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

SECOND EDITION

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by

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Foreword

This book is to be read by both clinical professionals and graduate students alike. It is a thoughtful an practical reference text that readers will find useful time and time again as they face the difficult-t 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 psychiatr The turn of events has been almost startling, with the DSM-III and IV giving these disorders a maj position, via Axis II, in their innovative multiaxial model.

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

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

His approach goes beyond merely describing the simple content of personality disorders. Dr. Sperr helps provide the reader with an understanding of the underlying sources and treatment implicatio 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 initi diagnostic contact to final treatment evaluation.

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

seen by clinicians today, the dysfunctions of personality have become omnipresent, whether on practices marital and family therapy, forensics, behavioral medicine and health psycholog neuropsychology, or any of the other main realms of outpatient work. Not unexpectedly, the literatu in this field has grown immensely and shortly will outstrip all other areas of psychological an psychiatric practice in the coming decade. If my own broad-ranging text *Disorders of Personality* ha seen some 30 printings in its two editions thus far, then Dr. Sperry's current volume will add further t 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 th highly prevalent realm of psychotherapeutic practice. It is a noteworthy commendation of this wo that his publishers encouraged him to write a revision, a thorough and updated text in a flourishin field of study.

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

Preface

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

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

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

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

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

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

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

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

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

–Len Sperry, February 200

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 Disorder* (Sperry, 1995) likened the paradigm shift occurring with personality disorders beginning in the ear 1990s to the paradigm shift that already had occurred with depressive disorders. Until the mid-1970 many clinicians felt relatively ineffective in treating depressive disorders, and until the early 1990 this same sentiment was shared by many clinicians about treating personality disorders. I insisted th such a paradigm shift involving personality disorders would require a major change in the wa clinicians conceptualize, assess, and treat these disorders. I predicted that while such a change attitude and practice patterns might be resisted by some, most clinicians would respond to th challenge. Such a shift would mean relinquishing the then prevailing view that personality disorde were essentially untreatable conditions. With some trepidation, I ended the chapter with a quo conveying the sentiment that clinicians might even come to consider that personality-disordere patients would "become our most welcome clients in the new century, clients who are deeply trouble 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, th paradigm seems to have shifted. While not all clinicians feel that they can help every personalit disordered individual with confidence, there is, nevertheless, an increasing consensus amon clinicians that many patients can be helped with current treatment interventions, even those meetin DSM-IV-TR criteria for borderline personality disorder.

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

THE NEW PARADIGM IN PERSONALITY DISORDERS

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

or character dimension. Neurobiological and bio-social formulations of personality disorder hav attracted considerable attention and have generated a considerable amount of research. Millon (Millo & Davis, 2000) and Cloninger (1987, 2000; Cloninger, Svrakic, & Przybeck, 1993) hypothesize th temperament and neurotransmitters greatly influence personality development and functionin Cloninger and colleagues (1993, 2000) describe personality as the influence of character an temperament wherein temperament refers to the innate genetic and constitutional influences o personality, and character refers to the learned psychosocial influences on personality. Cloninge hypothesizes that temperament has formed measurable biological subtracts: novel-seeking, har avoidance, reward dependence, and persistence; character has three quantifiable factors: sel directedness, cooperativeness, and self-transcendence. He believes that personality style reflects th individual's temperament factors plus positive or high scores on the three character factors. On th 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 psychologic models of personality disorders. FFM describes personality dimensionally in terms of the factors agreeableness, conscientiousness, neuroticism, extroversion, and openness (Costa & McCra 1990,1992).

Stone (1993) describes a “grand unified theory” of personality disorders. Basically, this unifie theory interdigitates the Five-Factor Model–a psychological model–and Cloninger's Seven-Fact Model–a biosocial model. This unified theory is essentially a biopsychosocial theory of personali disorders. In addition to these research-based theories and models, there are a number of differe clinical formulations of personality disorders (Beck, Freeman, & Associates, 1990; Benjamin, 199 Gabbard, 1990).

