The Structured Interview of Personality Organization (STIPO):

An Instrument to Assess Severity and Change of Personality Pathology

By

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Introduction

The assessment and diagnosis of personality disorders for clinical intervention and research purposes is at a crossroads. The diagnostic criteria for the personality disorders in DSM-IV TR Axis II are a listing of symptoms in search of a unifying assessment of personality dysfunction. The utilization the diagnosis of these criteria has resulted in an advance in the reliability of personality disorders, but is has become evident that there are numerous difficulties in the personality disorder diagnoses made by the criterion based, atheoretical approach of Axis II. The major problem involves the heterogeneity of the patient groups selected by the categorical system without any rating of severity of dysfunction. While a categorical approach to diagnosis focuses on the presence or absence of the disorder, based on a number of fulfilled criteria or symptoms, a dimensional approach also assesses the severity of symptoms or dimensions of personality pathology. As patients seen in clinical practice tend to present with different levels of severity of pathology, a dimensional approach provides the clinician with a diagnosis more reflective of the clinical picture, which also includes an assessment of strengths and deficits on each of the dimensions. The clinical usefulness of the categorical system has been seriously questioned [1]. The proposed changes in DSM-V define personality disorders as a failure to develop self-identity and capacity for adaptive interpersonal functioning, focuses the assessment on personality disorder prototypes, and provides a severity rating of personality disorder functioning. These proposed

changes are congruent with the object relations view of personality pathology and call attention to the need for reliable diagnostic instruments based on psychodynamic object relations theory. In this chapter, we describe such an instrument, which provides evaluation of core dimensions of personality functioning emphasized by the DSM V Personality Disorders Task Force (www.dsm5.org).

In sharp contrast to the atheoretical approach of DSM Axis II, clinical researchers have enunciated various theoretical approaches to the nature of the personality disorders in order to guide assessment and focus intervention with these patients. Psychodynamic clinicians have utilized object relations theory [2, 3, 4] and its derivative, attachment theory, [5] to understand the serious difficulties that personality disordered patients experience in the representation and understanding of self and others and the related behavioral difficulties in interpersonal behavior.

This chapter describes a semi-structured interview that was shaped by an object relations theory of personality pathology in its conception, item selection and scoring scheme. We present an object relations view of personality organization with its levels of severity of personality pathology, early attempts to construct a clinical interview to assess this pathology, and the development of a semi-structured interview called the Structured Interview for Personality Organization (STIPO) [6] for the clinical and research assessment of personality pathology. We hope to demonstrate by use of clinical examples, the necessity of

assessing the severity of the personality disorder, not just the type or category (e.g., borderline personality disorder) for clinical assessment and treatment planning. The criteria used for this object-relations based clinical interview are degree of identity diffusion, use of primitive versus advanced defenses, amount of aggression as well as degree of impairment of reality testing and integration of moral values. A typical question from the STIPO, focusing on the assessment of identity integration versus identity diffusion, is the following: "Would you say that your sense of who you are, or of what kind of person you are, changes across different situations or time?" In addition to assessing these areas of personality pathology by a host of questions, the focus on severity of pathology in these key functional areas is central to measuring the impact of treatment in clinical research.

Object Relations Orientation to Personality Pathology

Kernberg and colleagues [2, 3, 4] have articulated a model of personality pathology based on contemporary, psychodynamic object relations theory. This approach combines a dimensional view of severity of personality pathology with a categorical or prototypic classification based on descriptive traits consistent with the DSM-IV-TR Axis II. Within the object relations model of personality pathology, determination of the level of personality organization provides an assessment of severity of personality pathology. Level of personality organization carries prognostic implications and can be used to guide differential

psychotherapeutic treatment planning. Kernberg's model of personality pathology is organized around the core concept of identity, and he divides personality disorders into those characterized by consolidated identity and those characterized by pathology of identity formation (often referred to as the syndrome of identity diffusion). Table 1 summarizes how structural criteria relate to levels of personality organization according to Kernberg's model.

Table 1 about here

The neurotic level of personality organization (NPO), along with the normal personality, is characterized by a fully consolidated identity. Consolidated identity is associated with an experience of self and of others that is stable, well differentiated, complex, realistic and coherent. In contrast, the borderline level of personality organization (BPO) is characterized by the syndrome of identity diffusion. Poorly consolidated identity is associated with an experience of self and others that is unstable, superficial, poorly differentiated (black and white), distorted and discontinuous. In the object relations theory model, lower-level, splitting-based defenses (e.g., splitting, idealization/devaluation, projective identification, denial) are responsible for maintaining the fragmented and poorly integrated experience of self and others that colour the subjectivity of the individual with poorly integrated identity. In contrast, consolidated identity in the neurotic personality disorders is associated with the predominance of repression-based and mature defensive operations like intellectualization, reaction formation and sublimation. Individuals organized at

a borderline level of personality organization are distinguished from those with atypical psychotic disorders by virtue of having intact reality testing. However, clinically significant pathology of identity formation is associated with deficits in the ability to accurately infer the motivations and internal states of others, sometimes referred to as the capacity for mentalization (Fonagy et al., 2002) [7], and to accurately read social cues. These deficits are associated with some impairment of social reality testing in individuals organized at a borderline level of personality organization. In contrast, social reality testing is highly developed in individuals organized at a neurotic level, as well as in the normal personality.

The borderline level of personality organization, characterized by identity pathology, the predominance of lower-level, splitting-based defenses and deficits in social reality testing, covers a relatively broad spectrum of psychopathology. At the higher end of the BPO spectrum, patients have some capacity for dependent, albeit troubled, relationships, generally have relatively intact or only minor pathology of moral functioning, and are not overtly aggressive in most settings. In contrast, individuals at the lower end of the BPO spectrum have severe pathology of object relations, clinically significant deficits in moral functioning, and are overtly aggressive. Whereas individuals in the high BPO group have a relatively favourable prognosis in structured treatments, those in the low BPO group are far more challenging to treat and have a more guarded prognosis.

The neurotic level of personality organization is distinguished from the normal personality on the basis of rigidity of personality functioning. Whereas the normal personality is able to flexibly and adaptively manage external stressors and internal conflicts, the neurotic personality tends to rely on rigid and to some degree, maladaptive responses, reflecting the impact of neurotic-level, repression-based defenses on psychological functioning. As in the healthy/normal personality, individuals organized at a neurotic level have the capacity for full, deep and mutual relationships, though individuals in the NPO spectrum may have difficulty combining intimate relations with sexuality. Moral functioning is consistent and fully internalized in the neurotic personality, but may be excessively rigid, leading to a propensity to excessive self-criticism.

