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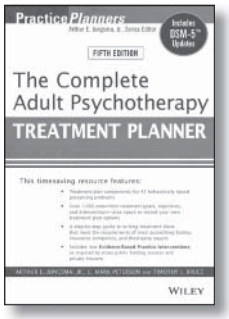

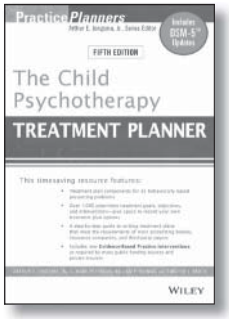

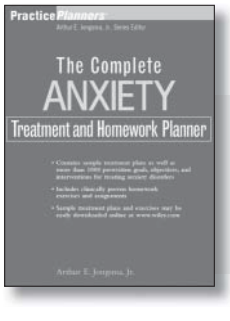

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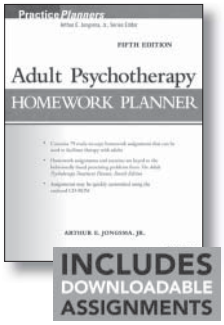

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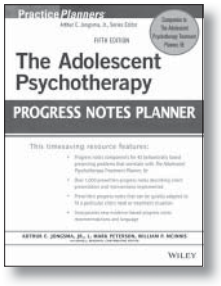

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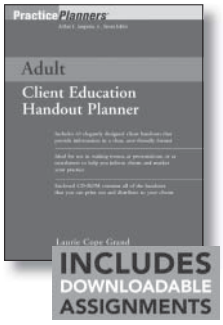

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The Personality Disorders Treatment Planner

Second Edition

Neil R. Bockian

Julia Christine Smith

Arthur E. Jongsma, Jr.

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Dedicated to the memory of Theodore Millon (1928–2014)—a great scholar, and my personal mentor and friend. His contributions to the field of psychology have been beyond measure, while his contributions to his family, friends, and those close to him, have been immeasurably greater.

And dedicated to my brother Jeffrey, a man of honor and integrity, my role model and hero.

And dedicated to my uncle Alan Brodsky, a fountain of kindness and generosity, a blessing to all who know him, and a major influence in my life.

—Neil R. Bockian

This book is dedicated to my husband, Mike; my parents, William and Janis; and my mentor, Alina Suris, whose ongoing support and acceptance gives me the energy to challenge myself and continue growing, even when it's difficult.

—Julia Smith

To Ruth and Rodger Rice, whose spiritual directedness and focus is a model for all to emulate.

—Art Jongsma

CONTENTS

*Denotes Elaboration of Dimensional Structure in Appendix A.
EBPIndicates that selected Objectives/Interventions are consistent with those found in evidence-based treatments.

FOREWORD*

Professor Bockian and Dr. Jongsma have found an intriguing way to organize an important therapeutic subject. I am especially impressed by the balance among diverse methods these authors have given and the skill with which they have executed the task of representing alternative therapeutic models. They have condensed as well as sharpened my own earlier efforts to develop a guide for treating the personality disorders. Employing an integrative framework, they have succeeded in organizing a pioneering work, one that will be valuable to mature professionals of diverse orientations, as well as being eminently useful for students.

The authors have outlined solutions to the personality treatment task with a series of powerful, concrete, and readily implemented tools that draw from numerous treatment methodologies. What has been especially helpful to the reader is that their approach to therapy not only addresses the patient's initial complaint—such as depression, anxiety, or alcoholism—but is designed to undercut the patient's long-standing habits and attitudes that give rise to these manifest symptoms. They fully recognize also that personality disorders are themselves pathogenic, that is, these disorders set into motion secondary complications that persist and intensify the patient's initial difficulties. Presenting symptoms not only discomfort the patient, but the forces that undergird them diminish life's potentials by creating persistent unhappiness, undoing close relationships, disrupting work opportunities, and undermining future aspirations.

I was extremely pleased to see the authors' willingness to grapple with the many subtypes of the classical personality disorders. Here they have sought to differentiate the conflicted avoidant from the hypersensitive avoidant as well as to separate the different ways in which one should deal with a petulant borderline compared to a self-destructive one. Their book is more than a simple listing of techniques—it shows sensitive awareness of the uniqueness of each patient and the subtle differences that are called for in their treatment.

