UNDERSTANDING PERSONALITY STYLE AND DISORDER FOR PASTORAL COUNSELING

With Special Analysis of Client Defense Mechanisms

First Edition
MARET Educational Series – Volume 1

UNDERSTANDING PERSONALITY STYLE AND DISORDER FOR PASTORAL COUNSELING

With Special Analysis of Client Defense Mechanisms

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Life begins on the other side of despair.
                                        Jean-Paul Sartre

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Preface

This book has been written for three purposes.

First, this book is the first volume in a series of volumes designed to be used in the MARET Educational Series. The MARET Educational Series is an intensive six-part training course designed to help pastors become efficient in their practice of pastoral counseling. This book is associated with the third course in that series.

Second, this book is designed to be a reference book for users of the MARET Counseling and Assessment Software Package. For those who use the Counseling and Assessment Software, this book will be a welcome guide for use with the Personality Style and Disorder section of the software – even if a pastor chooses not to engage in the six-part MARET Educational Series.

Third, although this book was written with the software owners in mind, individuals who do not use the MARET Counseling and Assessment Software will still find substantial benefits in this book. The classifications of Defense Mechanisms and their definitions will provide any therapist with vital information in the counseling process. Furthermore, the detailed descriptions of the DSM-IV personality categories from our unique view of personality as a continuum will be a welcome reference tool.

A word of warning is in order.

While this book is provided for the counseling and therapeutic community, it is not intended for use by those who are not from the therapeutic community. This book is not intended to be used by those who are not counselors for personal diagnosis, treatment or exploration of issues. Those capacities should be left to the professional community. This is not a self-help manual.

Finally, this book should not be considered as an endorsement of any technique, counseling style or therapeutic method. The therapist is solely responsible for their actions and any advice, direction, suggestions, or techniques described in this book are offered only as suggestions which must be interpreted in the therapeutic environment by the therapist themselves.

Robert Tippie, M.Div.
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DEFENSE MECHANISMS AND

PERSONALITY TYPES

Defence Mechanisms

$\mathbf{S}$INCE both anxiety and depression bring about discomfort, clients often resort to internal "techniques" to deal with the stressors. These techniques are called "defense mechanisms." They are mechanisms by which people attempt to protect their emotional state from the stressing events – whether those events are internal or external (or both).

There are a number of healthy defense mechanisms that people use. Those mechanisms either confront the stressor so that the stressor can be eliminated, or they help an individual effectively cope with a stressor that cannot be eliminated.

While there are a number of healthy defense mechanisms, there are also many maladaptive methods that people use to cope with internal and external stressors. The maladaptive defense mechanisms never aid in the resolution of the whole stressing event. Instead, they each result in the reinterpretation or dismissal of the stressor so that the actual stressor is not addressed properly. Often, this results in the perpetuation of the stressor and even in the creation of new stressors that would not

have come about if more mature methods had been used to resolve the original stressing event.

Defense mechanisms are classified in seven distinct categories. Those categories will be referred to as "Levels" throughout this document.[1] This textbook will deal with defense mechanisms extensively. Each defense mechanism will be described fully. Furthermore, summary treatment techniques will be suggested for all maladaptive defense mechanisms.

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[1] The defense mechanisms discussed in this textbook have been taken from the DSM-IV-TR (see pages 808-813). This book's textual descriptions of the defense mechanisms are either quotations or adaptations of the DSM-IV descriptions. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000.

Defense Mechanisms: An Introduction

The first Level of defense mechanisms includes eight healthy responses to internal and external stressing events. That Level is the only Level that contains appropriate and effective defense mechanisms. The remaining six Levels contain defense mechanisms that are both unhealthy and ultimately ineffective in dealing with stressors. Furthermore, the remaining six Levels are a continuum of sorts. The defense mechanisms in Level 7 are the most significantly dysfunctional while those in Level 2 are only moderately dysfunctional. As the individual moves more toward use of defense mechanisms in Level 7, they proceed toward failure of reality testing and they are in danger of persistent psychosis.

There are a number of factors that determine which defense mechanisms will be employed by an individual. There is an amount of predisposition among some people to use defense mechanisms that are inappropriate for dealing with stressing events. Although there may be some predisposition to use maladaptive defenses mechanisms by some people, everyone is

capable of using maladaptive defense mechanisms. No one is exempt from using them.

The defense mechanisms that a person will choose in response to stressing events will be determined by a complex correlation between the severity of the stressing event, the amount of threat that the individual perceives from the event, and the built-in personality style that the person already has.

Sudden and catastrophic events can cause the strongest of personalities to resort to using inappropriate and maladaptive defense mechanisms. On the other hand, weaker personality styles may routinely use maladaptive defense mechanisms simply because of the weaknesses in the personality style.

Use of inappropriate and maladaptive defense mechanisms over a prolonged period will accentuate the negative emotional state of the individual. In all likelihood, the individual who is experiencing a prolonged stressful event while using maladaptive defense mechanisms will begin to "choose" additional maladaptive defense mechanisms that move toward Level 7.

In other words, once a person begins to use maladaptive defense mechanisms and a stressing event continues, they will choose to use techniques that move them away from proper reality testing. Since these maladaptive techniques are not either resolving the stressor itself or relieving the internal negative emotional state associated with the stressor, the individual will move toward defense mechanisms that alter reality.

For example, an individual who loses a spouse to death may engage in *denial* of the fact that the spouse is dead. *Denial* is a Level 4 defense mechanism and involves image distortion. *Denial* is not a healthy response to the external stressor because it does not allow the individual to face the real and certain fact of the spouse's death.

In healthy individuals, *denial* will only be a transient defense mechanism used for a very short period. The healthy individual will move back up the continuum of defense mechanisms toward internal affective resolution of the death of their spouse.

The unhealthy individual, however, may progress in the opposite direction. Rather than moving toward resolution of the

stressing event, the individual may continue in their *denial*. They may drift in a direction that causes a failure in reality testing to the point where they may not only *deny* that their spouse has died, but that their spouse is still alive. They may begin to "see" their spouse and interact with the image that is not part of factual reality. This would be a drift into *psychotic denial*.

It is imperative, therefore, for individuals to use appropriate and healthy defense mechanisms when encountering internal and external stressing events. Prolonged negative emotional states (primarily centered on significant anxiety and/or depressive symptoms)[2] increases the potential that an individual will drift toward inappropriate and even dangerous defense mechanisms. Teaching individuals how to use appropriate coping skills will lessen the possibility of them drifting in the wrong psycho-affective direction.

The individual who uses maladaptive defense mechanisms on a consistent basis may "learn" to use those defense mechanisms even when stressing events are not present. There are a number of maladaptive defense mechanisms that can (and do) become self-perpetuating methods of dealing with everyday life – even when a stressing event or a crisis is not present. When an individual begins to use maladaptive mechanisms in the absence of a real stressor or crisis, their condition is much more tenuous than the average person. Moreover, the occurrence of a stressor or crisis in the individual's life will only exacerbate their diminished capacity.

The potential long-term effects of an individual employing maladaptive defense mechanisms — especially in the absence of a real stressing event – compels the therapist to work effectively in training an individual to use appropriate defense mechanisms. This mandates that the counselor understands the complete hierarchy of possible defense mechanisms. It also mandates that

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[2] The impact of both anxiety and depression on the overall psychological and emotional health of the individual emphasizes the need for the therapist to administer *QuikTest* on a regular basis throughout the therapy process.

the therapist is able to "spot" the consistent use of maladaptive defense mechanisms in individual therapy situations.

Level #1 Defense Mechanisms

Summary Information for this Defense Mechanism Level

ADAPTIVE LEVEL

High Adaptive Level

DESCRIPTION OF ADAPTIVE LEVEL

This level of defense functioning results in optimal adaptation to environmental stressors. These defenses usually maximize gratification and allow the conscious awareness of feelings, ideas, and their consequences. They also promote an optimum balance among conflicting motives and resolutions of stressors.

DEFENSE MECHANISMS AT THIS LEVEL

Level #1, Mechanism #1: ANTICIPATION

SUMMARY DESCRIPTION OF MECHANISM
- Experiences emotional reactions in advance
- Anticipates consequences
- Considers realistic alternatives

NARRATIVE DESCRIPTION OF MECHANISM
The client is able to experience emotional reactions in advance of possible future stressing events. The client is able to *anticipate* the consequences of possible future stressing events and to consider realistic, alternative responses or solutions.

RESOLUTION OF ANTICIPATION
Defense Mechanism of Optimal Adaptation – No resolution needed.

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Level #1, Mechanism #2: AFFILIATION

SUMMARY DESCRIPTION OF MECHANISM
- Able to turn to others for help and support
- Able to share problems without making someone else responsible

NARRATIVE DESCRIPTION OF MECHANISM
The client is able to turn to others for help or support during an internal or external stressing event. The client is able to openly share problems with others and does not attempt to make others responsible for their internal or external stressing events.

RESOLUTION OF AFFILIATION
Defense Mechanism of Optimal Adaptation – No resolution needed.

☐

Level #1, Mechanism #3: *ALTRUISM*

SUMMARY DESCRIPTION OF MECHANISM
- Dedication to meeting the needs of others even when faced with a stressing event

NARRATIVE DESCRIPTION OF MECHANISM
The client shows a dedication to meeting the needs of others even while they are experiencing an internal or external stressing event of their own. The client is able to receive and accept gratification from others.

RESOLUTION OF ALTRUISM
Defense Mechanism of Optimal Adaptation – No resolution needed.

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Level #1, Mechanism #4: *HUMOR*

SUMMARY DESCRIPTION OF MECHANISM
- Emphasizes the amusing and ironic aspects of current stressing events

NARRATIVE DESCRIPTION OF MECHANISM
The client is able to emphasize the amusing or ironic aspects of their current internal or external stressors in spite of the fact that they are currently experiencing the stressing event.

RESOLUTION OF HUMOR
Defense Mechanism of Optimal Adaptation – No resolution needed.

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Level #1, Mechanism #5: SELF-ASSERTION

SUMMARY DESCRIPTION OF MECHANISM
- Non-coercive and non-manipulative expression of feelings and thoughts

NARRATIVE DESCRIPTION OF MECHANISM
The client is able to express their feelings and thoughts directly in a way that is not coercive or manipulative to others.

RESOLUTION OF SELF-ASSERTION
Defense Mechanism of Optimal Adaptation – No resolution needed.

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Level #1, Mechanism #6: SELF-OBSERVATION

SUMMARY DESCRIPTION OF MECHANISM
- Able to reflect on personal thoughts, feelings, motivations, and behavior
- Able to respond appropriately

NARRATIVE DESCRIPTION OF MECHANISM
The client is able to personally reflect on their own thoughts, feelings, motivations, and behavior. They are able to respond appropriately to their *self-observations*.

RESOLUTION OF SELF-OBSERVATION
Defense Mechanism of Optimal Adaptation – No resolution needed.

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Level #1, Mechanism #7: SUBLIMATION

SUMMARY DESCRIPTION OF MECHANISM
- Channels potentially maladaptive feelings into socially acceptable behavior
- Channels potentially maladaptive impulses into socially acceptable behavior

NARRATIVE DESCRIPTION OF MECHANISM
The client is able to channel potentially maladaptive feelings or impulses into more socially acceptable behavior. For example, aggression may be channeled into physical sports activities rather than inappropriate physical manifestations (such as punching things, throwing things, etc).

RESOLUTION OF SUBLIMATION
Defense Mechanism of Optimal Adaptation – No resolution needed.

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Level #1, Mechanism #8: SUPPRESSION

SUMMARY DESCRIPTION OF MECHANISM
- Able to intentionally avoid thinking about disturbing problems, wishes, feelings or experiences

NARRATIVE DESCRIPTION OF MECHANISM
The client is able to intentionally avoid thinking about disturbing problems, wishes, feelings or experiences. Therefore, they maintain control over the conscious manifestation of these problems, wishes, feelings, or experiences.

RESOLUTION OF SUPPRESSION
Defense Mechanism of Optimal Adaptation – No resolution needed.

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Level #2 Defense Mechanisms

Summary Information for this Defense Mechanism Level

ADAPTIVE LEVEL

Mental Inhibitions Level (formation of a compromise)

DESCRIPTION OF ADAPTIVE LEVEL

Defense functioning at this level keeps potentially threatening ideas, feelings, memories, wishes, or fears out of awareness. All of these defense mechanisms will inhibit the therapeutic process somewhat. The general effect of these defense mechanisms results in avoidance of stressors. These defense mechanisms may also inhibit the proper and complete recognition of stressors. They obstruct the therapeutic process by inhibiting mental processes and diminishing the ability of the client to focus directly on the stressing event.

DEFENSE MECHANISMS AT THIS LEVEL

Level #2, Mechanism #1: DISPLACEMENT

SUMMARY DESCRIPTION OF MECHANISM
- Transfer of feelings from an appropriate object, person, or incident to a less threatening object, person or incident
- Transfer of responses from an appropriate object, person, or incident to a less threatening object, person or incident

NARRATIVE DESCRIPTION OF MECHANISM
The client transfers a feeling about, or response to, an object, person or incident onto another less threatening substitute. For example, a husband *displaces* his anger for his wife on the dog by yelling at the dog when he is actually angry with this wife.

RESOLUTION OF DISPLACEMENT
Use of defense mechanisms at this level of adaptation involves mental inhibitions on the part of the client. For some reason, the client has chosen to *displace* their feelings or responses to a substitute object. The therapist should consider the following questions.

Is the client *displacing* feelings or responses due to:

- …a real or perceived threat to the client?
- …emotional inability of the client to deal with the object, person, or incident?
- …lack of desire to deal with the object, person, or incident?
- …a significant personality disorder that prohibits them from dealing with the object, person, or incident?
- …personal irresolution regarding the object, person, or incident?
- …global avoidance of issues on the part of the client?

Answers to these questions (and others) may help the therapist determine the exact reason that the person is *displacing* their feelings or responses.

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Level #2, Mechanism #2: DISSOCIATION

SUMMARY DESCRIPTION OF MECHANISM
- Breakdown in usually integrated functions of consciousness, memory, perception of self or the environment
- Possible involvement of sensory and/or motor behaviors

NARRATIVE DESCRIPTION OF MECHANISM
The client experiences a breakdown in the integrated functions of consciousness, memory, and perception of themselves or their environment. This may include a breakdown of sensory/motor behaviors. A simple example would be the client who is suffering extreme anxiety that is obviously *associated* with a specific behavior that the individual is engaged in. The client, however, is no longer able to *associate* the anxiety with the behavior. Thus, the client has *dissociated* the anxiety from the obvious stressing event (i.e. the behavior).

RESOLUTION OF DISSOCIATION
Dissociation inhibits therapeutic progress since it does not allow the therapist and the client to associate conscious feelings, cognitive issues, memory, issues related to self, and the surrounding environment into a cohesive whole. *Dissociation* may result in some or all of these areas being compartmentalized to the place where conscious emotional states cannot be associated with environmental issues causing those emotional states.

   The therapist should carefully examine the event, situation or relationship that is related to the *Dissociation*. The cause of the

Dissociation must be resolved and should be considered a significant inhibitor to counseling success.

Until the therapist can bring the client to the place where they are associating all areas of their being together and focusing all of those areas on the stressor, it is not possible to deal with the stressor to any effective degree.

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Level #2, Mechanism #3: INTELLECTUALIZATION

SUMMARY DESCRIPTION OF MECHANISM
- Excessive use of abstract thinking or intellectual reasoning to minimize emotional discomfort

NARRATIVE DESCRIPTION OF MECHANISM
The client uses excessive abstract thinking, intellectual reasoning, or generalizations to control or minimize the emotional discomfort associated with an internal or external stressor. This is an effort on the part of the client to "shut of" the emotions associated with the stressor.

RESOLUTION OF INTELLECTUALIZATION
A client will *intellectualize* their emotions when they fear coming in contact with those emotions. Two groups of emotions can be *intellectualized* for two separate reasons.

- *Intellectualization* of softer emotions. A client will *intellectualize* these emotions if they feel that these emotions make them overly vulnerable or if they believe that these emotions indicate character weakness.
- *Intellectualization* of hostile emotions. A client will *intellectualize* anger and other hostilities if they believe that engaging in those emotions may result in a loss of impulse control. Sometimes abusive individuals will refrain from hostile emotions since they know that they will act out physically if they allow themselves to feel hostile emotions. In cases of abuse, however, the

> *Intellectualization* only lasts so long and then it erupts into physical actions.

The therapist needs to determine the motivating factor behind the *Intellectualization* of emotions. The therapist must help the client experience their emotions properly, in context and under appropriate control. The therapist should only engage the client's emotions when the therapist feels that the client is ready and able to confront their emotions.

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Level #2, Mechanism #4: ISOLATION OF AFFECT

SUMMARY DESCRIPTION OF MECHANISM
- Separation of ideas from feelings originally associated with them
- Once the separation is made, only cognitive elements remain

NARRATIVE DESCRIPTION OF MECHANISM
The client successfully separates ideas and cognitive thoughts from the emotions that were originally associated with them. *Isolation of Affect* differs from *Intellectualization* because with this defense mechanism there remains no conscious recognition of the emotion associated with the stressor. Only the cognitive elements remain in consciousness. This results in an individual "stuffing" their emotions.

RESOLUTION OF ISOLATION OF AFFECT
The therapist needs to assess the stressing event and its relative severity. If, in fact, the stressor is extreme, then the therapist might understand why the client has successfully excluded the emotion from conscious recognition. In some cases of trauma this is certainly understandable.

   If there is not an extremely traumatic event, however, and the client has *isolated an affective state*, then the therapist needs to deal with the stressor to determine why the stressor has had such

an impact on the individual. There can be a number of reasons. Among them are:

- Significant *Personality Disorder*
- Association of the "lesser" current stressor to a more significant previous trauma (common in cases of *Posttraumatic Stress Disorder*)
- Other complicating factors associated with the current stressor that have not been made apparent (sometimes abused individuals will have an *Isolation of Affect* for what might appear to be a rather insignificant stressor due to other "hidden" factors that they have not yet disclosed).
- Significant *Axis I Disorder* or *Disorders*

Without expression of appropriate emotion, therapy cannot logically proceed to a healthy resolution of all client issues. "Stuffing" of emotions will eventually result in other significant issues including manifestation of somatic complaints and *Axis I Disorders*.

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Level #2, Mechanism #5: REACTION FORMATION

SUMMARY DESCRIPTION OF MECHANISM
- Substitution of actual behaviors and thoughts with those that are not from the client's reality

NARRATIVE DESCRIPTION OF MECHANISM
The client substitutes their "real" behaviors, thoughts, or feelings with behaviors, thoughts, or feelings that are not really theirs. This is usually done out of the fear of losing social acceptability. For example, someone with internal homosexual desires and urges openly espouses hatred toward homosexuality.

RESOLUTION OF REACTION FORMATION
Examples will serve best to explain *Reaction Formation*:

- A person who is addicted to pornography strongly condemns those who use pornography
- A man who knows that he has very strong homosexual desires marries a female

One of the driving forces behind *Reaction Formation* is guilt. The guilt is usually associated with a perceived moral inadequacy. The perception of moral inadequacy may be imposed upon the individual by cultural or social associations. If the client admits to the perceived moral inadequacy, then they fear the condemnation that they believe will come to them. Thus, they *formulate* a pattern of thinking and behaving that is a *reaction* to this perceived moral inadequacy. The purpose is to prevent public or interpersonal shame for their "real" moral position.

The pastoral setting is probably the most appropriate place to deal with *Reaction Formation*, provided that the pastoral counselor can encounter the perceived moral dilemma from a perceived "neutral" moral position. If the pastoral counselor cannot do so, then the possibility of dismantling the *Reaction Formation* is greatly diminished.

Furthermore, many defense mechanisms are very easy to identify. *Reaction Formation*, however, is one of the hardest defense mechanisms to uncover. Its very existence is designed to cover up the reality of the client.

Freud was the first to identify this defense mechanism. He used the term "overboarding" in relation to this defense mechanism. What did he mean by that? Many times, an individual who uses *Reaction Formation* will go way overboard when reacting to the behavior or thought pattern that they actually espouse in "reality."

For example, when the issue of marital faithfulness arises in counseling, it might be an indicator to the therapist that an individual has had an affair (or is currently involved in an affair) if they go "overboard" in their condemnation of marital unfaithfulness. If a client responds with something like, "I hate

people who have affairs; They should be shot!" then it might be worth exploring the possibility that the individual has had or is having an affair. This may or may not be an episode of "overboarding" and an indication of a *Reaction Formation*.

When the pastoral therapist encounters an individual using *Reaction Formation*, they should gently and carefully explore the moral issues associated with the use of the defense mechanism. In almost all cases, *Reaction Formation* is associated in some way with moral or ethical issues that present a significant conflict to the individual.

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Level #2, Mechanism #6: REPRESSION

SUMMARY DESCRIPTION OF MECHANISM
- Expelling of disturbing wishes, thoughts, behaviors or experiences from consciousness
- Emotional states may remain

NARRATIVE DESCRIPTION OF MECHANISM
The client consciously learns to block out disturbing wishes, thoughts, behaviors, or experiences from the conscious mind. Emotions may remain although the cognitive aspects have been *repressed*. It is important to understand that this is a learned process and presents a difficulty in the effort to discover the real source of negative emotional issues.

RESOLUTION OF REPRESSION
Sometimes *Repression* is very hard to locate. There is a significant indication that a person is using *Repression* when the therapist locates strong emotions for which there is no connection to a stressing event. In some cases, this may indicate that the individual has *repressed* the disturbing elements of their environment that have brought about the emotions.

The first task of the therapist is to determine the underlying behaviors that are being *repressed*. This will likely present a significant problem for the therapist since there is a significant

aversion to the *repressed* behavior. It may take some time for the therapist to discover the specific aversion. The therapist must remember that at this Level of defensive regulation the individual is engaging in a mental inhibition.

The therapist is warned that the individual has likely blocked out some disturbing wishes, thoughts, behaviors, or experiences that are especially traumatic to them. While the therapist may not see the "event" that is blocked as significantly traumatic, the individual has deemed it as so.

There is a possibility that the "event" that has been blocked may have additional associations with other traumatic events. Those traumatic events may include elements from the individual's childhood experiences that were exceptionally traumatic to the individual. Thus, the surface "event" that the individual has blocked may be associated with additional and more profound trauma. Discovering the basis of *Repression* may result in the unraveling of a ball of yarn.

The therapist should be cognizant of the possibility of *Axis I Disorders* surfacing, full *Personality Disorder* developing, and psychotic symptomology in the case of significant decompensation.

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Level #2, Mechanism #7: UNDOING

SUMMARY DESCRIPTION OF MECHANISM
- Words or behaviors that are designed to negate or make amends for unacceptable thoughts, feelings, or actions

NARRATIVE DESCRIPTION OF MECHANISM
The client uses words or behaviors to negate or make amends for unacceptable thoughts, feelings, or actions. These words or behaviors are often used to "fix" perceived wrongs that the client has committed.

RESOLUTION OF UNDOING

It should be obvious to the therapist that guilt is one of the most significant motivators in the use of *Undoing*. However, there are two additional components associated with this maladaptive defense mechanism.

The use of this maladaptive defense mechanism indicates some mental inhibition that does not "allow" the person to 1) change the behavior that results in the need for *Undoing*; and, 2) directly confront the behavior that needs to be *undone* with a confession of wrongdoing. This maladaptive defense mechanism is self-perpetuating in the sense that the *Undoing* behavior "fixes" whatever the individual believes they have done wrong.

The use of this maladaptive defense mechanism will inhibit the progression of therapy somewhat since the client is essentially justifying their behavior with perceived reparations. Thus, as long as they are willing to continue "paying for" what they do, they can justify continuing the inappropriate behavior.

The first course of assessment when the therapist realizes that the client is using *Undoing* behavior is to assess the action that the client believes needs *Undoing*. That behavior needs to be investigated to determine the guilt factor associated with the behavior that needs to be *undone*.

If the client has validly assessed that the behavior is maladaptive, then the therapist must aid the client in stopping the behavior, rather than continually "fixing" the behavior with *Undoing*. On the other hand, if the client has wrongly assessed the behavior as a "bad" behavior, the therapist should adjust the client's understanding of the behavior.

The final aspect to resolving this maladaptive defense mechanism is to instruct the client regarding its use. The therapist should explain the maladaptive nature of the mechanism and teach the individual how to use more appropriate means of dealing with stressing events.

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Level #3 Defense Mechanisms

Summary Information for this Defense Mechanism Level

ADAPTIVE LEVEL

Minor Image-Distorting Level

DESCRIPTION OF ADAPTIVE LEVEL

This Level is characterized by distortions in the image of oneself, their body, or other people that may be employed to regulate the client's self-esteem. At this Level, the client is dangerously close to a break from proper reality testing. While they may still have substantial reality processing abilities, their maladaptive defense mechanisms involve significant distortions and/or exaggerations of objective reality.

DEFENSE MECHANISMS AT THIS LEVEL

Level #3, Mechanism #1: DEVALUATION

SUMMARY DESCRIPTION OF MECHANISM
- Attribution of grossly exaggerated negative qualities to self or others

NARRATIVE DESCRIPTION OF MECHANISM
The client attributes exaggerated negative qualities to themselves or to other people. This individual is grossly condemning to themselves and/or to others. Their negativity is obviously beyond reality.

RESOLUTION OF DEVALUATION
The therapist can easily identify this maladaptive defense mechanism. This maladaptive defense mechanism involves some minor image distortion on the part of the client. That image distortion, however, is far from failure of reality testing.

   This defense mechanism is likely an effort on the part of the client to regulate or influence self-esteem. There is some need for this person to *devalue* themselves or to *devalue* others. Usually, this action is done for the same reason, although that might not initially appear to be the case.

   The *Devaluation* of self is an attempt to gain the acceptance and approval of others. The *Devaluation* of others is usually because the individual feels inferior to others. Rather than "bringing themselves down" they bring others down to where they perceive that they are.

   The therapist should determine what self-esteem issues are driving the individual to *devalue* themselves. The therapist should also be aware that the individual could decompensate into a more maladaptive defensive state if they begin to use the mechanism of *Splitting*. When a person uses *Splitting*, they perceive something or someone as all good or all bad.

A good homework assignment would be for the individual to list both the good and bad qualities of anyone or anything that they seem to *devalue*.

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Level #3, Mechanism #2: IDEALIZATION

SUMMARY DESCRIPTION OF MECHANISM
- Attribution of grossly exaggerated positive qualities to others

NARRATIVE DESCRIPTION OF MECHANISM
The client attributes exaggerated positive qualities to other people. This individual grossly *idealizes* at least one other person. Their *Idealization* of another person is obviously beyond reality. It is not unusual for the focus of the *Idealization* to be on a religious or political figure.

RESOLUTION OF IDEALIZATION
The therapist will recognize this maladaptive defense mechanism rather quickly. The client will consistently speak very highly of another person (or other people). The praises given to the subject of *Idealization* will seem a bit unrealistic to the therapist.

The therapist should be aware that this person may switch from *Idealization* to *Devaluation*. If the therapist notes that switch then there is a possibility that the client is *Splitting*, rather than *idealizing*.

A few personality types might be associated with *Idealization*. They include the *Histrionic Personality Type*, the *Borderline Personality Type*, and, to a lesser degree, the *Dependant Personality Type*.

Idealization is usually a defense mechanism that prevents a person from fairly assessing the traits of another person. The reason that a client "needs" to *idealize* another person is probably associated with their fear of abandonment. Thus, if they fairly assess the other person, there is a fear of seeing the other person's negative aspects, which arouses the fear of separation.

The therapist needs to explore the deeper issues associated with this maladaptive defense mechanism. It is important to assess the personality structure. It is also important to determine if the client is simply using *Idealization*, a combination of *Idealization* and *Devaluation*, or if they are actually *Splitting*.

Minimally, self-esteem issues will be paramount in any counseling efforts associated with this maladaptive defense mechanism.

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Level #3, Mechanism #3: OMNIPOTENCE

SUMMARY DESCRIPTION OF MECHANISM
- Projection of the image that one possesses special powers or abilities
- Projection of the image of that one is superior to others

NARRATIVE DESCRIPTION OF MECHANISM
The client behaves or speaks in such a manner that they project the image to others that they possess special powers or special abilities. There is a distinct projection that they are in some way superior to others. It is not uncommon for this mechanism to be attached to religious beliefs and practices as a methodology for justification. Such religious attachment exacerbates the use of *Omnipotence*.

RESOLUTION OF OMNIPOTENCE
This maladaptive defense mechanism involves the distortion of one's own image in front of others. When this defense mechanism is used, it indicates potential self-image and self-esteem issues. The individual is very likely "externally-focused" and probably doesn't have much security in themselves internally. Thus, they must paint a "bigger-than-life" picture of themselves to the important people in their life.

The client, however, does not realize that those who view this self-portrait don't usually accept the veracity of the picture. The

very thing that the individual is trying to preserve (i.e. a good self-image) is eroded by the use of *Omnipotence*.

Therapy should focus on the client's self image and self worth.

There are a number of personality types that might favor *Omnipotence*. The most obvious of those types is the *Narcissistic Personality Type*. The *Antisocial Personality Type* might use this defense mechanism, if necessary. In some cases, both the *Schizotypal* and the *Paranoid Personality Types* might use *Omnipotence*. Those two personality types, however, will only be able to use *Omnipotence* if they are at the higher level of functioning in their personality types.

Finally, a closing comment is in order regarding *Omnipotence* and its use to manipulate and control individuals in a group setting. This note is of significance especially to pastors.

Some individuals who are given positions of visibility will use *Omnipotence* as a "tool" to build and maintain a group. Those individuals will usually have either a *Narcissistic Personality Type* or an *Antisocial Personality Type*. The pastor must be aware that *Omnipotence* is a dangerous tool in the hands of a person who is in charge of a group. With a self-centered focus, the individual could do significant damage to the balance of power in any organization. Weak individuals are often attracted to this defense mechanism when it is used in a group situation.

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Level #4 Defense Mechanisms

Summary Information for this Defense Mechanism Level

ADAPTIVE LEVEL

Disavowal Level

DESCRIPTION OF ADAPTIVE LEVEL

This Level is characterized by keeping unpleasant or unacceptable stressors, impulses, ideas, emotions, or responsibility out of awareness with or without a misattribution of these to external causes. Maladaptive defense mechanisms at this Level are a marked progression beyond those of Level #3. In Level #3, the client slightly *distorted reality* as their primary means of dealing with stressors. In Level #4, however, the client has moved to *dismissing negative aspects* of reality.

DEFENSE MECHANISMS AT THIS LEVEL

Level #4, Mechanism #1: DENIAL

SUMMARY DESCRIPTION OF MECHANISM
- Refusing to acknowledge some painful aspect of external reality or subjective experience that is apparent to others.

NARRATIVE DESCRIPTION OF MECHANISM
The client refuses to acknowledge some painful aspect of external relative or subjective experience that is apparent to others. An example is the man whose wife has died. Rather than deal with the reality of her death, he refuses to acknowledge it and continually states that his wife cannot be dead.

RESOLUTION OF DENIAL
Denial is a real potential in cases of a sudden and extreme stressor. For example, it is common for an individual to suffer from *Denial* when their spouse or child suddenly dies. If this is the case, and the therapist is fairly confident that the individual is relatively healthy emotionally, then the therapist should be able to move the client past *Denial* rather quickly. *Denial* will probably just be a passing state – a temporary "buffer" – that might only last a very short period of time.

However, there is a possibility that the therapist will note that the client uses *Denial* as more of a regular pattern of coping. In this case, the therapist is dealing with an individual who is much less healthy emotionally. The client is using *Denial* as the means of dealing (or not dealing) with reality. Thus, if the client cannot face a certain stressor, they *deny* that the event has occurred.

The therapist should carefully move the client toward acceptance of objective reality. The therapist will find that the client is not willing to deal with the emotional states created by the stressors. That is the core reason that the client is using *Denial*.

There is a possibility that the stressors that the client is experiencing are "connected" in some way to more significant

events in the client's past. These may have been childhood issues, but they may also be other traumas that the present stressor reminds the client of. Clients who have experienced *Posttraumatic Stress Disorder* may choose *Denial* as a maladaptive defense mechanism.

Therefore, the therapist may have to deal with all of those events in order to bring the client back to processing objective reality correctly. The therapist must be aware that *Psychotic Denial* is a remote possibility as well as *Apathetic Withdrawal*. These would likely occur during the decompensation of *Denial*.

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Level #4, Mechanism #2: PROJECTION

SUMMARY DESCRIPTION OF MECHANISM
- Falsely attributing to another person unacceptable feelings, impulses, or thoughts

NARRATIVE DESCRIPTION OF MECHANISM
The client falsely attributes their own unacceptable feelings, impulses, or thoughts onto another person without justification. This is sometimes a guilt-based reaction regarding their own perceived negative aspects. Rather than deal with those aspects in themselves, they *project* them onto someone for purposes of judgment. There may also be elements of anger associated with *Projection*.

RESOLUTION OF PROJECTION
This maladaptive defense mechanism is primarily associated with some moral, ethical, cultural, or social conflict in which the individual is engaged. It is associated with the belief that if an individual were to reveal their true conflict, they would be judged in some negative way. The feeling of judgment may or may not be realistic. And the judgment itself – should it be pending – may or may not be "just" judgment.

A "classic" example of *Projection* follows. John has an internal conflict regarding his sexual orientation. He has never

expressed that conflict to anyone – even to his own wife. Since John was raised in an environment where homosexuality was unacceptable, he *projects* his inner conflict regarding his own desires onto another person. He consistently tells others that he believes Bill (an associate of his) is a homosexual.

This maladaptive defense mechanism may be a means for the individual to "test" their closest interpersonal associates to determine the true feelings that their associates have about the client's conflict. Rather than being able to directly confront the issue, the client is waiting to see what their associates say about the conflicting issue.

If John's friends and associates react favorably, he may reveal the inner conflict that he has been experiencing. If not, however, he will likely be stuck in the loop of *Projection*.

However, John may be so convinced that his inner conflict is in fact "wrong" that he is not "testing" his associates at all. He is acting in a manner that can be construed as an indirect form of self-condemnation. Judging others for the conflict that he cannot resolve or face is more acceptable to him than dealing with his own inner conflict. For John, there appears to be no resolution to his conflict. This prospect exerts a significant amount of guilt on the individual.

The incidence of *Projection* and its resolution is "perfect" for the pastoral setting. As already stated, *Projection* often relates to some moral, ethical, cultural, or social conflict. All of those issues are pastoral in nature. The therapist should carefully explore the moral, ethical, cultural, or social issues that are causing a person to use *Projection*.

Although the client may have significant moral, ethical, cultural or social conflict that does cross acceptable moral "lines," the pastoral therapist must be careful not to relate to the client in a condemning manner. This is the most difficult aspect of a pastor dealing with *Projection*. The pastor will likely feel a need to immediately deal with the outward and unacceptable moral issue. That is a mistake and will probably result in premature termination of the counseling relationship.

The skilled pastor will investigate the entire life of the client looking for the root of the problem. The current conflict is only

an indicator that something in the client's life instilled this conflict long ago. Without resolution of that primary incident, the client will never be able to resolve the nearly constant guilt that they experience. While the moral issue may need to be addressed at some time, the process of information collection is much more important for the lasting health and recovery of the client.

Sometimes *Projection* is hard to locate. The therapist may have some indication that the client is using *Projection* if the client engages in "overboarding." Overboarding is indicated when a client very strongly condemns a specific moral, ethical, cultural or social issue. This may be a doorway for exploration of *Projection*.

When a client reacts with strong emotion regarding any issue, the therapist may have located *Projection*. The issue should not be overtly discussed but the therapist should begin an exploration process.

The therapist will find that getting a client to ultimately confess and admit to their *Projection* is very difficult. The more aversion there is on the part of the client to the conflict, the more the client will protect themselves from revealing their inner conflict. A client who is nearing the confession stage associated with *Projection* may begin to "drop" hints to the therapist. At that point, the therapist should move ahead slowly to get the client to say what they need to say.

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Level #4, Mechanism #3: RATIONALIZATION

SUMMARY DESCRIPTION OF MECHANISM
- Concealment of the true motivations for thoughts, actions, or feelings through incorrect, elaborate, reassuring, and self-serving but incorrect explanations

NARRATIVE DESCRIPTION OF MECHANISM
The client uses elaborate and incorrect but reassuring, coherent, self-assuring explanations or whole narratives to conceal the true

motivations of their thoughts, actions, or emotions. Their tactics are used to avoid emotional conflict or to cope with internal or external stressors.