In the past, criteria for the assessment of personality disorders were somewhat primitive. DSM subdivided personality disorders into five headings: personality pattern disturbance, personality tra disturbance, sociopathic personality disturbance, special symptom reactions, and transient situation personality disorders. DSM-II, which appeared in 1968, eliminated the subheadings and streamline the number of personality disorders. The descriptions were not based on clinical trials. Although bri descriptions of each disorder were given, diagnostic criteria were not provided. Furthermore, the 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. striking example is obsessive-compulsive disorder and obsessive-compulsive personality disorde 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 mak this distinction, referring to both as aspects of the “obsessive personality” (Salzman, 1980). Perhap this harkens back to Freud's case description of the Rat Man in which both obsessive-compulsiv disorder and obsessive-compulsive personality disorder were present (Francis, Clarkin, & Perr 1984). The implication was that both are essentially the same, so treatment should be the same f both disorders. Jenike (1991) notes that the concurrence of obsessive-compulsive disorder in patien with obsessive-compulsive personality disorder is small, probably less than 15 to 18 percen Currently, the DSMV Planning Group on Personality and Relational Disorders is considering majo changes regarding the diagnosis of the Axis II disorders.

In the past, assessment of personality disorder was by clinical interview and inferred fro standardized personality inventories such as the MMPI. Today, there are a number of formal measure of personality disorders. Some are theory and research based, such as Millon's MCMIIII (1994) an 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 Personali Disorders Questionnaire-Revised (PDQ-R). There are a number of semistructured schedules availabl

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

In large part, these assessment measures reflect the increasingly differentiated criteria of DSM-II 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 an self-defeating personality disorders to Appendix B. DSM-IV further differentiated criteria an dropped self-defeating and sadistic personality disorders. It relegated passive-aggressive personali disorder to the category personality disorder-not otherwise specified (NOS), as well as depressiv 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 psychodynam approaches. Psychoanalysis and long-term psychoanalytically oriented psychotherapy were considere the treatment of choice (Stone, 1993). The goal of treatment was to change character structur Unfortunately, outcomes were mixed even among patients adjudged amenable to treatment. For th most part, clinicians utilizing a traditional exploratory approach adopted a neutral and passive stan and primarily utilized clarification and interpretation strategies.

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

Furthermore, I emphasized that psychopharmacological research on treatment of selecte personality disorders was expanding rapidly. Prior to the paradigm shift, the consensus amon clinicians was that medication did not and could not treat personality disorders, per se, but rath concurrent Axis I conditions or target symptoms such as insomnia. This view has changed markedl Based on investigations of the biological correlates of personality disorders, Siever and Davis (199 proposed a psychobiological treatment model that has been of inestimable clinical and research valu Essentially, Siever and Davis believe that psychopharmacological treatment can and should b directed to basic dimensions that underlie the personality. The dimensions are cognitive/perceptu organizations, especially for the schizotypal and passive disorders, for which low-dose neurolepti might be useful; impulsivity and aggression in the borderline and antisocial, for which seroton blockers can be useful; affective instability for borderline and histrionic personalities, for whic cyclic antidepressants or serotonin blockers may be useful; and anxiety/inhibition, particularly avoidant personalty disorder, for which serotonin blockers and MAOI agents may be useful.

It was also noted that research was increasingly suggestive that effective treatment of personali disorders involved combining treatment modalities and integrating treatment approaches. Ston (1993) suggests combining three approaches. He notes that supportive interventions are particular 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 cognitiv behavioral interventions, which are useful in the development of new attitudes and habits. Winer an Pollock (1989) and Stone (1993) also recommend combing medication with individual and grou 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 la 1990s. Now, integrating and combining treatments is an emerging consensus that reflects th 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 effecti treatment outcomes with personality disorders. The passage of time has reinforced their clinic 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 seriou limitations (Stone, 1993). Similarly, viewing personality disorders as basically biological temperamental is limiting. On the other hand, there is considerable research and clinical support f viewing personality disorders from the perspective of character and temperament. Such biopsychosocial or integrative clinical formulation should be reflected in a treatment plan that biopsychosocially focused.

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

Treatability is a function of a patient's readiness and level of functioning. Patient readiness refers the individual patient's motivation for and expectations for treatment outcomes, as well as past histo of treatment compliance and success at efforts to change habits and behavior patterns. Level functioning can be operationalized in terms of the Global Assessment of Functioning Scale (GAF) Axis IV. High functioning refers to a score of about 65. Moderate functioning refers to a score of 45 t 65. Low functioning refers to a score below 45.

