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MANUAL FOR THE
STRUCTURED INTERVIEW of PERSONALITY ORGANIZATION-REVISED
(STIPO-R)

By

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History and Background of the STIPO and STIPO-R

The Structured Interview of Personality Organization (STIPO) (Clarkin, Caligor, Stern, & Kernberg, 2004), and its revision, the Structured Interview of Personality Organization-Revised (STIPO-R) (Clarkin, Caligor, Stern, & Kernberg, 2015) is a semi-structured interview organized to evaluate domains of personality functioning that are central to understanding the individual from an object relations model of personality and personality pathology (Kernberg, 1984; Kernberg & Caligor, 2005). The STIPO and the STIPO-R were constructed to provide the clinician and researcher with dimensional scores on key domains of personality functioning. The content areas and the severity of dysfunction in each domain can be used by the clinician for treatment planning, and by the researcher for selection of subjects and for measurement of change in relation to treatment interventions.

Object Relations Orientation to Personality Pathology

Kernberg and colleagues at the Personality Disorders Institute have articulated a model of personality pathology based in contemporary, psychodynamic object relations theory (Kernberg & Caligor, 2005; Caligor & Clarkin, 2010; Caligor, Kernberg, Clarkin, & Yeomans, in press). This approach combines a dimensional view of severity of personality pathology with a categorical or prototypic classification based on descriptive phenomenology consistent with many of the personality syndromes of DSM-5 (APA, 2013). Thus, the STIPO and STIPO-R provide both severity scores on domains of functioning, and profiles of scores in the domains indicating closeness/distance to prototypic descriptions of neurotic, high level borderline and low level borderline

personality organization. Level of personality organization has important prognostic implications and can be used to guide differential psychotherapeutic treatment planning (Caligor, Kernberg, Clarkin, & Yeomans, in press).

Kernberg's object relations model of personality pathology is organized around the core concept of "identity." The universe of personality disorders is divided into those characterized by consolidated identity and those characterized by pathology of identity formation (sometimes referred to as the syndrome of "identity diffusion"). The less severe (neurotic) level of personality organization (NPO), along with the normal personality, is characterized by a consolidated identity associated with an experience of self and of others that is stable, well differentiated, complex, realistic and coherent. 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 repression-based defences on psychological functioning. As in the 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.

Identity diffusion is a major characteristic of the borderline level of personality organization (BPO). Poorly consolidated identity is associated with an experience of self and others that is unstable, superficial, poorly differentiated, polarized ("black and

white”), distorted and discontinuous. In the object relations model, splitting-based defences (e.g., splitting, idealization/devaluation, projective identification, denial) are responsible for maintaining a 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. 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 social reality testing, the ability to accurately infer the motivations and internal states of others and to accurately read social cues. These deficits are associated with some impairment in accurate perception of others 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 splitting-based defences and deficits in social reality testing, covers a relatively broad spectrum of personality pathology. 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

psychodynamic treatments, those in the low BPO group are far more challenging to treat and have a more guarded prognosis, even in exploratory psychodynamic treatments with established parameters designed to ensure that the patient's difficulties are expressed in the treatment situation and to limit self-destructive and treatment-interfering behaviours outside the consulting room.

Determination of level of personality organization is essential to guiding differential treatment planning. Psychodynamic intervention with high level personality functioning (neurotic organization) is constructed differently (Caligor, Kernberg, & Clarkin, 2007; Caligor, Kernberg, Clarkin, & Yeomans, in press) than intervention with patients at a borderline level of organization (Yeomans, Clarkin, & Kernberg, 2015) (see Table 1). Individuals organized at a neurotic level of personality organization have a very favourable prognosis and can benefit from relatively unstructured psychodynamic treatments. These patients typically do not have difficulty establishing and maintaining a therapeutic alliance, and transference distortions tend to be slowly developing, consistent, and

Table 1 about here

subtle. In contrast, individuals organized at a borderline level, particularly those in the low borderline spectrum, require a highly structured treatment setting as described above. These individuals have great difficulty establishing and maintaining a therapeutic alliance; transference distortions develop rapidly, and are highly affectively charged and extreme, often leading to disruption of the treatment.

