
*HANDBOOK OF DIAGNOSIS AND
TREATMENT OF DSM-IV-TR
PERSONALITY DISORDERS*

SECOND EDITION

*HANDBOOK OF
DIAGNOSIS AND
TREATMENT OF DSM-IV-
TR PERSONALITY
DISORDERS*

SECOND EDITION

by

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Foreword

This book is to be read by both clinical professionals and graduate students alike. It is a thoughtful and practical reference text that readers will find useful time and time again as they face the difficult-to-treat patients who meet the criteria for personality disorders. Until two decades ago, the position these disorders occupied a peripheral, if not a strained place in clinical psychology and psychiatry. The turn of events has been almost startling, with the DSM-III and IV giving these disorders a major position, via Axis II, in their innovative multi-axial model.

Trained as both a psychologist and a psychiatrist, Dr. Sperry is well prepared to be a discerning and organized teacher of clinical diagnosis and treatment. A sound and effective communicator, he presents complex ideas in a clear, and easily understandable, fashion—a talent not especially common among authors in this increasingly central clinical field. His exposition and synthesis is most impressive.

Especially important, Sperry recognizes the significant advances that have taken place in the field of personality disorders in the past decade, hence justifying the updating of his well-received and widely read first edition. Moreover, the increasing need for mental health services has mounted astronomically, as people have become aware that their psychological needs can raise havoc on their health, career, social relationships, personal well-being, and creativity. No longer willing to accept their discontents and the unhappiness that has visited them by unkind circumstances, more people than ever are looking for competent professional help. What has also become strikingly clear is that most patients who seek assistance are suffering from the difficulties of longstanding maladaptive attitudes and coping styles, essentially what have come to be labeled personality disorders. What is needed are efficient diagnostic tools that enable clinicians to quickly recognize problematic character structure and a number of implementable, pragmatic, and short-term modes for treatment. It is in achieving these goals that Dr. Sperry's text will prove most useful.

His approach goes beyond merely describing the simple content of personality disorders. Dr. Sperry helps provide the reader with an understanding of the underlying sources and treatment implications of these disorders. The book will certainly assist those with considerable clinical experience, but will be especially appreciated by beginners who will soon be introduced to clinical work with the problematic patients. This text assists the novice clinician every step along the way, from initial diagnostic contact to final treatment evaluation.

As Sperry points out, the realm of personality disorders has become increasingly significant in psychotherapeutic practice; it now fills a space that formerly focused solely on schizophrenia and affective psychosis. Whereas these latter illnesses are present in only a small proportion of patients,

seen by clinicians today, the dysfunctions of personality have become omnipresent, whether in marital and family therapy, forensics, behavioral medicine and health psychology, neuropsychology, or any of the other main realms of outpatient work. Not unexpectedly, the literature in this field has grown immensely and shortly will outstrip all other areas of psychological and psychiatric practice in the coming decade. If my own broad-ranging text *Disorders of Personality* has seen some 30 printings in its two editions thus far, then Dr. Sperry's current volume will add further to the impressive growth and acceptance of useful books in the field.

Sperry's text adds meritoriously to the mental health field's decision to assign a key position to the highly prevalent realm of psychotherapeutic practice. It is a noteworthy commendation of this work that his publishers encouraged him to write a revision, a thorough and updated text in a flourishing field of study.

-Theodore Millon, Ph.D., D.S.
Dean and Scientific Director
Institute for Advanced Studies in Personology and Psychology

Preface

When the *Handbook of Diagnosis and Treatment of DSM-IV Personality Disorders* was released in 1995, it was the first personality disorders book based on DSM-IV to appear after the publication of DSM-IV. The *Handbook* was unique in many respects. It was a reader-friendly, single-authored text that offered a comprehensive and integrative approach to the diagnosis and treatment of personality disorders. Rather than focusing on a single treatment approach or modality, it basically covered all the approaches and modalities: individual therapies, group therapy, marital and family therapy, medication management, as well as combined and integrative approaches.

Since the *Handbook's* publication, a number of exciting and significant developments involving personality disorders have emerged. Most notable has been the increasing number of clinicians who are utilizing effective and successful treatments for what were previously considered untreatable disorders. The paradigm shift in clinicians' attitudes about the treatability of personality disorders was convincingly evident by the late 1990s. This attitude change, reflected in the actual treatment experience of many clinicians, involved a shift from a sense of dread and hopelessness to one of hope and optimism that even the most difficult of these disorders—including borderline personality disorder—are becoming increasingly treatable with the newer, focused treatment strategies and interventions.

In 2000, the American Psychiatric Association published the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision* (DSM-IV-TR). As the title suggests, the text and background information supporting the DSM diagnostic categories were primarily revised, rather than the specific diagnostic criteria. The main justification for this new DSM was that significant advances in both research and clinical practice had occurred since 1994—the year DSM-IV was published—and that warranted updating the text.

Because of these significant developments and advances in the diagnosis and treatment of personality disorders, a revised edition of the *Handbook* seemed inevitable. As with the first edition, the purpose of this revision would be to synthesize the many new theories, approaches, and research findings in a clinician-friendly handbook—that is, a comprehensive yet succinct and practical manual that would also be reader-friendly. I wanted to make this edition even more clinician-friendly and reader-friendly by summarizing material in tables and charts and by adding extra section headings to facilitate finding specific information more quickly.

The first chapter has been completely revised and considerably expanded. It details several exciting cutting-edge trends in both diagnosis and treatment. Diagnostic trends include the impact of attachment styles in the etiology of personality disorders, and the influence of temperament, culture,

emotional abuse, and neglect. This chapter also discusses the often unrecognized functional impairment associated with these disorders. Currently, the DSM-V Personality and Relationship Disorders Workgroup is evaluating five dimensional approaches to supplement or replace the current categorical models of diagnosis. Accordingly, these dimensional diagnostic models—one of which is likely to be the diagnostic schema adopted in DSM-IV—are briefly described. Treatment trends include the brain-behavior perspective, the utilization of newer medications, treatment utilization, and new interventions such as mindfulness, schema therapy, structured skill intervention and cognitive coping therapy, and developmental therapy.

[Chapters 2](#) through [11](#) profile each of the personality disorders with regard to its characteristic triggering event, behavioral style, interpersonal style, cognitive style, emotional style, temperament, attachment styles, parental injunction, self-view, worldview, maladaptive schemas, optimal diagnostic criterion, as well as its DSM-IV-TR description and diagnostic criteria. Similarly, psychodynamic, biosocial, cognitive-behavioral, interpersonal, and integrative-biopsychosocial clinical formulations and case conceptualization are described. Assessment of personality disorder is discussed in terms of interview behavior and rapport as well as psychological testing data including MMPI-2, MCMI-III, TAT, and Rorschach. Finally, treatment considerations for each disorder are described. These include virtually all treatment approaches and modalities: individual psychotherapy—that is, the various psychodynamic, cognitive-behavioral, and interpersonal approaches—group therapy; couples and family therapy; medication strategies; and integrative and combined therapy interventions.