Stone (1993) suggests that personality disorders lend themselves to a three-category classificatio with regard to treatability: (1) high amenability: includes dependent, histrionic, obsessive-compulsiv avoidant, and depressive personality disorders; (2) intermediate amenability: includes narcissisti borderline, and schizotypal personality disorders; (3) low amenability: includes paranoid, passiv aggressive, schizoid, and antisocial personality disorders. Stone adds that since patients sho mixtures of various personalty traits, prognosis is largely dependent on the degree to which traits the disorders in the third category are present. Prognosis also depends in part on the prominence of th psychobiological dimensions described by Siever and Davis (1991): cognitive/perceptu disorganization; impulsivity/aggression; affective inability or anxiety/inhibition. To the extent th dimensions such as impulsivity or anxiety respond to medication, concurrent psychosoci 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 th particular needs, circumstances, expectations, and overall level of functioning of the individua Tailoring refers to modifying or adapting a particular modality and/or therapeutic approach to th patient's needs, styles, and expectations.

A sartorial analogy might help distinguish between combining, integrating, and tailoring. An adu could go into a clothing store to purchase a gray business suit. The individual could randomly choo a suit from the rack and there would be a small chance of it fitting perfectly, but more likely it woul 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. C 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. Th blended fabric would be analogous to integrating treatment. Analogous to combined treatment woul be purchasing a blue sports jacket that might be worn with the pants of the gray suit for a more casu look. In short, there can be no one-size-fits-all protocols for successful treatment of personali disorders.

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

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

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

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

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

Finally, individuals with borderline personalities can create complex difficult situations treatment. For instance, they may provoke crises with suicide attempts and other self-destructiv behavior, or they have had multiple treatments with different clinicians and rejected many or all 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 inten relationships with those who are not in a position of authority. Yet borderline individuals can reser sharing a therapist– that is, the group therapist–and dislike being exposed to other group member feelings. Nevertheless, a group component has been shown to be an integral part of some treatme approaches developed specif ically for borderline personality-disordered individuals, such as dialect behavior therapy (Linehan, 1993a).

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

Confirming clinical experience, research is now documenting that personality disorders are significant source of psychiatric morbidity and lead to more functional impairment than maj depression (Skodol et al., 2002). Often, low levels of functional impairment are suggestive of lo treatability and in dicative of the need for combining treatment modalities and approaches. There h been increasing interest in combined therapies and integrative treatment. This follows a long period time in which clinicians were skeptical or even hostile about combining two modalities such individual psychotherapy and group therapy, or medication and psychoanalytic psychotherap However, research and clinical practice reveal several advantages for combined therapeut modalities. These include additive and even synergistic treatment effects, diluting unworkably inten 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 different treatment approaches or orientation, such as psychodynamic, cognitive, behaviora interpersonal, and so on. Combining treatment modalities is also referred to as multimodal treatmen Finally, tailored treatment refers to specific ways of customizing treatment modalities and/ therapeutic approaches to fit the unique needs, cognitive and emotional styles, and treatme expectations of the patient.

Once considered controversial, psychoanalytically oriented therapy combined with other modaliti is now being advocated by dynamically oriented clinicians. Winer and Pollack (1989) indicate th 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 becoming more evident that different treatment approaches are differentially effective in resolvi different types of symptom clusters. For example, in major depression, medication is more effecti in remitting vegetative symptoms, while psychotherapy is better at improving interpersonal relatio and cognitive symptoms (Frances, Clarkin, & Perry, 1984). Furthermore, the additive effect medication and psychotherapy has been established for both major depression (Rush & Hollon, 199 and agoraphobia (Greist & Jefferson, 1992).

What are the indications and contraindications for these various modalities? A working knowledg of these are probably more necessary for clinicians working with personality disorders than for Axis disorders. Francis, Perry, and Clarkin (1984) detail the relative indication, relative contraindicatio and enabling factors for three treatment modalities: individual, group, and family/marital. The read 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 clinicia considers offering treatment to a personality-disordered individual: Is treatment advisable or would n 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 n

progress in the course of interminable therapy.

Francis, Perry, and Clarkin (1984) offer specific criteria for making the treatment versus r treatment recommendation. They also note that patients were ten times more likely to initiate "r treatment" decisions than were clinicians to offer this option.