The origins of the STIPO: "The Structural Interview"

Utilizing an object relations approach to personality pathology, Kernberg (1984) described the structural interview, a clinical interview 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 (Whitehorn, 1944; Powdermaker, 1948; Fromm-Reichmann, 1950; Sullivan, 1954). Deutsch (1949) advocated interviewing that would reveal the unconscious connections between current difficulties and the patient's past. MacKinnon and Michels (1971; MacKinnon, Michels, & Buckley, 2006) 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. The interview focuses on the patient's conflicts thereby creating tension such that the patient's predominant defensive and structural organization of mental functioning emerges and the structural diagnosis of personality organization can be made.

The sequence of the structural interview was organized to proceed through three phases. The initial phase invites the patient to discuss major difficulties, symptoms, and reasons for seeking treatment. The middle phase focuses on potential pathological personality traits, and difficulties in interpersonal relations and perceived interpersonal needs. In the termination phase, the interviewer provides an opportunity for the patient to ask questions, and for the interviewer to evaluate the patient's motivation for continuation of the diagnostic process and treatment.

The yield of the structural interview was an assessment of both symptoms and the level of personality organization, characterized by levels of organization from identity consolidation with difficulties in object relations, to high level borderline personality organization with identity diffusion, to low level personality organization with identity diffusion combined with aggression, severe pathology of object relations, and deficits in moral functioning. 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 patient's degree of personality pathology and level of personality organization. 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.

Need for a Semi-Structured Interview

The structural interview is a carefully constructed guide to assist a tactful and talented clinician in an assessment of difficulties, symptoms, and personality organization of a potential patient seeking intervention. The flexibility of the structural interview is an asset in the hands of a talented clinician, but this very asset can lead to unreliability in the conclusions drawn from the interview. The generation of the semi-structured interview (STIPO and STIPO-R) was designed to provide standard questions, follow-up probes, and scoring guidelines to ensure reliability to the assessment. What

the STIPO loses in the subtle interview maneuvers of an experienced clinician, the STIPO gains in instrument psychometric properties. 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 standardization of procedure and scoring in the STIPO-R enhances its usefulness in the teaching of personality assessment, and it provides a vocabulary that clinicians can use to clearly communicate complicated clinical constructs to each other.

STIPO Compared to Similar Instruments

Possibly the nearest clinical interview and scoring system to the STIPO is the Clinical Diagnostic Interview (CDI) (Westen & Muderrisoglu, 2003) that focuses on reasons for treatment, symptoms, and interpersonal interaction patterns. It is a systematic diagnostic interview that can be administered in 2 and half hours. The interview yields the clinical information necessary to utilize the SWAP-200 reliably. The SWAP-200 is an assessment instrument that consists of 200 statements that 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 disorder (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 (Shedler, 2015). 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 (Hesse, 2008). 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. The AAI provides scores of coherence from the burdensome and complicated scoring system, and 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 OPD-2 (OPD Task Force 2008), devised by a group of psychoanalytic 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. OPD-2 was developed to assess all levels of personality pathology, whereas the STIPO focuses specifically on the nuances and levels of personality organization. As hypothesized, the STIPO level of

personality organization was significantly related with the OPD axis 4 total score ($r=.68$; $p<.001$) (Doering, Burgmer, Heuft, et al., 2013).

Transition from STIPO to STIPO-R

The STIPO-R is a revision of the original STIPO, undertaken to both shorten the longer STIPO to enhance its research and clinical usage, and to modify items that had less than desirable psychometric properties. In addition, our clinical experience motivated us to amplify the items in the original STIPO concerning narcissistic pathology into a full Narcissism scale.

Scope of the STIPO-R

Content

The STIPO-R contains 55 items covering five domains of functioning: 1) identity, 2) object relations, 3) defenses, 4) aggression, and 5) moral values. Three of the domains have ratings on important subdomains (see Table 2). From items embedded in the other domains, the STIPO-R also has scoring for a narcissism dimension.

Table 2 about here

The scoring system embedded in the STIPO-R enables the clinician/researcher to create a dimensional rating of health-severity in each of the six domains. The rating of severity is as important for treatment planning as the type of personality disorder style (Verheul, Andrea, Berghout, et al, 2008). In addition, the profile of dimensional ratings on the six domains provides a method of judging the proximity of the individual patient's profile to theoretically derived prototypes of neurotic, high borderline and low borderline organization (Horz, Stern, Caligor, et al, 2009).

Format

The format of the STIPO-R 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. STIPO-R utilizes standard questions, and additional probes that can be used when the answers are not clear or detailed enough to rate.