RESOLUTION OF RATIONALIZATION

The "classic" statement that a therapist might hear associated with *Rationalization* would be: "It will be OK." How many times has a therapist heard that statement in light of a significant outward stressor when it is apparent to the therapist that it will not be OK.

Rationalization indicates that the individual is not willing or not able to deal with the external stressor to the point that the individual is willing to dismiss the event altogether. The *rational* explanations that a person may use can be quite elaborate. They may construct a whole cohesive "logical" argumentation in order to *rationalize* away some real stressor that they are not willing to face. The issues might be relational. They might be financial. They might be health related.

A classic example might be the individual who is having chest pains. They may formulate a whole argumentation why the chest pains are no big deal. The real issue is that they are not willing to confront the emotional issues associated with a serious physical issue.

The best way for a therapist to deal with *Rationalization* is to intensively "take apart" the *rational* and cohesive argumentation of the client piece-by-piece. The client will likely not wish to engage this process. However, it is essential for the therapist to disrupt their illogical logic.

The therapist should understand that the decompensation of this maladaptive defense mechanism will likely result in the client using some other maladaptive defense mechanisms. The likelihood of *Axis I Disorders* is also elevated, especially anxiety states.

With great care, the therapist should be able to get the individual to face whatever it is that they are attempting to *rationalize* away.

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Level #5 Defense Mechanisms

Summary Information for this Defense Mechanism Level

ADAPTIVE LEVEL

Major Image-Distorting Level

DESCRIPTION OF ADAPTIVE LEVEL

This Level is characterized by gross distortion or misattribution of the image of oneself or other people. The client is employing at least some minimal tactics that can be characterized as significant distortions of reality.

DEFENSE MECHANISMS AT THIS LEVEL

Level #5, Mechanism #1: AUTISTIC FANTASY

SUMMARY DESCRIPTION OF MECHANISM
- Excessive daydreaming as a substitute for human relationships, more effective action, or problem solving

NARRATIVE DESCRIPTION OF MECHANISM
The client uses excessive daydreaming as a substitute for human relationships. They may fantasize about effectively dealing with problems or resolving stressors. This daydreaming behavior is a replacement and a substitute for actually performing in real life.

RESOLUTION OF AUTISTIC FANTASY
When a client is using *Autistic Fantasy*, the therapist may have a hard time determining that it is being used. This is evident since *Autistic Fantasy* involves daydreaming and as such is not an overt and outward behavior. The client can use this defense mechanism without anyone really knowing that they are using it.

The first cue to the therapist that the client may be using *Autistic Fantasy* is that they seem to "procrastinate" in their performance of both real life duties and homework assignments. The therapist will need to interview the individual to determine the reason for procrastination. At that point, the therapist may uncover *Autistic Fantasy* as a defense mechanism.

The use of *Autistic Fantasy* will impede the progress of therapy. It will also negatively effect the individual's life and work. The therapist should give the individual small tasks to perform, rather than larger tasks. It is likely that the individual will resort to *Autistic Fantasy* more readily when larger tasks are given.

There may very well be some emotional state that is causing the individual to "freeze" regarding progress in life and performance of tasks. The therapist should help the client encounter those emotional issues. The client may be overloaded with emotion and they may not be able to think clearly. Thus, investigation of emotional states is very important. Reduction of

negative emotional states will likely help reduce the use of *Autistic Fantasy*.

The therapist should understand that if there are significant emotional issues present, this individual could decompensate into *Apathetic Withdrawal* rather easily. *Autistic Fantasy* itself might be a decompensation of some Level #2 defense mechanisms that were designed to "ignore" emotional states.

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Level #5, Mechanism #2: PROJECTIVE IDENTIFICATION

SUMMARY DESCRIPTION OF MECHANISM
- Initial *Projection* of feelings, impulses, or thoughts onto another person (simple *Projection*)
- Eventually, those feelings, impulses or thoughts are "fulfilled" by the person upon whom they have been projected – *identification* with the *projection*

NARRATIVE DESCRIPTION OF MECHANISM
The client engages in *Projection* upon another person. Eventually, the *Projection* that was placed upon the other person is fulfilled. For example, a person says that someone hates them (when it isn't true). Eventually, because the *Projection* continues, the individual does indeed develop hatred toward the one *projecting* the hatred. They have now *identified* with the *Projection*.

RESOLUTION OF PROJECTIVE IDENTIFICATION
Projective Identification differs from simple *Projection* by matter of degree and the resulting outcome. In fact, sometimes *Projective Identification* is the result of continued *Projection*.

Projective Identification may be the end of a long road of structured internal *Denial* on the part of the client. It may have started initially with *Reaction Formation* wherein the client *reacted* outwardly in opposition to internal emotional states that the client could not face.

For example, the individual who has internal homosexual feelings that they cannot face may have started by *reacting* to their internal cues with outward *formation* of a condemning attitude toward homosexuality.

Oftentimes, when *Reaction Formation* doesn't sufficiently quell the internal conflicts of an individual, they will engage in *Projection*. They will *project* their negative conflicts on another person without justification.

When *Projective Identification* occurs, the individual on whom the *Projection* has been made will eventually become what the individual says they are.

As another example, a married client may have started the process by having internal desires for other women. Believing that an affair is immoral, the client openly and publicly denounces adultery. As the internal conflicts continue, the client openly begins to *project* an affair on his wife. He accuses her of having inappropriate relationships with others. After some time hearing this *Projection*, his wife indeed does have an affair. At this point, *Projective Identification* has occurred.

The "event" associated with *Projective Identification* may have already happened when the client enters therapy. In fact, it may be the reason that the client has entered therapy.

When a client enters therapy and a resulting crisis has already occurred, especially a relationship crisis, the therapist might suspect *Projective Identification*. This is especially true in cases where the client seems to have a general accusatory mindset.

The therapist should understand that consistent use of *Projection* can lead to *Projective Identification*. Thus, it is important to stop the use of *Projection* when it is located in therapy. Furthermore, in the case of *Projective Identification* that has already occurred, the therapist may have a difficult time determining that it has actually happened. The therapist may suspect it but may not be able to verify it.

In cases where *Projective Identification* is strongly suspected, the therapist may or may not wish to directly address the cause of the "incident" associated with the *Projection*. That will depend on the willingness of the client to listen. In cases where the therapist cannot directly address *Projective Identification*, the

therapist will need to take a longer course to prevent *Projective Identification* from happening in the future.

In any event, the therapist is dealing with a *Projection* "mindset" on the part of the client. The issue of *Projection* should be addressed.

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Level #5, Mechanism #3: SPLITTING

SUMMARY DESCRIPTION OF MECHANISM
- Compartmentalizing opposite affects
- Not able to see good and bad in something at the same time

NARRATIVE DESCRIPTION OF MECHANISM
The client is unable to integrate positive and negative qualities of self or others into a cohesive image. They compartmentalize opposite emotions. Opposite emotions cannot be experienced simultaneously. The image of self, others, and even objects tends to alternate between polar opposites. Something or someone will either be viewed as exclusively loving, powerful, worthy, nurturing and kind or bad, hateful, angry, destructive.

RESOLUTION OF SPLITTING
The first hint to the therapist that a client is engaging in *Splitting* is the presence of what appears to be either *Idealization* or *Devaluation*. In fact, *Splitting* may be a decompensation of both of those maladaptive defense mechanisms. The use of "absolutes" regarding any person, thing or event may be a significant cue to the therapist that a person is using any one of the three defense mechanisms mentioned.

The goal of the therapist is to help the individual form a more cohesive image of the "object," rather than the split image. This can be done through a complete assessment of the object of the *Splitting*. The therapist might try helping the client make a list of all good and all bad in any object.

There are potentially deeper issues associated with *Splitting*. The client may be averting the negative or positive qualities in the object. *Repression* or other maladaptive mechanisms that allow the client to push emotions out of their mind may be present.

Certain personality types may favor the use of *Splitting*. Those would include both *Borderline* and *Histrionic Personality Types*. The *Antisocial Personality Type* may also use *Splitting*.

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Level #6 Defense Mechanisms

Summary Information for this Defense Mechanism Level

ADAPTIVE LEVEL

Action Level

DESCRIPTION OF ADAPTIVE LEVEL

This Level is characterized by defensive functioning that deals with internal or external stressors by action or by withdrawal. At this point, a client's emotional state is no longer easily accessible by the therapist. The emotions associated with internal or external stressors are acted upon in such a manner that the emotions cannot be directly accessed.

DEFENSE MECHANISMS AT THIS LEVEL

Level #6, Mechanism #1: ACTING OUT

SUMMARY DESCRIPTION OF MECHANISM
- Outward physical action that is taken in response to internal reflections or feelings
- The *Acted Out* behavior is a direct response to the internal emotional cues

NARRATIVE DESCRIPTION OF MECHANISM
The client commits outward physical actions directly in response to internal reflections, feelings, or emotional states. These actions may be dangerous actions at times including attempted suicide and acts of violence toward others. They may also include actions like hiding car keys from a spouse because they are angry with the spouse.

RESOLUTION OF ACTING OUT
Acting Out is probably the result of a number of internal or external occurrences:

- The client has been using a number of Level #2 maladaptive defense mechanisms consistently for a significant period. Those might include *Displacement*, *Dissociation*, *Intellectualization*, *Isolation of Affect*, and *Repression*. Each of these defense mechanisms allows the client the "liberty" not to deal with an emotional state head-on.
- The client has now encountered a stressor (probably external) for which the Level #2 maladaptive defense mechanisms no longer function. The client is still unwilling to deal with the emotional state. Essentially, the client is in the process of decompensation.
- The therapist has not been cognizant enough regarding the client's uses of Level #2 defenses and has not been successful in the elimination of those defenses.

At this point, the client reaches a "breaking point" and the pent-up emotions must be dealt with and expressed in some way. The client, however, is not willing to deal with the internal or the external issues that have caused the emotional state in the first place. Thus, they do something physical in an effort to 1) relieve the internal conflict; and/or, 2) create a new and more acceptable emotional state (even though that emotional state is temporary and manufactured).

The act of physically *Acting Out* in response to internal emotional states gives the client some control again over their environment – even if that control is viewed by the client or by others as negative. It's still control. At the same time, there is some refocus on the physical event associated with *Acting Out*. This prevents the client from dealing with the reality of their situation and diverts their attention away from it temporarily.

The therapist should understand that when a client engages in *Acting Out*, they have reached a point of desperation. That desperation includes an internal struggle that will not let them encounter the core issues that are causing emotional discomfort. *Acting Out* is only a temporary "fix" – a temporary release of the emotion. The need to *act out* will probably resurface shortly.

The therapist must understand that this could be a very volatile and a very dangerous situation. There is a possibility that the client could further decompensate into even more significant maladaptive behaviors. There is a possibility of *Apathetic Withdrawal*. There is also a possibility of further *Acting Out*. Significant *Axis I Disorders* and psychosis are certainly not out of the question.

Acting Out may include rather mundane actions that are merely symbolic of the internal struggles. If the therapist witnesses those types of *Acting Out* episodes the therapist must realize that there is the potential for more significant *Acting Out*. In fact, the probability is very high.

Other more significant forms of *Acting Out* might range from punching things, harming pets, desertion of the family unit, destruction of property, quitting school or a job, domestic violence episodes, homicide or suicide. Sometimes the *Acting Out* behaviors can be extreme and generated very quickly.

Extreme agitation might be the first clue to a therapist that the individual has "reached a breaking point." Each *Acting Out* event must be assessed individually by the therapist. A contract with the client may be helpful to prevent further *Acting Out*, in the event that a less severe *Acting Out* event occurs.

Resolution of internalized emotions – and the cause of those emotions – is the only means by which *Acting Out* can be prevented again, once it occurs. Further degeneration of the general psychological state of the client is very likely.

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Level #6, Mechanism #2: APATHETIC WITHDRAWAL

SUMMARY DESCRIPTION OF MECHANISM
- Withdrawal from any attempts to deal with internal or external stressing events or emotional states
- The client gives up

NARRATIVE DESCRIPTION OF MECHANISM
The client withdraws from any attempts to deal with the internal or external stressing events or the emotional states associated with those stressors. The client no longer wishes to discuss the stressor nor do they desire to work toward resolution.

RESOLUTION OF APATHETIC WITHDRAWAL
This is a very serious situation for the therapist. *Apathetic Withdrawal* is different than a client simply leaving therapy and never coming back. *Apathetic Withdrawal* is the "shut down" of the desire and/or ability of the client to face the internal and/or external issues and events that are occurring.

Significant *Axis I Disorder* might ensue, including somatic issues. The potential for psychosis is increased and the likelihood of self-destruction is very high. When a client "shuts down" and will no longer deal with life's issues, there is a possibility that life itself will be too painful for them to tolerate. They no longer have a viable release for the issues that trouble them.

The therapist must give the client some small hope at this point – something that the client can hang onto during this crisis. There is a real possibility that this individual will need to be hospitalized if suicide appears to be a possibility or if psychotic symptomology is significant.

If a client cannot be recovered from this maladaptive defense mechanism quickly, the therapist should refer them to a Psychiatrist for treatment and possible medication.

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Level #6, Mechanism #3: HELP REJECTING COMPLAINING

SUMMARY DESCRIPTION OF MECHANISM
- Making repeated requests for help
- When help is offered, it is rejected

NARRATIVE DESCRIPTION OF MECHANISM
The client makes repeated requests for help. When viable help is offered, the client rejects all suggestions, advice, and/or help offered by others. Help is often viewed as deficient or inadequate.

RESOLUTION OF HELP REJECTING COMPLAINING
This Level of maladaptive defense mechanisms is characterized by either action or withdrawal in relation to the stressor. In this case, however, this mechanism is a combination of both action and withdrawal.

Certain personality types "favor" this maladaptive defense mechanism. The most significant of them is the *Antisocial Personality Type*. The therapist should understand that there may be some *Passive Aggression* involved in this type of mechanism.

The therapist should understand that this is a primary method for an individual to prematurely terminate counseling, if that is their intention. If it is truly the desire of the individual to leave therapy, there is probably nothing that the therapist can do to prevent it when this defense mechanism is used.

There are two different reasons that a person will use *Help Rejecting Complaining*.

First, a person may use this maladaptive defense mechanism as a form of "game playing." They may have been forced into therapy by a spouse or by someone else. This is their way of getting out of therapy. This individual was not serious to begin with. They may have entered therapy to pacify someone else. At the same time, the second reason may also apply to that same person.

Second, when a therapist begins to make significant headway regarding the deeper issues that a client faces, some of those issues may surface fully in the client's mind without being fully expressed in therapy. Some of those issues may frighten a client. There may be significant apprehension.

There is a possibility that the client who internally recognizes significant issues will use this maladaptive defense mechanism as a means of avoiding those issues. Since the individual does not wish to seem to be a fault, they will typically blame the therapist for their exit from therapy.

The therapist may never know which of the two reasons caused the *Help Rejecting Complaining* (or if it was a combination of both). It is very likely that the client will not return to therapy.

In the event that the therapist is able to get the individual to return, the therapist should make every effort to make a treatment contract with the individual. That contract would be an agreement that the individual would attend a specified number of sessions. It is best for the therapist to make that as low of a number as possible. The therapist who is successful at getting a client to agree to this should work as efficiently as possible during the few sessions that they have. It may be the only "shot" that they have.

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Level #6, Mechanism #4: PASSIVE AGGRESSION

SUMMARY DESCRIPTION OF MECHANISM
- Indirect and unassertive aggression toward others
- Overt and visible compliance masks covert resistance, resentment and hostility

NARRATIVE DESCRIPTION OF MECHANISM
The client engages in indirect and unassertive aggression toward at least one other person. Visible compliance masks the covert resistance, resentment, or hostility. *Passive Aggression* usually occurs in response to demands for independent actions or performance on the part of the individual engaging in its use. It may be attached to a sense of lack of gratification. *Passive Aggression* is often used by individuals who are or feel subordinate to others and feel that they have no other means of expressing assertiveness.

RESOLUTION OF PASSIVE AGGRESSION
In a way, *Passive Aggression* is a form of *Acting Out*. The client is *acting out* their emotions on their environment. *Passive Aggression*, however, is different since the action is passive and not intended to be seen by others as an active display. There are also elements of *Repression* and potentially *Displacement* involved with this maladaptive defense mechanism.

    This maladaptive defense mechanism is very difficult to locate since it is so passive. The intention of the individual is to hide the defensive action. In fact, there is a good possibility that the individual themselves may only remotely understand that they are using this maladaptive defense mechanism. The longer they use it, the more it will become an "automatic" response to internal queues.

    Probably the first indicator to the therapist that *Passive Aggression* is being used will be during discussions about interpersonal relationships that seem to "blow up." When there are consistent "blow ups" in certain significant relationships, and when the client complains about unfair treatment related to those

interpersonal "blow ups," the therapist should investigate the possibility of *Passive Aggression*.

The relationships that are most susceptible to *Passive Aggression* are relationships wherein authority is an issue (e.g. the work environment). Moreover, in those relationships the client will likely be "subject" to the authority figure. They may consistently complain that others are "out to get them" or they may say that others are never satisfied with their behavior or performance. In reality, if *Passive Aggression* is being used, the individual is "blowing up" those situations for the purpose of drawing the negative comments. The individual who uses *Passive Aggression* must always play the role of the victim.

There is an underlying need to be viewed as inferior. The individual will use *passive* techniques to be viewed as inferior by others. They will always display a subtle sense of inadequacy. This *passive* behavior "gives them permission" to harbor resentments and the anger that is undoubtedly *repressed* deep under the surface. These emotions are too dangerous or too volatile for them to openly express. In all likelihood, there is some amount of *displacement* associated with this maladaptive defense mechanism.

When a therapist locates and verifies the use of *Passive Aggression*, the therapist should realize that there are probably much deeper issues that need to be uncovered. It is unlikely that the individual is just encountering the surface environmental issues that become evident. The likelihood is that some maladaptive issue is being suppressed from their childhood that is acting as a template for their maladaptive social interaction.

The therapist must instruct the individual about their use of *Passive Aggression*. However, when this is done, there is a significant likelihood of decompensation. This is especially true if the purpose for the *Passive Aggression* is related to significant childhood issues. Those issues will need to be addressed and the client will need to resolve the childhood maladaptations prior to being able to cease the *Passive Aggression*.

Issues of self-esteem and self-assertion should be encountered and resolved.

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Level #7 Defense Mechanisms

Summary Information for this Defense Mechanism Level

ADAPTIVE LEVEL

Level of Defensive Dysregulation

DESCRIPTION OF ADAPTIVE LEVEL

This Level is characterized by failure of defensive regulation to contain the individual's reaction to stressors, leading to a pronounced break with objective reality. Use of defense mechanisms from this Level may indicate that an individual is suffering from some sustained psychotic symptomology.

DEFENSE MECHANISMS AT THIS LEVEL

Level #7,   Mechanism #1: DELUSIONAL PROJECTION

SUMMARY DESCRIPTION OF MECHANISM
- *Projection* with the added component of belief that the event or situation being *projected* is part of objective reality when in fact it is not

NARRATIVE DESCRIPTION OF MECHANISM

The client uses *Projection* with the added component of reality distortion. *Projection* places a person's own negative behaviors on another person – accusing another person of something that is not true of them but is true of the *projecting* individual. For example, an individual may *project* their own fixation for pornography onto another person while the *Projection* is not really true.

   Delusional Projection takes *Projection* into the arena of psychosis – the accuser believes and builds a case for the *Projection*. For example, John has been having an affair. He accuses Bill of having an affair (simple *Projection*). Through an unrealistic connection of "facts," John actually and truly believes that Bill is having an affair.

RESOLUTION OF DELUSIONAL PROJECTION

This Level of maladaptive defense indicates a breakdown of defensive regulation. This Level is indicative of a break with objective reality and reveals that the individual is suffering from some psychotic symptomology.

   Medical and psychiatric evaluation is required for an individual suffering from *Delusional Projection*. Medications will likely be required 1) to curb uncontrollable internal impulses and 2) to aid in the diminishing of psychotic symptomology.

   It is not reasonable for the therapist to engage in any form of "normal" therapy with this client until psychotic symptomology has been significantly reduced. The client will be unable to relate to and test reality on a consistent basis making traditional therapy a futile process.

Primary care of this individual should be conducted through Psychiatric care, which may include inpatient Psychiatric treatment. All pastoral efforts at this point should be supportive and secondary to the work of the Psychiatrist. Pastoral therapy should not resume until the Psychiatrist advises the pastor that such care is appropriate and useful.

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Level #7, Mechanism #2: PSYCHOTIC DENIAL

SUMMARY DESCRIPTION OF MECHANISM

- *Denial* with the added component of belief that the event or situation being *denied* can be verifiably proven to be false

NARRATIVE DESCRIPTION OF MECHANISM

The client uses *Denial* with the added component of reality distortion. *Denial* is an internal inability to admit that an event has occurred. *Psychotic Denial* builds a defense that "proves" to the individual themselves that the event has not occurred.

For example, a man's wife has died. He immediately engages in *Denial* as a primary defense mechanism regarding her death. Now, however, he has progressed in his *Denial*. Not only is he *denying* her death, but he now believes that he has seen her and talked with her. His "reality" now contains elements that can be verifiably proven as false.

RESOLUTION OF PSYCHOTIC DENIAL

This Level of maladaptive defense indicates a breakdown of defensive regulation. This Level is indicative of a break with objective reality and reveals that the individual is suffering from some psychotic symptomology.

Medical and psychiatric evaluation is required for an individual suffering from *Psychotic Denial*. Medications will likely be required 1) to curb uncontrollable internal impulses and 2) to aid in the diminishing of psychotic symptomology.

It is not reasonable for the therapist to engage in any form of "normal" therapy with this client until psychotic symptomology has been significantly reduced. The client will be unable to relate to and test reality on a consistent basis making traditional therapy a futile process.

Primary care of this individual should be conducted through Psychiatric care, which may include inpatient Psychiatric treatment. All pastoral efforts at this point should be supportive and secondary to the work of the Psychiatrist. Pastoral therapy should not resume until the Psychiatrist advises the pastor that such care is appropriate and useful.

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Level #7, Mechanism #3: PSYCHOTIC DISTORTION

SUMMARY DESCRIPTION OF MECHANISM
- Internal efforts to reshape the external world with hallucinations and delusions
- Creation of a new reality

NARRATIVE DESCRIPTION OF MECHANISM
The client experiences internal hallucinations (visual and/or auditory) and delusions. These elements reshape the client's view of external reality and create a new reality for the client that opposes objective reality as witnessed by others.

RESOLUTION OF PSYCHOTIC DISTORTION
This Level of maladaptive defense indicates a breakdown of defensive regulation. This Level is indicative of a break with objective reality and reveals that the individual is suffering from some psychotic symptomology.

Medical and psychiatric evaluation is required for an individual suffering from *Psychotic Distortion*. Medications will likely be required 1) to curb uncontrollable internal impulses and 2) to aid in the diminishing of psychotic symptomology.

It is not reasonable for the therapist to engage in any form of "normal" therapy with this client until psychotic symptomology

has been significantly reduced. The client will be unable to relate to and test reality on a consistent basis making traditional therapy a futile process.

Primary care of this individual should be conducted through Psychiatric care, which may include inpatient Psychiatric treatment. All pastoral efforts at this point should be supportive and secondary to the work of the Psychiatrist. Pastoral therapy should not resume until the Psychiatrist advises the pastor that such care is appropriate and useful.

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Personality Styles and Disorders

U NDERSTANDING the personality style of a client will give the therapist a considerable advantage in counseling both individuals and couples. Every person relates to their environment differently. One of the largest factors in a person's relationship to their environment is their personality structure.

Every personality has its strengths and its weaknesses. Every personality is subject to crisis under the "right" situations – situations that expose its vulnerabilities. This includes even the most resilient personalities.

Each personality style will exhibit disordered traits when the individual encounters an event that "triggers" the vulnerabilities in the personality structure. Each personality is subject to influence from triggers that are specific to the weaknesses of the personality structure itself.

The Forming of Personality

There are a number of theories regarding the formation of human personality. One thing is for sure – nearly every professional believes that the vast majority of an individual's personality is formed during childhood. Key points in childhood development instill within the growing child an "archetype" of the world that they will experience as adults. Using this archetype, the adult will interpret their world based on the collected and stored information from their childhood experience. After the childhood experience, the human personality becomes "plastic" and is not easily manipulated or altered to a significant degree. In adulthood, the personality must be "dealt with," not developed. The development is already done.

Two significant factors influence the development of personality in childhood. Those factors are the biochemistry of the child and the social environment of the home. It is impossible and even illogical to attempt to determine which of these is "more important" in the development of human personality. They usually function together in a psychic dance that no one ever sees.

BIOCHEMISTRY

Biochemical components – especially those agents that influence brain activity – play a unique role in the development of human personality. It would be absurd to assume that each person's personality was formulated solely on the basis of biochemical reactions in the brain during early childhood development. Biochemistry is more of a "predisposing factor" in personality development than a causative agent.

Two examples will help illustrate this assertion.

First, an individual with a biochemistry that predisposes them to antisocial personality traits may never develop those traits (to any significant degree) because the home environment mitigated against the development of that personality style. Another more adaptive personality structure will be the result.

Second, an individual with a biochemistry that is far removed from antisocial personality traits may grow up in a "classically-disordered" home environment that is most likely to produce an antisocial personality. In this case, there is still a possibility that the antisocial personality traits will appear. Nevertheless, due to the lack of biochemical predisposition, there is also a possibility that another (probably maladaptive) personality type will develop.

In the counseling setting, the need to determine the biochemical components that may or may not have predisposed the individual to a personality disorder don't seem to bear much weight. The damage has already been done and no biochemical understanding of infantile brain functionality will help the situation or influence the direction that the therapist takes.

Personalities that eventually degenerate into a full, diagnosable disordered state usually don't form solely because of biochemistry. The therapist will always be able to locate significant familial, social and environmental issues in the home of origin that acted as the primary mechanisms to develop the maladaptive personality.

THE MICRO-ENVIRONMENT OF THE HOME

To an infant, the home in which they live is their "whole world." And, early in the development of the child's life, the maternal figure (sometimes called the "maternal object" or simply the "object") is the first contact with the world. The influence that the "object" has on the development of the base of the child's personality cannot be overstated. This is the first consistent contact with the outside world, and, first impressions are "everything."

Interaction with the maternal figure – especially before a child is able to move about on their own and to communicate verbally – will be the primary mechanism that influences the development of the rest of the child's personality. A disruption in that relationship will usually result in significant potential for maladaptations in adulthood. As the child grows and experiences more and more of the surrounding world, their interpretation

with and reaction to that rapidly expanding world with go through the filter of their "first impressions."

That is not to say that if a mother figure performs somewhat inadequately that the child is "doomed for life" from the very beginning. There is some time in which the original impressions can be refined or adjusted. Each stage of development allows for some restructuring and testing of what was instilled in the previous stage.

This refinement and adjustment process, however, becomes increasingly unlikely to result in appropriate resolutions in cases where the maternal object was grossly deficient, neglectful, suffering from a personality disorder herself, or abusive in any way to the child. In those cases, the first impression will probably be instilled in the child as the archetype that dictates intrapersonal and interpersonal relationships into adulthood. The remainder of childhood personality development will likely be a process of verification ("see, I told you so") rather than testing and refinement.

Specific and complex patterns of social interaction in the home environment interact with biochemistry to form the personality. The development of a personality structure that can (and may) degenerate into a full personality disorder in adulthood usually has its origins in a number of maladaptive social mechanisms during childhood development. Those maladaptive social mechanisms will usually be somewhat consistent in their performance. The more consistent they are, the more likely that they will predispose the child to maladaptive incidents in adulthood – even full personality disorder given the right "triggering" events.

It is unlikely that one single social behavior on the part of the parent or parents will be significantly involved in the development of a maladaptive personality structure. There is usually a "collection" of parental behaviors – a parental behavioral pattern – that predisposes a child to maladaptation. In cases of abuse, neglect, torture, or other forms of severe parental neglect, it is unlikely that the child will develop free of a maladaptive personality structure. These instances mitigate against normalcy.

The Personality Continuum

There is no such thing as the "perfect home." When a client says that their home environment was perfect, they are either over simplifying things or cognitively blocking out elements that they cannot face.

Every home environment contains elements that were less than optimal for the development of a child. How many times have we heard parents say, "If I had it to do all over again, I would do it this way…"?

Some things are missed by parents when they raise children. Some things are over emphasized that they later realize were not really that important. Other factors come into play including cultural issues and economic factors. The relationship between two parents and their conflicting desires and parenting styles effect the development of personality. In short, there is no such thing as the "perfect home."

With that in mind, we can rest assured that each adult will have a personality structure that includes a reflection of some of those inadequacies. In essence, every single person contains the potential – given the right circumstances – of suffering from some significant maladaptive emotional or psychological malady. The disabling potential of that maladaptation will be influenced to a large degree by the degree of dysregulation in the home. However, the intensity of the triggering event cannot be overstated.

In a healthy individual who is not encountering a personal crisis, their personality style will allow them to function optimally in their environment. This optimal functioning will allow them to interact with their world with no substantial interference from personality deficiencies. They will not move toward a full diagnosable personality disorder.

When a crisis arises, every personality will be vulnerable to experiencing some type of disorder. That does not mean that the disorder will be a diagnosable personality disorder. The disorder might be an *Axis I Disorder*. Especially prevalent are both anxiety and depressive disorders. Even if the distressed individual does not experience a full personality disorder, there

is a possibility that they can demonstrate some of the maladaptive traits associated with individuals who have a full personality disorder. While a full personality disorder cannot be diagnosed in these situations, the individual may "drift" toward manifestation of some maladaptive traits that are not desirable nor are they optimal in interpersonal settings.

This *Manual* contains illustrations of the continuums for all ten *DSM-IV-TR Personality Types*. The therapist will find both optimal functioning traits and disordered traits for each of the personality types. This should act as a guide during the counseling process – especially when the therapist is attempting to determine the most appropriate means of moving a client back toward homeostasis.

This *Manual* also contains DSM-IV-TR diagnostic criteria for all ten personality disorders. The therapist should be aware of each of these personality disorders since the manifestation of a diagnosable personality disorder in the counseling setting may significantly alter treatment methods.

The therapist is reminded that the most significant factor in the technical diagnosis of a personality disorder involves three elements: 1) a pervasive pattern that meets minimum criteria, 2) consistency of that pattern over time, and, 3) onset at or about adulthood. Therefore, transient symptomology that appears to meet minimum criteria might be suspect and undiagnosable as a full personality disorder.

Effective Counseling

These issues might seem irrelevant to most individuals who will be reading this textbook. This textbook, after all, is being written to aid pastoral counselors (primarily) who counsel individuals from their congregation. Most pastors don't concern themselves with these issues. However, that is precisely the reason that this book has been written!

Some pastors will engage in some initial counseling with an individual who appears to be in a personal crisis. Many pastors

feel an obligation to counsel marriages that are in crisis. Most every pastor will counsel a couple prior to marrying them.

In every one of these situations, the issue of an individual's personality structure may play a vital role in the whole counseling process. Without an understanding of personality issues, the pastor is "blind" to some of the most significant factors that might be influencing or even causing the present crisis or a future crisis. It is not logical nor is it wise for a pastor to counsel others without taking advantage of every fact that can be accumulated. In fact, it is irresponsible. This textbook has been written to give pastors some of the tools that they have routinely ignored in the past – tools that might be essential in the performance of their expected duties as the "shepherds of the flock."

Personality Style Assessment

The *MARET Counseling Software System* contains a full *Personality Style Assessment* module. In conjunction with the information that is contained in this textbook, the pastor will gain valuable insights into the personality of every individual that they counsel.

Whenever a pastor takes on a new counseling case, he or she should use the usual battery of *MARET Assessments* that are appropriate to the counseling situation. As part of that assessment process, the pastor should routinely administer the *Personality Style Assessment*. With information from all of these assessments, the pastor will gain insights into the issues that the client has presented. This information will likely result in more effective counseling and greater (and more rapid) healing for the client.

Styles and Disorders

The following section of this textbook contains detailed information for each of the *DSM-IV-TR Personality Disorders*.

Included with that information is data that shows the style associated with the personality type.

The therapist who carefully reads this section will gain considerable insights into the functioning of human personality. Furthermore, the therapist will be able to determine appropriate means of dealing with individuals who have specific maladaptations related to their personality style.

The information contains summary techniques that can be used to develop specific interventions for clients. This will add to the efficiency of the pastoral counseling practice and enhance the confidence of pastors who wish to competently counsel.

Antisocial Personality Style and Disorder

The Antisocial Personality Type In A Nutshell

"The essential feature of *Antisocial Personality Disorder* is a pervasive pattern of, disregard for, and violation of, the rights of others."[3]

"The view of the world of individuals with ASPD is a personal rather than an interpersonal one. In social-cognitive terms, they cannot hold another's point of view at the same time as their own. As such, they cannot take on the role of another. They think in a linear fashion, anticipating the reactions of others only after responding to their own desires. Their actions are not based on choices in a social sense because of these cognitive

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[3] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000, p. 701.

limitations. Their view of self consists of a system of self-protecting appraisals and attributions."[4]

When this individual's personality becomes clinically disordered, they are often considered a "sociopath" or a "psychopath."

A CLOSER LOOK

When an individual with an *Antisocial Personality Type* moves toward the disorder side of the continuum, they will demonstrate at least six self-serving beliefs[5] about themselves and their environment. When personality disorder is evident, these six beliefs will be the driving force of the person's actions in their external environment. Those beliefs are:

- They are *always* justified in their actions and desires. "*When I want something, my actions are always justified in order to get what I want.*" This is true even at the expense or harm of someone else.
- Belief in the *absolute* validity of their own thinking. "*My thoughts and my feelings are completely accurate. This is true because they happen to me.*" There is no concept that their thoughts or feelings may be in error. In fact, they cannot be. They occur to them.
- They are *always* personally infallible. "*I always make the right choice. My choices are never wrong because I make them.*"
- Their feelings *create* their reality. "*I know I'm right because I feel that I'm right.*"
- The *absolute* irrelevance of other people. "*Other people are irrelevant to my own decisions unless they have some control in the consequences. Then, they must also be controlled.*"

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[4] Beck, A (Ed.). *Cognitive Therapy of Personality Disorders* (Second Edition). Guilford Press, New York, New York: 2004. p. 167.

[5] These six self-serving beliefs are found in Beck, A (Ed.). *Cognitive Therapy of Personality Disorders* p. 175.

- *Ignoring* possible negative consequences. "*Because I have made a decision, undesirable consequences will not occur. If they do, they will not matter*." Since this person has made a decision, that means that the consequences of that decision will be good. This is evident since this person is unable to believe that they can be fallible.

There are four significant patterns that can manifest in an individual who has an *Antisocial Personality Disorder.*

- Disruptions in cognition. The common denominator in the cognitive disruption of this individual involves pragmatic strategies for self-advancement in social situations. The cognitive disruption focuses on the individual's need to avoid or control others in all social situations.
- Disruptions in the affective state. The affective state of the individual with *Antisocial Personality Disorder* is self-focused. They would prefer to avoid emotional interaction with others choosing to be reclusive and disengaged. However, when in a "threatening" situation wherein they fear loss of control, they will usually resort to hostile emotions to attempt to gain control over an individual or a situation. They become masters at controlling others through emotional manipulation.
- Disruptions in interpersonal functioning. The interpersonal functions of an individual with *Antisocial Personality Disorder* are focused on their need to control and manipulate their environment for their own benefit. They may exhibit different sets of interpersonal skills depending on the situation and the need. Therefore, the antisocial individual may function at work with an apparently high degree of interpersonal functioning to "protect" their own interests on the job. At home, however, they may be more aggressive with their spouse and children. Interpersonal interactions are all related to their need to absolutely control their environment.

- Disruptions in impulse control. The individual with *Antisocial Personality Disorder* will attempt to control their environment with their own impulses. At times when this effort fails, the antisocial individual may exhibit a loss of impulse control. Furthermore, the antisocial individual may have "private" or personal disruptions in impulse control that may lead to illogical behaviors and substance abuses.

THE BOTTOM LINE

The more pathological this individual's symptomology is, the more unlikely they will respond favorably to any type of therapeutic intervention. If therapy is forced or mandated, there is almost no possibility of success. The therapist should understand that this individual is unable to understand or take another person's point of view.

