Personality disordered patients present with multiple problem areas and potential targets of change. This complex clinical situation can be addressed by an integrated approach to the treatment by using treatment strategies and techniques from the various schools of therapy, sequenced and adapted to the individual patient. An optimal choice and sequencing of treatment techniques is organized around general treatment strategies (assessment and case formulation, treatment structuring, observing the therapeutic relationship, addressing problematic personality organization, and addressing sequential goals) with the severity of the personality disturbance in mind. The biggest threat to successful integration of the treatment is the reaction of severe personality disordered patients who lack an integrated sense of self and suffer from intense, fluctuating emotions that challenge an inexperienced, reactive therapist.

The major schools of psychotherapy for patients suffering from personality disorders emphasize a range of therapeutic techniques that are unique to their intervention. These techniques are usually chosen because they relate to a specific theory or set of hypotheses about the nature and causes, both past and present, of the disorder being treated. A close examination of the treatment manuals, however, suggests that each manual contains some strategies and techniques that are unique and essential to the treatment, and some that are common (sometimes with different jargon) with other approaches. For example, providing structure in the treatment of borderline patients is a major treatment strategy introduced and emphasized by all major treatments for severe personality disorders, and thus it is difficult to empirically disentangle the impact of this important strategy with patients who lack their own inner structure on outcome from the impact of the specific techniques in each treatment (Roth & Fonagy, 2005).

The existing research on the treatment of personality disorders is con-
centrated on avoidant, mixed, and borderline personality disorder. In addition to the major gaps in this information, even in those studies showing symptom reduction in a specific personality disorder diagnosis, there is very little research on how each of the treatments work, i.e., the mechanisms of change related to the various treatment orientations (Clarkin & Levy, 2006). Since we know little about the mechanisms of change, typical treatment manuals—to paraphrase Kazdin (2006)—most probably contain low doses of effective practices, ancillary but important aspects that make delivery of the treatment more palatable, superstitious behaviors (those we think matter but do not), and factors that impede or fail to optimize therapeutic change. It is with uncertainty, therefore, that we recommend therapy that integrates techniques of unknown effectiveness.

The clinician using an integrated approach to the treatment of individuals with one or more personality disorders will, in a planned and strategic process, choose from the entire range of therapeutic techniques based on the individual patient’s personality difficulties (e.g., avoidant, dependent, narcissistic, borderline), the focus of change, and the stages of recovery. Integration is a process in a therapist’s mind that is open to applying all available treatment techniques that are useful in the course of the treatment of an individual patient. There are a number of elements in this process: (1) a working conception of the problems/dysfunctional areas of the individual patient; (2) a conception of how this patient could achieve a more effective level of adjustment; (3) a conception of how the patient can improve sequentially over time (e.g., reduce suicidal behavior, followed by improvement in interpersonal relations); (4) a use of therapeutic techniques timed to the salient patient problems and the readiness of the patient to change; and (5) a changing conception of the therapist as perceived by the patient, and the patient’s growing conception of self.

Central to the personality disorders is disruptions of perception of self and others, and related difficulties in interpersonal functioning. The application of a range of techniques from cognitive-behavioral to metallization/dynamic treatments will be described and strategically applied to a range of personality disorders/difficulties. It must be emphasized that the locus of integration is in the individual therapist’s mind. A receipt for integration is ultimately impossible, as integration is a function of the clinician who works over time with an individual patient.

WHY CONSIDER INTEGRATION?

With the development of empirically supported treatments for selected personality disorders, why would a clinician entertain the notion of integrating treatments? There are actually many reasons why this is a clinically desirable and practical step. It has become clear that there are not 10 discrete personality disorders, and the vision of empirically supported treatments for all 10 will never materialize. The so called comorbidity is rampant on Axis II, suggesting that the system does not carve the area
into discrete categories. Focus on central areas of personality function for assessment and treatment seems more practical.

Clinicians need a practical conception of the personality disorders that would relate to treatment planning, as Axis II does not. Essential areas of personality function and dysfunction may become central to the reconceptualization. A conceptual link should be made between current personality theory and understanding of the personality disorders as deviations from the normal condition.

Patients with personality disorders often have more than one disorder on Axis II, and often a co-occurring Axis I condition. Thus, these patients present with a variety and multiple targets of change, which could likely call for a variety of strategies of intervention, making single mechanism theories of therapeutic action unlikely to prove therapeutically useful (Gabbard, 2010). The existing treatment manuals for the personality disorders emphasize one or several of the areas of personality functioning, sometimes at the neglect of other areas. For example, Dialectical Behavior Therapy (DBT; Linehan, 1993) focuses on behavior, with less attention to the internal cognitive-affective units. The dynamic treatments such as Mentalization Based Treatment (MBT; Bateman & Fonagy, 2006) and Transference Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006), with attention to the internal working models or cognitive-affective units, could use some of the behavioral change technology from other orientations. An integrated approach would use methods from all approaches.