Scoring System

The standardized format and scoring system allows the interviewer to rate the subject's responses (0, 1 or 2) as the interview proceeds. 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 utilize his clinical impression, allotting greater or lesser weight to items in the scale or subscale based on his clinical impression of pervasiveness or severity, and/or adjusting the rating based on factors (non-verbal, interpersonal) that he feels are clinically significant and relevant to the domain being assessed. For both rating systems we have found satisfactory inter-rater reliability (Stern et al., 2010; Hörz et al., 2009). The scores in table 3 and the personality profiles in figure 1 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 six domains of interest, used to make a structural diagnosis as described by Kernberg (1984). Patients can be classified as falling into normal, neurotic or borderline range of organization. Based on the STIPO-R

dimensional ratings, this categorization can be made, differentiating 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 identity diffusion, the use of primitive defense mechanisms, overt manifestations of aggression, disturbance of object relations increase, and diminished use of internal standards of morality. Essentially, lower scores indicate lower pathology and higher scores indicate higher pathology.

Appropriate Subjects

All patients applying for treatment can be assessed with the STIPO-R that provides an overall picture of the level of personality organization that influences any treatment, including those focused almost entirely on symptom constellations such as anxiety and depression. However, the STIPO-R is most relevant in any clinical situation in which the patient is suspected of having personality pathology that will influence symptom treatment, or those whose treatment must focus primarily on personality disorder of various levels of severity.

Examiner Qualifications and Training

Potential STIPO-R interviewers must have prior training in psychodynamic concepts central to the instrument, and clinical experience with patients demonstrating

various levels of severity of personality pathology. The interviewer must be trained to use the probes to obtain ratable material from the patient. Training to reliability of scoring involves viewing of videotaped STIPO-R interviews, and accomplishment of ratings in agreement with standards.

Reliability and Validity of the STIPO

The data presented here are related to the STIPO. The psychometric properties of the STIPO-R are currently under evaluation. Preliminary unpublished data show acceptable reliability and good convergence with external measures of personality functioning.

Reliability

English, German, and Italian versions of the STIPO have demonstrated good inter-rater reliability. Intraclass correlation coefficients (ICC) ranged from .84-.97 in the English version (Stern et al, 2010), from .89-1.0 in the German version (Doering et al, 2013), and from .82-.97 in the Italian version (Preti et al, 2012).

Validity

The STIPO domains manifest internal consistency across studies. Cronbach's alpha for STIPO domains of Identity (.86) and Primitive Defenses (.85) were high, whereas the shorter Reality Testing domain (.69) was on the boarder of acceptability (Stern, Caligor, Clarkin, et al, 2010). In a study using the German language version of the STIPO (Doering et al, 2013), Cronbach's alpha ranged from .93 for Identity to .69 for Reality Testing, with .97 for the total score.

STIPO domains of Identity and Primitive Defenses were closely related to personality disorder symptom counts as assessed by the Schedule of Nonadaptive and Adaptive

Personality (SNAP; Clark, 1993), to measures of aggression, and to levels of positive and negative affect. In another study (Doering, Burgmer, Heuft, et al, 2013), significant correlations were found between the STIPO Primitive Defenses and the primitive defenses scale of the self-report Borderline Personality Inventory (Leichsenring, 1997).

Preti et al, (2012) found associations between the STIPO identity scale with measures of stability of self-image and the capacity of pursuing goals. The STIPO Defenses domain was associated with an external measure of primitive defenses, and another measure of lack of self-control and emotional instability (SIPP-118; Verheul et al, 2008). All of the STIPO domains discriminated between clinical and nonclinical subjects.

The STIPO manifests good construct validity in reference to DSM personality diagnoses. Patients with DSM personality disorder were found to be on a lower level of personality organization in all domains compared to patients without personality disorder (Baumer, 2010; Doering, et al, 2013). In a study of patients with chronic pain, there was a significant correlation between personality organization on the STIPO and the number of SCID-II diagnoses (Fischer-Kern, et al, 2011). Likewise, a very close but not complete association was found between STIPO structural diagnoses and DSM personality pathology in a sample of patients with opiate addiction (Rentrop Zilker, Lederle, Birkhofer, & Horz, 2014). Whereas there is a significant association between STIPO structural characteristics and DSM diagnoses, STIPO domains were able to identify treatment dropout among dual-diagnosis patients more effectively than personality disorder diagnoses (Preti, Rottoli, Dainese et al, 2015).

Clinical application of the STIPO: Measuring severity of personality pathology

The STIPO can be used as clinical tool to assess levels of severity of personality pathology across normal, neurotic, and high and low level 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 (Hörz, 2007). 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, evidence of poorly integrated aggression and the deterioration of moral values were helpful in differentiating between higher level and lower level BPO (Stern et al., 2010).