Several noteworthy additions have been made to [Chapter 4](#). These include an overview and critique of the American Psychiatric Association's recently published *Practice Guidelines for the Treatment of Patients with Borderline Personality Disorder*; a description of recent research on the impact of early child abuse on the treatment process and a discussion of choice of traumatic versus nontraumatic treatment pathways; the value of attachment theory and mindfulness skill training in treatment; updates on dialectical behavior therapy and schema-focused therapy; and the promise of structured skill training interventions and cognitive coping therapy.

Practicing clinicians in psychiatry, clinical psychology, counseling psychology, mental health counseling, marital and family therapy, and psychiatric nursing—as well as those in training—should find specific information and clinically useful tactics and strategies here to aid them in diagnosing, formulating, planning, and implementing treatment with personality-disordered individuals. It is my sincere hope and expectation that this book will enrich your understanding as well as your treatment outcomes.

—Len Sperry, February 2000

CHAPTER 1

Personality Disorders: Trends in Clinical Practice for a New Millennium

The first chapter of the *Handbook of the Diagnosis and Treatment of DSM-IV Personality Disorders* (Sperry, 1995) likened the paradigm shift occurring with personality disorders beginning in the early 1990s to the paradigm shift that already had occurred with depressive disorders. Until the mid-1970s many clinicians felt relatively ineffective in treating depressive disorders, and until the early 1990s this same sentiment was shared by many clinicians about treating personality disorders. I insisted that such a paradigm shift involving personality disorders would require a major change in the way clinicians conceptualize, assess, and treat these disorders. I predicted that while such a change in attitude and practice patterns might be resisted by some, most clinicians would respond to the challenge. Such a shift would mean relinquishing the then prevailing view that personality disorders were essentially untreatable conditions. With some trepidation, I ended the chapter with a quote conveying the sentiment that clinicians might even come to consider that personality-disordered patients would “become our most welcome clients in the new century, clients who are deeply troubled but whom we can help with confidence” (*Clinical Psychiatry News*, 1991, p. 26).

Since then, it appears that much has changed in clinician attitudes and practice patterns. Indeed, the paradigm seems to have shifted. While not all clinicians feel that they can help every personality-disordered individual with confidence, there is, nevertheless, an increasing consensus among clinicians that many patients can be helped with current treatment interventions, even those meeting DSM-IV-TR criteria for borderline personality disorder.

This chapter provides an introduction to the diagnosis and treatment of personality disorders. The main part of this chapter details several exciting, cutting-edge trends in both diagnosis and treatment that are further effecting this paradigm shift. Prior to detailing these trends, the chapter begins by explaining the nature of the paradigm shift underway in the conceptualization, assessment and diagnosis, and treatment of personality disorders, as well as the basic premises underlying effective treatment of these disorders; it also highlights the changes in DSM-IV-TR. Finally, the chapter concludes by providing the reader with an orientation and overview of the structure of [Chapters 2 through 11](#).

THE NEW PARADIGM IN PERSONALITY DISORDERS

What factors have been contributing to the paradigm shift in the diagnosis and treatment of personality disorders within the past 10 years? Primarily these factors include a broadened conceptualization, improved assessment methods and diagnostic criteria, and focused, potent treatment methods for personality disorders. More specifically, personality disorders are now being conceptualized to include the neurobiological and temperament dimensions in addition to the personal

or character dimension. Neurobiological and bio-social formulations of personality disorder have attracted considerable attention and have generated a considerable amount of research. Millon (Millon & Davis, 2000) and Cloninger (1987, 2000; Cloninger, Svrakic, & Przybeck, 1993) hypothesize that temperament and neurotransmitters greatly influence personality development and functioning. Cloninger and colleagues (1993, 2000) describe personality as the influence of character and temperament wherein temperament refers to the innate genetic and constitutional influences on personality, and character refers to the learned psychosocial influences on personality. Cloninger hypothesizes that temperament has formed measurable biological substrates: novel-seeking, harm avoidance, reward dependence, and persistence; character has three quantifiable factors: self-directedness, cooperativeness, and self-transcendence. He believes that personality style reflects the individual's temperament factors plus positive or high scores on the three character factors. On the other hand, personality disorders reflect negative or low scores on the three character factors.

The Five-Factor Model (FFM) has become the most prominent of the contemporary psychological models of personality disorders. FFM describes personality dimensionally in terms of the factors agreeableness, conscientiousness, neuroticism, extroversion, and openness (Costa & McCrae, 1990, 1992).

Stone (1993) describes a "grand unified theory" of personality disorders. Basically, this unified theory interdigitates the Five-Factor Model—a psychological model—and Cloninger's Seven-Factor Model—a biosocial model. This unified theory is essentially a biopsychosocial theory of personality disorders. In addition to these research-based theories and models, there are a number of different clinical formulations of personality disorders (Beck, Freeman, & Associates, 1990; Benjamin, 1990; Gabbard, 1990).

In the past, criteria for the assessment of personality disorders were somewhat primitive. DSM-I subdivided personality disorders into five headings: personality pattern disturbance, personality trait disturbance, sociopathic personality disturbance, special symptom reactions, and transient situational personality disorders. DSM-II, which appeared in 1968, eliminated the subheadings and streamlined the number of personality disorders. The descriptions were not based on clinical trials. Although brief descriptions of each disorder were given, diagnostic criteria were not provided. Furthermore, there was no clear distinction made between symptom disorders (Axis I) and personality disorders (Axis II).

This lack of specificity further reinforced some mistaken convictions about personality disorders. A striking example is obsessive-compulsive disorder and obsessive-compulsive personality disorder. Before DSM-III, little or no distinction was made between these disorders for which there is no consensus that there is relatively little overlap (Jenike, 1991). Yet some still fail or hesitate to make this distinction, referring to both as aspects of the "obsessive personality" (Salzman, 1980). Perhaps this harkens back to Freud's case description of the Rat Man in which both obsessive-compulsive disorder and obsessive-compulsive personality disorder were present (Francis, Clarkin, & Perrin, 1984). The implication was that both are essentially the same, so treatment should be the same for both disorders. Jenike (1991) notes that the concurrence of obsessive-compulsive disorder in patients with obsessive-compulsive personality disorder is small, probably less than 15 to 18 percent. Currently, the DSMV Planning Group on Personality and Relational Disorders is considering major changes regarding the diagnosis of the Axis II disorders.

In the past, assessment of personality disorder was by clinical interview and inferred from standardized personality inventories such as the MMPI. Today, there are a number of formal measures of personality disorders. Some are theory and research based, such as Millon's MCMIII (1994) and Cloninger's Temperament Character Inventory (TCI; Cloninger et al., 1993). Others are research-based self-report instruments such as the Personality Disorder Inventory (PDI) and the Personality Disorders Questionnaire-Revised (PDQ-R). There are a number of semistructured schedules available

such as the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II). Although methodological issues have been raised about these assessment devices, they have served both the clinician and the researcher well (Zimmerman, 1994).

