Chapter 12
Personality Disorders

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Description of the Disorders

According to the DSM-5, "A *personality disorder* is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (American Psychiatric Association, 2013, p. 645, emphasis in the original). The definition has some important elements. Personality disorders (PDs) persist over time, often for decades, sometimes for a lifetime. To determine whether or not an individual has a personality disorder, the characteristics must be considered to deviate markedly from the individual's culture or subculture. It must be pervasive, characterizing the individual, rather than a quirk or an isolated symptom. Signs of the disorder must also be present reasonably early in life. Given that personality traits have a fairly strong genetic basis (Bockian, 2006), and experiences that put one at risk for a personality disorder rather frequently occur early in life, there are children who have developed personality disorders (Kernberg, Weiner, & Bardenstein, 2000); there are no age restrictions on the diagnosis.

Inflexibility is also a key aspect of a personality disorder; behaviors that are appropriate in some circumstances are broadly overapplied. A metaphor is useful here. It is appropriate to wear formal attire to a wedding, jeans on a hike, and a bathing suit to the beach, but, if all one has is a bathing suit, one will be inappropriately attired most of the time. Similarly, as adults, relying on others is appropriate in some circumstances, but excessively relying on others most of the time for most things (a characteristic of dependent personality disorder) is maladaptive.

There is arguably no clear line between a personality disorder and a normal personality. At the extremes, the differences are easy to discern; someone who has a

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D. L. Segal (ed.), *Diagnostic Interviewing*,
https://doi.org/10.1007/978-1-4939-9127-3_12

clear case of paranoid personality disorder is quite different from someone who has "normal" levels of trust. However, differentiating someone with a "mild case" of paranoid PD from someone who is (subclinically) extremely guarded is not so easy. Likewise, differentiating someone who is "too" guarded from someone who is healthfully suspicious is also a rather fuzzy boundary. For that reason, various dimensional systems have arisen in recent years. An alternative model for personality disorders is included in an appendix of the DSM-5; it is heavily influenced by the five-factor model (Widiger & Gore, 2013). For our purposes, however, rather than focusing on an alternative system, I will include some allusions to the spectrum notion of personality disorders (Millon, 2011) that uses already familiar categories. Similar to the idea of the autistic spectrum, one can consider each personality disorder to be part of a spectrum in its own right, with a range of degrees of severity. However, with personality, we can go beyond the constraints of a psychopathological conceptualization; there are personality strengths that have a spectrum relationship with the disorders. So, for example, the guardedness that is on a spectrum relationship with outright paranoid PD can be an asset among people who are involved in law enforcement professions such as detectives and FBI agents. Similarly, the over-the-top drama and craving for attention of histrionic PD is on a spectrum relationship with the friendliness and "life of the party" vivaciousness of the healthy sociable individual (Millon, 2011; Oldham & Morris, 1995). Although the primary purpose of this chapter is to equip clinicians with the tools necessary to accurately diagnose personality disorders, noting the associated healthy characteristics will alert clinicians to possible strengths of the individual, and to set goals for treatment in alignment with the person's potential.

Personality disorders are often under-recognized in the clinical interview, especially an initial intake. Personality disorders can be rather subtle. Often, the presence of a personality disorder is detected indirectly. With depression, clients often tell us quite directly about feelings of sadness, lack of motivation, lack of pleasure, and suicidal ideation. In anxiety, clients can often readily describe their worries and fears, even when that anxiety is "free floating" and not clearly or consciously anchored to any thoughts. Conversely, almost by definition, personality disorders are *ego-syntonic*. They are experienced by the person as being "who they are," not a troubling and unusual state of affairs.

Due to this ego-syntonic perspective, people with personality disorders are often puzzled by the difficulties they are having in their interpersonal relationships, in their places of employment, and in school settings. People with some personality disorders tend to blame others for their difficulties; this is most notable in the paranoid, narcissistic, and antisocial personality disorders. Others blame themselves so strongly that they seem to approach delusional intensity; this occurs most strongly in the avoidant and masochistic personality disorders.

The proper assessment of personality disorders in the clinical interview, more than in other disorders, is a blend of art and science, of intuition and empiricism. To assess individuals with personality disorders accurately in a first interview, a variety of skills and perspectives will be necessary. I believe that most, if not all of these skills are well-known to the clinician, but their application in this context may be

rather novel. Part of the task, of course, is to be thoroughly familiar with the diagnostic criteria for each disorder. Beyond that, however, empathy is important in this context. The clinician must be able to radically see the world through the eyes of the individual with the disorder. In addition, I will argue that in order to optimize the proper initial assessment of the individual with a personality disorder, the clinician will be in touch with his or her intuitive self, and take a systematic approach to nurturing and encourage the growth of that intuition. Finally, it is important for the clinician to have a firm grounding in theory. My own grounding in theory is primarily from the perspective of Theodore Millon (2011), who provided novel insights, and, equally if not more importantly, integrated the perspectives of the current major schools of thought. Cognitive, behavioral, psychodynamic, humanistic, systems, sociological, and other theories have a seat at his broadly inclusive table. As previously noted, one idea that I will highlight is the *spectrum* notion of personality disorders, considering each personality disorder as part of a spectrum that ranges from healthy to normal, and then includes the mild, moderate, and severe psychopathology range. In this chapter, I hope to capture the essence of this theoretically inclusive path, with the aim of facilitating the practice of both the novice and the expert in diagnostic interviewing.

This chapter includes the aggressive–sadistic and self-defeating/masochistic PDs (from the appendix of DSM-III-R; American Psychiatric Association, 1987) as well as passive-aggressive/negativistic PD (DSM-III-R main text and DSM-IV appendix; American Psychiatric Association, 1994) and the depressive PD (from Appendix B of DSM-IV-TR; American Psychiatric Association, 2000). I have seen individuals with these disorders, and they must be treated. It is incumbent on mental health fields to address the social conditions, such as abuse, bullying, unstable social environments, problematic parenting, and so on, which have contributed to their development. The sadistic and masochistic personality disorders, especially, are the messengers from those dark places, and their voices must be heard.

A brief review of Millon's theory will be helpful in guiding the reader to a theory-driven and deeper understanding of personality disorders, and to the approach taken in this chapter. Millon's theory and observations are comprehensively captured in his 1100+ page magnum opus, completed in 2011, *Disorders of Personality.* The following summary of the key elements is, by necessity, a substantial simplification. That said, there are two elements that are most fundamental to Millon's approach for our present purposes, namely, the dimensions that underlie the derivation of each of the personality disorders, and the system of eight domains that integrate multiple perspectives into an understanding of the individual.

According to Millon, there are four dimensions that underlie psychic life, which tie into evolutionary adaptation. The healthiest state is one of balance; extremes in any of the polarities tend to be problematic. These four dimensions are labeled (Aims of) Existence, (Modes of) Adaptation, (Strategies of) Replication, and (Processes of) Abstraction. The derivation of the personality disorders is summarized in Table 12.1, and described below.

The first dimension is labeled "Existence" and has Life Enhancement (pleasure) and Life-Preservation (pain) at the opposing poles. Thinking in evolutionary terms,

Table 12.1 Polarity Model and its personality style and disorder derivatives. The Schizoid is low on both pleasure and pain; the Depressive is high on pain and low on pleasure. (Adapted from Millon, Grossman, Millon, Meagher, & Ramnath, 2004, p. 63)

	Existential Aim		**Replication Strategy**	
	Life Enhancement	Life Preservation	Reproductive Propagation	Reproductive Nurturance
Polarity	Pleasure–Pain		Self–Other	

Deficiency, Imbalance or Conflict	Pleasure (low) Pain (low or high)	Pleasure–Pain (Reversal)	Self (low) Other (high)	Self (high) Other (low)	Self–Other (Reversal)

Adaptation Mode	***DSM* Personality Disorders**				
Passive: Accommodation	Schizoid, Depressive*	Masochistic	Dependent	Narcissistic	Compulsive
Active: Modification	Avoidant	Sadistic	Histrionic	Antisocial	Negativistic
Structural Pathology	Schizotypal	Borderline, Paranoid	Borderline	Paranoid	Borderline, Paranoid

pain warns us of threats to our existence, while pleasure (e.g., eating tasty foods) tends to guide us toward living longer. In the broader sense, pleasures such as healthy relationships, love, and physical contact with others are life-enhancing but entail risk (e.g., rejection or even physical harm). Pain avoidance (e.g., staying home) is safe, but leads to other problems (such as isolation). With problems associated with risky pleasure-seeking behavior (Maclean, 2008) and loneliness (Leigh-Hunt et al., 2017) both causing problems on a large scale, the need to balance enhancement and preservation is amply illustrated. Imbalances with an excessive focus on pain are seen in the depressive and avoidant personality disorders, whereas insufficiencies in pain focus are seen in the emotionally flat schizoid (who is also low on the pleasure dimension), and insufficient pain focus paired with average levels of pleasure focus characterizes the antisocial PD.