Determination of level of personality organization can guide differential treatment planning. Psychodynamic intervention with high level personality functioning (neurotic organization) is constructed differently [8] than intervention with patients at a borderline level of organization [9] (see Table 2). Individuals organized at a neurotic level of personality organization have a very favourable prognosis and can benefit from relatively unstructured treatments. These patients typically do not have difficulty establishing and maintaining a therapeutic alliance, and transference

Table 2 about here

distortions tend to be slowly developing, consistent, and subtle. In contrast, individuals organized at a borderline level, particularly those in the low

borderline spectrum, require a highly structured treatment setting. These individuals have great difficulty establishing and maintaining a therapeutic alliance; transference distortions tend to be rapidly-developing, highly affectively charged and extreme, often leading to disruption of the treatment. In the next section, the development and psychometric properties of the Structured Interview of Personality Organization (STIPO) are described, followed by demonstration of its utility with clinical examples.

STIPO: Development and Psychometric Properties

Brief History of the STIPO

Utilizing an object relations approach to personality pathology, Kernberg [10] conceptualized the structural interview, a clinical interview that was designed to evaluate not only the patients' symptoms and areas of difficulty, but also the level of personality organization. At that time, Kernberg conceived of the structural interview in the context of existing psychodynamic interviews. A number of analytic authors had constructed modified psychiatric interviews that concentrated on the patient-therapist interaction as a major source of information [11, 12, 13, 14]. Deutsch [15] advocated interviewing that would reveal the unconscious connections between current difficulties and the patient's past. MacKinnon and Michels [16, 17] described an evaluation that uses the patient-therapist interaction to reveal character patterns useful for diagnosis. Kernberg's structural interview was a further extension of these procedures in order to focus

on the patient's conflicts in such a way to create tension so that the patient's predominant defensive and structural organization of mental functioning emerges and the structural diagnosis of personality organization can be made. This reference to the structural interview as going beyond fact finding to creating tension in which the patient's organized mental functioning is revealed is reminiscent of the Adult Attachment Interview and its presumed capacity to stimulate the attachment system [18].

The yield of the structural interview depends upon the clinical acumen and skill of the interviewer. The interviewer must make sophisticated decisions about which areas of the patients' functioning to evaluate in detail. The detailed examination of the patient's relations with others provides the interviewer with an opportunity to observe the patient's functioning in a tense situation. There is no scoring system, and the interviewer must make subjective judgments about the patients' degree of personality pathology and level of personality organization. A video demonstration of the structural interview is available (Symfora tapes: Master clinicians at work; www.symfora.nl). With its dependence on interviewer skill, flexibility in interview questions, and absence of an objective scoring system, it is difficult to ascertain interrater reliability. These shortcomings of a sophisticated clinical interview led to the construction of the STIPO.

What the STIPO loses in the subtle interview maneuvers of an experienced clinician, the STIPO gains in the psychometric properties of the

instrument. With its structured questions, and equally structured probes following vague or imprecise patient answers, and a structured scoring system, the STIPO lends itself to investigation of its reliable administration and scoring. The STIPO interview, instructions, and score form are available for download from the internet, both in English and German language [cf. 6].

Description of the STIPO

Content. The STIPO contains 100 items covering seven domains of functioning: 1) identity, 2) quality of object relations, 3) primitive defenses, 4) coping and rigidity, 5) aggression, 6) moral values and 7) reality testing [1]. Three of the domains have ratings on important subdomains (see Table 3). Six of these domains of functioning are central to the Kernberg theory of personality organization. The additional domain, coping and rigidity, was added to help distinguish between normal and neurotic personality organization.

Table 3 about here

The scoring system embedded in the STIPO enables the clinician to create a dimensional rating of health-severity in each of the seven domains. The rating of severity is quite consistent with other researchers that have noted that severity of personality pathology is more important for treatment planning than type of personality disorder style [19]. In addition, the profile of dimensional ratings on the seven domains provides a method of judging the proximity of the individual

[1] The item structure of the STIPO is currently being analyzed. The STIPO version described here and used in the following patient examples consists of 100 items and 7 domains. A shortened version available for download [6] consists of 87 items and 6 domains. After examination of the item structure a final version will be made available online.

patient's profile to theoretically derived prototypes of neurotic, high borderline and low borderline organization.

Format. The format of the STIPO involves standard questions, and additional probes that can be used when the answers are not clear or detailed enough to rate. An example is a question regarding the sense of others: "Do you find that people's responses to you surprise you, for example, do you have the experience of people regularly becoming angry or upset with you without you knowing why?" If this is endorsed, the additional probe "Can you describe the types of problems you experience with your close friends?" is given to clarify the severity of this problem. Then, the standardized format and scoring system allows the interviewer to rate the subject's responses (0, 1 or 2) as the interview proceeds. A score of zero reflects the absence of pathology in the characteristic being assessed by a given question, two reflects the clear presence of pathology in the characteristic being assessed, and a score of one represents an intermediate status in which some pathology in the characteristic being assessed is reflected in the response. These ratings of each question are then followed by summary 5 point ratings of each of the seven domains of functioning mentioned above. The two rating systems complement each other; the item-based rating system stays close to the individual's responses, whereas the 5-point rating system allows the interviewer to input his clinical impression. For both rating systems we have found satisfactory inter-rater reliability [20, 21]. The scores in table 5 and the personality profiles in figure 2 demonstrate the use of these

clinically oriented ratings. Using the clinical 5-point ratings, the interviewer can construct a profile of personality organization of the subject, based on the seven domains. The three primary domains of Identity, Primitive Defenses and Reality Testing are used to make a structural diagnosis as described by Kernberg [10]. Patients can be classified as falling into normal, neurotic or borderline range of organization. Based on the STIPO dimensional ratings, this categorization can be made, distinguishing normal, neurotic 1, neurotic 2, and borderline personality organization, which is differentiated into three levels according to severity: Borderline 1, 2 and 3. Subjects falling into normal and Neurotic 1 group have consolidated identity; show no use of primitive defenses or disturbance in reality testing. Patients falling into Neurotic 2 group have some degree of superficiality in sense of self and/or others and might show some use of primitive defenses. Patients located at borderline level of personality organization are divided according to severity of pathology into BP1, BP2, and BP3. Ranging from BP1 to BP3, there is an increase in levels of identity diffusion, use of primitive defense mechanisms, overt manifestations of aggression, disturbance of object relations, and diminished use of internal standards of morality. Essentially, lower scores indicate lower pathology and higher scores indicate higher pathology.

The format of the STIPO is carefully modeled on the International Personality Disorder Examination (IPDE) constructed by our Cornell colleague,

Dr. Armand Loranger. Dr. Loranger served as a consultant to the construction of the STIPO.

