Practical Management

of **Personality**

Disorder

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About the Author

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Preface

This volume deals with the treatment of severe personality disorder. The intent is to describe a practical approach based on what we know about personality disorder and interventions that work. A general framework is presented that will be useful to practitioners and trainees from all mental health disciplines working in such diverse settings as general hospital inpatient units, outpatient departments, community mental health services, managed care programs, and private offices. The approach provides guidelines for treating patients in therapies ranging from crisis intervention to long-term treatment.

In organizing my ideas about personality disorder and its treatment, I have attempted to address the questions posed by clinicians from all disciplines attending lectures and workshops that I have presented for more than two decades. Typically, two kinds of questions are raised: general and situation-specific. Questions of a general nature are usually variations on such themes as: "What is personality disorder?", "How do you treat personality disorder?", and "Can personality disorder really be treated?" More specific questions take the broad form of "What should I do when . . . ?" followed by a variety of problems including suicide threats, crises developing during long-term treatment, attempts to change the treatment plan, missing therapy sessions, attending sessions under the influence of alcohol, refusing to leave at the end of a session, demanding more time, and so on.

Both types of questions suggest that (1) the questioners would have benefited from a systematic account of personality disorder and a framework for organizing treatment, and (2) many clinicians rely on tactical interventions to deal with problems as they surface during treatment, rather than use an overall treatment strategy based on an understanding of the pathology involved. Although the clinicians were not inexperienced, uninterested, or uninformed, they probably acted in this way because person-

ality disorder is inordinately complex, and this complexity creates a gamut of management problems. Patients typically present with multiple problems and complicated clinical pictures. Diagnosis is complicated by difficulty untangling personality pathology from the symptoms of mental state disorders. Even when the proper diagnosis is reached, it does not really help: DSM-IV and ICD-10 personality diagnoses have limited value in treatment planning. The multiple problems of a given patient are also challenging because a combination of interventions is usually needed. Furthermore, there is the challenge of managing the therapeutic relationship when patients find it difficult to trust and collaborate with the clinician.

Personality disorder has a complex etiology; multiple biological, psychological, and cultural factors contribute to its development, and the implications of these multiple causes for treatment are rarely considered. This complexity accounts for both interest in the disorder and frustration with attempts to treat it. Few clinicians are not intrigued by personality disorder, the subtle ways it presents, the involved histories of many patients, and the complex interaction between clinical course and outcome. Yet there are few clinicians who have not also been frustrated in their attempts to understand it and to treat it. For most clinicians, treatment presents a series of dilemmas, beginning with the problem of how to organize information about the multiple problems and extensive psychopathology into a coherent case formulation that facilitates treatment planning, and continuing throughout the therapy in relation to which issues to address and in what order, how to manage the inevitable relationship problems, and how to select the appropriate intervention when faced with a variety of alternatives.

Unfortunately, complexity is not only an inherent attribute of the condition; professional reactions to personality disorder are also complex. Like the old adage that psychotherapy supervision often mirrors the therapist's relationship with the patient, professional reactions to personality disorder frequently seem to reflect the complexity of the disorder and the confusion that often surrounds those who attract the diagnosis. Many clinicians have difficulty approaching patients with personality disorder in the same organized and consistent way that they approach patients with other disorders. The problem is exacerbated by the complexity of some treatments and theoretical models, which are described in language that often obscures rather than clarifies. Many clinicians do not find current theories to be of practical help in daily clinical practice. Most of these theories have minimal empirical support, and there is no evidence that one approach is better than another. There is, however, evidence showing that some interventions are effective for some problems. This finding suggests the need for an eclectic and pragmatic approach that applies interventions on the basis of what works and a rational analysis of what is needed.

This volume attempts to provide a framework that clinicians can

adapt to their own style and the setting in which they work, and which can also be modified as our understanding grows. The goal is not to develop yet another treatment for the disorder but rather to define what we need to achieve in treatment and then identify the best way to accomplish these goals, based on the evidence. The approach presented here is eclectic *not* in the sense that it provides a compendium of current ideas on treatment—such is not my aim. Rather, *Practical Management of Personality Disorder* presents "reasoned eclecticism," to borrow a phrase from Gordon Allport. I have borrowed extensively from the concepts and intervention strategies of perspectives as diverse as self psychology, interpersonal therapy, psychodynamic and psychoanalytic therapies, cognitive therapy, behavior therapy, and constructivism, as well as combinations such as cognitive analytic therapy and dialectical behavior therapy. These are combined with medication, as necessary.