The empirical literature based on randomized clinical trials utilizes mean scores, reflecting an average change across groups of patients. The approach can obscure the fact that with all treatments examined, some patients change and some do not. No treatment works for all patients. The advantage of the integrated approach is that the therapist can consider all approaches to tailor the treatment to the individual patient.

**A CLINICALLY USEFUL CONCEPTION OF THE PERSONALITY DISORDERS**

In order to treat any pathology, the clinician needs a practical conception of the disorder/dysfunction that is the focus of intervention. Since the various schools of therapy are related to different theories of the personality pathology we are not in a position to adequately integrate the theories of personality disorder. Rather than an abstract and general theory, partially supported by research, the clinician needs a practical conception of the day to day dysfunction of the patient being evaluated and treated.

The DSM Axis II definition of personality disorder is highly relevant to assessment and treatment planning, as it highlights elements that every clinician must evaluate. A personality disorder is: (1) an enduring pattern; (2) both of internal experience and behavior; (3) involving cognition, affect, interpersonal functioning, and impulse control; (4) that deviates from the
cultural pattern; and (5) leads to functional impairment. The DSM Axis II description of the 10 individual personality disorders is minimally helpful for treatment planning, both in terms of psychotherapy and medications. This is so for a number of reasons that have been fully documented elsewhere (Livesley, 2001), including the focus on symptoms that are not enduring rather than enduring aspects of the personality, the rampant comorbidity between the 10 disorders as with Axis I disorders, and the polythetic nature of the diagnoses which insures much heterogeneity. In addition, the patient with personality difficulties is always faced with challenges in interacting with his/her unique environment, which cannot be captured in a diagnostic schema.

Since 1980, the introduction of personality disorders in DSM-III and successors has succeed in stimulating research on the phenomenology of personality pathology, but resulted in treatment research on only a few of the disorders. Part of the difficulty is the atheoretical approach of listing a mixture of behaviors, traits, and attitudes in the Axis II criteria. A possible corrective to this approach is to ground the conceptions of personality pathology to empirically supported theories of normal personality, thus clarifying the crucial human functions that are distorted or absent in the abnormal.

Mischel and Shoda (2008) have developed a meta-theory of personality in order to provide an overall framework in which the existing knowledge of personality functioning can be conceptualized. In contrast to a trait approach to personality, this Cognitive-Affective Processing System (CAPS) focuses on the processes by which individuals construe situations and themselves in adapting to the environment. Such a processing approach is most relevant to therapists who closely examine in the therapeutic context the cognitive-affective processing of the personality disordered patient. This meta-theory emphases five levels of experience: (1) an organized pattern of activation of internal cognitive-affective units (e.g., conceptions of self and others, expectancies and beliefs, affects, goals and values, self-regulatory plans); (2) behavioral expressions of this internal processing system; (3) self and other perception of these behaviors over time; (4) construction of one’s typical environment; and (5) the predispositions at the biological and genetic levels of existence. This framework suggests that personality dysfunction can occur at multiple levels, and the assessment of these crucial areas could each be a target for intervention.

It has become clear with longitudinal empirical research that personality disorder as defined by the Axis II criteria does not endure over time. The personality disorder criteria/symptoms change over time, but the dysfunction does not change (Skodol, et al., 2005). This raises the interesting question of what is the core of personality pathology that is relatively enduring, and what are the related elements that change with periods of development, stress, etc. This same issue of stability in the face of change has been paramount in the literature on normal personality for decades.
There is a growing consensus that the heart of personality disorder is conception of self, and related interpersonal behavior (Livesley, 2001). Others have articulated this as core human functions that enable the individual to adjust to the environment (Millon & Grossman, 2005). A growing number of researchers and clinicians involved with personality disorders are conceptualizing personality pathology in terms of severity of dysfunction, rather than just in terms of descriptive traits (Livesley, 2001; Parker et al., 2004; Verheul et al., 2008).

Parker and colleagues (2004) have helped disentangle the personality style (e.g., obsessive, narcissistic) from the degree or severity of dysfunction, captured in their research as lack of cooperation and poor coping (e.g., inflexibility, self-defeating, deficits in learning from experience). Obviously, there is more correlation of the two aspects in some personality disorder categories than others, given the intermixing of severity of dysfunction and descriptive features in the Axis II criteria. However, there is a growing awareness of the clinical necessity of evaluating both clinical style (e.g., obsessive, narcissistic) and degree of dysfunction.

Degree of severity of dysfunction relates to disruptions in work relations and in the range of friendship, intimacy, and love relations. In turn, these areas of function/dysfunction can be seen as outward manifestations of human capacities for self-definition, self-consistency, self-regulation, coping, interpersonal cooperativeness, and capacity for intimacy with others. Severity of personality pathology is usually seen as a dimensional phenomenon. Thus, the individual can be described in terms of severity of dysfunction in reference to essential human functions that are needed to survive and thrive in the environment. Rather than planning treatment around descriptive traits (e.g., obsessive, fearful), this approach focuses on central areas of human functioning such as self-regulation, perceptions of self and others, and interpersonal functioning that allows for pleasure, interdependence, and intimacy in relations with others (Caligor & Clarkin, 2010).

