

CHAPTER 15

Personality Disorders

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Generally, psychoanalytically or psychodynamically oriented clinicians find the classification system of personality disorders given in DSM-IV and DSM-5 (American Psychiatric Association [APA], 2000, 2013) to be of limited use in conceptualizing their patients. For that reason, there has been little interest in the DSM. Instead, psychodynamic clinicians have relied more on conceptualizations of character structure, but with little systematic basis for doing so consistently across patient groups. In fact, psychoanalytic explorations of personality disorders not only predate but also attempt to go beyond the symptom-and-sign approach of the DSM classification system (Blatt, 1995; Blatt & Levy, 1998; Kernberg, 1975; Levy & Blatt, 1999; Luyten & Blatt, 2011). With the introduction of the *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006), and the DSM-5, psychoanalytic and psychodynamic clinicians are increasingly becoming interested in empirically evaluating psychodynamic constructs for underlying personality pathology and establishing a stronger evidence base for a classification system based on psychodynamic ideas (Fonagy & Target, 1998; Levy & Blatt, 1999; Shedler & Westen, 2004).

This chapter contributes to that dialogue by reviewing and evaluating current psychodynamic approaches to personality disorders (a more specific discussion of both dependent personality disorder and borderline personality disorder [BPD] will be covered in Bornstein, Chapters 16, and Chapter 17, Clarkin, Fonagy, Levy, & Bateman, this volume; see also Luyten & Batt, Chapter 5, this volume). First, we review the current psychodynamic conceptualization of personality disorders. This review includes early efforts by Kernberg, Blatt, and others to think about personality pathology in a developmental/representational context, as well as more recent effort to systematize these models in the form of the PDM. Second, we discuss empirical research pertaining to this psychodynamic conceptualization. Specifically, we

examine Shedler and Westen's work suggesting a prototype/dimensional model of personality pathology. Third, we provide a clinical vignette illustrating the disparity between a DSM-based and psychodynamic-based conceptualization of a patient with a personality disorder. Finally, we discuss the implications of the current state of psychodynamic models of personality disorders for future research and future editions of the DSM. We explore the extent to which a new classification system should incorporate dimensional and prototype-based approaches, as well as the limitations of a system that does not integrate the etiology, predicted course, and treatment implications of personality pathology.

PSYCHODYNAMIC APPROACHES TO PERSONALITY DISORDERS

Psychodynamic theories of personality disorders must first be understood in the context of the central role that personality as a construct has played in conceptualizing both healthy and pathological psychological processes. Psychodynamic theories emphasize that the individual's personality structure organizes his or her characteristic ways of thinking, feeling, behaving, and being in relationships (Kernberg & Caligor, 2005; McWilliams, 1994; PDM Task Force, 2006). Thus, the individual's personality has significant implications for his or her success or difficulty in being in the world, including the capacity "to love and to work" as Freud famously said (quoted by Erikson, 1950). Although other theoretical orientations have emphasized some aspects of personality (with an emphasis on "thinking" in the cognitive perspective, "behaving" in the behavioral perspective, and a relative deemphasis on "feeling" and "loving" in each), what sets psychodynamic theory apart is (1) consideration of not only each of these facets of personality but also the level of integration and differentiation among personality structures (Blatt, 1995; Kernberg, 1975), and (2) a central emphasis on the unconscious nature of personality processes, particularly the unconscious affective and motivational processes that have been overlooked in other theoretical approaches (Westen, 1998).¹ Thus, how our personality shapes the ways we think, feel, act, and relate to others often, though not exclusively, operates outside of our awareness, and at times causes conflicts (e.g., one may hold unconscious attitudes that conflict with one's conscious self-perception).

Personality interacts with all aspects of our experience of the world, including our experience of distress and psychological symptoms (Kernberg & Caligor, 2005; McWilliams, 1994; PDM Task Force, 2006). Although DSM-5 continues to distinguish between "symptom disorders" and "personality disorders," psychodynamic theories have long maintained that personality will significantly shape the experience and expression of symptoms of all kinds, including those of the "symptom disorders."

¹Many "third-wave" CBT treatments place a much greater emphasis on affect than did earlier iterations of CBT, although they are primarily focused on the capacity to accept and tolerate negative affect states. Psychodynamic approaches are unique in emphasizing unconscious affective and motivational processes. A notable exception can be seen in recent developments in the social-cognitive approach, which has increasingly focused on unconscious affective and motivational processes, though often with little credit to its psychodynamic origins (see Hassin, Uleman, & Bargh, 2005).

Thus, for example, the experience and expression of panic attacks will differ as a function of the individual's underlying personality organization (Powers & Westen, 2009). Underlying personality pathology may also have prescriptive implication for treating panic attacks (Milrod, Leon, Barber, Markowitz, & Graf, 2007). Thus, conceptualizing the influence of personality on the experience and expression of all symptomatology is a central tenet of psychodynamic theory.

Personality disorders involve chronic, long-standing patterns of responding to distress, which are often limited in variability and rigidly applied regardless of appropriateness to context (PDM Task Force, 2006). Because such personality patterns tend to enact the very experiences the patient is trying to avoid, these patterns come to define the patient's experience (Wachtel, 1997). Thus, in personality disorders, the ways in which the individual thinks, feels, acts, and relates directly restrict his or her capacity to love and work, pursue goals, and enjoy intimate relationships.

Psychodynamic theories conceptualize personality along a continuum, from a healthy personality to severe personality pathology (Kernberg, 1975; Kernberg & Caligor, 2005; McWilliams, 1994; PDM Task Force, 2006). In a healthy personality, the individual's characteristic styles of thinking, feeling, and acting allow a flexible response to stressors with a range of adaptive defenses and coping strategies. Healthy personality functioning also allows the individual to establish stable, mutual, and intimate relationships with others. Higher-level personality pathology may negatively affect functioning, but this may be limited to a particular area of conflict, allowing adaptive functioning in other facets of the individual's life. For example, people with higher functioning narcissistic pathology may be socially adept and successful enough to function in social and occupational environments and receive some degree of the sought admiration, although they may struggle with deeper intimacy. In contrast, the impact of severe personality pathology on functioning will likely be pervasive across all contexts. For example, individuals with the most severe narcissistic pathology, malignant narcissism, are likely to display antisocial and paranoid features, as well as take pleasure in their aggression and sadism toward others, which would significantly inhibit most aspects of functioning (Kernberg, 1975).

