. Could it be that (such and such behavior here) is a reflection, in your relation with me, of what you have said troubles you with other people?"

To put it somewhat differently, from the viewpoint of the strategy of exploring various anchoring symptoms, if a patient with obvious indications of character pathology reveals such disturbance in affect, thought content, or behavior that his reality testing is in question, an exploration of these issues takes precedence over further exploration of his pathological character traits outside the present diagnostic situation. If, however, reality testing is assured, there is an advantage in first obtaining further information about pathological character traits and in gathering more evidence about difficulties in the patient's life outside this concrete situation. The objective is to gather information regarding both identity diffusion and primitive defensive operations in a relatively "neutral" area first, and only then to link this information with the exploration of the emotional implications of these characterological manifestations in the hour.

The issue of identity diffusion can thereby usually be fully clarified, and, to some extent, primitive defensive operations also diagnosed. Sometimes, however, in patients whose reality testing at first seems ap-

propriate, other evidence gradually accumulates regarding their lack of tact, social inappropriateness, general immaturity and arbitrariness of judgment, and the like, which may require a second exploration of reality testing. The interviewer must evaluate the extent to which these patients are able to maintain empathy with social criteria of reality by raising questions regarding their descriptions of relations with other people and exploring the socially inappropriate nature of some of the behavior that they may be describing in a matter-of-fact way.

In the typical borderline patient, neurotic symptoms tend to merge with diffuse, generalized, chaotic difficulties, reflecting serious personality malfunctioning. When there is lack of identity integration, it is often difficult or impossible to obtain a comprehensive view of the patient's life. By the same token the past histories of such patients are usually unreliable, highly distorted in the light of the current psychopathology. In other words, the severer the character pathology, the less reliable—and the less immediately relevant—is the past history. Here, therefore, in contrast to patients with neurotic personality structure, it is difficult or impossible to link predominant current conflicts with past psychodynamically significant material, and the attempt to do so is thus a highly questionable procedure. Paradoxically, however, mutually dissociated intrapsychic conflicts may make their appearance rather quickly in the manifest content of the borderline patient's communications. Key conflicts may therefore be more directly available in the initial interviews with borderline patients than with neurotic patients, while the dynamic links to their past remain obscure. By the same token, investigation of the current personality of patients with neurotic personality organization naturally leads into information about their past. In contrast, the initial information about the past obtained from patients with borderline personality organization is often no more than a retrospective expansion of current conflicts with significant others.

In patients with borderline personality organization, particularly those with narcissistic personality structure (whether or not their overt functioning is borderline), it is extremely important to evaluate antisocial behavior. Antisocial features, together with the quality of object relations, are crucial prognostic variables for intensive psychotherapy with borderline personalities and should always be probed before treatment is undertaken. Especially in patients with narcissistic personality, it is helpful to explore tactfully whether the patient has had difficulties with the law and to what extent such antisocial behaviors as stealing, shoplifting, chronic lying, and inordinately cruel behavior are significant antecedents. In practice this inquiry should be integrated with relevant information that the patient presents in other areas. When such questions are asked directly and naturally in the context of related information from the patient, the answers are often surprisingly direct and open.

(Naturally, the patient who freely admits chronic lying or "storytelling" is only giving a warning that he may soon be tempted to do the same with the therapist.)

Psychotic Personality Organization

The presence or absence of identity diffusion differentiates borderline from nonborderline character pathology in structural interviews. The presence or absence of reality testing differentiates borderline personality organization from psychotic structures.

I am referring here to patients with "functional" psychotic illness in contrast to psychotic developments secondary to an acute or a chronic organic brain syndrome. This group includes the entire spectrum of schizophrenic illness, major affective disorders, and paranoid psychoses that do not fit into the other two major psychotic syndromes. All these patients present loss of reality testing. In a typical case of a psychotic illness, the patient's response to the initial inquiry may already indicate absence of reality testing and, beyond that, such an incapacity to respond intelligibly to the interviewer's questions that the entire spectrum of functional psychotic illness, acute and organic brain syndrome, has to be evaluated.

In the extreme case of a patient who is totally unresponsive to the initial inquiry, the interviewer should first try to explore with him whether he has heard the question and has understood it. If the patient has been able to walk into the room and is obviously aware of and alert to the immediate environment, such total mutism is likely to indicate a functional psychotic illness rather than an organic brain syndrome. Nevertheless, it is helpful for the interviewer to proceed along the entire perimeter of the cycle of anchoring symptoms. Explore the sensorium, then memory and intelligence, before recycling to further focus on reality testing and major psychotic symptoms in behavior, affect, thought content and organization, and hallucinations.

