CHAPTER 1

Personality Functioning as One Thing

A Psychoanalytic Self–Other Perspective

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Ellen, who had been bounced around from treatment to treatment for her difficulties with finishing college because of attention and behavioral issues, was invited to join a research study on personality functioning. She had been diagnosed alternately with attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, depression, and even autism spectrum disorder. She was prescribed a collection of psychiatric medications and was enrolled in a skills program to help with her attentional and impulse control. After completing a set of self-report questionnaires, Ellen began the interview with the psychologist who was administering the interview assessment. The first question encouraged Ellen to describe herself as a person. She was startled by the query, responding that nobody had ever really asked her that before, that her previous encounters with mental health professionals always focused on what was wrong with her, and the ways she wasn't doing what people thought she should. She described herself as "scared, creative, emotional, loving, and confused."

Subsequent questions asking her to elaborate on her self-description, relationships, and aspirations led to a portrait of a young person who was raised to be who her status-conscious family needed her to be. Without adequate attention to and appreciation of her shy temperament and dismissal of her passion for weaving wonderful stories, Ellen's upbringing left her with an inadequate sense of self, conflicts about having to please others while wanting to retreat to her creative thoughts, and confusion and distress about how and who to be in the context of the complex demands and opportunities presented by university life. The previous assignment of multiple and perhaps contradictory symptom disorder diagnoses seemed like superficial attempts to throw DSM criteria at the wall to see what sticks, missing the core self–other foundation of her strengths and challenges.

It has been my practice as of late to begin talks about personality functioning by inviting my colleagues to imagine themselves at their best and/or doing something they enjoy. I then ask them to think of someone they care about a great deal, picturing being together with this person, perhaps noticing how they feel while reflecting on this connection. The intent of this exercise is to illustrate that we are all hard-wired as humans to create mental representations of self and others, and how we typically think and feel about ourselves and others are at the heart of how we get on and get along with others in life. If an individual does not have readily available, stable, cohesive, and positive-on-balance internal reference points for understanding and regulating one's self and relationships, navigating the world is an ongoing burden, and symptoms such as anxiety and depression may be signposts requiring exploration of a much more meaningful underlying story. As Lerner and Lerner (2007) noted, "[T]he implicit premise that each diagnosis signifies a separate and distinct disturbance is antithetical to the clinician who views various external expressions (e.g., symptoms, complaints) as arising from a common internal source" (pp. 70–71). Similarly, Blatt and Auerbach (2003) asserted that "all psychoanalytic orientations . . . agree that sustained symptom remission, while essential to any successful treatment outcome, is secondary to and dependent on more basic changes in the personality structure" (pp. 268–269).

Sharp and Wall (2021) recently observed:

> LPF [Level of Personality Functioning] therefore reintroduces the idea that self, identity, and personhood are central to personality functioning and, with that, to the subjective experience of being human—what it feels like to be "me"—or, an individual's dynamic and subjective experience of herself as coherent and integrated across time and space. . . . The idea that the core of personality functioning (disordered or not) is best defined by an intrapsychic (or metacognitive) process of reflection and integration of aspects of self in a coherent fashion reflects the early conceptualizations of personality functioning . . . the idea that personality does not simply describe a person (as traits do) but also captures how a person manages herself and her relationships. . . . (p. 328)

Thus, as we understand our fundamental charge as providing a meaningful and effective treatment, Lerner (2005) has summarized, "one assesses with the intent of understanding the other in his or her totality, complexity, and uniqueness so that such an understanding can then be used as a basis for making decisions and suggesting interventions that will be beneficial to that individual" (p. 271).