Psychodynamic Models of Personality Pathology

Ego psychology (A. Freud, 1936; Hartmann, 1937) has influenced psychodynamic models of personality pathology through its emphasis on psychological resources (i.e., ego functions and defenses) at an individual's disposal for adapting to internal and external demands. Personality pathology is viewed as the result of the habitual use of maladaptive defense mechanisms, with corresponding problems in functioning such as impulsive behavior, poor affect control, and an impaired capacity for accurate self-reflection. Mature defense mechanisms, such as humor or sublimation, may address the conflict with little interference in (or possible improvement in) the individual's functioning or feeling state. Neurotic defense mechanisms, such as repression or reaction formation, may address the conflict at the cost of circumscribed psychological symptoms, such as anxiety or impaired functioning, as in compulsive behaviors. The most primitive defenses, such as splitting or projective identification,

characterize the rigid and distortion-prone psychological structures found in personality disorders. Primitive defenses are likely to provide only the most immediate (and likely inadequate) decrease in anxiety, or they may successfully reduce anxiety at the expense of successful adaptation to life.

The self psychology model, developed by Kohut (1971, 1977), views personality pathology as resulting from a deficit in the structure of the self, without emphasis on conflict among structures within the psyche (Ornstein, 1998). Self psychology focuses on the cohesiveness and vitality versus weakness and fragmentation of the self, and on the role that external relationships play in helping to maintain the cohesion of the self. It posits that primary infantile narcissism, or love of self, is disturbed in the course of development by inadequacies in caretaking. In an effort to safeguard a primitive experience of perfection, the infant places the sense of perfection both in an image of a “grandiose self” and in an “idealized parent imago,” which are considered the archaic but healthy nuclei of the “bipolar self” that is the normal product of the evolution of these two nuclei. In the development of the bipolar self, the grandiose self evolves into self-assertive ambitions and involves self-esteem regulation, goal-directedness, and the capacity to enjoy physical and mental activities. The idealized parental imago becomes the individual’s internalized values and ideals that function as self-soothing, self-calming, affect-containing structures that maintain internal psychological balance.

Problems in either of these evolutions lead to personality pathology. Inadequate development of the grandiose self results in low self-esteem, lack of motivation, anhedonia, and malaise. Inadequate development of the idealized parental imago results in difficulty regulating tension and the many behaviors that can attempt to achieve this function (e.g., addictions, promiscuity), and a sense of emptiness, depression, and chronic despair. The individual responds to these deficits in psychic structure by developing defensive structures that attempt to fill that gap and lead to the manifest personality pathology.

Object relations models (Bion, 1962; Kernberg, 1975; Kernberg & Caligor, 2005; Klein, 1957) have had the most direct influence on current dynamic conceptualizations of personality pathology (e.g., the PDM). According to such models, in normal psychological development representations of self in relation to others become increasingly more differentiated and integrated. The infant’s experience, initially organized around moments of pain (“I am uncomfortable and in need of someone to care for me”) and pleasure (“I am now being soothed by someone and feel loved”), become increasingly differentiated and integrated representations of self and other. These mature representations allow for the realistic blending of good and bad, such that positive and negative qualities can be integrated into a complex, multifaceted representation of an individual. Such integrated representations allow for the tolerance of ambivalence, difference, and contradiction in oneself and others.

For Kernberg (1975; Kernberg & Caligor, 2005), the degree of differentiation and integration of these representations of self and other, along with their affective valence, constitutes personality organization. The level of organization of the personality is thought to differ as a function of the nature of the psychological structures that organize the individual’s experience and behavior. In a normal personality

organization, the individual has an integrated model of self and others, allowing for stability and consistency within his or her identity and in the perception of others, as well as a capacity for becoming intimate with others while maintaining one's sense of self. For example, such an individual would be able to tolerate hateful feelings in the context of a loving relationship without internal conflict or a sense of discontinuity in the perception of the other. Focusing on the degree of identity consolidation versus identity pathology (or "diffusion"), patients are classified according to their capacity to establish and maintain realistic, stable and meaningful experiences of self and significant others and to contextualize their day-to-day experience.

In this context, Kernberg (1975; Kernberg & Caligor, 2005) distinguishes between three levels of personality organization: neurotic, borderline, and psychotic. In the borderline level of organization, the lack of integration in representations of self and other leads to the use of primitive defense mechanisms (e.g., splitting, projective identification, dissociation), identity diffusion (inconsistent view of self and others), and unstable reality testing (inconsistent differentiation between internal and external experience). The high end of the borderline level of organization is thought to include the histrionic, dependent, avoidant, and narcissistic personality disorders as well as the sadomasochistic personality disorder. The low end of the borderline level of organization includes the paranoid, schizoid, schizotypal, borderline, malignant narcissistic and antisocial personality disorders as well as the hypochondriacal and hypomanic personality disorders. In the neurotic level of organization, the more integrated representations of self and other allow for the use of more mature defense mechanisms (e.g., repression, reaction formation) and stable reality testing, with more isolated areas of conflict repressed from the individual's conscious experience. The neurotic level of organization includes the obsessive-compulsive, hysterical, and depressive-masochistic personality disorders. Finally, in contrast to the fluctuations in reality testing seen in the borderline organization, the psychotic level of organization is characterized by chronic breaks in reality testing.

Relatedness and Self-Definitional Dimensions of Personality Pathology

Blatt and colleagues (Blatt, 1995; Blatt & Shichman, 1983) conceptualized personality development as involving two fundamental parallel developmental lines—(1) an *anaclitic* or relatedness line that involves the development of the capacity to establish increasingly mature and mutually satisfying interpersonal relationships, and (2) an *introjective* or self-definitional line that involves the development of a consolidated, realistic, essentially positive, differentiated, and integrated self-identity (see also Luyten & Blatt, Chapter 5, this volume). These two developmental lines normally evolve throughout life in a reciprocal or dialectic transaction. An increasingly differentiated, integrated, and mature sense of self is contingent on establishing satisfying interpersonal relationships, and, conversely, the continued development of increasingly mature and satisfying interpersonal relationships is contingent on developing a more mature self-concept and identity. In normal personality development, these two developmental processes evolve in an interactive, reciprocally balanced, mutually facilitating fashion from birth to senescence.