In large part, these assessment measures reflect the increasingly differentiated criteria of DSM-III, DSM-III-R, and DSM-IV. DSM-III subdivided 11 personality disorders into three clusters: odd/dramatic, and anxious, DSM-III-R maintained the essential features of DSM-III but added sadistic and self-defeating personality disorders to Appendix B. DSM-IV further differentiated criteria and dropped self-defeating and sadistic personality disorders. It relegated passive-aggressive personality disorder to the category personality disorder-not otherwise specified (NOS), as well as depressive personality disorder, which joined passive-aggressive personality disorder in Appendix B of DSM-IV.

In the past, the treatment of personality disorders was largely the domain of psychodynamic approaches. Psychoanalysis and long-term psychoanalytically oriented psychotherapy were considered the treatment of choice (Stone, 1993). The goal of treatment was to change character structure. Unfortunately, outcomes were mixed even among patients adjudged amenable to treatment. For the most part, clinicians utilizing a traditional exploratory approach adopted a neutral and passive stance and primarily utilized clarification and interpretation strategies.

Treatment methods were also changing, with interventions becoming more focused and structured and with clinicians taking a more active role in the treatment. Many of these treatment approaches and intervention strategies are theory based and have been researched in clinical trials in comparison with other treatment approaches or other modalities such as medication, group therapy, and family therapy. The cognitive therapy approach, the interpersonal psychotherapy approach (Benjamin, 1993), and some psychodynamic approaches have been specifically modified for the treatment of personality-disordered individuals.

Furthermore, I emphasized that psychopharmacological research on treatment of selected personality disorders was expanding rapidly. Prior to the paradigm shift, the consensus among clinicians was that medication did not and could not treat personality disorders, per se, but rather concurrent Axis I conditions or target symptoms such as insomnia. This view has changed markedly. Based on investigations of the biological correlates of personality disorders, Siever and Davis (1993) proposed a psychobiological treatment model that has been of inestimable clinical and research value. Essentially, Siever and Davis believe that psychopharmacological treatment can and should be directed to basic dimensions that underlie the personality. The dimensions are cognitive/perceptual organizations, especially for the schizotypal and passive disorders, for which low-dose neuroleptics might be useful; impulsivity and aggression in the borderline and antisocial, for which serotonin blockers can be useful; affective instability for borderline and histrionic personalities, for which cyclic antidepressants or serotonin blockers may be useful; and anxiety/inhibition, particularly avoidant personality disorder, for which serotonin blockers and MAOI agents may be useful.

It was also noted that research was increasingly suggestive that effective treatment of personality disorders involved combining treatment modalities and integrating treatment approaches. Stone (1993) suggests combining three approaches. He notes that supportive interventions are particularly useful in fostering a therapeutic alliance and should be augmented by psychoanalytic interventions, which are useful in resolving negative transferences at the outset of treatment, and cognitive-behavioral interventions, which are useful in the development of new attitudes and habits. Winer and Pollock (1989) and Stone (1993) also recommend combining medication with individual and group modalities for personality-disordered individuals. This prescription to integrate various approaches, as well as to combine treatment modalities, would have been considered heretical as recently as the late 1990s. Now, integrating and combining treatments is an emerging consensus that reflects the immensity of the paradigm shift.

EFFECTIVE TREATMENT OF PERSONALITY DISORDERS: BASIC PREMISES

The 1995 edition articulated four basic premises that were considered essential to achieving effective treatment outcomes with personality disorders. The passage of time has reinforced their clinical utility. An additional premise on treatment tailoring has been added.

Premise 1: Personality disorders are best conceptualized in integrative and biopsychosocial terms, and the more effective treatment will reflect this biopsychosocial perspective.

Viewing personality disorders simply from a psychosocial or characterological perspective has serious limitations (Stone, 1993). Similarly, viewing personality disorders as basically biological or temperamental is limiting. On the other hand, there is considerable research and clinical support for viewing personality disorders from the perspective of character and temperament. Such a biopsychosocial or integrative clinical formulation should be reflected in a treatment plan that is biopsychosocially focused.

Premise 2: Assessing treatability or amenability to treatment is critical to maximizing treatment planning and outcomes.

Treatability is a function of a patient's readiness and level of functioning. Patient readiness refers to the individual patient's motivation for and expectations for treatment outcomes, as well as past history of treatment compliance and success at efforts to change habits and behavior patterns. Level of functioning can be operationalized in terms of the Global Assessment of Functioning Scale (GAF) or Axis IV. High functioning refers to a score of about 65. Moderate functioning refers to a score of 45 to 65. Low functioning refers to a score below 45.

Stone (1993) suggests that personality disorders lend themselves to a three-category classification with regard to treatability: (1) high amenability: includes dependent, histrionic, obsessive-compulsive, avoidant, and depressive personality disorders; (2) intermediate amenability: includes narcissistic, borderline, and schizotypal personality disorders; (3) low amenability: includes paranoid, passive-aggressive, schizoid, and antisocial personality disorders. Stone adds that since patients show mixtures of various personality traits, prognosis is largely dependent on the degree to which traits of the disorders in the third category are present. Prognosis also depends in part on the prominence of the psychobiological dimensions described by Siever and Davis (1991): cognitive/perceptual disorganization; impulsivity/aggression; affective inability or anxiety/inhibition. To the extent that these dimensions such as impulsivity or anxiety respond to medication, concurrent psychosocial intervention efforts should be facilitated.

Premise 3: Effective treatment of personality disorders is tailored treatment.

The effectiveness of treatment outcomes is largely a function of how well treatment is tailored to the particular needs, circumstances, expectations, and overall level of functioning of the individual. Tailoring refers to modifying or adapting a particular modality and/or therapeutic approach to the patient's needs, styles, and expectations.

A sartorial analogy might help distinguish between combining, integrating, and tailoring. An adult could go into a clothing store to purchase a gray business suit. The individual could randomly choose a suit from the rack and there would be a small chance of it fitting perfectly, but more likely it would be a poor fit. The individual whose size is usually 38 short could look through the racks and try on 3

short, which might fit quite well but still needs minor fitting work by a tailor—partial tailoring. Of course, the individual could also go to a store for a fitting and have a suit completely custom made—total tailoring. The suit could be pure wool or pure silk, or it could be a blend of wool and silk. The blended fabric would be analogous to integrating treatment. Analogous to combined treatment would be purchasing a blue sports jacket that might be worn with the pants of the gray suit for a more casual look. In short, there can be no one-size-fits-all protocols for successful treatment of personality disorders.

The more treatment can be tailored to specific client factors, the more likely it is to be effective and tailoring involves much more than simply matching a treatment method to a specific personality disorder. Therefore, it is impossible for any article or book to provide a definitive all-treatment protocol for all personality disorders or even one specific disorder. That being said, it is possible to offer some generalizations about which treatment methods are more likely to be effective with specific personality disorders. Mindful of these generalizations and based on an integrative assessment including treatability and amenability to treatment, the clinician can then tailor treatment to the individual's unique circumstances, needs, and expectations.