This individual will feel completely justified in using whatever methods must be used to preserve and protect their own interests. The best hope in any therapeutic intervention is to move an individual as far toward "optimal functioning" as possible. Education of the client is a key element in this whole process.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Antisocial Personality Disorder* are:[6]

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

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[6] *DSM-IV-TR* p. 706.

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.

2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.

3. Impulsivity or failure to plan ahead.

4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.

5. Reckless disregard for safety of self or others.

6. Consistent irresponsibility as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.

7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of *Conduct Disorder* with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of *Schizophrenia* or *Manic Episode*.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by (or about) 15 years of age. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Antisocial Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

SUBSTANCE ABUSE DISORDER. Both disorders may coexist. *Antisocial Personality Disorder* must be a preexisting condition in order to diagnose both conditions.

SCHIZOPHRENIA, MANIC EPISODE, ANTISOCIAL BEHAVIOR. Antisocial behavior that occurs in the course of either *Schizophrenia* or a *Manic Episode* should not be diagnosed as *Antisocial Personality Disorder*.

NARCISSISTIC PERSONALITY DISORDER. Dual diagnosis can be accepted if criteria are met for both *Personality Disorders*.

HISTRIONIC PERSONALITY DISORDER. Individuals with *Histrionic Personality Disorder* do not typically engage in antisocial behaviors although they may have other traits associated with *Antisocial Personality Disorder*.

BORDERLINE PERSONALITY DISORDER. *Borderline Personality Disorder* individuals manipulate other people to gain nurturance while individuals with *Antisocial Personality Disorder* manipulate people for profit or power.

PARANOID PERSONALITY DISORDER. Individuals with *Paranoid Personality Disorder* manipulate others for revenge while individuals with *Antisocial Personality Disorder* manipulate others for profit or power.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Antisocial Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

MAJOR DEPRESSIVE DISORDER. An individual with an *Antisocial Personality Type* can suffer from consistent and sometimes extreme social isolation. Nobody else understands them because they are "different" from other people. Repeated failures are routine with the *Antisocial Personality Type* as well as

interpersonal conflicts. All of these factors result in the increased probability of a *Major Depressive Disorder*.

DYSTHYMIC DISORDER. *Dysthymic Disorder* is a lesser form of *Major Depression* and doesn't meet all of the criteria. However, the depressive symptomology continues over a longer period of time – at least two years. This disorder may exist in the *Antisocial Personality Type* for the same reason as a *Major Depressive Disorder*.

ANXIETY DISORDERS. The *Antisocial Personality Type* elicits consistent and long-lasting conflicts between people, rules, social situations and social standards. This constant conflict may result in a variety of *Anxiety Disorders*.

SOMATIZATION DISORDER. *Somatization Disorder* may be present in the *Antisocial Personality Type*. This disorder results in significant physical complains that involve repeated visits to a medical doctor. In order to meet criteria for the disorder, the physical complaints must be from four categories: pain symptoms, gastrointestinal symptoms, sexual symptoms, and pseudoneurological symptoms. These physical manifestations may be a result of the fact that the individual is not in contact with their emotional state. Thus, the buried emotions manifest themselves in somatic displays.

SUBSTANCE-RELATED DISORDERS. In order to mask the anxiety and depressive symptomology, the *Antisocial Personality Type* may be prone to substance abuse. This is a logical escape mechanism from the harsh realities of life.

PATHOLOGICAL GAMBLING. The *Antisocial Personality Type* may use pathological gambling for the same purpose as substances. However, the added element of this individual being "special" may lead them to believe that they have an edge to winning.

The Antisocial Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[7] the optimally functioning *Antisocial Personality Style* contains ten elements. Correspondingly, there are ten elements that indicate the breakdown of each of those ten optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Antisocial Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Antisocial Personality Style* without allowing for diminution toward more maladaptive traits.

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[7] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 39.

Sperry's continuum includes the following ten elements:

Optimal Functioning	Maladaptation
• The person prefers a free-lancer living style, and lives well by their talents, skills, ingenuity, and wits	• The individual is unable to sustain work behavior.
• The individual tends to live by their own internal code of values and they are not much influenced by others or society's norms.	• The individual fails to conform to social norms with regard to lawful behavior, performing antisocial acts that are grounds for arrest.
• As an adolescent, the individual tended to be a high-spirited hell-raiser and a mischief maker.	• The person is irritable and aggressive as indicated by physical fights or assaults.
• The person tends to be generous with money.	• The person experiences repeated failures to honor financial obligations, believing that money will turn up somehow.
• The person tends to be a wanderlust, but is able to make plans and commitments for limited time periods.	• The person fails to plan ahead and/or is impulsive as indicated by moving about without a prearranged job or clear goals.
• The individual tends to be silver-tongued – gifted in the art of winning friends.	• The individual has no regard for the truth as indicated by repeated lying, use of aliases, or conning others for personal profit.
• The person tends to be courageous, physically bold and tough; they will stand up to others who take advantage of them.	• The person is reckless regarding their own and others' personal safety as indicated by driving intoxicated or recurrent speeding.

Optimal Functioning	Maladaptation
• The individual tends not to worry too much about others. They expect others to be responsible for themselves. • The person has a strong libido, and although they may desire several partners, they can remain monogamous. • The individual tends to live in the present and doesn't feel much guilt.	• As a parent or guardian, the individual lacks ability to function as a responsible parent. • The person has never sustained a totally monogamous relationship for a long period of time. • The individual lacks remorse and feels justified having hurt, mistreated, or stolen from others.

The Antisocial Personality Style under Stress

The following behaviors will likely manifest when an individual with an *Antisocial Personality Type* faces a triggering event. In the case of the *Antisocial Personality Type*, triggering events will be situations related to the individual's need to conform to social standards that do not allow them to maintain control of their environment. The same holds true of established social rules that interfere with the individual's need to maintain control.

- Mistrust of everyone that might be associated with the triggering event. This may involve questioning the fidelity of a spouse in case of a marital crisis.
- Dissociation may be a factor if the individual is sufficiently disordered.
- Hyper vigilance due to perceived threats in their environment.
- Explosive exercise of power for purposes of gaining environmental control.
- "Quiet" behind the scenes manipulation through channels that the individual has open to them. This may involve manipulation of co-workers (in the case of a

work-related crisis) or children (in the case of a marital crisis).

- Cognitive distortions of reality due to denial of obvious environmental realities.
- Extreme efforts to regain control that may include subtle threats of violence or retribution against those involved in the perceived loss of control. The therapist must understand that these may be directed toward them if the individual perceives that the therapist is somehow at fault.
- Apathetic withdrawal when the individual fails to regain control of environmental factors.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with an *Antisocial Personality Type*.

PSYCHOSOCIAL ETIOLOGY FOR THE ANTISOCIAL PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Antisocial Personality Type*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the psychosocial development of the *Antisocial Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- PARENTAL NEGLECT, CRUELTY, OR ABUSE. The neglect, cruelty or abuse was likely severe in nature, extent and degree. This parental behavior creates a "stranger self-object." The child sees the parent figure as a stranger who cannot be trusted. The child believes that the parent harbors ill will toward them.
- PARENTAL HOSTILITY. The child experienced substantial vindictive behavior from at least one parent.
- INTERRUPTION OF THE ATTACHMENT PROCESS. The interaction between parent (most likely the mother) and child leaves the child fixated in the separation-individualization stage of development. In adulthood the person is unable to differentiate between themselves and others. They simply cannot tell the difference.
- ABSENCE OF A LOVING MATERNAL OBJECT. Thus, the concept of object permanence cannot occur. If

something is not currently seen, it probably doesn't really exist. Mother is often internalized as a predator. There was probably little consistent authority or parental guidance. This causes significant malformation of the superego and leaves the adult with no real ability to sort out moral issues or to experience guilt.

- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include cruel and harsh attacks against the individual, gross neglect at a crucial age, physical abuse of the child, alcoholism of at least one parent, spousal abuse, dereliction of parental duty, incompetent parental nurturance, adult responsibilities as a child, and erratic/unpredictable parental discipline.[8]

[The above list does not contain biochemical considerations associated with the etiology of the *Antisocial Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with an *Antisocial Personality Style*.

ACCEPTED SOCIAL STANDARDS. An individual with an *Antisocial Personality Type* may encounter commonly accepted social standards that disrupt their plans or desires. When they encounter those social standards and cannot resolve their desire to go against those standards, the conflict between the standards and their desires may trigger a disorder event.

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[8] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

CONFRONTATION WITH RULES. As is the case with accepted social standards, an *Antisocial Personality Type* may have a conflict with established rules that will trigger a disorder event. These individuals do not typically understand the reason for either standards or rules that conflict with their desires.

Treatment Course For Antisocial Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with an *Antisocial Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are seven major defense mechanisms that are commonly used by individuals with the *Antisocial Personality Type*. Five of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

INTELLECTUALIZATION. This mechanism involves the excessive use of abstract thinking or intellectual reasoning to minimize emotional discomfort. This is a mechanism of choice for the *Antisocial Personality Type* since affective states are feared by antisocial individuals because emotions lead to loss of control and vulnerability. [Level #2 – Mental Inhibitions Level]

ISOLATION OF AFFECT. This mechanism involves the segregation of cognitive "facts" from the feelings that were originally associated with them. Only the cognitive elements remain and the emotions are disposed of. This mechanism is used for the same reason as *Intellectualization*. [Level #2 – Mental Inhibitions Level]

OMNIPOTENCE. The client behaves or speaks in such a manner that they project the image to others that they possess special powers or special abilities. There is a distinct projection that they are in some way superior to others. Since the individual with an *Antisocial Personality Type* is unable to see beyond themselves, this is a very logical defense mechanism for them to use. [Level #3 – Minor Image Distortion Level]

RATIONALIZATION. The client uses elaborate and incorrect but coherent and self-assuring explanations or whole narratives to conceal the true motivations of their thoughts, actions, or emotions. These tactics are used to avoid emotional conflict or to cope with stressors. Cognitive distortion is a key element for the individual with the *Antisocial Personality Type*. [Level #4 – Disavowal Level]

SPLITTING. The client is unable to integrate both positive and negative qualities of self or others into cohesive images. They compartmentalize opposite effects. Opposite emotions cannot be experienced simultaneously. Therefore, another person will be viewed as either totally "bad" or totally "good." These good and bad assessments may change quickly regarding the same person. This is due to the cognitive distortions of the *Antisocial Personality Type*. [Level #5 – Major Image Distortion Level]

ACTING OUT. The client commits physical actions directly in response to internal reflections and feelings of affective states. These actions may be dangerous actions at times including attempted suicide and acts of violence toward others. Another likely form of *Acting Out* during an *Antisocial Personality Type* crisis might be the client removing themselves from the

environmental situation that they perceive is causing their distress. This option will only be chosen, however, with "higher level" functioning antisocial individuals (especially those with an elevated *Narcissistic Personality Type*). [Level #6 – Action Level]

APATHETIC WITHDRAWAL. The client withdraws from any attempts to deal with the internal or external stressing events or the affective states associated with those stressors. The client no longer wishes to discuss the stressor nor do they desire to work toward resolution. The client is now "frozen" in their crisis. This option will only be chosen, however, with "higher level" functioning antisocial individuals (especially those with an elevated *Narcissistic Personality Type*). [Level #6 – Action Level]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Antisocial Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the

50% threshold. This is not abnormal.[9] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

In the beginning of any therapeutic effort, the therapist must realize that the prognosis is guarded for success in counseling the *Antisocial Personality Type*. This fact is heightened on two points: 1) when the client's disorder score is significantly elevated (about 50%), and/or 2) the client is being "forced" into counseling. The force could be something as official as a mandate from a court system or as simple as a spouse threatening to leave if the individual doesn't engage in therapy.

The *Antisocial Personality Type* is usually not interested in treatment. The therapist must be very realistic about the potential for success.

With that in mind, the therapist needs to think realistically if they really want to engage in a therapeutic relationship with this

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[9] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

individual. Meloy has identified five reasons that the therapist should consider prior to accepting a case.[10] If any of these five exists, the therapist should strongly consider not taking the case.

- The client has a history of sadistic or violent behavior toward other people.
- The client exhibits a total absence of remorse for violent or sadistic behaviors.
- The client has a long-standing incapacity to develop emotional attachments.
- The client displays apparent high or low intelligence. Either of these will thwart the therapy process.
- The therapist has an uneasiness or fear for their own safety during the therapy process.

To help a therapist make a determination whether or not they will counsel an individual with an *Antisocial Personality Type*, the therapist may wish to consider these five points.

- What is the motivation for the individual entering therapy? If they are being "forced" to enter therapy, there is little possibility of success. Did the client self-initiate therapy or did someone else ask them to go?
- If their score on the *Narcissistic Personality Type* is also elevated substantially, there is a slightly better possibility of success in counseling. The narcissist is concerned about themselves and their image. This may be enough motivation to keep the individual focused in therapy.
- Is the client in serious personal crisis or emotional distress? If so, that may be a reason for them to voluntarily enter therapy. The therapist should understand that many times crisis will be enough to get them in, but once the immediate distress is gone, there is

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[10] Meloy, J. *The Psychopathic Mind: Origins, Dynamics, and Treatment.* Northvale, New Jersey. 1988.

a significant possibility of premature termination of therapy.

- Is the client apparently suffering from a *Major Depression Episode*? Is the client suffering from another *Axis I Disorder*? That, again, may be a reason for them to self-initiate and stay in therapy.

- Does it appear from the initial interview that the therapist can form an alliance with the client? The therapist must realize that this individual is probably very good at winning people over in the beginning. They need to keep all options open. If the therapist believes they can form an alliance with the client, there is a possibility of making some success moving the personality from distress toward style.

"The idea that a patient with ASPD is like other patients, just more difficult, is a massive under-evaluation."[11]

The therapist who does decide to counsel an individual with an *Antisocial Personality Type* should realize the following:

- The therapist should be well trained and must submit the case to supervision and oversight of some type. It is essential that the therapist has someone to discuss the case with so that they can gain additional insight into direction for therapy.

- The therapist should understand that therapy may only provide better management skills for the individual and may not lead to complete healing.

- The therapist must be willing and able to work with significant manipulative anger, dissociation, dishonesty, and relationship difficulties without losing control themselves.

- It is always unwise to counsel a couple in a joint session when one of the individuals has an elevated antisocial

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[11] Beck, A (Ed.). *Cognitive Therapy of Personality Disorders* p. 169.

disorder score.[12] This is especially true when the spouse is a *Dependant Personality Type*.

- The individual with an *Antisocial Personality Type* will use anger, hostility, threats and rage during therapy to control the therapist. The therapist must not allow those elements to control or influence therapy. These are attempts to derail and discredit the therapist. Usually when the client is successful, the therapist is discounted as an ineffective agent by the antisocial individual. If this occurs, the therapist should immediately refer the individual to another therapist.

- The antisocial person will do everything to "prove" that the therapist is not good enough or knowledgeable enough for them. Once the client has accomplished this, the antisocial person will no longer cooperate in therapy. The therapist has lost their effectiveness. The therapist must immediately refer the individual to another therapist.

- The client will consistently deny their problems and their personality characteristics.

- The client will always be right. They will not question their actions, motives or beliefs as being wrong. Consistent justification will be demonstrated to prove they are right.

- The therapist must be active and confrontational during each session. They must never take a passive role in the process of therapy. Passivity is seen as weakness by the client and they will immediately use passivity to end the effectiveness of the therapist.

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[12] It is possible to counsel a couple when one has an antisocial type if the antisocial score is substantially toward the style side rather than the disorder side. If the therapist chooses to engage in couples' therapy under these conditions, the therapist must realize that the antisocial type will still be quite manipulative in the sessions – even thought their antisocial score is toward the style side of the continuum.

- The client will always minimize, deny, and justify their actions and beliefs. They are never as "bad" as they seem.
- The therapist must never exhibit empathy toward the client. The client will attempt to illicit empathy. When the client is able to gain empathy from the therapist, the therapist has lost their effectiveness. The client must be referred.
- Even though they may not show it, the client will always distrust the therapist. They will appear to be "on the therapist's side" but that is never the case. They are on their own side and they are unable to consider anyone else's side. They simply cannot recognize the viewpoints of another person.
- The therapist must never engage in a "power struggle" with the client. The client will always win.

The following themes will consistently recur during counseling sessions. The therapist must take advantage of these themes each time they surface. Each of these themes must be confronted and dispelled.

- Other people are always out to abuse, humiliate, cheat, lie, manipulate, or take advantage of the client.
- The client is superior to others and not bound by the rules and norms that govern normal social interaction. They are "special people."
- The client will believe they are incapable of self-control and frustration tolerance. This excuses many of their behaviors (especially their impulsivity).
- The client may display a belief that they are defective, bad, unwanted, or inferior. This is a tactic to gain empathy from the therapist. It is a trap.
- The client will say that though they have a desire for an emotionally stable relationship other people are simply unable to meet their needs.

- The client will espouse the belief that significant others will not or cannot provide reliable and stable support. They believe that there is always the potential for abandonment.
- The client may believe that they are alienated, different from others, or not part of any group. No one understands them.

There are three techniques that might meet with some success when counseling an individual with an *Antisocial Personality Type*. While these techniques may not result in complete healing, they may result in an effective reduction in disordered symptomology.

- The therapist must attempt to link the client's actions to their internal states. This should be done by demonstration to the client that what they "do" is associated with what they "think."
- Use cognitive methodology to instruct a client about the *Antisocial Personality Type*. While this technique is not always beneficial for other personality types, it is most effective with the antisocial individual since it subverts their denial of the systematic course of their personality. It puts within the mind of the individual the complete knowledge of the disorder, which makes it harder for the individual to deny the nature of their behaviors.
- The individual with the *Antisocial Personality Type* must learn to engage their decision-making skills. Their impulsivity will mitigate against them thinking through decisions. They tend to act out of a need for control and power. The therapist should instruct the individual to create a problem list to be completed between every session. That problem list should contain a listing of specific problems that the individual encounters during the week. The individual should think through the problem and come up with every potential solution – even solutions that are totally uncharacteristic for the

individual. During the next therapy session, the therapist and the individual should review all problems listed on the problem list. Each possible solution should be examined in light of the *Antisocial Personality Continuum*. The therapist should help the individual understand the difference between solutions that are from the "disorder" side of the continuum and solutions that are from the "optional functioning" side of the continuum.

A SPECIAL NOTE ABOUT THE MARITAL RELATIONSHIP

The individual with a significantly disordered *Antisocial Personality Type* must be in complete control of their environment. In all likelihood, that individual will not be able to engage in any long-term marital relationship unless the individual to whom they are married has a corresponding personality style that allows for comprehensive control of the spouse.

While this individual may in a "fit" of idealism (because of their impulsive tendencies) marry someone that does not have a controllable personality, the likelihood of that marriage surviving long is slim. When an individual with a significantly disordered *Antisocial Personality Type* has been married for a significant period of time, the therapist will likely find that the spouse has some passive form of personality that is easily controlled and manipulated by the individual. The most likely fit is the *Dependant Personality Type*. This is a "classic" match for someone with an *Antisocial Personality Type*.

When these two are paired together, the antisocial person is able to trigger an almost continual crisis in the dependant individual so that they can easily manipulate them and control them. The spouse, therefore, becomes an "extension" of the antisocial individual.

The therapist must understand that the likelihood of resolving this interpersonal interaction is slim. In order to resolve this marital combination, both individuals need to "wake up" at the same time, realize the extremely maladaptive nature of their

personality types and their relationship, and desire together to make significant and lasting changes. This possibility is highly unlikely.

More likely is the termination of the relationship. In many cases, a crisis event associated with the marriage will precipitate the need for therapy. The antisocial individual may engage in counseling simply because the spouse has already engaged in counseling. The purpose for the antisocial individual engaging in counseling in this situation is to "scope out" the ability to control the therapeutic process.

If the dependant spouse is able to recover themselves in any way from their dependant behaviors, the antisocial individual will be thrown into personal crisis. Many of the attributes listed above under the *Style in Crisis* heading will come into play.

One of two events will likely occur at this point.

- The dependant spouse will exit therapy prematurely due to the successful controlling efforts of the antisocial individual. The home will return to its maladaptive dysfunctional status. Now, the antisocial individual will have gained even more power and ability to control. The dependant individual may never attempt to reach out for help again. The antisocial individual may never let them.
- The dependant spouse, having seen "freedom," may decide that they want to be healed from their dependency at all costs. That may indeed mean at the expense of the marriage. When a dependant individual realizes that they do have power to make their own choices (that they never really acknowledged before) they may grab a hold of that power and free themselves from their dependant tendencies. At this point, the marriage is over.

When an antisocial individual is in a marriage relationship, the therapist must assess the spouse to determine the personality interaction that is maintaining the relationship. The therapist must be fully aware from the beginning that this is a most volatile situation that might indeed end less than favorably.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Antisocial Personality Type*. The therapist must understand that the more the client tends toward true personality disorder, the more possible these dangers become. The dangers include the following:

- Potential suicide of client.
- Homicide of the therapist. This is especially possible if the therapist is also counseling the client's spouse. If the client feels that they are losing control in the home, the client may react in a violent manner.
- Familial homicide/suicide. Usually this happens for the same reason as above. The antisocial husband who feels he is losing control of his wife may kill his wife and himself.
- Assault and battery of the therapist.
- Commission of criminal behavior during the course of therapy.
- Litigation. This is especially true in marital cases. The client may engage in a tort case for something like "alienation of affection" if they feel that the therapist has driven the spouse away emotionally.
- Early termination of therapy. Many times the *Antisocial Personality Type* will enter therapy to resolve a significant, uncomfortable crisis. When the immediate discomfort from the crisis is relieved, the client may exit therapy before the resolution of the personality type issues.

SUCCESSFUL COMPLETION OF TREATMENT

Success with an individual who has an *Antisocial Personality Type* may be a relative term. In all likelihood, the best results that a therapist can expect is to move the personality from

disorder to style and to educate the client about their personality type so that the client might take action throughout their life to maintain an optimal functioning of their personality. This will be a continual battle for the individual.

The therapist should consider their efforts successful when the client has learned to regulate some of the most consistent maladaptive beliefs that they have instilled within their personal belief system. That will include:

- Resolution of the belief that other people are always out to abuse, humiliate, cheat, lie, manipulate, or take advantage of the them.
- Resolution of the belief that the client is superior to others and not bound by the rules and norms that govern normal social interaction.
- Resolution of the belief that the client is incapable of self-control and frustration tolerance. They will no longer excuse their behaviors and will learn to control their impulsivity.
- Resolution of the belief that they are defective, bad, unwanted, or inferior.
- Resolution of the belief that others will simply be unable to meet their emotional needs.
- Resolution of the belief that significant others will not or cannot provide reliable and stable support.
- Resolution of the belief that they are alienated, different from others, or not part of any group.

Avoidant Personality Style and Disorder

The Avoidant Personality Type In A Nutshell

"The essential feature of *Avoidant Personality Disorder* is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation."[13]

The *Avoidant Personality Type* tends to avoid close interpersonal relationships and social situations. While the schizoid individual has the same aversion to interpersonal situations, the reason for the avoidant individual's aversion to interpersonal relationships is due to fear of embarrassment or being hurt by others. The schizoid individual simply doesn't have the desire for interpersonal relationships.

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[13] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington D.C., American Psychiatric Association. 2000. p. 718.

A CLOSER LOOK

This individual will often use various rationalizations to reinforce their need to refrain from significant interpersonal relationships. These will be elaborate explanations loaded with apparently reasonable examples based on past experience. This will immediately present a significant problem for therapeutic intervention.

In cases of crisis, the client is likely to fall into apathetic withdrawal, especially if the therapist moves too quickly to help resolve the social fears. It is not unreasonable that the therapist will see the individual completely isolate themselves socially. This may include actual cases of *Agoraphobia*.

The *Avoidant Personality Type* can originate from a variety of childhood sources. It is important for the therapist to attempt to locate the source since that may provide valuable information for healing. The therapist should carefully read through the *Psychosocial Etiology* section of this personality description.

This individual is subject to numerous *Axis I Disorders*. Those include *Panic Attacks*, *Anxiety Disorders*, various *Mood Disorders* including *Dysthymic Disorder* and *Major Depression*.

In the event that the avoidant individual has engaged in a serious interpersonal relationship and that relationship has ended badly, the therapist should understand that client reactions might be more significantly pronounced.

THE BOTTOM LINE

Fear of being hurt or embarrassed is the key to this personality crisis. Although the individual may wish to engage in significant interpersonal relationships, they will refrain due to those fears.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Avoidant Personality Disorder* are:[14]

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning in early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection.

2. Is unwilling to get involved with people unless certain of being liked.

3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.

4. Is preoccupied with being criticized or rejected in social situations.

5. Is inhibited in new interpersonal situations because of feelings of inadequacy.

6. Views self as socially inept, personally unappealing, or inferior to others.

7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

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[14] *DSM-IV-TR*, p. 721.

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Avoidant Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

SOCIAL PHOBIA. This is a possible alternative diagnosis especially based on the diagnostic criteria of pervasiveness.

PANIC DISORDER WITH AGORAPHOBIA. *Panic Disorder* with or without *Agoraphobia* can coexist with *Avoidant Personality Disorder*. The avoidance with *Panic Disorder* typically starts after the onset of *Panic Attacks*. The avoidance in *Avoidant Personality Disorder* tends to have an early onset.

DEPENDENT PERSONALITY DISORDER. *Avoidant Personality Disorder* occurs to avoid humiliation and rejection. With *Dependent Personality Disorder* avoidance is related to being taken advantage of.

SCHIZOID AND SCHIZOTYPAL PERSONAL DISORDERS. All three disorders have social isolation as a criteria. *Avoidant Personality Disorder* desires to have a relationship and the individual suffers loneliness without one. Whereas, with *Schizoid* and *Schizotypal Personality Disorders* the individual is indifferent to relationships.

PARANOID PERSONALITY DISORDER. The common element between these two is reluctance to confide in others. *Avoidant Personality Disorder*, however, also has the fear of being embarrassed as a key element.

PERSONALITY DISORDER DUE TO MEDICAL CONDITION. Both disorders may be diagnosed but *Avoidant Personality Disorder* must exist before the medical condition.

CHRONIC SUBSTANCE ABUSE. Both conditions may be diagnosed but *Avoidant Personality Disorder* must exist before the substance abuse.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Avoidant Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

MOOD DISORDERS. Various *Mood Disorders* may be present with the *Avoidant Personality Type*. These may include *Major Depression Disorder*, *Cyclothymic Disorder*, *Dysthymic Disorder*, and (less likely) *Bipolar Disorder*.

ANXIETY DISORDERS. Since the *Avoidant Personality Type* is socially inhibited and has feelings of social inadequacy, these traits may result in a number of *Anxiety Disorders*.

SOCIAL PHOBIA. The hypersensitivity to negative evaluation may result in the *Avoidant Personality Type* suffering from a *Social Phobia*.

The Avoidant Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of

disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[15] the optimally functioning *Avoidant Personality Style* contains six elements. Correspondingly, there are six elements that indicate the breakdown of each of those six optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Avoidant Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Avoidant Personality Style* without allowing for diminution toward more maladaptive traits.

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[15] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 61.

Sperry's continuum includes the following six elements:

Optimal Functioning	Maladaptation
• The individual is comfortable with habit, repetition, and routine; and they prefer the known to the unknown.	• The person exaggerates the potential difficulties, physical dangers, or risks involved in doing something ordinary but outside of their usual routine.
• The individual has close allegiance with family and/or a few close friends and tends to be a homebody.	• The individual has no close friends or confidants (or only one) other than first-degree relatives.
• The individual is sensitive and concerned about what others think and tends to be self-conscious.	• The person is unwilling to get involved with people unless certain of being liked. They are easily hurt.
• The person is very discrete and deliberate in dealing with others.	• The person fears being embarrassed by blushing, crying, or showing signs of anxiety in front of other people.
• The individual tends to maintain a reserved, self-restrained demeanor around others.	• The person is reticent in social situations because of a fear of saying something inappropriate or foolish.
• The individual tends to be curious and can focus considerable attention on hobbies.	• The individual tends to be an underachiever and finds it difficult to focus on job tasks or hobbies.

The Avoidant Personality Style under Stress

The following behaviors will likely manifest when an individual with an *Avoidant Personality Type* faces a triggering event. In the case of the *Avoidant Personality Type*, triggering events will be situations related to demands for close interpersonal relationships or requirements for social appearances.

- Social isolation. This individual may refrain from all social or interpersonal interactions.
- Panic attacks. This is especially likely if the individual is asked to engage in some public, social event. The potential for a panic attack is heightened if the individual is required to speak at a public appearance. They may not be able to engage in this type of activity.
- Apathetic withdrawal. The individual may completely shut down in their ability to interact with others.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with an *Avoidant Personality Type.*

PSYCHOSOCIAL ETIOLOGY FOR THE AVOIDANT PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Avoidant Personality Type*. Many of these issues will not be cognitively

accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the development of the *Avoidant Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- PEER GROUP / FAMILY REJECTION. The "rejection" that causes this personality type appears to originate either in Stage #4 or Stage #5 of Erikson's scheme of psychosocial development.[16] Although it is possible for this type to emanate from the home environment, it is more likely to be social in origin. These experiences cause it to invoke timidity and avoidance.

- INITIAL APPROPRIATE NURTURANCE AND SOCIAL BONDING. This individual appears to have been raised initially in an appropriate setting, then something changed. That change resulted in relentless social embarrassment and even humiliation by someone. (It does not really matter who at this point.) This social conflict has derailed the desire of the individual from seeking further social interaction out of fear. Thus, they *avoid* social situations.[17]

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[16] Stage #4 is *Industry versus Inferiority* (occurring about 6 years to 11 years). Stage #5 is *Identity versus Identity Confusion* (occurring after 11 years old).

[17] Some situations that might cause the change from appropriate to inappropriate nurturance would include the following: A family move to

- SHAME-BASED SOCIAL EXPERIENCES. The development of this personality type most likely occurs sometime shortly before or after the onset of puberty. It may develop from social experiences and may not be directly attributable to familial issues. Humiliating experiences are the primary cause (friends, school associates, family). Development is likely not to occur from a single incident. The humiliation that causes the avoidant personality is longer in term.
- FAMILY / SOCIAL BEHAVIOR PATTERNS[18] to investigate at the disorder level include possible relentless parental control, parental need for the child to cultivate a good social image, visible flaws were discouraged especially when they were social, *mockery* (possibly related to "imperfections" like obesity), *shunning*, *banishment*, *exclusion*, *ridicule*, *rejection* (all italicized items could have occurred in the home or in a social context).[19]

[The above list does not contain biochemical considerations associated with the etiology of the *Avoidant Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

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an area that is radically different than the one the child was raised in, a change in parental custody, social group intimidation at or about puberty (schools can be brutal to children who do not "fit the mold" – obese children, children with handicaps, or any other situation that would put the child outside of the "accepted" social group of the school).

[18] The therapist should understand that avoidant individuals appear to have begun the development process with appropriate nurturance and social bonding. This may indicate that at least part of the psychosocial developmental issues might have been purely social and not familial. The most likely period of time that this could have happened would have been during the school years.

[19] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with an *Avoidant Personality Style*.

DEMANDS FOR CLOSE INTERPERSONAL RELATIONSHIPS. The very nature of the *Avoidant Personality Type* is to avoid close interpersonal relationships. Demands placed on an individual for close interpersonal relationships might result in the promotion of a crisis event depending on the significance of the event.

SOCIAL OR PUBLIC APPEARANCES. The *Avoidant Personality Type* is subject to hypersensitivity regarding negative evaluation in social situations. They are unusually inhibited in social situations and suffer (sometimes quite severely) from feelings of inadequacy. These feelings are heightened when the individual is placed in a social situation where they must perform.

Treatment Course For Avoidant Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with an *Avoidant Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality types "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are four major defense mechanisms that are commonly used by individuals with the *Avoidant Personality Type*. Two of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

INTELLECTUALIZATION. The client uses excessive abstract thinking, intellectual reasoning, or generalizations to control or minimize the emotional discomfort associated with social and interpersonal relationships. This is an effort on the part of the client to "shut off" the emotions associated with social and interpersonal involvement. [Level #2 – Mental Inhibitions Level]

REPRESSION. The client consciously learns to block out disturbing wishes, thoughts, behaviors, or experiences from the conscious mind. The affective states remain even though cognitive aspects have been repressed. [Level #2 – Mental Inhibitions Level]

RATIONALIZATION. The client uses elaborate and incorrect explanations to conceal the true motivations of their thoughts, actions, or emotions. The explanations are usually reassuring coherent and self-assuring. [Level #4 – Disavowal Level]

APATHETIC WITHDRAWAL. The client withdraws from any attempts to deal with the internal or external stressing events associated with social or interpersonal relationships. The client no longer wishes to discuss the issues nor do they desire to work toward a resolution. [Level #6 – Action Level]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Avoidant Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[20] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to

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[20] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

The therapist should understand that this client may be unable to attend social functions or even return things to the store – even if they don't know the people they will be encountering. Other situations involve specific fear in situations where the individuals encountered may be more "important" to the client. The client will usually have anxiety thinking about social situations – not just engaging in them.

There is considerable pain connected with rejection in all social or interpersonal relations. Thus, they will exhibit hypersensitivity to perceived criticism. Consequently, they will evade criticism and embarrassment by avoiding relationships with others.

The client may exhibit a very judgmental system of morals and ethics. They tend to be harsh on themselves. They may have unrealistic expectations for themselves and may project these onto others.

The therapist must demonstrate appreciation for the client's fear of humiliation and embarrassment in social situations. These factors may not be dismissed or treated lightly by the therapist since it will only increase the uneasiness of the client to the whole therapeutic process.

The therapist must work carefully to build trust with the client so that the client does not feel threatened in the therapy situation. It is best for the therapist to be continually reminded that the therapy process is in fact a social situation and the client has a significant issue with all (or most) social situations.

Due to the anxiety of this "social situation," the client may have trouble keeping regular counseling appointments. Therapy will likely cause them substantial anxiety.

The first effort on the part of the therapist should be to increase the client's self esteem and confidence in the controlled therapeutic relationship. This will begin to desensitize the individual to social interaction. However, it is important for the therapist not to prematurely challenge the automatic thoughts of the client. This will cause them to leave therapy.

Due to anxiety issues (largely) the client may routinely react non-verbally in therapy. When the therapist sees that the client is reacting non-verbally, the therapist should explore the client's feelings at that time. The therapist should not conclude that non-verbalization is an act of therapeutic failure or non-compliance on the part of the client.

The therapist should explore the underlying causes of the shame and apprehension regarding social situations. This largely relates to past developmental experiences sometime during childhood.[21] Discovering this information can allow the therapist to recreate the situation using current situations and potentially root out and resolve the original issue.

Early in the therapy process, the therapist should use anxiety management training to reduce the client's social anxiety. Desensitization methods might be useful. The therapist may also use structured social skills training.

Among some of the first essential automatic thoughts that the therapist must confront is the client's likely belief that disapproval in a social situation is the same as rejection. The devastation that the client sees in the disapproval must be put into context. The client needs to understand that people can disagree with each other (sometimes strongly) without rejection being involved in the disagreement.

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[21] The childhood issues that might instill the *Avoidant Personality Type* span a large time period. While it might indeed include elements from early childhood, there are also indications that it might be caused by issues of later development in childhood. This might include such things as abrasive situations with social peers. This is very likely in the case that the social peers made the child feel like an outcast in their social environment. Issues of appearance are likely "targets" for childhood social situations that might cause an avoidant type to develop.

Since the issues that initially instilled the "need" to avoid in the client are far removed from the client's present reality, the client will be somewhat uncertain about who they actually fear in social situations. They may be vague and global when expressing their fears, not specific. The therapist should explore these issues when the client demonstrates their social fears in transference. When the therapist does locate specifics in a present situation, the therapist should attempt to connect that fear situation with the original social situation that originally caused the avoidant development.

The therapist should be aware of two common forms of countertransference that occur when counseling the *Avoidant Personality Type*. Those countertransference issues are:

- Therapeutic protectiveness. The therapist is too careful with the client and ends up insolating the client from all social risks.
- Over aggression. The therapist may believe that the client has progressed further than they actually have. Therefore, the therapist may "force" the client into substantial social situations too early.

When the therapist has moved the avoidant individual toward significant stability, the therapist will need to help the client restructure the way that they relate to their environment. These are some key elements in the re-constructive counsel of the therapist:

- The therapist should explore the automatic thoughts of the client by probing them. The therapist will know when the client has engaged in an automatic thought (sometimes) because the client often displays a change in emotion. For example, the therapist may be discussing a social encounter and the client may exhibit anxiety or fear on their face. At that point, the therapist can

evaluate the feeling with the client and the thought behind the feeling.