**PRINCIPLES, STRATEGIES, AND TECHNIQUES**

Therapeutic principles specify how a treatment is to be organized and conducted (Livesley, 2005). A principle of therapeutic intervention has been described as a concept which is not too general or theory-specific which addresses an “if . . . then” situation (Castonguay & Beutler, 2006). An example of a therapeutic principle with personality disorders is that the patient’s level of functional impairment should be matched with treatment intensity.

Strategies of intervention translate the principles into action. The strategies are composed of a number of related techniques that share a common objective (Livesley, 2005). The strategies of intervention with the personality disorders articulated here, similar to those stated by Livesley (2005), are: (1) assessment of severity of personality disorder; (2) structur-
ing the treatment; (3) monitoring the therapeutic relationship; (4) maintaining a balance of a working relationship and the challenge for change; and (5) focus on the unfolding of treatment goals and targets of intervention.

TARGETS AND TECHNIQUES

In order to examine the use of treatment techniques in the psychotherapy of personality disorders, we need an agreed upon list of these techniques. Dividing up a 2-person interaction (personality disordered patient and therapist) into clearly defined and delineated techniques is difficult and somewhat arbitrary.

One guide is the delineation of techniques by other experts in the field. De Groot et al. (2008) have listed 10 techniques in the treatment of PD patients with borderline personality disorder. This list includes: psycho educational, motivational, behavioral, cognitive, affective, interpersonal, psychodynamic mindfulness, experiential, and nonverbal techniques. In this delineation the authors seem to have in mind the realm of human function (e.g., cognitive, affective, interpersonal, etc.) that is being addressed. The authors relate this breakdown of techniques to the hypothesis that some treatments are better than others in managing specific problems, e.g., deliberate self-harm treated by cognitive and behavioral techniques, and interpersonal behavior best treated by interpersonal and psychodynamic techniques. Leichsenring and colleagues (Leichsenring, Hiller, Weissberg, & Leibing, 2006) have also reviewed cognitive-behavioral and psychodynamic psychotherapy techniques and their relative effectiveness. Their selective lists of techniques for both orientations are representative.

Another guide to techniques for the treatment of patients with personality disorders is to identify the empirical studies of these treatments, and examine the relevant treatment manuals for techniques that have proven successful. This would include treatment manuals for intervention with avoidant patients and borderline patients. A problem with this approach is that the successful treatments in RCTs provide a package of interventions and the data do not clarify which are the operative techniques. For example, MBT is successful in reducing symptoms, but there is no evidence that it does so by increasing mentalization. Instead of focusing only on manuals of therapies that have been empirically supported, we have reviewed manuals of different orientations to search for overlaps and themes, placing value in the notion that consensual validation between experienced clinicians generates useful methods of treatment. Thus, we have focused on cognitive behavioral approaches (Linehan, 1993; Pretzer & Beck, 2005), related approaches that focus on metacognitive failures (Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007) interpersonal approaches (Benjamin, 1996), approaches that combine cognitive-behavioral and psychodynamic techniques (Svartberg, Stiles, & Seltzer, 2004), those influenced by attachment theory (Bateman & Fonagy, 2006; Meyer & Pilkonis, 2005), and those using object relations theory from the psy-
chodynamic tradition (Clarkin et al., 2006). These authors often specify the mini-steps toward the final outcome (symptom change, change in disordered functions) as yoked to the therapeutic techniques that address them (see Table 1). In this article, we have nested the techniques with the overall strategies of the treatment.

The delivery of the techniques can be skillfully done or done in an abrasive, authoritarian, or uninterested aloof way. Our focus on techniques should not detract from the data on the efficacy of the individual therapist, which can be as potent as or more so than the techniques used. Techniques are used in a relationship between patient and therapist, the nature of which can drastically alter the impact of the technique itself. This issue is highlighted again in the section below on keeping focus on the relationship.

Above all, it is essential that techniques are viewed in the context of the particular relationship between the therapist and individual patient, and the characteristics of the individual patient, not just diagnosis but also nondiagnostic qualities and characteristics. In an excellent and comprehensive review of therapist variables in psychotherapy, Beutler and colleagues (Beutler et al., 2004) have summarized the empirical work on therapist qualities and activities, including therapy techniques. They point out that while most empirical research has focused on therapist interventions and techniques, there is little support for the view that any one class is particularly effective. Rather, the evidence indicates that all procedures have an effect with a receptive patient, but this effect approaches zero when patient factors are not taken into consideration. The conclusion is that much research is needed on the match and compatibility between patient and therapist interventions.