Generally speaking, individuals with antisocial, borderline, and histrionic personalities need more confrontation, whereas those with avoidant, dependent, and obsessive-compulsive personalities need more reassurance. For the most part, insight-oriented therapy tends to be more appropriate for individuals with high motivation and fairly high functioning. Furthermore, such therapy appears to achieve better outcomes with less severe forms of narcissistic and obsessive-compulsive personalities (Sperry, 1999).

Individuals with certain personality pathology, such as schizoid and schizotypal personality, find it difficult to tolerate emotional probing or a taxing personal relationship with a therapist. Nevertheless, they can respond better to behavioral, coping-oriented, and supportive therapy. Similarly, avoidant personalities tend to be responsive to supportive efforts initially. Only then can they be expected to respond to challenges and new situations (Millon & Davis, 2000). Cognitive therapy can be helpful in analyzing their fears of rejection and humiliation.

Initially, the treatment with obsessive-compulsive personalities should focus on feeling expression over intellectual discussion of their concerns. Often, cognitive therapy is helpful in altering their rigid thinking and obsessional worrying. In addition, relaxation training can aid in reducing tension and compulsive mental strivings. Both psychodynamic and cognitive therapies can be useful in moderating the irrational thinking and excessive emotional reactions common in histrionic personalities. Group and couples therapy may show individuals how their behavior affects others. On the other hand, group therapy usually requires too much self-revelation for paranoid personalities. Furthermore, these individuals often find behavior therapy difficult to tolerate because they are reluctant to take instructions from anyone. The therapist should preserve a cool and respectful relationship with the patient, not challenging or interpreting paranoid ideas but understanding and sympathizing with the underlying feelings (Millon & Davis, 2000).

Individuals with antisocial personalities need to be shown the limitations of the way they respond to the world. They must learn how to weigh the advantages and disadvantages of their actions, partly by being made to understand that there will be clear and consistent consequences (Cloninger, 1999). Because they rarely agree to treatment except under coercion, and they may use psychotherapy as another way to exercise their powers of deceit and manipulation.

Finally, individuals with borderline personalities can create complex difficult situations in treatment. For instance, they may provoke crises with suicide attempts and other self-destructive behavior, or they have had multiple treatments with different clinicians and rejected many or all of them. Sometimes these individuals need confrontation and limit setting, whereas other times the

need comfort and affection. Group therapy may prove helpful by providing less emotionally intense relationships with those who are not in a position of authority. Yet borderline individuals can resent sharing a therapist— that is, the group therapist—and dislike being exposed to other group members' feelings. Nevertheless, a group component has been shown to be an integral part of some treatment approaches developed specifically for borderline personality-disordered individuals, such as dialectical behavior therapy (Linehan, 1993a).

Premise 4: The lower the level of treatability, the more combining and integrating of treatment modalities and approaches is needed.

Confirming clinical experience, research is now documenting that personality disorders are a significant source of psychiatric morbidity and lead to more functional impairment than major depression (Skodol et al., 2002). Often, low levels of functional impairment are suggestive of low treatability and indicative of the need for combining treatment modalities and approaches. There has been increasing interest in combined therapies and integrative treatment. This follows a long period of time in which clinicians were skeptical or even hostile about combining two modalities such as individual psychotherapy and group therapy, or medication and psychoanalytic psychotherapy. However, research and clinical practice reveal several advantages for combined therapeutic modalities. These include additive and even synergistic treatment effects, diluting unworkably intense transference relationships, and rapid symptom relief (Francis, Clarkin, & Perry, 1984).

In short, combined treatment refers to adding modalities, such as individual, group, couple, family, either concurrently or sequentially, while integrative treatment refers to the blending of different treatment approaches or orientation, such as psychodynamic, cognitive, behavioral, interpersonal, and so on. Combining treatment modalities is also referred to as multimodal treatment. Finally, tailored treatment refers to specific ways of customizing treatment modalities and/or therapeutic approaches to fit the unique needs, cognitive and emotional styles, and treatment expectations of the patient.

Once considered controversial, psychoanalytically oriented therapy combined with other modalities is now being advocated by dynamically oriented clinicians. Winer and Pollack (1989) indicate that combined treatment—insight-oriented individual sessions with medication, group or family therapy—particularly valuable in cases of personality disorders.

Treatment delivered in combination can have an additive, and sometimes synergistic, effect. It is becoming more evident that different treatment approaches are differentially effective in resolving different types of symptom clusters. For example, in major depression, medication is more effective in remitting vegetative symptoms, while psychotherapy is better at improving interpersonal relationships and cognitive symptoms (Francis, Clarkin, & Perry, 1984). Furthermore, the additive effect of medication and psychotherapy has been established for both major depression (Rush & Hollon, 1990) and agoraphobia (Greist & Jefferson, 1992).

What are the indications and contraindications for these various modalities? A working knowledge of these are probably more necessary for clinicians working with personality disorders than for Axis I disorders. Francis, Perry, and Clarkin (1984) detail the relative indication, relative contraindication, and enabling factors for three treatment modalities: individual, group, and family/marital. The reader is referred to their excellent discussion and summary table.

These authors also discuss a very basic question that needs to be asked every time a clinician considers offering treatment to a personality-disordered individual: Is treatment advisable or would no treatment be the preferred recommendation? The “no treatment option” may be the treatment choice for individuals who have had negative therapeutic reactions or who have made little or no

progress in the course of interminable therapy.

Francis, Perry, and Clarkin (1984) offer specific criteria for making the treatment versus no treatment recommendation. They also note that patients were ten times more likely to initiate "no treatment" decisions than were clinicians to offer this option.

While combined treatment refers to combining different modalities of treatment (i.e., individual, group, marital and family therapy, day treatment, or inpatient) either concurrently or sequentially, integrative or tailoring treatment is different. Integrative treatment refers to blending various treatment approaches (i.e., psychodynamic, cognitive, behavioral, interpersonal, and medication management). Several researchers have advocated integrative treatment for treatment of borderline personality disorder (Stone, 1992; Linehan, 1993). Cognitive-behavior therapy represents the integration of two therapeutic approaches: cognitive therapy and behavior therapy. The specific type of cognitive-behavior therapy developed by Linehan, dialectal behavior therapy, is an integration of various cognitive-behavioral intervention strategies and Zen practice (Heard & Linehan, 1994). Stone (1992) prescribes blending psychoanalytic, behavioral, cognitive, and medication intervention or approaches.

The higher the patient's treatability—that is, level of functioning and treatment readiness—the less immediacy there may be to combining and blending most of the modalities and approaches. On the other hand, the lower the functioning, the more modalities and approaches will need to be combined and blended.

This premise may seem quite demanding of the clinician's professional resources. It is. Not every clinician is suited for working with all personality-disordered individuals, particularly those with low amenability to treatment. Specialized training and supervision in the utilization of various approaches is needed in the treatment of personality disorders. It is not being suggested that clinicians should also be trained in the various treatment modalities. Obviously, referral to group or family therapy or other treatment modalities beyond the clinician's competence is a reasonable option.

Premise 5: The basic goal of treatment is to facilitate movement from personality-disordered functioning to personality-style functioning.