- Avoidant individuals often feel that when they establish a relationship with another person, they must continually please that person or else the relationship will end. The therapist must carefully deal with this issue. Testing this in real social situations is the real goal. Any initial testing should be done on small and limited cases and then moved to more substantial relationships.

- The therapist may use assertiveness training and social skills training in a role-playing manner to help the client prior to actually engaging in real-life situations.

- The client may confuse strong emotions with being out of control emotionally. Role playing for the purpose of eliciting strong emotions may be a key element in the client being able to understand that expression of strong emotion can be engaged without being out of control or being rejected by the therapist. During role-playing and the evoking of emotion, the therapist will likely encounter resistance to continue on the part of the client. It is at that point that the therapist can make headway in the client understanding and expressing emotion. The therapist may use increasingly painful issues to continue this process until the individual is ready to put it into practice in the real world.

- The therapist can structure a "designed failure" assignment. This may involve the client intentionally engaging in a social situation with the "goal" of failure. For example, the client who is not married may engage in a "designed failure" assignment that involves them asked two women out on dates during the week. Their goal is to get a "no" response so that they can learn to respond to and deal with negative social responses. If the client expects a "no" response when they engage in the social experiment, they will be somewhat desensitized to the negative result. In the counseling session prior to this exercise the therapist and the client can decide and

experiment with how the client will react to the negative response.

- Marital therapy may be indicated with the avoidant individual, especially as progress is gained in therapy. This should only be done after the client has achieved a significant ability to face emotions in real situations. The primary goal of this therapy will likely be the restructuring of the spouse's response to the newly found emotional abilities of the avoidant person. These emotions will probably not have been a significant issue in the relationship previously.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Avoidant Personality Type*. These include the following:

- The individual who has a significantly disordered personality structure may degrade into a more volatile and unstable personality type (as indicated by their subdominant personality types). This will usually only occur in extreme cases, but the therapist must be aware of the possibility.
- The individual may not be able to easily continue therapy due to the inability to face their emotions.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment for the *Avoidant Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- The elimination of the belief that the client is defective, bad, unwanted or inferior to others.

- Social isolation or social alienation must be reduced or eliminated.
- The client's belief that they must sacrifice themselves in order to maintain relationships must be reversed.
- The client's need to seek approval from others must be reduced.

Borderline Personality Style and Disorder

The Borderline Personality In A Nutshell

"The essential feature of *Borderline Personality Disorder* is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity."[22]

When a full personality disorder can be diagnosed, there is every indication that the family of origin was a place of excessive chaos. The chaos may have included extreme forms of physical, emotional, and sexual abuse – even conditions that might be considered tortuous. These conditions may be indicated by the client's desire to mutilate themselves in some way (e.g. cutting themselves).

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[22] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000, p. 706.

A CLOSER LOOK

Sometimes therapists have a hard time differentiating between *Borderline Personality Disorder* and *Histrionic Personality Disorder*. There is a possibility that the two can co-exist. The combination of both conditions is usually considered as the decomposition of the histrionic personality structure. In such cases, the *Histrionic Personality Type* will most likely be pre-existent. A significant crisis situation may cause the *Histrionic Personality Type* to degenerate into the *Borderline Personality Type*, if psychosocial etiology exists to allow the borderline condition to form.

In one respect, the differences between the two are a matter of degree. Both include a fear of being alone and a fear of abandonment – with the borderline being frantic in their efforts to avoid those conditions. Both are also impulsive – again, with the borderline being potentially dangerous in their impulsive actions.

In another respect, however, there is a very significant difference in self-image. The histrionic individual has a higher level of functioning in the respect that they are interactive with their interpersonal environment. They openly use attention-seeking behaviors to seek and maintain relationships.[23] The borderline person is much more frantic in their relationship efforts. Also, the borderline individual has a propensity toward paranoid ideations and severe dissociative symptoms. These are usually not present with the histrionic individual.

When a therapist encounters a significant elevation of disorder in the personality structure, the therapist should be aware of the possibility of very significant abusive behaviors

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[23] In both disorders, the individuals fear being alone. The histrionic individual, however, believes that they can do something to avoid abandonment. Thus, they use whatever assets they have (including overt sexuality, attractiveness, and other flamboyant measures) to secure relationships so that they can avert being alone. The borderline individual has either forfeited those efforts or they see those efforts largely as a failure.

being present in the home of origin. Depending on the degree to which the personality is disordered, the therapist may find nearly total chaos existed in the home of origin. In those cases, the therapist should carefully read this entire report, especially noting the *Psychosocial Etiology* section. At the end of that section the therapist will find a list of likely events that may have transpired in the home.

THE BOTTOM LINE

In a crisis situation, this individual will be very hard to manage in the office setting. The therapist will need to help the client manage the instability of their interpersonal relationships and their extreme impulsivity. Rapidly shifting and intense emotional states will complicate the treatment.

    If the client does not regain stability in a relatively short period then the therapist should refer the individual to someone who has expert training with *Borderline Personality Disorder*.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Borderline Personality Disorder* are:[24]

    A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
        1. Frantic efforts to avoid real or imagined abandonment
        2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
        3. Identity disturbance: markedly and persistently unstable self-image or sense of self

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[24] *DSM-IV-TR*, p. 710.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity or mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Borderline Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

MOOD DISORDERS. Both *Mood Disorders* and *Borderline Personality Disorder* may coexist.

HISTRIONIC PERSONALITY DISORDER. *Borderline Personality Disorder* is especially characterized by the potential for self-

destructive behavior. Both can be diagnosed, if criteria are met for both.

SCHIZOTYPAL PERSONALITY DISORDER. Both can be diagnosed, provided that appropriate criteria for each are met.

PARANOID PERSONALITY DISORDER / NARCISSISTIC PERSONALITY DISORDER. *Paranoid* and *Narcissistic Personality Disorders* lack the self-destructiveness, impulsivity, and abandonment criteria associated with *Borderline Personality Disorder*. Those two personality disorders should be investigated if this individual lacks those three essential criteria.

ANTISOCIAL PERSONALITY DISORDER. Both of these personality disorders contain elements of manipulation. *Borderline Personality Disorder* is manipulative for purposes of gaining the concern of caretakers while *Antisocial Personality Disorder* is manipulative for profit and power.

DEPENDENT PERSONALITY DISORDER. Both of these disorders are characterized by fear of abandonment. *Borderline Personality Disorder* tends to feel a sense of emotional emptiness, rage and demands. The individual with *Dependent Personality Disorder* reacts with appeasement and submissiveness.

IDENTITY PROBLEM. The *Identify Problem* diagnosis is specifically for an adolescent. *Borderline Personality Disorder* should not be diagnosed in an adolescent.

PERSONALITY DISORDER DUE TO MEDICAL CONDITION. Both disorders can be diagnosed but *Borderline Personality Disorder* must exist before the medical condition.

CHRONIC SUBSTANCE ABUSE. Both disorders can be diagnosed but *Borderline Personality Disorder* must exist before the diagnosis of chronic substance abuse.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Borderline Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

ANXIETY DISORDERS. Due to the volatile nature of this individual's personality structure, anxiety will play a key role in their functionality. This will be even more evident during episodes of relational dysfunction.

MOOD DISORDERS. Various Mood Disorders may be present with the *Borderline Personality Type*. These may include *Major Depression Disorder*, *Cyclothymic Disorder*, *Dysthymic Disorder*, and (less likely) *Bipolar Disorder*.

SUBSTANCE-RELATED DISORDERS. Due to the impulsive nature of this personality type, these individuals have a higher occurrence of *Substance Abuse* related disorders.

EATING DISORDER (ESPECIALLY BULIMIA). The *Borderline Personality Type* is more susceptible to *Eating Disorders* including *Bulimia* and *Anorexia*.

POSTTRAUMATIC STRESS DISORDER. The pervasive instability of the *Borderline Personality Type* leaves them more susceptible to *Posttraumatic Stress Disorder*.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER. *Impulsivity* may be the reason that the *Borderline Personality Type* may be more susceptible to *Attention-Deficit Hyperactivity Disorder*.

BRIEF REACTIVE PSYCHOSIS. The most essential difference between *Brief Reactive Psychosis* and *Schizophrenia* is that Schizophrenia lasts more than one month. The same delusional features exist. This disorder is understandable due to the erratic

nature of the personality type and probably displays a very significant crisis.

SCHIZOAFFECTIVE DISORDER. This diagnosis includes *Criterion A* from *Schizophrenia*. That includes the potential for *delusions*, *hallucinations*, *disorganized speech*, and *disorganized behavior* (at least two of these must be met). In addition to these symptoms the individual must suffer from one of the following episodes: *Major Depression*, *Mania*, or a *Mixed Episode*. These symptoms must exist for a minimum of two weeks. This disorder is understandable due to the trauma that was likely part of their home environment.

The Borderline Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[25] the optimally functioning *Borderline Personality Style* contains six elements. Correspondingly, there are six elements that indicate the breakdown of each of those six optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Borderline*

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[25] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 83.

Personality Disorder. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Borderline Personality Style* without allowing for diminution toward more maladaptive traits.

Sperry's continuum includes the following six elements:

Optimal Functioning	Maladaptation
• The person tends to experience passionate, focused attachments in all relationships.	• The person has a history of unstable and intense relationships alternating between extremes of over idealization and devaluation.
• The person is emotionally active and reactive – they show their feelings and put their hearts into everything.	• The person is impulsive in at least two areas that are potentially self-damaging (spending, sex, substance abuse, shoplifting, driving, eating, suicidal threats, etc).
• The individual tends to be uninhibited, spontaneous, fun-loving, and undaunted by risk.	• The person experiences affective instability marked by shifts from baseline mood to depression, irritability or anxiety lasting a few hours and only rarely a few days.
• The person tends to be creative, lively, busy, and engaged – they show initiative.	• The person tends to have inappropriate intense anger or lack of control of anger.

Optional Functioning	Maladaption
• The person is imaginative and curious – willing to experience and experiment with other cultures.	• The individual has marked and persistent identity disturbance characterized by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals, type of friends, preferred values.
• The individual regularly tends to be deeply involved in a romantic relationship with one person	• The person makes frantic efforts to avoid real or imagined abandonment.

The Borderline Style under Stress

The following behaviors will likely manifest when an individual with a *Borderline Personality Type* faces a triggering event. In the case of the *Borderline Personality Type*, triggering events will usually be associated with real or perceived threats of abandonment.

- Extreme outbursts of anger. Loss of anger management capabilities.
- Rapid, unstable and intense shifts in the affective state (usually from extreme depression to extreme anxiety).
- In the case of a real loss of a relationship (real abandonment) the individual may take extreme measures to recover the relationship.
- Increase in impulsive behaviors that may include shopping sprees, sexual overindulgence, substance abuse, shoplifting episodes, reckless driving, over eating or under eating.
- The individual may exhibit self-destructive behaviors during a crisis (or may make suicidal insinuations). In

the case of sexual abuse, the individual may resort to self-mutilation.

- The individual may experience significant identity disturbance including disruptions associated with self-image, confusion regarding their sexual orientation, illogical friendships and acquaintances, and value confusion.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *Borderline Personality Type.*

PSYCHOSOCIAL ETIOLOGY FOR THE BORDERLINE PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Borderline Personality Type*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial

(which is very common) these are the most commonly accepted reasons for the development of the *Borderline Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- INCONSISTENT MATERNAL BEHAVIOR. This is especially true during the rapprochement subphase of child development (8 to 18 months). This inconsistent behavior results in at least a partial loss of "object permanence." The range of maternal inconsistencies can range from lack of consistent emotional availability to neglect or even abuse. This provokes a number of adult-level issues including abandonment depression, feelings of emptiness, tendencies toward major depression, rage, and annihilation panic.

- PARENTAL OVERPROTECTION (usually maternal). This potential psychosocial factor is associated with the mother's own emotional state wherein the mother does not want the child to grow up and become independent. Like the previous factor, it results in at least partial loss of the concept of "object permanence." This will engender an inability in the adult to summon up internal images of nurture when the nurturing "object" is not present. This results in the fear of abandonment and the internal emptiness that these individuals face.

- PHYSICAL, EMOTIONAL OR SEXUAL ABUSE. Research indicates that individuals with the *Borderline*

Personality Type report physical, emotional or sexual abuse to a greater extent than individuals with other personality types. In most cases, the presence of abuse in childhood will result in very significant manifestations of the *Borderline Personality Disorder* traits. In cases of abuse, there is a significant increase in the potential for suicidal (or other self-destructive) behaviors in the adult.

- EXTREME FAMILY CHAOS. This is indicated especially when the individual manifests a personality disorder. The chaos that is generated in the home will confuse the concepts of pleasure and pain. Family chaos also leads to a propensity for the individual to engage in intimate relationships that are abusive.

- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include extreme family chaos, a painful yet erotic incestuous sexual relationship,[26] terrible family fights, alcoholism in the family, divorce, affairs, abortions, suicide attempts, extreme blaming (e.g. blaming the child for the breakup of a marriage), disowning of the child (e.g. "I wish you would have never been born"), traumatic abandonment experiences, physical isolation (e.g. locking a child in a closet or basement), physical violence toward the child, satanic or other ritual sexual abuse, and verbal attacks.[27]

[The above list does not contain biochemical considerations associated with the etiology of the *Borderline Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

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[26] This experience is likely to result in acts of self-mutilation (e.g. cutting oneself). Self-mutilation is the result of confusing pleasure and pain.

[27] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *Borderline Personality Style*.

EFFORTS TO AVOID PERCEIVED ABANDONMENT. The individual with a *Borderline Personality Type* usually engages in relationships that are somewhat volatile to begin with. When close interpersonal relationships become unstable this fact greatly effects the self-image of the individual. Their fear of abandonment may lead to the escalation of a personal crisis.

Treatment Course For Borderline Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with a *Borderline Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are five major defense mechanisms that are commonly used by individuals with the *Borderline Personality Type*. Four of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

UNDOING. The client uses symbolic words or behaviors designed to negate unacceptable thoughts, feelings, or actions. These words or behaviors are often used to make amends for perceived wrongs that the client has committed. The borderline individual routinely pushes individuals away with their words and emotions. It is not unlike these individuals to do some symbolic thing to recover a damaged relationship. [Level #2 – Mental Inhibitions Level]

DEVALUATION. The client attributes exaggerated negative qualities to themselves or to other people. This individual is grossly condemning to themselves or to others. [Level #3 – Minor Image Distortion Level]

IDEALIZATION. The client attributes exaggerated positive qualities to other people. This individual grossly idealizes at least one other person. Their idealization of another person is obviously beyond reality. [Level #3 – Minor Image Distortion Level]

SPLITTING. The client is unable to integrate positive and negative qualities of self or others into cohesive images. The client tends to compartmentalize opposite affects. Opposite emotions cannot be experienced simultaneously. The image of self, others, and even objects tends to alternate between polar opposites – something is all bad or all good. [Level #5 – Major Image Distortion Level]

ACTING OUT. The client commits physical acts directly in response to internal reflections, feelings, or affective states. With the borderline individual, this may include substantially self-destructive acts. [Level #6 – Action Level]

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The first course in treatment for the *Borderline Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[28] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

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[28] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

The following is general information regarding the disorder that is appropriate as an introduction to the therapeutic process regarding borderline individuals.

The individual with a significantly disordered *Borderline Personality Type* will have a pervasive pattern of instability in most areas of their life. This is especially true concerning their interpersonal relationships, their self-image, the affective states, and their impulsivity. Since there is a propensity for relationships to end tragically and suddenly, this individual will lack the ability to trust most everyone.

It cannot be overstated that in the case of *Borderline Personality Disorder*, the therapist will likely find significant and even traumatic dysfunction in the home of origin. Those events will likely influence or even dictate the behaviors of the individual. It is imperative for the therapist to explore the home of origin during the early phase of therapy.

They will be characterized by anger, anxiety, and depressive symptomology. These issues will be heightened during relationship losses. The individual is likely to be suicidal (or even homicidal in some cases). Their distress at times will disrupt their ability to function in every situation.

This disorder "can be among the most difficult and frustrating conditions to treat. Clinical experience suggests that it is important to assess the individual for overall level of functioning

and treatment readiness in making decisions about treatment approaches, modalities and strategies."[29]

The therapist should acknowledge and accept the client's difficulty in trusting the therapist. The therapist will also find that the client may have difficulty communicating clearly and honestly.

The therapist should encourage the client to examine risks and benefits in the office setting. It is important to remember that growth during therapy is threatening to the client. Altering long-established behavior patterns – even though those patterns cause the client distress – can be a very stressful prospect for the client.

Noncompliance with treatment objectives is a common problem when dealing with individuals who have the *Borderline Personality Type*. These individuals usually have a significant fear of change. Therefore, in order to see significant progress in therapy, the therapist and client should engage in a "formal" treatment contract. The therapist should not press for change too quickly.

The first priority with a borderline client is to assess the potential for self-destructive behaviors on the part of the client. Among the most serious of all self-destructive behaviors, of course, is suicide. That, however, is not the only self-destructive behavior that needs to be assessed. The client may routinely engage in behaviors that result in other forms of "self-destruction." The behaviors might include continual sabotaging of interpersonal relationships that result in hurt to the client. It is important for the therapist to remember that the borderline individual often confuses pleasure and pain. Any pleasurable situation must be followed by a painful one. Pleasure and pain go together.

The first effort of the therapist should be to make all self-destructive behaviors ungratifying to the client. Even in the case where the therapist feels relatively successful in this effort, the therapist must continually watch for the sudden re-emergence of self-destructive behaviors – especially suicide.

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[29] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* P. 95.

Results of therapy should be expected to be "uneven." Conventional treatment is very difficult. The therapist should understand that in some cases conventional outpatient treatment is not appropriate with borderline clients.

Among other top priorities for the therapist would be the reduction of negative emotions that continually interfere with the client's functionality. These negative emotions include anger, anxiety and depressive symptoms. In the process of aiding the client in reducing these negative affects, the therapist should help the client become more aware of these emotions. In all likelihood, the client is oblivious to the constant occurrence of these emotions in their life. The client's emotional state is largely disorganized and the therapist can carefully help the client reorganize the affective state.

The therapist will need to focus on reality testing with the client. The client should be encouraged and given direction. The therapist should also focus on aiding the client in the development of problem solving skills.

An individual with a significantly elevated disorder score may need to visit a medical doctor, if the therapist believes that medication should be used in conjunction with therapy. Medication can be used to modulate or normalize dysregulated behaviors during the course of therapy.[30]

As therapy progresses the therapist should use a method that will allow the client to engage in guided discovery. The client should learn to recognize their behaviors by examining relational and situational problems that evoke a crisis event. The client and therapist should work through each of the situations to help the client learn new ways to deal with situations. The most

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[30] Psychopharmacological treatments should only be used in conjunction with active therapy – never as a substitute for it. This is the case with borderline individuals and all other therapy situations. Medication should never be the sole means of dealing with an emotional or psychological issue. Such singular use of psychoactive drugs is irresponsible since the client never learns to deal with the environmental and personal factors that are involved in their crisis.

significant effort of the therapist should be to curtail the propensity of the client to act out.

Therapy for the borderline can be done in two different ways. It can be a rather short-term effort. That effort, however, is designed to curtail the immediate crisis event. In all likelihood, the client will engage in behaviors that will result in another crisis at some time in the near future. Thus, the short-term method of dealing with the borderline individual is not the most optimal means of dealing with their personality issues.

Usually, comprehensive treatment for the borderline disorder will take a number of years to modify. Rather than simple behavioral modification, the borderline needs comprehensive personality reconstruction. The concept of "object permanence" – which was never established in childhood – must be accomplished. This effort, essentially, is an effort to "reparent" the individual.

This presents significant difficulties for the therapist and the client. Those difficulties are magnified in the pastoral setting. The difficulties include:

- The time commitment demanded by this disorder is usually too much for any pastor to perform.
- The possibility of emotional involvement between the therapist and the client (if it is a male-female relationship) is extremely high. This is a position that the pastor cannot afford to risk.
- Thus, if would seem most reasonable for the therapist to simply refer the individual to an outside counseling agency. This, however, will likely not result in a complete healing of the individual since the demands of therapy will mandate one or two sessions per week for a number of years. The possibility that the client will be able to financially bear the demands of this counseling regiment is slim.

Thus, the likelihood of this individual receiving the therapy that they need is not promising.

There is an alternative treatment method in which this individual can be helped, however.[31] The alternative treatment method would involve an individual within the congregation "taking on" the borderline individual for purposes of acting as their modeling "parent" in life. The amount of communication and the intensity of relationship that will be needed to help this individual is not likely from any other source.

In order for this unique relationship to work, the "reparenting" individual would need to understand the needs of the client. The pastor may be aware of a mature individual who is ministry-minded in the congregation who is willing to befriend the client. The pastor may contact that individual and discuss the potential of that individual engaging in a social and interpersonal relationship with the client.

The best relationship would be one where the "reparenting" individual was a number of years older than the client. Both individuals (the client and the reparent) should be of the same gender since the amount of emotion that will be invested in the relationship will be significant. There is a significant possibility that there will be sexual misconduct if the individuals are not from the same gender.

There would be six long-term objectives of the individual who is re-parenting the client. Those are:

- Establishment of a relationship that defuses the belief of the client that all relationships are unreliable and unstable. The fear of abandonment must be diminished.
- The removal of the belief that the client is defective, bad, unwanted or inferior to other people.
- The belief that others will abuse, humiliate, cheat, lie, manipulate or take advantage of the client.

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[31] Although the professional psychological community may not accept this method.

- Diffuse the client's belief that their desire for emotional support cannot be met by others.
- Develop a sense of social inclusion with the client. They must learn that they are not alienated and different from others.
- Help the client develop self-control. Aid them creatively in the development of frustration tolerance. This is one of the essential missing elements from the client's childhood experience.

If this alternative method is used, the therapist and the individual doing the re-parenting must maintain contact. The therapist should aid the individual in the performance of the re-parenting process.

Also, this reparenting method should never be used when a client is still in substantial crisis. The therapist must help the individual resolve their immediate crisis prior to the reparenting process. That includes helping the client resolve any home of origin issues that arose during therapy. This, in itself, may take some time.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Borderline Personality Type*. These include the following:

- The *Borderline Personality Type* is considered a "high risk" for adult suicidal behavior. The risk for suicide may be as high as *ten times* that of the normal population, especially for clients who have experienced childhood sexual abuse.[32] Feelings of hopelessness, impulsive behavior, impulsive aggression, antisocial

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[32] Statistics from *Western Psychiatric Institute and Clinic*, Department of Psychiatry, University of Pittsburgh.

behavior and loss of a significant relationship greatly increase the potential for self-destructive behaviors.

- During a crisis episode, the client may experience a psychotic event. This might range from *Brief Reactive Psychosis* to Schizophrenic-type disorders (most commonly *Schizophrenia* or *Schizoaffective Disorder*). Psychotic symptomology may range in duration from a very short period of time to a very significantly long period of time.

- This client may suddenly leave therapy when it appears that progress is being made. The client will fear any type of change – even when that change is substantially positive.

- When short-term therapy is conducted, there is a very strong possibility of the client having another significant crisis event in a short period of time. Crisis management does not help the client resolve long-term issues.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of short-term treatment of the *Borderline Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- Resolution of their abandonment fear. This client must realize that others can provide reliable and stable support in relationships.

- Reversal of the client's belief that they are defective, bad, unwanted or inferior to others.

- Recognition that others are not out to abuse, humiliate, cheat, lie, manipulate or take advantage of them.

- Development of significant relationships so that the client is able to obtain emotional support from other people.

- The client must learn to be socially active in an appropriate way so that their social isolation is lessened.
- The client must learn self-control and frustration tolerance.

Dependent Personality Style and Disorder

The Dependant Personality Type In A Nutshell

"The essential feature of *Dependant Personality Disorder* is a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation."[33]

The dependant individual is often viewed as everybody's friend. They rarely cause strife or conflict. They are usually willing to help most anyone who needs their help. Their internal world, however, may contain excessive anxiety and depressive symptoms.

A CLOSER LOOK

While a dependant individual may seem like a peaceful and content person, they are deeply troubled with the fear that they

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[33] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000, p. 721.

will be abandoned by others. They will usually do whatever they need to do to prevent the prospect of abandonment.

Although these individuals may seem to be emotionally passive, their passivity is outward only. Inside, the dependant individual holds onto both fear and anger. The fear is associated with abandonment – an ever-present prospect. The anger is associated with the fact that others seem to have such control over them. They know (deep inside) that they are sacrificing themselves unduly to others. They cannot help it.

When others take advantage of them – especially in very important interpersonal relationships like marriage – they develop a repressed anger against both the individual and the whole situation. They will usually not recognize or express this anger even to the therapist. They don't even know it exists, in some cases.

The indication to the therapist that there is a significant anger issue should be the presence of either a *Dysthymic Disorder* or an incidence of *Major Depression*. Depressive symptomology can be associated with repressed anger (especially when the anger is totally repressed from the conscious recognition of the individual).

If the therapist explores the issue of anger, it will take some time to uncover it. It is very threatening for a dependant individual to recognize, admit, and then express the anger – even as a transference to the therapist. It is not safe for them since unmasking the anger may result in a threat to a relationship, which invokes the fear of abandonment associated with dependency.

If anger is present, however, uncovering it and dealing with it will move the client ahead in the healing process. Until the anger surfaces and is recognized by the individual there is little probability of healing.

THE BOTTOM LINE

The dependant individual presents unique difficulties for the therapist. The therapist will find the client overly compliant in the counseling process. It is important for the therapist to

carefully read through the treatment section of this report and follow the directives there that seem most appropriate in the specific situation. It is especially important for the therapist to watch for transference and countertransference issues that could present significant problems.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Dependent Personality Disorder* are:[34]

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval.
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Dependant Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

MOOD DISORDERS, PANIC DISORDER, AGORAPHOBIA. *Dependent Personality Disorder* has an early onset, a chronic course, and a pattern of behavior that does not occur exclusively during *Axis I* or *Axis III Disorders*.

BORDERLINE PERSONALITY DISORDER. Both disorders have reactions to abandonment issues. With *Borderline Personality Disorder* cases, the reaction is with emptiness, rage and demands while *Dependent Personality Disorder* tends to increase appeasing behaviors and submission.

HISTRIONIC PERSONALITY DISORDER. Both disorders contain a strong need for reassurance and approval. *Dependent Personality Disorder* is self-effacing while *Histrionic Personality Disorder* is flamboyant.

AVOIDANT PERSONALITY DISORDER. Both disorders are characterized by strong feelings of inadequacy and

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[34] *DSM-IV-TR*, p. 725.

hypersensitivity to criticism. *Avoidant Personality Disorder* contains a strong fear of humiliation while *Dependent Personality Disorder* has a history of seeking and maintaining connections.

PERSONALITY DISORDER DUE TO MEDICAL CONDITION. Both disorders can coexist as long as *Dependent Personality Disorder* existed prior to the onset of the medical condition.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Dependant Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

MOOD DISORDERS. Various Mood Disorders may be present with the *Dependant Personality Type*. These may include *Major Depression Disorder*, *Cyclothymic Disorder*, *Dysthymic Disorder*, and (less likely) *Bipolar Disorder*.

ANXIETY DISORDERS. When the *Dependant Personality Type* fears separation or the need to exert themselves, they may suffer from *Anxiety Disorders*.

ADJUSTMENT DISORDERS. *Adjustment Disorder* is the development of emotional or behavioral symptoms as a result of environmental stressors. The *Dependant Personality Type* may experience *Adjustment Disorder* when they are put in a situation that pushes them out of their dependant state and forces them to make their own decisions. The *Adjustment Disorder* may include *depression*, *anxiety* (or a combination of both), and *conduct disturbance*.[35]

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[35] *DSM-IV-TR*, pp. 679-683.

The Dependant Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[36] the optimally functioning *Dependent Personality Style* contains seven elements. Correspondingly, there are seven elements that indicate the breakdown of each of those seven optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Dependent Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Dependent Personality Style* without allowing for diminution toward more maladaptive traits.

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[36] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 113.

Sperry's continuum includes the following seven elements:

Optimal Functioning	Maladaptation
• When making decisions, this person is comfortable seeking out the opinions and advice of others but ultimately makes their own decisions.	• The person is unable to make everyday decisions without an excessive amount of advice or reassurance from others – allow others of make their most important decisions.
• This person carefully promotes harmony with important persons in their life through being polite, agreeable, and tactful.	• This person agrees with people even when they believe they are wrong because of a fear of rejection.
• Although they respect authority, this individual prefers the role of a team member.	• This individual has difficulty initiating projects or doing things on their own.
• This person is thoughtful and good at pleasing others – maybe to the point of personal discomfort occasionally.	• This individual volunteers to do things that are unpleasant or demeaning in order to get other people to like them.
• This person prefers the company of one or more individuals to being alone.	• This person feels uncomfortable or helpless when alone – goes to great lengths to avoid being alone.
• This person tends to be strongly committed to relationships and works hard to sustain them.	• This person feels devastated or helpless when close relationships end and is frequently preoccupied with fears of being abandoned.
• This individual can take corrective action in response to criticism.	• This individual is easily hurt by criticism or disapproval.

The Dependant Personality Style under Stress

The following behaviors will likely manifest when an individual with a *Dependant Personality Type* faces a triggering event. In the case of the *Dependant Personality Type*, triggering events will be those events or interactions with others that demand self-reliance. This includes the prospect of the individual being alone for any significant period of time. The following elements may be involved in the individual's crisis:

- *Anxiety Disorders*. This individual may be subject to extreme anxiety disorders. This is especially true in cases of crisis and irresolution. The anxiety is likely generated by latent fear that is not being overtly expressed.
- *Mood Disorders*, especially depressive symptomology. This individual is always subject to depressive symptomology, especially conditions like *Dysthymic Disorder*.
- The individual in crisis may be unable to make decisions or greatly troubled by making decisions.
- The individual may be unable to work in crisis situations. This is especially true when depressive symptomology is extremely elevated.
- The individual will be overly compliant and may engage in activities that they do not really wish to participate in just to please another individual.
- The crisis in the dependant individual may be extreme when there is a perceived threat to loss of a significant relationship.
- The individual may be unable to be alone or may experience panic attacks when they are alone.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *Dependant Personality Type.*

PSYCHOSOCIAL ETIOLOGY FOR THE DEPENDANT
PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Dependant Personality Type*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the development of the *Dependant Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the

same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- MATERNAL OVER INVOLVEMENT AND INTRUSIVENESS. This usually occurs early in childhood development and continues throughout all phases of development. It usually begins prior to the development of self-directed coping skills. Thus, the child never really learns to solve their own problems and make decisions on their own (without the "guidance" of the maternal object). In adulthood, therefore, this individual will always need the help of others to make decisions. The adult will feel helpless and inadequate to formulate their own choices. There will likely be a fear in the whole decision-making process.

- PARENTAL REWARDING. This parental behavior "rewards" the child for maintaining loyalty to the parent. This behavior is employed once the child is of sufficient age that the parental figure might feel threatened in some way that the child will make their own decisions. Many times this parental behavior is presented to the child in a non-threatening manner so that the parent appears to be aiding the child with their superior knowledge. There may be subtle and creative "punishments" when a child makes a decision that counters the desires of the parent.

- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include over nurturing,[37] over care, non-

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[37] It appears that the first stage of child development was completed successfully. That stage is often called the "oral stage" or the stage of "trust versus mistrust." The individual learned to count on others since nurturance was readily available from caretakers. The problem develops after the oral stage when the caretakers do not allow the child to experience frustration. The child never learns to do things on their own but continues in the nurturance stage of reliance on others.

contingent nurturance, no options presented to the child, possible overly hostile and controlling family environment (all of these behaviors would have occurred after Freud's oral stage). [38]

[The above list does not contain biochemical considerations associated with the etiology of the *Dependant Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *Dependant Personality Style*.

EXPECTATIONS OF SELF-RELIANCE. The individual with a *Dependant Personality Type* displays an excessive need to be taken care of. When the individual faces the need to be self-reliant, that need can precipitate a personal crisis.

PROSPECT OF BEING ALONE. The prospect of being alone is somewhat associated with the need for self-reliance. When the dependant individual loses their dependence base, they may face a crisis.

Treatment Course For Dependant Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with a *Dependant Personality Type*. As is the case with any client engagement, when the therapist feels that

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[38] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are six major defense mechanisms that are commonly used by individuals with the *Dependant Personality Type*. Three of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

DISPLACEMENT. The client transfers a feeling about, or in response to, one object onto another less threatening substitute object. In the case of the dependant individual, this is usually done with anger that the individual is not able to express directly toward the individual they are angry with. [Level #2 – Mental Inhibitions Level]

ISOLATION OF AFFECT. The client separates ideas and cognitive elements from their originally associated affective states. There is no longer any recognition of the emotional state associated with the stressor. [Level #2 – Mental Inhibitions Level]

REPRESSION. The client learns to block out disturbing wishes, thoughts, behaviors, or experiences from the conscious mind. Affective states remain even though the cognitive aspects have been repressed. [Level #2 – Mental Inhibitions Level]

DEVALUATION. The client attributes exaggerated negative qualities to themselves. This will usually happen with the

dependant individual during depressive episodes. [Level #3 – Minor Image Distortion Level]

DENIAL. The client refuses to acknowledge some painful aspect of external relative or subjective experience that is apparent to others. This may especially be true in the case of the dependant individual who is being abused by a spouse. [Level #4 – Disavowal Level]

APATHETIC WITHDRAWAL. The client withdraws from any attempts to deal with internal or external stressing events or affective states. The client gives up. This may happen if the therapist moves too quickly. More likely, however, this may happen in relation to conflict between the dependant individual and their spouse regarding therapeutic influence in the home. [Level #6 – Action Level]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Dependant Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the

50% threshold. This is not abnormal.[39] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

These are some key elements that will aid in the therapy of an individual who is dependant:

- The likelihood of success in counseling a dependant individual is increased if the client is currently facing a crisis situation. A quick alliance with the therapist will also increase the possibility of success.
- If the client has a subdominant *Histrionic Personality Type* or a *Borderline Personality Type*, this may complicate treatment. Especially in the case of the histrionic, the dependant individual may use overtly seductive behaviors to gain the admiration of the

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[39] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

therapist. The therapist should be fully prepared to deal with this eventuality.

- Since the client will have a tendency to attach to the therapist in a dependant manner, the therapist can work against this tendency by setting a termination date for therapy during the first or second session. The therapist should involve the client in the planning of treatment and the setting of treatment goals very early in the treatment process. This, also, will mitigate against dependency on the part of the client. The client will likely resist this structured therapy situation since they may have entered therapy for the purpose of remaining dependant.

- Furthermore, the client may be hypersensitive to decision making. This may complicate an attempt to get the client involved in therapeutic planning.

- The client may view the therapist as the "expert" and may hang on every word spoken by the therapist. The therapist should be able to recognize this and work against it by asking the client for their own opinion.

- The primary purpose of therapy is to increase the client's sense of independence and self-sufficiency.

- The therapist must be aware of marital issues, including the personality type of the spouse. This may play a key role in the abilities of the client to move forward in therapy. In the case of an extremely controlling spouse, the client may wish to make substantial changes in thinking and behavior at home but will be discouraged by the spouse. This interaction will prevent any significant progress and healing for the client. [See *Dangers of the Therapeutic Process*].

- Issues of transference and countertransference may play a significant role in the interaction between the client and therapist [See *Dangers of the Therapeutic Process*].

- The therapist must gradually increase the level of expectation for self-initiated behavior on the part of the

client. As therapy progresses this is a positive sign that the client is moving ahead positively.

- The therapist should become the symbol of the losses that the client feels so that the losses can be dealt with in the process of the transference.
- The therapist must prompt the individual to engage in independent thoughts and behaviors. This will be initially very hard for the client. As time goes on, however, the therapist should begin to see progress toward individualization.
- The therapist must encourage the client to express their real feelings and wishes. They will likely hide their deepest desires. Desires, feelings and wishes will initially revolve around pleasing others. The therapist must get the client past those desires, feelings and wishes to understand that they are separate from other people and that it is not inappropriate for them to have their own deep desires.
- The client has dysfunctional beliefs about personal inadequacy. The client needs to learn ways in which to increase assertiveness without learning aggression. They need to experience the fact that conflict and confrontation does not need to be the end of a relationship.
- The dependent client is often laden with guilt and anger, although they will not usually outwardly display the anger in aggressive ways. The anger will all be passively stated or stated in a very controlled manner. It is likely that the individual will not be able to admit that they are deeply angry. The anger may be totally repressed. The therapist needs to explore areas where the client may be repressing anger and extract it from the individual. The therapist is warned that when the dependant individual finally expresses anger it may be quite substantial (in the therapy situation). The client may at first transfer the anger to the therapist and display some displeasure with the therapist. Later, however, the client will properly

locate the anger. Expression of significant anger on the part of any client who has been repressing it might result in some significant *Axis I Disorders* (most likely *Dysthymic Disorder* or a *Major Depressive Disorder*, although others are likely).