My hat is off to Drs. Bockian and Jongsma for undertaking the awesome task of guiding others who treat their patients with personality difficulties—

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*This Foreword was written by the late Dr. Millon in reference to *The Personality Disorders Treatment Planner*, First Edition (2001).

and for carrying out their work with clarity and utility. Most textbooks shy away from discussing the treatment of personality disorders owing to their intricacies and uniqueness. By contrast, the good doctors have organized a treatment model that can be understood by all well-trained and motivated students and professionals.

Theodore Millon, *Ph.D., D.Sc.*

ACKNOWLEDGMENTS

First and foremost, I would like to thank my series editor, coauthor, and friend, Dr. Art Jongsma, whose clinical acumen and pragmatic wisdom provided a solid anchor throughout the writing of the manuscript. My coauthor, former student, and friend, Julia Smith, Psy.D., made invaluable contributions to this draft. There is a particular and indescribable pleasure in seeing one's former student exceed one's own knowledge in a particular area (in this case, Dr. Smith's expertise with Acceptance and Commitment Therapy), which enhanced the quality of this manuscript. In addition, Art's excellent assistant, Sue Rhoda, was extremely helpful. Sue reformatted my drafts, without which the process would have bogged down completely. I will always be grateful for the patience, persistence, and encouragement of these three colleagues. I would also like to thank my (really, our) editor, Marquita Flemming, for her patience and support throughout this project. On those occasions when we met, she was both gracious and thoughtful, and it has been a pleasure working with her.

Undertaking a project as large as writing a book is inevitably a family effort. I would like to thank my wife, Martha, and my children, Chaya and Yaakov, for their love and support as I plowed ahead. Similarly, I owe a debt of gratitude to my parents, Fred and Sandra Bockian, my brother, Jeffrey, as well as my uncle and aunt, Alan and Barbara Brodsky, who were with me in spirit throughout this journey. I am truly blessed to have all of these people in my life.

There are also several professional colleagues to whom I owe a debt of gratitude. From the first edition of this volume, several of my colleagues provided key insights into several different theoretical approaches. Marc Lubin, Ph.D., provided essential feedback on operationalizing the psychodynamic approaches to treating personality disorders. In a similar vein, Marge Witty, Ph.D., provided feedback on client-centered interventions, while Jill Gardner, Ph.D., was instrumental in developing interventions using the self-psychology approach. My continued gratitude goes to Garry Prouty, Ph.D., who provided insights into his unique approach to connecting with extremely detached and psychotic clients; his memory is a blessing to all who knew him. From the current volume, several additional colleagues were instrumental in the development of some important interventions. Sue Johnson, Ph.D., was generous with her time and support, helping me to operationalize several key interventions in

Emotion-Focused Therapy. Similarly, Leigh Johnson-Migalski, Psy.D., provided support that allowed me to include Adlerian interventions in several chapters. Tim Bruce, Ph.D., provided us with a pithy review of the status of evidence-based practice in the personality disorders area. Erin Fletcher, Psy.D., my former student, friend, and a talented clinician, gave invaluable feedback on the use of exposure therapy. I thank Anthony Bateman, Ph.D., for his outstanding feedback on mentalization, as well as my colleagues Cathy McNeilly, Psy.D., and Richard Rutschman, Ed.D., for their invaluable feedback on operationalizing Motivational Interviewing. Aimee Daramus, M.A., my teaching assistant and soon-to-be colleague, did important work on the reference section and helped with the research on evidence-based practice; Gesa Kohlmeier, B.A., also my teaching assistant, provided much-needed help in organizing the various chapters in during the later stages of the project. Special thanks go to my exuberant former student and current colleague and friend Stacy Zeidman, M.A., for her drafting of several sections of the dimensional appendix. Finally, I would like to thank my insightful and talented former student and current colleague and friend Tatiana Zdyb, Ph.D., for her comments on last-minute drafts and for her encouragement during the project's final phases.

Last, but certainly not least, I would like to thank Ted Millon, Ph.D., of blessed memory, for his ongoing guidance and support during my career. He taught me how critically important a relationship with a mentor can be. His teachings and support are gifts that I could never reciprocate. I can only pay it forward by sharing what he has taught me with my students and with the readers of my writings.