I had thought of giving the approach a name that could form a suitable acronym. It seems that an approach is nothing without an apt title that can be referred to as a set of letters. However, to do so seems to violate the spirit and intent of the exercise. If the study of personality disorder is to progress and treatment to become more effective, we need to break away from one-dimensional approaches and adherence to theoretical models that, despite their claims and even their elegance, are based on little more than speculation. The framework offered is clearly not the last word on the treatment of personality disorder; rather, it is a work in progress that will evolve as our knowledge about these conditions progresses from our current somewhat scanty understanding to something more systematic and profound.

As I look over the final proofs, I feel tremendous gratitude toward the patients with whom I have worked over the years. Their struggles with personality disorder were a source of stimulation. At the same time, their insightful descriptions of their problems and struggles, and the metaphors they used to communicate their distress, transformed my understanding and guided the development of an approach that could be tailored to their needs.

I am grateful to Seymour Weingarten, Editor-in-Chief of The Guilford Press, for patiently encouraging my efforts with this volume and for his support over the years, and to Rochelle Serwator, who rather amazingly managed to transform the original manuscript into something that might be understood. My assistant, Roseann Larstone, provided much valued assistance throughout.

Finally, I owe much to my family. I am deeply grateful to my wife, Ann, who has not only patiently tolerated my absorption in the task of writing in her uniquely loving and supportive way but also actively encouraged my efforts; and to my children, Adrian, Nigel, and Dawn, for their support and benign tolerance and encouragement.

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CHAPTER 1

Introduction

Some years ago a patient told me that therapy was boring. Her comment was surprising, since she seemed to be making good progress. She went on to declare that before treatment, life was exciting—painful and difficult, but nonetheless exciting. Now she was not sure that she could tolerate the boredom. These comments were troubling. Not only did they indicate a problem in treatment, they also raised fundamental questions about the nature and treatment of personality disorder—questions that are not easy to answer.

The patient, an intelligent, articulate woman in her late 20s, had a long and complex psychiatric history of the kind that invariably attracts the diagnosis of borderline personality disorder. She engaged in self-harming behaviors, including frequent overdoses, and she was often rushed to the emergency room with serious self-inflicted injuries. Her mood was labile. She was impulsive. Her social life was chaotic. She sought the company of others who shared and encouraged drug and alcohol abuse. She frequently found herself in fights and arguments, and she was often the center of incidents in restaurants and bars that would culminate in arrest. The behavioral turmoil was associated with considerable affective lability and a profound disturbance in her sense of self. She was unsure of who she was; her self-image changed from one occasion to the next; and she had little sense of what she wanted out of life. Relationships with others were superficial and unrewarding. Lasting intimate relationships eluded her. Instead, she lurched from one temporary but intense relationship to another. Nevertheless, her lifestyle generated an excitement that was satisfying as well as painful. These problems had begun more than 10 years previously, and she had seen many therapists over the years. Therapy tended to mirror her life—therapeutic relationships were established only to be abandoned. At the time in question, she had been in treatment for nearly 1 year. The

parasuicidal, self-harming, and impulsive acts had ceased some months previously. Her life was more stable, but she missed the excitement and activity of her previous lifestyle.

If we consider this case in a commonsense way, free from the constraints imposed by speculative theories, we see that although it has idiosyncratic features, it illustrates many key issues and dilemmas in understanding and treating personality disorder. First, the vignette reveals the diverse problems that characterize typical cases. The multiple symptoms include anxiety, cognitive disorganization, and generalized distress. Situational problems and interpersonal crises are common. There are problems with affect and impulse regulation. Traits are expressed in rigid and maladaptive ways. Interpersonal relationships involve repetitive and dysfunctional patterns of relating. Self and identity are impaired. Thus the problems of personality disorder are not circumscribed; rather, they affect all aspects of the person. Indeed, *disorder* seems to be woven into the very fabric of personality. To manage such diverse problems and pathology, we need to organize complex, multifaceted information in a systematic way that can be used to develop a treatment plan that helps clinicians to tackle problems in an effective sequence.