The second dimension, Adaptation, has at its poles Ecologic Adaptation (passive) and Ecologic Modification (active). This refers to the tendency of the individual to yield and adapt to surrounding circumstances (adaptation/passive), as opposed to actively making efforts to change the current environment or circumstances (modification/active). People with dependent and schizoid personality disorders are classically passive, while the active types are illustrated by the aggressive–sadistic, antisocial, and histrionic personalities.

The third dimension, Replication, has Reproductive Individuation (self-oriented) and Reproductive Nurturance (other-oriented) as its two polar extremes. The individuation or "self" strategy is the investment of one's energy in self-actualization, to fulfilling one's own potential. Conversely, the nurturance or "other" strategy is to invest one's energy in encouraging others to fulfill *their* potential. The prototype of the "self" strategy is the narcissistic, antisocial, aggressive–sadistic, and paranoid spectrum. People on the dependent and histrionic spectra typify the nurturing "other" strategy.

Notably, Millon describes individuals who are intrapsychically conflicted, a dimension that is given little attention in cognitive-behavioral approaches, although examined in psychodynamic therapies as well as the Motivational Interviewing approach (Miller & Rollnick, 2013). Millon describes two types, active and passive, who are ambivalent with regard to the individuation–nurturance polarity. The most notable example is the passive–aggressive/negativistic PD (Millon's "active-ambivalent" category). Millon (2011) notes:

> Those persons whom the evolutionary theory refers to as "ambivalent" are oriented toward *both* self and others, but there is an intense conflict between the two. A number of these patients, originally represented in the *DSM* as the passive-aggressive personality, vacillate between giving primacy one time to *others* and then to *self* the next, behaving obediently one time, and reacting defiantly the next. Unable to resolve their ambivalence they weave an *actively* erratic course. (p. 526, emphasis in the original)

The reader likely notices a similarity to the borderline personality disorder, which is also conflicted on the self–other polarity; as we shall see, people with borderline PD are conflicted in other ways as well. The passive–ambivalent type is far subtler, and manifests as, perhaps surprisingly, the obsessive-compulsive personality spectrum. Millon (2011) states:

> The … compliant-compulsive personality spectrum displays a picture of distinct *other*-directedness, a consistency in social compliance and interpersonal respect: their histories usually indicate having been subjected to constraint and discipline, parental strictures and high expectations. Beneath an overtly *passive* veneer they experience intense desires to rebel and assert underlying oppositional feelings, a covert self-oriented desire and impulse. Trapped in their ambivalence they are often unable to make decisions or act (p. 479, emphasis in the original).

Two other intrapsychically conflicted types have the pain–pleasure polarities reversed, according to Millon's theory. The active variant is the aggressive–sadistic spectrum, in which inflicting pain (e.g., cruelty) is "the preferred mode of relating *actively* to others" (Millon, 2011, p. 616). The passive variant is the self-defeating/masochistic spectrum, in which receiving or experiencing pain has become, in some ways, preferred to pleasure, and is passively accepted, and perhaps even encouraged.

In deriving the personality disorders, one might think that Millon would cross this 2×2×2 matrix into eight personality types. This was not done originally, in part because he did not consider pleasure to be pathological. Instead, the self–other dimension is divided into four parts: detached, dependent, independent, and ambivalent, and a fifth part, discordant, is a subversion of the pain–pleasure dimension. Each of these five dimensions was crossed with the active–passive polarity to create 10 basic personality types. Three additional types, the structurally defective/more severe disorders, were derived as decompensations from the more basic types. The schizotypal (severely detached) was considered a deterioration of the schizoid and/or avoidant PDs, while the paranoid, a deterioration of the independent dimension (narcissistic and antisocial PDs). Borderline PD is a bit more complex, representing internal conflicts on all three dimensions (active–passive, pain–pleasure, self–other). Typically, admixtures of the histrionic and dependent

PDs (dependent dimension) as well as negativistic PD (ambivalent dimension) can be seen, and often, in the more acting out types, antisocial PD; any or all of these disorders can be in a severe form. I once had a student diagnose a person with antisocial and dependent personality disorders, and, indeed, the individual met criteria. The correct diagnosis, however, was borderline PD. In this quixotic personality disorder, criteria for the near-opposite antisocial and dependent PDs can coexist in the same person.

The other critical piece of Millon's approach that we will review here is the functional/structural trait domains (see Table 12.2). There are four basic categories of domains: Behavioral, Phenomenological, Intrapsychic, and Biophysical. The Behavioral category has two domains: Expressive Emotion and Interpersonal Conduct. The Intrapsychic category is broken down into three functional domains: Intrapsychic Dynamics, Intrapsychic Contents, and Intrapsychic Architecture. The final category, Biophysical, includes the Mood/Temperament domain. These are further broken down into Functional and Structural domains. Functional domains, as the name implies, refer to how the person copes with and interacts with the environment, that is, how the person functions. The Structural domains refer to deeper, more enduring features of the person—how the person is put together, so to speak. The structural aspects of the person provide templates or platforms for the functional areas.

The meaning of most of the domains is rather self-evident from their labels. The Expressive Emotions domain refers to how the person's feelings manifest in their words and behaviors; the Interpersonal domain refers to relationships with others, and the Cognitive domain refers to the thoughts, beliefs, and schemas of the person. The Mood/Temperament domain refers to the biological realm; this refers to the heritability and other biological factors that influence personality. The Self-Image domain is also rather intuitive—our image of ourselves—and generally this refers to our comparison of ourselves (similar to or different from) others, as well as the person's general "sense of self." The other domains require a bit more explanation. The Intrapsychic Dynamics domain refers to the ego defense mechanisms, such as projection, rationalization, and reaction-formation, as described by Anna Freud (1936). Intrapsychic content is derived primarily from the object-relations school of

Table 12.2 Functional and structural domains of personality. (Adapted from Millon, 2011; see also https://www.millonpersonality.com/theory/functional-structural-domains/)

Functional Domains		Structural Domains
	Behavioral Level	
Expressive Emotion		
Interpersonal Conduct		
	Phenomenological Level	
Cognitive Style		Self-image
	Intrapsychic Level	
Intrapsychic Dynamics		Intrapsychic Contents
		Intrapsychic Architecture
	Biophysical Level	
		Mood/temperament

thought. The way I believe is most concise to explain it is like this. I have a mother. She is a real person, out there in the world. Inside my head, there is a representation of my mother. Believe me, those two are not the same. The Intrapsychic Content refers to the latter—the symbolic internalized representations of important people in our lives inside of our minds, conscious and unconscious. Often, these internal representations are merged from experiences with several individuals, especially those experiences that occur early in life, and are evidenced simply as our expectations of others. Finally, Intrapsychic Architecture is the overall organization of the psyche, which gives it cohesion and fortitude. A metaphor is useful here. There are many architectural structures in the world—single-family homes, barns, skyscrapers, and so on. Further, each of these external structures bears within it an internal structure—division into rooms, closets, and so on. In addition, any particular structure can be solid, flimsy, or somewhere in between. The type of structure and the interior design correspond to the type of personality; the strength of the structure would refer to the resilience of the psyche. So, for example, a pathological narcissistic personality disorder might be akin to a skyscraper, glitzy on the outside, but hollow within; the overall structure is flimsy, and at risk of collapse; a healthy obsessive–compulsive spectrum individual might resemble a modest home, solidly structured, with an efficient internal layout, and with neat and well-organized material within.

One can readily see how the domains help to integrate various disparate theories into a more unified whole. The Expressive Emotions, Interpersonal, and Cognitive domains are emphasized in cognitive-behavioral therapy; the Intrapsychic domains are prominent in psychodynamic, object relations, and self-psychology approaches; humanistic/person-centered approaches tend to emphasize the Phenomenological domains, and, of course, the Interpersonal school is associated with the Interpersonal domains. Adlerian psychotherapy (Individual Psychology) is holistic and integrative, and brings in Intrapsychic, Cognitive, Expressive Emotions, and other elements. As our knowledge of biology grows, the relevance of factors such as heredity, exposure to toxins, nutrition, as well as brain structure, neural activity, and neurochemistry are becoming increasingly clear in all forms of therapy. With the theoretical considerations above, as well as an eye to the DSM-5, below is a description of each of the personality disorders. I have organized them alphabetically by cluster (Clusters A, B, and C from the DSM-5) followed by the disorders that are no longer in the manual but have appeared in the appendices of previous DSMs.