NEIL R. BOCKIAN

The Personality Disorders Treatment Planner

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INTRODUCTION

ABOUT WILEY *PRACTICE PLANNERS® TREATMENT PLANNERS*

Pressure from third-party payers, accrediting agencies, and other outside parties has increased the need for clinicians to quickly produce effective, high-quality treatment plans. Wiley *Treatment Planners* provide all the elements necessary to quickly and easily develop formal treatment plans that satisfy the needs of most third-party payers and state and federal review agencies.

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- Has an easy-to-use reference format that helps locate treatment plan components by behavioral problem or diagnosis.

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ABOUT THIS SECOND EDITION *PERSONALITY DISORDERS TREATMENT PLANNER*

This second edition of the *Personality Disorders Treatment Planner* has been improved in many ways:

- Updated with new and revised evidence-based Objectives and Interventions in the Borderline chapters

- Many new and revised best practice Objectives/Interventions have been added to every chapter
- Many more suggested homework assignments integrated into the Interventions
- Appendix A demonstrating the use of the personality disorders Proposed Dimensional System of *DSM-5.* Chapters that are represented in Appendix A are denoted with an asterisk (*) in the contents and in the chapter titles
- Expanded and updated self-help book list in Appendix B
- Revised, expanded professional references in Appendix C
- New Appendix D, "Recovery Model Objectives and Interventions," allowing the integration of a recovery model orientation into treatment plans
- Integration of *DSM-5* diagnostic labels and codes into the Diagnostic Suggestions section of each chapter

Evidence-based practice (EBP) is steadily becoming the standard of care in mental health care as it has in medical health care. Professional organizations, such as the American Psychological Association, National Association of Social Workers, and the American Psychiatric Association, as well as consumer organizations such the National Alliance for the Mentally Ill have endorsed the use of EBP. In some practice settings, EBP is becoming mandated. It is clear that the call for evidence and accountability is being increasingly sounded. So, what is EBP, and how is its use facilitated by this *Planner*?

Borrowing from the Institute of Medicine's definition (Institute of Medicine, 2001), the American Psychological Association (APA) has defined EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 17). Consistent with this definition, we have identified those psychological treatments with the best available supporting evidence, added Objectives and Interventions consistent with them in pertinent chapters, and identified these with this symbol: EBP As most practitioners know, research has shown that although these treatment methods have demonstrated efficacy (e.g., Nathan & Gorman, 2007), the individual psychologist (e.g., Wampold, 2001), the treatment relationship (e.g., Norcross, 2002), and the patient (e.g., Bohart & Tallman, 1999) are also vital contributors to the success of psychotherapy. As noted by the APA, "Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations" (2006, p. 275). For more information and instruction on constructing evidence-based psychotherapy treatment plans, see our DVD-based training series titled *Evidence-Based Psychotherapy Treatment Planning* (Jongsma & Bruce, 2010–2012).

For any chapter in which EBP is identified, references to the sources used are listed in the Appendix C and can be consulted by those interested for further information regarding criteria and conclusions. In addition to these references, Appendix C also includes references to clinical resources. Clinical

resources are books, manuals, and other resources for clinicians that describe the details of the application, or "how to," of the treatment approaches described in a chapter.

There is debate regarding EBP among mental health professionals, who are not always in agreement regarding the best treatment or how to weigh the factors that contribute to good outcomes. Some practitioners are skeptical about changing their practice on the basis of research evidence, and their reluctance is fueled by the methodological challenges and problems of psychotherapy research. Our intent in this book is to accommodate these differences by providing a range of treatment plan options, some supported by the evidence-based value of "best available research" (APA, 2006), others reflecting common clinical practices of experienced clinicians, and still others representing emerging approaches, so users can construct what they believe to be the best plan for their particular client.

Each of the chapters in this edition has also been reviewed with the goal of integrating homework exercise options into the Interventions. Many (but not all) of the client homework exercise suggestions were taken from and can be found in the *Adult Psychotherapy Homework Planner* (Jongsma, 2014). This second edition of *The Personality Disorders Treatment Planner* contains many more homework assignments than the previous edition did.

Appendix B of this *Planner* has been expanded and updated from the previous edition. It includes many recently published offerings as well as more recent editions of books cited in the earlier edition. Most of the self-help books and client workbooks cited in the chapter Interventions are listed in this appendix. Many additional books listed are supportive of the treatment approaches described in the chapters. In addition, we reviewed a number of computer/smartphone applications (apps) that can be helpful in supporting therapeutic endeavors.