- The client needs to learn to develop mutual, interpersonal relationships. Dependent individuals function from the basis of two opposing automatic thoughts: 1) A person must choose to be totally dependent and helpless; or, 2) a person must choose to be independent and totally isolated. Since these individuals cannot face being isolated, they prefer helplessness. The client must be taught that autonomy does not mean isolation.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Dependant Personality Type*. These include the following:

- *Axis I Disorders*. This will likely include various anxiety states and depressive symptomology, potentially intense. The risk of *Axis I Disorders* is highest during elevated crisis periods and breakthroughs in therapy.
- Complete apathetic withdrawal into a catatonic or nearly catatonic state. This may result in a *Major Depressive Episode* or a significant and prolonged *Anxiety Disorder*.
- Transference issues. The client may see the therapist as their savior or their rescuer. They may transfer dependant behaviors onto the therapist and use the therapist as a means of fixating their dependency.
- Countertransference complications. In some cases, therapists may experience aggravation or even anger toward the client (actively or passively) due to their own intolerance with dependant behaviors and attitudes. A more likely countertransference issue would be romantic

attachments by the client onto the therapist (transference) and the therapist responding with inappropriate behavior, feelings, or thoughts about the client (countertransference). Dependant individuals can be clingy "love magnets" and the therapist needs to guard against this from the beginning.

- Spousal interference in treatment and client progress. In the case of a dependant female client who is either married or significantly involved with an individual, the therapist is advised to entertain at least one session with the spouse. The purpose of this session should be: 1) to gain the spouse's approval for treatment; 2) to understand the client's issues from the spouse's perspective; 3) and to determine the spouse's own personality type. In some cases, the therapist will find that the dependant person has attached themselves to an individual who has an *Antisocial Personality Type*. It is best to determine support in this case since the antisocial individual may react adversely to the client's progress toward independence. If the antisocial individual is somewhat disordered themselves this progress on the part of the client may present a significant threat to the antisocial spouse. The antisocial spouse may react with emotional attempts to reign in the client and prevent further client independence. In extreme cases, there is a potential for domestic violence.

- Potential for litigation. In the case that the dependant individual is associated with a spouse who has a severe personality issue themselves there is a potential for litigation from the spouse in the event that the spouse feels that the therapist has unduly "torn" the dependant individual away from the spouse. This is especially true in cases where the spouse is antisocial. If it appears that the client's views toward the spouse are deteriorating as the client gets stronger, the therapist should probably engage the spouse in therapy also. Every effort must be

taken to ensure that there will be no appearance that the therapist was involved in the dissolution of the marriage.

- Self-destruction, including suicidal behavior. This is most pronounced in situations where the client is married to an individual with a very dominant personality who is also significantly disordered or in crisis (e.g. *Antisocial Personality Disorder*). When dealing with a client who is significantly disordered with the *Dependant Personality Type*, it is important to do some initial screening of the spouse (especially determining the personality type).

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment for the *Dependant Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- Development of self-image and self-esteem so that the person no longer feels defective, bad, unwanted, or inferior to others.
- Development of the client's ability to act on their own without constantly seeking the advice and direction of others.
- Elimination of the need of the client to sacrifice themselves in order to meet the needs of others.

Histrionic Personality Style and Disorder

The Histrionic Personality Type In A Nutshell

"The essential feature of *Histrionic Personality Disorder* is pervasive and excessive emotionality and attention-seeking behavior."[40]

Individuals who have a *Histrionic Personality Type* may engage in relationships that contain heightened emotions. They typically pull people in through emotionality (including overt seductive behaviors) and then blow up the relationship in overly dramatic emotional outbursts. After the explosion, they will reel the person back in for another round on their emotional roller coaster. The cycle continues over and over with close or intimate contacts.

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[40] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000, p. 711.

A CLOSER LOOK

Sometimes therapists have a hard time differentiating between *Borderline Personality Disorder* and *Histrionic Personality Disorder*. There is a possibility that the two can co-exist. The combination of both conditions is usually considered as the decomposition of the histrionic personality structure.

In one respect, the differences between the two are a matter of degree. Both include a fear of being alone and a fear of abandonment – with the borderline being frantic in their efforts to avoid those conditions. Both are also impulsive – again, with the borderline being potentially dangerous in their impulsive actions.

In another respect, however, there is a very significant difference in self-image. The histrionic individual has a higher level of functioning in the respect that they are interactive with their interpersonal environment. They openly use attention-seeking efforts to seek and maintain relationships.[41] The borderline is much more frantic in their relationship efforts. Also, the borderline individual has a propensity toward paranoid ideations and severe dissociative symptoms. These are usually not present with the histrionic individual.

THE BOTTOM LINE

Although securing lasting relationships with significant people is the primary need of these individuals, they have not learned enough about their own self image to secure a lasting and stable relationship. Thus, all of their efforts are simply attention-seeking behaviors. Without a thorough understanding of self these individuals cannot differentiate themselves from others enough to maintain the relationships that they seek.

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[41] In both disorders, the individuals fear being alone. The histrionic individual, however, believes that they can do something to avoid abandonment. Thus, they use whatever assets they have (including overt sexuality, attractiveness, and other flamboyant measures) to secure relationships so that they can avert being alone. The borderline

There is often a confusion between feeling and fact with these individuals. What they feel is often what they believe. Thus, if they "feel" stupid, then they are stupid. If they "feel" ugly, then they are ugly. They cannot differentiate between feeling and fact. In a relationship, this inability to differentiate results in their abandonment terror. If, for example, they have some "feeling" of abandonment in a relationship, then certainly the relationship must be over! Facts regarding commitment and the history of the relationship are not considered.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Histrionic Personality Disorder* are:[42]

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the center of attention.
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.

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individual has either forfeited those efforts or they see those efforts as largely a failure.

[42] *DSM-IV-TR*, p. 714.

7. Is suggestible, i.e., easily influenced by others or circumstances.

8. Considers relationships to be more intimate than they actually are.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Histrionic Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

BORDERLINE PERSONALITY DISORDER. Dual diagnosis can be made, if appropriate criteria are met for both disorders.

ANTISOCIAL PERSONALITY DISORDER. *Antisocial Personality Disorder* engages in manipulation to gain power and profit while *Histrionic Personality Disorder* engages in manipulation to gain nurturance.

NARCISSISTIC PERSONALITY DISORDER. Both disorders involve attention seeking. *Narcissistic Personality Disorder* uses attention seeking to gain superiority over others and *Histrionic Personality Disorder* uses attention seeking because the individuals are willing to be viewed as fragile.

DEPENDENT PERSONALITY DISORDER. *Dependent Personality Disorder* is not characterized by flamboyant, exaggerated

emotional features while *Histrionic Personality Disorder* contains those elements.

PERSONALITY CHANGE DUE TO MEDICAL CONDITION. Dual diagnosis can be made. *Histrionic Personality Disorder* must exist prior to the onset of the medical condition.

CHRONIC SUBSTANCE ABUSE. Dual diagnosis can be made. *Histrionic Personality Disorder* must exist prior to the onset of chronic substance abuse.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Histrionic Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

SOMATIZATION DISORDER. *Somatization Disorder* may be present in the *Histrionic Personality Type*. This disorder results in significant physical complains that involve repeated visits to a medical doctor. In order to meet criteria for the disorder, the physical complaints must be from four categories: *pain symptoms*, *gastrointestinal symptoms*, *sexual symptoms*, and *pseudoneurological symptoms*. These physical manifestations may be a result of the attention-seeking behavior of this personality type.

CONVERSION DISORDER. *Conversion Disorder* is the presence of physical symptomology related to motor or sensory function. Symptoms vary widely including *paralysis*, *difficulty swallowing*, *lump in the throat*, *urinary issues*, *loss of touch or pain sensation*, *double vision*, *blindness*, and *deafness*.[43] These symptoms usually simulate neurological or other medical conditions quite closely. *Conversion Disorder* may only be diagnosed when a medical doctor has completely ruled out a

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[43] *DSM-IV-TR*, pp. 492-498.

medical source for the seemingly medical issues. *Conversion Disorder* among individuals with the *Histrionic Personality Type* may be associated with *attention-seeking behaviors* and the *excessive emotionality*.

MAJOR DEPRESSIVE DISORDER. Relationships associated with the *Histrionic Personality Type* are often roller coasters. When relationships fail, there is a possibility of a *Major Depressive Disorder*. The general emotionality of this disorder may also precipitate depression.

DYSTHYMIC DISORDER. *Dysthymic Disorder* contains many of the same elements as *Major Depression*. One of the main differences is the prolonged nature of the depressive symptomology (existing over at least a two-year period). Although the symptoms may be less severe, they include a depressed or "blue" mood. The tendency of the *Histrionic Personality Type* toward *Dysthymic Disorder* may be related to their consistent interpersonal conflicts.

SOCIAL PHOBIA. Due to the potential for consistent interpersonal conflict experienced by the individual with a *Histrionic Personality Type*, the prospect of a *Social Phobia* is a distinct possibility.

ANXIETY DISORDERS. Again, due to the prospect of consistent interpersonal conflict, this individual may experience various anxiety disorders.

The Histrionic Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that

might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[44] the optimally functioning *Histrionic Personality Style* contains seven elements. Correspondingly, there are seven elements that indicate the breakdown of each of those seven optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Histrionic Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Histrionic Personality Style* without allowing for diminution toward more maladaptive traits.

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[44] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 133.

Sperry's continuum includes the following seven elements:

Optimal Functioning	Maladaptation
• This person enjoys compliments and praise.	• This individual constantly seeks or demands reassurance, approval, or praise.
• This individual is charming, engaging, and appropriately seductive in appearance and behavior.	• This individual is inappropriately sexually seductive in appearance and behavior.
• This person is attentive to their appearance and grooming.	• This person is overly concerned with physical attractiveness.
• This individual is lively and fun-loving, often impulsive but can delay gratification.	• This person expresses emotion with inappropriate exaggeration, is self-centered.
• This individual enjoys being the center of attention and can rise to the occasion when all eyes are on them.	• This person is uncomfortable in situations where they cannot be the center of attention.
• This person is sensation oriented, emotionally demonstrative, and physically affectionate.	• This person displays rapidly shifting and shallow expression of emotion.
• This individual uses a style of speech that is appropriately global and specific.	• This individual uses a style of speech that is excessively impressionistic and lacking in detail.

The Histrionic Personality Style under Stress

The following behaviors will likely manifest when an individual with a *Histrionic Personality Type* faces a triggering event. In the case of the *Histrionic Personality Type*, triggering events will be those events that are associated with relationships involving the opposite sex – especially relationships that become

emotionally volatile. Simple participation in relationships with the opposite sex is likely to involve at least some stressing symptoms.

- Constant need for reassurance, approval and praise.
- Extreme attention-seeking behaviors (including seduction and use of emotionality).
- Over concern with physical appearance (and attractiveness in females).
- Exaggerated emotional displays including irrational outbursts and temper tantrums.
- Extreme impulsiveness.
- Potential for suicide threats or attempts the focus of which is to draw attention to themselves when other methods fail. However, sometimes these individuals intend to commit suicide and are successful. This is a significant sign of decompensation.
- Development of a significant *Axis I Disorder* during decompensation. This may be the result of the breakdown of the defense mechanism system or it may be an attention-seeking episode (especially in the case of physiological manifestations).

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *Histrionic Personality Type.*

PSYCHOSOCIAL ETIOLOGY OF THE HISTRIONIC
PERSONALITY TYPE

The formulation of personality (and, consequently, the potential
for disorder) occurs during child development. No parent and no
family environment is perfect. Thus, the imperfections of that
home environment will lead to the development of some
personality "skew." That skew is called a personality style.

In cases where the home environment was significantly
maladaptive, traumatic, or damaging to the psyche of the child,
the potential for development of a full-blown personality
disorder increases with the onset of early adulthood.

   The following list contains likely issues that arose during
childhood that precipitated the formulation of the *Histrionic
Personality Type*. Many of these issues will not be cognitively
accessible to the client and there is a likelihood that many of
these issues will be denied by the client. In spite of client denial
(which is very common) these are the most commonly accepted
reasons for the development of the *Histrionic Personality Type*.

   The therapist must recognize the difference between an
optimally functioning personality style and a personality that is
moving (or has moved) toward disorder. The personality that is
not in a state of disorder but skews toward the personality style
may contain a few of the events from this list, some items may
be repressed, or less severe family behaviors that follow the
same "theme" may have existed (but not necessarily with the
same intensity).

   The therapist should not "automatically" assume that each of
these items was a reality in the person's home of origin. This list
should be used for investigation and exploration in order that the
therapist might understand the dynamics of the home of origin.

- LACK OF MATERNAL EMOTIONAL NURTURANCE (female
  child). The nurturance that the child likely received was
  external in nature. The mother was likely concerned with
  the appearance of the child and neglected the emotional

needs and development of the child. The child turns to the father for emotional gratification. The female child may use a number of methods to gain the gratification of the father. Those methods will probably be age appropriate and (in the later years) may include flirting and exhibitionism. These methods are all designed to gain the gratification of the father and to hold his emotional attention. Often, these girls become "daddy's little girl." In adulthood, however, the lack of maternal nurturance causes the continual cycle of acceptance (of a male figure) and pushing away (of the same male figure). As the female gains the nurturance of the male figure (who is a replacement for her father) she drives him away emotionally since the real deprivation internally is the need for maternal nurturance.

- LACK OF MATERNAL EMOTIONAL NURTURANCE (male child). When a male child is not sufficiently nurtured emotionally by his mother, he too will turn to his father for nurturance. If the father is not able to fulfill his emotional needs, the individual may develop effeminate characteristics later in life. The result may be homosexuality (or latent homosexual desires). However, homosexuality is not the only course that the lack of maternal emotional nurturance may take. The adult may develop a distrust for all females (even though they may be married). No female will be able to satisfy what was missing in the maternal relationship. Macho behavior may result to "prove" that the male is superior. Celibacy is also a strong possibility.

- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include being loved for attractiveness or entertainment value, no emphasis on competence or personal strength, relationship with mother was competitive, flirtatious attachment to father figure, father caters to the child, submissive love contingent on looks or entertainment value, child learned to control using appearance, possible unpredictable changes due to

parental instability, "interesting" and non-threatening drama and chaos in the home, demands to pretend that everything is OK in the home, and possible nurturing and rewarding of the child for being ill.[45]

[The above list does not contain biochemical considerations associated with the etiology of the *Histrionic Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *Histrionic Personality Style*.

PARTICIPATION IN OPPOSITE SEX RELATIONSHIPS. The individual with a *Histrionic Personality Type* will engage in volatile relationships that rapidly swing from love to hate. This is largely for the purpose of gaining attention. During the course of these emotionally charged relationships, the histrionic individual may enter a personal crisis. This is especially true when they realize that a reactive relationship is in the process of ending.

Treatment Course For Histrionic Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with a *Histrionic Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Furthermore, in the event

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[45] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are eight major defense mechanisms that are commonly used by individuals with the *Histrionic Personality Type*. Six of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

REPRESSION. The client consciously learns to block out disturbing wishes, thoughts, behaviors, or experiences from the conscious mind. Affective states may remain even though the cognitive aspects have been repressed. [Level #2 – Mental Inhibitions Level]

UNDOING. With this mechanism, the histrionic individual uses words or behaviors to negate or make amends for unacceptable thoughts, feelings, or actions. This is all part of the histrionic attention-seeking "game." [Level #2 – Mental Inhibitions Level]

DEVALUATION. The client attributes exaggerated negative qualities to themselves or to other people. The histrionic individual uses *Devaluation* as a mechanism to gain attention – either by *Devaluing* themselves or by *Devaluing* others for the purpose of attention. [Level #3 – Minor Image Distortion Level]

IDEALIZATION. The client attributes exaggerated positive qualities to other people. With the histrionic individual, this idealization may only last as long as the emotional affect associated with the *Idealization* has significant impact on their

relationship. The *Idealization* is part of the attention-seeking behavior. [Level #3 – Minor Image Distortion Level]

PROJECTION. The client falsely attributes their own unacceptable feelings, impulses, or thoughts onto another person without justification. In the histrionic individual, this is usually a reaction to their own perceived negative aspects. Rather than deal with those aspects in themselves, they *project* them onto someone for purposes of judging the negative aspects. [Level #4 – Disavowal Level]

SPLITTING. The client is unable to integrate positive and negative qualities of self or others into cohesive images. They compartmentalize opposite affects. Opposite emotions cannot be experienced simultaneously. The image of self, others, and even objects tends to alternate between polar opposites. Something or someone is either totally good or totally bad. *Splitting* most likely occurs in the histrionic individual due to the conflicted state of maternal nurturance and affection. [Level #5 – Major Image Distortion Level]

ACTING OUT. The client commits physical actions directly in response to internal reflections, feelings, of affective states. These actions may be dangerous actions at times including attempted suicide and acts of violence toward others. For the histrionic individual these *Acting Out* events may include a number of other relationship associated acts. [Level #6 – Action Level]

APATHETIC WITHDRAWAL. The client withdraws from any attempts to deal with the internal or external stressing events or the emotional states associated with those stressors. The client no longer wishes to discuss the stressor nor do they desire to work toward resolution. The client is now "frozen" in their crisis. When this occurs in the course of treatment for a *Histrionic Personality Type* the therapist should be aware of the potential for suicide or suicide gestures. [Level #6 – Action Level]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Histrionic Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[46] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to

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[46] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

This individual is usually dramatic, impulsive and manipulative. They can often be seductive, especially females. They may use temper tantrums and illogical thinking as part of their behavioral reactions. All of these characteristics are an effort to gain the attention of others.

There are some elementary starting points that the therapist should consider when engaging an individual with the *Histrionic Personality Type*.

- The therapist should understand that the *Histrionic Personality Type* can decompose into the *Borderline Personality Type*, especially when in crisis and when established defense mechanisms fail. This condition might result in the dual diagnosis of both disorders. This event will significantly complicate the counseling process.
- Since these individuals are attention-seekers, they can be seductive (especially as females). The therapist of the opposite gender should realize that transference may involve erotic or seductive behaviors toward the therapist. This can be used to the benefit of the therapist during therapy by explaining to the client what is happening.
- Treating the histrionic individual will usually present a considerable challenge to the therapist. This is even more so when the individual is a lower functioning individual.

- Lower functioning individuals should be counseled as the therapist would normally address and treat a borderline individual.
- Higher functioning individuals readily develop a therapeutic relationship. The therapist must be aware, however, that the client may tend toward a dependant role. There is a possibility in a positive client-therapist relationship that the client will begin to view the therapist as a savior or a rescuer. The therapist cannot allow this feeling to exist for too long.
- The therapist can reduce this savior mentality by involving the client in the establishment of goals very early in the process. When the therapist and the client collaborate on goals, there is less likelihood of the client becoming dependant on the therapist. As time progresses in the therapeutic relationship, the therapist must insist more and more on the client becoming independent.
- The client will tend to set broad and non-specific goals. The therapist must help them set specific and concrete goals. This effort will be largely resisted by the client.
- From the beginning of therapy, the therapist must teach the client how to control their impulses. Controlling impulsiveness will be a key factor in client progress.
- The client who has a histrionic mindset will focus on attention-seeking behaviors. They largely ignore or do not understand their own real needs and feelings – only those needs and feelings that fulfill their need for attention. The therapist must help the client come in contact with their own real needs and feelings rather than attention.
- During the course of counseling, the therapist needs to keep track of the methods that the client uses to gain the attention of others. The therapist should instruct the client about their attention-seeking behaviors and help them see the nature of those behaviors.
- Impulsivity is a major issue with individuals who have a *Histrionic Personality Type*. They tend to "fly off" in

interpersonal situations, acting before thinking. Impulsivity can be curtailed by telling the client to stop before reacting. This technique will give them two skills: 1) the ability to recognize an impending impulsive event, and 2) the ability to think through various responses prior to taking action.

Once the client has established themselves in therapy and the therapist feels that there is a good working relationship, the therapist can move ahead with more substantial personality reconstruction. The therapist may employ some of these methods:

- Discuss interpersonal situations with the client that did not work out well. Help the client to explore all options that could have been taken rather than the action that they took. Help the client to select a more appropriate response to past situations.
- The therapist can also use role playing for the same exercise, inventing potential situations for the client to resolve.
- Clients should be made to pinpoint what they want in a relationship. Then, the therapist can help them structure interactions in a manner that prevents the usual emotional content of a relational interaction. Since relationships are typically centered around the impulsive emotional reactions of the client, they may have a hard time establishing what they need and want from a relationship. Many times, the emotionality of a relationship is what keeps them in a relationship.
- The therapist may have the client express exactly how it would feel to have a significant change in their life. This should be done to help the client see the difference between the lifestyle that they have and the one that they can have. This can be used in the goal setting process.
- Histrionic individuals typically have a problem understanding cause and effect. As incidents occur

during the course of counseling, the therapist needs to emphasize the relationship between cause and effect. "You did this, and this is what happened." The therapist should understand that the client may have a hard time grasping cause and effect.

- They will have a hard time focusing on homework (although homework is a key element in therapy). The therapist will need to explain homework assignments a number of times. The client needs to understand the goal of homework in order to engage in it. Homework assignments will likely be viewed as dull and boring.

- Loss of any significant relationship is always seen as a disaster to the histrionic person. Role playing about the loss of previous relationships or the prospect of the loss of a future relationship may help the client to realize that even though there may be trauma in the loss of a relationship, the loss of a relationship is not the end of the world.

- Later in therapy, problematic interpersonal relationships will need to be addressed. This should only be done when the therapist is confident that the histrionic individual is willing and able to work on those issues. The typical histrionic client will usually engage in interpersonal relationships that contain some "reward" for involvement. The reward is usually the reinforcement of their negative beliefs about themselves. Thus, they will choose relationships where they can use emotional demonstrations, jealousy, charm and seduction as the means of pulling individuals in. After they pull them in, they typically push them away. The client will use emotional outbursts as the key to manipulation in interpersonal relationships. This must be taught to the client and the therapist must help the individual to learn other more reasonable means of dealing with relationships.

Key elements that should be resolved during the therapy process include:

- The client's belief that they cannot expect the emotional support that they need from others to be met by them. They feel emotionally deprived.
- The client maintains a belief that they are somehow defective, bad, unwanted, or inferior to others.
- The behaviors of the client all focus on seeking the approval of others. They constantly seek to belong at the expense of developing a true sense of self.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Histrionic Personality Type*. These include the following:

- The therapist must be aware of the potential for suicide gestures and attempts. While most of these gestures will be attempts to get attention, the therapist must understand that the client may actually commit suicide, especially as they degenerate in crisis.
- The therapist must understand that histrionics don't typically stay in therapy long enough to make significant change. Once they begin to "feel better" they usually want to exit therapy. This does not allow for alteration of the long established behavioral patterns that precipitated a crisis in the first place.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment for the *Histrionic Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- Alter the client's belief that their desire for emotional support from others cannot be met.
- Change the client's belief that they are defective, bad, unwanted, or inferior to others.
- Eliminate the approval-seeking behaviors of the client. These behaviors diminish the potential for the client to realize a true sense of themselves by constantly seeking the approval of others.

Narcissistic Personality Style and Disorder

The Narcissistic Personality Type In A Nutshell

"The essential feature of *Narcissistic Personality Disorder* is a pervasive pattern of grandiosity, need for admiration, and lack of empathy."[47]

The usual understanding of the narcissistic individual is that they are "full of themselves." This, however, may be a simplistic estimation. The personality issues are much more complex than that.

A CLOSER LOOK

Many would immediately write off the narcissistic individual as a person obsessed with themselves. They seem self confident and self assured. Outwardly, that is certainly the case. But there is

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[47] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000, p. 714.

more to the outward confidence of the narcissistic individual that needs to be considered.

The narcissistic individual has a fractured ego. Their childhood experience involved some significant interaction that never fully allowed them to structure their own ego independent of the maternal object. This could have been due to insufficient maternal nurturing or it could have been the result of over nurturing by the mother. Either way, the individual never learned to separate themselves fully from the maternal object.

Thus, the individual must function in their intrapersonal and interpersonal relationships in a manner that continually seeks the approval of others. They need others to reaffirm that they are indeed worthy of nurturing. This translates in the "real world" into behaviors that look like blatant self-promotion simply for the purpose of letting others know that they are special people.

All the while the narcissistic individual has a void inside of themselves. They are unsure of themselves and even though they present a "front" of being the greatest, they sorely doubt that fact deep inside. For this reason, the most likely trigger for a crisis associated with the narcissistic personality is anything that will bring about a defacing of their control over their "manufactured" special person. When they encounter environmental situations that result in them doubting themselves and their personal value, they will likely face a crisis. If that crisis looms for too long, it may have significant manifestations in *Axis I Disorders*.

THE BOTTOM LINE

The therapist must understand that the strong and self-assured person that they see in the office is not the "real" person that exists buried deep inside this individual. Deep inside is a very insecure and frightened individual. This person may likely face a significant personal crisis when they begin to admit to themselves that they are not a "beautiful swan" but simply one of the many "ugly ducklings." That is a prospect that will case considerable insecurity – maybe even a long-term crisis.

This crisis is brought on by the fact that the ego of the individual is fractured. It never fully separated from the maternal

object. Those issues must be resolved and the treatment section of this report should give the therapist some direction in helping the client to face their greatest fears.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Narcissistic Personality Disorder* are:[48]

> A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
> 2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
> 3. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
> 4. Requires excessive admiration.
> 5. Has a sense of entitlement i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations.
> 6. Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends.
> 7. Lack empathy: Is unwilling to recognize or identify with the feelings and needs of others.
> 8. Is often envious of others or believes that others are envious of him or her.
> 9. Show arrogant, haughty behaviors or attitudes.

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[48] *DSM-IV-TR*, p. 717.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Narcissistic Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

HISTRIONIC PERSONALITY DISORDER, ANTISOCIAL PERSONALITY DISORDER, BORDERLINE PERSONALITY DISORDER. The most significant difference between these three disorders and *Narcissistic Personality Disorder* is that *Narcissistic Personality Disorder* is excessively grandiose regarding self while the others do not contain that element.

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER. *Narcissistic Personality Disorder* lacks self-criticism. Self-criticism is a component of *Obsessive-Compulsive Personality Disorder*.

SCHIZOTYPAL/PARANOID PERSONALITY DISORDER. *Narcissistic Personality Disorder* does not contain suspiciousness and social withdrawal as a characteristic while those traits are present in the other two disorders.

MANIC/HYPOMANIC EPISODES. Mood change and functional impairments are a significant component in *Manic/Hypomanic Episodes*. Those elements are not present in *Narcissistic Personality Disorder*.

PERSONALITY CHANGE DUE TO MEDICAL CONDITION. Dual diagnosis can be made. *Narcissistic Personality Disorder*, however, must exist before the diagnosis of the medical condition.

CHRONIC SUBSTANCE ABUSE. Dual diagnosis can be made. *Narcissistic Personality Disorder*, however, must exist before the diagnosis of substance abuse.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Narcissistic Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

DYSTHYMIC DISORDER. *Dysthymic Disorder* contains many of the same elements as *Major Depression*. One of the main differences is the prolonged nature of the depressive symptomology (existing over at least a two-year period). Although the symptoms may be less severe, they include a depressed or "blue" mood. The tendency of the *Narcissistic Personality Type* toward *Dysthymic Disorder* may be related to their constant need for admiration and their lack of empathy.

MAJOR DEPRESSIVE DISORDER. A *Major Depressive Episode* is also a distinct possibility for the *Narcissistic Personality Type* due to the same reasons for the *Dysthymic Disorder*.

ANOREXIA NERVOSA. *Anorexia* appears with the *Narcissistic Personality Type* more frequently than normal. The reasoning for this is not clear. It may be associated with the need for self-promotion and the need for admiration.

SUBSTANCE-RELATED DISORDERS. *Substance Disorders* may be elevated among the *Narcissistic Personality Type* due to the constant stresses of self-focus.

The Narcissistic Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[49] the optimally functioning *Narcissistic Personality Style* contains nine elements. Correspondingly, there are nine elements that indicate the breakdown of each of those nine optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Narcissistic Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Narcissistic Personality Style* without allowing for diminution toward more maladaptive traits.

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[49] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 153.

Sperry's continuum includes the following nine elements:

Optimal Functioning	Maladaptation
• Although this person is emotionally vulnerable to negative assessments and feelings of others, they can handle these with style and grace. • This individual is shrewd in dealing with others, using the strengths and advantages of others to achieve their own goals. • This individual energetically sells themselves, their ideas, and their projects. • This person tends to be an able competitor who loves getting to the top and staying there.	• This person reacts to criticism with feelings of rage, stress, or humiliation (even if those feelings are not outwardly expressed). • This person is interpersonally exploitive, taking advantage of others to achieve their own ends. • This person has a grandiose sense of self-importance. • This individual believes that their problems are unique and that those problems can only be understood by other special people.
• This individual can visualize themselves as the best or most accomplished in their field. • This person believes in themselves, their abilities, and their uniqueness but does not demand special treatment. • This individual accepts accomplishments, praise, and admiration gracefully and with self-possession. • This person possesses a keen awareness of their thoughts and feelings.	• This person is preoccupied by fantasies of unlimited success, power, brilliance, beauty, or ideal love. • This person has a sense of entitlement and unreasonable expectations of especially favorable treatment. • This individual requires constant attention and admiration. • This person has a lack of empathy and an inability to recognize and experience how others feel.

Optional Functioning	Maladaptation
• This individual expects others to treat them well at all times.	• This person is preoccupied with feelings of envy.

The Narcissistic Personality Style under Stress

The following behaviors will likely manifest when an individual with a *Narcissistic Personality Type* faces a triggering event. In the case of the *Narcissistic Personality Type*, triggering events will center around some significant self-evaluation exercise. This exercise will likely be associated with a significant life-event. That life event does not need to be a negative event in order to trigger a crisis: any event may trigger an event (e.g. loss of job, loss of relationship, graduation from school, birth of a child, etc). These are some of the probable manifestations associated with a crisis:

- Depressive symptomology is likely, including *Dysthymic Disorder* and a *Major Depressive Episode* (especially in significant crisis situations).
- Substance abuse issues.
- Over working issues.
- Consistent irritability, anger, or potential rage (especially illogical "placement" of hostilities).
- Self isolation. Since the tendency of the narcissistic individual is to believe that no one understands them, they may isolate themselves during crisis situations.
- The individual may strike out at others with apparently unwarranted attacks.
- Morbid attempts to control both situations and other people.
- *Apathetic Withdrawal*.
- Self devaluation.

- Somatic symptoms due to the stress of a crisis situation. The narcissistic individual tends to internalize issues.
- In extreme and prolonged crisis situations wherein the client feels "trapped" and unable to see any resolution to the crisis that has forced self evaluation, psychosis may be a result. This might be a *Brief Psychotic Reaction* or a more prolonged episode such as *Delusional Disorder*.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *Narcissistic Personality Type.*

PSYCHOSOCIAL ETIOLOGY OF THE NARCISSISTIC PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Narcissistic Personality Type*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial

(which is very common) these are the most commonly accepted reasons for the development of the *Narcissistic Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- MATERNAL OVER GRATIFICATION. This is the primary cause of narcissistic tendencies. The over gratification likely occurred quite early in life (infancy) and continued on throughout childhood. The oral stage is the most likely point of beginning for the over gratification since the narcissistic individual seems to have a significant issue with self-gratification. There are also issues of "object love" involved.

- SELFLESS, UNCONDITIONAL MATERNAL LOVE. While unconditional love sounds like a "good idea," it is not functional in real life. This creates expectations in the child that are devoid of realism. This overindulgence often creates a feeling of "specialness" in the individual. Consequently, they will feel weak and exploited when their adult environment does not provide what they need.

- FRUSTRATION EXPERIENCE FAILURE. The maternal caretaker did not provide consistent and appropriate maximum frustration experiences for the child. The child, instead, was given what they wanted prior to maximum frustration. Maximum frustration is a key element in the development of self and the ability to differentiate between self and others. When a child is

frustrated (at the appropriate age) the child will "invent" ways to get what they need for themselves. For example, the child who has learned to crawl wants a toy that is across the room. The child will likely cry and point to the toy. The proper means of parenting is for the parent to encourage the crawling child to go get the toy themselves. The frustration experience will encourage the child to develop their own logical resolutions to their needs. The parent who continually responds to the desires of a child (that the child can fulfill themselves) will risk fragmentation of the child's ego. This will result in the adult "crying" for others to continually get what they themselves should be providing for themselves.

- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include selfless, non-contingent love and adoration;[50] "worship" of the child; exaggerated and distorted love; adoration not accompanied by genuine self-disclosure; isolation from "clashes" with reality; and, the threat of disappointing the one who is adoring the child.[51]

[The above list does not contain biochemical considerations associated with the etiology of the *Narcissistic Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

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[50] This behavior goes beyond the normal time frame associated with the oral stage. The behavior patterns may be engendered outside of the home with another relative like a grandparent, if there is sufficient interpersonal contact with the individual.

[51] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *Narcissistic Personality Style*.

SELF EVALUATION. The *Narcissistic Personality Type* is a self-focused personality type. As long as the individual is in control of their environment and the effects that their environment has on them they will not usually experience a crisis. However, when situations that are out of their control occur, the individual with the *Narcissistic Personality Type* may experience a crisis.

Treatment Course For Narcissistic Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with a *Narcissistic Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are eleven major defense mechanisms that are commonly used by individuals with the *Narcissistic Personality Type*. Eight of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

INTELLECTUALIZATION. The client uses excessive abstract thinking, intellectual reasoning, or generalizations to control or

minimize emotional discomfort. [Level #2 – Mental Inhibitions Level]

ISOLATION OF AFFECT. Separation of ideas from feelings originally associated with them. Only the cognitive elements remain. [Level #2 – Mental Inhibitions Level]

REPRESSION. The client expels disturbing wishes, thoughts, or experiences from consciousness. The emotions may remain. [Level #2 – Mental Inhibitions Level]

DEVALUATION. The client attributes grossly exaggerated negative qualities to themselves or to others. [Level #3 – Minor Image Distortion Level]

IDEALIZATION. The client attributes grossly exaggerated positive qualities to others. This will be done by the narcissistic individual in an effort to gain approval or to get another individual to cooperate with them. [Level #3 – Minor Image Distortion Level]

OMNIPOTENCE. The client behaves or speaks in such a manner that they project the image to others that they possess special abilities. There is a distinct projection that they are superior to others. [Level #3 – Minor Image Distortion Level]

PROJECTION. The client falsely attributes to another person their own unacceptable feelings, impulses or thoughts. This is a protective measure to prevent the erosion of self. [Level #4 – Disavowal Level]

RATIONALIZATION. The client conceals their true motivations for their own thoughts, actions, or feelings through the elaboration of reassuring or self-serving but incorrect explanations. [Level #4 – Disavowal Level]

PROJECTIVE IDENTIFICATION. The client projects their feelings, impulses, or thoughts onto another person (as in normal

projection). Eventually, those feelings, impulses, or thoughts are fulfilled by the person on whom they are projected. This is an effort by the narcissistic individual to control others. [Level #5 – Major Image Distortion Level]

APATHETIC WITHDRAWAL. The client withdraws from any attempts to deal with internal or external stressing events. The narcissistic individual will experience this if they are unable to resolve emotions associated with a self-evaluation crisis. [Level #6 – Action Level]

PSYCHOTIC DISTORTION. The client engages in internal efforts to reshape the external world with hallucinations and delusions. This is the creation of a new reality. This will usually only happen to the narcissistic individual if they are unable to resolve a self-evaluation crisis of substantial nature. [Level #7 – Level of Defensive Dysregulation]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Narcissistic Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the

50% threshold. This is not abnormal.[52] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

In the clinical population, the prevalence of *Narcissistic Personality Disorder* is only between 2 and 16 percent. Yet, a very large percentage of the American population exhibits significant narcissistic traits. These individuals may be prone to "black and white" expressions and beliefs.