A Psychoanalytic Paradigm and the Evolution and Persistence of a Core Self–Other Dimension of Personality Functioning

Conceptualizing a Psychoanalytic Approach

The purpose of this chapter is to delineate personality functioning from a psychoanalytic perspective, a discipline that has been contributing to theory, research, practice, and collective Western cultures for well over a century. Central to a psychoanalytic or psychodynamic self–other personality functioning paradigm is the understanding that how we think about ourselves and ourselves in relation to others is at the core of who we are and how we fare in navigating the tasks of living. Working from this perspective embraces investment in creating with each individual a productive way of exploring their personhood—strengths, struggles, disavowed, or as yet unrevealed aspects of the mind—together crafting a language and a process for illuminating, affirming, and improving a life in progress. What is perhaps most notable about a psychoanalytic/psychodynamic approach is what constitutes the data to be considered in the process of getting to know someone and navigating an effective treatment: everything—the whole person, how they think, act, feel—and how these experiences and inclinations manifest in the therapeutic relationship. Psychodynamic clinicians focus on anything that has meaning for the individual, such as trauma expressed physically because there are no words, dreams that hold clues to wishes and conflicts, and internal scripts about self and others that have powerful impacts on adaptation. This chapter title suggests "the one thing" characterizing a psychoanalytic approach—and we focus on a self–other orientation from this tradition to define personality functioning—but it is important to consider that the transcendent "one thing" is pursuing an understanding to the extent possible of the whole personhood of each individual through learning about their subjective being—their stories, uniqueness, strengths, and vulnerabilities. This means meeting each individual where they are in various phases of treatment, adapting one's therapeutic stance in accord with what the individual needs and is capable of. Those of us who are well trained to work with people who have more significant personality challenges know it is a fool's errand to try to impose recommendations, interpretations, or even an alternative perspective to the patient's narrative when that person can barely tolerate being in the room.

The Evolution of a Core Personality Functioning Dimension

Turning to another "one thing," it has been asserted by this author and others that perhaps there is a unitary self–other dimension at the heart

of personality and personality dysfunction (e.g., Hopwood et al., 2025; Morey & Bender, 2021; Morey et al., 2011; Sharp & Wall, 2021). In fact, the literature is replete with examples of unitary continua characterizing universal human developmental processes of self–other adaptation (e.g., Freud's psychosexual development and evolution of primary narcissism to object-love, Piaget's theory of cognitive development, Kohlberg's stages of moral development, and Erikson's stages of life development), and there have been notable ideas about such a continuum for quite a long time. Nineteenth-century notions such as moral insanity and good/bad temper were unitary (albeit problematic) dimensional constructs centered on the degree to which one possesses self-control, with impairment in functioning resulting in harm to self and others (Morey & Bender, 2021).

A significant 20th-century contributor to the tradition asserting that personality (and psychopathology overall) may be represented by a single dimension is Karl Menninger, one of the first psychoanalytically trained psychiatrists in the United States. After a sweeping assessment of psychiatric classification over millennia, Menninger concluded that diagnostic approaches had over time trended toward representations composed of less than a handful of dimensions (Morey & Bender, 2021). Hence, he proposed a single-dimension classification centered on "personality dysorganization" consisting of five levels defined by increasing impairments in adaptive self-management, reality testing, and impulse control (Menninger, 1963). Sabshin (1964) noted that Menninger was not so much invested in the widespread adoption of his proposed classification system but was most concerned about the increasing "pigeonholing rather than individualizing" in the psychiatric diagnosing of patients (p. 475).

The Enduring Self–Other Nature of Personality Functioning

The 1970s ushered in the creation of the neo-Kraepelinian DSM-III (American Psychiatric Association, 1980), a burgeoning catalog of axes, diagnoses, and criteria, with an explicit orientation toward being neutral regarding the etiology of mental disorders, a stance noted by Bornstein (2006) as de facto encouraging clinicians and researchers to largely turn away from thinking about individuals' internal worlds, resulting in a loss of important personality underpinnings, including defenses, ego strength, and the centrality of mental representations of self and others, in favor of more superficial indicators. Bender and Skodol (2007), in anticipation of the DSM-5 process, posited that borderline personality disorder (BPD) is fundamentally a self–other representational disorder,

and that, in fact, DSM-IV criteria are saturated with self and other language. For example, the PD general criteria referred to disturbed cognitive perceptions of self, other people, and events, and BPD is marked by such issues as unstable self-image and a tendency toward assuming abandonment by other people. Hence, in spite of professed etiological neutrality, the authors of the DSM-IV PDs could not cover the personality landscape if self–other formulations were omitted; hence, the so-called psychoanalytic orientation never left. Bach and colleagues (2025) support this notion that a self–other approach has been implicit in the DSM-IV PD diagnostic categories, along with citing a number of studies that demonstrate a general p-factor of personality psychopathology that has been instantiated by the development of the DSM-5 LPFS.