The use of techniques across time in the treatment must be conceptualized not only in the context of the relationship between patient and therapist, but also in the context of the unfolding of the patient’s difficulties.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Techniques</th>
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<tr>
<td>Assessing Personality Pathology</td>
<td>Interview</td>
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<td></td>
<td>Focus on domains of dysfunction</td>
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<tr>
<td>Structuring the treatment</td>
<td>Formal verbal contract discussion</td>
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<td></td>
<td>Agreements</td>
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<td></td>
<td>Commitment to work on therapy targets</td>
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<td></td>
<td>Setting priorities in addressing therapy targets</td>
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<tr>
<td>Monitoring the relationship</td>
<td>Validating the patient</td>
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<tr>
<td></td>
<td>Therapist alert to indications of patient positive-negative views of therapist/therapy</td>
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<td></td>
<td>Reciprocal communication strategies</td>
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<td></td>
<td>Mentalizing interventions</td>
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<tr>
<td>Balance of Acceptance and Change</td>
<td>Validation and urging change</td>
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<tr>
<td>Unfolding of treatment goals and targets</td>
<td>Crisis intervention</td>
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<td></td>
<td>Intervention with destructive behaviors</td>
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<tr>
<td></td>
<td>Intervention with symptoms</td>
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<td></td>
<td>Interpersonal difficulties</td>
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and pathology over time. It has been noted that there is often a sequence to this unfolding of personality pathology, from crises and ensuring safety, to containment of emotional and behavioral instability, to self-management, exploration, and change (Livesley, 2005). This sequence from addressing overt behavioral difficulties that are potentially destructive of the patient’s life followed by a calmer period of self-understanding and exploration is most typical of the personality disorder patients on the severe end of the functioning continuum, such as borderline patients.

STRATEGIES AND RELATED TECHNIQUES
We consider the overall strategies in the treatment of personality disorder and their related techniques. The strategies considered here in treatment personality disorders are: (1) initial assessment and conceptualization of the case, (2) structuring the treatment, (3) observing the patient-therapist relationship, (4) addressing the problematic personality organization, and (5) sequential goals in the progress of the treatment.

INITIAL ASSESSMENT OF THE INDIVIDUAL PATIENT
The initial assessment of the patient with suspected personality pathology is crucial to the planning of the intervention and potential use of an integrated approach. First of all, patients with PD often are comorbid with one or more Axis II disorders, and Axis I symptom disorders. Secondly, patients with one personality disorder often have at least one other. The characterization of the PD is never just one PD but a range of PD pathology. Krueger and colleagues (Krueger, Markon, Patrick, Benning, & Kramer, 2007) have preliminary data suggesting that the relationships between Axis I symptoms and personality disorders may not be arbitrary but lawful, related to supraordinate concepts of internalizing and externalizing behaviors and tendencies. Relevant here are the various functions mentioned previously that are disordered in the patient, i.e., affect regulation, self-reflection, quality of relationships with others. Third, one always considers the patient with his/her particular life situation, as the individual interacts with the environment. Each individual constructs his/her own environment according to personality styles and preferences that have developed over time (Mischel & Shoda, 2008).

The assessment of the patient must first determine if there is a personality disorder, that is, a habitual way of thinking, feeling, perceiving that interferes with the patients functioning in relationships and/or work. Given the presence of a personality disorder, the assessment can continue to specify the personality style, the severity of the personality disorder, and the nature of the patient’s conflicts.

In a national probability sample of 1,800 clinicians about their assessment strategies, it was found that they rely on inferences from the patients’ narrative descriptions of their relationships, and from the patients’
behavior toward the clinician (Westen, 1997). Clinicians focus the evaluation around domains of functioning, such as integrity of thought processes, cognitive style, affect relation, complexity and integration of representations of others, capacity for self reflection, conception and beliefs about the self, and sexuality (Westen, 2006). This is interesting, as it suggests that many therapists are in fact integrative, or, one might say practical in their approach and interested in what seems to help the patient in their current interpersonal environment.

The most important area of assessment that relates to the nature of the treatment (foci, duration, difficulty) is the severity of the PD (see Table 2; see Caligor & Clarkin, 2010). This is so because the severity of the personality dysfunction relates not only to how extensive the dysfunction in the patient’s environment, but also because the dysfunctions interfere with the therapeutic interaction and process between patient and therapist. For example, as narcissistic and antisocial features increase and there is evidence of lack of moral development and behavior, dishonesty can begin to corrupt the therapeutic relationship. Some patients with severe needs for attachment with no relationships outside of treatment may become intensely attached to and preoccupied with the therapist in ways that are detrimental to growth. Thus, as the severity of the PD increases, the more the therapist must anticipate and structure the treatment with clarity, firmness, and respect. For example, the patient with intense needs for guidance and closeness and diffuse sense of boundaries may need a treatment contract that specifies the limits of the therapist’s availability. Patients with high levels of aggression and emotional lability may need guidelines for what behaviors are allowed in the sessions. Patients with multiple previous suicide attempts and self-destructive behavior may need guidelines for how that behavior might reoccur in the present treatment.

The way the clinician focuses the assessment, guided by his practical theory of personality disorder, begins to shape the focus, strategies, and techniques of the treatment (see Table 3). Integration begins in the therapists’ mind with a focused assessment. With the least severe personality disorder, assessment is straightforward; however, with more severe personality disorders, therapists must anticipate and structure the treatment with clarity, firmness, and respect.