Second, the case provokes typically puzzling questions: Why does this patient need so much excitement and stimulation, and why is this need so strong that it threatens treatment by leading her to prefer a chaotic and painful lifestyle over a more normal existence? What is the origin of traits such as sensation seeking? What accounts for their persistence? Can they be changed?

Third, the vignette raises questions about the changes that can reasonably be expected from treatment. As the case illustrates, impulsive and self-harming behaviors can be treated effectively (Linehan, Armstrong, Suarez, Allman, & Heard, 1991). Once these problems have resolved, however, fundamental interpersonal difficulties and self and identity problems remain. The result is often what Linehan has termed "a life of quiet desperation." Follow-up studies show that even after long-term psychoanalytic therapy, core self and interpersonal problems are relatively unchanged in this population (McGlashan, 1986; Stone, 1990, 1993, 2001). The various components of personality disorder do not seem to respond similarly to treatment or to the same approach, which suggests that an array of interventions is required to treat most cases. This conclusion raises additional questions about the best way to organize treatment, manage multiple interventions, and effectively treat the self and interpersonal problems that are central to personality disorder—and so intractable. Finally, evidence of limited change prompts the question of whether there are aspects of personality that cannot be changed using currently available techniques. If so, what can be done about these untreatable aspects?

These challenging questions require answers if we are to develop a rational and comprehensive treatment that achieves something more than mitigation of impulsive and parasuicidal behavior. The answers, based on empirical findings as far as possible, will form a framework for understanding personality disorder that, in turn, will shape an approach to treatment. We begin our search by examining briefly how various common theories and treatments would view this patient's problems, and the limitations and disparities of these ideas.

CONTEMPORARY THEORIES

When we consider this case from a *psychoanalytic perspective*, we encounter the immediate problem that contemporary psychoanalysis incorporates several competing models (Wallerstein, 1988; Westen, 1990). Many therapists with an eclectic psychodynamic viewpoint would consider the need for excitement to be a defense against a profound sense of inner emptiness and a chaotic sense of self and identity: Excitement fills an otherwise painful void. This formulation is a simplified expression of the *conflict model* of classical psychoanalytic theory, which considers all personality processes to be the product of conflicts and compromises involving basic drives, especially sexual and aggressive impulses. Thus personality constellations are assumed to originate in developmental conflicts and defenses against conflicts that become translated into the trait structure of personality.

This idea was first proposed in Freud's (1908) classic paper on anal eroticism that linked a triad of traits—orderliness, miserliness, and obstinacy—to the anal stage of psychosexual development. Later, Abraham (1921, 1925) expanded the idea into a typology that related personality structure to problems encountered at specific psychosexual stages. For example, dependent traits are said to originate in oral conflicts. Reich (1949) extended this approach by suggesting that psychoanalysis should address traits that form what he referred to as "character armor." These traits were assumed to be ego-syntonic, unlike the symptoms of neuroses that were usually assumed to be ego-dystonic. Consistent with the classical model, character armor was assumed to arise from successful defenses against developmental conflicts. Contemporary extensions of the model see longstanding patterns of personality traits as "a series of compromise formations between wishes and defenses that oppose these wishes, on the one hand, and constellations of internal representations of self and others, on the other" (Gabbard, 2001, p. 360; see also Gabbard, 2000).

Treatment based on the conflict model focuses on resolving significant conflicts and developing a more coherent sense of self. The implication for the above case is that this treatment outcome should reduce the need for excitement and hence interest in an exciting but dysfunctional

lifestyle. But is sensation seeking simply a defensive reaction to conflict? Is this idea consistent with knowledge about the origin of personality traits generally, and the etiology of stimulus seeking in particular? Are the self and interpersonal problems that are so central to this patient's difficulties simply the product of conflicts centered on basic drives and instincts?