Furthermore, Bender and Skodol (2007) illustrated how defining personality psychopathology as self–other representational disturbance is, in fact, cross-theoretical, very much part of traditions including interpersonal and cognitive-behavioral, and prominent in some trait models such as a proposal by Livesley and colleagues (1998). It could be argued that a self–other orientation was not completely eliminated in DSM-III and IV but was deemphasized, and that training in the assessment and treatment of personality and personality disorders, never adequate across professions to begin with, was now even more at sea amidst a bewildering and uncompelling collection of polythetic criteria. Whether its constructs ever completely left the DSM or not, self–other-oriented psychoanalytic/psychodynamic training, practice, and research have persisted. Readers are encouraged to travel beyond the brackets of "psychoanalytic/psychodynamic" because the parsing of theories, concepts, and treatments into buckets with labels threatens to parallel the division and dismissal all too present in much of the modern world.

Understanding the Centrality of Internal Representations of Self and Others in Human Psychological Life

A fundamental point of departure for psychoanalytic thinking about humans is that personality emanates from how people mentally represent themselves, others, and interpersonal dynamics—a universal adaptational capacity present throughout the lifespan—with internal worlds shaped by early experiences with primary caregivers. Psychopathology, then, can be understood in part as due to disruptions at various points of development, sometimes attributable to problems in early caretaking relationships that can lead to maladaptive representations of self and others. Freud outlined in *Mourning and Melancholia* (1917/1957) how depression may result if the loss of a significant other is not adequately

mourned but instead a representation of that other is unconsciously cathected through identification. Rather than experiencing the thoughts and feelings that arise because of an actual absence, or emotional inadequacy of a caregiver, the person psychologically becomes that caregiver to maintain connection and disavow the psychic pain. (It is not uncommon to know someone who is compelled to be a caretaker in multiple contexts to compensate for receiving inadequate care in their own childhood.) Freud (1923/1961) also described that, as part of the normal developmental process, the superego is formed through creation of significant-other representations serving the same functions as previously experienced in important relationships (particularly with parents). In other words, social environment and life experiences shape each individual's characteristic internal landscape, but we are all genetically hardwired to create mental models of self-in-relation-to-others as guides for understanding ourselves and for navigating the tasks of work and love.

Object relations theory is a prominent component of psychoanalytic thought organized around the idea that representations of self and others serve as core influential entities in the unconscious and conscious mind. How an individual symbolizes the self, relationships, and interactions between the internal and external worlds is considered fundamental in understanding personality development. Examples of contributors to this tradition are Klein (1957/1993), who conjectured that infants use the psychic defenses of splitting and projective identification to adapt to frustrating and gratifying elements of being cared for, and Jacobson (1964), who characterized the child's identity formation as emerging through a process of mentally differentiating from a fused self-caretaker object representation. How an individual experiences interactions with others has been emphasized by several more contemporary writers (e.g., Blatt & Behrends, 1987; Kernberg, 2004; Mitchell, 1988) as primary in shaping the individual's self-concept and interactional proclivities. Pine (1985) described the psychology of the individual "as coming about through the laying down as memories and fantasies of early interactions (or imagined interactions) between the person and significant caretakers, so that behavioral expectancies, longings for particular gratifications, knowings of behaviors that will produce expectable responses are recorded and can be repeated" (p. 174). This suggests that not only is it important to understand what significant others do, but also how the individual child assimilates interpersonal experiences into their psychic infrastructure. People are meaning-making creatures. Kernberg (1987) argued that, as developmental processes unfold, there may be factors that cause the child to internalize relationships as "bad," leading to maladaptive constructions of the self and others. This formulation is central

to Kernberg's model of level of personality organization, predicated on the idea that the more primitive an individual's self–other representations remain, the greater the disturbance in personality functioning.