The core of the disorder is a stunted development of the whole self (the ego). This is called a *narcissistic wound*. Thus, the narcissistic individual must always be doing something to promote themselves. This is not because they are "in love" with themselves, but it answers the belief that if they don't, they will fall to a worthless status very quickly. This, again, is due to the

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[52] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

fractured ego. Their ego is only supported and reinforced by external factors.

When feelings of inferiority are present, the client may tend to judge others. They may be manipulative or may tend to dominate relationships. This is to prevent the continual feelings of inferiority. They must bring others down to the level at which they recognize themselves.

The client generates the automatic thought that if they are not "special" then they are inferior or even worthless. This "specialness" is designed to cover up their inferiority feelings. This often creates very intense internal emotional states. Sometimes those emotional states are projected outwardly. Without special recognition from those around them, the individual may feel completely inferior.

This individual's feeling of deep interpersonal rejection, disappointment or inferiority is generated from the injury to the ego in childhood. When the individual feels persistently vulnerable over a significant period of time, they will often experience a *Major Depressive Episode*, *Dysthymic Disorder*, or somatic complaints.

The somatic symptoms and complaints may present themselves in therapy. This is especially true in cases of significant personal assessment or personal questioning on the part of the client. When the client is involved in a significant environmental situation that causes them to "doubt" the special structure that they have surrounded themselves with, the emotional conflict that is generated may not be allowed to surface in its true form. If it did, the individual might be forced to face their fractured ego head-on. Since that is too intense of an emotional situation, the emotional issues may surface in somatic complaints. Those somatic complaints may include chest pains, muscle and bone pains, headaches, dizziness, stomach ailments, or a wide variety of other generalized physical issues. The therapist should have the client consult a medical doctor when these somatic complaints arise since real physical factors need to be ruled out. Somatic symptoms are likely associated with the narcissistic wound.

If a medical doctor rules out a physical cause for the somatic issues, the therapist may find the somatic symptomology very useful in therapy. The therapist should investigate the specifics of the crisis situation in which the client is engaged. The therapist should be able to locate the exact break in the ego. At that point, the therapist may be able to help the client restructure their thinking so that the ego can be restructured. The therapist is forewarned that this will be a very emotionally charged event for the client. If considerable care and attention is not given to the client, there is a significant possibility of *Axis I Disorders* developing.

The therapist must realize that with a fractured ego the client will be hypersensitive to criticism. The client will also be opposed to change. They have established what they feel is a viable means of dealing with their inferiority. Since the therapy process itself represents change, the narcissistic individual will have only a limited capacity to develop a working relationship with the therapist. Anything more than that will represent too significant of a threat. Disclosing weaknesses and shortcomings is alien to the narcissistic person.

Therefore, behavior modification exercises may be the most appropriate place to start any therapy process. This process will be easier for the individual to deal with. Allowing the narcissistic individual to be involved in the formation of goal setting in therapy is also useful. This reduces the fear that the individual doesn't know where the therapist is going with the sessions. The therapist must get the client to agree on specific treatment objectives. When the client has a sense of ownership in the treatment process, they are more likely to continue.

Initial therapy should focus on the underlying symptoms associated with any *Axis I Disorders* that are present. Reduction of anxiety and depressive symptomology is essential to therapy productivity.

The client is reluctant to engage in self-evaluation because it threatens to activate the core negative belief of inferiority. The narcissistic individual promotes their "special" status to protect themselves from consciously expressing their perceived status of inferiority. The therapist must realize that the individual will

likely leave therapy quickly and unexpectedly if they begin to consciously recognize their inferiority. They are not equipped to deal with the humiliation of inferiority. Prolonged negative emotions will leave the client powerless and inadequate. This may be another reason for them to leave therapy unexpectedly.

The initial efforts of the therapist must be to increase the self-esteem of the individual. This is essential for further treatment since somewhere in the process the individual will need to encounter their feelings of inadequacy and inferiority. It may also be helpful for the client to engage in some type of behavior that does not involve their own self-advancement. This may involve working as a volunteer somewhere. They must also learn to totally relax and separate themselves from "doing." The narcissistic individual will sometimes be absorbed in work, hobbies, or other interests that do not allow them the "down time" to simply enjoy other people. Having fun for the sake of having fun is something that is foreign to these individuals. They need to have fun.

The following are all issues that should be explored some time during the therapy process. The therapist will not always find issues in each of these areas, but exploring these areas will root out many of the client's issues:

- The therapist must explore the client's understanding of success. The client will likely have an ultraistic concept of success.
- The therapist may generally use role-playing as a key element in therapy. The individual will not like role playing in the beginning since there is too much lack of control during the interaction on their part. Nevertheless, this is a useful tool for the therapist.
- The issue of boundary awareness must be discussed. Where does the individual start and where does the individual stop? They must realize the rights of others and respect those rights.

- The therapist should intensively explore the individual's concept of self-worth. This should only be done after a solid working relationship is developed between the client and the therapist. The client will likely present themselves in a very good light. They will use personal accomplishments as the key to their worth. The therapist must continue to discuss the concept of self-worth until the therapist discovers the true sense of worth that the client has concerning themselves. Restructuring self-worth is essential to healing since the client will likely feel that they are worthless without the external input from others. Self worth must be internalized inside of the client in spite of their personal accomplishments and the opinions of others.
- As hard as it is, the therapist must explore the missing elements in the ego of the individual. The therapist must devise ways to instill those missing components within the individual so that the fractured ego can be reconstructed. As the client moves toward recognition of being self-contained and self-sufficient without the need for affirmation from others they are moving forward. This will be indicated by the loss of their "specialness" and the recognition of the true value of everyone who is "different" from them.
- The client may have an automatic thought that some people are of lesser "value" than others. These individuals will likely be people who are not involved in making them special. They will not have a desire to focus on those people. The therapist may wish to explore homework with the individual that forces them to observe others that are totally outside of their sphere of influence. In this exercise, the client should intensively think about the value of those individuals independent of the value of the client themselves. The therapist may assign the client to go visit a homeless shelter (even working with the homeless for a short period of time). If the therapist can get the client to recognize the human

value of people that are outside of themselves, they can then move that toward the client recognizing their own self-value and self-worth separated from those that are more "important" to the client.

- It has been emphasized that the client needs to be "special." Deep inside, they believe that they are inferior to others and they have an incessant need to cut off any recognition of their own inferiority. The therapist must get the client to recognize their own faults and limitations. In this same context, the therapist must get the client to recognize that their faults and inferiorities are acceptable – even though the client will think they have to "do better" to eliminate these issues. Accepting personal limitations is usually not acceptable to the narcissistic individual. When the therapist brings the narcissistic individual to this point, they have made considerable headway toward healing.

- Every narcissistic individual must continually work to prove that they are a "beautiful swan." They cannot accept anything else. They are constantly searching for the maternal nurturance that they never separated themselves from. Considerable healing has been accomplished when the individual forfeits the desire to be a "beautiful swan" and realizes that is acceptable to just be one of the "ugly ducklings." This factor eliminates the need to be recognized as "special."

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Narcissistic Personality Type*. These include the following:

- In extreme cases wherein the client faces a crisis of personal evaluation that they cannot resolve or gain control over, there is the possibility of self-destructive behavior including suicide or suicide attempts. This is related to the "loss of self" in the crisis.

- Decompensation into psychosis or significant *Axis I Disorders* in extreme cases where resolution of personal evaluation cannot be resolved or is out of the control of the individual.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment for the *Narcissistic Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- The client has forfeited their sense of entitlement. This individual must realize that they are bound by the rules and norms that govern normal social interaction.
- The client must learn to lean on others for emotional support.
- The belief that the client is in some way defective, bad, unwanted, or inferior must be reconciled. This effort on the part of the therapist may take some time and may involve research into the client's home of origin issues. Those issues may be significant in both the cause and the cure of this issue.
- The client must substantially relax their desire to meet unrealistically high standards. The therapist should understand that these standards are in place to help the client avoid criticism and to be accepted by others.
- The client must learn self-control and frustration tolerance. The therapist will need to research the exact self-control mechanisms that are malfunctioning in the client. There may be issues of substance abuse, over working, or a number of other issues related to self-control. It is advisable for the therapist to administer the *Addictions and Dependency Scale* to determine both abuses and behaviors associated with those abuses.

Obsessive-Compulsive Personality Style and Disorder

The Obsessive-Compulsive Personality Type In A Nutshell

"The essential feature of *Obsessive-Compulsive Personality Disorder* is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency."[53]

The obsessive-compulsive pattern is "a devise for preventing any thought or feeling that could produce shame, loss of pride, a feeling of deficiency or weakness."[54]

Compulsive behavior is "a neurotic strategy that protects these individuals from exposure to any thoughts or feelings that could endanger their physical or psychological existence."[55]

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[53] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Washington D.C., American Psychiatric Association. 2000. p. 725.

[54] Salzman, L. *Treatment of the Obsessive Personality*. Jason Aaronson. New York, 1980. As cited in the *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (second edition) by Len Sperry, pg. 180.

A CLOSER LOOK

Many people recognize the obsessive-compulsive person as someone who washes their hands five hundred times a day – sometimes separated by only a few minutes. While this may be a "classic" example of a compulsive behavior, it may not be a good example because it is too restrictive in scope.

Before going further, we need to define the terms "obsessive" and "compulsive." That will begin to shed more light on this disorder and the maladaptations associated with the personality style.

Obsessions are persistent, repetitive thoughts that seem to intrude upon the mind and are either meaningless or frightening to the individual. *Compulsions* are performed to relieve the anxiety caused by the obsessive thoughts. They can be behaviors or thoughts.

Thus, the person who has repetitive thoughts about catching some disease from touching things in their environment will engage in the compulsive behavior of washing their hands every time the obsessive thought comes into their mind.

Over the years, psychological research has broadened the understanding of this personality type. The "classic" compulsive behavior is now only one small facet of the whole scope of obsessive-compulsive behaviors. Many of the obsessive and compulsive behaviors associated with this personality type are much more subtle.

The research community now recognizes groups of obsessive thought patterns. They include:[56]

- Obsessive thoughts about sexual issues
- Obsessive thoughts about environmental contamination
- Obsessive thoughts about religion

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[55] Ibid. p. 181.
[56] Penzel, Fred Ph.D. *Obsessive-Compulsive Disorders – A complete Guide to Getting Well and Staying Well*. Oxford University Press. New York, New York. 2000. See pp. 211, 212.

- Obsessive thoughts about harm, danger, loss, or embarrassment
- Obsessive thoughts about magical practices or superstitions
- Obsessive thoughts about body image
- Obsessive thoughts about perfection

Compulsive behaviors are used by an individual who has obsessive thoughts as a "response" to those obsessive thoughts. The compulsive behavior "answers" the obsessive thought. Thus, if the individual is obsessed with their environment being full of germs (the obsessive thought), they will wash their hands every time the obsessive thought enters their mind (the compulsive behavior).

Compulsive behaviors are a response to an obsessive thought pattern. They include:[57]

- Behaviors associated with eliminating contamination
- Behaviors associated with hoarding useless objects
- Behaviors associated with checking things
- Behaviors associated with magical thinking
- Behaviors associated with perfection
- Behaviors associated with counting things for no reason
- Behaviors associated with touch and movement
- Behaviors associated with self-mutilation and self-hurt
- Behaviors associated with the individual's body image
- Behaviors associated with grooming
- Behaviors associated with protection

Further research has again broadened the scope of this personality type. Penzel has indicated that the act of compulsion may exist on a continuum from truly compulsive behaviors (e.g.

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[57] Ibid, p. 237, 238.

hand washing) to impulsive actions that are not so readily "connected" to the obsessive thought complexes. [58]

At one end of the continuum, we find true compulsivity including over control, avoidance of harm, and fear of one's impulses. At the other end of the continuum we find purely impulsive behaviors that are under controlled (or even uncontrolled), risky and potentially dangerous behaviors, and complete spontaneity. The key element, however, is that the compulsive/impulsive behavior is always associated with an obsessive thought (or, in some cases, with an obsessive feeling that might not actually be a cognitively recognizable thought).[59] The bottom line is that these compulsions are a response to a perceived threat from the environment. They are an effort to do away with that perceived threat.

It is my own belief that the determining factor that regulates whether compulsive reactions will be true compulsive behaviors or more impulsive behaviors is associated with the psychosocial phase of childhood development in which the *Obsessive-Compulsive Personality Type* developed. If the imprinting on the individual's psyche occurred early in child development (pre-vocal) then the tendency will be toward impulsiveness.[60] If, however, the imprinting on the personality occurred later – in the post-verbal stage of development – then the behaviors will be more traditionally compulsive in nature.

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[58] Ibid, p. 7.

[59] It appears that if the *Obsessive-Compulsive Personality Type* was imprinted prior to vocalization abilities in childhood that the obsessive "thinking" may be more "feeling" than actual logical thought processes.

[60] When research concerning personality development is examined, it appears that those issues that were imprinted on the personality structure of a child prior to the time that the child could talk seem to be more "automatic" and non-conscious in performance. The imprint on the child is not associated with verbal reasoning abilities – only with "pictures" and images. This presents a potential complexity in therapy since the use of reason with a client may not be as effective as the therapist might hope.

THE BOTTOM LINE

Control of the environment is a key element associated with the *Obsessive-Compulsive Personality Type,* especially when the individual is in crisis. The individual will be preoccupied with "orderliness, perfectionism, and mental and interpersonal control" in frantic efforts to avoid losing control over whatever obsesses them. Their "compulsion of choice" will be a direct response to their fear of losing control (as dictated by the obsession). Thus, personality crisis "trigger events" are all associated with environmental factors that present situations in which the individual perceives they could lose control. Usually, there is a "breakdown" in the effectiveness of the compulsive behavior so that the behavior no longer functions effectively to protect them in their environment.

Another essential factor associated with the *Obsessive-Compulsive Personality Type* in distress is their need to avoid affective expression. These individuals reject softer emotions, sometimes even to the point of revulsion. Any environmental factor that presents charged emotions may precipitate a crisis in this personality type.

The emotional response of choice for this individual will be hostilities – including anger and rage. They will use hostilities to "push away" significant others with whom they must interact emotionally. When the individual is no longer able to avoid emotions that they cannot face, they may physically remove themselves from the place or places wherein those emotions are engendered.[61]

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[61] The inability for individuals to face "softer" emotions is a common element in most maladaptations in personality style. Softer emotions demand vulnerability. These individuals are unable to be placed in situations of emotional vulnerability since that would mitigate a loss of control. Loss of control is not acceptable. The therapist must understand that avoidance of these emotions will disallow progress in therapy. Furthermore, in the case of the *Obsessive-Compulsive Personality Type,* if the crisis in which the client is engaged is disruptive enough to the psyche of the client, psychosis may be the result (likely *Brief Reactive Psychosis*). The potential onset of

In summary, Penzel says,

Compulsive "activities are unpleasant, repulsive, senseless, or even disgusting to the person doing them, even from the beginning. They do not seem natural or appealing in any way, and *they are done in order to relieve anxiety and doubt* – not to give the person some kind of 'high,' lift, or pleasure...."[62]

Compulsive behaviors are used for the purpose of relieving both anxiety and doubt. The behavior reassures the individual that they are in control of their environment. When the prospect of compulsive behaviors failing is apparent to the individual, a crisis will likely ensue.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Obsessive-Compulsive Personality Disorder* are:[63]

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.

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psychosis in the client may be indicated by their use of more maladaptive defense mechanisms (especially those from level #4 or above). This is largely due to *decompensation* (the breakdown of previously working methods of defense or, in this case, failure of their compulsive behaviors to protect them from environmental changes).

[62] Penzel, *Obsessive Compulsive Disorders*, p. 293.

[63] *DSM-IV-TR*, p. 729.

2. Shows perfectionism that interferes with task completion (e.g. is unable to complete a project because his or her own overly strict standards are not met).

3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).

4. Is over-conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).

5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.

6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.

7. Adopts a miserly spending style toward both self and others, money is viewed as something to be hoarded for future catastrophes.

8. Shows rigidity and stubbornness.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Obsessive-Compulsive Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

NARCISSISTIC PERSONALITY DISORDER. The *Narcissistic Personality Type* contains elements of perfectionism. That personality type posits the belief that the individual has already achieved perfection, whereas the *Obsessive-Compulsive Personality Type* is self-critical of their lack of perfection and is on an endless quest to achieve it.

ANTISOCIAL PERSONALITY DISORDER. The *Antisocial Personality Type* will indulge themselves while the *Obsessive-Compulsive Personality Type* is generally miserly concerning everyone, including themselves.

SCHIZOID PERSONALITY DISORDER. Both of these disorders tend toward detachment from social situations. With the *Obsessive-Compulsive Personality Type* this detachment stems from discomfort with emotions (especially emotions that leave the individual emotionally vulnerable) and excessive devotion to work while with the *Schizoid Personality Type* there is a fundamental lack of capacity for intimacy.

PERSONALITY DISORDER DUE TO GENERAL MEDICAL CONDITION. These two conditions/disorders may co-exist. However, the *Obsessive-Compulsive Personality Disorder* must exist prior to the change in medical condition.

CHRONIC SUBSTANCE ABUSE. These two conditions/disorders may co-exist. However, the *Obsessive-Compulsive Personality Disorder* must exist prior to chronic substance abuse.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Obsessive-Compulsive Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

ANXIETY DISORDERS. Since the core of the *Obsessive-Compulsive Personality Type* seeks to control the environment in order to prevent shame, the loss of pride, and feelings of weakness, these individuals are often overly vigilant. Their over vigilance may result in a number of anxiety disorders.

OBSESSIVE-COMPULSIVE DISORDER. *Obsessive-Compulsive Disorder* is an *Axis I Disorder*. It is slightly (but significantly) different in diagnosis than *Obsessive-Compulsive Personality Disorder* (an *Axis II Disorder*). The therapist is encouraged to examine the criteria for *Obsessive-Compulsive Disorder* since many times both Disorders co-exist. Furthermore, an individual with an *Obsessive-Compulsive Personality Style* (and not a *Personality Disorder*) many exhibit *Obsessive-Compulsive Disorder*.

SOCIAL PHOBIAS AND OTHER PHOBIAS. The *Obsessive-Compulsive Personality Type* fears rejection and loss of control. This is one of the components associated with its etiology. This fact may be one of the reasons for the formation of anxiety states. In addition, it may result in social phobias or phobias associated with a variety of other issues that might be considered threatening to the individual's ability to control their environment.

MOOD DISORDERS. Various *Mood Disorders* may be present with the *Obsessive-Compulsive Personality Type.* These may include *Major Depression Disorder*, *Cyclothymic Disorder*, *Dysthymic Disorder*, and (less likely) *Bipolar Disorder*.

EATING DISORDERS. Since the *Obsessive-Compulsive Personality Type* is associated with issues of control, there is a potential for these individuals to exhibit eating disorders. This is especially true if their obsessions are related to body image issues. Usually, the eating disorders associated with the *Obsessive-Compulsive Personality Type* will be either *Bulimia* or *Anorexia*.

Some recent research, however, has indicated that morbid obesity[64] may also be associated with the *Obsessive-Compulsive Personality Type*.[65] Technically, obesity is not considered as a *DSM-IV-TR Disorder* on any *Axis* other than *Axis III* (Medical Condition).[66] There are indications, however, that morbid obesity may have significant psychological associations.

One of the most significant maladaptations of the *Obsessive-Compulsive Personality Type* is emotional isolation. Individuals with this personality type usually do not exhibit softer emotions as part of their usual emotional expression. Furthermore, these individuals typically reject those same emotions when they are demonstrated by others. They may even do so with substantial vigor – using anger or some other form of hostile behavior to stem off softer emotions.

It is probable that food consumption could be used as a compulsive behavior under certain circumstances. This is likely under two conditions: 1) when the *Obsessive-Compulsive Personality Type* was formulated during the oral stage of psychosocial development,[67] and 2) the primary obsession is avoidance of emotional vulnerability.

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[64] In medical terms, morbid obesity is excess weight above 120% of suggested normal weight. That would mean that an individual who should weigh 150 pounds actually weighs 180 pounds. The presence of significant health compromises directly associated with excess weight acts to confirm the diagnosis of morbid obesity. Health compromises would include *Type II Diabetes*, *hypertension*, and *heart disease.*

[65] These topics related to obesity, sexual abuse, revulsion from emotion, and *Obsessive-Compulsive Personality* are discussed by Dr. Raymond Richmond. See *A Guide to Psychology and its Practice* (available by searching the Internet). The discussion here is a synopsis of his thoughts.

[66] This is likely to change with the next edition of the DSM.

[67] Thus, an orally satisfying agent will be chosen for the compulsive behavior. Oral agents would be any substances that directly involve the mouth -– food, drugs, alcohol, etc. A typical parental behavior that might aid in the development of the *Obsessive-Compulsive Personality Type* would be the over pacification of the infant. Many parents use a pacifier to stop all vocal emotional expressions of an infant. This prospect instills within the infant two maladaptive imprints: 1) emotion must always be stopped, and 2) the primary means of stopping emotional response is by putting something in the infant's mouth. Therefore, when the adult who was over pacified as an infant

In this case, the primary obsessive "thought" would be more "feeling-based."[68] When the environment of the individual demands significant (expected) interaction that involves emotional vulnerability (the obsession) the individual might respond with an oral fixation as a primary compulsion (intake of food). This compulsion serves two purposes: 1) it acts as a "placebo" to pacify the obsessive feeling, and 2) it creates body mass for the purpose of insolating an individual from other people. In essence, the individual perceives that obesity makes them less appealing. Since they perceive that they are less appealing, they "believe" that the demands for emotional vulnerability will be lessened.[69]

The Obsessive-Compulsive Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

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encounters emotion, they respond by putting something in their mouth. Whatever emotion the adult feels, it is an occasion to eat! If this is the case, the obesity cannot be resolved until the individual learns to encounter their emotions.

[68] See the discussion above under "*A Closer Look*" regarding pre-vocal onset of the *Obsessive-Compulsive Personality Type*.

[69] The therapist should understand that when a female (especially) uses morbid obesity as a defense against emotional vulnerability, this might be an indication of child sexual abuse that is not cognitively recognized by the individual. If this is the case, it only complicates the issue of emotional vulnerability. Other key indicators of child sexual abuse may be present (although those indicators are not an "acid test" of sexual abuse). Those indicators are associated with sexual dysfunctions including sexual frustration, lack of sexual desire, and inability to achieve orgasm with their partner (but not necessarily a complete inability to achieve orgasm). The therapist should not assume that these indications absolutely prove sexual abuse. That is not the case. These are only secondary (but yet important) indicators.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[70] the optimally functioning *Obsessive-Compulsive Personality Style* contains nine elements. Correspondingly, there are nine elements that indicate the breakdown of each of those nine optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical manifestation of *Obsessive-Compulsive Personality Disorder* traits. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Obsessive-Compulsive Personality Style* without allowing for diminution toward more maladaptive traits.

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[70] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 177.

Sperry's continuum includes the following nine elements:

Optimal Functioning	Maladaptation
• This person has a desire to complete tasks and projects without flaws or errors.	• This person is a perfectionist to the point of interference with job completion.
• This person takes pride in doing all jobs and tasks well, including the smallest details.	• This person is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
• This individual tends to want things done "just right" with some tolerance for things being done another way.	• This individual has an unreasonable insistence that others submit exactly to their way of doing things because of the conviction that they will not be done correctly otherwise.
• This individual is dedicated to working hard and is capable of intense, single-minded effort.	• This individual has an excessive devotion to work and productivity to the exclusion of leisure activities and friendships.
• This person carefully considers alternatives and their consequences while making decisions.	• This person is indecisive – decision-making is either avoided, postponed, or protracted.
• This person tends to have strong moral principles and strongly desires to do the right thing.	• This person is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values.
• This person is a no-nonsense individual who does work without much emotional expenditure.	• This individual displays a restructured or manufactured affection (emotional state).

Optional Functioning	Maladaptation
• This person is generally careful, thrifty, and cautious but able to share from their abundance. • This person tends to save and collect objects and may be reluctant to discard objects.	• This individual displays a lack of generosity in giving time, money, or gifts when no personal gain is likely to result. • This individual is unable to discard worn-out or worthless objects even when they have no sentimental value.

The Obsessive-Compulsive Style under Crisis

The following behaviors will likely manifest when an individual with an *Obsessive-Compulsive Personality Type* faces a triggering event. In the case of the *Obsessive-Compulsive Personality Type*, triggering events will be those events that cause anxiety and/or doubt that cannot be solved by compulsive behaviors. These events will likely be associated with loss of environmental control and disruption of the meticulous security system that the individual has created.

- Obsession with their "compulsion of choice" in an attempt to regain environmental control.
- Unreasonable, unrealistic, irrational and overbearing demands on others in order to "prove" to themselves that they can control their environment.
- Defensiveness, aggression and hostility toward "targets of opportunity" when external threats are perceived.
- Anger and/or rage in situations that are obviously out of their control.
- Discomfort with, avoidance of, and aggression toward individuals, relationships, or situations that illicit or demand emotional vulnerability and expression of softer emotions.

- Manifestation of *Axis I Disorders* when anxiety states cannot be managed through compulsive behaviors or other defense mechanisms.
- Bending of reality through use of defense mechanisms that involve image distortion. [The therapist must recognize that this event may be a precursor to psychosis.]
- Potential *Brief Reactive Psychosis* if/when decompensation occurs.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with an *Obsessive-Compulsive Personality Type*.

PSYCHOSOCIAL ETIOLOGY OF THE OBSESSIVE-COMPULSIVE PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for personality disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

   In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

   The following list contains likely issues that arose during childhood precipitating the formulation of the *Obsessive-Compulsive Personality Type*. Many of these issues will not be

cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (a common defense mechanism) these are the most commonly accepted reasons for the development of the *Obsessive-Compulsive Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- INSUFFICIENT VALUING BY AT LEAST ONE PARENT. Compulsions are used to prevent shame, loss of pride, and feelings of deficiency or weakness. Perfectionism is an effort to gain the approval of the under valuing parent. Control becomes a key factor in the child's behavior.
- PARENTAL OVER CONTROL. Control is learned by the child through overly firm and punitive behaviors on the part of at least one parent. Sometimes the punitiveness is subtle and not necessarily vocalized. In this situation, the child learns which behaviors are acceptable and repetitively performs those behaviors.
- AN OBSESSIVE-COMPULSIVE PARENT. A child who grows up in a home where at least one of the parents is *Obsessive-Compulsive*, may themselves develop an *Obsessive-Compulsive Personality Type* as an adult. This child does not develop options in life but simply learns to do what they have already seen in the home. This presents a problem in life when the adult is faced

> with decisions that must be made that were not part of the home experience.

- AN EMOTIONALLY RESTRICTED ENVIRONMENT. This home is focused on productivity and hard work. Emotions (especially softer emotions that mandate emotional vulnerability) are strongly discouraged. There may be subtle punitiveness for expression of those emotions. Emotions associated with vulnerability are considered dangerous and a sign of weakness.

- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include relentless coercion to perform correctly; discouragement of emotions that lead to vulnerability; emphasis on orderliness; harsh moralism or rule-keeping; condemnation and persecution of others who are different; racism; at least one cold and controlling parent; no rewards for success; unmoderated power on the part of at least one parent; focus on child's mistakes; child was given enormous responsibility with no rightful power; and, the desire of the child not to rebel and face punishment as observed with one or more siblings.[71] This was a cold, calculated, controlled, emotionless, environment with no rewards.

[The above inventory *does not* contain biochemical considerations associated with the etiology of the *Obsessive-Compulsive Personality Type*. The therapist should understand that there might be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

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[71] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with an *Obsessive-Compulsive Personality Style*. Each of these relates to loss of environmental control or elevation of anxiety.

ISSUES WITH AUTHORITY. A wide variety of issues associated with authority structures can act as a triggering event for the onset of *Obsessive-Compulsive Personality Style* maladaptations. The issues may range from confrontation by an authority figure or the need for the individual to confront an authority figure. Generally, any conflict with authority can precipitate the escalation of maladaptive traits. Authority figures may include everyone from superiors at work to the individual's spouse.

UNSTRUCTURED SITUATIONS. Since the core of the *Obsessive-Compulsive Personality Style* demands order, structure and ability to control the individual's environment, any unstructured situation or event may trigger maladaptation. The potential for an unstructured situation to trigger maladaptive behaviors will depend on the perceived threat to the individual's ability to control their environment. If the unstructured situation presents significant potential for loss of control or the need to "face the unknown" the risk of crisis greatly increases.

RELATIONSHIP DEMANDS. Significant demands from intimate relationships or very close friendships may precipitate a movement toward maladaptive behaviors. This is especially true if those relationships mandate emotional vulnerability. The prospect of emotional vulnerability is very likely to precipitate an active crisis.

Treatment Course For Obsessive-Compulsive Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with an *Obsessive-Compulsive Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Furthermore, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are seven major defense mechanisms that are commonly used by individuals with the *Obsessive-Compulsive Personality Type*. Three of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

INTELLECTUALIZATION. This mechanism involves the excessive use of abstract thinking or intellectual reasoning to minimize emotional discomfort. This is a mechanism of choice for the *Obsessive-Compulsive Personality Type* since these individuals usually reject softer emotions and emotional vulnerability in favor of a constricted affective range. [Level #2 – Mental Inhibitions Level]

ISOLATION OF AFFECT. This mechanism involves the segregation of cognitive "facts" from the feelings that were originally associated with them. Only the cognitive elements remain and the emotions are disposed of. This mechanism is used for the

same reason as *Intellectualization*. [Level #2 – Mental Inhibitions Level]

UNDOING. With this mechanism, the individual uses words or behaviors in order to negate or make amends symbolically for unacceptable thoughts, feelings, or actions. For example, when an *Obsessive-Compulsive Personality Type* uses anger to stem off the appropriate softer emotions of a spouse, they may later buy something for the spouse to "make up" for the angry outburst. This action enables the person's behaviors by allowing them to "fix" their negation of the spouse's emotions. [Level #2 – Mental Inhibitions Level]

REACTION FORMATION. In this case, the client substitutes their "real" behaviors, thoughts, and/or feelings with behaviors, thoughts, and/or feelings that are not from their reality. This is usually done out of fear of loss of social acceptability. For example, someone with "secret" homosexual desires openly espouses hatred toward homosexuality. [Level #2 – Mental Inhibitions Level]

PROJECTION. The client falsely attributes their own unacceptable feelings, impulses, or thoughts onto another person without justification. This is usually a guilt-based reaction to their own perceived negative aspects. Rather than deal with those aspects in themselves, they *project* them onto someone for purposes of judgment. [Level #4 – Disavowal Level]

ACTING OUT. The client commits physical actions directly in response to internal reflections and feelings of affective states. These actions may be dangerous actions at times including attempted suicide and acts of violence toward others. Another likely form of acting out related to an *Obsessive-Compulsive Personality Type* crisis might be the client removing themselves from the environmental situation that they perceive is causing their distress. They may quit their job or suddenly abandon their family. [Level #6 – Action Level]

APATHETIC WITHDRAWAL. The client withdraws from any attempts to deal with the internal or external stressing events or the affective states associated with those stressors. The client no longer wishes to discuss the stressor nor do they desire to work toward resolution. The client is now "frozen" in their crisis. [Level #6 – Action Level]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Obsessive-Compulsive Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[72] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to

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[72] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

Early in the treatment phase, the therapist should inventory the obsessions and compulsions of the client. The therapist should determine the "benefit" that the obsessions and compulsions have to the client. When the therapist correlates all of this data, they will be able to focus treatment. Based on the previous client interview, the therapist may be able to determine the relative etiology of the maladaptation in the client's home of origin.

If the client is in extreme crisis, the therapist should investigate the locus of that crisis. There will likely be issues of control that have been threatened. The client will be suffering from specific threats to their security. These will be unacceptable to the client and will result in continued escalation of the crisis unless the therapist helps the client reconcile those issues.

Since the client is deeply influenced by anxiety, guilt and insecurities about loss of control, the client will not open up to the therapist until there is some elevation in the self esteem of the client. Although the client may portray themselves as quite self-assured, the therapist should realize otherwise. The client is in fact threatened by everything in their environment. Boosting the client's self-esteem must be the first order of therapy.

Once the therapist has the confidence of the client, the therapist should begin to help the client understand the functionality of their obsessions and their compulsions. This is a

frightening prospect for the client since the client will recognize the immediate threat to their control. This will likely increase the client's anxiety level.

The client will make attempts to forestall therapy. This will often be done creatively by using long and elaborate discussions that contain minute details that are unnecessary. The therapist should realize this tactic and cut it off. The client may also change the subject in the midst of discussion to something that they have more control over.

One of the key elements in the client moving forward in therapy is the recognition that their personality structure is a defense against accepting their own weaknesses. Little or no progress can be made in therapy until a client understands that their compulsions are a defense against their own weaknesses.

The client must realize that their behaviors defend against deep feelings of insecurity and uncertainty. It is for this reason that their environment must be filled with structure and security. All situations in which the client will not have complete control will arouse anxiety. (The arousal of anxiety feelings associated with unstructured environmental issues is a good place to begin unmasking of the client's maladaptive affective state.)

The therapist should uncover the client's unrelenting standards. During the interview process, the therapist will uncover the client's unrealistic goals for both themselves and for others. These unrealistic goals are all control-based.

The therapist will also note that the client is excessively punitive toward others. This was likely a key element in the client's home of origin. The client will "punish" both themselves and others for making errors. This is a common tactic when the client feels that emotions associated with vulnerability might be exposed.

The main issue with the client is affective restraint. Emotions that center around hostility are the core of the client's emotions. However, the client may not recognize or admit this fact. They will use *intellectualization* and *isolation of affect* to disprove this fact. When the therapist begins to unmask the client's hostility base, the client may react will hostile affects.

The therapist will discover that the client is largely unable to express emotions that might make them emotionally vulnerable to others. Salzman says that this is the core of the *Obsessive-Compulsive Personality Type*.[73] Tender emotions are both dangerous and threatening. They are a sign of weakness and must be avoided – even condemned in others when they are seen.

The therapist should understand that the client may have a distorted concept of an "intimate" relationship. It is likely that the client views an intimate relationship as a relationship built on loyalty and trust and not on tender emotions that would lead to mutual emotional vulnerability. The client will have a hard time understanding the benefit of an emotionally vulnerable relationship since emotional vulnerability is strongly viewed as a weakness.

The therapist will need to spend considerable time and effort helping the client come in contact with those emotions experientially.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Obsessive-Compulsive Personality Type*. These include the following:

- This client will exhibit significant anticipatory anxiety that might not be overtly evident to the therapist. Remember, the client needs to be in control of every situation – including their therapy. Anticipatory anxiety will be a constant reason for sudden termination of therapy. The therapist might not be aware of the anticipatory anxiety since it might surface after a session and result in the client never returning.
- The client may creatively terminate therapy by shifting the therapy from themselves to a spouse. The therapist

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[73] Salzman, L. *Compulsive Personality Disorder*. In Karasu, T. (Ed.), *Treatment of Psychiatric Disorders* (pp.2771-2782). Washington, DC: American Psychiatric Press. 1989.

must be aware that the client will do everything to shift the blame to someone else. The inexperienced therapist may fall prey to this tactic.

- If the therapist is successful in bringing about *decompensation*,[74] the client may experience a *Brief Psychotic Reaction*.[75] The therapist needs to be prepared for this eventuality since it will be quite traumatic to the client and may be another reason for early termination of the therapy process. This is especially true if the client is currently engaged in a crisis that has significantly disrupted their ability to control their environment.

- In the case of a current crisis that is familial in nature, the therapist should realize that there is a potential for *acting out* on the part of the client. If the client cannot release their need for control and security, there is a possibility of them doing something rather extreme as a result of their psychological distress. This *acting out* may or may not be associated with a psychotic episode. *Acting out* may result in this individual suddenly abandoning their family unit in favor of maintaining control and preserving security.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment for *Obsessive-Compulsive Personality Type* maladaptation is indicated when the therapist has moved

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[74] *Decompensation* is the failure to maintain defense mechanisms that have been useful to the individual in the past. When these defense mechanisms are removed, the client is often faced with stark realities that they have never been able to see. Thus, there is the possibility of psychotic symptomology associated with the successful removal of defense mechanisms. This should be viewed as a positive step forward by the therapist. However, the therapist must earnestly seek to reconstruct the client's motivations so that the defense mechanisms are not re-engaged and so that the disconnection from reality is eliminated.