Treatment goals can be thought of in terms of levels. The first level involves symptoms. The second level involves personality features that are related to environment and are modifiable. The third level involves personality features that are related to character. The fourth level involves personality functions related to temperament. Treatment of levels one and two is relatively straightforward. Medication or behavioral treatments like exposure may quickly remit symptoms of personality disorder. Psychotherapeutic interventions of various approaches and modalities can often be useful at level three. But they may not be, as in the case of rule-breaking behavior of the antisocial individual. Level four is temperament and human nature and is not easily changed.

Stone (1993) uses the analogy of the cabinet maker and carpenter to describe this level of treatment. The clinician working with personality-disordered individuals is not a carpenter who rebuilds structure, but is rather like a cabinet maker who sands down and takes the rough edges off. The individual's temperament remains, but treatment renders the individual somewhat easier to work with. Essentially, then, personality style will be used in the subsequent chapters to refer to high adaptive functioning behavior for a particular personality type, whereas personality disorder refers to functioning that is characterized by specific DSM-IV diagnostic criteria.

Today, I would modify this premise to read: *The basic goal of treatment is to facilitate movement from personality-disordered functioning to adequate personality-style functioning or even to optimal functioning.* From a developmental psychotherapeutic perspective (Sperry, 2002), the continuum of functioning, and subsequently treatment, is broadened to include an optimal level of functioning. (S

FROM DSM-IV TO DSM-IV-TR

In 2000, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision* (DSM-IV-TR) was published (American Psychiatric Association, 2000). As the title suggests, the revision was primarily of the text supporting diagnostic categories and criteria. While there were some changes in diagnostic criteria—that is, paraphilias—this was not the main focus. Significant advances in clinical research since the DSM-IV publication in 1994 warranted updating the text.

There were no changes in diagnostic criteria for any of the personality disorders. Furthermore, passive-aggressive personality disorder (negativistic personality disorder) and depressive personality disorder remained relegated to Appendix B: “Criteria Sets and Axes Provided for Further Study.” Nevertheless, there were changes in the narrative text throughout the personality disorders chapter. These are briefly summarized.

In the introductory section of the personality disorders chapter, there was a further delineation and updating of the categorical versus dimensional issue of diagnosis. Specifically, additional dimensional models under consideration for possible adoption in DSM-V were noted.

In the “Specific Culture, Age and Gender Features” section on dependent personality disorder, the text was changed “to remove the suggestion that reported gender differences is largely artifactual” (p. 842). More specifically, it was noted, “In clinical settings, this disorder has been diagnosed more frequently in females, although some studies report *similar* prevalence rates among males and females” (p. 723, italics added).

The “Associated Features and Disorders” section of obsessive-compulsive personality disorder was updated to clarify the relationship between obsessive-compulsive disorders and obsessive-compulsive personality disorders. Presumably, this clarification was necessary because of the prevailing belief that the disorders are often comorbid or that they are essentially variants of the same disorder, as in Freud's famous case of the Rat Man, or in Melvin Udall, the main character in the movie *As Good as Dead*. The revised text notes, “The majority of individuals with Obsessive-Compulsive Disorders do not have a pattern of behavior that meets criteria for Obsessive-Compulsive Personality Disorders” (p. 727).

Similarly, in the “Associated Features and Disorders” section of antisocial personality disorder, the text was updated to “clarify that features that are part of the traditional conception of psychopathy may be more predictive of recidivism in settings (e.g., prisons) where criminal acts are likely to be nonspecific” (p. 842). Specifically, the features referred to are “lack of empathy, inflated self-appraisal and superficial charm” (p. 703).

Finally, text in the “Course” section of borderline personality disorder was added to “emphasize that, contrary to many clinicians' preconceived notions, the prognosis for many individuals with Borderline Personality Disorder is good” (p. 842). The new text reads, “During their 30s and 40s the majority of individuals with this disorder attain stability in their relationships and vocational functioning. Follow up studies of individuals identified through outpatient mental health clinics indicate that after ten to about 10 years, as many as half of the individuals no longer have a pattern that meets full criteria for Borderline Personality Disorder” (p. 709).

TRENDS IN THE DIAGNOSIS OF PERSONALITY DISORDERS

This section describes a number of cutting-edge clinical and research trends that are and will continue

to impact the assessment and diagnosis of personality disorders. These include attachment style, temperament, culture, emotional abuse and neglect, functional impairment, and dimensional vs. categorical models of diagnosis.

Attachment Styles and Personality Disorders

Attachment researchers insist that early life relational deficits lead to both neurophysiological brain deficits as well as psychological deficits (Siegel, 1999). A sensitive and responsive parent helps grow the connections in the orbitofrontal cortex of the infant's brain by communicating—or “collaborating”—with the baby via eye contact, facial expression, gestures, tone of voice, and so on. The gurgling, smiling infant is picked up and “answered” by the parents with a smiling and joyful expression and words. Or, the baby cries in pain or frustration and the parent soothes and consoles it, or calms down the overexcited child at bedtime. These routine and continuous interactions serve to stimulate the growth of synapses in the orbitofrontal cortex of the brain, which enable children to modulate their frustration, rage, and fear, and to respond flexibly to others.

Research indicates that securely attached children develop neural pathways for resilience. Even when their parents are upset or impatient, their brain's wiring “knows” from experience that they will not be abandoned and will reconnect after the storm has passed. Unfortunately, children with insecure attachment styles do not experience such reciprocal parental attention, and consequently they tend to be more vulnerable to emotional assaults—that is, they are less able to modulate rage and aggressive affects, calm and soothe their anxieties and sadness, as well as tolerate high levels of pleasure and excitement (Ainsworth et al., 1978). Needless to say, they are also less likely to correctly interpret others' social cues because of deficits in their orbitofrontal cortex, which further complicates interpersonal relationships.

Types of Attachment Styles in Early Life

Attachment refers to the emotional bond that develops between child and parent or caregiver and subsequently influences the child's capacity to form mature intimate relationships in adulthood. An inborn system of the brain influences and organizes motivational, emotional, and memory processes that involve caregivers. The impact of the process of attachment on development cannot be underestimated, since the “patterning and organization of attachment relationships during infancy are associated with characteristic processes of emotional regulation, social relatedness, access to autobiographical memory, and the development of self-reflection and narrative” (Siegel, 1999, p. 67).

Distinct patterns or styles of attachment in early life can be described. When the style of attachment is characterized by emotional interdependence, trust, and mutual feelings, it is called a *secure* style. As adults, individuals with secure styles exhibit more physical and emotional resilience as compared to those with insecure styles (Erdman & Caffery, 2003). That is to say, they are less vulnerable to stressors and, consequently, are less likely to experience health problems, depression, anxiety, substance abuse, or sexual and other psychiatric disorders. On the other hand, vulnerability is associated with *insecure* styles—that is, attachment styles characterized by inconsistency or emotional unavailability (Ainsworth et al., 1978).