With the publication of the *DSM-5* (American Psychiatric Association, 2013), we have updated the Diagnostic Suggestions listed at the end of each chapter. The *DSM-IV-TR* (American Psychiatric Association, 2000) was used in the previous edition of this *Planner.* Although many of the diagnostic labels and codes remain the same, several have changed with the publication of the *DSM-5* and are reflected in this *Planner.*

In its final report entitled *Achieving the Promise: Transforming Mental Health Care in America*, The President's New Freedom Commission on Mental Health called for recovery to be the "common, recognized outcome of mental health services" (New Freedom Commission on Mental Health, 2003). To define recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation (SAMHSA, 2004). Over 110 expert panelists participated including mental health consumers, family members, providers, advocates,

researchers, academicians, managed care representatives, accreditation bodies, state and local public officials, and others. From these deliberations, the following consensus statement was derived:

> Mental health recovery is a journey of healing and transformation for a person with a mental health problem to be able to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential. Recovery is a multi-faceted concept based on the following 10 fundamental elements and guiding principles:
>
> Self-direction
> Individualized and person-centered
> Empowerment
> Holistic
> Nonlinear
> Strengths-based
> Peer support
> Respect
> Responsibility
> Hope

These principles are defined in Appendix D. We have also created a set of Goal, Objective, and Intervention statements that reflect these 10 principles. The clinician who desires to insert into the client treatment plan specific statements reflecting a recovery model orientation may choose from this list.

Last, some clinicians have asked that the Objective statements in this *Planner* be written such that the client's attainment of the Objective can be measured. We have written our Objectives in behavioral terms, and many are measurable as written. For example, this Objective from the Obsessive—Compulsive chapter is measurable as written because it either can be done or it cannot: "Reduce clutter by throwing out one or more items that are no longer useful." But at times the statements are too broad to be considered measurable. Consider, for example, this Objective, from the same chapter: "Reduce negative thoughts about self that produce guilt, shame, and self-recrimination." To make it quantifiable, a clinician might modify this Objective to read, "Give two examples of identifying, challenging, and replacing negative thoughts about self that produce guilt, shame, and self-recrimination with balanced, realistic, and empowering self-talk." Clearly, the use of two examples is arbitrary, but it does allow for a quantifiable measurement of the attainment of the objective. Or consider this example from the Avoidant—Conflicted chapter: "Implement relaxation techniques to counteract anxiety during gradual exposure to social situations." To make it more measurable, the clinician might add more specificity to the type, number, or duration of relaxation techniques used, thus: "Implement a specific relaxation technique (e.g., diaphragmatic breathing) for xx minutes

prior to or during a social function." The exact target number that the client is to attain is subjective and should be selected by the individual clinician in consultation with the client. Once the exact target number is determined, the clinician can very easily modify our content to fit the specific treatment situation. For more information on psychotherapy treatment plan writing, see Jongsma (2005).

Changes in the Current Edition

We made several decisions in order to make the current edition more compact and accessible than the previous one. We eliminated some subtypes, for a variety of reasons. Generally, when we felt that the subtype was a rather linear extension of the main type, we eliminated the subtype. An example of this is the Puritanical Obsessive-Compulsive, which was more extreme, but not different enough in kind, from the Obsessive-Compulsive main type to be included. We eliminated other subtypes because the main disorder is rare. So we eliminated the Schizoid and Schizotypal subtypes that were present in the first edition of this planner; we reasoned that for the vast majority of clinicians, having the main type would suffice. Strong preference was given to retaining subtypes that include elements of the disorders that were in *DSM* appendices but are no longer in the personality disorders section. Specifically, these include the Passive-Aggressive/Negativistic, the Aggressive-Sadistic, and the Self-Defeating/Masochistic. These are incorporated into subtypes such as Borderline-Petulant; see Table I.1 for a complete list.