Blatt (1995) and colleagues (e.g., Blatt & Levy, 1998; Blatt & Shichman, 1983; Levy & Blatt, 1999) conceptualize various forms of psychopathology as an overemphasis and exaggeration of one of these developmental lines (relatedness or self-definition) at the expense of the development of the other line. This overemphasis defines two distinctly different configurations of psychopathology, each containing several types of disordered behavior that range from relatively severe to relatively mild. Anaclitic psychopathologies are those disorders in which patients are preoccupied mainly with issues of relatedness, and who use primarily avoidant defenses (e.g., withdrawal, denial, repression) to cope with psychological conflict and stress. Anaclitic disorders involve a primary preoccupation with interpersonal relations and issues of trust, caring, intimacy, and sexuality, ranging developmentally from more to less disturbed, and include nonparanoid-undifferentiated schizophrenia, BPD, infantile (or dependent) character disorder, anaclitic depression, and hysterical disorders.

In contrast, introjective psychopathology includes disorders in which the patients are primarily concerned with establishing and maintaining a viable sense of self, with issues ranging from a basic sense of separateness, through concerns about autonomy and control, to more complex and internalized issues of self-worth. These patients use primarily counteractive defenses (projection, rationalization, intellectualization, doing and undoing, reaction formation, overcompensation) to cope with conflict and stress. Introjective patients are more ideational and concerned with establishing, protecting, and maintaining a viable self-concept than they are with the quality of their interpersonal relations and with achieving feelings of trust, warmth, and affection. Issues of anger and aggression, directed toward the self or others, are usually central to their difficulties. Introjective disorders, ranging developmentally from more to less severely disturbed, include paranoid schizophrenia; overrideational borderline, paranoia, and obsessive–compulsive personality disorders; introjective (guilt-ridden) depression; and phallic narcissism.

Attachment-Based Models of Personality Pathology

From its inception, Bowlby conceptualized attachment theory in both normal and psychopathological development. He (1973) believed that attachment difficulties increase vulnerability to psychopathology, and can help identify the specific types of difficulties that arise. Bowlby contended that internal working models of attachment help explain “the many forms of emotional distress and personality disturbances, including anxiety, anger, depression, and emotional detachment, to which unwilling separations and loss give rise” (Bowlby, 1977, p. 201). Bowlby (1977) held that childhood attachment underlies the “later capacity to make affectional bonds as well as a whole range of adult dysfunctions,” including “marital problems and trouble with children as well as . . . neurotic symptoms and personality disorders” (p. 206).

Bowlby postulated that insecure attachment lies at the center of disordered personality traits, and he actually tied the overt expression of felt insecurity to specific characterological disorders. For instance, he connected anxious ambivalent attachment to “a tendency to make excessive demands on others and to be anxious and

clingy when they are not met, such as is present in dependent and hysterical personalities,” and avoidant attachment to “a blockage in the capacity to make deep relationships, such as is present in affectionless and psychopathic personalities” (Bowlby, 1973, p. 14). Avoidant attachment, Bowlby (1973) postulated, results from the individual constantly being rebuffed in his or her appraisals for comfort or protection, and the individual “may later be diagnosed as narcissistic” (p. 124). Thus, Bowlby proposed that early attachment experiences not only have effects that tend to persist across the lifespan but are among the major determinates of personality organization and pathology.

Levy and Blatt (1999), integrating Blatt’s (1995) cognitive-developmental psychoanalytic theory with attachment theory, proposed that within each attachment pattern, there may exist more and less adaptive forms of dismissing and preoccupied attachment. These developmental levels are based on the degree of differentiation and integration of representational or working models that underlie attachment patterns. In terms of personality disorders, Levy and Blatt noted that several personality disorders (i.e., histrionic, dependent, borderline) appear to be focused in different ways, and possibly at different developmental levels, on issues of interpersonal relatedness. They proposed that preoccupied attachment would run along a relatedness continuum from nonpersonality-disordered individuals, who value attachment, intimacy, and closeness; to the gregarious, who may exaggerate relatedness; to those with a hysterical style, who not only exaggerate closeness and overly value others but may defend against ideas inconsistent with their desires; to more histrionic individuals, who are overly dependent and easily show anger in attachment relationships; to those with BPD. In contrast, another set of personality disorders (i.e., avoidant, paranoid, obsessive–compulsive, narcissistic) appear to express a preoccupation with establishing, preserving, and maintaining a sense of self, possibly in different ways and at different developmental levels. Levy and Blatt proposed that avoidant attachment would run along a self-definitional continuum from nonpersonality-disordered individuals, who are striving for personal development, to those who are more obsessive; to those with avoidant personality disorder; to those with narcissistic personality disorder (NPD); and finally, at the lowest developmental levels, to those with BPD and antisocial personality disorder.

Levy and Blatt (1999) note that this integration allows us to observe that the two primary types of insecure attachment, avoidant and anxious-preoccupied, can occur at several developmental levels. Differences in the content and structure of mental representations (or internal working models) distinguish more and less adaptive forms of avoidant and anxious-preoccupied attachment, thereby bringing a fuller developmental perspective to the study of attachment patterns. Different patterns of attachment involve not only differences in the content of internal working models but also differences in the structure of those models (e.g., the degree of differentiation and integration). It may be the structure of these models, more so than the content, that results in different capacities and potentials for adaptation. Research has supported the notion that within specific attachment styles, internal working models may vary in the degree of differentiation, integration, and internalization (Levy, Blatt, & Shaver, 1998).

More recently, Peter Fonagy, Mary Target, and colleagues have developed a psychodynamic developmental theory about impairments in the emergence of the agentic self in relation to personality disorders, stressing the importance of the capacity to mentalize, that is, the ability to conceive of mental states as explanations of behavior in oneself and in others (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy, Gergely, & Target, 2007). This model, rooted in attachment theory, goes beyond Bowlby's claims concerning the evolutionary advantages of a system that regulates proximity seeking to the protective caregiver by arguing that the capacity for mentalizing has provided humans with a major evolutionary advantage in terms of the capacity for social intelligence and meaning-making (Bateman & Fonagy, 2003).