Paranoid Personality Disorder (Cluster A)

Paranoid PD is characterized by suspiciousness, mistrust, and reading malicious intentions into others' behaviors. The main difficulty in evaluating individuals with paranoid PD is the profound difficulty maintaining rapport, and the extreme difficulty obtaining useful information from the client. Metaphorically, I find paranoid PD to be like the HIV virus. Just as HIV attacks the immune system, which is the pathway to recovering from the disease, paranoid PD attacks the therapeutic

relationship, also the pathway to recovery. Paranoid PD tends to overlap most often with narcissistic, antisocial, avoidant, and sadistic personality disorders. Individuals with healthy personalities on the paranoid spectrum are vigilant, and are able to detect subtle deceptions from others. They naturally fill roles such as law enforcement, security, watchdogs and crusaders for justice.

Schizoid Personality Disorder (Cluster A)

People with schizoid PD are emotionally muted or flat, and generally prefer to engage in solitary activities rather than spend time with other people. Schizoid PD is relatively rare, and, due to the general lack of strong feelings, motivation to engage in therapy is generally weak. People with schizoid PD seek treatment, typically, for mild to moderate anxiety associated with being in social situations, difficulties at work (related to social or motivational problems), and/or difficulties in a relationship (e.g., feeling pressured to be more emotional with a significant other). They can also become lonely; it can be difficult to obtain meaningful contact with others on an intermittent basis without becoming completely isolated. Schizoid PD tends to overlap with avoidant, dependent, and obsessive–compulsive personality disorders. Healthy variants of this type are stoic, unflappable, calm, and grounded.

Schizotypal Personality Disorder (Cluster A)

People with schizotypal PD are odd and eccentric. Genetic studies have shown that schizotypal PD has a spectrum relationship with schizophrenia (Siever, 1992). It overlaps with schizoid, avoidant, and paranoid PDs. On the other end of the spectrum, individuals with normal and healthy variants of schizotypy are creative and offbeat, and are comfortable being unconventional.

Antisocial Personality Disorder (Cluster B)

Colloquial usage of the word “antisocial” can mean someone who avoids social contact, but in the technical sense, it would be better construed as anti-society, or unsocialized. Individuals with this disorder, according to DSM-5, evidence “a pattern of disregard for, and violation of, the rights of others” (American Psychiatric Association, 2013, p. 645). Individuals with antisocial PD generally come across as harsh and unempathic; however, con artists (who can use empathy-like qualities to sense vulnerabilities) are also included in the group. By definition, the person is generally self-serving, with little regard for the harm their behaviors may do to others. Healthy variants of this disorder are bold, adventurous, and free spirited.

Borderline Personality Disorder (Cluster B)

Of all the personality disorders, borderline PD has received the most scholarly and public consideration (Bockian, Porr, & Villagran, 2002). Characterized by substantial emotional dysregulation, impulsivity, and an unstable identity, individuals with borderline PD command the attention of those around them. A number of studies indicate that the risk of death by suicide hovers at approximately 8–10% (Zanarini, Frankenburg, Hennen, Bradford Reich, & Silk, 2005) with suicidal ideation and attempts being extremely common. Naturally, clinicians, family members, and loved ones become greatly concerned. Healthy variants of this disorder are emotionally intense; regarding the "Mercurial" style, Oldham and Morris note, "No other style…is so ardent in its desire to connect with life and with other people. And no other style is quite so capable of enduring the changes in emotional weather that such a fervidly lived life will bring" (1995, p. 293).

Histrionic Personality Disorder (Cluster B)

As the name suggests, individuals with histrionic PD are dramatic in their presentation, and crave being the center of attention. Other features include having a shallow, vapid internal world, fickleness, and seductiveness. Histrionic PD tends to overlap with dependent, antisocial, and narcissistic PD; perhaps ironically, mixtures of obsessive–compulsive and histrionic PDs are not uncommon (e.g., the perfectionistic actor). On the healthy end of the spectrum are individuals who are sociable, energetic, vivacious, and fun-loving.

Narcissistic Personality Disorder (Cluster B)

The definition of narcissistic PD includes traits such as arrogance, grandiosity, lack of empathy, and self-centeredness. There are two important subtypes that must be addressed in order to have a basic understanding of narcissistic PD. The psychodynamic view (e.g., Kernberg, 1970; Kohut, 1971) sees narcissism as a defense against underlying feelings of inadequacy or inferiority. The typical experiential background of such an individual is humiliation by others. The child asserts, essentially, that not only is he or she not inferior to those who put him or her down, but is superior to them. Deep down, however, underlying feelings of shame and inferiority remain. Other theorists (e.g., Benjamin, 2003; Millon, 2011) have seen narcissism as more authentic, with the grandiosity and unrealistic expectations of reward being fostered through simple learning. Lorna Benjamin (2003) colorfully labels the phenomenon "His majesty, the baby" in her classic text (p. 141). To review briefly, imagine a child is extremely overvalued by his parents, for example, and praised for

even the most ordinary achievement. Often such children are very cute, handsome, or pretty, and receive a great deal of attention for that alone. I like to imagine a prince, raised to royalty, expecting to become king of the entire land simply for existing, and being informed that he is special from the moment of his birth; some (but by no means all) such individuals have a benign, passive arrogance. The child's "grandiosity" is in alignment with his experience. Which one is "really" narcissism? Such questions do not concern us for our present purposes. Both types exist in the real world, and such disagreements are semantic battles for the meaning of the word "narcissism." The insecure/defensive type has been labeled the "compensatory narcissist" (Bockian, 1987; Bockian, Smith, & Jongsma, 2016; Millon, 2011) and the insecure narcissist (Millon, 2011). The latter type has been previously referred as a "secure narcissist" (Bockian, 2006; Millon, 2011). Narcissistic PD tends to overlap with antisocial, histrionic, aggressive–sadistic, schizoid, and obsessive–compulsive personality disorders. The healthy variant of this type is the genuinely self-confident individual, a trait associated with career and interpersonal success.

Avoidant Personality Disorder (Cluster C)

People with avoidant personality disorder actively avoid social contact due to fears of being ridiculed, rejected, or humiliated. Unlike the person with schizoid PD, who are socially isolated due mainly to apathy, individuals with avoidant PD long for social contact, crave it, even, but hesitate out of intense fear. Thus, they usually come across as deeply conflicted, wanting to reach out but afraid to do so. A key underlying belief is, "if someone gets to know me, that person will reject me." The avoidant individual tries to walk a tightrope of having the relationship be close enough to maintain it, but distant enough that the other person will not discover how "terrible" they are and reject them. It is among the most emotionally painful of the personality disorders. I suspect that avoidant PD is under-recognized and under-treated, as such individuals tend to be quiet, to avoid causing trouble, and, most importantly, view the therapeutic relationship, with the expectation of sharing a good deal of personal information, to be threatening. Avoidant PD tends to overlap with schizoid, dependent, and paranoid personality disorders. Healthy variants include individuals who are deeply sensitive, introspective, and deep thinkers; they are often creative, which may find expression in poetry or other artistic works.

Dependent Personality Disorder (Cluster C)

People with dependent PD have, according to the DSM-5, "A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation" (p. 675). Such individuals tend to have poor self-esteem. Their actual competence tends to be impaired, at least in part due to a self-fulfilling prophecy in

which they engage since childhood: believing that they are incapable, they spend their energy finding ways to persuade others to do things for them, rather than developing skills; naturally, their skill development proceeds at a lower rate. Dependent PD often overlaps with schizoid, avoidant, histrionic, and obsessive–compulsive PDs. Healthy variants of this type tend to be warm, affectionate, supportive, interconnected, and devoted (Bornstein, 2005).

Obsessive–Compulsive Personality Disorder (Cluster C)

Individuals with obsessive–compulsive PD are rule-bound, constricted, and overly stringent about matters of morality. Their relationships are characterized by coolness and formality, which can slip into coldness and aloofness in more extreme cases. A telling characteristic is that they often become so invested in details that they lose sight of the overall situation, or even the goal they are trying to achieve. For example, a person with OCPD can become so invested in the timing of activities during vacation that the entire situation becomes very stressful—thereby losing the point of a vacation, which is to enjoy oneself. Typical reasons for coming to therapy, then, are difficulties in close relationships, in which a partner desires more affection, and difficulties at work, in which their productivity suffers due to excessive attention to detail and indecisiveness. Ironically, people with the healthy variant of this type are among the most productive on the planet. Organized, efficient, knowledgeable, and hardworking, they are often the "right hand" of the CEO of an organization. In relationships, their loyalty, conscientiousness, and attentiveness often make them excellent partners in long-term relationships. Obsessive–compulsive personality disorder frequently overlaps with schizoid, dependent, and narcissistic personality disorders.

The following are descriptions of PDs that have been included in prior editions of the DSM.