Yield. The yield or product from the STIPO can be compared to that provided by more conventional semi-structured interviews of Axis II pathology such as the Structured Clinical Interview for DSM Axis II Disorders (SCID-II). The yield or product from the SCID II is a diagnosis of one or more of the ten personality disorders as described by DSM-Axis II. In contrast, the yield of a STIPO interview is dimensional ratings of seven domains of personality functioning. Scores on these seven domains provide a profile of the patients' functioning which range from areas of adequate to inadequate functioning. The resulting profile can be used to assist the interviewer to assess the closeness of the patient to prototypic descriptions of patients at a neurotic, high or low level borderline organization [22]. This approach to personality assessment is consistent with object relations theory, and is also consistent with the direction that the DSM-V committee is taking on the reshaping of the DSM system [23].

Psychometric properties

Overview. A preliminary psychometric report in a diverse sample of mixed personality pathology demonstrated that the STIPO can be administered in a reliable fashion and that its component scales evidence a degree of convergent and discriminant validity [20]. Although preliminary reliability data is available for all seven STIPO scales, the focus of this initial study was on the three primary STIPO domains, Identity, Primitive Defenses, and Reality

Testing, insofar as those domains, according to Kernberg's theory, are central to the determination of personality organization. The 142-person sample included a mix of inpatients (n = 30) and outpatients from a various sources (n = 112). Thirty-eight percent of the participants were male and sixty-two percent female, with ages ranging from 20 to 55 years and a mean age of 32 years. The majority of participants had a clinician assigned primary diagnosis, the most common diagnosis being some affective disorder. Additionally, a significant percentage of the sample evidenced clinically meaningful levels of personality pathology as measured by clinician-assigned diagnoses and self-reports of personality disorder traits.

Reliability. The seven STIPO scales demonstrated generally sound internal consistency, with coefficient alpha estimates ranging from .63 (Reality Testing) to .92 (Quality of Object Relations) and a mean alpha of .83. Inter-rater reliability was calculated from a subset of the clinical population sampled in this study, and Intraclass Correlation Coefficients [24] were acceptable for all STIPO domains, with values ranging from .84 to .97 and a mean ICC of .92, demonstrating that the scoring system can be reliability employed by raters a various levels of training.

Validity. Validity findings from this initial psychometric study of the STIPO reveal that the STIPO Identity and Primitive Defenses domains, as expected, are related to constructs closely linked to personality disorders, including personality disorder traits themselves, in line with previous research

findings involving the same model of personality [25]. A hierarchical multiple regression analytic strategy was selected, following the model articulated by Darlington [26], allowing for the simultaneous entry of the three primary STIPO scales as a single block of variables after statistically controlling for demographic variables (age, gender, education, and recruitment). This model was employed in separate analyses for each of several validity measures, including measures of affect, aggression, cognitive disturbance, and personality disorder trait scores. This analytic method was chosen because it would allow us to examine both the overall contribution of the STIPO domains as a group, but also the unique predictive contributions of each individual STIPO domain. Results indeed revealed a differential pattern of prediction, suggesting some measure of discriminant validity among the STIPO scales.

Measures of affect. Applying the aforementioned multiple regression model in separate analyses to measures of negative and positive affect resulted in an increment of variance for the block of the three primary STIPO scales of 36% for negative affect ($p < .001$), and 12% for positive affect ($p < .001$) after controlling for demographic variables and recruitment site. The Identity domain was positively associated with negative affect and inversely related to positive affect, suggesting a moderate link between the STIPO Identity domain and measures of affect.

Measures of aggression. Additional and similarly modelled regression analyses were conducted for a set of measures of aggression, including the

Aggression scale from the Schedule for Nonadaptive and Adaptive Personality (SNAP) [27] , the Buss-Durkee [28] Irritability and Assault scales, and the IPO [29] Aggression domain. The overall regression model resulted in significant increments in variance explained by the STIPO domains over and above the demographic variables entered as a first step, ranging from 21% (SNAP Disinhibition and SNAP Aggression; $p < .001$) to 42% (Buss-Durkee Irritability; $p < .001$), for each of the four measures. For the majority of the aggression measures the STIPO Primitive Defenses domain was found to uniquely contribute significant portions of variance explained.

Measures of cognitive impairment. The relationship between measures of cognitive impairment and the STIPO domains was also assessed. Despite an increment in variance explained in these measures by the block of STIPO domains after controlling for demographic variables, no clear pattern of prediction of variance in cognitive impairment by specific STIPO scales was revealed [20].

Personality disorder traits. The last set of regression analyses sought to determine the extent to which the three primary STIPO domains, hypothesized by Kernberg as being linked to the DSM personality disorders [2, 10] were predictive of actual measures of DSM personality disorder traits as well as the types of interpersonal difficulties characteristic of the personality disorders. In order to aggregate the personality disorder trait data derived from the SNAP have you referenced SNAP earlier? Yes, Cf. Ref. 27! personality disorder scales

[27] into meaningful composites, we computed scores from the personality disorder trait indices that correspond to the Cluster A (odd, eccentric), Cluster B (erratic, impulsive), and Cluster C (anxious, avoidant) personality disorders in the DSM-IV (the composites were simple sums of the traits for each of the personality disorders in clusters A, B, and C). We also conducted regression analyses using as a dependent measure the total score from the IIP-PD, a measure of interpersonal dysfunction that has been shown to be highly predictive of personality disorder diagnoses [30, 31]. The regression model specified above, which involved the simultaneous entry of the three STIPO domains as predictor variables after controlling for demographic variables, was carried out for each of the personality trait clusters and the IIP-PD total score in order to determine the unique contribution of the three STIPO domains to prediction of each of these validity measures. As expected, the STIPO domains yielded a significant increment in variance explained after controlling for demographic variables for each of the three personality disorder cluster indices: 29% for cluster A ($p < .001$); 23% for cluster B ($p < .001$); and 17% for cluster C ($p < .001$). A significant increment of 42% of variance ($p < .001$) was also explained by the STIPO scales in the IIP-PD scores. A varied pattern of unique contribution by the STIPO domains to the prediction of the personality disorder traits was observed, with the STIPO Identity and Reality Testing domains each uniquely predicting variance in cluster A, the Primitive Defenses domain

uniquely contributing to the explanation of variance in cluster B, and the Reality Testing domain uniquely predicting variance in cluster C.

