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Mini Review

An Attachment-Based Framework for Disordered Personality Development: Implications for Intersubjective Psychodynamic Psychotherapy

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ABSTRACT

Infant-caregiver dyads range show high heterogeneity in terms of goodness-of-fit. Several lines of evidence indicate that the modalities by which areas of good and poor fit were emotionally recognized and managed by caregivers influence the infant's personality development, the integration of its personality traits, the overall sense of authenticity, as well as the modalities of transference that typically manifest during psychodynamic psychotherapy. Within an intersubjective framework, the relationship between patient and psychotherapist will inevitably recreate goodness-of-fit issues, although the specific areas of poor fit will likely differ from the ones emerged with caregivers. In other words, emotional disharmony may originate from personality traits that were not problematic in the first place. The author hypothesizes that disclosure of the challenges associated with the management of areas of poor fit will not only promote emotional honesty within the dyad, but also offer an excellent opportunity for introjection. Such disclosures are not at risk of being interpreted as an attempt to build an intersubjective experience, but represent as a window into authenticity, which in turn enables patients to develop awareness of their personality and relational traits, along with the challenges and vulnerabilities that occur when such traits interface with otherness.

Keywords: Attachment; Intersubjectivity; Psychodynamic psychotherapy; Personality development; Personality disorders

INTRODUCTION

Several lines of evidence for psychological and biological research indicate that at birth every person is born with biopsychological traits [1,2]. These traits are unique modalities by which the individual perceives, processes end expresses emotions; operates, responds to interpersonal stimuli, behaves socially, and manages inner and outer conflict; reflects, develops and ultimately communicates thoughts [3].

As newborns are entirely dependent on their caregivers, the early relational environment, however, has great power in determining the paths of development, emergence, and possible impairment of such traits [4]. Whereas the role and/or the intention of a caregiver is to make room for the development of their infant's authentic traits, to perceive their wishes and needs, and to adapt to them, it is undeniable that every caregiver is first and foremost an individual who carries his own biopsychological traits. Therefore, there is a pre-intentional, non-verbal level where infant and caregiver interface on an equal footing, and continuously perceive and experience areas of harmony and disharmony as the relationship evolves [5].

Depending on the intrinsic traits that the infant and caregiver carry, a lesser or greater degree of goodness of fit may occur [6]. For example, an infant may experience emotions in an energetic, intense, expansive, rapid-onset, and rapid-metabolism manner. If the caregiver shares aspects of this way of perceiving emotions, an instinctual understanding will likely spur between them, one that is based on emotional resonance, i.e., identification [7-10]. Vice versa, if the caregiver has, for example, a soft, slow, and private way of processing emotions, this could easily generate in both caregiver and infant a non-verbal experience of emotional otherness [11].

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Although it can be assumed that the caregiver has experienced otherness in many ways throughout their life, and has developed his own response to it, the experience of pregnancy and possibly nursing can pose exceedingly hard challenges for mothers, who are to navigate the complex transition from oneness to otherness-a separation that is no less psychological than physical [12]. As much as responding to emotional otherness is very much a learnt behavior as life evolves [13-15], given that individuals are increasingly exposed to complex interpersonal scenarios, said response is no less influenced by biopsychological traits [16]. Some individuals are aversive to emotional otherness, while for others specific kinds of otherness can be naturally attractive [17]. When emotional otherness is experienced between caregiver and infant, it could elicit different responses [18,19], one being attraction ("I like how you emote"), another being emotional disharmony ("I do not resonate with how my baby feels"; "my caregiver does not resonate with how I feel").

Areas of good fit within the dyad, whether that comes from resonance or attraction, generate harmony between the infant and the caregiver: Traits that fit between infant and caregiver can commonly polarize the relationship: The caregiver tends to respond harmoniously to them, so that they become identification opportunities for the infant [20]. Areas of poor fit, instead, can generate emotional disharmony-to which caregiver and infant can respond very differently [21]. While a caregiver has putatively developed cognitive resources he can mobilize to handle disharmony, an infant likely cannot count on such resources because he has not reached the necessary milestones of neurodevelopment [22]. Therefore, the emotional management of areas of poor fit is a responsibility that largely belongs to the caregiver.