Other important contributors to psychoanalytic personality developmental theory include Margaret Mahler and her colleagues who studied mother and infant/toddler interactions and formulated separation-individuation as a primary task the child must navigate. How phases of becoming a psychologically separate person unfold for the individual child greatly influences how they symbolize self and others and significantly impacts the trajectory of personality formation (Mahler et al., 1975). Similarly, Piaget created a framework for understanding child cognitive development, including the progressively evolving capacity to symbolize one's experiences, which leads to the creation of mental schemas for how to understand an interpersonal world (Ginsberg & Opper, 1969). Bricker and colleagues (1993) posited a model for understanding personality psychopathology–based "maladaptive schemas" that formed early in life due to adverse experiences, with these belief constellations persisting into adulthood. A comprehensive review of psychoanalytic theories of developmental psychopathology has been provided by Fonagy and Target (2003).

With representations of self and others central to human adaptation, modifying pathological images of self and others within the context of a treatment relationship constitutes therapeutic action that must occur for a successful psychotherapy (e.g., Blatt & Behrends, 1987; Caligor et al., 2018; Gruen & Blatt, 1990; Loewald, 1956–57/1980; Strupp, 1978). Most broadly, within a psychoanalytic paradigm, the therapist–patient relationship is considered the primary agent of change. It is assumed that patients' characteristic ways of thinking and behaving will become manifest in the therapy dyad, affecting the nature of the person's participation in treatment. One example of how to conceptualize this includes Pine's (1985) assertion that, similar to processes in child development, "the patient uses the therapist as an object of *identification*, a source of *education*, and a source of *confirmation*" (p. 171). Loewald (1956–57/1980) has characterized therapeutic action as the patient internalizing a new object relationship (with the therapist) as a means of discovering the characteristics of earlier relationships and experiencing new ways of relating. Blatt and Auerbach (2003) have suggested the patient internalizes the psychotherapy relationship, navigating separation-individuation by addressing issues of union and separation that arise in the treatment relationship. There is a vast literature of theory, case studies, and empirical work on object relations-oriented mechanisms of change, and discussions around this topic are ongoing.

Self–Other Assessment Models of Personality Functions

There have been several formalized psychoanalytic/psychodynamic-oriented assessment systems developed over the course of the past several decades. Table 1.1 presents key self–other elements of the DSM-5 Level of Personality Functioning Scale (LPFS; American Psychiatric Association, 2013, pp. 775–778); the M-Axis of the *Psychodynamic Diagnostic Manual, Second Edition* (PDM-2; Lingiardi & McWilliams, 2017, pp. 75–133); the Structured Interview of Personality Organization—Revised (STIPO-R; Clarkin et al., 2021); and Axis IV of Operationalized Psychodynamic Diagnosis, Version 2 (OPD-2; Ristl & von der Tann, 2008, pp. 76–85). While not explicitly endorsed as psychoanalytically based (although recognized by some as informed by that tradition; see Blüml & Doering, 2021), the ICD-11 factors for determining severity of PDs, which are dominated by self–other facets, have been included as well.

While it is notable that these various approaches have several facets to define the self–other continuum, we can understand this as including various processes and capacities that humans employ to make meaning and regulate both the internal constructions of oneself and other people and also interactions with the social world. For instance, the LPFS includes "the ability to self-reflect productively" (self-direction), and empathy elements of "comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding of the effects of own behavior on others" in the definitions of two of its facets. These arise, in part, from consideration of the processes of mentalization and reflective functioning used to develop this measure. The four facets of the LPFS self-interpersonal dimension—identity, self-direction, empathy, and intimacy—were derived from research on interviewer-administered instruments from the psychoanalytic tradition (Bender et al., 2011), including the Reflective Functioning Scale (Fonagy et al., 1998). Mentalization is an adaptational capacity that involves the ability to understand what is going on in one's own thinking processes and having a mostly realistic sense of what others are thinking and feeling (Fonagy & Target, 2006). As Table 1.1 shows, the PDM-2 also explicitly includes mentalization and reflective functioning in its definition of the M-Axis, and the ICD-11 criteria include "ability to understand and appreciate others' perspectives."