Table I.1 Personality Disorder Subtypes

Subtype	Personalities of Which It Is Composed
Conflicted Avoidant	Avoidant/Passive-Aggressive (Negativistic)
Hypersensitive Avoidant	Avoidant-Paranoid
Selfless Dependent	Dependent-Depressive
Appeasing Histrionic	Histrionic/Dependent/Obsessive-Compulsive
Disingenuous Histrionic	Histrionic-Antisocial
Unprincipled Narcissist	Narcissistic-Antisocial
Compensatory Narcissist	Narcissistic/Passive-Aggressive (Negativistic)
Malevolent Antisocial	Antisocial/Aggressive-Sadistic/Paranoid
Bedeviled Obsessive-Compulsive	Obsessive-Compulsive/Passive-Aggressive (Negativistic)
Insipid Schizotypal	Schizotypal-Schizoid
Timorous Schizotypal	Schizotypal-Avoidant
Petulant Borderline	Borderline Passive-Aggressive (Negativistic)
Self-Destructive Borderline	Borderline/Depressive/Self-Defeating
Fanatic Paranoid	Paranoid-Narcissistic
Malignant Paranoid	Paranoid/Aggressive-Sadistic

In perhaps the strongest theoretical stance taken in this volume, we included the Aggressive-Sadistic and Self-Defeating/Masochistic (which we label "Intropunitive/Guilty") personality disorders. Although the *DSM* has not recognized these disorders since the appendix of the *DSM-III-R* (American Psychiatric Association, 1987), they remain part of Millon's taxonomy, and clinicians still see these patients in clinical practice. Once removed from the official nomenclature, a precipitous decline in research and clinical attention follows. These disorders are particularly perplexing. In the Self-Defeating Personality Disorder, how do we work with someone for whom the usual behavioral principles of reward and punishment seem turned inside out? In which rewards that produce pleasure produce, simultaneously, overwhelming feelings of guilt and urges toward self-punishment? Or with the Aggressive-Sadistic, how do we guide someone to stop being harmful when descriptions of hurting others cause pleasure and perhaps even sexual arousal? Millon (1999, 2011) refers to this as the reversal of the pain-pleasure dimension and provides a theoretical description of how this emotional framework came about in the individual and how to treat it. These ideas, and others based on the lead author's clinical experience, are embodied in this work.

Similarly, the Passive-Aggressive (Negativistic) Personality Disorder is the one that has most frequently tied my supervisees into knots. Eager, helpful emerging clinicians would offer advice, support, encouragement, insights, and behavioral suggestions—the usual therapeutic array—only to find "yes. . . but" at every turn. Most perplexing of all are the smiles, the betrayals of obvious pleasure on the part of the person with Passive-Aggressive Personality Disorder at having "defeated" the therapist . . . even though it is in the task of helping the client himself or herself. Again, ideas are woven into the chapter on this disorder and the relevant subtypes that are helpful in those areas.

Finally, attention is paid to the Depressive Personality Disorder, which is distinguished from its depressive diagnosis cousins by its ego-syntonic quality; individuals with Depressive Personality Disorder see the world as an awful place rather than seeing their downcast mood as a problem (as is the case for Dysthymic Disorder and Recurrent Major Depression). All of these personality types must be coded as "Personality Disorder Otherwise Specified," as there is no category for them. For subtypes, such as the Compensatory Narcissist, the clinician may use a Narcissistic Personality Disorder designation or the otherwise specified designation noting narcissistic features.

Returning to the Aggressive-Sadistic and Self-Defeating (Intropunitive/Guilty) Personality Disorders, we must urge caution to clinicians when labeling individuals who have one of these conditions. Historically, it is important to note that one reason why the disorders were eliminated from the *DSM* is that the labels were being grotesquely misused in forensic settings. Defense attorneys were arguing, in domestic violence cases, that people with

sadistic personality disorder were unable to control themselves due to their mental disorder and, further, that they could not be blamed for injuring the masochist, who was "asking" to be hurt. I (NB) believe that there were better solutions than to eliminate the diagnoses (e.g., for the American Psychiatric and American Psychological Associations to write unequivocal briefs on how such uses of these diagnoses is inappropriate and misleading), but I understand the committee's decision, given the harm being done by the misuse of these diagnostic labels. So, we advise the clinician to be mindful of the implications of the use of language and labels, especially if there is the likelihood of documentation being used for legal purposes.