This capacity is assumed to develop primarily within the context of secure attachment relationships, with attachment figures promoting the understanding of internal mental states (e.g., emotions, thoughts, wishes), which contributes in turn to the development and consolidation of the self, effortful control, and affect regulation more generally. In contrast, attachment disruptions typically lead to impairments in the capacity for mentalizing, resulting in a disorganized self structure, and poor affect, stress regulation, and attentional control systems. This may even completely inhibit mentalizing as a defensive attempt to avoid thinking about the abuser's potentially malevolent and dangerous states of mind. Specifically in attachment contexts, when arousal is high, there is a constant pressure for externalization of this persecutory part of the self, which explains many of the key features of patients with severe personality pathology, including persistent projective identification, self-harm, and parasuicidal behavior. Considerable empirical support for this model has accumulated (Fonagy et al., 2007; Fonagy & Luyten, 2009), and a range of empirically supported treatment and intervention strategies have been developed based on these views (Allen, Fonagy, & Bateman, 2008). Research has also begun to explore the underlying neural circuits of mentalizing as well as neuroendocrine processes underlying relationships among mentalizing, attachment, and affect regulation (Fonagy & Luyten, 2009; Fonagy et al., 2010; Luyten, Fonagy, Lowyck, & Vermote, 2012) (see also Clarkin et al., Chapter 17, this volume).

The PDM: An Integrative Approach to Personality Pathology

The PDM (PDM Task Force, 2006) has integrated many of the aforementioned theories in its approach to classifying personality disorders. First, it explicitly states that patients with personality disorders should be characterized according to level of severity. Following Kernberg (1975), the PDM describes a continuum from neurotic to more severely disturbed personality pathology. Second, in contrast to the DSM-5's description of manifest signs and symptoms, the PDM specifies other aspects of mental functioning to be considered when diagnosing personality disorders, including quality of cognitive capacities (regulation, attention, learning), affect (experience, expression, communication), relationships (depth, range, consistency), internal representations (differentiation, integration, self-regard, morality, self-reflection), and defenses (range, flexibility). Third, the PDM outlines prototypes of personality disorders, moving away from the observable trait approach of the DSM toward typologies

of patients characterized by patterns of thinking, feeling, behaving, and relating to others.

Although the prototypes of personality disordered patients in the PDM share some overlap with the DSM categories, there are notable differences. The selection of prototypes is based on a body of clinical literature (McWilliams, 1994) and research findings (Westen & Shedler, 2000), although some key divergences from the research literature are discussed here. The PDM highlights six personality disorders that are not in the DSM-5 system: depressive, sadistic/sadomasochistic, masochistic/self-defeating, dissociative, somatizing, and anxious personality disorders. The first few of these additions resemble categories that are relegated to the DSM's "criteria sets and axes provided for further study" (i.e., depressive and passive-aggressive personality disorders). In fact, significant empirical support exists for depressive personality disorder as a valid construct that can be reliably measured, although challenges remain in discriminating it from similar disorders, most notably dysthymia and other personality disorders with predominantly internalizing symptoms (Bradley, Shedler & Westen, 2006; Huprich, 2009). Passive-aggressive personality disorder has similarly evidenced strong reliability and validity data. Although it has been criticized as better representing a pathological behavior found in multiple personality disorders, recent research has shown it to be a distinct construct (Bradley et al., 2006; Hopwood et al., 2009). However, there is significantly less evidence for sadistic/sadomasochistic or masochistic/self-defeating personality disorders as conceptualized in the PDM, which are better conceptualized as subtypes of other personality disorders (Bradley et al., 2006). Sadistic personality disorder was found to be better represented as a subtype of antisocial personality disorder, whereas self-defeating personality disorder was found to be better represented by borderline and dependent personality disorders. Thus, despite having a rich tradition in the clinical literature, the empirical literature is less supportive of the inclusion of sadistic/sadomasochistic and masochistic/self-defeating personality disorders.

A number of the other personality disorder additions in the PDM (dissociative, somatizing, and anxious personality disorders) are conceptualized by the DSM as "symptom disorders" with little consideration for the influence of personality pathology (i.e., dissociative identity disorder, somatization disorder, generalized anxiety disorder). With regard to these "symptom disorders" in the DSM, it is notable that the differential diagnoses for generalized anxiety disorder and somatization disorder do not list personality disorders as diagnoses to be considered, and they receive a cursory mention in the differential diagnosis for dissociative identity disorder. This stands in contrast to research on Axis I and Axis II comorbidity, which has found the Cluster C personality disorders to be strongly associated with anxiety and somatoform disorders (Tyrer, Gunderson, Lyons, & Tohen, 1997), and BPD to be distinguished from other personality disorders by high rates of comorbid anxiety and somatoform disorders (Zanarini et al., 1998). In contrast, the PDM conceptualizes the symptom presentation of these disorders (anxiety, somatization, dissociation) as the manifestation of disturbances in the individual's underlying personality organization. However, despite strong empirical support for the co-occurrence of personality pathology with anxiety and somatoform disorders, suggesting a central role of

personality organization in these pathologies, to date no empirical support has been presented for somatizing and anxious personality disorders as distinct diagnostic constructs that can be reliably measured.

The PDM also omits two categories in the DSM system: schizotypal personality disorder and BPD. Schizotypal personality disorder as described in the DSM-5 is considered a problematic category for many reasons. From a diagnostic perspective, research has demonstrated that the observable features of schizoid and schizotypal personality disorders overlap considerably and tend to load together in factor-analytic models, making it quite difficult to distinguish them in the DSM system (Huprich, Schmitt, Chelminski, & Zimmerman, 2010; Shedler & Westen, 2004). From a biological perspective, research indicates that patients with schizotypal personality disorder share more commonalities with patients with schizophrenia, in terms of genetic basis as well as structural and functional brain abnormalities, than with patients with other personality disorders (Parnas, Licht, & Bovet, 2005). This finding has led some authors to suggest that clinicians should evaluate the trait of schizotypy independently from personality pathology (Shedler & Westen, 2004). Furthermore, in the PDM system, consistent with Kernberg's model (Kernberg, 1975; Kernberg & Caligor, 2005), borderline personality is conceptualized as a level of organization within which many of the aforementioned disorders will fall (i.e., sadistic and sadomasochistic personality disorders) rather than a specific prototype with characteristic features. However, there is considerable support for BPD as a distinct diagnostic construct, albeit a heterogeneous one in which patients may vary in important ways in terms of their symptom picture and prognosis and yet each meet criteria for the disorder (Clarkin, 1998; Johansen, Karterud, Pedersen, Gude, & Falkum, 2004). As is discussed in more detail later, while some research has supported the notion of borderline personality as a superordinate structure encompassing subgroups, specifically an emotionally dysregulated group and a histrionic-impulsive group, borderline cannot be implicated as organizationally encompassing all personality disorders (Shedler & Westen, 2004; Westen & Shedler, 2007).