Another example of a psychoanalytic element employed to understand personality functioning is quality of defenses, reflected in several of the systems in Table 1.1. Humans use mental processes we refer to as defenses to deal with sometimes challenging thoughts and feelings about self and others. For instance, someone who is relatively high functioning may typically employ constructive humor to deal with anxiety about

TABLE 1.1. Self–Other Assessment Approaches

Definitions of the LPFS self–other facets (American Psychiatric Association, 2013)

Self

Identity: Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience

Self-direction: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively

Interpersonal

Empathy: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding of the effects of one's own behavior on others

Intimacy: Depth and duration of positive connections with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior

***Psychodynamic Diagnostic Manual, Second Edition* (PDM-2; Lingiardi & McWilliams, 2017)**

M-axis: Profile of mental functioning

Cognitive and affective processes

Capacity for regulation, attention, and learning:

- Capacity for affective range, communication, and understanding
- Capacity for mentalization and reflective functioning

Identity and relationships:

- Capacity for differentiation and integration (identity)
- Capacity for relationships and intimacy
- Capacity for self-esteem regulation and quality of internal experience

Defense and coping:

- Capacity for impulse control and regulation
- Capacity for defensive functioning
- Capacity for adaptation, resiliency, and strength

Self-awareness and self-direction:

- Self-observing capacities (psychological mindedness)
- Capacity to construct and use internal standards and ideals
- Capacity for meaning and purpose

Structured Interview of Personality Organization—Revised (STIPO-R; Clarkin et al., 2021)

Domains

Identity:

- Capacity to invest in work/studies and recreation
- Sense of self
- Sense of others

Object relations:

- Interpersonal relations
- Intimate relationships and sexuality
- Internal working model of relationships

(continued)

TABLE 1.1. *(continued)*

Defenses:
Lower-level, primitive defenses
Higher-level defenses
Aggression:
Self-directed aggression
Other-directed aggression
Moral values:
Experience of guilt; moral and immoral behavior
Operationalized Psychodynamic Diagnosis, Version 2 (OPD-2; Ristl & von der Tann, 2008)
Axis IV structure
Self-perception
Object perception
Self-regulation
Regulation of object relationship
Internal communication
Communication with the external world
Attachment capacity: Internal objects
Attachment capacity: External objects
ICD-11 Criteria for Assessing Personality Disorders (World Health Organization, 2024)
Self–other aspects of personality functioning that contribute to severity determination in personality disorder
Degree and pervasiveness of disturbances in functioning of aspects of the self:
Stability and coherence of one's sense of identity (e.g., extent to which identity or sense of self is variable and inconsistent or overly rigid and fixed)
Ability to maintain an overall positive and stable sense of self-worth
Accuracy of one's view of one's characteristics, strengths, limitations
Capacity for self-direction (ability to plan, choose, and implement appropriate goals)
Degree and pervasiveness of interpersonal dysfunction across various contexts and relationships (e.g., romantic relationships, school/work, parent–child, family, friendships, peer contexts):
Interest in engaging in relationships with others
Ability to understand and appreciate others' perspectives
Ability to develop and maintain close and mutually satisfying relationships
Ability to manage conflict in relationships

how they are presenting in a social situation. Those who have more troubled internal worlds may resort to such strategies as splitting, where the self, people, and situations are perceived as all good or all bad, or projection when a person attributes their own unwanted thoughts, feelings, or behaviors to someone else. These psychological strategies are often unconscious; hence, part of the treatment process would be to gradually help the person recognize, reclaim, and understand these disowned parts of the self in the service of achieving more psychic integration and improved personality functioning.

While there is considerable overlap across the featured systems in the concepts used to assess personality functioning, one may choose which approaches best suit their theoretical perspectives and practical needs. It is beyond the scope of this chapter to review the literature for each of the systems, which is extensive and growing. Readers are encouraged to explore the models cited in Table 1.1 to learn more about the construction and utilization of each.

Application of the LPFS

As mentioned, the self–other-oriented LPFS was constructed using what we have learned over decades of research from a psychoanalytic tradition employing instruments that measure universal human constructs: identity, self-direction, empathy, and intimacy (Bender et al., 2011). There are now a number of interview and self-report instruments for assessing the LPFS dimension in research and practice (Bach et al., 2025), but the instrument was primarily designed for ready use in the normal course of treatment. Keeping in mind the definitions of the four facets, a therapist can listen for material, ask strategic questions, and observe behaviors revealing qualities of the individual's self and other representations and the extent to which they have adequate capacity for mentalizing, constructively pursuing goals, and so on. The following are two case examples of how to use the LPFS to understand core self–other aspects of individuals.