Personality Disorders and Subtypes

Personality disorders have traditionally been considered difficult to treat. Because they are established early, are deeply ingrained, and are ego-syntonic (i.e., are often not seen as problematic or targets of change by the client), prognosis was initially considered poor (Millon, 1981). It is clear, however, that it is necessary to treat personality disorders. In addition to creating problems in their own right, personality disorders have strong associations with reduced quality of life (e.g., Bockian, Dill, Lee, & Fidanque, 1999) and poorer treatment outcomes for other mental illness conditions (e.g., Shea, Widiger, & Klein, 1992). The question, then, is not *whether* to treat them, but *how.*

In the past 35 years, there has been an explosion of research and clinical innovation in the treatment of personality disorders. A variety of treatments have been empirically shown to have a powerful impact on a variety of important outcomes. One exciting example of an accepted, evidence-based therapy is Marsha Linehan's Dialectical Behavior Therapy (DBT) model for treatment of borderline personality disorder (BPD). Treatment with DBT has produced substantial improvements on important outcomes, such as reduced hospitalizations and suicide risk (Koerner & Linehan, 2000). Unfortunately, the vast majority of research has been applied to BPD, with treatment research for the other personality disorders languishing. Indeed, it is only for BPD that there are true evidence-based treatments available.

Theodore Millon (1969, 1981, 1996, 1999, 2011) developed arguably the most comprehensive theoretical understanding of the personality disorders as a whole. Millon, a member of the *DSM-III* and *DSM-IV* Personality Disorders task forces, has had an important impact on personality disorder theory, research, and practice. This *Personality Disorders Treatment Planner* draws heavily on *Personality Guided Therapy* (1999) and the third edition of *Disorders of Personality* (2011). In these works, Millon provided a general outline for the treatment of personality disorders that integrates a variety of theoretical perspectives: behavioral, cognitive, client-centered, interpersonal,

family systems, and psychodynamic. In general, the suggested approach is to establish rapport, then find some areas for change that will be reasonably easy to accomplish; positive changes provide encouragement and also secure the therapeutic bond. Once some basic behavioral change has been established, a more comprehensive approach (e.g., cognitive, interpersonal, and psychodynamic/object relations) can be employed to help the client overcome the ways of thinking, feeling, and behaving that perpetuate the personality disorder. This Wiley *Treatment Planner* draws heavily on Millon's Personality-Guided Psychotherapy approach (also known as Synergistic Psychotherapy and Personalized Psychotherapy), which is described in the two volumes mentioned already.

Although most or all clinicians who use this book are familiar with the personality disorders, some may not be familiar with the various subtypes that have been developed. Subtypes can be extremely useful and are also quite prevalent. Comorbidity studies bear this out, showing not only high degrees of overlap among many of the personality disorders but also indications that many individuals who meet the criteria for one personality disorder also meet the criteria for one or more *additional* personality disorder diagnoses. For example, although there is a prototype for Antisocial Personality Disorder, the clinician who is experienced with this population will immediately recognize that there are several important variations on the theme. There is the brutal, vicious, callous sociopath who becomes a serial killer or rapist and then there is the slick, charming, usually nonviolent con artist who fleeces vulnerable people out of their life's savings. Both have elements of Antisocial Personality Disorder as defined by the *DSM*, but they are in fact rather different types. In this book, the former is labeled the Malevolent Antisocial, while the latter is the Disingenuous Histrionic (a mixture of histrionic and antisocial features) or the Unprincipled Narcissist (a mixture of narcissistic and antisocial features). Table I.1 lists the subtypes. We would advise using the subtype rather than the main type when appropriate, since the subtype treatment plan is inevitably more specific to a particular set of characteristics. Because the subtypes are not codified in the *DSM*, continue to select one or more of the corresponding *DSM* main personality disorders for purposes of formal diagnosis.

The Dimensional Appendix

The *DSM-5* includes an appendix that provides a proposed dimensional system for assessing personality disorders. Back when I scratched my dissertation out on papyrus using a quill pen, I looked into dimensional systems of personality disorders (Bockian, 1990). In a nutshell, dimensional systems have some important advantages. It seems fair to say that personality disorders generally represent extremes of normal personality

dimensions. For example, the Avoidant Personality Disorder can be viewed as a severe extension of shyness, passing through descriptors such as introverted, withdrawn, and, finally, avoidant. Dimensions comfortably capture thorny aspects of categorical systems, such as the fuzzy boundary between normality and pathology and the somewhat perplexing reality that a person can have one personality but meet the criteria for four or five personality disorders; indeed, if someone meets the criteria for one personality disorder, it is typical that he or she will meet criteria for several. Categorical systems, however, create vivid pictures of disorders; these exemplars tend to facilitate learning about the disorders for practitioners and the general public, and facilitate communication among practitioners; these descriptors also tend to be quicker for paperwork purposes. Regarding communication, for example, Brandon Marshall, NFL wide receiver for the New York Jets, announcing to the media that he has Borderline Personality Disorder probably packs a lot more communicative punch than an announcement that he has "extremes on the lability dimension, impulsivity dimension, and relational inconsistency dimension." Thus both dimensional and categorical systems have pros and cons; the *DSM* committee's choice to add a dimensional appendix should stimulate significant debate and contributions in this area.