Passive–Aggressive (Negativistic) Personality Disorder

Passive–aggressive personality disorder was in the DSM-III-R as part of the official nomenclature (not an appendix). It is described as, "A pervasive pattern of passive resistance to demands for adequate social and occupational performance…" (American Psychiatric Association, 1987, p. 356). Examples of such behavior (from the criteria) include procrastination, doing poorly on a task the person does not want to do, and so on. Problems with authority figures marked this personality type. It was thought to be too narrow a construct, as it consisted, essentially, entirely of passive–aggressive behavior, with nearly all of the criteria being examples of such behavior. It was reformulated as passive–aggressive (negativistic) personality disorder in Appendix B of the DSM-IV and DSM-IV-TR; for ease of reference, I will

refer to it as "negativistic" going forward. The idea of "negativistic attitudes" was added to the resistance to demands concept of its predecessor; they are characterized as sullen, moody, and irritable. Millon's (2011) formulation is that negativistic individuals are the "active ambivalent" type. Such individuals, then, tend to have mixed feelings, especially in relationships; they swing back and forth between being self-oriented (such as the narcissistic type) and other-oriented (such as the dependent type). It creates a confusing and often frustrating picture for individuals in relationships with them…including therapists. Oppositional-defiant disorder shares many characteristics with passive–aggressive/negativistic PD formulations, but is diagnosed in children and adolescents. Passive–aggressive PD overlaps with borderline, paranoid, avoidant, antisocial, and histrionic PDs. Although passive–aggressive behavior is generally problematic, it is noteworthy that such behavior formed the backbone of the civil rights movements in India under Gandhi, and in the United States under Martin Luther King, Jr. Healthy personalities on the negativistic spectrum have traits that are consistent with "type 'B'" personalities—they tend to value personal and leisure time, to not be overly ambitious or pressured about time, and hold to the right to resist inappropriate or excessive efforts to control them.

Sadistic Personality Disorder

Not to be confused with sexual sadism, sadistic personality disorder is a pattern characterized by "cruel, demeaning, and aggressive behavior" (American Psychiatric Association, 1987, p. 371). It appeared in Appendix A of DSM-III-R. Aggressive–sadistic individuals take pleasure in seeing others suffer, and use violence and psychological intimidation to get others to bend to their will. The disorder is well-illustrated by novels and films, with world-class villain's nearly always having this character type; examples include Voldemort in the "Harry Potter" series, Sauron in "Lord of the Rings," and Hannibal Lecter in "The Silence of the Lambs." Sadistic PD overlaps primarily with paranoid, antisocial, and narcissistic personality disorders. Healthy variants of the disorder are characterized by their commanding style, leadership abilities, competitive spirit, and action orientation.

Self-Defeating Personality Disorder

Introduced in Appendix A of the DSM-III-R (American Psychiatric Association, 1987), and drawn from nonsexual conceptualizations of masochism (e.g., moral masochism), self-defeating personality disorder is characterized by self-sacrifice, rejecting help from others, and being drawn to relationships in which he or she will suffer. Importantly, the DSM notes, as exclusion criteria, that these behaviors occur when other, more positive alternatives exist, and does not occur "exclusively in

response to, or in anticipation of, being physically, sexually, or psychologically abused" (American Psychiatric Association, 1987, p. 374). An excellent metaphor for the psychopathology exhibited by this group is a capacity to "snatch defeat from the jaws of victory." Self-defeating PD overlaps primarily with dependent, passive–aggressive, and depressive personality disorders. Healthy variations of this personality type are giving, generous, nonjudgmental, tolerant, humble, and responsible. It includes the type of person who is beloved for their long-standing support of a cause or an organization, putting needs of others first with little if any personal gain, who smiles shyly and cannot wait to get out of the spotlight when recognized at award ceremonies.

Depressive Personality Disorder

Individuals with depressive personality are characterized by a pervasively gloomy mood, feelings of guilt, as well as beliefs of inadequacy and worthlessness. They tend to be self-critical, self-derogatory, and pessimistic. There may also be a negativistic, critical, and judgmental attitude toward others. Beck's (Beck, Rush, Shaw, & Emery, 1987) "Cognitive Triad" of negative beliefs about the self, the world, and the future, would fit most such individuals.

Depressive personality disorder has a somewhat complex history. Dysthymic disorder was derived from depressive personality disorder formulations, and thus the distinction between them can be difficult to establish. Indeed, in the DSM-III, under "Age at Onset" for Dysthymic Disorder, states, "This disorder usually begins in childhood, adolescence, or early adult life, and for this reason has often been referred to as Depressive Personality." As noted by Widiger and Gore (2013) "There is no meaningful distinction between early-onset dysthymia, an officially recognized mood disorder diagnosis, and depressive personality disorder" (p. 7). The distinction, such as it is, emphasizes cognitive aspects of depressive PD (e.g., beliefs of worthlessness) as well as the early onset and pervasive nature of depressive PD. I would side with those who would argue that early-onset, chronic, pervasive depressiveness would be better conceptualized within the personality disorder realm. Depressive PD overlaps most notably with negativistic PD, as well as avoidant, dependent, and obsessive–compulsive PDs.

While at first glance it may be difficult to conceive of a healthy version of depressiveness, Oldham and Morris' (1995) "Serious" type connotes the adaptive qualities of such a style. "Serious" individuals are realists, who eschew modern pressures to put on rose-colored glasses and "spin" negative situations into positive ones. Note Oldham and Morris (1995):

> What they sacrifice in silver linings, they gain in ability to carry on in even the worst of circumstances. No other personality style is quite so able to endure when a harsh climate seems to descend on the planet. This is a no-frills, no-nonsense, just-do-it personality style, whose strength in hard times can help everyone to survive (p. 366)

Procedures for Gathering Information

Unlike many other mental disorders, gathering information regarding individuals with personality disorders presents some special challenges. As noted above, insight is often poor, inaccurate, or distorted. It is therefore necessary, in formulating the questions one asks of individuals with personality disorders, to radically empathize with the client, and see the world from their perspective.

To illustrate the distinction, let us compare, for a moment, assessing for Major Depressive Disorder and Narcissistic Personality Disorder. Criterion A1 from Major Depressive disorder states, "Depressed mood most of the day, nearly every day, as indicated by subjective report (e.g., feels sad, empty, hopeless) or observations made by others (e.g., appears tearful)" (American Psychiatric Association, 2013, p. 160). It would be quite reasonable to ask, "Do you feel sad often these days? Would you say you are sad most of the day, on most days? Do you find yourself feeling hopeless?" Most depressed clients could answer those questions readily. Criterion A1 from Narcissistic PD, states, "Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)." Now imagine asking, "Do you have an exaggerated sense of self-importance? Do you exaggerate your achievements? Do you expect to be recognized as superior, beyond what your achievements would warrant?" Clearly, this approach is problematic. Radically empathizing with the client would entail seeing it through their eyes. So, rather than asking the questions in the aforementioned manner, one might say, "it appears that you find that others do not fully appreciate your ideas and your potential." Notice the careful wording—by inserting "you find that," the clinician can emphasize the subjectivity of the client's impressions.

The use of our own subjectivity—our countertransference—can further refine our ability to tune into our clients, and provide appropriate responses. Intake interviews are much more effective when we are able to validate the valid (Linehan, 1993), and finding the validity in the statements of our clients can be challenging when their views are somewhat distorted. For example, I have had exchanges with clients that are similar to the following:

Therapist:	And what did you say when your partner started to cry?
Client:	She does that a lot. She cries all the time.
Therapist:	What do you make of that?
Client:	She's just a crier, that's all.
Therapist:	Did you ask her what was going on?
Client:	Not really. We have a lot of money, a big house, and a nice car. There's nothing to cry about, really.

I could feel the muscles in my shoulders tightening up. Paying attention to the sensations, I can usually experience the connected emotions: anger bubbles up, along with anxiety. Tracing the trail further, I notice the associated thoughts in my mind. The statements the client is making are contrary to some of my most deeply

held values, that people "should" try to understand one another, that the feelings of others are to be treasured, that kindness should prevail, and that the sharing of feelings should be encouraged, especially in committed relationships. It is from these beliefs that the anger has emerged. The anxiety—also connected to the tightened muscles—is connected with concerns regarding my role. A first session is too early to be confrontational; my role here is to provide support and validation, and to gather appropriate information to make an accurate diagnosis. Hiding my feelings—not being genuine—is contrary to some of my most important values regarding not only the therapeutic relationship, but relationships in general.

Awareness of this complex of physical sensations, thoughts, and emotions allows me to take the next step: radical empathy. What is it like to be him? He sees his partner crying, and probably he is unresponsive. I let go of my own thoughts and associations, let go of my compassion for his partner, and return to *his* needs and feelings. She is crying. No empathic arousal is stirred in him; that is currently beyond him. Her crying does not move him, but it's a safe bet that she is hoping for an emotionally supportive response, one he is currently, likely, unable to give. It's just pressure. What he probably feels is annoyed.