While combined treatment refers to combining different modalities of treatment (i.e., individua group, marital and family therapy, day treatment, or inpatient) either concurrently or sequentiall integrative or tailoring treatment is different. Integrative treatment refers to blending variou treatment approaches (i.e., psychodynamic, cognitive, behavioral, interpersonal, and medication Several researchers have advocated integrative treatment for treatment of borderline personali disorder (Stone, 1992; Linehan, 1993). Cognitive-behavior therapy represents the integration of tw therapeutic approaches: cognitive therapy and behavior therapy. The specific type of cognitiv behavior therapy developed by Linehan, dialectal behavior therapy, is an integration of variou cognitive-behavioral intervention strategies and Zen practice (Heard & Linehan, 1994). Stone (199 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 le immediacy there may be to combining and blending most of the modalities and approaches. On th other hand, the lower the functioning, the more modalities and approaches will need to be combine and blended.

This premise may seem quite demanding of the clinician's professional resources. It is. Not ever clinician is suited for working with all personalitydisordered individuals, particularly those with lo amenability to treatment. Specialized training and supervision in the utilization of various approach is needed in the treatment of personality disorders. It is not being suggested that clinicians should must also be trained in the various treatment modalities. Obviously, referral to group or famil 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 secon level involves personality features that are related to environment and are modifiable. The third lev involves personality features that are related to character. The fourth level involves personali functions related to temperament. Treatment of levels one and two is relatively straightforwar Medication or behavioral treatments like exposure may quickly remit symptoms of personalit Psychotherapeutic interventions of various approaches and modalities can often be useful at lev three. But they may not be, as in the case of rule-breaking behavior of the antisocial individual. Lev 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 treatmen 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. Th individual's temperament remains, but treatment renders the individual somewhat easier to work live with. Essentially, then, personality style will be used in the subsequent chapters to refer to hig adaptive functioning behavior for a particular personality type, whereas personality disorder refers 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 moveme from personality-disordered functioning to adequate personality-style functioning or even to optima functioning*. From a developmental psychotherapeutic perspective (Sperry, 2002), the continuum o functioning, and subsequently treatment, is broadened to include an optimal level of functioning. (Se

the section on treatment trends.)

FROM DSM-IV TO DSM-IV-TR

In 2000, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revisio* (DSM-IV-TR) was published (American Psychiatric Association, 2000). As the title suggests, th revision was primarily of the text supporting diagnostic categories and criteria. While there we some changes in diagnostic criteria–that is, paraphilias–this was not the main focus. Significa 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. Furthermor passive-aggressive personality disorder (negativisitic personality disorder) and depressive personali 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 chapte These are briefly summarized.

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

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

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

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

Finally, text in the "Course" section of borderline personality disorder was added to "emphasiz that, contrary to many clinicians' preconceived notions, the prognosis for many individuals wi Borderline Personality Disorder is good" (p. 842). The new text reads, "During their 30s and 40s th majority of individuals with this disorder attain stability in their relationships and vocation functioning. Follow up studies of individuals identified through outpatient mental health clini indicate that after ter about 10 years, as many as half of the individuals no longer have a pattern th 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 continu

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

Attachment Styles and Personality Disorders

Attachment researchers insist that early life relational deficits lead to both neurophysiological bra deficits as well as psychological deficits (Siegel, 1999). A sensitive and responsive parent helps gro 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 gurglin smiling infant is picked up and "answered" by the parents with a smiling and joyful expression an words. Or, the baby cries in pain or frustration and the parent soothes and consoles it, or calms dow the overexcited child at bedtime. These routine and continuous interactions serve to stimulate th growth of synapses in the orbitofrontal cortex of the brain, which enable children to modulate the frustration, rage, and fear, and to respond flexibly to others.

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

Types of Attachment Styles in Early Life

Attachment refers to the emotional bond that develops between child and parent or caregiver an subsequently influences the child's capacity to form mature intimate relationships in adulthood. A inborn system of the brain influences and organizes motivational, emotional, and memory process that involve caregivers. The impact of the process of attachment on development cannot b underestimated, since the "patterning and organization of attachment relationships during infancy associated with characteristic processes of emotional regulation, social relatedness, access 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 attachme is characterized by emotional interdependence, trust, and mutual feelings, it is called a *secure* styl As adults, individuals with secure styles exhibit more physical and emotional resilience as compare to those with insecure styles (Erdman & Caffery, 2003). That is to say, they are less vulnerable t stressors and, consequently, are less likely to experience health problems, depression, anxiet substance abuse, or sexual and other psychiatric disorders. On the other hand, vulnerability associated with *insecure* styles–that is, attachment styles characterized by inconsistency or emotion unavailability (Ainsworth et al., 1978).