CASE EXAMPLE 1

Vanessa, 33 years old, was referred for psychotherapy by her ob/gyn physician, who was concerned that Vanessa might be depressed and abusing substances. Given the referral question, the therapist in the initial meeting inquired about Vanessa's mood and her use of alcohol and drugs. Vanessa confirmed that she does feel down at times but said anyone would if they were in her situation. She said her husband does not respect her and they get into arguments over trivial things.

Vanessa explained that sometimes she hates her husband but offhandedly observed that at least he pays attention to her when they fight. When asked how she tries to cope with the situation, she replied, "Like I have my whole life, run away. You can't really count on anyone." The therapist asked her what running away meant, and Vanessa revealed that she sometimes leaves the house after an argument with her husband and goes to bars and drinks too much.

Prior to her marriage, Vanessa worked professionally as a graphic artist, but reported her real passion was painting. She made extra income teaching oil and watercolor painting at a local studio but ended up quitting because she found the role to be very difficult, often experiencing her students as critical, disrespectful, or mean. She stopped working outside the home altogether after her two sons were born, which has left her feeling completely dependent on her husband and somewhat aimless and out of control at times.

During one particular blowup with her husband, he told her she should get out of the house and "do something productive." Vanessa decided to take tennis lessons and promptly started an affair with her younger instructor. She says he is "perfect" and has everything her husband does not have, except money. She reported she also feels alive when she is with him because it is exciting and "he treats me like I am someone who actually has something to offer, even though I probably don't." However, after trysts with her instructor, she feels horrible guilt and remorse and becomes very distressed and nauseated. When trying to reflect on her behavior, she said, "I don't know why I act this way. My husband really is a good person. I am such a loser."

When asked about how she sees herself as a mother, Vanessa replied that she loves her children "more than my life" but has a very hard time being patient with them. She recently "exploded" at her 7-year-old son when he made a mess in the kitchen, and it makes her feel overwhelmed when her house is not neat. She describes being adequate at looking after her children's basic needs, and sometimes manages to play with them, helps with their homework, and takes them to do fun activities. Other times, when she is feeling too stressed, her husband has to step in and take over the care.

Another attempt to do something outside the home to bring some fulfillment to her life was Vanessa's signing up for an art class at the local community center. She said she is glad to be creating paintings again, but she has a very hard time with the other members of the group, who like to get coffee together after the session. Vanessa said she "kinda likes" a few of the people and wishes she could become friends with them, but keeps her distance because "they will find out what a boring and stupid person I am." She is thinking she will likely quit.

Broadly speaking from a self–other vantage point, Vanessa is troubled by an inner world where she is cast as inadequate and damaged, and other people are assumed to be inevitably unreliable,

demeaning, and rejecting. Considering the LPFS identity facet, she struggles intensely with figuring out who she is and sees herself as "boring and stupid" and a "loser." She attempts to regulate her emotions and self-esteem through drinking and an extramarital affair. She struggles with self-direction, unable to engage in a satisfying way with activities she may actually like, such as tennis and painting, because of her adverse inner world, and has little insight about her behaviors. Vanessa has a difficult time with empathy, unable to realistically assess how others might see her, and always assuming their assessment of her will ultimately be bad. Achieving real intimacy is a challenge, as she feels utterly dependent on her husband, and either despises him while idealizing her lover, or idealizes him while denigrating herself. Other people are important to Vanessa, as evidenced by her attempts to be a good mother and her longing for friends in her art group, but her problems with self-loathing and emotional fragility make it very difficult for her to establish fulfilling relationships. Vanessa's global personality functioning would best be characterized by LPFS Level 3 = severe impairment.