Therapist: Do you feel annoyed when she does that?
Client: Exactly! Man, she can be so annoying…

So, for diagnostic purposes, what I have done over the years is to recognize patterns of reactions that I have, and how they are associated with various traits. I have observed that the responses are quite reliable. So, at this point, when I feel a particular type of tightening in my neck and shoulders, my alarm bells go off. I no longer need to tie the sensations and emotions to particular cognitions. I have connected with my intuition, or my intuitive self, in order to "feel" that I may be dealing with narcissistic personality disorder. Suspecting that there is narcissistic PD, I can begin to ask questions specific to the disorder to confirm or disconfirm my hunch. Although there is preliminary evidence that there are "normal" countertransference reactions (Colli & Ferri, 2015; Rossberg, Karterud, Pedersen, & Friis, 2008), my approach here is more idiographic, and challenges each of us to be aware of our own reactions, rather than to list common responses to any given disorder. While my "gut" is usually pretty accurate, there is room in the above snippet to imagine that the person has antisocial or aggressive–sadistic PD. Further interaction, involving asking questions that are aligned with the criteria for each relevant disorder, as well as a further back and forth between my intuitions and the selection of such questions, continues to move the interviewing process forward.

A few words are in order here about the meaning of countertransference. The concept of countertransference has evolved substantially over the course of many decades, and now involves many conceptually nuanced meanings; I will describe two. Among my students, and I would guess among most professionals in the field, the word countertransference is associated with a therapist's unconscious reaction to a client, generally regarding issues that are unresolved areas of conflict for the therapist (Gelso & Hayes, 2007). It is the exact parallel of transference—a client's unconscious reaction to the therapist—but in the opposite direction. As it dates back

to Freud and the emergence of the concept, this is described as the "classical" approach to countertransference. Because it is unconscious and involves the therapist's unresolved issues, classical countertransference is, by this definition, highly problematic to the therapy, and it is essential that therapists be able to recognize and address their problematic reactions as they arise.

However, another definition of countertransference is Kernberg's (1965) "totalist" approach, which involves the total emotional response of the therapist to the client, conscious and unconscious, healthy and unhealthy. My approach to countertransference in this chapter is within the totalist camp. I would say that during a session I am able to reach conscious and preconscious thoughts as indicated above, although getting to deeper levels requires time outside of the session. It can arise, of course—for example, if there is a client to whom I have a strong negative reaction but do not know why. There are behavioral indicators of classical countertransference, such as dreading sessions with the person, procrastinating on returning phone calls, over-involvement, rescuing, and so on. In such situations, reflection and/or consultation is important, in order to maintain a healthy relationship. Conscious awareness, of course, is crucial to distinguishing between classical countertransference and basic emotional responses. If I know why I am having a negative emotional reaction to a client, which happens, for example, rather regularly when a client reports being callously and remorselessly cruel to another person, it is not countertransference in the classical sense; it is an emotional response, understandable within the totalist framework.

While there are a variety of pathways to self-understanding, I have found mindfulness to be particularly useful in maintaining awareness during a session. It is commonly defined as "…paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994, p. 4). Consistent with my experience, preliminary research is very promising in this regard, some of which will be described presently.

Bruce and his associates (Bruce, Manber, Shapiro, & Constantino, 2010) developed a model of how therapists can improve their work through mindfulness.

> … we propose that mindfulness practice may be a means for training psychotherapists to better relate to their patients. We posit that mindfulness is a means of self-attunement that increases one's ability to attune to others (in this case, patients) and that this interpersonal attunement ultimately helps patients achieve greater self-attunement that, in turn, fosters decreased symptom severity, greater well-being, and better interpersonal relationships. (p. 83)

Notably, a double-blind study showed that therapists trained in mindfulness meditation had better outcomes with their clients, as shown by greater improvement on a wide variety of symptoms (Grepmair et al., 2007). Applying this model to the process of assessment, I would posit that the attunement process can increase both the accuracy of assessment, and the ability to maintain rapport with the client.

Self-awareness combined with empathic attunement can lead to an uncannily accurate and rapid understanding of a client. Tansey and Burke (1989) describe an interaction with a consultant, who has come in, received some basic demographics, and listened to a few minutes of a tape-recorded session between a resident and a client.

> Turning to face the presenting resident, he proceeds to deliver a series of well-articulated formulations about the nature of the current therapeutic interaction, its relationship to the genetic history, and some feelings with which the therapist might be struggling that had not yet been mentioned. The presenter nods vigorously on all counts, and the consultant…goes so far as to predict a shift in the direction of the material that might be coming within the very session under examination. The recording is turned back on, to the wide-eyed anticipation of all, and—voila!—the predicted shift irrefutably occurs. (p. 2)

The authors attribute the process by which the consultant reached his conclusion to be based primarily on empathy, which they understood in the context of countertransference theory. In other words, our understanding of others at a deep level is related to our unflinching examination of ourselves, and ourselves in relation to that person.

The value of having a rapid "feel" for the diagnostic category into which our client falls cannot be underestimated. Knowing the personality style and possible personality disorder of an individual is extremely helpful in the establishment of rapport. For example, a client with a dependent personality style or disorder will attach rapidly, especially when the messages such as "we will work through this difficult time together" and "our team is here to support you" are sprinkled throughout the interview by the clinician. Conversely, such messages to individuals who view themselves as autonomous (e.g., the narcissistic, antisocial, and aggressive–sadistic types), a nurturing approach is often received negatively, especially early on in the relationship. Although later on in therapy, often more than a year into it, the person with one of these "independent" (Millon, 1999, 2011) personalities may be able to receive badly needed and restorative nurturance from the therapist, such is not the case in the first interview. A better approach is to emphasize the consulting role of the therapist, and emphasize the power that the client has. With the exception of forensic settings, generally a client is free to leave therapy, thereby having control over the therapy's duration. While generally we therapists are highly empowered, it is a reality that most of our clients can "fire" us at any time. Thus, for the independent types, phrasing such as, "should you choose to engage in this treatment, then…" and "what is it that you hope to gain from this treatment?" followed by a straightforward discussion of the potential benefits and limitations of the treatment is, perhaps somewhat ironically, more inviting.

With radical empathy in mind, we have a framework within which to word questions so that people with personality disorders will resonate, and thus respond accurately to the intent of the question. Samples of such wordings are listed in Table 12.3. As will be noted below, there are many examples of such wordings in the carefully constructed semi-structured interviews presented below.

In sum, then, the model presented in this chapter is that, ideally, a person involved in the diagnosis of personality disorders should (1) know the diagnostic criteria, both for PDs in general and for each personality disorder in particular; (2) be able to radically empathize with the client, so as to be able to translate the criteria into a form that is meaningful for the client; (3) be highly self-aware in order to facilitate that empathy, with mindfulness being recommended as a pathway through which that self-awareness can be fostered.

Table 12.3 Select translations of DSM-5 criteria into useful assessment questions

Personality Disorder	Assessment question(s)/statement(s)
Cluster A:	
Paranoid	You keep your radars up to make sure others are being straight and honest with you. {Depending on rapport} Have others hurt or betrayed you in the past?
Schizoid	Do you prefer to engage in solitary activities, such as going for a walk by yourself, or even just sitting home alone, rather than going to events with other people?
Schizotypal	Are you an "outside the box" thinker? Are you open to ideas that are outside of the mainstream, such as telepathy and ESP? Do you believe you have ESP or are able to sense others' thoughts directly?
Cluster B	
Antisocial	Hey, it's a dog-eat-dog world out there, right? Given a choice of being the winner or the loser, you'll take being the winner.
Borderline	You are a sensitive person, and you find that being rejected hurts so badly that it makes you feel completely blown away. Does it ever get so bad that you want to end your life?
Histrionic	Do you find that there seems to be one drama after the other in your life?
Narcissistic	Do you find that others have difficulty appreciating or understanding many of your more advanced ideas?
Cluster C	
Avoidant	Would you say that you fear rejection more than most people do? Are you afraid that if someone gets to know you pretty well, he or she will reject you and hurt you? Has that been your experience?
Dependent	Do you find that you need help with everyday decisions? Do you like for (your significant other) to help you pick out what to wear, and things like that?
Obsessive–Compulsive	Staying organized is really important to you. Do you like to keep a pretty strict routine, so that you can be as efficient as possible?
Appendices from prior DSMs	
Depressive	When you look back, how long would you say you have been at least somewhat depressed and negative? {Looking for answers such as "since childhood" or "always."}
Aggressive–Sadistic	Would you say you are highly competitive? Do you get annoyed when other people whine or complain? Do you feel a need to "put them in their place" if they do?
Masochistic (Self-Defeating)	When something good happens, do you feel like you don't deserve it? Does that make you uncomfortable? {Depending on rapport:} Do you think that you should be punished for being bad, or for bad things you have done?
Negativistic (Passive–Aggressive)	Do you find that other people are annoyed or angry with you a lot, for no apparent reason? Do you wish you could get out from under the thumb of people who are in authority over you?