At its core, attachment is based on parental sensitivity and responsivity to the child's needs an signals that foster collaborative parent-child communication. This is referred to as continge communication, and as such results in secure attachments characterized by collaborative reciproci of signals and mutual sharing between parent and child. Suboptimal attachments arise from a 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 ambivale

attached child– dismissing style–experiences the parent's communication as inconsistently contingen sometimes being intrusive, while at other times being aligned. If the parent is a source disorientation or terror, the child will develop a disorganized attachment. Here communication is n only noncontingent but the parent's messages create an internal state of chaos and overbearing fear the parent in the child (Siegel, 1999).

Types of Attachment Styles in Adulthood

Attachment styles tend to persist into adulthood (Main & Solomon, 1990; Bartholomew & Horowit 1991; Hazen & Shaver, 1990). Reflecting Bowlby's (1973) concept of working models of self an others, Bartholomew (1990) developed a four-category system of adult attachment that organizes person's working models along two dimensions: (1) the distinction between self and others and (valence– positive vs. negative evaluation. Based on these dimensions, Bartholomew derived fo prototypical styles of adult attachment: *secure* (positive view of self and others), *preoccupie* (negative view of self and others), *dismissing* (positive view of self, negative view of others), *an fearful* (negative view of self and others). Subsequently, based on clinical experience, th *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 th have become self-confirmatory. These working models of self and other have become relativel inflexible and closed to new information, and as a result, the individual experiences significa distress in social, occupational, and relational functioning. It is possible to characterize the variou personality disorders in terms of this dimensional model of self and others. It should be noted th Bartholomew (1990) does not assume that "all individuals are expected to exhibit a single attachme style" (p. 162).

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

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

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

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

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

of attachment. Their avoidance is based on the desire to be liked and accepted by others while fearin 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 sel 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 f others who can potentially hurt them. Accordingly, they use others to meet their needs while beir wary and dismissive of them. Antisocial, narcissistic, and schizotypal personality disorders a characterized by such a fearful-dismissing adult attachment style.

Disorganized Attachment Style. Individuals with vacillating views of both self and others exhib disorganized attachment style. "Disorganize attachment develops from repeated experiences in whic the caregiver appears frightened or frightening to the child" (Siegel, 1999, p. 117). This style associated with dissociative symptomatology that increases proneness to posttraumatic stre disorder. Borderline personality disorder is characterized by unstable personality structure that seem 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 utilit Temperament refers to "the characteristic phenomena of an individual's emotional nature, includin his susceptibility to emotional stimulation, his customary strengths and speed of response, the quali 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 origin" (Allport, 1937, p. 54). Although proposed many years ago, Allport's definition is remarkabl consistent with many contemporary formulations of the construct.

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

Temperamental traits and patterns are evident from birth. For instance, while some infants are qui sensitive to light and loud sounds, others are not; while some are calm and placid, others are ve active or very fussy. Three main temperament patterns have been observed in infants: *easy* (usual 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 temperament tends to be reflected in adult patterns. For example, optimism and consistency of effo are more common in adults who have easy temperaments, while negativity and suspiciousness a 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 adul including impulsivity, irritability, hypersensitivity to stimulation, reactivity, emotional labilit

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

Culture, Temperament, and Personality Disorders

As already indicated, research strongly suggests that insecure attachment influences the developme of personality disorders (Brennan & Shaver, 1998). But what about the influence of temperament ar culture on the development of personality and personality disorders? Brennan and Shaver (199 believe that the same environmental conditions that contribute to the development of insecu attachments and subsequently personality disorders also interact with an individual's temperamen "In addition, cultural variations in the extent to which particular traits (e.g., independenc eccentricity) are also likely to result in cross-cultural differences in the expression of personality" (868).

