

# A Neuropsychanalytic Formulation of Personality Disorder: Linking Affective Neuroscience, Object Relations Theory and DSM-5/ICD-11 Diagnosis through a Case Series

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## Background and Aim

Personality disorder (PD) is increasingly conceptualised as a disorder of self and interpersonal functioning as described in the DSM-5 Alternative Model for Personality Disorders and in ICD-11's dimensional classification [1].

Neuropsychanalysis integrates psychoanalytic theory with affective neuroscience and states that humans are born with Basic Emotional Systems (BES), described by Panksepp as SEEKING, LUST, CARE, PANIC/GRIEF, PLAY, RAGE and FEAR [2,3]. Our behaviours are attempts to meet unmet BES needs. These attempts may become enacted in the transference, where the patient's expectations of self and other are repeated in the therapeutic relationship. Object relations theory (ORT) similarly holds that that early caregiver interactions are internalised as self–other dyads personality pathology in internalised self–other dyads, and that disordered personality arises when these dyads remain unintegrated and split [4,5].

This study aimed to examine whether a neuropsychanalytic formulation of unmet BES needs could be mapped onto ORT formulations and DSM-5/ICD-11 concepts of personality dysfunction in patients assessed within a specialist NHS Personality Disorder service.

## Methods

A retrospective case-series record review was conducted for 22 patients routinely assessed in an NHS Personality Disorder service. Clinical records were reviewed for diagnostic formulation, primary unmet BES, dominant self-representation, representation of others, and predicted behaviour. Formulations were then compared across diagnostic presentations, and DSM-5/ICD-11 diagnoses.

Ethical approval was sought from the Ethics Committee at East London Foundation Trust.

## Results

Of the 22 patients assessed, 14 had borderline personality disorder (BPD only; 63.6%), 6 had narcissistic personality disorder (NPD only; 27.3%), and 2 had comorbid BPD and NPD (9.1%). Table 1 shows the Primary and Secondary BES of each diagnostic group.

Diagnosis	N (%)	Primary BES (n; %)	Secondary BES (n; %)
BPD	14 (63.6%)	PANIC/GRIEF (9; 64.3%)	PLAY (3; 33.3%)
		PLAY (5; 35.7%)	none
NPD	6 (27.3%)	PLAY (6; 100%)	RAGE (2; 33.3%)
BPD + NPD	2 (9.1%)	PLAY (2, 100%)	PANIC/GRIEF (1; 50%)

Patients with BPD had self-representations of being unworthy, unlovable, and not good enough, with others experienced as neglecting, controlling, rejecting, or hurtful. Their predicted behaviours were organised around maintaining proximity, and monitoring for abandonment.

Patients with NPD were commonly formulated as having self-representations of inferiority, alongside a representation of others that they would perceive them similarly. Their predicted behaviours were oriented towards overcoming this experience through controlling themselves, others, or the situation.

The 2 patients with comorbid BPD and NPD appeared to combine features of both patterns.

## Conclusions

A neuropsychanalytic formulation is clinically compatible with object relations theory and with contemporary DSM-5/ICD-11 models of PD focused on self and interpersonal dysfunction.

In this sample, PANIC/GRIEF was most commonly identified as the primary unmet BES in patients with BPD only, while PLAY was the primary unmet BES in all patients with NPD only and in those with comorbid BPD and NPD. These patterns correspond with distinct self–other representations and predicted behaviours. From a neuropsychanalytic perspective, these behaviours are understood as attempts to meet unmet emotional needs; from an object relations perspective, they represent enactments of internalised self–other dyads.

In the 5 BPD patients with the primary BES of PLAY, longitudinal review showed that they were subsequently better understood as fitting an NPD formulation rather than BPD, despite initially meeting BPD criteria. This suggests that a primary unmet BES of PLAY may indicate the need for later diagnostic reassessment in some patients initially presenting with BPD features.

The 2 NPD patients who had RAGE as secondary BES were clinically understood as fitting a malignant narcissistic presentation, consistent with Kernberg's formulation of malignant narcissism as a more severe narcissistic pathology involving aggression and antisocial dimensions.

This framework helps clinicians identify predicted behaviours enacted in the transference. As the transference is in the unconscious, it may be missed in assessment. Making these patterns explicit may support assessment, formulation and treatment planning by problematizing the behaviours and thus converting them into specific, therapeutic objectives. Further prospective research is required with clearer operational definitions, inter-rater reliability testing, and outcome measures to examine whether BES-informed formulation improves assessment, engagement, or therapeutic improvement.



## References

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