**TABLE 2. Severity of Personality Pathology**

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Representative Axis II Disorder</th>
<th>Domains of Dysfunction</th>
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<tbody>
<tr>
<td>Less Severe Personality Disorder</td>
<td>Avoidant PD</td>
<td>Clear conception of self</td>
</tr>
<tr>
<td></td>
<td>Dependent PD</td>
<td>Organized conception of others</td>
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<td></td>
<td></td>
<td>Conflicted behavior</td>
</tr>
<tr>
<td>Severe Personality Disorder</td>
<td>Borderline PD</td>
<td>Non-integrated conception of self and others</td>
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<tr>
<td></td>
<td>Narcissistic PD</td>
<td>Emotion dysregulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Impulsivity</td>
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<tr>
<td></td>
<td></td>
<td>Extensive defensiveness</td>
</tr>
<tr>
<td>Most Severe Personality Disorder</td>
<td>Antisocial PD</td>
<td>Lack of empathy toward others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lying</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Absence of moral guidance of behavior</td>
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<tr>
<td></td>
<td></td>
<td>Aggression toward others</td>
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</table>
disorders, the therapist can usually assume that the patient recognizes and follows appropriate boundaries toward the therapist. The patient is most likely to perceive his/her contribution to problems, and will work with the therapist cooperatively to correct them. These same assumptions cannot be made with the severe personality disordered individual. An explicit verbal treatment contract may be useful to strategically specify the boundaries of the relationship before the relationship becomes intense, and distorted by the needs of the patient. Done in this manner early in the treatment, the therapist can refer back to the initial agreements when needed later in treatment. The therapeutic relationship with the most severe personality disordered individuals is marred by the aggression and lack of moral values the patient brings to the treatment. A strict verbal contract is necessary, and treatment may be impossible due to the functional limitations of the patient.

It should be noted that this assessment is most focused and targeted at the beginning of treatment, but takes place throughout the treatment. In order to focus on sequential goals (see below) one needs accurate information on the patient’s life outside the therapy sessions.

STRUCTURING THE TREATMENT

Our clinical impression shared by others (Roth & Fonagy, 2005) is that for the severe personality disordered patients, the structuring of the therapy done by the therapist is extremely important. A consistent therapist who provides rationale and hope for change is essential. Techniques used by such a therapist would include setting the treatment time at the same
time each week, being on time, telling the patient well in advance about
time each week, being on time, telling the patient well in advance about
vacation absences, providing backup, etc.

The more severe the personality disorder/pathology and the more exter-

The more severe the personality disorder/pathology and the more exter-
alizing (Krueger et al., 2007) the pathological symptoms, the more the
therapist will need to structure the treatment with the patient. Several
manualized treatments for the severe personality disorders (e.g., DBT,
TFP) include a specific verbal treatment contract between patient and
therapist. This contract structures the treatment in terms of the treat-
ment goals and the responsibilities of both patient and therapist in work-
ing toward those goals. The contract is an implicit statement that therapy
is not magical, and that two individuals must put effort into it if it is to
bear fruit. This may seem obvious, but the more severe the personality
disorder, the more likely that the patient will either be unmotivated for
change or expect that change will come somewhat magically from the out-
side. This is a verbal discussion between patient and therapist about the
roles and responsibilities of each party in order for the therapy to succeed.
The treatment contract provides personality disordered patients with
some cognitive parameters of the relationship before potential distortions
are introduced. While the contract does not eliminate future distortions of
the relationship, it does provide both patient and therapist with guidelines
that are essential for the treatment to succeed. The contract can also add
to the safety felt by the therapist. Especially with patients with severe per-
sonality disorders who can become agitated, impulsive and self-destruc-
tive, the therapist must feel safe in order to think clearly and be able to
respond adequately to the patient.

MONITORING THE THERAPEUTIC RELATIONSHIP

Monitoring the therapeutic relationship includes: (1) closely observing the
way the patient relates to the therapist, (2) being alert to ways the patient
relates to the therapist and therapy that might be expressed in prema-
turely ending the treatment, (3) using the relationship as an indication of
how the patient might damage relationships with others in his/her cur-
rent life, and (4) therapist observation of own feelings toward the patient
that could affect the alliance and progress of the treatment. The psycho-
therapy research literature captures what is termed here as monitoring
the relationship under the rubrics of therapeutic alliance (Horvath, 2000),
overcoming ruptures in the alliance (Safran & Muran, 2000), and manage-
ment of transference and countertransference.

By definition, patients with personality disorders have difficulties in re-
lating to others, whether it takes the form of avoiding others due to mis-
trust, overly depending on others, intense ambivalence toward others, be-
ing dishonest with others, or arrogantly dismissing others. An interesting
example of how the science of personality disorders is progressing is a re-
cent fMRI study of borderline patients compared to normal individuals
engaging in an investment game (King-Casas, 2008). In comparison to
normals, borderline subjects were mistrusting of the other, and thus behaved in a way to disrupt profitable interactions for both parties. Neural correlates of this interaction behavior were detected that differentiate between the borderline subjects and normal controls.