The focus on the sensorium can be carried out by first testing the patient's attention: "I asked you some questions, and you have not responded; were you able to hear and understand what I asked?" If the patient continues to be unresponsive, it is helpful to find out whether he can indicate that he hears, understands, and agrees or disagrees with various questions asked by nodding his head or by any other signal. Under such extreme circumstances, it is important to clarify whether he understands and is trying to communicate, even though he may not be able to speak.

A lack of response to this probing behavior usually indicates negativism as part of a catatonic syndrome or schizophrenic illness in general or severe psychomotor retardation in extreme degrees of depressive ill-

ness. Sometimes, in the totally unresponsive patient, direct testing of catatonic features, particularly negativism, may elicit behavior directly opposed to the instructions given, flexibilitas cerea, and/or stereotyped posture or behavior that points to schizophrenic illness. In other cases, only a full exploration of the history of the present illness, obtained from other sources, will provide more definite information. Organic patients whose degree of consciousness is sufficient to be alert to their environment are usually able to respond to simple questions that would complete the exploration of the sensorium, such as the patient's orientation, consciousness, comprehension, and judgment of the immediate situation. (Because these areas are amply covered in guides to standard mental-status examination, I am not illustrating them with further concrete questions.)

If, in the course of the initial inquiry, it turns out that the patient's sensorium is clear, one can then explore whether the lack of response or the confusing response to the initial set of questions was due to loss of memory or lack of intelligence—that is, an incapacity to understand clearly what was asked or to retain the questions sufficiently while preparing an answer. Again, without going into a detailed analysis of the loss of cognitive functions that would characterize an organic brain syndrome, I want to stress the general point that, when a patient demonstrates severe incapacity to respond to the initial set of questions, the anchoring symptoms reflecting abnormalities in the sensorium, memory, and intelligence should be explored before returning to the examination of the major anchoring symptoms of functional psychosis.

If it is evident that the patient shows severe disturbance in verbal or nonverbal behavior but no alteration of the sensorium, memory, or intelligence, then the interviewer should return to the initial set of questions regarding what brings the patient to treatment, the nature of his difficulties, what he expects from treatment, and where he is now. If the response to this second cycle of inquiry is still inappropriate, confused or confusing, or accompanied by affect or behavior that seems inappropriate, the interviewer should now focus on such pathological thought content, affect, and behavior, tactfully share his observations with the patient, and explore in detail the extent to which the patient can empathize with the diagnostician's experience of the patient's responses as strange or puzzling.

If it is clear that reality testing has been lost regarding any aspect of the patient's behavior, thought, or affect during the interview, the diagnosis of a functional psychosis should be considered, and the diagnostician may then shift to a different approach to the patient's disturbed manifestations by attempting to explore with him possible meanings of these manifestations in terms of the patient's present subjective experience. In other words, once the loss of reality testing has been confirmed, there is an advantage in temporarily abandoning a confronting approach and in pursuing the patient's internal experience corresponding to his behavioral manifestations. Further exploration of the patient's subjective experiences may lead to an understanding of the connections among his affect, thinking, and behavior and open the road to a differential diagnosis. Is the patient suffering from a schizophrenic illness (with disorganization of these linkages) or an affective illness (in which an internal organization links inappropriate affect, behavior, and thought so that a degree of internal harmony among these psychic functions is maintained within a highly pathological organization of them)? The evaluation of hallucinatory experiences may now enrich the diagnosis of loss of reality testing formulated earlier on the basis of interactional processes. The confirmation of hallucinations indicates, by definition, loss of reality testing. Similarly, the diagnosis of delusions also confirms loss of reality testing and usually provides further clues about the nature of the psychotic illness.

A general principle of structural interviewing with psychotic patients is that, once clarification and tactful confrontation confirm loss of reality testing, the patient's thought processes, reality distortion, and internal experience are no longer challenged. To the contrary, an effort should now be made to empathize maximally with the patient's internal reality in order to deepen the understanding of the psychotic process itself. By the same token, in the middle and termination phases of structural interviewing of psychotic patients, the diagnostician may implicitly adjust his interventions to the severe distortions in the interaction with the patient, helping the patient to achieve a nonthreatening or anxiety-reducing termination phase of the interview.