The system that is proposed by the *DSM-5* has two parts. First, the practitioner is instructed to assess the person on Level of Personality Functioning. These levels are broken into two domains (Self and Interpersonal), each of which has two components. The Self domain contains Identity and Self-Direction, while the Interpersonal domain includes Intimacy and Empathy. Clinicians are instructed to rate each of these areas from 0 (healthy/no impairment) to 4 (extreme impairment).

The practitioner then assesses Pathological Personality Traits. These traits fall into five domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. Within each domain, there are a number of facets, that number varying from domain to domain, with a total of 25 facets. For example, under Negative Affectivity (similar to Neuroticism), there are facets such as Anxiousness, Depressivity, and Emotional Lability. It is clear to anyone familiar with the Five Factor Model that there is a strong tie, although the *DSM* has not explicitly acknowledged this, and there are some differences (Widiger & Gore, 2013). Six of the current personality disorders were retained in the proposed dimensional system: Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal; the remainder are to be described only in the dimensional terms.

We selected 12 of the personality disorders and translated the behavioral definitions from them into the dimensional system. Ten are the personality disorders from the current system: Paranoid, Schizoid, Schizotypal; Antisocial, Borderline, Histrionic, Narcissistic; Avoidant, Dependent, and Obsessive-Compulsive. We then added Depressive and Passive-Aggressive (Negativistic). We chose not to include the Aggressive/Sadistic and

Masochistic/Self-Defeating (Intropunitive/Guilty) —we struggled in our efforts to apply the dimensional system to these disorders, and felt that the system needed modification to capture their essence. For example, with the Aggressive/Sadistic, there is harsh behavior, but unfeeling callousness (in the Empathy domain) did not capture the essence of the problem; indeed, the person is experiencing strong emotion—generally, some form of pleasure. We did not attempt to capture each of the four Levels of Personality categories; rather, we picked the one or two that we believed were most central. Also, note that we were translating a particular criterion/behavioral definition rather than the disorder as a whole, which is a somewhat different mission from that of the *DSM* appendix, and produces somewhat different results. In utilizing the *DSM* proposed dimensional system, we came to understand that there is room for interpretation, and some might disagree with the labels we used for particular criteria. With these caveats noted, we believe our inclusion of the appendix will be thought-provoking and useful to our readers. Each chapter of this volume that has a corresponding dimensional approach in our appendix is marked with an asterisk and a denotation as such.

It is not clear that the proposed dimensional appendix (A) will ever be adopted as the official system. I (NB) have some reservations and have noted some shortcomings as I tried to apply it. I prefer Millon's theory-driven system (active-passive, pain-pleasure, and self-other dimensions) which Millon (2011) explicitly designed for personality disorders. However, we liked the idea of helping clinicians think in dimensional terms and believe that our appendix can help them transition to the new system if necessary.

A Range of Theoretical Approaches

The authors have made a sincere effort to include a diversity of therapeutic approaches. Interventions were inspired by these schools of thought/theorists: Dialectical Behavior Therapy (Linehan), Personality-Guided Psychotherapy (Millon), Cognitive Therapy (Beck), Rational Emotive Therapy (Ellis), Schema Therapy (Young), Emotion-Focused Therapy (Johnson; Greenberg) Acceptance and Commitment Therapy (Hayes), Milan-Systemic Family Therapy (Selvini-Palazzoli), Multigenerational Family Therapy (Bowen), Experiential Family Therapy (Satir), Structural Family Therapy (Minuchin), Psychodynamic Psychotherapy—especially Transference-Focused Psychotherapy (Kernberg et al.), Client-Centered Therapy (Rogers; Gendlin; Prouty), Stress Management/Meditation/Hypnosis (McKay; Kabat-Zinn; Alman; Hammond), Mentalization Therapy (Bateman & Fonagy), Motivational Interviewing (Miller & Rollnick), Behavior Therapy, and, to a lesser degree, Self-Psychology (Kohut; Gardner) and Interpersonal Psychotherapy (Benjamin). Unfortunately, using every theoretical approach for every short-

term objective would lead to a book that is so cumbersome that it is virtually unusable. The authors encourage readers to modify therapeutic interventions to fit therapeutic goals. For example, the Schizoid chapter includes the following Short-Term Objective and Therapeutic Intervention pairing:

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
List the difficulties experienced in forming intimate attachments in prior relationships.	Validate the client's concerns regarding intimate relationships and express unconditional positive regard (i.e., that the feelings are understandable from the client's perspective).