Emotional Abuse and Personality Disorders

A history of childhood verbal, emotional, physical, and/or sexual abuse or neglect can significant impact functioning in adulthood. Research has confirmed that childhood emotional abuse is associate with development of borderline personality disorder (Zanarini, 1997). This has led to clinicia awareness of this traumatic pathway and has also influenced clinical practice of this disorde Accordingly, potent therapeutic approaches, such as dialectic behavior therapy (Linehan, 1993a), hav emphasized this traumatic pathway. Such approaches downplay or discourage the use of explorato 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 adul 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 predictiv of the development of personality disorders in all three Axis II clusters: odd, dramatic, and anxiou childhood emotional neglect was predictive of schizoid personality disorder. Bernstein (200 indicates that childhood histories of *severe* emotional abuse are noted in adults diagnosed wi borderline, narcissistic, antisocial, and paranoid personality disorders; *moderate to severe* abuse present in obsessive-compulsive and histrionic personality disorders; *moderate* levels are noted avoidant and dependent personality disorders. He also found that a childhood history of *seve* 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 ho prevalent is such trauma in clients presenting for treatment? A perusal of the literature on borderlin personality leaves the reader with the impression that childhood abuse is a major risk factor or th antecedent cause of borderline personality disorder. However, neither research data nor clinic experience supports this impression. Rather, several research reports, including a meta-analytics stud (Fossatti, Madeddu, & Maffei, 1999), indicate that individuals diagnosed with borderline personali 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 th development of personality disorders, there are also nontraumatic pathways. The implication is th clients who were not traumatized but rather may have been wounded as children in their efforts meet emotional needs are likely to be responsive to a broader range of therapeutic interventions. Th would include exploratory, uncovering, and abreactive interventions, which are less likely to b regressive or iatrogenic than they would be with clients with trauma histories (Graybar & Boutilie 2002).

Functional Capacity and Impairment

It is a common belief among clinicians that although Axis II disorders can present treatme challenge, they are less impairing than serious Axis I disorders such as major depressive disord (Skodol et al., 2002). The extent of impairment of individuals with personality disorders as compare to Axis I symptom disorders has been the focus of large-scale research efforts lately. Initial resul from the ongoing Collaborative Longitudinal Personality Disorders Study are particularly telling. Th is one of the first studies to document and quantify the extent of functional impairment in patien with an Axis II disorder in contrast to patients having an impairing Axis I disorder. It compare psychosocial functioning and impairment among four groups of per sonality disorders –borderlin schizotypal, avoidant, and obsessive-compulsive–with a group of patients with major depressiv disorder and no personality disorder. Patients with borderline and schizotypal personality disorde were found to have significantly more impairment at work, in social relations, and in leisure activiti than patients with obsessive-compulsive or major depressive disorder. In contrast, patients wi avoidant personality disorders experienced intermediate levels of impaired functioning. Of particul note is that these differences were found across all assessment modalities and remained significa after statistically controlling for demographic differences and comorbid Axis I pathology (Skodol al., 2002). These results not only underscore clinicians' misconceptions of the extent of psychiatr morbidity attendant to Axis II disorders but also suggest the importance of utilizing integrativ treatment interventions that emphasize psychosocial rehabilitation to mitigate the pernicious effec 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 categoric approach. In the categorical approach, an individual either has or does not have a personality disord depending on whether the individual meets or exceeds a specified threshold, usually four or fiv criteria depending on the particular disorder. For example, an individual who meets four of th borderline personality disorder criteria is considered to have borderline traits, whereas if th individual meets five of the criteria, a diagnosis of borderline personality disorder would be give Unfortunately, the thresholds established in DSM-IV are somewhat arbitrary based on limite empirical research. "Furthermore, there is no documented clinical utility for the DSM-IV categories terms of guiding treatment decisions" (First, 2002, p. 12).

An alternate method is the dimensional approach. In this method, a personality trait is considered be a maladaptive variant of general personality functioning. Over the years, several differe 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 dimension items are limited to personality disorder symptoms or reflect a full range of normal and abnorm functioning. Prior to the publication of DSM-IV, the dimensional approach was considered to replac 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, th DSM-V Personality and Relational Disorders Workgroup is evaluating five such approache Presumably, one of these approaches will be incorporated into DSM-V. A brief description of each o these follows.