Clinical application of the STIPO: Assessing severity of personality pathology

The STIPO can be used as a clinical tool to assess levels of severity of personality pathology across normal, neurotic and borderline personality organization. In a study using the English version of the STIPO, based on the domain ratings of the STIPO, a prototypical profile of BPO was developed and tested in its ability to discriminate between BPO and non- BPO [22]. The presence of severe identity diffusion, use of primitive defenses as well as disturbed object relations, along with overall maintained reality testing differentiated between patients located at low BPO and non-BPO. Individuals with ratings that were close to a prototypical profile of BPO, consisting of ratings of 3 or higher in the domains "Sense of Self" and "Sense of others", 4 or higher in "Object Relations" and "Primitive Defenses", showed more pathology in variables closely associated with borderline pathology, for example negative affect and aggression. Similarly, an inverse relation between the profiles of individuals with BPO-prototypical ratings and variables of positive affect was found, e.g. serenity. In addition, the use of primitive aggression and the deterioration of moral values were helpful in differentiating between higher level and lower level BPO [20].

In a treatment study examining 104 patients with Borderline Personality Disorder, the STIPO was employed and compared to results from the SCID-I

and SCID-II as well as indicators of clinical severity of the disorder (suicide attempts, self-harming behavior, health service utilization) [32]. Specific patterns were found, demonstrating the ability of the STIPO to assess levels of severity. The patient group with one or more comorbid DSM-personality disorders showed more pathology in the STIPO domains and overall level of personality organization than the patient group with the sole diagnosis of BPD (e.g. Identity: $M = 3.88$ vs. $M = 3.59$, $t = -2.13$, $p < .04$). Similar results were found for individuals with at least one suicide attempt versus no suicide attempts, and also for patients with a history of emergency room visit versus those without emergency room visits. Moreover, correlational analyses showed that several indices of personality pathology, for example the number of BPD-criteria, were meaningfully associated with more pathology in the STIPO domains of Identity, Primitive Defenses, Coping, Aggression and with the overall level of personality organization (cf. table 4). In sum, these results demonstrate the clinical usefulness of the STIPO in that patients with clinically more severe disorders revealed a more impaired level of personality organization [33].

Table 4 about here

Three case examples of patients at different levels of pathological personality organization, from the same study, display the clinical use of the STIPO (see Table 5). Examples from specific STIPO sections were chosen to show

differences between levels of severity within the realm of borderline personality organization.

Table 5 about here

Patient 1

Patient 1 is a 21-year old female office assistant who had been hospitalized after a suicide attempt, and was interviewed with the STIPO as part of the initial assessment for the randomization in a RCT for the treatment of BPD [32]. She met criteria for four personality disorders on the SCID-II: borderline, histrionic, passive-aggressive and paranoid personality disorder. During the interviewing process, she was very impatient and hostile. She reported having had numerous short-term jobs without the possibility of pursuing longer-term job goals, but was very enthusiastic about her hobbies in her spare time.

Examples from the Identity domain. One of the central questions of the STIPO for the assessment of identity diffusion is for the subject to describe herself (question 12). She answered: "Well, I am not very tolerant, ehm, curious. Mhm, stupid. Sometimes. Hmm,… well, I have no idea, I don't know. I know these were only negative things. I also am fast in my perception… am tidy. Sometimes I can be funny…" Probed about a more detailed description of what made her unique, she repeated, "No idea!" Asked if she felt that it was difficult to describe herself, she answered "Yes, I don't know why." Her answer

indicated a very meager and fragmented representation of herself as a whole person, using superficial terms and difficulties in presenting examples and facets about her.

Another example from the Identity section is the question: "Do you enjoy spending time alone – would you say that it makes you feel free and relaxed when you're on your own, or do you tend to become anxious, or confused about who you are?" The patient replied "Yes, when I am alone, I don't have any feelings anymore. I feel nothing. (Interviewer: Every time you are alone?) Yes. I don't sense anything anymore. And being alone starts for me the moment my boyfriend is not at home…as soon as he returns home, feelings return". She adds that being alone leads to severe discomfort and/or anxiety.

When asked about her interactions with and perception of others, the patient described serious difficulties in understanding others and trying to imagine what others might think about her. Each of these questions was scored with a "2", indicating significant to severe and pervasive difficulty estimating how others view her, and preoccupation with a fear of people's opinions of her changing rapidly and unpredictably. Both the Identity subdomains "sense of self" and "sense of others" were scored with a clinical overall rating indicating severe pathology in the realm of identity.

Examples from the Primitive Defenses domain. When asked about the nature of her relationships with others (question 56), the patient answered: "Trust…. I always think I trust someone, then something happens, and I realize

it is not a person I can trust. Then my feelings for the person change completely." Asked if this was the case only with specific people or in all relationships, she confirmed that it happened in most relationships ("my friends change frequently, my family is a single disappointment, and at work I have often seen how many faces my colleagues have"). The item was rated with a 2, indicating an unstable view of relationships and unpredictable shifts in view of others based on idealization / devaluation.

Part of an inquiry on the use of projective identification (question 60), "When you are feeling disrespected or slighted by someone do you tend to withdraw, or is it your tendency to get angry, to provoke people right back?" was answered: "Of course I do, that is the only way I can react, and sometimes I know it is not right. I hurt others in situations like those. I don't know why my friends are still friends with me." Again, a score of 2 was chosen according to the anchor "Vulnerable and sensitive to lack of respect / disregard; perceives lack of respect or disregard frequently and in different circumstances; responds to even slight provocation with hostility and overt verbal or/ physical aggression".

Examples from the Aggression domain. In response to questions probing instances of self-directed aggression, the patient described having tried to commit suicide, having consumed party drugs for several years regularly and practicing unprotected sex. The section "self-directed aggression" was rated as serious disturbance (5). On a question concerning other-directed aggression

(question 80), the patient revealed the following, “A couple of weeks ago, I hit a foreign woman, because she tried to approach my boyfriend…her own fault if she doesn’t respect me….” She reported not being concerned about the person (“I’m not interested how she did afterwards”) and not having felt any remorse.

In sum, this patient presented with severe pathology in nearly all STIPO domains. A high degree of identity diffusion, pervasive use of primitive defenses, disturbed object relations as well as severe self- and other directed primitive aggression, and finally a lack of integrated moral values (antisocial features) indicate that her level of personality organization is in the severely disturbed realm, i.e. Borderline 3. This patient’s STIPO profile, based on the 5-point clinical ratings, is shown in table 5 as the most severely disturbed patient (Borderline 3).

Patient 2

Patient 2 is a 35-year old female sales-person who had been hospitalized due to repeated self-mutilation, temper outbursts toward her husband and daughter, and an eating disorder. She was diagnosed with borderline, histrionic and passive-aggressive personality disorders on the SCID-II. In the STIPO, she reported hardly ever feeling her normal self and urgently wanting to change her life and finding more stability.