These ways of relating to others in complicated and less than satisfactory ways will be manifest in the way the patient relates to the therapist during the assessment and treatment. The personality disordered patient comes to therapy with problems in interpersonal relations. Theories of normal personality (Mischel & Shoda, 2008) and personality dysfunction (e.g., internal working models, schemas) suggest that it is likely that the personality disordered patients, especially the severe ones, will play out these interpersonal paradigms with the therapist. This process has now been observed in laboratory settings (Andersen & Chen, 2002). These behaviors of the patient toward the therapist have been viewed as therapy interfering behaviors (Linehan, 1993) or as central information and a focus of intervention in the treatment (Bateman & Fonagy, 2006; Clarkin et al., 2006).

The interactive process between patient and therapist is of vital concern to the progress and outcome of the treatment. There is no one approach to the process as patients are different in how they relate to others, including the therapist. Patients come with widely different attitudes toward the therapist and treatment, some related to the personality diagnosis and others not. First of all personality disordered patients differ in the degree to which they think they contribute toward their difficulties. Some patients feel distress from their condition but think that others are to blame (e.g., Narcissistic PD). Others are painfully aware of their own cognitions that lead to behavior that painfully affects their lives (e.g., Avoidant PD).

Personality disordered patients also differ in their styles of attaching to others, and attachment theory (see Cassidy & Shaver, 2008) has been a useful paradigm in which to understand this. Borderline patient have been found to be either predominantly dismissing in their attachment style or preoccupied (Fonagy et al., 1996; Levy et al., 2006). Even those who do not utilize the attachment paradigm note the different ways the borderline patient attaches to the therapy process and the therapist. For example, Linehan (1993) refers to the “butterfly” borderline patients.

The concept of transference refers to patterns of thoughts, feelings, motivations, and behavior that emerge in the patients' relationship with the therapist. Defined in this broad sense, therapists in cognitive-behavioral as well as dynamic treatments observe and can report on the patients' typical ways of relating to them (Bradley, Heim, & Westen, 2005). Nearly 200 therapists of various treatment persuasions reported on a patient they had treated for a period of time, and five factor patterns emerged: tendency to make excessive demands of the therapist while being angry and dismissive, behavior characterized by fear of disapproval and rejection by the therapist, patient comfort in working with the therapist, avoidance of meaningful connection to the therapist, and seductive approach to
the therapist. These patterns in the reports related both to adult attachment styles, and, not surprisingly, to types of working alliance, such as factor 3.

Treatment manuals emphasize the relationship between patient and therapist and how to approach it (see Bateman & Fonagy, 2006; Clarkin et al., 2006; Dimaggio et al., 2007; Linehan, 1993). Attempts to enhance the relationship (e.g., cheerleading, validation, mentalizing) are emphasized along with attempts to motivate the patient to change without an aura of criticism. These various approaches have probably worked for those clinicians who describe them, and they may or may not feel comfortable or work for other therapists. There is no direct evidence that these suggestions work for some, let alone all PD patients.

A relationship over time with a personality disordered patient is much different than a relationship in a short-term therapy. Most of our therapeutic alliance and relationship data have been generated from brief treatments. The relationship over time is much more likely to stimulate intense feelings of the patient toward the therapist—positive and negative—and reciprocal feelings on the part of the therapist toward the patient. A long term relationship is also much more likely to stimulate the patient’s characteristic ways of perceiving self and others in relationships and acting upon it.

Both therapist and patient contribute to an interaction with each other that begins to take shape and have some consistency over time. How this relationship is co-constructed with its valences of positive and negative affect has a great deal to determine whether or not the treatment continues, and to the success or failure of the treatment outcome.

The therapist is not a technique-dispensing machine. Many of the techniques are applied common sense, and could be read out of a book. So, above all else, the therapist must develop and shape a relationship with the patient that will help contain the patients’ self-destructive behaviors, motivate the patient for positive change, and organize the change process so that the patient has both hope for improvement, and a relationship that will meaningfully take the patient through times of falling back and loss of hope.

Keeping an eye on the relationship also means that the therapist is continually aware of his/her feelings toward the patient. Patients, especially those in the severe to most severe range of personality pathology in a longer term therapy, can arouse intense feelings in the therapist. This is a major reason that therapists are encouraged to obtain on-going consultation from colleagues when treating severe personality disorder patients (Clarkin et al., 2006; Linehan, 1993).