Other psychoanalytic models offer alternative views on these issues. The *object relations approach* rejects the psychosexual model and conflict–compromise framework as explanations of the development of personality, in favor of the idea that personality structures, including self and identity, are shaped by interactions with significant others (Fairbairn, 1952). Problems arise from the failure to integrate different representations of the self or others, leading to fragmented images of self and others. In Kernberg's (1975, 1984) concept of borderline personality organization, which attempts to combine the classical model with object relations theory (although the formulation emphasizes the primacy of conflict), biologically determined aggressive feelings are assumed to impede integration of positive and negative object representations, resulting in splitting and other primitive defenses that lead to ego weakness. Clearly the patient in our vignette has considerable hostility and seems to hold conflicting views of the self and others. But is Kernberg's formulation a sufficient explanation of what is happening?

Self psychology (Kohut, 1971, 1977) maintains that the self is not the product of conflict and compromise but of empathic parenting. This is a *deficit model*, in which personality pathology is assumed to involve structural problems involving the failure to establish a cohesive self due to the empathic failure of caregivers (Blanck & Blanck, 1974). Following Kohut, Buie and Adler (1982) advanced a deficit model of borderline pathology that posits unsatisfactory mothering during the separation–individuation phase, leading to failed internalization of holding–soothing representations. This failing creates difficulty in self-soothing, leaving the person vulnerable to painful and panicky feelings of aloneness and abandonment. This model is radically different from that of Kernberg and leads to very different intervention strategies.

Kernberg's approach (see Clarkin, Yeomans, & Kernberg, 1999; Kernberg, 1984, 2001) with this patient would involve the clarification, confrontation, and interpretation of the primitive defenses and affective shifts associated with fragmented and split-off aspects of identity as they are manifested within the transference relationship. The expectation is that this approach would lead to a strengthening of personality and hence to a stronger sense of self or identity. The theoretical assumption of underlying problems with aggression leads to a more confrontational approach. In contrast, the Kohutian model advocates an empathic approach, with the expectation that experiencing empathic responses would facilitate the development of a more cohesive self. Two issues are important here. First,

the two approaches make very different assumptions about the nature and origin of core aspects of personality disorder: *conflict* versus *deficit* models. To develop a coherent treatment, we need to consider the evidence available to resolve this apparent inconsistency. Second, the two approaches offer different explanations of change. According to the classical model and Kernberg, personality is transformed through insight achieved via the confrontation and interpretation of defenses, especially in transference. According to Kohut, in contrast, change results from an empathic therapeutic relationship. To make an informed choice about the models, we need to know how they relate to empirical knowledge about the causes of personality disorder and the factors influencing therapeutic change.

Cognitive and *cognitive-behavioral therapies* offer a different theoretical framework. Cognitive therapy would consider the patient's need for excitement to be the product of maladaptive beliefs and expectations that lead the patient to construe normality as boring. Similarly, self pathology would be understood in terms of maladaptive self schemata. The task would be to change these schemata by using the techniques of cognitive therapy—a very different method from those that characterize the different versions of the psychoanalytic model. Cognitive therapy assumes that dysfunctional cognitions are the central problem of personality disorder. But can cognitive dysfunctions account for all features of personality disorder? How does the model fit with ideas that traits such as sensation seeking have a genetic basis? With more behaviorally oriented models, social skills deficits and limited problem-solving abilities also may be invoked to explain the patient's behavioral problems. Under these circumstances, treatment might include skill training—again, a very different approach from that espoused by more psychodynamic orientations. Despite the potential utility of these techniques, it is not clear how they would change core self and interpersonal pathology.

Interpersonal theory (Benjamin, 1996; Benjamin & Pugh, 2001) postulates that the destructive, maladaptive patterns characteristic of personality disorder are directly related to behaviors learned in relationships with loved ones or attachment figures. These patterns are said to involve what Benjamin refers to as "copying processes": the person strives to be like the attachment figure (identification), acts as if the attachment figure were still present and in charge (recapitulation), or treats the self as the attachment figure did in the past (introjection). Benjamin suggests that these copying patterns repeat earlier behaviors because of a wish for reconciliation with, or validation by, the attachment figure. Treatment involves identifying these patterns and consistently addressing the underlying attachment, until the wish for reconciliation or validation is abandoned and new patterns are learned. This goal may involve interventions derived from any theoretical framework. Interpersonal theory shares, with object relations theory and self psychology, the assumption that the maladaptive

patterns of personality disorder originate in early relationships with important others; it differs in that a structural model of interpersonal behavior is used to account for these patterns. The model has many attractive features, including a systematic way to describe the maladaptive interpersonal patterns that characterize personality disorder. But, like the cognitive approach, it does not seem to account for all features of personality disorder. Interpersonal difficulties are not the only problems observed in personality disorder (Widiger & Kelso, 1983). Furthermore, the model does not provide an adequate explanation of traits such as the sensation seeking observed in this patient.