Recommendations for Formal Assessment

There are several strategies for formal assessment that can be useful for personality disorders. As this chapter is dedicated to diagnostic interviewing, I will keep this section brief, and limited to two self-report instruments (MCMI-IV; MMPI-2-RF) and two semi-structured interviews (SIDP-IV; SCID-5-PD) as well as some comments on the use of informants. The interested reader is directed to more comprehensive reviews (Clark et al., 2018; Miller, Few, & Widiger, 2012).

Structured and semi-structured interviews are considered the best available methods for accurately diagnosing personality disorders (Rogers, 2003). They have the advantage of being systematic and comprehensive. They can also be outstanding tools for sharpening the clinician's ability to provide assessments. The SIDP-IV (Pfohl, Blum, & Zimmerman, 1997) and the SCID-5-PD (First, Williams, Benjamin, & Spitzer, 2016) are both worded in ways consistent with the guidelines I provided above—that is, the diagnostic questions are generally worded in a way that would be palatable to the person being interviewed. For example, on the SIDP-IV, the criterion for negativistic, "Passively resists fulfilling routine social and occupational tasks," is worded "When some people get tired of doing their daily chores at work or at home, they might try to get out of them by inventing excuses, pretending to forget, or deliberately not working very hard. How often do you do things like this?" As noted above, such framings are crucial in order to conduct a valid diagnostic interview for this population.

The SIDP-IV takes about 60–90 minutes to administer. It has scales for Negativistic (Passive–Aggressive), Self-Defeating (Masochistic), and Depressive personality disorders, in addition to the 10 personality disorders currently in the DSM-5. Although an alternate form is available, in which it is organized by personality disorder, in its standard format it is organized by topic: A. Interests and Activities, B. Work Style, C. Close Relationships, D. Social Relationships, E. Emotions, F. Observational Criteria (i.e., the examiner's observations); this layout provides a natural feel to the interview. The inter-rater reliability has been shown to be good, with kappa values generally above 0.70 (Jane, Pagan, Turkheimer, Fiedler, & Oltmanns, 2006). A corresponding self-rating form and an informant form are available. Although the SIDP-IV has not been updated for DSM-5, it is also true that the diagnostic criteria for personality disorders have not changed with the most recent revision of the manual.

The Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) is a semi-structured interview that assesses the 10 personality disorders from the DSM-5. It takes approximately 30–120 minutes to administer, depending on how much follow-up is needed to determine the diagnosis. It is organized by personality disorder. A corresponding self-rating form and an informant form are available. The SCID instruments are widely used in both clinical and research practice, and are considered to be valid and reliable.

Self-report inventories can also be very helpful in assessing individuals with personality disorders. Originally designed primarily for personality disorders, the

Millon Clinical Multiaxial Inventory (currently in its 4th edition) provides clinicians with a good deal of useful information (Millon, Grossman, & Millon 2015). It includes scales for the 10 DSM-5 personality disorders, as well as scales for disorders previously from the appendices of prior DSMs (depressive, aggressive–sadistic, masochistic/self-defeating, passive–aggressive/negativistic) and a new designation, the "turbulent" personality (an active–pleasure-oriented personality, associated with hypomania). Each of the personality disorders are now on a spectrum that includes normal personality (style), a personality "type" (intermediate), and a personality disorder. Each personality disorder scale also has three "facet scales" that provide more precise meaning to the scale elevations. For example, the Borderline scale has the facets "Uncertain Self-Image, Split Architecture, and Temperamentally Labile." There are three modifying indices (disclosure, desirability, and debasement) that describe test-taking style, and two scales (validity and consistency) that control for random responding, inability to understand the questions, and other issues that could render the profile invalid. There are 10 clinical syndrome scales (generalized anxiety, somatic symptoms, persistent depression, alcohol use, drug use, posttraumatic stress, schizophrenia, major depression, and delusional disorder). Internal consistency values are very strong, ranging from 0.67 (obsessive–compulsive) to 0.91 (borderline) on the primary scales, and 0.63–0.87 on the Grossman Facet Scales; nearly all of the scales exceed the 0.70 cutoff for good internal consistency. Test–retest reliabilities (at 1 week) were also strong, with the majority of the correlations exceeding 0.80. External validity studies with similar instruments (the MMPI-2-RF, BSI, and MCMI-III) indicated good continuity with the prior version of the test, and appropriate correlations with related instruments. The MCMI-IV has 195 items, and takes about 25–30 minutes to administer.

The Minnesota Multiphasic Personality Inventory (MMPI) is extremely well-known, and I will thus only (briefly) review the personality disorder scales on the latest version, the MMPI-2 RF (MMPI-second edition, Restructured Form). A recent study demonstrated that specially developed personality disorder scales are reliable and valid (Sellbom, Waugh, & Hopwood, 2018). The study, which included a normative community sample, a university sample, a mental health sample, and a prison sample generated 10 personality disorder scales corresponding to the 10 personality disorders of the DSM-5. Internal consistency estimates ranged from 0.60 to 0.88, with the median score being above 0.70 in all four samples. Test–retest reliability (1 week) was also solid, ranging from 0.78 to 0.91, with a median of 0.86. With regard to convergent validity, correlations were measured between the MMPI-2-RF-PD scales and the SCID-II-PQ (a self-report inventory designed to accompany the SCID-II, the semi-structured interview that is the predecessor to the current SCID-5-PD). The correlations ranged from 0.28 to 0.70, with large correlations (>0.5) for the paranoid, schizotypal, borderline, histrionic, avoidant, and dependent PDs; moderate correlations (>0.3) for antisocial, narcissistic, and obsessive–compulsive PDs; and a weak correlation (<0.3) for schizoid ($r = 0.28$). The MMPI-2-RF has 338 items, and takes about 35–50 minutes to administer. In general, the MMPI-2-RF Personality Disorder scales performed well enough to be useful in clinical practice, although stronger convergent validity for a few of the scales would be desirable.

Informants can be extremely helpful in diagnosing a personality disorder. Given the ego-syntonic nature of personality disorders, significant others not infrequently have a clearer awareness of the individual's problems. There is a risk that a person with antisocial PD, for example, will be dishonest in an interview, that the person with histrionic PD will have only a vague sense of their historical information from childhood, that a person with borderline personality disorder will misconstrue the intentions of others, and that someone with paranoid PD will be fearful of revealing personal information. Parents, spouses, siblings, children, and close friends can be invaluable sources of information. I usually try to interview informants in the presence of the client. This helps to avoid foreseeable problems with trust. However, informants are not a panacea; they can have their own biases and agendas, and their input must be considered part of a larger overall strategy.

Impact of Gender, Race, Culture, Age, and Other Aspects of Diversity

In my experience as a clinician, knowing about diversity factors in a person's life is as important as knowing their diagnosis—and sometimes more so. Training in diversity issues is prominent in accredited training programs, so at this point many clinicians are aware of the impact of the variables summarized usefully by Pamela Hayes' "ADDRESSING" acronym: Age, Developmental and acquired Disability, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender (Hayes, 2008). To address each of these for each personality disorder would be a book in its own right, so I will address some issues that I believe are relatively central and more common.

The most general, global issue is to determine, in alignment with DSM principles, the degree to which any particular behavior is normative within a particular cultural context. Further, there is a fine balance between discussing cultural norms and stereotyping. I draw heavily on McGoldrick et al.'s (2005) classic, *Ethnicity and Family Therapy* in order to navigate these waters. The distinction between acknowledging norms and stereotyping lies in thinking in terms of likelihoods, rather than absolutes. So, for example, it is well-known that Chinese families, influenced by *Confucianism*, tend to be relatively hierarchically structured (compared to American families) with special authority given to the male head of household. An ethos of working hard is also common in this culture. Expectations are that children follow a moral code of obligations and duty, including filial piety (Lee & Mock, 2005). Of course, any specific case can vary tremendously from that pattern, with degree of acculturation being one important variable (e.g., if that family is fourth-generation American, they may fit more closely with American norms than Chinese ones) as well as simple individual difference (e.g., even a first-generation Chinese man could be very low in dominance, for a variety of psychological reasons). The question incumbent upon us for present purposes is whether an

individual should be diagnosed with a personality disorder, given a certain set of characteristics, within a particular subculture. So, in the example above, does this Chinese father fit criteria for obsessive–compulsive PD? The personality disorder has criteria such as rigidity, strict adherence to a moral code, and authoritarian behavior toward subordinates. The proper analysis, diagnostically, is to ask whether these traits are excessive *relative to the norms in the Chinese community* at a similar level of acculturation. If the behavior is not unusual or only modestly deviant from norms in his community, then these behaviors would not be considered meeting criteria. Similarly, regarding paranoid personality disorder, members of minority groups, immigrants, and refugees, for example, who have experienced discrimination may respond with guardedness to members of mainstream culture. This should not be interpreted as paranoia.