In the case of some psychotic patients, with whom the initial communication is much more appropriate and freer, where only the exploration of what initially appeared as severe character pathology leads the interviewer into evaluating reality testing and eventually to the decision that reality testing is lost, the interview may appear much more similar to that of the typical borderline patient. In fact, patients with true hallucinations and delusions sometimes initially present their delusions or hallucinations as, respectively, overvalued (even obsessive) ideas or illusions (or pseudohallucinations). Under these conditions, it may be helpful to explore to what extent the patient is trying to maintain a "reasonable" or "normal" evaluation of his thought or sensory perceptions because he is afraid that otherwise he might be considered "crazy."

For example, an illustrative question might be: "You have told me that at times you feel you are Jesus Christ, but that, of course, you are aware that you are really not Jesus Christ. Could it be that, deep down, you are really convinced that you are Jesus Christ but afraid that this conviction will be interpreted as 'crazy' by me or by others?" In other

words, when delusional or hallucinatory phenomena are potentially present, reality testing should include a confrontation not only with external reality but also with psychotic reality, in a nonthreatening way.

When the exploration of inappropriate behavior, affect, or thought content does not clarify the issue of reality testing and when there is no clear indication of hallucinations or delusions, a further, more complex interviewing technique may be utilized—namely, the interpretation in the here-and-now of the patient's primitive defensive operations. As I have suggested (see chap. 1), the interpretation of primitive defensive operations in the here-and-now tends to increase reality testing in patients with borderline personality organization but to decrease it in psychotic patients.

For example, a typical intervention interpreting a projective identification might be: "I notice that you have been talking in a very cautious and fearful way with me, as if you were afraid of some danger connected with me. I also notice that you have been frowning at some of my questions (for example, . . .). Could it be that you are afraid I might think badly of you or attack you in some way because you are afraid of some similar tendencies in yourself, such as feeling critical or angry toward me?"

The interpretation of primitive defensive operations is difficult. The diagnostician must develop a hypothesis about the nature of the primitive, fantastic, dissociated object relations activated. He must also develop a hypothesis about the defensive function of that primitive defensive operation. Then he must share his hypothesis with the patient.

Sometimes there may be dramatic shifts toward improvement or worsening in the immediate interaction following such an interpretive hypothesis. At other times, the response is uncertain. Patients with paranoid psychotic illness who have preserved sufficient awareness of reality to hide their real thoughts or fears may simply show increased evasiveness after such probing interventions. Some of the most difficult challenges to structural interviewing (as well as to all diagnostic approaches) are presented by paranoid patients in whom the differential diagnosis between paranoid personality and paranoid psychosis is unclear. Repeated diagnostic interviews may be required to reach a more definite conclusion.

In the case of patients with active psychotic illness, particularly schizophrenia and manic-depressive illness, the main emphasis of the structural interview should be on the nature of the presenting symptoms, with the objective of differentiating the major psychoses as well as subtypes within them. In these cases and in patients with organic brain syndrome and loss of reality testing, systematic investigation of the history of the present illness, as well as of the past history, usually requires input from other sources and does not form part of the structural interview itself.

Acute and Chronic Organic Brain Syndromes

As mentioned before, a patient's incapacity to respond appropriately to the initial set of questions may indicate an alteration of the sensorium (typical of an acute organic brain syndrome) or severe deficit of memory and intelligence (typical of a chronic organic brain syndrome). When the patient is apparently conscious yet unresponsive to the initial inquiry or, though responding to it, reveals severe disorganization in his response, a minimal or an inadequate reaction, or a general attitude of confusion or perplexity, cycling from the presenting problems to the evaluation of the sensorium, memory, and intelligence is indicated.

The evaluation of the sensorium, including the patient's spontaneous and induced attention, his orientation, the degree of consciousness, his comprehension and judgment, may clarify whether a confusional state exists characteristic of an acute organic brain syndrome or whether this confusional state represents an acute functional psychosis, particularly acute schizophrenia (a schizophreniform disorder in DSM-III). The tactful evaluation of the patient's awareness of his difficulties in grasping the interviewer's questions or the total interviewing situation may gradually produce evidence of disorientation, decrease of consciousness, and diffuse difficulty in understanding concepts—all of which are typical of an acute organic brain syndrome. In contrast, highly idiosyncratic responses in which perplexity and confusion coexist with bizarre yet organized formulations are more characteristic of schizophrenia. A series of direct questions having to do with clarifying and confronting the difficulties the patient experiences in communicating and exploring his ability to introspect may contribute to the differential diagnosis of organic and schizophrenic confusional states.