Pure Dimensional Approach

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

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

Prototype Matching Approach

This approach permits the clinician to diagnose personality pathology on a continuum from less more severe. Rather than the current DSM-IV system that compares client symptoms or behavio against specific diagnostic Axis II criteria, the clinician simply rates the overall similarity resemblance between the client and specific prototypes that describe each personality disorder in i "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 thousan experienced clinicians, this system provides a set of personality descriptions or prototypes that refle what clinicians see in everyday clinical practice. There are three differences in this approach to th current Axis II system: First, the diagnostic criteria are different since they were empirically derive from actual clients in typically clinical settings. Second, personality pathology is diagnosed on continuum from less to more severe. Third, like the prototype matching approach, the clinician rat the overall similarity or resemblance between the client and specific prototypes. This approach w 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, extroversio openness to experience, conscientiousness, and agree ableness. Each factor is further differentiate into six specific facets or components, yielding 30 facets. It is believed that this Five-Factor Mod provides a comprehensive description of both adaptive and maladaptive personality traits that mo individuals find important in describing themselves and others. In this approach the clinician rates client against each of the 30 facets on a scale of 1 to 7. While these ratings do not translate in specific Axis II diagnostic categories–that is, borderline personality disorder–they provide a rath comprehensive factor map of the client. This approach is advocated by Widiger, Costa, and McCra (2002).

Two-Step Psychobiological System Approach

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

as multifactorial combinations, reflect specific personality patterns. Thus, high ratings on novel seeking and harm avoidance with low ratings on reward dependence are specific for borderli 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 continu to impact the treatment of personality disorders. These include treatment utilization, brain-behavi perspective, medication, and various psychotherapeutic interventions such as mindfulness, schem 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-disordere individuals often have higher rates of treatment utilization than individuals with other diagnose Until recently, there was little research on the actual extent and variety of utilization of mental heal 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. Th major psychiatric epidemiological study indicates that personality-disordered individuals utiliz considerably more mental health treatment than individuals diagnosed with clinical depressio without a concomitant personality disorder. In addition to the amount of services, the type or varie of utilized services was studied. The treatment histories of four personality disorder groups borderline, schizotypal, avoidant, and obsessive-compulsive–were compared with a group individuals diagnosed with major depressive disorder. Compared to the clinical depression grou those with borderline personality disorder were more likely to have received inpatient hospitalizatio day treatment, medication, residential care, in addition to outpatient individual and group therap whereas those with obsessivecompulsive personality disorder had greater utilization of individu therapy. Of all groups, those with borderline personality disorder utilized not only more treatment b more treatment modalities –except for couples therapy, family therapy, and self-help groups–tha other groups (Bender et al., 2001). Unfortunately, the study provides no evidence that thes 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 th conceptualization of the treatment of personality disorders as either top-down or bottom-up strategie particularly regarding efforts to normalize the expression of overmodulated maladaptive personali traits with various psychotropic and behavioral interventions (Fawcett, 2002). *Top-down* refers treatment efforts that are primarily focused on cortical structures and neural tracts (top), which ca also influence subcortical circuits, particularly in the limbic system (down). *Bottom-up* refers to th treatment efforts that are largely focused on limbic circuits, which also can produce changes cortical circuits.

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

medication in order to modulate harmful personality traits and emotional states by normalizing th activity of limbic structures. Besides medications, it appears that skill training interventions, such cognitive coping therapy (Sharoff, 2002), function as bottom-up treatments. A subsequent sectio 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 dru treatments for specific DSM-IV personality disorders as there are for panic disorder or maj depressive disorder. The possible exception is avoidant personality disorder, wherein venlafaxin (Effexor), a selective serotonin-norepinephrine uptake inhibitor, appears to be particularly effective reducing avoidant personality traits. Since avoidant personality disorder appears to be on quantitatively different from social phobia, it may be that medications effective in treating soci phobia are also likely to be effective with this personality disorder (Altamura et al., 1999; Reic 2000).

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

Each of these three clusters is briefly described in this section. He indicates that such medicatio trials should last at least 4 to 6 weeks, barring problematic side effects. The question of the duration medication treatment is complicated, but given that personality-disordered behaviors and concerns a typically long term, ongoing use may be justified if the medication or combination of medicatio 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 onehalf the usual topic rang maintenance dose for psychosis. If there is no response, incrementally increase the dosage. If there no response at the top dose, switch to another atypical. If there is a partial response, consider addi divalproex. Clozapine should be considered only in refractory individuals. When dissociativ 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 parti response, an adjunctive atypical psychotic agent or a mood stabilizer such as valproate carbamazepine can be considered. For individuals in whom rejection sensitivity is prominent, a tri 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