In contrast to the DSM-5's (APA, 2013) description of manifest signs and symptoms, the PDM characterizes each disorder in terms of prototypical internal representations of self and others, predominant defenses, central affects, and possible temperamental contributions. As is noted below, proposed revisions for future editions of DSM, included in Section III of DSM-5, consider the inclusion of evaluating higher-order personality trait domains (i.e., negative affectivity, detachment, antagonism, disinhibition, and psychoticism) as well as evaluating levels of both self and interpersonal functioning. This balance of internal dimensions and external manifestations is essential for case conceptualization, as there are often disparities between these aspects of functioning in patients with personality disorders—a level of nuance that is often lost in the DSM-5 system. For example, the manifest presentation of schizoid personality disorder is an apparent indifference to the interpersonal world, and the DSM-5 criteria reflect such behaviors (i.e., has no desire for friendships or sexual relationships, chooses solitary activities, is indifferent to praise/criticism, is emotionally detached). However, the PDM characterizes the internal experience of an individual with schizoid personality disorder as highly vigilant of

and intolerably pained by difficulty engaging the social world, which is defended against by an apparent indifference toward relationships. Such individuals often long for intimacy and yet have intense fears of the implications of such closeness; therefore, withdrawal becomes a safe but unsatisfying method of coping with this fear. Thus, the DSM-IV captures only the defensive manifestation, rather than the internal experience of individuals with this disorder—a difference that has significant implications for treatment.

EMPIRICAL FINDINGS

Research on Personality Disorder Prototypes

From an empirical standpoint, the most influential contributor to the PDM's personality disorder sets has been Shedler and Westen's work on empirically derived prototypes of personality disorders (Shedler & Westen, 2004; Westen & Shedler, 2007). Using a Q-sort method called the Shedler–Westen Assessment Procedure, large samples of clinicians characterized their own patients as well as prototypical patients on a wide range of personality descriptors, and the results were used to create empirically derived diagnostic factors. Although their work is influenced by core principles of psychodynamic case conceptualization (experience-near descriptors of mental life, focus on both internal experience and external behaviors), their personality descriptors are atheoretical, and clinician-based prototypes have been consistent across both dynamic and nondynamic therapists.

Shedler and Westen's empirically derived prototypes for personality disorders share some overlap with the DSM categories, but notable differences were found. With regard to the Cluster A disorders, as previously discussed, the observable features of schizoid and schizotypal (and to a lesser extent paranoid) personality disorders overlap considerably, making them difficult to distinguish empirically (Shedler & Westen, 2004). The empirically derived prototypes also include a greater emphasis on the internal experience of these disorders. For example, their description of paranoid personality disorder goes beyond the overt suspiciousness emphasized in the DSM to include an inner experience of anger, victimization, and hypersensitivity to slights. Furthermore, their description of schizoid personality disorder goes beyond interpersonal avoidance to describe an inner experience of fear of embarrassment and humiliation.

With regard to the Cluster B disorders, their prototype of antisocial personality disorder differs from the DSM criteria in important ways. In contrast to the focus in the DSM on criminality and other asocial behaviors, their prototype more closely resembles psychopathy as originally described by Cleckley (1976), with an emphasis instead on internal dimensions such as lack of empathy, remorse, and concern for consequences. In terms of narcissistic personality disorder (NPD), they found that the DSM captured most of the important features as seen in clinical practice. However, narcissistic patients as described by clinicians were characterized as more controlling and competitive, more likely to get into power struggles, and more externalizing of blame than DSM-5 suggests.

Not surprisingly, BPD as characterized by the DSM was found to have significant limitations in terms of its correspondence to clinician ratings. Shedler and Westen (2004) identified prominent symptoms of the disorder not adequately represented in the DSM, including feeling intense emotional pain, dysphoria, rage, inadequacy, helplessness, anxiety, and victimization. Furthermore, they identified distinctions among symptoms that distinguish BPD from other disorders (Bradley et al., 2006). For example, although negative affect (i.e., dysphoria) is characteristic of BPD, it does not distinguish it from other disorders (e.g., dysthymia). In contrast, they note that emotional dysregulation is not only characteristic but also distinctive of BPD. Lastly, they note that not all symptoms of BPD emerge in all contexts (e.g., cutting) and therefore may be distinctive but unstable. Another limitation of the diagnosis concerns the fact that borderline and histrionic personality disorders share many key features (fear of abandonment, dependency, provocative behaviors), leading to difficulty distinguishing between the two (Blagov & Westen, 2008; Shedler & Westen, 2004). They instead found support for a hierarchical structure, with borderline as a superordinate structure encompassing an emotionally dysregulated group and a histrionic-impulsive group (Westen & Shedler, 2007). (See Luyten & Blatt, Chapter 5, and Clarkin et al., Chapter 15, this volume, for a discussion of other limitations of the BPD diagnosis.)

Similarly, with regard to the Cluster C disorders, avoidant and dependent personality disorders were found to share many key features, leading to some difficulty distinguishing between the two (Shedler & Westen, 2004). However, unlike the overlap between the borderline and histrionic disorders, the core features shared between the avoidant and dependent disorders are not included in the DSM-5 criteria but are revealed in their respective prototypes. Shedler and Westen found that patients with avoidant and dependent personality disorders share a depressive core (i.e., “tends to feel inadequate, inferior, a failure,” “helpless, powerless,” and “will be rejected/abandoned”) from which different coping strategies arise: excessively avoiding and needing people, respectively. While these manifest behaviors appear at odds, the fact that they share such high comorbidity suggests that clinicians recognize and make diagnostic decisions based on this core similarity, even though it is not represented in the DSM. Lastly, in terms of obsessive–compulsive personality disorder, the DSM was found to capture most of the important features as seen in clinical practice, although the empirically derived prototype described a somewhat healthier patient than the DSM would suggest.