Examples from the Identity domain. The patient described a continuous commitment toward work and good relationships with her colleagues but stated that “I am always under pressure to show good work results and get respected by

others". She described herself (question 13) with the following: "I feel different when I am together with a friend or with other people, I have different faces. (Do you play a role in these different situations?) I always play a role. I never show my real face, how I really am. Nobody really knows how I am. (Would friends who know you in one context be surprised to see what you were like in a different context?) Yes, they wouldn't really recognize me." Reported marked shifts in sense of self across situations were rated with a score of 2.

In addition to the request for self description, the description of others is a central question on the STIPO. The patient described her husband as "… a wonderful person; he means the world to me. He does everything for me, nobody else does that. That is why I value him so much. Personal conversations with him are very good. If something goes against what he likes, he gets very aggressive. He has changed over time – he used to react differently to me than in the past. He tells me he is embarrassed of me, for example after a recent dinner party. (What makes him different from other people?) That he gets along very well with children, they all love him. What I am bothered by is that he is very jealous and very egoistic. A lot has changed last year. I think that is it." A rating of 1 was given to reflect her somewhat superficial description of others. A rating of 3 was given for the overall identity section, and this patient's more severe difficulties in self perception were rated with a 4, whereas the problems in object perception with a 3.

Examples from the Object Relations domain. Over the last five years, the patient described having relatively good friendships (score of 3) and good work relations. Throughout these years, she repeatedly had long-term extra-marital affairs, but always returned to her husband.

On a query about trust and disclosure in the relationship with her husband (question 37), she answered as follows: “I can depend on him, but he cannot depend on me. I can trust my husband, but don’t know what he does behind my back. And with me cheating on him, it is not really a trustful relationship.” A score of 2 reflects her significant problems in interdependence and intimacy.

Examples from the Aggression domain. The patient describes neglecting her physical health, cutting her arms and legs regularly, and regular use of cannabis. She also reported having unprotected sex. Two suicide attempts within the last five years that were rather serious were scored with an overall rating of 5 for the section “self-directed aggression”. In terms of other-directed aggression, the patient described regular temper outbursts toward daughter and husband, but no physical attacks or intimidation. To a question about dangerous sexual behavior (question 82), she describes: “With my last partners, I enjoyed cutting them with a scalpel during sex. They did not enjoy it, but they had to accept it. I would prefer doing this with all my partners, but my husband does not want that (yet).” This behavior is scored in the severe range. An overall score of 4 was chosen for the section aggression.

Overall, this patient's personality pathology can be summarized at the level Borderline 2: Moderate identity diffusion, difficulties in interpersonal relationships, in particular within romantic relationships, circling around need-fulfillment with impaired empathy, maladaptive coping, and aggression primarily self-directed and primarily as part of a sexual perversion in the other-directed realm. Her moral values appear poorly integrated and poorly internalized (e.g. lying regularly without remorse) and Reality Testing is impaired only by regular dissociation, but no other perceptual distortions (cf. table 5 for the STIPO patient profile).

Patient 3

Patient 3 is a 26-year old female student, who met criteria for BPD and no other personality disorder on the SCID-II, and was also interviewed with the STIPO. She was seeking psychotherapy primarily due to difficulties maintaining contact with her friends and relationship difficulties.

Examples from the Identity domain. This patient showed good commitment to her studies and to a part-time job in a department store. In her free time, she was able to engage in specific interests and enjoy them. She described a rather coherent perception of self across time and situations. For example, on a question about the capacity to enjoy time alone, she responded, "When I feel good, I enjoy it, but when I am not doing well, I get anxious. Sometimes I need my boyfriend to be with me to feel stronger." A score of 1 was given as she described some discomfort or anxiety associated with being

alone. Her perception of others, also reflecting on others' feelings and thoughts, is not too disturbed. For example on a question about perceiving cues in social situations (question 29), she observed, "usually I realize when I did something that is totally off, but it happens every once in a while. Especially with people I know well." For this item, a score of 1 on the 3-point scale was chosen due to some, but not severe impairment. An overall score of 3 was given for the identity section to reflect moderate identity disturbance.

Examples from the Primitive Defenses domain. Asked about erratic behavior (question. 54) she replied "this happens sometimes, but not frequently. When I have really counted on something I can be very mad and my boyfriend cannot always understand why I react so strongly". On a question concerning the use of defensive idealization and devaluation, the patient described "regarding my boyfriend, sometimes I am so tired of him I wish I didn't have to see him anymore. And at other times, I really think he is the best thing that happened to me. But that doesn't happen too often and really only with him". This answer provides evidence of some tendency to use this form of primitive defensiveness. Overall a score of 3 reflects this patient's mixed pattern of endorsement of primitive defenses; shifts in perception of self and others that are not pronounced, and limited impairment in functioning due to use of primitive defenses.

Examples from the Aggression domain. To a question (question 75) inquiring about risky and dangerous behaviors she answered: "I don't really do

anything that is risky, only sometimes I hit the wall with my fist when I am angry. And when I drink alcohol, I ride my bike. But nothing else." (Score 1: Some, infrequent risk-taking behavior as described). She described having cut herself in the past, but not within the last five years. No other-related aggression, neither overtly nor through intimidation were endorsed by the patient. An overall score of 2 was chosen, corresponding to the anchor describing self-neglect, minor self-destructive behaviors, and controlling interpersonal style.

In summary, this patient is located at level 1 (Borderline 1), the least disturbed level of borderline personality organization. The primary areas of difficulty are in her sense of self and others, and a mixed pattern of defense mechanisms, with some albeit moderate splitting. She describes long-term commitments (boyfriend, friends) which have some degree of conflict, primarily centered on self-disclosure. Aggression is self-directed and she describes only slight impairment in the utilization of moral values (cf. table 5 for the STIPO patient profile).

Degrees of Patient Pathology and Treatment Planning

All three of these patients met criteria for BPD and require a structured treatment addressed at behavioral, Dialectical Behavior Therapy [DBT; 34], and personality change, Mentalization-Based Treatment [MBT; 35] or Transference-Focused Psychotherapy [TFP; 9]. However, while all three patients meet the criteria for the BPD disorder, they vary substantially in the severity of their personality pathology. This difference in extent and severity of personality

pathology is reflected most directly in the severity scores on the domains of the STIPO and indirectly in the co-morbid personality diagnoses on SCID-II.

The use of the STIPO in treatment planning adds value to the multiple personality diagnoses found on the SCID-II from a number of perspectives. Axis II and the instrument structured according to the criteria, SCID-II, are formulated to suggest separate personality disorders, but the extensive co-morbidity of patients suggests otherwise. A number of the Axis II personality disorder categories lack construct validity. The theoretical background of the STIPO is more consistent with a view of personality pathology that envisions a number of key patient functional areas (identity formation, quality of relations with others including intimate romantic and sexual relations, development of an internal sense of morality, control and modulation of aggression) that can vary in degree of disturbance across individuals. The severity of disturbance in these key areas of personality functioning is directly relevant to the focus and process of psychotherapeutic intervention and change.