With patients whose difficulty in grasping and responding to the initial inquiry appears to reflect mostly a deficit in memory and intellectual understanding, an open ventilation of such difficulties may facilitate a systematic evaluation of memory and intelligence functions (particularly abstraction). For example, the interviewer might comment: "I have the impression from your reaction that you are struggling with problems in concentrating or memory. May I ask you some questions to clarify whether, indeed, you have some difficulties with your memory?" This inquiry may initiate the transition toward a more standard systematic evaluation of memory and intelligence.

If and when deficits in memory and intelligence have been confirmed, the interviewer may tentatively explore with the patient the extent to which he is aware of or preoccupied with his difficulties in remembering or formulating his thinking clearly, and how upsetting this is to him. If the patient is unable to grasp his obvious difficulties or vehemently denies them, tactful confrontation may test the discrepancies between what the diagnostician observes and the patient's reaction.

If such confrontation increases the denial, loss of reality testing regarding such organic deficits may be assumed, and the interviewer may ascertain a tentative diagnosis of dementia (that is, a chronic organic brain syndrome with secondary loss of reality testing).

In a less severe case of chronic organic brain syndrome, the patient may present some awareness of his difficulties and acknowledge them. Nevertheless, there may be a lack of appropriate anxiety or depression over this loss, which also may indicate personality changes and loss of reality testing commensurate with dementia. Under these conditions, before exploring the discrepancies between the patient's memory and intellectual deficits, on the one hand, and his affect state, on the other, it is helpful to explore whether he has experienced similar difficulties in relation to studies, work, other people, and his social life in general. The investigation of the symptoms of chronic organic brain syndrome is thus expanded via "recycling" through the evaluation of neurotic symptoms and pathological character traits in the patient's social life.

In this manner, structural interviewing may contribute to the differential diagnosis of confusional states (organic versus schizophrenic) and to the evaluation of the severity of personality deterioration and loss of reality testing in chronic organic brain syndrome—that is, the evaluation of dementia.

By and large, when the interviewer sees that the patient is having severe difficulty responding to the initial inquiry or seems very anxious, depressed, or confused, he should share his impressions with the patient. Further, he should ask whether these impressions correspond to the patient's feelings about himself and whether part of his apprehension or fearfulness may relate to the interview itself. In fact, this approach to the expression of intense fear and apprehension should be applied to patients along the entire spectrum of psychopathology. Psychotic and organic cases and patients with severe paranoid personality traits and severe degrees of social inhibition (shyness, timidity, and the like) may appear intensely anxious in the interview, especially in the early phase. On the other hand, the initial inquiry, with its structuring properties, may have a tranquilizing or reassuring effect on nonorganic, nonpsychotic patients by modifying their unrealistic fantasies about the interview itself. Therefore, persistence of intense anxiety after the initial inquiry usually indicates severe psychopathology of some kind.

The Termination Phase of Structural Interviewing

Having completed the exploration of neurotic symptoms and pathological character traits, predominant defensive operations, and identity diffusion, reality testing, and the major psychotic or organic anchoring symptoms, the interviewer should now acknowledge to the patient that

he has completed his task. He should then invite the patient to provide him with information regarding additional issues that the patient considers important or thinks the interviewer should know about. A very helpful question, suggested by Dr. Robert Michels (personal communication, 1981), is "What do you think I should have asked you and have not yet asked?" This inquiry may sometimes lead to significant new information or to further reflections on areas already explored. It also provides an opportunity for the patient to express anxieties activated during the interview, which can now be explored further and reduced by bringing in reality considerations.

It is important to leave enough time at the end not only for the patient to raise questions but also for the interviewer to respond to them and to deal with unexpected anxiety and other complications. The interviewer may decide that further interviews are warranted before a definite diagnosis can be arrived at, or perhaps that both participants will need more time to think before discussing treatment recommendations, or perhaps that a treatment disposition can be completed now. In any case, the decision-making process should be shared with the patient. The interviewer may tell the patient that he has learned enough about him to make a recommendation or feels he would like to continue the diagnostic process; in either event, the interviewer may wish to obtain pertinent information from other sources.