As mentioned earlier, Shedler and Westen (2004) evaluated a hierarchical structure for these empirically derived prototypes for personality disorders and identified three superordinate categories: internalizing, externalizing, and borderline. The internalizing category encompasses the depressive, anxious, dependent, and schizoid groups. The externalizing category encompasses the psychopathic, narcissistic, and paranoid groups. The borderline category encompasses an emotionally dysregulated group and a histrionic-impulsive group.

These empirically derived prototypes for personality disorders have a number of advantages over the DSM’s categorical system. A study by Westen, Shedler, and Bradley (2006) found that using a prototype approach to diagnosis led to significant decreases in comorbidity, improved clinical utility, and no loss of validity in

predicting external measures of functioning. Furthermore, they found that the inclusion of a prototype considering aspects of personality health accounted for additional variance in predicting external measures of functioning. Thus, consideration of personality strengths and adaptive personality features can strengthen assessment of personality disorders.

Research on Subtypes within Personality Disorders

One of the major controversies regarding the DSM-5 personality disorders concerns whether or not they represent distinct diagnostic entities. The controversy has been most clearly seen in the diagnosis of NPD, which has been the focus of controversy since its introduction in DSM-III. Studies have generally confirmed the validity of some of the overt characteristics of NPD as defined in DSM-IV (and thus also in DSM-5), such as grandiosity, grandiose fantasy, desire for uniqueness, need for admiring attention, and arrogant, haughty behavior (Morey, 1988; Ronningstam & Gunderson, 1990; Westen, 1990). However, theoretical and empirical work has suggested that NPD is not a homogeneous disorder, and subtypes likely exist within this group. Several prominent theories and a few empirical studies are summarized below.

Kernberg (1975) classified narcissism along a dimension of severity from normal to pathological and distinguished between three levels of pathological narcissism—high, middle-, and low-functioning groups. At the highest functioning level, patients are able to achieve the admiration necessary to gratify their grandiose needs. These patients may function successfully during their lifetime but are susceptible to breakdowns with advancing age as their grandiose desires go unfulfilled. At the middle level, patients present with a grandiose sense of self and have little interest in true intimacy. At the lowest level, patients present with comorbid borderline personality traits. These patients' sense of self is generally more diffuse and less stable; they frequently vacillate between pathological grandiosity and suicidality. Finally, Kernberg also identified an NPD subtype known as malignant narcissism. These patients are characterized by the typical NPD; however, they also display antisocial behavior, tend toward paranoid features, and take pleasure in their aggression and sadism toward others. Malignant narcissists are at high risk for suicide, despite the absence of depression, given that suicide for these patients represents sadistic control over others, a dismissal of a denigrated world, or a display of mastery over death. Despite the richness of Kernberg's descriptions, we could find no direct research on malignant narcissism. It will be important to differentiate malignant narcissism from NPD proper (as well as from antisocial, paranoid, and borderline personality disorders) and to show that patients meeting Kernberg's criteria for malignant narcissism are at risk for the kind of difficulties that Kernberg described clinically.

Other subtype distinctions in the expression of NPD have been noted. Kohut and Wolf (1978) described three subtypes based on interpersonal relationships. "Merger-hungry" individuals must continually attach and define themselves through others; "contact-shunning" individuals avoid social contact because of fear that their behaviors will not be admired or accepted; and "mirror-hungry" individuals tend to display themselves in front of others. Millon (1998) conceptualized NPD as a prototype and

distinguished among the several variations, or subtypes, in which the basic personality style may manifest itself. These subtypes represent configurations of a dominant personality style (e.g., NPD) and traits of other personality styles. For example, in addition to meeting criteria for NPD, Millon's "amorous" subtype would show elevations in histrionic traits, his "unprincipled" subtype would show elevations in antisocial traits, and his "compensatory" subtype would show elevations in avoidant and/or passive-aggressive traits. To date, little research has been performed to establish the reliability or validity of Kohut and Wolf's or Millon's distinctions.

The DSM criteria for NPD were derived mainly from the theoretical and clinical work of Kernberg, Kohut, and Millon, with little empirical input. Since DSM-III, the criteria for NPD have transitioned from a mixed polythetic/monothetic set of criteria to an entirely polythetic set. The interpersonal criteria, which originally included four parts (entitlement, interpersonal exploitativeness, alternating between extremes of overidealization and devaluation of self and others, lack of empathy), were reduced to three parts through elimination of alternating between extremes of overidealization and devaluation of self and others. The criterion that included grandiosity and uniqueness was split into two separate criteria, and a criterion about preoccupation with feelings of envy was added.

Several theorists and researchers have noted that the DSM criteria for NPD, following the conceptual approaches of Kernberg and Millon, have emphasized a more overt form of narcissism. More recently, Cooper (1981), Akthar and Thomson (1982), Gabbard (1989), and Wink (1991) suggested that there are two subtypes of NPD: an overt form, also referred to as grandiose, oblivious, willful, exhibitionist, thick-skinned, or phallic; and a covert form, also referred to as vulnerable, hypersensitive, closet, or thin-skinned (Bateman, 1998; Britton, 2000; Gabbard, 1989; Masterson, 1981; Rosenfeld, 1987). The grandiose type is characterized by grandiosity, attention seeking, entitlement, arrogance, and little observable anxiety. These individuals can be socially charming despite being oblivious of others' needs, interpersonally exploitative, and envious. In contrast, the vulnerable type is hypersensitive to others' evaluations, inhibited, manifestly distressed, and outwardly modest. Gabbard described these individuals as shy and "quietly grandiose," with an "extreme sensitivity to slight" that "leads to an assiduous avoidance of the spotlight" (p. 527). Both types are extraordinarily self-absorbed and harbor unrealistically grandiose expectations of themselves. This grandiose-vulnerable distinction has been empirically supported in a number of studies using factor analyses and correlational methods (Dickinson & Pincus, 2003; Hendin & Cheek, 1997; Hibbard & Bunce, 1995; Rathvon & Holmstrom, 1996; Rose, 2002; Wink, 1992).