The management and use of transference and countertransference material is an area of major difference between the existing treatment manuals. Cognitive behavioral treatments are attentive to the interpersonal schemas that patients can articulate (Pretzer & Beck, 2005). The cognitive behavioral therapist examines these schemas as the patient manifests
them with individuals in their environment, and asks the patient to question and examine these schemas in everyday life. Linehan (1993) focuses on these interpersonal behaviors as they occur between DBT therapist and patient, but addresses them as therapy interfering behaviors that must be changed for treatment to work. MBT (Bateman & Fonagy, 2006) conceptualizes patient behavior toward the therapist as a transference phenomenon, but cautions the therapist about addressing this phenomenon directly in patients in the severe range of personality pathology as it may upset the patient or be passively endured by the patient. TFP places a central focus on examining how the patient relates to the therapist as a manifestation of the patients’ ways of conceptualizing self and others. This focus is used both for the milder personality disordered (Caligor, Kernberg, & Clar-kin, 2007) and the severe personality disordered (Clarkin et al., 2006).

ADDRESSING THE PROBLEMATIC PERSONALITY ORGANIZATION

While all personality disordered patients are organized with a structure that will probably continue without intervention, the problematic elements of this organization, which are often out of the patient’s awareness, must be challenged and the notion of new behaviors and organization introduced by the therapist. The manner and timing of this strategic intervention is variously articulated by those who work with personality disordered patients. There are many factors in determining how the individual clinician approaches this issue, including the therapist’s personality, comfort with the individual patient, theoretical orientation, and match with the particular patient. There are no clear empirical results that inform this process.

Beutler and colleagues (Beutler et al., 2004) have pointed out that patients vary in their receptivity to input from the therapist. These authors suggest that the success of treatment techniques depends upon the therapist flexibility in monitoring the acceptance-reactance of the patient to utilization of therapist input. Directive techniques can be used successfully with patients who are open to learning from the therapist (i.e., not narcissistic) and whose reactance level is low. Patients high in reactance may need technical approaches that are less directive and more exploratory, at least in style.

This dialectic of clarifying, exploring, and understanding the patient’s view of self and others, and challenge for change is especially fraught with difficult in treating patients in the severe range of personality pathology. These patients are sometimes unaware of how they appear to others, how they impact others, and how their interaction styles lead to their own difficulties. The extent to which the personality disorder patient recognizes their own contribution to their interpersonal difficulties varies from patient to patient, and from time to time in the same patient.

MBT (Bateman & Fonagy, 2006) is most cautious, suggesting that the severe personality disordered patient must be assisted in learning basic
mentalizing skills before any attempts at interpretation. DBT (Linehan, 1993) attempts to balance acceptance and respect, and a challenge to the patient for change. Metacognitive therapy uses techniques to enhance the atmosphere between patient and therapy, and after some time introduces suggestions for change in metacognitive failures (Dimaggio et al., 2007). TFP rapidly focuses on the evolving relationship between patient and therapist, and uses a process of clarification, confrontation of contradictory aspects of the patient’s understanding and behavior, and interpretation to introduce change (Clarkin et al., 2006). It is premature to argue that any one approach is the effective approach to this dilemma, as patients vary, even within one PD diagnosis, the therapist’s vary, and the process between the individual patient and therapist takes on a life of its own.

This tension between respect, acceptance, understanding, and a call for change can take place over many domains of the patient’s life. It can center on self-destructive behavior such as suicidal acts, self-cutting, engaging in unprotected sex, etc. It can take place around the environment the patient creates, such as choosing to live with a mate who is aggressive and attacking. Or it can take place around the patient’s conception of self and others in interaction with important figures in the patient’s current life and/or in interaction with the therapist.

The clinical literature describes the dangers of confronting patients with their inconsistencies and destructive behaviors that can result in the possibility of emotional arousal and discontinuation of treatment. On the other hand, there is also the danger in dealing with patients with mild to severe personality pathology that the therapy will continue without any patient change, because the therapist continues to accommodate to the patient. In the spirit of integration, the therapist may feel the need to support rather than confront the patient. Reaching a therapeutic balance in acceptance and change, as so thoroughly emphasized by Linehan (1993) is at the heart of therapist skill.

SEQUENTIAL GOALS IN THE HERE-AND-NOW

In relation to time frame, the therapist should be most alert to the present, i.e., the present of the relationship with the patient, and the present of the patient’s extra-therapy investments (or lack thereof) in relationships and work or profession. While some would disagree, our experience is that focus on the present symptoms and current adjustment of the personality disordered patient is important without immediately getting immersed with past traumas, poor parenting, etc. This is especially true for patients in the severe and most severe range of personality pathology.