Turning to *normal personality theory*, this patient's need for stimulation and excitement is characteristic of someone with a high level of sensation seeking—a trait that includes thrill and adventure seeking, experience seeking, disinhibition, and boredom susceptibility (Zuckerman, 1971, 1991). Empirical evidence suggests that sensation seeking has a genetic basis (Livesley, Jang, Jackson, & Vernon, 1993; Zuckerman, 1994a, 1994b). From this perspective, sensation seeking does not develop out of a defense against a sense of emptiness and other aspects of self pathology, or even developmental conflicts, although it may be used for defensive purposes. Rather, it is an enduring characteristic that emerges from the combined effects of genetic predisposition and experience. This perspective introduces a third model, the *vulnerability model*, that assumes that underlying dispositions, which may have a biological basis, predispose an individual to the development of personality problems. This model raises additional issues for treatment. If traits are stable entities that are partly inherited, can we expect to change maladaptive traits such as sensation seeking? What implications does the evidence of a heritable component to traits have for treatments and theories that emphasize a psychosocial etiology to personality disorder and the theoretical models underlying psychoanalytic and cognitive therapies? How do we reconcile conflict, deficit, and vulnerability models?

Finally, *biological psychiatry* would probably view the affective lability and impulsivity of this patient in terms of problems in specific neurotransmitter systems (Coccaro, 2001; Coccaro et al., 1989; Coccaro, Kavoussi, & Hauger, 1995; Siever & Davies, 1991), for which specific pharmacological interventions may be warranted (Markovitz, 2001; Soloff, 1998, 2000). This perspective raises further questions about the role of biological factors in the etiology of personality disorder and how pharmacological interventions can be integrated effectively with interventions based on other theoretical models.

This overview of common theories and therapies illustrates the many varied and often confusing ideas held about the nature and treatment of personality disorder: personality disorder as the result of conflict and compromise versus a deficit resulting from empathic failure; personality disor-

der as the result of psychosocial adversity versus genetic predisposition; and personality as stable versus changeable. Views on intervention also differ: confrontation and interpretation versus empathy, validation, and mirroring; and structured, skill-building approaches versus unstructured exploration. Given this range of perspectives, concepts, and strategies, it is not surprising that many clinicians are confused about how to treat personality disorder or pessimistic about the outcome. Nor is it surprising, as some authorities have commented, that many patients seem to deteriorate rather than improve through contact with the health-care system (Frances, 1992; Rockland, 1992).

As noted, personality disorder and its treatment are inherently complex. However, the plethora of theories and treatment strategies, many based on minimal evidence, makes treatment more complicated than necessary. Many therapies are presented as comprehensive or even definitive, forcing clinicians to choose among them without the evidence required to make an informed choice. With each model, an intervention strategy is offered based on an underlying theory. As a result, each approach offers a limited array of interventions, and interventions derived from other theories are ignored, even if they are known to be effective. Theory, rather than an empirical understanding of personality disorder or evidence of treatment efficacy, guides treatment decisions. The result is that personality disorder is treated as a cognitive problem, a behavioral problem, an interpersonal problem, or a motivational problem. Personality disorder, however, is all these. Few approaches, if any, offer a comprehensive set of interventions to cover the range of problems seen in most cases. Moreover, the assumptions of some approaches seem inconsistent with our contemporary knowledge about the nature and origins of normal and disordered personality.

BASIC ASSUMPTIONS OF THEORETICAL MODELS

Although the different theoretical models and associated therapies are in some ways incompatible, they share two assumptions:

1. Personality disorder is primarily a psychosocial disorder caused mainly by adverse developmental experiences.
2. Personality is malleable and can be changed with therapy.

To develop a science-based approach to treatment, we need to examine the validity of these assumptions. The advent of the *Diagnostic and Statistical Manual of Mental Disorders–III* (DSM-III) in 1980 changed the study of personality disorder from a field dominated by theories based on clinical observations of a few patients in rarefied settings to an active area of em-