If we consider the initial referral questions of depression and substance abuse, viewing those symptoms in isolation would leave out very significant information on how to approach treatment with Vanessa. Her very fragile and denigrated self-image and unstable views of others, which fuel her emotional dysregulation, are at the heart of her difficulties. The therapist will need to adopt an accepting and affirming stance to work toward fostering a firm alliance, which is one of the goals of treatment for patients with these types of vulnerabilities. Softening self-punitive thinking and promoting self-care and compassion might serve as the foundation in the initial phase of the needed longer-term treatment. Knowing that Vanessa assumes important people in her life will condemn and reject her informs the clinician about possible challenges in the therapeutic relationship. At the same time, having an empathic appreciation of Vanessa's painful inner life can sustain the therapist's engagement and guide interventions, particularly during likely trying times over the course of the therapeutic journey when the therapist may be experienced as untrustworthy or disappointing by Vanessa.

CASE EXAMPLE 2

Gary is a 56-year-old man encouraged to seek treatment by his sister, who was worried he might be depressed. He found a therapist through a local referral service provided by a nearby psychoanalytic institute. Gary explained that he had lost his wife to a terminal illness 7 months prior, was struggling with ongoing grief and stress caring for his two teenaged children. He works as an accountant but had experienced difficulty meeting the demands of his job during the recent tax-return preparation period. When asked about his social network,

Gary reported that he comes from a local family that is well known and whose members are liked by many and are active in community organizations. He is the youngest of five siblings and feels he has a good relationship with them. He is a leader at his church and has a number of male friends whom he used to enjoy seeing regularly prior to his wife's illness, but it has been difficult for him to socialize since her passing.

The therapist asked him to talk about his wife. He responded, "She was my best friend. We had so much fun together and built a great life." He wept as he recalled his wife's decline and death and explained that he had lost his mother to cancer when he was 8 years old. When his mother died, he felt like he had to "keep it together" because other members of his family were extremely distressed. He finds himself still crying at home these days at times but tries to call a friend or sibling to help him talk things through. Continuing to feel as it is his job to carry on in spite of everything just like he did as a child, he expresses some embarrassment about his emotional reactions.

Gary is also very sad that his children have to experience what he went through as a child in losing his mother. He has made sure that both of his children have the opportunity to attend grief counseling, and family members have been very attentive to them as well. When asked what other things he is doing to help himself through this hard period, he said he spends a lot of time watching movies on late-night television. He knows this is somewhat of a problem because he then does not get an adequate amount of sleep, but it is an activity he enjoyed with his wife and cannot easily stop himself from spending too much time doing so. He has refrained from seeking therapy previously because he thought he would be better by this point but knows now that he needs some professional help to "get back on track." He realizes that it will take time to work through his loss, and he feels a bit better knowing he can now come to therapy to process things.

The death of Gary's wife greatly taxed his coping skills, he remains highly emotional months after the event, and there is strain on his relationship with his children and ability to function at work. Gary's grief reaction has also been exacerbated by his memories of losing his mother when he was a child. Discussing the importance of this loss with his therapist helped him better understand his reactions to his wife's death, and he was able to reflect productively on how these losses relate to his current emotional distress and impact on his close relationships.

Gary has a wide and supportive social network of friends and family and is mostly capable of seeking them out and effectively using their help at times to deal with his grief. His recognition of himself as a competent professional, valued friend, and beloved husband, family and community member, reflects a solid sense of identity and capacity for intimacy. Prior to his wife's death, he seemingly had no issues with self-direction, and his concern for his family as a child and focus

on his children's emotional well-being right now suggest an empathic attunement to others. While he is struggling in some areas of his life at the moment, from the perspective of personality functioning, Gary's overall presentation is consistent with 0 = little or no impairment on the LPFS. Engaging in psychotherapy, perhaps time-limited, will likely be helpful to Gary in finding his way back to a flourishing life.

Conclusion

A psychoanalytic understanding of personality functioning, and psychopathology more generally, is oriented by the universal developmental processes underpinning the creation and evolution of psychological representations of self and others. The centrality of these mental models, and associated psychic functions such as mentalization and defenses, determines how well an individual adapts to the social world and the tasks of life: ways of being and relating.

Treatment therefore is a journey of discovery of an individual's stories, of creating shared understanding, and of strengthening capacities, aimed at freeing the self to thrive with others.

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