A usual progression of treatment of personality disordered patients proceeds from control and modulation of destructive behaviors to reflection and change in the way the patient views self and others. One can perceive this progression in clinical illustrations of PD patients in treatment (see Dimaggio & Norcross, 2008).
In describing an integrated treatment of a patient in the severe range of personality pathology (married female of 30 years of age, with diagnoses of borderline and dependent personality disorder), Livesley’s (2008) integrated treatment involved medication, skill development to manage symptoms, cognitive techniques to modulate ways of thinking about self and relationships with others, and dynamics techniques of focusing on beliefs about self and others in the relationship with the therapist. The way the treatment unfolded over time is typical of treatment with severe personality disordered individuals: a stormy beginning with mistrust of the therapist and the therapy, and reporting of current crises with instances of self-harm. The therapist used support and validation of the patient’s feelings to begin to develop the patient’s trust in the relationship. After about 3 months, the patient settled into treatment, and the focus moved to reduction of self-harm and emotion regulation. Events leading up to distress and self-harm were examined in detail, and alternatives to self-harm in managing her stress were discussed and considered. This naturally led to a more detailed discussion of her heightened emotional response to her cognitive understanding of the events. The patient conceptualized herself as a victim of the husband’s and extended families many demands, to which she resentfully submitted. The therapist encouraged the patient’s expanding ability for self-observation and gradual self-assertion to modify her own submissiveness. Throughout the treatment, the patient’s memories of childhood abuse emerged with feelings of current and past exploitation. The therapist acknowledged these events and related feelings and provided support. Only toward the end of treatment were self-definitions of worthlessness and past abuse approached with caution, as she tended to dissociate and decompensate when these issues arose.

From the point of view in this article, the case illustrates the strategy of initial assessment and conception of the case not so much around a diagnosis but around four key areas of dysfunction: emotional dysregulation, dissocial or psychopathic behaviors, social withdrawal, and compulsivity. The severity range of pathology was established. The structure of the treatment was not made explicit, but can be inferred as arising from the therapist’s attention and consistency in the way the patient settled into treatment following the stormy first 3 months. The patient’s experience was explored in detail, and change was introduced delicately in terms of suggestions for re-conceptualizing the crises, using forms of self-regulation other than harmful self-cutting, and emotion reduction and enhanced self-observation with introduction of new behaviors via assertiveness training. The therapist does not discuss his feelings toward the patient. His steady concern and empathy with her struggles seems obvious between the lines, but there may have been moments when he had to contain his frustration regarding the patient’s limitations.

Especially as the severity of the personality pathology increases, there is
a hierarchy of targets of intervention, going from initial priority on attention to suicidal and self-destructive behavior, to destructive behavior toward others, to the difficulties in adjusting to the demands of everyday life especially in work and relationships.

**POTENTIAL DIFFICULTIES OF INTEGRATION**

Emphasis in this article is on the advantage of integration as it develops in a clinician’s mind and carried out in a process over time with an individual patient. A major advantage of integration is the utilization of a range of strategies and techniques that can address the unfolding patient problem areas across time. But, what are the potential dangers or pitfalls in the process of integration? Manualized treatments for severe personality disorders have a sequence and coherence based in one theoretical approach that is an advantage for the therapist but may not fit all patients. The clinician who is attempting to integrate strategies across treatment orientations and adapt it to a particular patient is making individual decisions throughout the treatment. This is not an easy task, especially with patients in the severe range of personality pathology who can stimulate intense feelings in the therapist, and probably becomes easier for therapists as they gain experience with personality disordered patients.

Probably the biggest integration threat is that an inexperienced therapist with the goal of integrating techniques from many schools of psychotherapy begins to be shaped in the process over time by the momentary and here-and-now behaviors of the patient. The more severe the personality pathology, the more likely the patient has a fragmented and diffuse sense of self with fluctuating and affects ridden momentary views of the therapist. Personality disordered patients without a coherent sense of self and related goals and investments in relationships and work can fluctuate, sometimes dramatically, from day to day in terms of their moods, likes and dislikes, and evaluation of others, including the therapist.

Finally, as the therapist with an integrated treatment approach proceeds through treatment, actively introducing cognitive-behavioral techniques of problem solving, social skills training, and homework assignments in the first phase of treatment, it may be difficult for the therapist to become more reflective in the second phase. As we have seen previously, there is often a progression of reduction of symptomatic behavior to reflection on conceptions of self and others that guides interpersonal behaviors. The therapist shifts from the active first phase to the more reflective second phase may be difficult for the therapist to carry out, as the shift may confuse the patient about the therapist’s role. The therapists’ skill in integrating the treatment approaches may be most importantly reflected in this shift.

Two different loci of integration are central to the thesis in this article. Given the complexities of clinical work with personality disordered pa-
patients, a therapist’s open-minded knowledge of the range of potential therapeutic techniques is a real advantage. A knowledge of and application of these techniques is not enough, however. The difference between a technician and a professional is that the latter integrates the techniques with the dominant relationship patterns of the patient, with timing geared to maximum impact, while fostering the patient’s hope for change, and encouraging new conceptions of self and other with healthier interpersonal behavior.

A second center of integration taking place during the therapy is in the patient. Referring once again to the CAPS model of personality functioning, the personality disordered patient suffers both from disturbances and distortions in the cognitive-affective units which relate to disturbed and disturbing interpersonal behavior. A thorough, integrated treatment will address both the disturbed behavior and the distortions in the cognitive-affective units. In this way, behavioral change is maintained over time. Treatment is an attempt to assist the patient in his/her smooth integration of balanced views of self and others with affective modulation and cooperative and satisfying interpersonal relations.

REFERENCES


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