To use this client-centered intervention for a different problem—say, feelings of alienation—the clinician would merely need to modify a few words (shown in bold):

List the difficulties that **are associated with feelings of alienation**.	Validate the client's concerns regarding **his/her feelings of alienation**. Express unconditional positive regard (i.e., that the feelings are understandable from the client's perspective).

By making such modifications, a clinician could create a customized set of interventions suited to his or her approach. These modifications can be made using either the software or printed version of the *Personality Disorders Treatment Planner.*

Some additional examples capture key applications of some of the approaches noted. The cognitive and behavioral interventions were rather straightforward to translate into the Wiley *Treatment Planner* format. However, the psychodynamic interventions were trickier, and are worth mentioning here. Note that the basic idea is to communicate, to the degree possible, a behavioral/procedural description, despite the deep and esoteric theories that undergird such interventions.

The following is an intervention from self-psychology, taken from the Narcissistic—Compensatory chapter:

Interpret the underlying grandiosity and disappointment when the client falls short in an effort, connecting the client's affective experience to his/her wishes and needs. Help him/her transform it into something realistic (e.g., "When they went with someone else's idea, you felt massively disappointed and deflated; you wanted them to think your idea was wonderful and would

save the day, and when they rejected it you felt defeated and empty"). See "Using Self Psychology in Brief Psychotherapy" (Gardner) and "Speaking in the Interpretive Mode and Feeling Understood: Crucial Aspects of the Therapeutic Action in Psychotherapy" (Ornstein & Ornstein).

The analysis of the transference is a broadly applicable intervention for psychodynamic work; the next quote is taken from the Borderline chapter. The technique is not specific to Transference-Focused Psychotherapy (TFP), but the example here refers to that approach.

> When the client becomes angry with the therapist, process the feelings, noting similarities between the therapeutic relationship and other important relationships in the client's life. Work collaboratively toward an appropriate resolution of the angry feelings (see *Transference-Focused Psychotherapy for Borderline Personality Disorder* by Clarkin, Yeomans, and Kernberg).

We also encourage the reader to note the use of Acceptance and Commitment Therapy (ACT) across many of the personality disorders. ACT is quite nonspecific; it is not driven by specific symptoms but rather by the ability to sit with the discomfort of a particular situation or feeling. Thus, we were able, across the various chapters, to create a fairly complete set of ACT interventions.

Similarly, we encourage clinicians of any of the listed theoretical orientations to skim the book to find examples of the interventions they wish to use. For example, Motivational Interviewing is used heavily in the Passive-Aggressive/Negativistic chapter; Exposure Therapy is included in the Obsessive-Compulsive chapter. Those interventions could be adapted for use with any of the personality disorders, as relevant.

Evidence-Based Practice

It is beyond the scope of this introduction to do a comprehensive review of Evidence-Based Practice (EBP) for personality disorders. In preparation for this volume, the lead author (NB) reviewed a number of studies. Ultimately, we relied primarily on the wisdom embodied in Jeffrey Magnavita's (2010) *Evidence-Based Treatment of Personality Dysfunction* and a systematic review by Sneed and his colleagues (Sneed, Fertuck, Kanellopoulos, & Culang-Reinlieb, 2012). Magnavita's volume emphasizes the use of the best available evidence and the creative use of appropriate treatments, which we applied to the personality disorders other than borderline; for borderline personality disorders, evidence-based treatments are available. One other study also was particularly noteworthy. Bamelis, Evers, Spinhoven, and Arntz (2014) randomly assigned a group of 323 individuals who, collectively, had a wide array of personality disorders to either Schema Therapy or to one of two control groups (treatment as usual or clarification-oriented psychotherapy). In general, the results of the study supported the use of Schema Therapy.