[75] This is especially true on two accounts: 1) if the client is currently in a crisis situation, or 2) if the client's *Disorder Score* is significantly elevated toward *Disorder* rather than *Style*.

the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- Cessation of obsessive thinking and feeling styles.
- Cessation of the compulsive behavior.
- Release of unrelenting standards for self and others.
- Ability to accept "unsecure" situations in life without extreme emotional distress or need to control.
- Cessation of punitiveness toward others.
- Removal of inappropriate use of hostile emotional expressions.
- Expression of a full range of emotions including the softer emotions and engagement in a mutually satisfying emotional relationship of vulnerability.

Paranoid Personality Style and Disorder

The Paranoid Personality Type In A Nutshell

"The essential feature of *Paranoid Personality Disorder* is a pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent."[76]

A CLOSER LOOK

The following characteristics are common to one degree or another with the individual having a *Paranoid Personality Type*.

- The person may exhibit a general mistrust of others. They tend to believe that others will abuse, humiliate, cheat, lie, manipulate, or take advantage of them.

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[76] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Washington D.C., American Psychiatric Association. 2000. p. 690.

- The person may have a basic belief that they are defective, bad, unwanted or inferior to others.
- They may live reasonably productive lives and there is a distinct possibility that they will marry another paranoid individual.
- The core of their understanding is centered around shame and humiliation.
- They have an inner sense of weakness, defectiveness, vulnerability and powerlessness.
- The client will "create" experiences that seem to confirm their assumptions about the malevolent character of the actions of others. This will be done by the way they treat other people. This will create a self-perpetuating cycle. Their beliefs will be self-fulfilling.
- Paranoid individuals are often racially or ethnically prejudiced individuals. They may group together everyone from a specific race, ethnic group, or social class and paint everyone in that group with the same brush. They may make prejudgments on individuals based on their color or other social orientation. They may exhibit significant distrust of the group as a whole. On occasion, they will note that a few individuals from the selected group don't "fit the mold" of their class. This is a key indicator of at least some (maybe latent) paranoid characteristics.

THE BOTTOM LINE

The paranoid individual is an over vigilant individual who is overly conscientious about their relationships with others. Those relationships are often influenced by a defective belief that others are prone to mistreat them. This belief is not totally unjustified since the paranoid's treatment of other people can lead to substantial conflict with other people.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Paranoid Personality Disorder* are:[77]

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
4. Reads hidden demeaning or threatening meanings into benign remarks or events.
5. Persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights.
6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counter attack.
7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

B. Does not occur exclusively during the course of *Schizophrenia*, a *Mood Disorder With Psychotic Features*, or another *Psychotic Disorder* and is not due to the direct physiological effects of a general medical condition.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has

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[77] *DSM-IV-TR.* p. 694.

drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Paranoid Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

DELUSIONAL DISORDER, SCHIZOPHRENIA, MOOD DISORDER WITH PSYCHOTIC FEATURES. Each of these is a possible additional diagnosis. However, the *Paranoid Personality Disorder* must be present prior to any additional diagnosis.

PERSONALITY CHANGE DUE TO MEDICAL CONDITION. This is a possible additional diagnosis. However, the *Paranoid Personality Disorder* must be present prior to the additional diagnosis.

CHRONIC SUBSTANCE ABUSE. This is a possible additional diagnosis. However, the *Paranoid Personality Disorder* must be present prior to the additional diagnosis.

SCHIZOTYPAL PERSONALITY DISORDER. The difference between *Paranoid Personality Disorder* and *Schizotypal Personality Disorder* is that *Schizotypal Personality Disorder* includes magical thinking, unusual perceptual experiences, odd thinking and speech while *Paranoid Personality Disorder* does not.

SCHIZOID PERSONALITY DISORDER. The difference between *Paranoid Personality Disorder* and *Schizoid Personality Disorder* is that there is no prominent paranoia with *Schizoid Personality Disorder* while there is with *Schizotypal Personality Disorder*.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Paranoid Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

BRIEF PSYCHOTIC REACTION. A *Brief Psychotic Reaction* may be the result of distrust, suspicion, and the interpretation of the motives of others as malevolent. This might especially be true if the individual with a *Paranoid Personality Type* is able to "justify" the psychotic ideations.

DELUSIONAL DISORDER. *Delusional Disorder* is associated with nonbizarre delusions involving situations that could potentially occur in real life. These include the feeling that one is *being followed*, *poisoned*, *infected by disease*, or *deceived* by a significant person. This follows course with the *pervasive distrust* associated with the *Paranoid Personality Type*.

SCHIZOPHRENIA. *Delusional Disorder* is a potential *Axis I Disorder* associated with the *Paranoid Personality Type*. *Schizophrenia* is similar to *Delusional Disorder* except that the delusions are bizarre rather than nonbizarre. Furthermore, *Schizophrenia* contains the possibility of *hallucinations*, *disorganized speech*, and *catatonic behavior*. This is probably associated with *pervasive distrust* and *suspiciousness*.

MAJOR DEPRESSIVE EPISODE. Since the *Paranoid Personality Type* is suspicious of others, their suspicion may end up isolating them from social contacts. This extreme isolation may result in a *Major Depressive Episode*.

AGORAPHOBIA. The general paranoia associated with this disorder may lead the individual to being unable to leave their residence. This would be a fear-based response to their generally suspicious personality.

OBSESSIVE-COMPULSIVE DISORDER. To avoid the intrusion of paranoia, this individual may resort to compulsive behaviors as a mechanism to resolve their obsessive thoughts of suspicion.

SUBSTANCE ABUSE (and other addictive disorders). Substances may be used as a means of stifling the constant pressures and anxieties associated with the over-vigilance of the paranoid individual.

The Paranoid Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[78] the optimally functioning *Paranoid Personality Style* contains six elements. Correspondingly, there are six elements that indicate the breakdown of each of those six optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Paranoid Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Paranoid Personality Style* without allowing for diminution toward more maladaptive traits.

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[78] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 199.

Sperry's continuum includes the following six elements:

Optimal Functioning	Maladaptation
• This individual is self-assured and confident in their ability to make decisions.	• This person is reluctant to confide in others because of unwarranted fear that the information will be used against them.
• This individual is a good listener, and is aware of subtlety, tone, and multiple levels of meaning.	• This person reads hidden meanings or threats into benign remarks or events.
• This individual is able to take criticism seriously without becoming intimidated.	• This person bears grudges or are unforgiving of insults or slights.
• This individual places a high premium on loyalty, fidelity, working hard to earn and maintain loyalty.	• This person questions, without justification, the fidelity of their spouse or sexual partner.
• This person is careful in dealings with other people, preferring to size up individuals before entering into a relationship.	• This person expects, without sufficient basis, to be exploited or harmed by others.
• This person is assertive and can defend themselves without losing control and becoming aggressive.	• This person is easily slighted and quick to react with anger or to counterattack.

The Paranoid Style under Stress

The following behaviors will likely manifest when an individual with a *Paranoid Personality Type* faces a triggering event. In the case of the *Paranoid Personality Type*, triggering events will be those events that involve mandated close interpersonal relationships or events that cause significant personal queries.

- Extreme aversion to interpersonal communication and interaction.
- Self fulfilling behaviors that reinforce the client's belief that others are malevolent toward them.
- Extreme erosion of self-image.
- Substantial mistrust and distrust of others.
- Quick to react to perceived attacks from others. This may include substantial anger or counterattack from the individual.
- Unforgiving and often bears grudges.
- May read hidden meanings into common events.
- Potential disruption of the individual's ability to maintain relationships including work relationships and marital relationships.
- Potential development of *Schizophrenia*, especially paranoid or catatonic types.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *Paranoid Personality Type*.

PSYCHOSOCIAL ETIOLOGY FOR THE PARANOID PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that

home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Paranoid Personality Type*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the development of the *Paranoid Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- CRITICAL, HARSH FAMILY ATMOSPHERE. Family atmosphere charged with criticism, blame, hostility, and harshness. Hurts in the home were seldom forgotten. Grudges were long-lasting.
- PARENTAL OVER VALUATION OF THE CHILD. Over indulgence of the child by the parent. This develops an air of superiority in the child at an early age. This seems to disrupt or even destroy interpersonal abilities since the individual learns that they cannot relate to others as peers.

- EXCLUSIVITY AND SPECIALNESS. The child is told that they (or even the whole family) are special. This results in the focus on the inferiority of others. It also develops the suspicion that others are against them. It is from this basis that mechanisms like *projection* develop. "Special" people don't have problems. They *project* them onto other people.
- PUNISHMENT FOR SOFTER EMOTIONS. In this home, softer emotions were prohibited. Negative assessments would be made for anyone who exhibited the "forbidden" emotions. Special people don't cry.
- TRAINED TO FEAR. Fear was invoked from the outside world. This home typically taught the child not to trust. The paranoid child identifies with the hypercritical parent.
- POTENTIAL ABUSE. While all types of abuse are possible, there is a significant possibility of physical abuse – especially abuse that would have been sadistic and cruel (e.g. locking a child in a closet or basement). The physical abuses/punishments may have been for relatively trivial issues like the display of certain emotions.
- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include a sadistic, degrading and controlling parent; harshness and cruelty; hostility that occurred without alcohol or drug influence; "righteous" indignation on the part of the parent; forced loyalty to the family; physical abuse; lack of comfort even for child's injuries; rejection of emotions that lead to vulnerability; possible punishment for emotions that lead to vulnerability;[79] comparisons by a parent between the child and one of the other siblings; siblings were

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[79] The rejection of and punishment for emotions such as sadness, fear, and others that make an individual vulnerable cause serious and potentially insurmountable barriers to the development of intimacy in the future. In some cases, the punishment for displaying emotions of vulnerability may have been physical. In other cases, however, the punishment may have been with hostile emotions.

preferred by the parent; and, open discussion of the "bad aspects" of the child while the child was present as if the child was not present.[80]

[The above list does not contain biochemical considerations associated with the etiology of the *Paranoid Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *Paranoid Personality Style*.

CLOSE INTERPERSONAL RELATIONSHIPS. Since the *Paranoid Personality Type* exhibits a pervasive distrust and suspiciousness of others interpreting their motives as malevolent, any significant prospect for a close interpersonal relationship could bring about a crisis event in this individual. This prospect is greatly increased when the demand for a close interpersonal relationship is mandated by circumstances out of the individual's control.

PERSONAL QUERIES. When an individual with a *Paranoid Personality Type* faces a life situation that brings about a significant personal query, there is a possibility that the personal query can precipitate a crisis event. This is especially true if the query is associated with other individuals or if the query involves significant involvement with their external environment.

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[80] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

Treatment Course For Paranoid Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with a *Paranoid Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are those maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client is using. They should especially explore those indicated below.

There are six major defense mechanisms that are commonly used by individuals with the *Paranoid Personality Type*. Four of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

DISPLACEMENT. The client transfers a feeling about, or response to, one object onto another (usually less threatening) substitute object. For example, a person angry with their spouse decides to displace their anger. Rather than confronting their anger with their spouse, they yell at the dog. [Level #2 – Mental Inhibitions Level]

REACTION FORMATION. The client substitutes their "real" behaviors, thoughts, and/or feelings with behaviors, thoughts, and/or feelings that are not from their reality. This is usually done out of fear of loss of social acceptability. Example: Someone with "secret" homosexual desires openly espouses hatred toward homosexuality. [Level #2 – Mental Inhibitions Level]

PROJECTION. The client falsely attributes their own unacceptable feelings, impulses, or thoughts onto another person without justification. This is usually a guilt-based reaction to their own perceived negative aspects. Rather than deal with those aspects in themselves, they *project* them onto someone for purposes of judgment. [Level #4 – Disavowal Level]

DENIAL. The client refuses to acknowledge some painful aspect of external relative or subjective experience that is apparent to others. An example is the man whose wife has died. Rather than deal with the reality of her death, he refuses to acknowledge it and continually states that his wife cannot be dead. [Level #4 – Disavowal Level]

RATIONALIZATION. The client uses elaborate and incorrect but reassuring, coherent, self-assuring explanations or whole narratives to conceal the true motivations of their thoughts, actions, or emotions. Their tactics are used to avoid emotional conflict or to cope with internal or external stressors. [Level #4 – Disavowal Level]

PROJECTIVE IDENTIFICATION. The client engages in *projection* upon another person. Eventually, the *projection* that was placed upon the other person is fulfilled. Example: A person says that someone hates them (when it isn't true). Eventually, because the *projection* continues, the individual does indeed develop hatred toward the one *projecting* the hatred. They have now caused *identification* with the *projection*. [Level #5 – Major Image Distortion Level]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Paranoid Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are

undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[81] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

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[81] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

The therapist must understand the basic assumptions of the individual with the *Paranoid Personality Type*. This list should give the therapist a basic review of the individual's assumptions.

- The client exhibits a general mistrust of others. They believe that others will abuse, humiliate, cheat, lie, manipulate, or take advantage of them.
- The client has a basic belief that they are defective, bad, unwanted or inferior to others.
- Paranoid individuals may live reasonably productive lives and there is a distinct possibility that they will marry another paranoid individual.
- The core of their understanding is centered around shame and humiliation.
- They have an inner sense of weakness, defectiveness, vulnerability and powerlessness.
- The client will "create" experiences that seem to confirm their assumptions about the malevolent character of the actions of others. This will be done by the way they treat other people. This will create a self-perpetuating cycle. Their beliefs will be self-fulfilling.
- Paranoid individuals are often racially or ethnically prejudiced individuals. They may group together everyone from a specific race, ethnic group, or social class and paint everyone in that group with the same brush. They may make prejudgments on individuals based on their color or other social orientation. They may exhibit significant distrust of the group as a whole. On occasion, they will note that a few individuals from the selected group don't "fit the mold" of their class.

There are a number of clear objectives when a therapist is dealing with an individual who has a *Paranoid Personality Type*. These general principles must be understood by the therapist in order for therapy to be effective.

- The client initially will not be able to relax during the interview. The therapist should be aware of this and should accept it without making comments to the client.
- Although they can easily confront others, they cannot tolerate being confronted themselves. The therapist should avoid confrontation of the client.
- Therapeutic abruptness may be viewed by the client as an attempt to trap them.
- Treatment requires empathy, patience, and sensitivity.
- Therapy should be conducted at a slow pace (especially in the initial phase). There should be limited and long-term goals. The therapist should be sensitive to the vulnerabilities of the client.
- If there is to be any progress at all, the therapist must develop an atmosphere of trust with the client.
- At all cost, the therapist must avoid defensiveness. The therapist must avoid challenging the client regarding their paranoid perceptions – even if those perceptions are viewed as completely illogical to the therapist.
- The therapist must respect the client's fragile and threatened sense of reality.
- When the client experiences a crisis, the potential of productive treatment increases.
- The therapist should understand that the initial phase of treatment can be exceedingly stressful for the client because of the fear of self-disclosure, issues related to trusting, and acknowledging their own weaknesses. This prospect is extremely dangerous for them.
- The therapist should give the client more than usual control over scheduling appointments and the context of sessions.
- The therapist should acknowledge and accept the difficulty that the client has with trusting the therapist. No comment should be made regarding this issue.
- The first treatment goal should be to decrease sensitivity to criticism and modify the individual's social behavior.

- The therapist must understand that the client assumes that others are likely to prove themselves to be malevolent and deceptive. The client will actually work to make those behaviors happen through their own social interactions.

When dealing with an individual with the *Paranoid Personality Type* the therapist must understand that the treatment process is a two-phase process. The initial phase of therapy should include the following components:

- The therapist must understand that the individual with a *Paranoid Personality Type* engages in self-fulfilling behaviors. The client will provoke others to fulfill their beliefs regarding malevolent intentions of others. The therapist must accept this in the beginning.
- Sometimes it is beneficial for the therapist to deal with depressive symptomology (if it exists) as a primary means of initially confronting the client.
- The initial effort of the therapist must be to increase the self-confidence of the client. This can be done by reassurance and initial efforts to modify interpersonal behaviors.
- The therapist should endeavor to receive feedback from the client in a non-defensive manner and should use it constructively and in a non-condemning manner.
- The therapist should create an on-going record of client dysfunctional thinking and reasoning for use in later therapy. This record should include interactions that the client relates to the therapist even if the therapist doesn't initially use that information in session. The therapist can use this information for future construction of role playing examples for the client at more advanced stages of therapy.
- The therapist should increase the client's conviction that they can learn to deal with problems that arise.

- The therapist should carefully begin to modify the basic assumptions of the client regarding the malevolent intentions of others.
- The therapist must carefully help the client evaluate the perceived threats of others.
- The therapist should carefully discuss the actions of other people that the client perceives as threatening or malevolent. Other perceptual options should be given to the client.
- The therapist should help the client relax regarding their vigilant focus on the behaviors of other people. They should help the client to begin treating other people differently with a reduced amount of aggression. This is an initial effort to reduce the self-fulfilling nature of the paranoid's interaction with others.

Once the therapist has gained the confidence of the client and has seen some progress, the therapist will want to employ some or all of the tactics below as more advanced therapeutic techniques.

- The therapist must teach the client to anticipate the impact of their actions. Although it might not be a good idea to overtly describe to the client how their personality type functions, the therapist can creatively instruct the client about treating people in ways that are different than the means that they would normally use. The therapist may wish to say, "Rather than saying (or doing) this, why don't you try this instead…"
- When a negative social situation occurs, the therapist should help the individual take an inventory of the whole situation. This should include an assessment of the situation, analysis of the client's actions regarding the situation, and evaluation of the outcome. Alternative actions and behaviors should be considered.
- The therapist should engage in assertive (not aggressive) communication exercises with the client. These should

be role played exercises that illustrate both paranoid reactions and non-paranoid reactions.

- The therapist should help the client interpret social information more accurately.
- The therapist should help the client understand that some people do indeed have malevolent intentions. That fact does not preclude the fact that many people do not have malevolent intentions. The therapist should help the client understand the difference in real life situations that the client encounters during the week.
- As the client progresses in therapy, the therapist should help the client employ the newly-learned techniques in real life situations. Evaluation should be a significant component in this process.
- The therapist should select real life problems (maybe from the dysfunction report compiled throughout therapy) and help the client think through all options that could be used to deal with the problem. This will enhance the client's ability to employ those skills in real life situations.
- The therapist should persuade the client to think through situations before acting. They should think through all potential responses prior to acting when the client is handling interpersonal conflicts.

DANGERS OF THE THERAPEUTIC PROCESS

There are two significant obstacles or dangers associated with the therapeutic process for the *Paranoid Personality Type*. Those include the following:

- Potential for degeneration into *Schizophrenia*, especially catatonic and paranoid types. This usually occurs with decomposition of defense mechanisms.
- If, during the course of therapy, the client experiences a significant event that "disproves" the attempts of the therapist to lessen their paranoia regarding the

malevolent nature of others, this event may cause the client to exit therapy prematurely. That event may solidify their paranoid ideations.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment of the *Paranoid Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

This is indicated by the substantial reduction in the individual's mistrust of the intentions of other people. The client must learn that the largest number of people do not intend to abuse, humiliate, cheat, lie, manipulate or take advantage of them.

The client must also understand that they are not essentially defective, bad, unwanted or inferior.

Schizoid Personality Style and Disorder

The Schizoid Personality Type In A Nutshell

"The essential feature of *Schizoid Personality Disorder* is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings."[82]

This individual will appear as self-contained, emotionally under control, and in need of little or no social interaction.

A CLOSER LOOK

The schizoid individual chooses not to engage in deep and intimate social or interpersonal relationships. This is not usually done out of fear (as is the case with the avoidant individual). It is

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[82] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000. p. 694.

simply the choice of the individual not to interact with others deeply. They are indifferent to close interpersonal relationships.

And, it is that prospect that will likely result in a significant crisis in the life of an individual with a schizoid personality. When they do engage in a relationship and that relationship presents them with a crisis, they will be subject to an adverse reaction.

The crisis in a relationship might be the prospect of a close relationship ending. It might be, however, something of lesser significance – something like the need to resolve significant conflicts in the relationship. This individual doesn't typically like to face strong emotions or social situations that demand expression of emotion. They would rather stay away from strong emotion (sometimes at all cost).

THE BOTTOM LINE

The therapist will find this situation to be a real challenge to counsel. The individual may use silence on a regular basis. They will also refrain from expressing pent-up emotions that are likely buried deep inside. The surfacing of those emotions may result in significant arousal of *Axis I Disorders*. Among those *Disorders* there may be some delusional indications, if the crisis is severe enough. The therapist needs to ensure that the client does not decompensate into a more maladaptive personality style such as *Schizotypal Personality Type*.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Schizoid Personality Disorder* are:[83]

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and

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[83] *DSM-IV-TR.*, p. 697.

present in a variety of contexts, as indicated by four (or more) of the following:

> 1. Neither desires nor enjoys close relationships, including being part of a family.
> 2. Almost always chooses solitary activities.
> 3. Has little, if any, interest in having sexual experiences with another person.
> 4. Takes pleasure in few, if any, activities.
> 5. Lacks close friends or confidants other than first-degree relatives.
> 6. Appears indifferent to the praise or criticism of others.
> 7. Shows emotional coldness, detachment, or flattened affectivity.

B. Does not occur exclusively during the course of *Schizophrenia*, a *Mood Disorder With Psychotic Features*, another *Psychotic Disorder*, or a *Pervasive Development Disorder* and is not due to the direct physiological effects of a general medical condition.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Schizoid Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

DELUSIONAL DISORDER, SCHIZOPHRENIA, MOOD DISORDER WITH PSYCHOTIC FEATURES. The difference between *Schizoid*

Personality Disorder and these three disorders is that these three disorders include persistent psychotic symptoms while *Schizoid Personality Disorder* does not.

AUTISTIC DISORDER, ASPERGER'S DISORDER. *Schizoid Personality Disorder* is often difficult to differentiate from these two disorders. These two disorders, however, usually have more profound impairment of social interaction.

PERSONALITY CHANGE DUE TO A GENERAL MEDICAL CHANGE. This diagnosis should be used if symptomology appears directly related to the general medical change.

SCHIZOTYPAL PERSONALITY DISORDER. *Schizoid Personality Disorder* does not contain cognitive nor perceptual distortions while *Schizotypal Personality Disorder* does.

PARANOID PERSONALITY DISORDER. *Schizoid Personality Disorder* does not contain suspiciousness and paranoid ideation while *Paranoid Personality Disorder* does.

AVOIDANT PERSONALITY DISORDER. *Avoidant Personality Disorder* contains the element of profound fear of being embarrassed or found inadequate and excessive anticipation of rejection. *Schizoid Personality Disorder* does not.

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER. *Obsessive-Compulsive Personality Disorder* contains many of the same traits as *Schizoid Personality Disorder*, but *Obsessive-Compulsive Personality Disorder* has an underlying capacity and desire for intimacy.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Schizoid Personality Type*. The

therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

DELUSIONAL DISORDER. *Delusional Disorder* is associated with nonbizarre delusions involving situations that could potentially occur in real life. These include the feeling that one is being followed, poisoned, infected by disease, or deceived by a significant person. This follows course with the detachment from social relationships and the expression of emotions associated with the *Schizoid Personality Type*.

SCHIZOPHRENIA. *Delusional Disorder* is a potential *Axis I Disorder* associated with the *Schizoid Personality Type*. *Schizophrenia* is similar to *Delusional Disorder* except that the delusions are bizarre rather than nonbizarre. Furthermore, *Schizophrenia* contains the possibility of *hallucinations*, *disorganized speech*, and *catatonic behavior*. This is probably associated with the same reasons as *Delusional Disorder*.

MAJOR DEPRESSIVE DISORDER. The *Major Depressive Disorder* associated with *Schizoid Personality Type* may be a result of the social detachment and isolation that is part of the personality type.

The Schizoid Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of

disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[84] the optimally functioning *Schizoid Personality Style* contains five elements. Correspondingly, there are five elements that indicate the breakdown of each of those five optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Schizoid Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Schizoid Personality Style* without allowing for diminution toward more maladaptive traits.

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[84] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 221.

Sperry's continuum includes the five following elements:

Optimal Functioning	Maladaptation
• The individual exhibits little need of companionship and is most comfortable when alone.	• The person does not desire nor enjoy close relationships. This includes being part of a family. They have no close friends or confidants.
• The person tends to be self-contained and does not require interaction with others in order to enjoy experiences or to live their lives.	• The individual almost always chooses solitary activities.
• The person is even-tempered and dispassionate. They are usually calm and rarely sentimental.	• The individual rarely if ever claims to have or appears to experience strong emotion such as anger or joy.
• The individual is not driven by sexual needs. While they can enjoy sex, they do not suffer without it.	• The person experiences only an indirect battle or desire (if any) to have sexual experiences with another person.
• The person tends to be unswayed by either praise or criticism and can confidently come to terms with their own behavior.	• The person is indifferent to praise and criticism of others. They display constricted affects. They are aloof, cold, and rarely do they ever reciprocate gestures made by others or exhibit facial expressions.

The Schizoid Personality Style under Stress

The following behaviors will likely manifest when an individual with a *Schizoid Personality Type* faces a triggering event. In the case of the *Schizoid Personality Type*, triggering events will be associated with close interpersonal relationships. Both demands

from close interpersonal relationships and crisis situations involving close interpersonal relationships may act as triggers.

- The individual may feel defective or engage in self devaluation.
- Social isolation is a distinct possibility especially when the individual was hurt in a relationship.
- Depressive symptomology, especially *Dysthymic Disorder*.
- Outward "flattening" of emotions as the individual attempts to control their social and interpersonal environment.
- *Major Depressive Episode*. This is especially a possibility in cases where the individual had engaged in a close interpersonal relationship and got hurt in that relationship. It is not unlikely that the individual will feel that they were deceived in the relationship.
- In extreme cases, the individual may suffer from *Delusional Disorder*.
- In extreme cases, the individual's personality structure may decompensate into the *Schizotypal Personality Type*.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *Schizoid Personality Type*.

PSYCHOSOCIAL ETIOLOGY FOR THE SCHIZOID PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Schizoid Personality Type*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the development of the *Schizoid Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- PERCEIVED INADEQUATE MOTHERING. The child projects the belief that they did not receive appropriate emotional nurturance to sufficiently meet their needs. This covers a very broad scope and the perception may not indicate either neglect or indifference on the part of the mother (or the parents). While it may be that the

mother did not adequately nurture the child, another facet of nurturance may have been the realistic inability of the mother (or the father) to nurture due to circumstances that were out of their control. This is sometimes the case when children are injured or when they suffer from some physical malady that the parents cannot control. The child may experience an "emotional void" that allows for the development of the belief that they cannot expect to receive emotional nurturance from any place in their environment.[85]

- PARENTAL INDIFFERENCE TO EMOTIONAL ISSUES. This would be indicated as a secondary cause of schizoid tendencies. This might be the cause when there was significant interpersonal reserve, formality, superficial and cold emotions in the home of origin. This would cause a constricted emotional state in the child and may cause the child to isolate themselves from social situations that could cause emotional states they were not familiar or comfortable with.

- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include an orderly home; a formal home; possibility of colorless home life; over protection from the "world out there"; and no significant parental attempts to socialize the child.[86]

[The above list does not contain biochemical considerations associated with the etiology of the *Schizoid Personality Type*. The therapist should understand that there may be biochemical

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[85] An example of such a physical case would be early onset of seizure disorder. That physical malady may imprint on the child that the mother was indifferent or unable to provide emotional nurturance when in fact that may not have been the case. The trauma of the situation might override the reality of maternal nurturance.

[86] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *Schizoid Personality Style*.

CLOSE INTERPERSONAL RELATIONSHIPS. Since the *Schizoid Personality Type* exhibits a pervasive pattern of detachment from social relationships and a restricted range of emotional expression in interpersonal relationships, any significant prospect for a close interpersonal relationship could bring about a crisis event in this individual. This prospect is greatly increased when the demand for a close interpersonal relationship is mandated by circumstances out of the individual's control. Also, when the schizoid individual does engage in a close interpersonal relationship and the relationship ends, they are likely to experience a significant crisis including the potential for *Axis I Disorders*.

Treatment Course For Schizoid Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with a *Schizoid Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others.

The therapist should thoroughly research all defense mechanisms that the client might be using.

There are three major defense mechanisms that are commonly used by individuals with the *Schizoid Personality Type*. Two of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

INTELLECTUALIZATION. The client uses excessive abstract thinking, intellectual reasoning, or generalizations to control or minimize the emotional discomfort associated with an internal or external stressor. This is an effort on the part of the client to "shut off" the emotions associated with the stressor. [Level #2 – Mental Inhibitions Level]

DENIAL. The client refuses to acknowledge some painful aspect of external relative or subjective experience that is apparent to others. [Level #4 – Disavowal Level]

PROJECTION. The client falsely attributes their own unacceptable feelings, impulses, or thought onto another person without justification. This is usually a guilt-based reaction to their own perceived negative aspects. [Level #4 – Disavowal Level]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Schizoid Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool

since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[87] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

The therapist must recognize the fact that the whole demeanor of the schizoid individual is functional and not relational. They do what has to be done to function – not to relate. In higher functioning individuals, their relational interactions will likely be associated with functioning and not the pleasures of interacting with others.

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[87] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

While therapy with lower functioning individuals can be challenging and difficult, counseling individuals who are higher functioning can be quite productive. Reframing persistent negative self-beliefs is essential. The minimum goal of therapy should be to greatly reduce anxiety and apprehension related to social and interpersonal situations.

The therapist should thoroughly investigate the possibility of *Axis I Disorders*. The propensity of this client will be toward depressive symptomology (although other *Axis I Disorders* are a distinct possibility). The therapist is warned that this personality type may decompensate into a more serious condition, including *Schizotypal Personality Type*. *Delusions* and *Schizophrenia* are a distinct possibility in extreme crisis situations, especially for lower functioning schizoid individuals.

These individuals usually enter therapy due to unacceptable *Axis I Disorder* symptomology. Internally, they usually have a "plan" to only stay around until the most discomforting symptomology is resolved. This is a safe and acceptable treatment plan for them. Anything else presents fears that are not acceptable. The therapist must realize that early exit from therapy after elimination of persistent negative emotions is a real possibility. Structuring a treatment plan early with the acceptance of the client may prevent early withdrawal.

The following suggestions are included as appropriate treatment objectives during the course of counseling.

- The therapist should understand that silence is a non-verbal form of relating rather than as treatment resistance. This may be unacceptable to the therapist but resistance to silence must be controlled or eliminated.
- It is important during the therapy process to help the client correct their emotional experience. The emotions of the client will be very controlled. They must learn to deal with stronger emotions that may seem threatening. Internalizing these emotions will only result in other adverse reactions including *Axis I Disorders* (e.g. *Mood*

Disorders, *Delusional Disorders* (in extreme cases), and *Somatic Disorders*).

- If the therapist believes it is warranted, the therapist should role-play social skills development. This can easily be done in the course of counseling and employed as homework assignments.
- As therapy progresses, the therapist should carefully increase social interaction on the part of the client. It is important that this increase in interaction should be carefully discussed with the individual. The therapist must be sensitive to the emotional reactions of the client regarding this progress. Also, when the client is successful in engaging in increased social interaction the therapist must note the progress that the client has made. Complete assessment of increased social interaction must be made and both the positive and negative accomplishments must be noted. The negative issues must be analyzed and any residual emotional hesitancy must be eliminated.
- It is important in this process that the therapist completely involves the client. The therapist should get the client "excited" about the potential for growth in interpersonal communication. Prior to homework assignments, the therapist and the client must be in full agreement regarding the exercise.
- All social interactions should be appropriate to the growth level of the client. The client should never be "pushed" beyond their emotional limits. This could cause sudden cessation of therapy and relapse.
- The therapist must defuse and eliminate the client's belief that they are defective, bad, unwanted, or inferior to others.
- The client must be moved away from social isolation. They may feel that they are alienated, different from others, or not part of any group.
- The individual must enlarge their acceptance of emotions. They will typically refrain from emotions that

are "charged," especially in interpersonal situations. This issue must be resolved and those "charged" emotions must be made acceptable to the individual. This will be a challenge to the therapist.

- The client's belief that they must suppress their own desires, needs, and feelings in order to meet the needs of others must be corrected. To some degree, this will be part of the social training that the therapist does.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Schizoid Personality Type*. The therapist must understand that the more the client tends toward true personality disorder, the more possible these dangers become. The obstacles and dangers include the following:

- Exiting treatment due to the anxiety of treatment.
- Total social isolation.
- Decompensation into schizotypal personality traits *Delusional Disorder*, or *Schizophrenia*.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment for the *Schizoid Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- The client must restructure their frame of reference regarding social isolation. The client feels alienated from other people. This prevents interaction in social and interpersonal situations.
- The client's belief that they are defective, bad, unwanted, or inferior to others must be reversed.

- The client must understand that others can meet their emotional needs in consistent interpersonal relationships.
- The client's belief that they must be emotionally close with others at the expense of their own individualization must be reconciled.
- The client must realize that they do not need to meet the needs of other people at their own expense.

Schizotypal Personality Style and Disorder

The Schizotypal Personality Type In A Nutshell

"The essential feature of *Schizotypal Personality Disorder* is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior."[88]

These individuals are characterized by excessive paranoia, especially in social and interpersonal situations. They are hypervigilant, and hypersensitive and fearful. They are prone to various anxiety states. Cognitively, they have automatic thoughts and beliefs about their environment that seem to "protect" them from the harm that they believe others might bring on them.

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[88] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington D.C., American Psychiatric Association. 2000, p. 697.

A CLOSER LOOK

The *Schizotypal Personality Type* is most likely the product of a serious and consistent parental behavior in an individual's childhood. Minimally, the parental behavior indicates a significant form of neglect. There may have been some form of fragmented communication. Other issues that may have caused this problem include such extreme issues as death of a parent or both parents, torture of the individual, physical or sexual abuse, or consistent emotional abuse that might be construed as nearing a torturous situation.

As a method to "protect" themselves from the outside social world, these individuals have a series of automatic thoughts that they use to insolate themselves against the potential of being harmed by other people. These automatic thoughts are all associated with beliefs that others are conspiring against them, watching them, talking about them, or in some other way plotting against them.

They use these beliefs as a shield that protects them against social interaction. Since everyone (from their viewpoint) is malevolent toward them, they use those beliefs to eject from any possibility of stable interpersonal relationships.

THE BOTTOM LINE

In order to counsel this individual, the therapist must help the individual "test" their beliefs regarding others. The therapist must help the individual reconstruct their cognitive processes so that the automatic thinking is stopped.

A therapist should only attempt to counsel this individual if they are a higher functioning schizotypal. A lower functioning schizotypal will likely need medical attention, possible hospitalization (if a crisis is presented) and significant medication.

Technical DSM-IV-TR Criteria For Diagnosis of a Full Personality Disorder

The official DSM-IV-TR diagnostic criteria for *Schizotypal Personality Disorder* are:[89]

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Ideas of reference (excluding delusions of reference)

2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g. superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"' in children and adolescents, bizarre fantasies or preoccupations)

3. Unusual perceptual experiences, including bodily illusions

4. Odd thinking and speech (e.g. vague, circumstantial, metaphorical, over elaborate, or stereotyped)

5. Suspiciousness or paranoid ideation

6. Inappropriate or constricted affect

7. Behavior or appearance that is odd, eccentric, or peculiar

8. Lack of close friends or confidants other than first-degree relatives

9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgment about self

B. Does not occur exclusively during the course of *Schizophrenia*, a *Mood Disorder With Psychotic Features*, another *Psychotic Disorder*, or a *Pervasive Development Disorder*.

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[89] *DSM-IV-TR*, p. 701.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

Differential Diagnosis

There are a number of other disorders that contain similar characteristics to *Schizotypal Personality Disorder*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

DELUSIONAL DISORDER, SCHIZOPHRENIA, MOOD DISORDER WITH PSYCHOTIC FEATURES. Psychotic symptomology is associated with all three of the differential diagnoses. Psychotic symptomology, however, is not present with *Schizotypal Personality Disorder*. While dual diagnosis can be made, *Schizotypal Personality Disorder* must be present prior to diagnosis of the differentials.

PERSONALITY CHANGE DUE TO GENERAL MEDICAL CONDITION. Both diagnoses can be made. However, *Schizotypal Personality Disorder* must be present first.

CHRONIC SUBSTANCE ABUSE. Both diagnoses can be made. However, *Schizotypal Personality Disorder* must be present first.