The termination of the structural interview is a crucial opportunity for evaluating the patient's motivation for continuation of the diagnostic process and/or treatment, the management of acute dangers that have been diagnosed and require urgent action (for example, acute suicide risk in severely depressed patients), and the extent to which the patient can tolerate and respond positively to statements regarding his problems as perceived by the interviewer. Every consultation should carry with it the possibility for the diagnostician to extend it with a number of additional interviews if necessary. The patient's magical assumption that all diagnostic conclusions can be made in one or two interviews should be realistically explored if necessary. Most patients are usually appreciative when a psychiatrist honestly acknowledges that, although he has learned much, he does not yet know enough to decide what, if any, the treatment needs are.

Some Further Considerations on the Interviewer's Attitude

Structural interviewing requires time, including time for experiencing and thinking while the interview goes on. Therefore, I recommend that at least an hour and a half be reserved for an initial interview. In our borderline diagnosis research project (Kernberg et al., 1981), after much experimenting, we settled on two 45-minute periods, separated by a 10-

to-15-minute intermission. In my private practice I often set aside the last two treatment hours of the day for the initial interview of a new patient.

The diagnostician should be comfortable, relatively "at his best" in the sense of not being disturbed by extraneous considerations, and able to remain emotionally alert and receptive, yet very much in the background, while all his attention is focused on the patient. In spite of (or because of) his unobtrusive attitude, the interviewer may initially appear as an "ideal" person to the patient; he may elicit strong tendencies toward idealization or dependency in patients with a capacity for basic trust, regardless of the anxieties and difficulties that brought them to treatment. In patients with severe disturbances in their object relations, an incapacity for basic trust, paranoid dispositions, or intense unconscious envy, the very calmness, receptivity, and "untroubledness" of the diagnostician may evoke suspicion, resentment, fear, or derogation.

In any case a double relationship is quickly established between the patient and interviewer: a realistic, socially appropriate one of patient and therapist, and an underlying, more or less subtle one reflecting the patient's predominant transference dispositions and the diagnostician's potential corresponding countertransference dispositions. The latter jointly activate a conflictual, "fantastic" object relationship (in the sense of both a fantasy and its unrealistic nature). Early expression of conscious or unconscious erotic, aggressive, and/or dependent affective dispositions on the patient's part creates not only a cognitive awareness of them in the diagnostician but also concordant or complementary affective dispositions in him (Racker, 1968).

The diagnostician faces the task of simultaneously (a) exploring the patient's subjective, inner world, (b) observing the patient's behavior and interactions with him, and (c) utilizing his own affective reactions to the patient in order to clarify the nature of the underlying activated object relation. This underlying object relation is the basic material that should permit the interviewer to formulate tentative interpretations in the here-and-now of the patient's defensive operations, if such operations become apparent, dominant, and require exploration.

From a different perspective, the diagnostician also builds up in his own mind a model of the patient's image of himself, his self representation. At the same time, he explores the extent to which the communications from the patient really lend themselves to building up such a model. The diagnostician also attempts to build up a model in his mind of the significant others with whom the patient is interacting in his life and raises the same question: whether it is possible to obtain an integrated representation of them. Here, of course, the diagnostician is evaluating identity integration versus identity diffusion.

From a still different perspective, the diagnostician is evaluating

what appears to be most inappropriate in the patient's affect, thought content, or behavior, preparing himself to explore his perceptions with the patient in an honest yet tactful way, evaluating, in this context, the patient's capacity to empathize with the diagnostician's experience—which will reflect, at one level, the patient's capacity for introspection or insight and, at a different level, the patient's capacity for reality testing.

To carry out all these tasks is difficult; it requires knowledge of and experience with the standard mental-status examination, psychotherapeutic experience in working interpretively with transference developments, and clinical experience with a broad spectrum of psychiatric patients. It is, however, a technique that can be taught to and acquired by gifted third-year psychiatric residents and further developed with personal experience and practice. The structural interview represents what might be called a "second generation" of the earlier "dynamic interview," which reflected the impact of a psychoanalytic frame of reference on the diagnostic interview in descriptive psychiatry.[1]

1. For the research implications of diagnostic interviewing see Carr et al. (1979), Bauer et al. (1980), and Kernberg et al. (1981).