At its core, attachment is based on parental sensitivity and responsiveness to the child's needs and signals that foster collaborative parent-child communication. This is referred to as contingent communication, and as such results in secure attachments characterized by collaborative reciprocity of signals and mutual sharing between parent and child. Suboptimal attachments arise from an ongoing pattern of noncontingent communication. A parent's communication and own internal state may be oblivious to the child's needs as in fearful attachment. On the other hand, an ambivalent

attached child— dismissing style—experiences the parent's communication as inconsistently contingent, sometimes being intrusive, while at other times being aligned. If the parent is a source of disorientation or terror, the child will develop a disorganized attachment. Here communication is not only noncontingent but the parent's messages create an internal state of chaos and overbearing fear of the parent in the child (Siegel, 1999).

Types of Attachment Styles in Adulthood

Attachment styles tend to persist into adulthood (Main & Solomon, 1990; Bartholomew & Horowitz, 1991; Hazen & Shaver, 1990). Reflecting Bowlby's (1973) concept of working models of self and others, Bartholomew (1990) developed a four-category system of adult attachment that organizes a person's working models along two dimensions: (1) the distinction between self and others and (2) valence— positive vs. negative evaluation. Based on these dimensions, Bartholomew derived four prototypical styles of adult attachment: *secure* (positive view of self and others), *preoccupied* (negative view of self and others), *dismissing* (positive view of self, negative view of others), and *fearful* (negative view of self and others). Subsequently, based on clinical experience, the *disorganized* (fluctuating positive and negative views of self and others) style was added (Main & Solomon, 1990; Main & Goldwyn, 1998).

Accordingly, personality disorders can be viewed as the outcome of insecure working models that have become self-confirmatory. These working models of self and other have become relatively inflexible and closed to new information, and as a result, the individual experiences significant distress in social, occupational, and relational functioning. It is possible to characterize the various personality disorders in terms of this dimensional model of self and others. It should be noted that Bartholomew (1990) does not assume that “all individuals are expected to exhibit a single attachment style” (p. 162).

Instead, these attachment styles are conceptual prototypes, and thus it is more appropriate to view adult attachment multidimensionally, with individuals exhibiting one or more style types as predominant. Accordingly, DSM-IV personality disorders can be categorized in the following adult attachment style designations (Lyddon & Sherry, 2001).

Preoccupied Attachment Style. The preoccupied attachment dimension is characterized by a sense of personal unworthiness and a positive evaluation of others. These individuals tend to be very externally oriented in their self-definitions. Personality disorders that seem to exemplify this adult attachment style include dependent, obsessive-compulsive, and histrionic.

Fearful Attachment Style. Individuals with a fearful attachment style exhibit a sense of personal unworthiness combined with an expectation that other people will be rejecting and untrustworthy. They trust neither their own internal cognitions or feelings nor others' intentions. While they believe themselves to be special and different from others, they guard against threats and unexpected circumstances, since they cannot trust that others will protect them. Paranoid personality disorder is the most characteristic of such a fearful adult attachment style.

Dismissing Attachment Style. Individuals with a dismissing attachment style are characterized by a sense of self that is worthy and positive, as well as a low and negative evaluation of others that typically manifests as mistrust of others. Because they believe they are emotionally self-sufficient while others are emotionally unresponsive, they dismiss the need for friendship and contact with others. Schizoid personality disorder is the most characteristic of such a preoccupied and fearful adult attachment style.

Preoccupied-Fearful Attachment Style. Individuals with a self-view that is negative and an other-view that vacillates between positive and negative exhibit a composite preoccupied and fearful style.

of attachment. Their avoidance is based on the desire to be liked and accepted by others while fearing rejection and abandonment. Avoidant personality disorder is the most characteristic of such preoccupied and fearful adult attachment style.

Fearful-Dismissing Attachment Style. Individuals with an other-view that is negative and a self-view that vacillates between positive and negative exhibit a composite fearful-dismissing style attachment. They tend to view themselves as special and entitled but are also mindful of their need for others who can potentially hurt them. Accordingly, they use others to meet their needs while being wary and dismissive of them. Antisocial, narcissistic, and schizotypal personality disorders are characterized by such a fearful-dismissing adult attachment style.

Disorganized Attachment Style. Individuals with vacillating views of both self and others exhibit disorganized attachment style. "Disorganized attachment develops from repeated experiences in which the caregiver appears frightened or frightening to the child" (Siegel, 1999, p. 117). This style is associated with dissociative symptomatology that increases proneness to posttraumatic stress disorder. Borderline personality disorder is characterized by unstable personality structure that seems to shift among the various insecure attachment styles, creating a disorganized profile.

Temperament and Personality Disorders

Like attachment, temperament is a construct that appears to have both research and clinical utility. Temperament refers to "the characteristic phenomena of an individual's emotional nature, including his susceptibility to emotional stimulation, his customary strengths and speed of response, the quality of his prevailing moods, and the peculiarities and fluctuation and intensity of moods; the phenomenon being regarded as dependent on constitutional makeup and therefore largely hereditary in origin" (Allport, 1937, p. 54). Although proposed many years ago, Allport's definition is remarkably consistent with many contemporary formulations of the construct.

Reflecting the clinician's view that temperament and attachment styles are related, temperament is viewed as "a filter of personality through which information is processed, attachments evolve, and emotions are experienced and expressed" (Graybar & Boutilier, 2002, p. 156). While clinicians seem convinced that temperament influences attachment and vice versa, researchers are still trying to clarify the exact nature of the relationship between the two constructs. This is largely because both constructs represent different origins and different research agendas. Whereas temperament represents a biological determinant of personality (nature), attachment style represents an environmental determinant of personality (nurture). As in other nature-nurture discussions, the relationship is seldom *either-or but* usually *both-and*. Currently, the research consensus seems to be that attachment and temperament are *modestly* related and that "both will influence the formation and expression of personality and self-concept as these are assembled during early childhood" (Vaughn & Bost, 1999, p. 221).

Temperamental traits and patterns are evident from birth. For instance, while some infants are quite sensitive to light and loud sounds, others are not; while some are calm and placid, others are very active or very fussy. Three main temperament patterns have been observed in infants: *easy* (usually predictable and in a good mood), *slow to warm* (more likely to be resistant to attention and moody) and *difficult* (typically unpredictable and with irritable moods) (Thomas & Chess, 1977). A child's temperament tends to be reflected in adult patterns. For example, optimism and consistency of effort are more common in adults who have easy temperaments, while negativity and suspiciousness are associated with the difficult temperament, and passivity and overdependency with the slow-to-warm-up temperament. Several other temperament traits or descriptors have been identified in adults, including impulsivity, irritability, hypersensitivity to stimulation, reactivity, emotional lability,

inhibition, reflectivity, mood constriction, hypervigilance, and intensity.

Culture, Temperament, and Personality Disorders

As already indicated, research strongly suggests that insecure attachment influences the development of personality disorders (Brennan & Shaver, 1998). But what about the influence of temperament and culture on the development of personality and personality disorders? Brennan and Shaver (1999) believe that the same environmental conditions that contribute to the development of insecure attachments and subsequently personality disorders also interact with an individual's temperament. "In addition, cultural variations in the extent to which particular traits (e.g., independence, eccentricity) are also likely to result in cross-cultural differences in the expression of personality" (p. 868).