Using cluster analysis, DiGiuseppe, Robin, Szeszko, and Primavera (1995) reported three clusters of narcissistic patients in an outpatient setting. They named these clusters the *True Narcissist*, the *Compensating Narcissist*, and the *Detached Narcissist*. Patients in all three clusters exhibited self-centeredness and entitlement. However, patients in the True and Detached clusters reported experiencing little emotional distress; in contrast, patients in the Compensating cluster reported high levels of emotional vulnerability. The True and Detached clusters were similar, except that the Detached cluster was characterized by extreme interpersonal avoidance.

Using Q-factor analysis for all patients meeting criteria for NPD, Russ, Shedler, Bradley, and Westen (2008) also found three subtypes: grandiose/malignant, fragile, and high-functioning/exhibitionistic. Grandiose narcissists were described as angry, interpersonally manipulative, and lacking empathy and remorse; the grandiosity was not defensive or compensatory. Fragile narcissists demonstrated grandiosity under threat (defensive grandiosity) and experienced feelings of inadequacy and anxiety, indicating that they vacillate between superiority and inferiority. High-functioning narcissists were grandiose, competitive, attention-seeking, and sexually provocative; they tended to show adaptive functioning and utilize their narcissistic traits to succeed.

Overall, theory and empirical evidence suggest that NPD is a heterogeneous diagnosis that likely contains different subtypes not reflected in the current DSM system. While the problem of heterogeneity of diagnosis is most evident in NPD, it is not limited to this disorder (see Clarkin et al., Chapter 17, this volume, on BPD for further elaboration).

PSYCHODYNAMIC TREATMENT OF PERSONALITY DISORDERS

A meta-analysis by Perry, Banon, and Ianni (1999) suggested that psychotherapy is an effective treatment for personality disorders and may be associated with up to a sevenfold faster rate of recovery in comparison with the natural history of disorders. A more recent meta-analysis examined the effectiveness of psychodynamic therapy and cognitive-behavioral therapy (CBT) in the treatment of personality disorders (Leichsenring & Leibing, 2003; see also Leichsenring, Kruse, & Rabung, Chapter 23, this volume). The study found that psychodynamic therapy yielded a large overall effect size of 1.46, with effect sizes of 1.08 for self-report measures and 1.79 for observer-rated measures. This contrasted with CBT, for which the corresponding values were somewhat lower (i.e., 1.00, 1.20, and 0.87, respectively). Furthermore, it was found that the longer the treatment, the greater the effect size. However, these studies are difficult to interpret because the studies differ, even within the same therapy group, in terms of therapy content, patient diagnosis, length of treatments, outcome assessments, and other variables.

Few controlled studies exist on treatment outcomes for specific personality disorders. To date, there have been no controlled or uncontrolled outcome studies for histrionic, dependent, schizotypal, schizoid, narcissistic, passive-aggressive, or paranoid personality disorders. Most studies have focused on BPD, supporting the efficacy of specific psychodynamic psychotherapies for this condition (see Clarkin et al., Chapter 17, and Leichsenring et al., Chapter 23, this volume, for a review of these studies). In addition, a number of studies have used samples that included Cluster C patients or a mixture of personality disorders with primarily Cluster C patients (Abbass, Sheldon, Gyra, & Kalpin, 2008; Diguier et al., 1993; Hellerstein et al., 1998; Karterud et al., 1992; Monsen, Odland, & Eilertsen, 1995; Rosenthal, Muran, Pinsker, Hellerstein, & Winston, 1999; Turkat, 1990; Winston et al., 1991, 1994). Although these studies generally show improvement in treated patients, particularly with the brief

psychodynamic treatments, they are difficult to interpret in terms of specific personality disorders because they do not denote specific diagnostic cohorts.

Svartberg, Stiles, and Seltzer (2004) reported findings from a randomized controlled trial examining the treatment of Cluster C personality disorders. They compared a short-term psychodynamic treatment with CBT and found a significant main effect for reduction in symptomatology for the psychodynamic group but not the CBT group (although there were no between-group differences). Hardy and colleagues (1995) reported the outcome for a subsample of patients with Cluster C personality disorders who had participated in a larger study comparing interpersonal-psychodynamic psychotherapy with cognitive therapy for major depression. Findings indicated that Cluster C patients continued to show more severe symptomatology than non-Cluster C patients if they received dynamic therapy, but not if they received cognitive therapy. In a comparative outcome study, Muran, Safran, Samstag, and Winston (2005) found brief relational therapy, short-term dynamic therapy, and CBT all to be effective in reducing symptomatology (with no significant between-group differences) in a sample of mixed personality disorder patients with primarily Cluster C features. Abbass and colleagues (2008) found that intensive short-term dynamic therapy, in comparison to a delayed-treatment control group, was associated with significant improvements in symptomatic and interpersonal functioning in a sample of mixed personality disorder patients with primarily borderline, avoidant, and obsessive-compulsive personality disorder diagnoses. Patients evidenced an 83% reduction of personality disorder diagnoses at 2-year follow-up.

Numerous uncontrolled outcome studies also suggest promising treatment approaches for personality disorders (for a review, see Fonagy, Roth, & Higgitt, 2005). For example, in an open trial, Barber, Morse, Krakauer, Chittams, and Crits-Cristoph (1997), found that a supportive-expressive psychodynamic psychotherapy was effective for treating both obsessive-compulsive and avoidant personality disorders. At the end of one year of treatment, 85% of obsessive-compulsive and over 60% of avoidant personality disorder patients no longer met criteria for the disorders.

Finally, preliminary research suggests that Axis I patients with comorbid personality pathology may be more likely to benefit from psychodynamic therapy than those without such comorbidity. For example, Milrod and colleagues (2007) found that the presence of comorbid Cluster C personality diagnosis in patients with panic disorder moderated treatment outcome, with superior improvement in panic-focused psychodynamic psychotherapy. Thus, the presence of personality pathology may act as a prescriptive indicator for psychodynamic treatments. This finding reinforces the importance of clinicians attending to personality pathology when planning treatment for patients with Axis I disorders.

CLINICAL ILLUSTRATION

The following vignette is a clinical illustration of the value of a psychodynamic framework for diagnosing personality disorders, using the example of NPD. As discussed

earlier in this chapter, DSM-5 presents a number of limitations to the diagnosis of NPD, most notably increased emphasis on overtly haughty and arrogant behaviors, and decreased emphasis on the pattern of alternating between idealization and devaluation of self and others. As a result, many personality-disordered patients who struggle with narcissistic issues do not meet the criteria for NPD, and yet narcissistic dynamics have significant implications for the assessment and treatment of these individuals.