If poor fit evokes feelings of unsuitableness, discomfort or distress in the caregiver, this is something that the infant is likely to perceive [23]. If the emotions of the caregiver translate into overt behaviors of avoidance, denial, or judgment, the infant is at risk of introjecting the caregiver's reaction [24]. Common examples can include: Considering a part of oneself as 'bad', repudiating a part of oneself, denying the presence of emotional and communicative needs because their caregiver is unable to meet them [25]. Another option-based on his biopsychological traits, neurodevelopmental stage, and extended relational environment-is for the infant to safeguard the authentic trait that has created poor fit, even if that means coping with the absence of attunement with the caregiver [26].

LITERATURE REVIEW

Attachment literature indicates that from a very early developmental stage, infant-caregiver dyads range show high heterogeneity in terms of goodness-of-fit [27]. The validation and integration of the infant's personality traits, the overall sense of authenticity, as well as the modalities of transference that could manifest during psychodynamic psychotherapy, are all heavily influenced by how areas of good and poor fit were emotionally handled in the context of the relationship with caregivers [28]. Caregivers with greater areas of poor fit with their infant are therefore to do more emotional management if they want to promote the normal development of the infant's personality [29]. Nonetheless, all individuals carry, to various degrees, the distress that originates from lack of authenticity (not feeling seen for who they truly are), and such distress commonly emerges during psychodynamic psychotherapy [30].

In a very similar way to that of a caregiver, the role of a 'good enough' psychotherapist is to make room for the development of their patients' authentic traits, to perceive their wishes and needs, and to adapt to them [31]. However, this encounter exists and lives at multiple levels, including the nonverbal and sensorial one where, from the very first moment and for the entire duration of the therapy, therapist and patient interface as two symmetrical individuals, and mutually experience emotional harmony and disharmony that originate from areas of good and poor fit [32,33].

As much as psychodynamic psychotherapists are trained on internalizing their emotional experiences to facilitate the patient's transference and countertransference, especially during vis-a-vis psychotherapy they perceive no less than they are, in fact, perceived [34]. Whether it is the tone with which they greet or farewell their patients, a ritualistic gesture that recurs during sessions, a change in posture or body language, or even the timing of silence, the person behind the profession, with their full set of biopsychological traits, is unequivocally seen [35,36]. As a matter of fact, with areas of emotional harmony and disharmony inevitably emerging from the beginning of psychotherapy, it will come as no surprise that psychotherapists anecdotally speak of patients with whom they have better fit as 'favorite' patients, and those where areas of poor fit prevail as 'more difficult' patients [37].

Would recognizing and discussing goodness-of-fit benefit the psychotherapy process? Despite psychotherapists being trained on how to not act upon unpleasant feelings originating from areas of poor fit with behaviors that can negatively influence the introjection processes that occur during psychotherapy, should there be a conversation about such feelings? And when should that conversation occur?

During the initial phase of psychotherapy, patients are encouraged to freely describe their psychological distress. Through the content that is endorsed session after session, psychotherapists have an excellent opportunity to grasp the patient's modalities to perceive, process end express emotions, as well as to reflect, develop and communicate their thoughts. The psychotherapist will inevitably notice that some of these traits are being reported and/or expressed less authentically [38]. Why is that happening? Are these traits that could not develop adequately in the context of the relationship with their caregiver-that is, transference is obscuring authentic intersubjectivity-or has the patient unconsciously detected an area of poor fit, one where unpleasant feelings could easily be generated? [39].