One could anticipate a number of difficult issues that might arise in the treatment of patient 1. Patient 1 is a patient with borderline personality disorder with a high severity of pathology. The severity of pathology is evident across all domains of functioning. A clear and firmly orchestrated treatment contract is needed, so that both therapist and patient have guidelines to follow if and when the patient becomes suicidal and/or self-destructive. Her level of self and other directed aggression suggests that a treatment choice could be made between TFP

and DBT. She might enter a therapeutic relationship with suspicion and mistrust of the therapist, and find it difficult to imagine that another person might desire to help her without reciprocal demands. Her mistrust in the therapist and therapy could manifest in denigration of both, and hostile and irritable episodes.

In contrast to patient 1, patient 2 has some strength in interpersonal relations, with long-standing friends and an enduring, but conflicted, relationship with her husband. She is a patient with borderline personality disorder with a moderate range of severity. She has serious deficits in self-directed aggression, poor coping with stress, and inadequate relations with others. Her sense of self, captured in the Identity domain, is better than patient 1, as is her sense of moral values.

Patient 3 is the least severe of the three patients with borderline personality disorder. Compared to the other two patients, she has relatively good object relations, aggression is not an issue, and she has a sense of moral values. One could consider a treatment choice between the more structured TFP and the less structured dynamic treatment for high level personality organization [8]. With this patient, a depressive transference could be expected, manifested by a clinging and dependent behavior toward the therapist.

For all three patients, a structured dynamic treatment, such as TFP or MBT, could be chosen that focuses on the patients' internal representations of self and others. The focus of these treatments is based on the hypothesis that disturbed internal representations direct interpersonal behavior that is

dysfunctional. The STIPO domains of identity and object relations directly assess representations of self and other. In addition, the STIPO domains of moral values and aggression further explicate how the individual modifies his/her behavior toward others with varying degrees of aggression and use of a moral code.

These three cases exemplify the range of borderline pathology that can be described differentially by the STIPO. Combining the STIPO with other diagnostic instruments e.g. the SCID-II or IPDE, provides a multidimensional diagnosis that describes both severity of pathology and makes it possible to use information on personality style and traits for treatment planning. From the perspective of the DSM, the number of comorbid diagnoses can be seen as an index of axis II pathology. In the three described cases, all patients meet diagnostic criteria for the diagnosis of BPD. The number of additional personality disorder diagnoses corresponds roughly to the level of severity in the STIPO. Thus, the STIPO can help distinguish between levels of severity and help develop foci for treatment. Clearly, the first patient, who also presented four comorbid SCID-II axis II disorders, also was located at the most severely disturbed level of personality organization in the STIPO. Regarding therapy, this patient is expected to present with difficulties around aggression within and outside of therapy and is likely to benefit from a treatment with a clearly formulated frame and structure. For patient 2, with two axis II disorders, the difficulties lie less in other-directed and more in self-directed aggression, and in

unstable relationships. Patient 3, who only met criteria for one SCID-II personality disorder (BPD), is located at higher level BPO based on the STIPO. Here the treatment foci could be primarily her romantic relationship and sense of self and others. Overall, in comparison to patients 1 and 2, she is expected to show greater self-reflection and readiness to commit to relationships as well as to therapy (cf. overall score of 2 in object relations). In sum, the STIPO profiles and levels of borderline pathology correspond to severity of pathology according to SCID-II and assist the therapist in making conclusions regarding treatment choices and prognosis.

Clinical application of the STIPO: Using the STIPO as a measure of change

The usefulness of the STIPO as a measure to assess changes in personality organization is currently being examined. In an RCT comparing the efficacy of Transference-Focused Psychotherapy (TFP) to treatment by experienced community psychotherapists in a sample of 104 BPD patients, the STIPO was used as an outcome instrument [32]. The time frame in the STIPO usually refers to the prior five years. However, in order to assess changes within one year of treatment, we chose the last month as the time frame for the second STIPO interview. Using this measure, significant changes after one year of psychotherapy were found at the level of personality organization. In this analysis, the overall level of personality served as the outcome variable, using the STIPO levels of personality organization on a 6-point categorical scale,

ranging from normal (1) to Neurotic 1 (2), Neurotic 2 (3), Borderline 1 (4), Borderline 2 (5) to Borderline 3 (6). In both treatment groups, the mean for the level of personality organization pathology decreased after one year of therapy (Figure 1). This was the case both for patients in TFP (pre: M=5.00, SD=0.56; post: M=4.46, SD=0.67; d=1.0, p<.001) and for patients in the community psychotherapist group (pre: M=4.77, SD=0.58; post: M=4.62, SD=0.53; d=0.3, p=.004), with a significant superiority for the TFP group (F=12.136; df=1, 101; p=.001) [32]. A more detailed analysis of changes in the individual STIPO domains is currently ongoing.

Figure 1 about here

To illustrate the use of the STIPO for assessing change in personality, the changes by one of the patients from this study will be described. Patient 1, whose STIPO profile was discussed in the previous section, was re-assessed after one year of TFP. On the SCID-II, she no longer met criteria for BPD (3 of 9) nor for histrionic, passive-aggressive or paranoid personality disorder. This change in personality disorder criteria corresponds to the changes manifested in the clinical interview situation as well as on the STIPO. Asked if she was still in treatment, she replied “Yes, and I will not let go of my therapist!” indicating some positive attachment toward her therapist, but also a continuing felt need for therapy. She experienced the therapist as being strict with her, but also understanding and patient with her. Apparently, following a clear treatment frame as established by her TFP-therapist helped with her impulsivity and

acting-in. This patient's life situation had changed substantially. She had married her partner and had become pregnant. She spoke with increased positive affect about the people in her life, and, although she remained hostile toward some (e.g. coworkers), she seemed softer when mentioning her husband.

Examples from the Identity domain.