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-injurious behavior, service utilization) (Doering et al, 2010). 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, was meaningfully associated with more pathology in the STIPO domains of Identity, Primitive Defenses, Coping, Aggression and with the overall level of personality organization ($r = .29$, $p < .01$). In sum, these results demonstrate the clinical usefulness of the STIPO in that patients with clinically more severe disorder revealed a more impaired level of personality organization (Hörz et al., 2017).

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 was 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 (Doering et al, 2010). 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 in this study. 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 Borderline 3 (6). In both treatment groups, the mean for the level of personality organization pathology decreased after one year of therapy. 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 ($F=12.136$; $df=1, 101$; $p=.001$) (Doering et al., 2010). A more detailed analysis of changes in the individual STIPO domains is currently ongoing.

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 lack in DSM-5 and leaves a blind area for treatment planning. One unfortunate result of this deficiency in DSM diagnosis is the existing psychotherapy treatment trials that 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 six key domains of personality functioning. The resulting profile of scores in six areas of functioning can be used to match prototypic models of neurotic personality functioning, and various levels of borderline personality organization and functioning.

DSM 5, PDM2, and the STIPO-R

The DSM-5 description of 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.

In contrast, the STIPO and STIPO-R are theory driven in their conceptualization and dimensional profiles. 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, 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.

The yield or product from the STIPO-R can be compared to that provided by semi-structured interviews of Axis II pathology such as the 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. There is little theoretical basis behind the personality disorders in DSM-5, and the categories as described do not hold up to empirical investigation.

In contrast, the yield of a STIPO-R interview is dimensional ratings of six domains of personality functioning. Scores on these six domains provide a profile of the patients' functioning that 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 (Hörz, 2007). This approach to personality assessment is consistent with

object relations theory, and is also consistent with the direction that the DSM-5 is taking with the Section III approach to the assessment and diagnosis of personality pathology.

The Psychodynamic Diagnostic Manual-2 (Lingiardi & McWilliams, 2017) is an effort to bring diagnosis and related treatment planning closer to a theoretically coherent view of personality functioning/dysfunctioning and related symptom disorders. The object relations orientation to personality functioning is explicitly referenced in this system, and the STIPO is noted as a key instrument related to the clinical assessment of patients.

Translations of the STIPO and STIPO-R

We have encouraged colleagues at other sites to translate the STIPO into their local language. There are established versions of the STIPO in English (Stern et al, 2010), German (Doering et al, 2013), and Italian (Preti, Prunas, Sarno, & De Panfilis, 2012). Researchers are working on versions of the STIPO-R in Poland, China, Turkey, Hungary, Czech Republic, Russia, Argentina, and Brazil.

Limitations of the STIPO-R

Like all interviews, the STIPO-R is limited by the honesty and ability to provide detailed information by the subject. However, unlike self-report questionnaires, the interview format provides an opportunity for the interviewer to probe and obtain further amplification from the subject.

Frequently Asked Questions About the Administration of the STIPO-R

Can I use the STIPO-R in my routine assessment of patients? The STIPO-R can be used exactly in its written format, or sections of the STIPO-R can be used to guide clinical assessment of patients.

Should the STIPO-R be used only in assessing patients suspected of personality pathology? The STIPO-R is particularly relevant for the assessment of both symptoms and personality organization in patients suspected of having personality pathology. However, since all patients who arrive for treatment have a personality profile that will affect motivation for treatment, perception of self, and perception and interaction with the clinician, the STIPO-R and its profile can be useful in all clinical evaluations.

Do I have permission to use the STIPO-R as a research instrument? To ensure the competent use of the STIPO-R in research projects, we ask that the investigator enter into an agreement with us in regard to training in the reliable use of the instrument, and consideration of utilizing a battery of validating instruments.

Table 1. 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 and then confrontation to set the stage for interpretation
Focus on present, related to past	Focus on the present

Table 2. STIPO-R Domains and Subdomains

Domain	Subdomain
Identity 15 items	Capacity to invest in work/studies and recreation Sense of self Sense of others
Object Relations 14 items	Interpersonal relations Intimate relationships and sexuality Internal working model of relationships
Defenses 10 items	Lower-level, primitive defenses Higher-level defenses
Aggression 9 items	Self-directed aggression Other-directed aggression
Moral Values 6 items	

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