## Intervention with Personality Disorders: A Clinical Update

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## Level of Personality Organization

- Normal
- Borderline
- Psychotic

- Source of data: External versus Internal
- Defense mechanisms
- Self and other representations

## Identity and Identity Diffusion

- Erikson – "…both a persistent sameness within oneself and a persistent sharing of some kind of essential character with others"
- Kernberg – It is the presence or absence of identity diffusion that most clearly differentiates borderline from non-borderline conditions

## Identity Diffusion/Borderline Personality Organization

- Impaired relationship capacity –
- Incompatible personality aspects –
- Poor time integration –
- Absence of authenticity –
- Body image difficulties –
- Primitive defense mechanisms -

## Temperament and Character

- Temperament -
  1) Novelty seeking - (dopaminergic)
  2) Harm avoiding - (serotonergic)
  3) Reward dependent - (noradrenergic)
  4) Persistence -
- Character -
  1) Self-directedness -
  2) Cooperativeness -
  3) Self-transcendence

Adapted from Cloninger et al., 1993

## Heritability of Traits

- Emotional dysregulation – 47%
- Dissocial behavior - 50%
- Inhibitedness - 48%
- Compulsivity - 38%

Livesley, W. J. (2003) *Practical management of personality disorder.*

## Treatment Principles (1)

- The overall goal in treating PD is to improve adaptation by developing a more coherent sense of self and the capacity for more effective relationships with others.
- Treatment helps individuals adapt to their basic personality traits and express them more constructively as opposed to changing the trait structure of personality.

Livesley, W. J. (2003) *Practical management of personality disorder.*

## Treatment Principles (2)

- Treatment should include strategies and interventions to change, modulate, or management environmental factors that contribute to maladaptive function.
- The most appropriate stance for treating PD is one of support, empathy, and validation.

Livesley, W. J. (2003) *Practical management of personality disorder*

## Treatment Prerequisites

- Collaborative relationship –
- Consistent treatment process –
- Validating treatment process –
- Building and maintaining motivation

Livesley, W. J. (2003) *Practical management of personality disorder*

## Levels of Care

- Hospital – 24/7 –
- Partial hospital –
- Intensive outpatient –
- Outpatient –

## Borderline Personality Disorder

- Pervasive pattern of instability of interpersonal relationships, self-image, and affects - marked impulsivity -

## Dialectical Behavior Therapy

- The *dialectic* is between acceptance and change –
- Individual therapy –
- Skills training
  - Mindfulness
  - Distress tolerance
  - Emotional regulation
  - Interpersonal effectiveness

## Narcissistic Personality Disorder

- Pervasive pattern of grandiosity (in fantasy or behavior) - need for admiration and lack of empathy -

## Hypervigilant Narcissism

- Very sensitive to others' reactions - feelings easily hurt - inhibited and shy -
- Directs attention outward -
- Avoids being center of attention -
- Vigilant for slights, criticism, humiliation -

Adapted from Gabbard, 1989

## Oblivious Narcissism

- Unaware of reactions, hurt feelings, communications of others -
- Arrogant and aggressive -
- Seeks to be center of attention -

Adapted from Gabbard, 1989

## Antisocial Personality Disorder

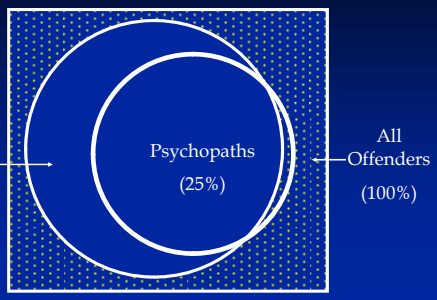
- Pervasive pattern of disregard for/violation of rights of others, since age 15 –
- Evidence of Conduct Disorder with onset before age 15 -

## Psychopathy

- Callous, aggressive, exploiting , remorseless -
- Criminal lifestyle -

Adapted from Hare, 1993

## Psychopathy and APD



## Treatment of Psychopathy - I

- Therapeutic communities – violent recidivism lower for non-psychopaths but higher for psychopaths when compared with untreated offenders – 78% of treated psychopaths versus 55% of untreated psychopaths – (Rice et al., 1992) –

## Treatment of Psychopathy – II

- Cognitive behavior therapy – token economy – (Wong & Hare, 2005) -
  - Explicit reinforcement of behaviors incompatible with psychopathy – Penalties for psychopathic behavior – contingencies based on staff observation of overt behavior -
  - No expectation of "graduation" –
- Protection of potential victims -

## Splitting

- Keeping contradictory self-other configurations separated from each other

attentive mother ←==========→well-nurtured child
contentment

unavailable mother←==========→insatiable child
rage

Adapted from Gabbard, 1989

## Consequences of Splitting

- Contradictory behavior accompanied by indifference and denial –
- Selective absence of impulse control –
- Others viewed as all-good or all-bad, with frequent shifts –
- Self viewed as all-good or all-bad, with frequent shifts -

Adapted from Kernberg, 1967

## Projective Identification

- Patient projects one self-other configuration onto one treater, an opposite one onto another treater –
- Each treater unconsciously identifies with projected role and begins to behave accordingly -

Adapted from Ogden, 1986

## Consequences of Projective Identification

- Staff members uphold polarized positions with disproportionate intensity
- Staff members play out the patient's various self-other configurations –
- "Projective identification is the vehicle that converts intrapsychic splitting into interpersonal splitting." (Gabbard, p. 446)

## Manipulation

- Going from one treater to another with the same complaint as a way of getting attention –

  This may be manipulative, but it is not splitting/projective identification

## Lying

- Conscious misrepresentation of one treater's statements to another treater –

  This is exploitive and antisocial, but it is not splitting/projective identification -

## Staff Differences

- Various staff members may disagree about treatment approaches –
  This is not caused by splitting/projective identification on the patient's part, and that rationalization should not be used as a way to avoid discussing honest differences of opinion –
- Inflexibility is a good barometer -

## Recognition of Splitting/Projective Identification

- Recognition and early identification are crucial –
- Therapeutic versus administrative is a common format for splitting/projective identification –
- Uncharacteristic treater behavior (too nice, too punitive) is a warning sign -

Adapted from Gabbard, 1989.

## Recognition of Splitting/Projective Identification (continued)

- One treater defends patient from critical or negative descriptions by other treaters -
- One treater feels a special understanding of a patient that goes beyond that of other treaters -

Adapted from Gabbard, 1989.

## Management of Splitting/Projective Identification

- It may be useful to have an external consultant –
- The ability of treaters to integrate the different self-other configurations may communicate back to the patient -