The patient described some increased awareness about herself and her internal processes. Asked about her sense of self across time (question 13), she replied: "I think I am more grown up now. I am more myself. Five years ago I was more like a child, two years ago I was a mess, but within the last months I have become more myself. (Does the passage of time or the series of events in your life feel like a steady flow, or would you say that it feels choppy or broken up?) It feels more like a set of stairs, steadily getting better and clearer." Asked about the experience of being alone (question 16), she said "I really enjoy it. Nobody is there to bother me. That is different now; I can sit on the couch and am very relaxed. Most of the time it is great…." This item was scored with a 1, indicating some discomfort or anxiety associated with being alone and minor avoidance of being alone. She described her partner as follows: "He is a very funny guy, but also he can be extremely boring. That is not because he is stupid or slow – he simply is very balanced: Just the opposite of me. But sometimes he can be hilarious. What is very special about him is his patience. He was courting me for months, even while I had another boyfriend. In retrospect I realized that it must have hurt him that I had another partner and was not interested in him,

but at that time I did not realize that. But he simply stayed persistent because he wanted me. I am very proud of him and happy to have him as my husband." This slightly superficial and self-referential description was scored a 1, as it is considered not that elaborated, but some descriptors could be given. The subdomain concerning sense of self was scored a 3, the subdomain concerning sense of others a 4, reflecting a rather superficial perception of others while her sense of self across time and situations was considered moderately discontinuous.

Examples from the Primitive Defenses domain.

Asked about "Primitive Projection" (Item 53), Do you tend to keep information about yourself from others? Would you consider yourself someone who is cautious about what other people know about you; would you call yourself "guarded"?" She replied, "My husband is the only person in front of whom I don't have secrets. With the other people I don't know, there is so much that is none of their business." A score of 1 was chosen, reflecting some discomfort with disclosure and openness in relationships in which it is typical to be unconcerned and unguarded. She describes behaving quite erratically (score of 2 in item 54), but with no persistent use of idealization and devaluation. "Only with shoes, my opinion changes drastically, not with other things. With people? I usually trust my husband, but if I had the sense he was not honest, that would be the end. There would be no love left! (…) Some people I used to hate in the past, I don't think they are that bad anymore…" Scores of 1 were chosen for

items 55 and 56, showing some tendency to idealization and devaluation. The section Primitive Defenses was rated with an overall 3, showing a mixed pattern of endorsement of primitive defensive operations.

Examples from the Aggression domain.

The patient reported no self-directed aggression within the last months, including an absence of suicide attempts, drug use or self-mutilation. She did neglect her physical health by not going for regular check-ups and exhibited some risky behavior such as excessive use of alcohol (before the pregnancy). This was scored 1 (Question 74 Self Neglect, 75 Risky Behavior), and she was given an overall score of 2 on the 5-point scale. Asked about temper outbursts (Question 79) she replied: "I often yell at others, actually every time I see my mother-in-law… How I feel afterwards? Good!" A score of 1 was given ("Some problems with temper, e.g., occasional outbursts of yelling and screaming; may be limited to certain relationships "). Her answer to question 84, "Do you like it if other people are afraid of you? Her response to "Do you ever do things that make others afraid of you so that you will then be able to control them?" was "I like it when others are afraid of me, although I do nothing. My husband says he never wants to be close to me when I really get mad! But it is not on purpose if others are afraid of me…" An overall score of 3 on the 5-point scale, corresponding with the anchor "Loss of control with verbal aggression; some pleasure in controlling and intimidating others" was chosen for other-directed aggression and an overall score of 3 was chosen to reflect that aggressive

behaviors may be predominantly self-directed and include hostile verbal aggression.

After one year of psychotherapy, the STIPO demonstrated that the patient had changed substantially in several personality domains. The stark identity diffusion that had been prominent at baseline had changed insofar as her sense of herself had become more stable, she was able to reflect on changes she had gone through and become more aware that she was provoking interpersonal conflicts. She still used primitive defenses like idealization/devaluation, but in combination with more adaptive defenses. She described a rather constant attachment to her partner and realized that this had changed. She now missed him and would prefer him to be with her more often but was able to tolerate his absence more than in the past. Overall, decrease of identity diffusion, more constant attachments and interpersonal relationships, a more mixed pattern of defenses and less aggression against self and others (also shown in a less controlling interpersonal style) as well as an increased capacity for guilt reflect a change of personality organization. The overall level of personality organization has moved from borderline 3 to borderline 2. Figure 2 shows the personality profile at baseline (Pre-Treatment Assessment) and after one year of therapy (Post-Treatment Assessment).

Figure 2 about here

A retrospective account of patient 1's treatment by the male therapist provides some perspective on the process. The therapist describes a protracted

period in which the patient attacked the treatment and the therapist with somewhat dramatic affective storms. The therapist remained in therapeutic neutrality, and from that therapeutic position pursued the contradiction between her faithful appearance for sessions and her attack on the treatment. Only after a long time did the patent begin to trust the therapist's consistent intent to help her face her difficulties.

Discussion

Atheoretical Assessment Compared to Theoretical Assessment

The DSM description of a personality disorder is based on lists of symptoms, traits and problematic behaviors. This list adheres closely to reportable and observable behaviors with the intent of ensuring reliability of assessment. This symptom oriented description/assessment of personality disorders is not guided by a theory of personality or an articulated theory of the personality disorders.

The advantage of a theory driven assessment is that the theory provides a guide for efficient use of assessment time. A theory guided assessment also ensures that in the limited time, one assesses essential areas of personality and personality disorder functioning. For example, current theories of personality indicate that the major areas to consider are cognitive-affective units [36, 37], behavior and the person's unique pattern of relating to and seeking out certain environments. A theory guided assessment of essential areas of personality functioning can subsequently and logically lead to focused interventions on the

areas of dysfunction. For example, if in the initial diagnosis a high level of identity diffusion is found, indicated by a severe deficit in sense of self and others, this could provide a focus of treatment.

STIPO Compared to Similar Instruments

A number of outcome measures relevant to psychodynamic research have been developed and validated (cf. Siefert and DeFife, this volume). You can also cite the Gerber/Fonagy/Jones volume about 10 years ago. Sorry, don't know the reference – do you mean the IPA Open Door Review? Possibly the most similar clinical interview and scoring system to the STIPO is the Clinical Diagnostic Interview (CDI) [38, 39] which focuses on reasons for treatment, symptoms, and interpersonal interaction patterns. It is a systematic diagnostic interview that can be administered in two and a half hours. The interview yields the clinical information necessary to utilize the SWAP-200 reliably. The SWAP-200 (Shedler, Westen, 2007) [40] is an assessment instrument that consists of 200 statements which may describe a patient very well, somewhat, or not at all. The statements reflect content capturing personality traits in non-clinical populations, and interpersonal pathology consistent with personality disorders; coping, defense, and affect-regulatory mechanisms, as well as symptoms such as anxiety and depression. Utilizing the information from the CDI, the clinician describes the patient with the 200 SWAP items based on a Q-sort method which requires the clinician to distribute the 200 items into a fixed distribution, i.e., a

set number that are least and most descriptive of the individual [40]. The SWAP distribution provides the clinician with dimensional scores for each of the personality disorders described in DSM. In addition, a narrative case description is generated that can be used for case conceptualization and treatment planning.