Jennifer is a single, 32-year-old woman who is underemployed for her level of education and intelligence. She was administered a structured interview for personality disorders by an independent evaluator prior to the beginning of treatment. She met the criteria for BPD, endorsing unstable relationships, impulsivity, affective instability, anger, identity disturbance, and emptiness. In contrast, she did not meet the full criteria for any symptoms of NPD, although she was found to have subclinical features of a grandiose sense of self-importance, fantasies of success and power, and belief in oneself as special or unique.

In her initial presentation, Jennifer came across as somewhat entitled, but not haughty or arrogantly so, and the primary expression of this entitlement was a resentment of others in a superior position whom she felt did not deserve that status. Although she did not act superior to others or express the feeling that she should receive special treatment, there was a feeling of envy toward others for their superior standing as well as contempt for their not deserving their status. Similarly, she did not express a global grandiose sense of self-importance or achievement—in specific contexts, such as work, she thought she could do a given task better than the “idiot” above her, but not better than people in general. Jennifer did not act in interpersonally exploitative ways but, rather, she was very sensitive to perceived exploitativeness from others. Similarly, she never appeared to be overtly lacking in empathy, but she was quite sensitive to the unempathic behaviors of others, and would react with anger and resentment at these perceived behaviors from others.

Thus, the three main domains of NPD in the DSM-5 criteria (entitlement, interpersonal exploitativeness, and lack of empathy) are not overt in Jennifer’s behavior but, rather, covertly expressed through a fear of being victim to such behaviors from others. In terms of NPD symptoms no longer included in DSM-5, one of Jennifer’s most notable features concerns extremes of overidealization and devaluation of self and others. This aspect was evident in her self-perception (i.e., “I am right because I know how life works, but my life is a mess so apparently I know nothing”) and her perception of others (i.e., “the therapist’s opinion has enormous weight because he is a professional, but has no weight because he appears incompetent”). Jennifer also displays many of the features described by Russ and colleagues (2008) in their narcissistic prototype but not found in DSM (i.e., controlling, competitive, power struggles). She was noted to exert a high level of control in her relationships, including with her therapist, motivated by fear that she would be made too vulnerable if others took control, which often led to power struggles in her relationships.

In conclusion, this vignette demonstrates how a patient may not meet DSM-5 criteria for NPD and yet narcissistic dynamics may dominate within sessions and in external life.

CONCLUSIONS AND FUTURE DIRECTIONS

Proposals for modifying personality disorder diagnosis in the fifth edition of the DSM for a time suggested a radical restructuring of the way in which these disorders are diagnosed, but due to a lack of research support for such changes the DSM-5 has retained the categories of the DSM-IV. Although such radical changes will likely require further research before being adopted in future editions of the DSM, a consideration of the advantages and disadvantages of the proposed changes from the Personality Disorders Workgroup is warranted. During the open-comment phase of DSM-5's development, a system was offered that involved evaluating a limited number of personality disorder types (i.e., antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal) dimensionally; evaluating higher-order personality trait domains (i.e., negative affectivity, detachment, antagonism, disinhibition, and psychoticism) as well as lower-order trait facets for each trait domain; evaluating levels of both self and interpersonal functioning; and evaluating failures in adaptive functioning (APA, 2011). Taken together, this system was intended to provide a multidimensional profile of personality types and traits, pathology, and level of functioning.

Including a prototype approach to the classification of personality pathology in future editions of the DSM has many advantages. Many authors have noted that in such an approach the most prototypical behavioral qualities of a disorder form the center of a diagnostic category, while less descriptive behaviors form the periphery (Livesley & Jackson, 1986; Westen, 1997). This approach allows clinicians to distinguish between essential and nonessential symptoms, which a categorical system cannot do (Shedler & Westen, 2007). Ideally, this method of classification would reduce overlap between personality disorder criteria and lead to more precise diagnoses.

Furthermore, the evaluation of self and interpersonal functioning bears some resemblance to the structural models of Blatt and Kernberg (Luyten & Blatt, 2011). Impairments in self-functioning would be indicated by problems related to identity and self-direction; this is consistent with Blatt's (1995) *introjective* or self-definitional line of development, as well as the central role of identity cohesion/diffusion in Kernberg's (1975) model. Impairments in interpersonal functioning would be indicated by problems in the capacity for empathy and intimacy; this is consistent with Blatt's *anaclitic* or relatedness line of development, as well as the central place of the identity role of love, intimacy, and healthy sexual relations in Kernberg's model.

However, a number of experts in the field of personality disorders (Shedler et al., 2010) have expressed concern about an approach that blends prototype and trait-based dimensional ratings. Clinicians tend not to think of their patients along trait-based dimensions, nor do they tend to draw from multiple conceptually unrelated models to identify dimensions of personality pathology. A blended system calls to mind the axiom "A camel is a horse designed by committee" (D. Westen, quoted in Holden, 2010) in that it is "an unwieldy conglomeration of disparate models that cannot happily coexist and raises the likelihood that many clinicians will not have the patience and persistence to make use of it in their practices" (Shedler et al., 2010, p. 1026).

Future editions of the DSM would benefit from moving beyond overt descriptions of signs and symptoms to include multiple domains of functioning— affect, behavior, cognitions, and quality of relatedness. Such an approach should include not just deficits in these domains of functioning, but also the presence of internal resources that might buffer against the impact of symptoms, for example, the capacity for intimacy (Shedler & Westen, 2007). Diagnosis needs to account for not only overt behaviors but also inner experience (Shedler & Westen, 2004). Thus the patient's total life circumstances need to be taken into account in diagnosing personality disorders (Kernberg & Caligor, 2005).

Future editions of the DSM would also benefit from increased consideration of levels of pathology within personality disorders (Kernberg, 1975). Personality disorder diagnosis needs to be placed in the context of etiology, predicted course, and treatment implications. Finally, the assessment of personality pathology cannot remain segregated from the assessment of “symptom disorders.” Rather, there needs to be an appreciation of how they interact, and often the dichotomy between these groups of disorders may be a false one.

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