Emotional Abuse and Personality Disorders

A history of childhood verbal, emotional, physical, and/or sexual abuse or neglect can significantly impact functioning in adulthood. Research has confirmed that childhood emotional abuse is associated with development of borderline personality disorder (Zanarini, 1997). This has led to clinical awareness of this traumatic pathway and has also influenced clinical practice of this disorder. Accordingly, potent therapeutic approaches, such as dialectic behavior therapy (Linehan, 1993a), have emphasized this traumatic pathway. Such approaches downplay or discourage the use of exploratory interventions, which can be regressive, in favor of supportive and other nonregressive methods.

Recently, researchers have suggested that a history of early abuse or neglect is common in adults with other personality disorders as well (Herman, Perry, & van der Kolk, 1989; Zanarini et al., 2000). For instance, Bernstein et al. (1998) found that a childhood history of emotional abuse was predictive of the development of personality disorders in all three Axis II clusters: odd, dramatic, and anxious. Childhood emotional neglect was predictive of schizoid personality disorder. Bernstein (2000) indicates that childhood histories of *severe* emotional abuse are noted in adults diagnosed with borderline, narcissistic, antisocial, and paranoid personality disorders; *moderate to severe* abuse is present in obsessive-compulsive and histrionic personality disorders; *moderate* levels are noted in avoidant and dependent personality disorders. He also found that a childhood history of *severe* emotional neglect was found among adults with schizoid personality disorders.

Such research is beginning to document the levels of severity of abuse or trauma. But exactly how prevalent is such trauma in clients presenting for treatment? A perusal of the literature on borderline personality leaves the reader with the impression that childhood abuse is a major risk factor or the antecedent cause of borderline personality disorder. However, neither research data nor clinical experience supports this impression. Rather, several research reports, including a meta-analytic study (Fossatti, Madeddu, & Maffei, 1999), indicate that individuals diagnosed with borderline personality disorder report rates of abuse in the range of 60 to 80 percent. Thus, 20 to 40 percent of the individuals do not report such histories. In other words, while there are traumatic pathways in the development of personality disorders, there are also nontraumatic pathways. The implication is that clients who were not traumatized but rather may have been wounded as children in their efforts to meet emotional needs are likely to be responsive to a broader range of therapeutic interventions. They would include exploratory, uncovering, and abreactive interventions, which are less likely to be regressive or iatrogenic than they would be with clients with trauma histories (Graybar & Boutilic, 2002).

Functional Capacity and Impairment

It is a common belief among clinicians that although Axis II disorders can present treatment challenge, they are less impairing than serious Axis I disorders such as major depressive disorder (Skodol et al., 2002). The extent of impairment of individuals with personality disorders as compared to Axis I symptom disorders has been the focus of large-scale research efforts lately. Initial results from the ongoing Collaborative Longitudinal Personality Disorders Study are particularly telling. This is one of the first studies to document and quantify the extent of functional impairment in patients with an Axis II disorder in contrast to patients having an impairing Axis I disorder. It compares psychosocial functioning and impairment among four groups of personality disorders—borderline, schizotypal, avoidant, and obsessive-compulsive—with a group of patients with major depressive disorder and no personality disorder. Patients with borderline and schizotypal personality disorders were found to have significantly more impairment at work, in social relations, and in leisure activities than patients with obsessive-compulsive or major depressive disorder. In contrast, patients with avoidant personality disorders experienced intermediate levels of impaired functioning. Of particular note is that these differences were found across all assessment modalities and remained significant after statistically controlling for demographic differences and comorbid Axis I pathology (Skodol et al., 2002). These results not only underscore clinicians' misconceptions of the extent of psychiatric morbidity attendant to Axis II disorders but also suggest the importance of utilizing integrative treatment interventions that emphasize psychosocial rehabilitation to mitigate the pernicious effects of personality disorders on functioning.

Dimensional Models: Anticipated Changes in DSM-V

The current DSM-IV method for diagnosing and specifying personality disorders is the categorical approach. In the categorical approach, an individual either has or does not have a personality disorder depending on whether the individual meets or exceeds a specified threshold, usually four or five criteria depending on the particular disorder. For example, an individual who meets four of the borderline personality disorder criteria is considered to have borderline traits, whereas if the individual meets five of the criteria, a diagnosis of borderline personality disorder would be given. Unfortunately, the thresholds established in DSM-IV are somewhat arbitrary based on limited empirical research. "Furthermore, there is no documented clinical utility for the DSM-IV categories in terms of guiding treatment decisions" (First, 2002, p. 12).

An alternate method is the dimensional approach. In this method, a personality trait is considered to be a maladaptive variant of general personality functioning. Over the years, several different dimensional approaches have been proposed in place of the categorical approach (First, 2002). The dimensional approaches differ in both how they were developed and the extent to which dimensional items are limited to personality disorder symptoms or reflect a full range of normal and abnormal functioning. Prior to the publication of DSM-IV, the dimensional approach was considered to replace the categorical method of DSM-III and DSM-III-R but was rejected because there was no consensus to which dimensional approach had sufficient research support and clinical utility. Currently, the DSM-V Personality and Relational Disorders Workgroup is evaluating five such approaches. Presumably, one of these approaches will be incorporated into DSM-V. A brief description of each of these follows.

Pure Dimensional Approach

Although this approach emphasizes the dimensional model, it is closest to the existing Axis I category system. It basically transforms the existing categories into dimensional representations of specified personality disorders in DSM-IV. Dimensional criteria are simply the number of criteria that

are met or present in a particular client. The clinician simply checks each of the diagnostic criteria for each of the ten personality disorders. If one to three criteria are met, a *personality trait* is considered present. If four or five criteria are met, a *disorder* can be specified (depending on whether the diagnostic threshold for the disorder is four or five criteria). The dimensional designation is *pervasive* if five to eight criteria are met and *protypic* if seven to nine are present. In short, the pure dimensional approach allows a client to be mapped in terms of all ten personality disorders—a map similar to the profile configuration of the MMPI-2 and other personality inventories. This approach is advocated by Oldham and Skodol (2000).

Prototype Matching Approach

This approach permits the clinician to diagnose personality pathology on a continuum from less to more severe. Rather than the current DSM-IV system that compares client symptoms or behaviors against specific diagnostic Axis II criteria, the clinician simply rates the overall similarity or resemblance between the client and specific prototypes that describe each personality disorder in its “purest” form. These pure types are based on DSM criteria.

Clinically Derived Personality Prototypes Approach

Developed empirically from descriptions of actual clients provided by more than one thousand experienced clinicians, this system provides a set of personality descriptions or prototypes that reflect what clinicians see in everyday clinical practice. There are three differences in this approach to the current Axis II system: First, the diagnostic criteria are different since they were empirically derived from actual clients in typically clinical settings. Second, personality pathology is diagnosed on a continuum from less to more severe. Third, like the prototype matching approach, the clinician rates the overall similarity or resemblance between the client and specific prototypes. This approach was developed and is advocated by Westin and Shedler (2000).