The Adult Attachment Interview (AAI) is a structured interview with a complicated scoring system organized to assess attachment style [18]. In contrast to the STIPO, the AAI is not designed to provide a treatment guide for therapeutic intervention with the personality disorders, as the AAI has a narrower focus. Apart from the scores that the AAI provides from the burdensome and complicated scoring system, the interview offers rich clinical material from the subject; especially about the subject's representations of interactions with intimate others. A major portion of the AAI asks the subject for adjectives to describe his/her relations with mother and father. Examples of interactions exemplifying the adjectival description are then requested. These answers are, in fact, mental representations of self and others that could become foci of treatment intervention.

The Operationalized Psychodynamic Diagnostics [OPD-2;[41], devised by a group of psychodynamic clinicians in Germany, is an instrument consisting of four psychodynamic axes as well as the ICD-10 as a fifth axis: 1) experience of illness and prerequisites for treatment, 2) interpersonal relations, 3) conflicts, 4) psychic structure and 5) psychic and psychosomatic disorders (ICD-10 diagnoses). The axis that most closely relates to the STIPO is the fourth axis

which comprises dimensions of self and other representation, attachment, affect differentiation or impulse regulation. It was developed to be used for all levels of personality pathology, whereas the STIPO focuses specifically on the nuances and levels of personality organization. Two ongoing studies are examining the interface between OPD-2 and STIPO in a clinical and a non-clinical population (Hörz, Rentrop, Doering).

Use of the STIPO for Treatment Planning and Change

The diagnosis of personality disorders by categories or types without taking into consideration the dimension of severity of dysfunction is a serious limitation of DSM-IV and leaves a blind area for treatment planning. One unfortunate result of this deficiency in DSM diagnosis is that existing psychotherapy treatment trials do not take into account the severity of the personality dysfunction in data analysis. We have designed the STIPO using a psychodynamic object relations model to assess seven key domains of personality functioning: Identity, Object Relations, Primitive and Advanced Defenses, Aggression, Moral Values and Reality Testing. The resulting profile of scores in seven areas of functioning can be used to match prototypic models of neurotic personality functioning, as well as various levels of borderline personality organization and functioning.

The development of the STIPO was based on a sophisticated clinical interview. The semi-structured nature of the STIPO has resulted in reliable use of the instrument, as we have described in this chapter. The interview also has

construct validity, as manifested in its correlation with related constructs [20, 33]. Our use of the STIPO in a randomized clinical trial of Transference Focused Psychotherapy (TFP) compared to treatment provided by community expert therapists has demonstrated that the STIPO can be used effectively to measure patient change in treatment [32]. In this study, the overall level of personality organization improved significantly after one year of treatment. The patient example described above shows how the individual STIPO domains captured clinical change as well, for example improvement in object relations, less self-directed aggression and also use of less primitive defense operations after one year of treatment.

Patients assessed by the STIPO who share the diagnosis of borderline personality disorder are clearly quite different in severity of dysfunction. The domains of functioning assessed in the STIPO are central to an understanding of the patients' internal representations of self and others, and provide information on the quality of interpersonal relations in reference to friendships, family relations, and intimate romantic and sexual relations. These dimensions of personality functioning correspond with the general diagnostic criteria for personality disorders proposed by the DSM-V Workgroup (www.dsm5.org), i.e. impaired sense of self-identity and difficulties in interpersonal functioning with several specific features, and examination of the STIPO domains will predict whether or not a person meets these criteria for a DSM-V personality disorder. Overall, the STIPO can be seen as an important step forward for diagnosis and

focused treatment planning, providing structured assessment of personality pathology guided by modern object-relations theory and congruent with recent developments in the diagnostic classification of personality disorders. The STIPO provides the clinician with a detailed picture of the patient's strengths and deficits in several core domains of personality functioning, and can be used to guide differential treatment planning and to identify specific foci for clinical intervention.

Table 1. Structural Criteria and Level of Personality Organization

Structural Criteria	Normal Personality Organization	Neurotic Personality Organization	Borderline Personality Organization
Identity Integration	Consolidated Identity	Consolidated Identity	Identity Diffusion
Object Relations	Lasting and deep Relations with others	Deep Relations; Focused conflicts with selected others	Varies across levels of BPO: Troubled Interpersonal Relations
Defensive Operations	Advanced Defenses; Flexibility	Advanced Defenses, Rigidity	Primitive Defenses
Aggression	Anger Modulated	Inhibited Aggression	Varies across levels of BPO: Self/Other Directed Aggression
Moral Values	Stable, independent, individualized	Guilt; Inflexibility	Varies across levels of BPO: Contradictory values; absences of certain values
Reality Testing	Intact Reality Testing	Intact Reality Testing	Intact Reality Testing, some impairment of social reality testing

Table 2. Treatment Differences Related to Level of Personality Organization

Neurotic Personality Organization	Borderline Personality Organization
Use of treatment frame	Treatment frame includes a carefully articulated treatment contract
Therapist operates from a stance of therapeutic neutrality	Therapist deviations from therapeutic neutrality are used in certain crises
Therapeutic techniques of clarification, confrontation, interpretation	More extensive use of clarification to set the stage for interpretation
Focus on present, related to past	Focus on the present

Table 3. STIPO Domains and Subdomains

Domain	Subdomain	Example item
Identity 30 items	Capacity to invest in work/studies and recreation	How stable have your work goals and ambitions been – do they frequently change?
	Sense of self	How would you describe yourself to me so that I get a live and full of picture of the kind of person you are?
	Sense of others	Are you able to understand well what people are feeling or thinking based on their behavior, or on the way they act?
Object Relations 22 items	Interpersonal relations	Tell me about your friendship; what do you share with one another that makes it a friendship?
	Intimate relationships and sexuality	Did the relationship involve trust and disclosure, or would you say that are cautious and guarded with your partner?
	Internal working model of relationships	Do you have the experience of feeling surprised or disappointed when people don't seem to recognize your value or status?
Primitive Defenses 11 items		About people whom you know well, would you say that your feelings change quickly or frequently?
Coping/Rigidity 10 items		When it comes to stressful or troubling situations that you are powerless to change, are you able to put it out of your mind until later, or does it nag at you?
Aggression 12 items	Self-directed aggression	Do you at times do things that seem unwise and potentially dangerous to yourself, such as having unprotected sex, heavy drinking or drug use?
	Other-directed aggression	Do you lose your temper with others?
Moral Values 8 items		When faced with a situation that clearly goes against what you know to be right, do find yourself having a struggle over what to do?

Reality Testing 7 items		Do you sometimes have distrustful or suspicious thoughts or feelings, for example, that your partner or friend is lying to you, or cheating on you?