One of the more difficult issues in the diagnosis of antisocial personality disorder is to appropriately assess antisocial behaviors when societal forces make such behaviors adaptive. Individuals in high-crime/high-violence neighborhoods often adapt by becoming tough and harsh. Individuals may join gangs for self-defense, but the price of being in the gang is illegal activity and violence. It is also fair to say, however, that individuals exposed to such a background are at greater risk for developing the disorder. There is no completely satisfactory resolution to the problem. However, the key approach is to fully understand what is meant by antisocial personality disorder, apart from its behavioral manifestations. Antisocial personality disorder, according to Millon (2011) is the "active independent" personality type. Individuals who are "followers" do not belong in this category. There are some in gangs, for example, who are for the most part following a leader or the group. Such individuals are more likely to have issues with dependency than hyper-independence.

In addition, antisocial PD is generally characterized by impulsivity. Planning and reasoning can be useful differentiators. Individuals who engage in solitary antisocial behavior, who have an "eat or be eaten" attitude, who chafe at any kind of authority, who are cold, callous, or cruel (e.g., meets the criterion related to torturing animals) are likely to have the disorder. None of these are generally characteristic of people from even the most dangerous neighborhoods and impoverished circumstances; the average low-SES person is a law-abiding citizen, trying to make the best of extremely trying circumstances. However, underdiagnosis is just as big a problem as overdiagnosis, and we must carefully check our biases. Are we excusing behavior that should not be excused, due to the person's difficult circumstances? Are we diagnosing as if their circumstances made no difference? Either one is an inappropriate bias. Lack of a diagnosis leads to under-treatment; overdiagnosis leads to inappropriate treatment and, unfortunately, possible stigma in our society, in which stigma against individuals with mental illness still is prevalent.

An important differential diagnosis is between antisocial PD and borderline PD, particularly in men. Don Dutton's groundbreaking work in domestic violence is truly eye-opening in this regard. Superficially, domestic violence against women by men would seem to indicate antisocial personality disorder—the anger, the violence, the seeming callousness, and so on. However, upon closer inspection, the

pattern does not fit well. The well-known pattern of the abuser being contrite and feeling guilty and begging for forgiveness and for the person not to leave is one clue; the fact that the risk of violence is highest when the partner leaves or threatens to leave is another. Dutton notes that attachment insecurity fits the pattern more closely, and traits of borderline PD—impulsivity and anger (shared between the two disorders) but also feelings swinging from loving to hating the other person (and back again) as well as feelings of guilt, worthlessness, anxiety, and other traits, indicate that borderline PD is the far superior conceptualization (Dutton, 2007). Surely, a person committing domestic violence may very well have antisocial or sadistic PD; however, we must be very mindful of gender bias in this regard. It is particularly important in this area, because the treatments for antisocial and borderline PD are generally very different. People with antisocial PD are by definition, callous (literally, thick-skinned, emotionally) while Linehan describes people with borderline PD as having extreme emotional hypersensitivity, as if they had a bad burn on their psychological "skin" (Linehan, 1993, pp. 69–70). There are times when, with antisocial PD, I feel as if I need to "turn up the volume," emotionally, in order to be heard. In contrast, such an approach would overwhelm the person with borderline PD. Evidence is growing that treating people who commit domestic violence with DBT is effective (Sonkin & Dutton, 2003).

Millon's analysis of social conditions that contribute to the recent dramatic increase in borderline personality disorder can act as a template for understanding social factors that foster mental disorders in general, and personality disorders in particular. Millon notes that borderline symptoms parallel various changes in society. The identity disturbance that plagues many individuals with borderline PD is correlated with a breakdown in institutions that once supported identity formation. Once anchors for individual identity, churches, synagogues, and other religious institutions have experienced declining membership and participation for many years. Television shows also model behaviors that are borderline in nature. Notes Millon (1987):

> …"life stories" must be composed to capture the attention and hold the fascination of their audiences—violence, danger, agonizing dilemmas, and unpredictability, each expressed and resolved in an hour or less—precisely those features of social behavior and emotionality that come to characterize the affective and interpersonal instabilities of the borderline. (p. 365)

In addition, characters are often portrayed as being right or wrong in simplistic ways, supporting the "split" thinking characteristic of borderline PD. Marriages, too, are divided, with a majority ending in divorce; sadly, and all too often, parents carry on their feud, painting the other as all bad, and themselves as all good; the parallels to borderline thinking are obvious. Using mind-altering drugs can further erode emotional stability and clarity of thought. Finally, the dizzying pace of change in our society, including changes in social norms, rapid technological advance, and shifting moral values contribute to the difficulties in identity formation. These societal conditions are not necessarily problematic in and of themselves; however, they do complicate the task of identity formation, and in certain vulnerable individuals, lead to problematic outcomes.

Case Illustrations

Case 1: "Jamie." "Jamie" is a 32-year-old married Caucasian cis-gender heterosexual woman of Anglo Saxon and German origin. Describing herself as "spiritual but not religious," Jamie was raised in a Mormon home. She had been in therapy, on and off, since childhood. Jamie came to therapy due to feelings of depression, fears of having a serious illness, rumination, and difficulties in relationships. She denied a history of physical or sexual abuse.

Fearing that she had a serious illness despite substantial reassurance from physicians following numerous tests, Jamie would sometimes spend hours researching illnesses on the Internet, often going to work with just 2 hours of sleep. Although highly intelligent and possessing a graduate-level degree, she was significantly underemployed, working in the shipping department of a local department store. Perhaps most prominent were overwhelming feelings of guilt, which plagued her almost constantly. She did not believe that she deserved what she had. Her income was low, but financial support from her family of origin, her husband while she was married, and boyfriends, allowed her to live a middle-class lifestyle; for this, she felt overwhelmed by feelings of guilt and inadequacy. She reported that when she was growing up, according to her family, "nothing she ever did was good enough." Praise was virtually never given, but harsh verbal reprimands were given if her work and behavior were less than perfect. She described her father as extremely competent and financially successful, but emotionally "clueless." She often experienced feelings of despising herself; on a few occasions, she reached the point where she would slap herself in the face or punch herself in the stomach to express her self-loathing. She described her husband as a completely unemotional and emotionally unavailable man with a significant alcohol problem; although I never worked with him, if her description was accurate, he was on the schizoid spectrum, perhaps with full-blown schizoid personality disorder. They divorced because she felt completely neglected. Her dating relationships were characterized by fears of abandonment and several "preemptive strikes," breaking up with a partner before he broke up with her, even though, by her reports, his verbal behaviors were consistently affectionate. There were several longer-lasting relationships in which her partner was dismissive, neglectful, or critical; these relationships felt more authentic to her. At times in her relationships, she would get angry and harshly critical of her partner, and then feel guilty and contrite. In many of her friendships, Jamie would listen to her friend's problems and provide support, way past the point where she felt comfortable in terms of time and energy, though few if any of her friends were supportive during her times of trouble. Although she tutored students in writing, and helped her friends, Jamie had great difficulty completing her own papers, as her self-doubts and perfectionism interfered. When Jamie was growing up, her mother was ill much of the time; much of the household revolved around the efforts not to disturb her, and much of her father's energy was consumed with caring for her.

Diagnostically, then, Jamie is highly complex. With the self-injurious behavior, fears of abandonment, and mood problems, borderline personality disorder must be

considered. For symptom disorders, her fears regarding having a serious illness indicate Illness Anxiety Disorder, while her rumination and painful paralysis suggest possible Obsessive–Compulsive Disorder. Dominating the clinical picture, however, is Self-Defeating/Masochistic Personality Disorder. The criteria associated with the disorder—believing that she deserves to be punished, rejecting help, guilt following positive personal events, provoking rejection then feeling hurt, achieving for others but not for herself, rejecting opportunities for pleasure, losing interest in individuals who treat her well, and self-sacrifice—were virtually all met in this case. My emotional reactions were very helpful in guiding me in this case. When she described deserving to be punished, and not deserving anything good, I felt mostly perplexed and confused. Attempting to intervene to make her feel better, often resulting in intense guilt on her part, deepened my confusion, and left me feeling de-skilled. With cognitive–behavioral therapy as a base upon which I build a good deal of my therapeutic work, what was I to do with someone who reacted to what would ordinarily be considered positive reinforcers with waves of guilt, self-recrimination, and, at times, self-hatred? I often felt an incongruous wave of revulsion (e.g., when she described hitting herself) or frustration (as I struggled to find a way to help her improve her mood and functioning without triggering her guilt and self-loathing) mixed with deep and sincere compassion (since she was in tremendous psychic pain). These feelings helped me to see the conflicted inner world she inhabited, and the distortion of pain and pleasure that she experienced. It is important to note that the idea that people with self-defeating personality disorder "enjoy suffering" is a substantial distortion. Although individuals with this disorder may believe that they deserve to suffer, with suffering providing some form of guilt reduction or sense of justice being served, they are still suffering…badly. Having experienced a taste of Jamie's, and others', internal world, I believe that self-defeating personality disorder is one of the more painful of the psychological conditions.