In such moments, disambiguation is rather necessary, and so is emotional honesty [40]. The patient could be asked if he imagines that the psychotherapist is unlikely to perceive or appreciate the personality trait under scrutiny [41]. This allows to investigate transference and raise awareness of possible projections, while giving the psychotherapist the opportunity to acknowledge that such trait is perceived, validated, accepted,

and, in fact, fully legitimized [42]. Above and beyond inevitable transference and countertransference mechanisms, what about the emotional response that the patient's specific trait is eliciting in the person-psychotherapist? If such response was negative, should the psychotherapist disclose that? Whenever areas of poor fit are experienced, should psychotherapists exclusively be preoccupied with successfully managing the emotions associated with poor fit? [43].

Once projections are disentangled from areas of poor fit, the patient can begin to appreciate the psychotherapist's efforts to overshadow their own personality, and to navigate in a constructive and mature way the areas of disharmony that are unique to their relationship, as this may not have happened in the context of the relationship with their caregiver [44]. When a psychotherapist shows how to emotionally manage areas of poor fit and the patient notices that, it becomes an excellent opportunity for introjection [44]. Yet, there is a great risk for the psychotherapist in sending ambivalent messages, such as a verbal message that states the acceptability of a certain trait of their patient, and a non-verbal message that expresses how challenging it was for him to actually handle that area of poor fit [45].

DISCUSSION

In light of the above, it follows that any relationship between patient and psychotherapist will recreate goodness-of-fit issues, except that the specific profile of areas of poor fit will likely differ from the one that was experienced with caregivers. In other words, emotional disharmony may originate from personality traits that were not problematic in the first place [46].

In this framework, concepts such as "negative transference", "unending analysis", or "still analysis" may stem from the belief that areas of poor fit within the therapeutic dyad originate from unelaborated experiences on the patient' part or even the psychotherapist' part [47], and as such, become therapeutic targets that need to be worked through [48,49]. If the patient instead comes to take the relationship with his psychotherapist as the relational model that he tends to unconsciously reenact or that he should aspire to, the risk is to subject him to the process of identify reconfiguration with the sole purpose of establishing the highest possible degree of adaptivity to a figure who, just like the caregiver, is rarely chosen [50,51].

Once it is openly communicated and agreed upon that the goal of psychotherapy is not to develop a harmonious relationship with the psychotherapist, but to recognize and further develop the patient's traits (even if that translates into areas of emotional disharmony within that specific dyad), areas of poor fit in the psychotherapeutic relationship will no longer need to be psychoanalyzed or worked through [52]. Disclosing the emotional challenges associated with the management of areas of poor fit will then not be interpreted as an attempt to build an intersubjective experience, but rather as a window into authenticity [53]. Thanks to the relational experience with the psychotherapist, patients develop awareness of their inclinations, vocations and relational traits-along with the challenges and the vulnerabilities that emerge when such traits interface with various forms of otherness [54]. This in turn enables the patient to investigate the type of relational dynamic that he benefits from and/or desires, and to pursue relational experiences with awareness, assertiveness, and maturity.

CONCLUSION

The goal of this article was to describe the emergence of areas of poor fit in the context of the infant-caregiver dyad, and elaborate upon how the emotional management of such areas may influence the patient-therapist dyad. The article discusses disclosure and non-verbal communication as tools to shed light on areas of poor fit in the patient-therapist dyad, so that patients can develop awareness of their personality and relational traits, along with the challenges and vulnerabilities that occur when such traits interface with otherness.

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STATEMENT OF CONTRIBUTION

- Modalities by which areas of good and poor fit were emotionally recognized and managed by caregivers influence the infant's personality development, and integration, as well as the modalities of transference in psychodynamic psychotherapy
- Disclosure of the challenges associated with the management of areas of poor fit within the patient-therapy dyad offers opportunities for introjection and intersubjective authenticity.
- Research should rigorously assess whether disclosures about intersubjective poor-fit mediates efficacy of the psychotherapeutic process.

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