Five-Factor Model Approach

This approach is based on five broad factors of personality functioning: neuroticism, extroversion, openness to experience, conscientiousness, and agreeableness. Each factor is further differentiated into six specific facets or components, yielding 30 facets. It is believed that this Five-Factor Model provides a comprehensive description of both adaptive and maladaptive personality traits that most individuals find important in describing themselves and others. In this approach the clinician rates the client against each of the 30 facets on a scale of 1 to 7. While these ratings do not translate into specific Axis II diagnostic categories—that is, borderline personality disorder—they provide a rather comprehensive factor map of the client. This approach is advocated by Widiger, Costa, and McCrae (2002).

Two-Step Psychobiological System Approach

This approach conceptualizes personality as a complex interaction between temperament—that is, heritable neurobiological dispositions—and character—that is, social learning and cultural factors. It specifies personality in terms of three character traits—self-directedness, cooperativeness, and self-transcendence—and three temperament traits—harm avoidance, novelty seeking, and reward dependence. The clinician evaluates a client on the three character traits. Low scores on these traits represent a personality disorder. Once such a diagnosis is established, temperament is used for specifying a particular personality disorder. Extreme scores on the temperament traits, individually or

as multifactorial combinations, reflect specific personality patterns. Thus, high ratings on novelty seeking and harm avoidance with low ratings on reward dependence are specific for borderline personality disorder. This approach was developed and is advocated by Cloninger (2000).

TRENDS IN THE TREATMENT OF PERSONALITY DISORDERS

This section describes a number of cutting-edge clinical and research trends that are and will continue to impact the treatment of personality disorders. These include treatment utilization, brain-behavior perspective, medication, and various psychotherapeutic interventions such as mindfulness, schema therapy, structured skill intervention and cognitive coping therapy, and developmental therapy.

Treatment Utilization

Clinicians who work with a variety of psychiatric presentations recognize that personality-disordered individuals often have higher rates of treatment utilization than individuals with other diagnoses. Until recently, there was little research on the actual extent and variety of utilization of mental health services by such individuals. A large-scale study of individuals diagnosed with personality disorder—the ongoing Collaborative Longitudinal Personality Disorders Study, has addressed this matter. The major psychiatric epidemiological study indicates that personality-disordered individuals utilize considerably more mental health treatment than individuals diagnosed with clinical depression without a concomitant personality disorder. In addition to the amount of services, the type or variety of utilized services was studied. The treatment histories of four personality disorder groups—borderline, schizotypal, avoidant, and obsessive-compulsive—were compared with a group of individuals diagnosed with major depressive disorder. Compared to the clinical depression group, those with borderline personality disorder were more likely to have received inpatient hospitalization, day treatment, medication, residential care, in addition to outpatient individual and group therapy, whereas those with obsessive-compulsive personality disorder had greater utilization of individual therapy. Of all groups, those with borderline personality disorder utilized not only more treatment but more treatment modalities—except for couples therapy, family therapy, and self-help groups—than other groups (Bender et al., 2001). Unfortunately, the study provides no evidence that these personality-disordered individuals are receiving adequate or even appropriate treatment.

Brain-Behavior View of Treatment Processes

One of the outcomes of recent neuroscience investigations into the brain-behavior correlates is the conceptualization of the treatment of personality disorders as either top-down or bottom-up strategies, particularly regarding efforts to normalize the expression of overmodulated maladaptive personality traits with various psychotropic and behavioral interventions (Fawcett, 2002). *Top-down* refers to treatment efforts that are primarily focused on cortical structures and neural tracts (top), which can also influence subcortical circuits, particularly in the limbic system (down). *Bottom-up* refers to treatment efforts that are largely focused on limbic circuits, which also can produce changes in cortical circuits.

Of particular promise are recent efforts to normalize the expression of under- and overmodulated maladaptive personality traits with psychotropic and behavioral interventions. For example, top-down treatment strategies typically utilize psychotherapies and behavioral interventions—that is, cognitive behavior therapy—to enhance cortical influences on limbic circuits. The goal is to undo negative learning, particularly maladaptive schemas, and to increase the modulating or normalizing effects on emotional responses. Bottom-up treatment strategies typically involve the use of psychotropic

medication in order to modulate harmful personality traits and emotional states by normalizing the activity of limbic structures. Besides medications, it appears that skill training interventions, such as cognitive coping therapy (Sharoff, 2002), function as bottom-up treatments. A subsequent section further describes this intervention.

Medication Strategies

Until recently, medication treatment of personality-disordered individuals has been largely empirical, that is, largely trial and error. That is because, generally speaking, there are not specific drug treatments for specific DSM-IV personality disorders as there are for panic disorder or major depressive disorder. The possible exception is avoidant personality disorder, wherein venlafaxine (Effexor), a selective serotonin-norepinephrine uptake inhibitor, appears to be particularly effective in reducing avoidant personality traits. Since avoidant personality disorder appears to be only quantitatively different from social phobia, it may be that medications effective in treating social phobia are also likely to be effective with this personality disorder (Altamura et al., 1999; Reich, 2000).

Even though there are currently no specific psychotropic agents for specific personality disorders except as noted above, there appears to be increasing confidence that medication treatment can be effective if it focuses on maladaptive personality *traits* associated with various personality disorders. There is mounting clinical research evidence, including some double-blind studies, that specific medications can effectively target such maladaptive personality traits as impulsivity, anger and aggression, inhibition, suspiciousness, and mood lability. Reich (2002) summarizes the efficacy of various classes of psychotropic medications for specific personality traits. He describes three clusters of such traits and provides suggested protocols for treatment.

Each of these three clusters is briefly described in this section. He indicates that such medication trials should last at least 4 to 6 weeks, barring problematic side effects. The question of the duration of medication treatment is complicated, but given that personality-disordered behaviors and concerns are typically long term, ongoing use may be justified if the medication or combination of medications improves symptoms and/or functioning and has an acceptably low level of side effects (Reich, 2002).

Paranoid, Mild Thought Disorder and Dissociation Cluster

Start with an atypical antipsychotic, such as risperidone, at one-fourth to one-half the usual typical range maintenance dose for psychosis. If there is no response, incrementally increase the dosage. If there is no response at the top dose, switch to another atypical. If there is a partial response, consider adding divalproex. Clozapine should be considered only in refractory individuals. When dissociative symptoms are prominent, naltrexone can be considered.

Depressed, Angry, Labile Mood Cluster

Begin with an SSRI at antidepressant dosages. If that SSRI fails, try another. If there is a partial response, an adjunctive atypical psychotic agent or a mood stabilizer such as valproate or carbamazepine can be considered. For individuals in whom rejection sensitivity is prominent, a trial of an MAOI is reasonable, particularly if the individual has a history of medication compliance. Naltrexone may be a useful adjunctive for individuals with self-harming behavior.

Anxious, Inhibited Behavior Cluster

For personality-disordered individuals with prominent anxiety but without impulsivity, begin with a

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