Several diversity factors appeared to have played a role in Jamie's developing self-defeating personality disorder. Self-defeating PD is disproportionately diagnosed in women, presumably primarily due to expectations of women within families and our society. Her upper-middle-class upbringing, contrasted with her relatively low earnings, fed her self-recriminations regarding being "undeserving." Finally, her national origin (Anglo-Saxon/German) emphasizes productivity, wherein she believed that she fell short. Although in some cases, experiences with religious interpretations that emphasize guilt can increase the risk of feeling excessive guilt, that was not the situation in this case as her family was relatively nonpracticing.

Although overapplied, Jamie had many of the strengths that are associated with this character type. Her characteristics included, per the characteristics listed for the healthy end of the self-defeating spectrum above, being generous, nonjudgmental, tolerant, humble, and responsible. While it is beyond the scope of the chapter to discuss her treatment, ultimately it was these characteristics that enabled her to connect meaningfully with others, and, in connection with a loving partner, overcome her self-doubts and negative beliefs.

Case 2: “Juan” was a 42-year-old first-generation Hispanic cis-gender married heterosexual male. He worked as a physical therapist in a state hospital. Juan was referred for difficulties with his immediate supervisor, and for some difficulties with patients.

Juan stated that his supervisor expressed frustration that he (Juan) was often late with paperwork. He never became licensed in PT, but was still able to work due to the particular rules in the state facility where he was employed. Juan noted that his boss was “too hard on him,” and “too critical,” and “did not understand him.” He was resentful of suggestions that his boss or others made to help him to improve his work. He would often argue with individuals on his treatment team about diagnoses, even those that were outside of his area of expertise. His mood came across as sad, irritable, and discontented.

While at first I felt sympathetic toward Juan, I soon found myself feeling more and more frustrated. Any suggestion I would make was met with, “yes, but…” He seemed to get a strange sense of satisfaction from “defeating” any efforts I made to help him. I also found myself working harder than the client in trying to find solutions to his difficulties. In one notable interaction, after running through a list of possible solutions, when I could not think of any more, he smiled. My interpretation was that defeating me was more important than feeling better or getting well.

Juan is a rather pure case of passive–aggressive (DSM-III-R) or negativistic personality disorder (DSM-IV-TR appendix). Other than some modest depression and anxiety (due to his difficulties with his supervisors and others) there were few symptoms other than his personality disorder (and even those could be considered largely secondary). The fundamental issue—his ambivalence over whether to be self-focused or other focused, in a hierarchically superior position, or an inferior one, played itself out in the therapeutic relationship, just as it did in his interpersonal relationships. My reaction—feeling frustrated over his active undermining of my efforts to help, and perplexed at his apparent lack of motivation to improve—have been reliable pointers to this personality type.

Case 3: “Hope” is a 68-year-old divorced mother of six grown children. She grew up in an African nation, and has been residing in the United States for approximately 40 years. A number of months before I began to see her, Hope had had a stroke. This event led to her transition from community residence with her granddaughter to living in a nursing home. Christian throughout her life, following the stroke she became a Baptist and was “reborn.” Since that time, according to her daughter, she has been extremely religious. Hope’s memory was somewhat impaired, thus some of the details in her history were rather sketchy.

I had no difficulty connecting with Hope; she was interested in having a relationship with me and with her family members. I have often found that in nursing homes, due to the under-stimulating and often isolating environment, clients are very eager for a relationship, even those with relatively detached or independent personality styles. Simply providing an opportunity to talk about her concerns established a comfortable therapeutic rapport. Hope’s initial complaint to me was that she was seeing “devils,” shadowy spirits that would hide in corners or under her bed. She claimed that they were stealing her clothes and otherwise tormenting her.

Sadly, Hope's clothing *was* disappearing, and needed to be replaced by the nursing home; staff believed that in fact the clothing was being stolen. Nonetheless, several diagnostic possibilities jumped to mind. Psychosis secondary to stroke and its attendant brain damage? Schizophrenia? Schizotypal PD? Atypical psychosis?

Hope's voice was sad and pleading as she reported her story, and I felt a distinct cry for help. Paying attention to my emotional reactions to her, I noticed that I felt sad, heavy, and helpless, and I experienced a strong urge to rescue her. This is a common gut-reaction I have noticed within myself when I encounter a client with depression, especially if the person has a tendency toward dependency. With clients who are more classically psychotic (e.g., schizophrenia) I often experience confusion and a struggle to create coherence. Hope, however, was more in the schizotypal range of functioning—she was having illusions (criterion 3), rather than frank hallucinations; she probably did see shadows, or vague movements on the ground, but interpreted them to be demons. Her behavior was odd and eccentric (criterion 7) most notably singing her prayers loudly in bed, and preaching to no one in particular. Her affect was often inappropriate, either overly excited or overly muted to the topic at hand (criterion 6). She was suspicious that others were talking about her negatively (criterion 5). Her speech was also odd, often being vague or circumstantial; I needed to redirect her speech fairly often in order to make progress in a conversation (criterion 4).

I believed, then, that the best way to initially conceptualize the case was major depression with mood-congruent delusions, in the context of schizotypal personality disorder. Since the belief in spirits is common in Hope's African culture of origin, the content of her thoughts was not particularly bizarre (Black, 1996), although the whole of the clinical picture was well outside the norms of her subculture (e.g., her daughter expressed concerns). Because of the behavior change after the stroke, one could consider it a personality change due to a medical condition; the personality to which she had changed, however, was best characterized as schizotypal PD. For further elaboration of this case, see Bockian (2006).

Information Critical to Making a Diagnosis

What is critical to making a diagnosis of personality disorder is to note how well the disorder under investigation fits the general guidelines for categorizing a PD, as noted above. It (1) must be an enduring pattern of inner experience and behavior; (2) deviate markedly from expectations of that individual's culture; (3) is pervasive and inflexible; and (4) has onset in adolescence or early adulthood (although I would add that diagnosis prior to adolescence is a possibility). An excellent clue that the person has a personality disorder is that it is *ego syntonic*, that is, the person views the personality tendencies as a normal part of the self, and therefore sees the reactions of others as being what is problematic. Once the clinician determines that a personality disorder diagnosis is appropriate, then one should assess the specific criteria under each of the personality disorders.

Dos and Don'ts

1. Do a comprehensive evaluation, including multiple sources of information, such as self-report inventories, clinical interviews, and, where practical, structured or semi-structured interviews, as well as informant interviews.
2. Do learn the diagnostic criteria well, and become familiar with major theories in the PD field so that you understand their meaning.
3. Do *radically empathize* with your client during the intake interview, seeing the world through their lens, even if that lens is distorted in some areas. Validate the valid in what they say. Be authentic.
4. Do learn to word questions in accordance with the radical empathy noted above, whether through attunement, through practice with semi-structured interviews, or, best of all, both.
5. Do attend to your emotional reactions, and learn what you typically experience in response to particular traits. Develop and hone your intuition.
6. Do use your ability to rapidly get a feel for the personality style of the individual to improve your rapport for the remainder of the interview.
7. Don't become overwhelmed by the strong emotional reactions that occur due to personality disorders.
8. Don't lose hope that the person can improve.
9. Don't hesitate to seek supervision, peer consultation, or professional consultation as warranted.
10. Don't *reify*—that is, think that the label indicates a real, tangible entity, which often leads to systematically ignoring information that does not fit our preconceptions. Personality disorder labels are there to provide guideposts to our understanding. The real person is always richer and more complex.

Summary

Diagnosing personality disorders is a blend of art and science, intuition and empiricism. In this chapter I have provided a model that includes relatively objective measures, such as semi-structured interviews and self-report tests, along with the most intimately subjective, namely, our emotional reactions to our clients. Radically empathizing with our clients helps us to connect with them more fully, and gain information that is more valid. Learning to hone your intuition is, to my mind, an essential ingredient in optimizing our ability to recognize personality disorders, and connect with the people who have them. While not the only pathway, I recommend mindfulness meditation as an excellent gateway, one which has preliminary scientific support in being used for such purposes. I recommend practicing with structured interviews, especially during training or early in one's career, to gain an understanding of how to ask questions that will elicit meaningful responses. Working with people with personality disorders can be emotionally overwhelming,

even in early interviews, and accessing appropriate support—whether through supervision (during training), peer support, or professional consultation is healthy and at times an ethical imperative. Finally, there is no substitute for being highly familiar with the diagnostic criteria and relevant theory. Read, go to training sessions, and interact with fellow professionals about how to interact in a productive way with individuals with personality disorders.

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