PARANOID PERSONALITY DISORDER, SCHIZOID PERSONALITY DISORDER. The two differential disorders are not characterized by the odd, eccentric behaviors and the cognitive and perceptual distortions characterized by *Schizotypal Personality Disorder* are not present.

AVOIDANT PERSONALITY DISORDER. The primary reason for lack of relationship with *Avoidant Personality Disorder* is fear of rejection whereas the reason for such with *Schizotypal Personality Disorder* is a lack of desire for relationships generally.

NARCISSISTIC PERSONALITY DISORDER. The primary reason for lack of relationships with *Narcissistic Personality Disorder* is due to the fear of having imperfections exposed while the reason for lack of relationships with *Schizotypal Personality Disorder* is due to lack of desire for relationships generally.

Commonly Associated Axis I Disorders

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *Schizotypal Personality Type*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

ANXIETY DISORDERS. Since this individual is hypervigilant and hypersensitive to social and interpersonal settings, there is always the possibility that demands for social or interpersonal interaction can result in various anxiety states or syndromes.

BRIEF PSYCHOTIC DISORDER. Since the *Schizotypal Personality Type* involves cognitive or perceptual distortions the prospect for a *Brief Psychotic Disorder* is elevated.

DELUSIONAL DISORDER. *Delusional Disorder* is associated with nonbizarre delusions involving situations that could potentially occur in real life. These include the feeling that *one is being followed*, *poisoned*, *infected by disease*, or *deceived* by a significant person. This follows course with the *cognitive* or *perceptual distortions* of the *Schizotypal Personality Type*.

SCHIZOPHRENIA. *Delusional Disorder* is a potential *Axis I Disorder* associated with the *Schizotypal Personality Type*. *Schizophrenia* is similar to *Delusional Disorder* except that the

delusions are bizarre rather than nonbizarre. Furthermore, *Schizophrenia* contains the possibility of *hallucinations*, *disorganized speech*, and *catatonic behavior*. This follows course with the *cognitive* or *perceptual distortions* of the *Schizotypal Personality Type*.

SCHIZOPHRENIFORM DISORDER. *Schizophreniform Disorder* contains the same criteria for *Schizophrenia* except for the duration of the symptomology and the level of impairment suffered by the individual. This follows course with the *cognitive* or *perceptual distortions* of the *Schizotypal Personality Type*.

MAJOR DEPRESSIVE DISORDER. The potential for a *Major Depressive Disorder* with the *Schizotypal Personality Type* is probably related to the severe interpersonal and relational deficits associated with the personality type.

The Schizotypal Personality Continuum

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[90] the optimally functioning *Schizotypal Personality Style* contains six elements. Correspondingly, there

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[90] Sperry, Len, M.D., Ph.D. *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 199.

are six elements that indicate the breakdown of each of those six optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *Schizotypal Personality Disorder*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *Schizotypal Personality Style* without allowing for diminution toward more maladaptive traits.

Sperry's continuum includes the following six elements:

Optimal Functioning	Maladaptation
• This individual tends to be tuned into and sustained by their own feelings and belief.	• This individual has ideas of reference, suspicious or paranoid ideation, and inappropriate or constricted affect.
• This person has a keen observation of others and are particularly sensitive to how others react to them.	• This individual has excessive social anxiety (extreme discomfort in social situations involving unfamiliar people).
• This person tends to be drawn to abstract and speculative thinking.	• This person has odd beliefs or magical thinking in-fluencing behavior and inconsistent with subcul-tural norms.
• This person is receptive and interested in the occult, the extrasensory, and the super-natural.	• This person has unusual perceptual experiences (il-lusions, sensing the pre-sence of a force, etc).
• This individual tends to be indifferent to social conven-tion and they lead inter-esting and unusual lifestyles.	• This person exhibits odd or eccentric behavior or appearance.
• This individual is usually self-directed and independ-ent, requiring few close relationships.	• This individual has no close friends or confidants (or only one) other than first-degree relatives.

The Schizotypal Personality Style under Stress

The following behaviors will likely manifest when an individual with a *Schizotypal Personality Type* faces a triggering event. In the case of the *Schizotypal Personality Type*, triggering events will be situations related to the individual's paranoid ideations about interpersonal relationships. When the client is

overwhelmed with the presence of automatic thoughts regarding the malevolent intentions of others, a crisis may result.

- Extreme irritability.
- Excessive states of anxiety, anxiety disorders and anxiety syndromes.
- Significant and nearly consistent paranoia, especially related to social or interpersonal demands.
- Obsession with automatic thoughts and the behaviors that are a response to them. Most of these automatic thoughts will be associated with their beliefs concerning the malevolent nature of their social or interpersonal environment.
- Diminution toward morbid psychotic or pseudo-psychotic symptomology. These states may include auditory and/or visual hallucinations as well as other psychotic ideations.
- Psychotic *Axis I* incident.
- Social isolation due to perceived threats.

Disorder Etiology and Triggers

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *Schizotypal Personality Type*.

PSYCHOSOCIAL ETIOLOGY FOR THE SCHIZOTYPAL PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no

family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *Schizotypal Personality Type*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the development of the *Schizotypal Personality Type*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- EXTREME TRAUMA IN THE HOME. This may range from the death of one or both parents (especially traumatic death), abandonment of the child by parental figures, abuse of all types including physical abuse and/or torture, emotional abuse and/or torture,[91] as well as sexual abuse (including *Ritual Sexual Abuse*).

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[91] Incidents of physical torture would include acts on the part of a caretaker such as burning the child with cigarettes or other physical acts of "punishment" that are outside of the socially-accepted means of child correction. Incidents of emotional torture might include

- INSUFFICIENT EMOTIONAL WARMTH IN THE HOME. The home was likely a cold and formal place with little or no emotional safety. The environment was probably hypercritical and charged with guilt.
- FRAGMENTED PARENTAL COMMUNICATION. The parent typically condemned the child for behaviors that the parent consistently exhibited. There was an obvious and extreme parental depreciation of the child.
- IMPOVERISHED INFANTILE STIMULATION. This was due to parental indifference to the stimulatory needs of the child. This may be one of the causes for the fantasy life of the adult. Punitiveness and social control might also be a factor in the development of the fantasy life.
- "MAGICAL KNOWLEDGE" ON THE PART OF THE PARENT. The parent instills within the child the belief (usually early on in childhood) that they "know" what the child was thinking or doing while the parent was not there. The purpose of this parental behavior appears to be an effort to control both thinking and behavior from a distance. The parent implants suspicions and false beliefs in the mind of the child. This develops automatic generation of suspicions in the mind of the child so that guilt reactions become dissociated from actions. The child suffers from constant fear of attack and humiliation because of the "belief" that the parent is somehow "inside" their head.
- PARENTAL RESPONSIBILITIES AS A CHILD. The child was given parental / adult responsibilities and threatened if those responsibilities were not done. This exercise may have been for the purpose of controlling the time of the child while the parent was not present. It also cuts the child off from social communication and interaction.
- PERSONALITY DECOMPENSATION. This personality disorder may be the decompensation of either a *Schizoid Personality Type* or an *Avoidant Personality Type*.

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extreme isolation and stimulation reduction such as locking a child in a dark basement or closet for any period of time.

- ABUSE. The parental behavior that formulates this personality disorder must be considered as a very strong form of emotional and psychological abuse.
- FAMILY BEHAVIOR PATTERNS to investigate at the disorder level include severe abuse (especially "mind games", but also potentially physical or sexual);[92] punishment for allegedly inappropriate autonomy; parental "secret knowledge" that the child had done something inappropriate; punishment of the child for performing the same behaviors exhibited by the adult ("do as I say, not as I do"); circumstantial events tied to the child's behavior ("If you didn't stay after school, your mother wouldn't have gotten in a car accident"); victimization of the child; and, strong injunctions against leaving the home.[93]

[The above list does not contain biochemical considerations associated with the etiology of the *Schizotypal Personality Type*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *Schizotypal Personality Style*.

CLOSE INTERPERSONAL RELATIONSHIPS. Since the *Schizotypal Personality Type* exhibits acute discomfort with and reduced capacity for close interpersonal relationships, any significant

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[92] In cases of severe abuse, the therapist may find that the client resorts to paranoid withdrawal.

[93] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

prospect for a close interpersonal relationship could bring about a crisis event in this individual. This prospect is greatly increased when the demand for a close interpersonal relationship is mandated by circumstances out of the individual's control.

Treatment Course For Schizotypal Personality Issues

The following is a summary of treatment objectives when a therapist is dealing with a *Schizotypal Personality Type*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are six major defense mechanisms that are commonly used by individuals with the *Schizotypal Personality Type*. Five of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

INTELLECTUALIZATION. The client uses excessive abstract thinking, intellectual reasoning, or generalizations to control or minimize the emotional discomfort associated with an internal or external stressor. This is an effort on the part of the client to "shut off" the emotions associated with the stressor. [Level #2 – Mental Inhibitions Level]

DENIAL. The client refuses to acknowledge some painful aspect of external relative or subjective experience that is apparent to others. [Level #4 – Disavowal Level]

PROJECTION. The client falsely attributes their own unacceptable feelings, impulses, or thoughts onto another person without justification. This is usually a guilt-based reaction to their own perceived negative aspects. [Level #4 – Disavowal Level]

DELUSIONAL PROJECTION. The client uses *projection* with the added component of reality distortion. *Projection* places a person's own negative behaviors on another person. With *Delusional Projection*, the individual actually believes what they have *projected* onto another person because they believe they have evidence. [Level #7 – Level of Defensive Deregulation]

PSYCHOTIC DENIAL. The client uses *Denial* with the added component of reality distortion. *Denial* is an internal inability to admit that an event has occurred. *Psychotic Denial* builds a defense that "proves" to the client that the event has or has not occurred. [Level #7 – Level of Defensive Deregulation]

PSYCHOTIC DISTORTION. The client experiences internal hallucinations (visual and/or auditory) and other delusions. These elements reshape the client's view of external reality and create a "new reality" for the client that opposes objective reality. [Level #7 – Level of Defensive Deregulation]

The Treatment Process

PRIOR TO THERAPEUTIC INTERVENTION

The first course in treatment for the *Schizotypal Personality Type* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The

Addictions and Dependency Scale may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[94] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

OBJECTIVES OF THERAPY

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

- The therapist should understand that treatment of lower functioning schizotypal individuals in an outpatient setting is potentially non-productive. The likelihood is that these individuals will need psychiatric control, significant medication, and in-patient treatment. This

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[94] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET Counseling and Assessment Personality Style Analysis*. The therapist should carefully examine those results.

will be indicated rather quickly to the therapist when an individual is unable to focus in therapy or is unable to separate reality and fantasy.

• Some higher functioning schizotypal individuals do respond well to outpatient therapy. This will depend, to some degree, on the motivation of the client and their ability to begin working through their fears and paranoias. In order to facilitate this environment, the therapist must adopt a permissive and accepting attitude toward the client. The therapist must understand that this individual may believe that everyone is plotting against them. The therapist must develop a relationship that disproves that fact to the client without condemning the client.

• Clients with some depressive symptoms fair better in therapy because of the motivation to get past the negative and troubling emotion. Clients with higher level ego functioning are also better prospects.

• The therapist should expect that the client will routinely use *Projective Identification* as a defense mechanism in and out of the therapy office. The therapist must deal with this issue without being overly corrective initially.

• The therapist must also understand that extreme states of agitation and anxiety are often present, especially when the individual perceives that they are going to be placed n a situation that threatens them. The therapist must help the client manage and modify their hypersensitivity, hypervigilance and anxiety.

• Early in the treatment process, the therapist and the client together should produce both a problem list and a goal list. It is essential that the client is involved in this effort for two reasons: 1) the therapist will be able to see the issues that are most important to the client; and, 2) the client will be less likely to believe that the therapist is conspiring against them.

• The client has significant irrational beliefs about others. Most of those irrational beliefs are based in some type of

fear related to how others perceive them. Therefore, the therapist must ensure that the client doesn't develop an aversion toward the therapist. If this occurs, the therapeutic relationship may be over and the client is probably best referred to another therapist.

- The goal of the therapist is to help the client develop a correct emotional response to life's experiences. The client needs a new cognitive structure for internalization of thoughts and feelings (and not just behavioral modification or restructuring). The client is basically nonrelational in their mode of functioning.

- Thus, the goal of treatment is to improve adaptive functioning through restructure of automatic thoughts.[95] The cognitive structure of the individual must be carefully questioned, including all of the maladaptive automatic thoughts that a person has (e.g. "people are following me," "people are watching me," or "people are plotting against me").

- The therapist should understand that sometimes silence is a means by which the client responds in some cases. The therapist must be careful not to push the client past silence since it may be too threatening for the client to speak. The therapist should not act on silence. The fact that the therapist will not push the client past silence reinforces to the client that the therapist is on their side.

- The therapist should carefully review the psychosocial etiology of the *Schizotypal Personality Type*. It appears that the *Schizotypal Personality Type* originates from some extremely traumatic situation or event in the

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[95] "Automatic thoughts" are any thoughts that pre-exist facts. Thus, the client will believe (i.e. think) that someone is "out to get them" or someone is "talking about them behind their backs" even though there is no justification for the thought. These are automatic thoughts and they form the basis for the cognitive functioning of the schizotypal individual. This is little prospect of aiding these individuals if automatic thoughts and beliefs are not curtailed.

client's childhood experience.[96] This may include very severe cases of abuse and neglect (although those are not the only psychosocial elements in the etiology of this Type). The traumatic events of childhood have instilled an archetype of paranoid mistrust of others within the client's cognitive thought processes as a means of preventing even more trauma.

- With this in mind, it will serve the therapist best to develop some overall concept of where the paranoia originated. It is unlikely that the paranoia developed anywhere outside of the home of origin, but at the same time, there are a number of different reasons that could have generated the paranoia. This case-building exercise on the part of the therapist should be done over a number of sessions without the explicit knowledge of the client. This will greatly aid the therapist in pinpointing treatment methodologies.
- The core of treatment for the schizotypal individual in crisis involves helping them to develop new and more realistic cognitive conceptions of their social and interpersonal environment. The therapist should understand that this process will be slow, especially in the beginning due to both anxiety and paranoia.
- The therapist must aid the client in exploring their automatic thoughts and beliefs about their environment. The therapist must help the client "test" those automatic thoughts. As therapy progresses, the therapist must help the client examine the evidence concerning the reality of the automatic thoughts. It is very important that the therapist uses questions as a primary method of helping the client rethink their automatic thoughts. If this is not done, the client may think that the therapist is acting against their best interest.

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[96] While some non-typical occurrences of *Schizotypal Personality Disorder* may find their primary etiology in biochemical abnormalities, the therapist will likely determine that biochemical etiology as a primary mechanism for the development of this personality type is very rare.

- The goal of the therapist is to draw out these automatic thoughts and help the client determine if the thoughts are true or not. If they are not, the therapist needs to help the client develop abilities that will subvert and stop the automatic thoughts.
- After this process has begun, the therapist must help the client learn more appropriate emotions related to their thinking. This is a two-step process: 1) stop the automatic and illogical thinking process; and, 2) restructure the emotional content associated with thinking processes.
- After the client is assured that the therapist is not "out to get them," the therapist must work to increase the social support network of the client. This is done partly through increase of the client's socially appropriate behaviors and partly through the establishment of more appropriate thinking patterns.
- Modifying the paranoid ideations of a client is sometimes very difficult. The client may ascribe very positive benefits to these automatic thoughts and beliefs. They may provide a safe environment that prevents harm to them. An example will best illustrate this fact.

  Therapist: Has anyone every done anything to hurt you?
  Client: No. Not really.
  Therapist: But you seem to stay away from other people because you think that they will hurt you.
  Client: Well, better safe than sorry… (an automatic thought)

- Thus, even though the client has never been hurt significantly in some adult social situation, they use the aversion to social situations as a positive quality that prevents what they fear. This is only reinforced further if the client has managed to actually be hurt in a social situation. This is not uncommon at all due to the social ineptness of the individual.

- Role-playing may be a significant element in the development of cognitive and social skills as therapy progresses. This should only be done when the therapist believes that it will not overwhelm the client.

DANGERS OF THE THERAPEUTIC PROCESS

There are significant obstacles and potential dangers associated with the therapeutic process for the *Schizotypal Personality Type*. These include the following:

- Inability to trust the therapist due to paranoid ideations of harm being done by everyone that they are associated with. This issue can only be resolved by referral once it occurs.
- Major psychotic episode. The type and extent of the psychotic episode cannot be predicted. This will likely occur when the client begins to explore the world without the "aid" of their automatic thoughts. The world may be too scary of a place to encounter without preconceived and automatic beliefs.
- Self-harm or harm to others. This is a possibility especially in the presence of a psychotic episode. The individual may engage in a self-destructive act or an act that harms another person without even understanding what they are doing.

SUCCESSFUL COMPLETION OF TREATMENT

Termination of treatment for the *Schizotypal Personality Type* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- Resolution of the abandonment fear that the client will have regarding all or nearly all interpersonal relationships that they engage in.
- Resolution of the belief that the client is alienated from others and that others cannot understand them or meet their needs. This can be done to a significant degree by helping the client repattern their cognitive abilities by preventing automatic thoughts.
- The belief that the client is always vulnerable to harm must be addressed. The client is unusually susceptible to paranoid ideations. These must be addressed and diminished in order for the therapist to deal with the client's fear of imminent catastrophe.
- The client must be taught that they can competently deal with everyday responsibilities without considerable help from others. This is a learned process that goes along with the cessation of automatic thoughts.

DSM-IV-TR

SINGLE CLUSTER ELEVATIONS

&

COMPLEX CLUSTER ELEVATIONS

Introduction

This section of the textbook has been included for use with the *MARET Counseling and Assessment Software*. Specifically, the contents of this section should help the therapist understand and interpret complex analysis of Personality Styles and Disorders as assessed and evaluated in the context of the Diagnosis portion of the *MARET Counseling and Assessment Software* package.

This section contains two parts. First, the section details the general and broad characteristics of each of the *DSM-IV Personality Clusters* in their elevated state. Second, the section examines the combination of elevations when more than one Cluster is elevated in the analysis of a client's personality assessment.

The analysis of elevated Clusters mandates that certain specific information related to each of the Personality Styles/Disorders is generalized. Therefore, it is expedient for the therapist to print the individual *Personality Type* information sheets for each elevated personality. Those specific sheets will give details for each of the personalities without generalizations. The therapist should examine each of the sheets carefully. This is even more important on two accounts: 1) In the case of a

significantly elevated Cluster; and 2) in cases where significant personality disorder scores are present.

Finally, when a therapist encounters an elevation of at least one *DSM-IV Personality Cluster*, it is advisable for the therapist to conduct a complete *Personal Matrix Analysis* for that client. In all likelihood, the therapist will encounter significant issues using that *Matrix* that will act as an aid in the counseling process.[97]

The *Matrix* includes such assessments as the *Personal Crisis Inventory*, the *Marriage* or *Premarriage Inventory*, the *Home Safety Index*, *Addictions and Dependency Scale*, and the *Foundations Home of Origins Assessment*. With the significant elevation of any Cluster it is likely that the therapist will find other significant issues. Those issues will potentially include relationship issues, addictions/dependency issues, and home of origin issues.

The latter is usually true since personality is formed during the early childhood years. Therefore, it is not likely that an individual will have a personality disorganized enough to exhibit a Cluster elevation without some profound home of origin factors involved.

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[97] The *Personal Matrix* is available in *MARET Counseling and Assessment Software* version 2.3.0 and above.

Single
DSM-IV Personality Cluster
Elevations

DSM-IV Personality Cluster A Elevation

General Characteristics of the Cluster

The Personality Types included in *Cluster A* are *Paranoid Personality Type*, *Schizoid Personality Type*, and *Schizotypal Personality Type*. These three Personality Types are generally characterized by eccentric or odd behaviors.

An elevation in the Cluster indicates that in all likelihood at least one of the Types is very significantly elevated with at least one of the other Types being marginally elevated. These would be minimum criteria for elevation of the Cluster and the individual Personality Type elevations may be even more prominent.

While elevation of a Cluster does not indicate (necessarily) that the individual has a personality disorder, the elevation does indicate some amount of personality pathology that will disrupt normal human living. This disruption will be both intrapersonal and interpersonal.

All Cluster elevations have a common thread: A fear-based approach to intrapersonal and interpersonal life. This fear base

leads to a variety of different reactions personally and socially described in the details below. Emotional disruption will be evident in the form of aversion and rejection of softer emotions (which elevates fear responses). This will mandate that the individual remains emotionally at arms length from everyone, including a spouse.

A *Personal Matrix* analysis will aid the therapist in determining exactly which areas of an individual's life are most significantly disrupted by intrapersonal and interpersonal issues.

Triggers that Typically Precipitate a Full Personality Disorder

Personality styles are stable states of personality. Every personality is subject to moving on a continuum from stable to unstable. The most likely "trigger event" that will move a stable Cluster A personality toward a full personality disorder is an *interpersonal relationship crisis*. Additionally, In the case of a *Schizoid Personality Style*, a *significant personal quarry* may also precipitate a crisis in the personality under Cluster A.

Behavioral Characteristics

Individuals with Cluster A personality elevations often appear eccentric. They may resist external influences, suffer from chronic tension due to perceived threats and they may be defensive (*Paranoid Type*). They may be lethargic and inattentive (*Schizoid Type*). Finally, they may have incoherent speech and logic patterns (*Schizotypal Type*).

Interpersonal Behaviors

The interpersonal style of individuals with Cluster A personality elevations includes avoidance of intimacy and engagement in superficial relationships. This presents a special challenge when dealing with marital relationships since these individuals largely cannot bond emotionally to others very easily. They will usually

refrain from any type of relationship that demands significant emotional vulnerability. This also presents a special challenge to the therapist since the client will likely not engage the therapist at the emotional level.

These individuals may be socially apprehensive or even engage in social isolation, if the elevation is extreme. They may distrust others (*Paranoid Type*). They may also be socially aloof and desire to be alone (*Schizoid Type*).

Cognitive Traits

The cognitive style of Cluster A personality elevations is substantially scattered (*Schizotypal Type*). They are often cognitively distracted (*Schizoid Type*). Thinking and communication are easily derailed by external influences (*Schizoid Type*). This individual often attempts to confirm preconceived beliefs and ideas rather than focusing on data and facts to make decisions (*Paranoid Type*).

This will present a special challenge to anyone who wishes to use reason as a mechanism to deal with this individual. Often, their own internal biases will be accepted even in the face of obvious and undeniable facts that should alter either behavior or belief. These traits will also result in the individual using illogical argumentation. When confronted with obvious facts that should change beliefs or behaviors, the individual may change the subject or resort to emotional reactions to quench the argumentation.

Emotional Behaviors

The emotional behaviors of individuals with Cluster A personality elevations is substantially cold and aloof. They often lack a sense of humor. Their primary emotions are mostly centered on the harsher emotions like anger, hostility and jealousy (*Paranoid Type*). This is a common thread that occurs in all three Cluster elevations and this hostility focus appears to be a fear-based complex in all three Cluster elevations.

Their concept of empathy is poor, if it exists at all (*Schizoid Type*). Many times their affects are constricted. This constriction of emotion disallows a full range of emotional expression (*Schizotypal Type*). At times, they may be confused or even disturbed by some normal emotions expressed by others (*Schizotypal Type*).

It appears that the constriction of emotion is somehow related to a fear reaction. Harsher emotions "protect" them from others by not allowing others to gain access to them in an emotionally vulnerable manner. This tends to keep everyone at arms length.

This presents a significant problem for marriage relationships specifically and all intimate relationships in general. It also presents a hurdle that the therapist must jump in order to accomplish any type of healing and restoration in the individual's life since there must be an emotional encounter during the therapy process.

Attachments to Others

As is the case for the other two Cluster elevations, the most primary motivation for attachment to other people with Cluster A elevations is fear-based. The individual may suffer from a deep-seated feeling of unworthiness (*Paranoid Type*). There may also be global issues of trust (*Schizoid Type*). Finally, these individuals may use others to meet their own needs (*Schizotypal Type*).

Attachment based on emotional vulnerability is not likely without substantial healing. This individual will remain surface in their attachments and will not allow others into their life in a way that will place them in an emotionally vulnerable situation.

DSM-IV Personality Cluster B Elevation

General Characteristics of the Cluster

The Personality Types included in Cluster B are *Antisocial Personality Type*, *Borderline Personality Type*, *Histrionic Personality Type* and *Narcissistic Personality Type*. These four Personality Types are generally characterized by dramatic, emotional and erratic behaviors.

An elevation in the Cluster indicates that in all likelihood at least one of the Types is very significantly elevated with at least one of the other Types being marginally elevated. These would be minimum criteria for elevation of the Cluster and the individual Personality Type elevations may be even more prominent.

While elevation of a Cluster does not indicate (necessarily) that the individual has a personality disorder, the elevation does indicate some amount of personality pathology that will disrupt normal human living. This disruption will be both intrapersonal and interpersonal.

All Cluster elevations have a common thread: A fear-based approach to intrapersonal and interpersonal life. This fear base leads to a variety of different reactions personally and interpersonally described in the details below. Emotional disruption will be evident in the form of aversion and rejection of softer emotions (which elevates fear responses). This will mandate that the individual remains emotionally at arms length from everyone, including a spouse.

A *Personal Matrix* analysis will aid the therapist in determining exactly which areas of an individual's life are most significantly disrupted by intrapersonal and interpersonal issues.

Triggers that Typically Precipitate a Full Personality Disorder

There are multiple "trigger events" that will move a stable Cluster B personality toward a full personality disorder. Trigger events include *confrontation with social standards and rules* (*Antisocial Type*), *efforts to avoid real or imagined abandonment* (*Borderline Type*), *relationships with the opposite gender* (*Histrionic Type*), and *a significant personal evaluation of self* (*Narcissistic Type*).

Behavioral Characteristics

Individuals with Cluster B personality elevations are often impulsive and irritable (*Antisocial Type*). They are usually aggressive toward others (*Antisocial Type*). They may be conceited, self-assured, self-centered, impatient, and hypersensitive (*Narcissistic Type*). In certain cases, they may reveal erratic behaviors that are designed to gain attention. These erratic behaviors will vacillate from being very charming to people and then suddenly becoming very demanding (*Histrionic Type*). In other cases, these individuals could be potentially self-destructive in their actions (*Borderline Type*). This self-destructive behavior may be conscious actions or unconscious behaviors that appear as carelessness.

Interpersonal Behaviors

Individuals with elevated Cluster B personalities are usually rejection sensitive (*Borderline Type*) and sometimes intolerant of being alone (*Borderline Type*). They can be interpersonally explosive (*Narcissistic Type*). These individuals may be irresponsible in interpersonal relationships due to self-centered behaviors (*Narcissistic Type*) and may use other people to indulge themselves (*Narcissistic Type*). In certain cases, they may be exhibitionists, attention seeking, and manipulating (*Histrionic Type*).

Cognitive Traits

The cognitive style of Cluster B personality elevations is centered on impulsiveness. These individuals are very externally oriented and, thus, do not like encountering their inner person.

They are often inflexible (*Antisocial Type*) and intolerant (*Borderline Type*). These individuals are expansive and exaggerated in their thinking styles (*Narcissistic Type*). They are often highly suggestible, although they will likely not admit it (*Histrionic Type*). They are not totally analytical, but, again, will not admit it (*Histrionic Type*). Sometimes they take liberty with the facts (*Narcissistic Type*). In some cases, they set unrealistic goals (at times even ultraistic goals) and have an exaggerated sense of self-importance (*Narcissistic Type*).

Because of their external bias and their inability to encounter their inner person, they often believe they are powerless to change their behaviors and lifestyle (*Borderline Type*). This fact may lead to significant personal crisis.

Emotional Behaviors

The emotional behaviors of individuals with Cluster B personality elevations are shallow and do not include the whole range of healthy human emotion. Cluster B personalities engage hostility, anger and rage as the core of emotional responses while the softer emotions are significantly rejected. This is a common

thread that occurs in all three Cluster elevations and this hostility focus appears to be a fear-based complex in all three Cluster elevations.

When emotions other than hostile emotions are exhibited, those emotions are likely to be mechanical and superficial. These individuals may tend toward depression and depression-like syndromes.

This emotional bias against a full range of human emotions, presents significant disruption of any attempts to engage in an intimate relationship – especially marriage. This emotional behavior will likely result in significant frustration on the part of the spouse and will make sustaining a significant and emotionally vulnerable relationship nearly impossible.

These behaviors seem to be associated with an internal fear of encountering emotions that lead to vulnerability. Since these individuals are largely external themselves, they cannot allow another individual to encounter their inner person since they cannot even encounter that person themselves. In cases where such interaction is expected or encountered, these individuals will resort to hostile emotional reactions to push others away.

Attachments to Others

As is the case for the other two Cluster elevations, the most primary motivation for attachment to others in Cluster B personality elevations is fear-based. There is usually a negative view of others (*Antisocial Type*). This may be a defensive action. Individuals in Cluster B often use others to meet their own needs while being wary of the individuals that they are using (*Antisocial Type* and *Narcissistic Type*). These individuals may experience a strong sense of personal unworthiness (*Histrionic Type*). Attachments are externally-based and do not relate to deep emotional attachment. Deep emotional attachment would be too threatening to these individuals.

In some extreme cases, there may be dissociative symptomology (*Borderline Type*).

DSM-IV Personality Cluster C Elevation

General Characteristics of the Cluster

The Personality Types included in Cluster C are *Avoidant Personality Type*, *Dependant Personality Type*, and *Obsessive-Compulsive Personality Type*. These three Personality Types are generally characterized by anxiety- and fear-based behaviors.

An elevation in the Cluster indicates that in all likelihood at least one of the Types is very significantly elevated with at least one of the other Types being marginally elevated. These would be minimum criteria for elevation of the Cluster and the individual Personality Type elevations may be even more prominent.

While elevation of a Cluster does not indicate (necessarily) that the individual has a personality disorder, the elevation does indicate some amount of personality pathology that will disrupt normal human living. This disruption will be both intrapersonal and interpersonal.

All Cluster elevations have a common thread: A fear-based approach to intrapersonal and interpersonal life. This fear base

leads to a variety of different reactions personally and socially described in the details below. Emotional disruption will be evident in the form of aversion and rejection of softer emotions (which elevates fear responses). This will mandate that the individual remains emotionally at arms length from everyone, including a spouse.

A *Personal Matrix* analysis will aid the therapist in determining exactly which areas of an individual's life are most significantly disrupted by intrapersonal and interpersonal issues.

Triggers that Typically Precipitate a Full Personality Disorder

There are multiple "trigger events" that will move a stable Cluster C personality toward a full personality disorder. Trigger events include *demands for close personal relationships* (*Avoidant Type*), *demands of close interpersonal relationships* (*Obsessive-Compulsive Type*), *demands for social appearances* (*Avoidant Type*), *expectations of self-reliance* (*Dependant Type*), *confrontation with authority figures* (*Obsessive-Compulsive Type*), *unstructured situations* (*Obsessive-Compulsive Type*) and *the prospect of being alone* (*Dependant Type*).

Behavioral Characteristics

Behaviors associated with Cluster C personality elevations are widely variable. Social withdrawal (*Avoidant Type*) and non-assertiveness (*Dependant Type*) are predominant. These individuals may be aloof (*Avoidant Type*), passive and compliant (*Dependant Type*). While they are dependable (*Obsessive-Compulsive Type*), they are also sometimes perfectionistic (*Obsessive-Compulsive Type*).

Interpersonal Behaviors

Individuals with elevated Cluster C personalities are usually rejection sensitive (*Avoidant Type*). Thus, they may have a

constant need for assurance from others (*Dependant Type*). In order to prevent rejections, they may be pleasing and self-sacrificing (*Dependant Type*). Finally, in some cases, they may be unsatisfied with the performance of others (*Obsessive-Compulsive Type*).

Cognitive Traits

The cognitive style of Cluster C personality elevations includes heightened perceptions (*Avoidant Type*), but in some cases these individuals may suffer the opposite characteristic of unperceptiveness (*Dependant Type*). In short, with an elevation in Cluster C, there is often a cognitive disturbance of perception.

In some cases, these individuals will minimize difficulties (*Dependant Type*). They often suffer from low self-esteem (*Avoidant Type*). These individuals usually have a constricted thinking style (*Obsessive-Compulsive Type*) and often show too much attention to detail (*Obsessive-Compulsive Type*).

Emotional Behaviors

The emotional behaviors of individuals with Cluster C personality elevations include lack of deep feelings of intimacy (*Obsessive-Compulsive Type*). Routinely, these individuals avoid softer emotions and feelings (*Obsessive-Compulsive Type*) and prefer harder emotions centered around hostility. This is a common thread that occurs in all three Cluster elevations and this hostility focus appears to be a fear-based complex in all three Cluster elevations. This fear-based reaction may be related to the fear of abandonment (*Dependant Type*).

The logic of this avoidance of softer emotions appears to be that if a person doesn't risk intimacy they can avoid the pain of potential future rejection. This thinking, however, results in insecurity (*Dependant Type*) and anxiety (*Dependant Type*). The anxiety and insecurity are generated out of the deep human "understanding" that intimacy is an essential component of

human life. Significant feelings of emptiness and loneliness are also usually the result (*Avoidant Type*).

This leaves the individual with a core emotional state that centers on anger and hostility (*Obsessive-Compulsive Type*). The hostile emotions may be the result of the knowledge and deep-seated desire to fulfill the human need for intimacy and emotional vulnerability and the revulsion from it that is generated by insecurity and fear. This leaves the individual in a constant emotional state of conflict and tension.

Attachments to Others

As is the case for the other two Cluster elevations, the most primary motivation for attachment to others in Cluster C personality elevations is fear-based. This seems to be based on feelings of unworthiness. Relationships are external in their orientation and the potential for close interpersonal relationships based on emotional vulnerability are not very probable. The prospect of a constructive and emotionally sound marital relationship is dismal since this individual will not typically risk emotional vulnerability.

Complex
DSM-IV Personality Cluster
Elevations

Elevation of Complex, Multiple Clusters

An Introduction

In the most desirable scenarios, the therapist will find that a healthy personality contains elevation of a few personality styles, usually across two or three Clusters. The therapist will find that only one personality style in a Cluster will be elevated, and thus, the prospect of a complete elevation of the personality Cluster itself will not exist.

In such cases, the therapist can review information for the specific elevated personality styles to determine the relationship structure of the individual's personality. At the same time, the healthiest personalities will exhibit a very low Disorder score. This indicates that the individual is interacting well with their environment and that they are avoiding the pitfalls that could potentially move their personality from style to disorder.

However, in some cases, the personality of an individual contains a number of elevations in the same Cluster. In that case, the therapist will find an elevation of the Cluster score as described above in the individual Cluster elevation descriptions. As the Cluster elevation score increases, the therapist is likely to

find many of the traits and behaviors listed in the descriptions above.

In the extreme cases, however, the therapist will find that two or all three of the Clusters contain significant elevations. In this case, the personality is quite convoluted and contains elements that are both illogical and erratic. This case will make counseling the individual quite difficult since the therapist will have a hard time determining a consistent pattern associated with the individual's personality style.

The common elements that span all three of the personality Cluster elevations will present a significant – maybe even insurmountable – challenge to both the individual and the therapist. Those common elements are their fear-based reality and their emotional inability to come in contact with any emotions other than hostility-based emotions. These two facets of the personality structure will greatly impede any movement toward normalcy.

These individuals will be on an endless cycle of fear-based attempts to attach to others and repulsion from true emotional vulnerability. They will attach to others in an effort to avoid the fear of being alone. But, since they cannot engage in a full emotional relationship, they will use hostility to push others away – out of the fear of exposing feelings that they cannot confront. This cycle is largely the result of deep internal insecurities that have been instilled in the personality since childhood. Overcoming these insecurities demands that the individual stops the cycle, first of all. Then, they must recognize that the problem lies within them and that the problem is not the fault of others. This is nearly an insurmountable task for someone whose whole basis is centered on fear – especially the fear of softer emotions.

The therapist should carefully study each of the elevated personality types for the individual. Those specific types should be printed and read until the therapist has a consistent and thorough understanding of all of the components that make up the elevated personality types. With that information, the therapist should look for means to subvert the fear-based structure of the personality.

Ultimately, the therapist's goal should be to get the client to express a full range of appropriate emotions. The client must also learn to accept those emotions in others. Finally, the therapist should motivate the client toward emotional vulnerability with another significant person.

It is advisable for the therapist to run a complete battery of assessments on each client that has a complex elevation of Clusters. The therapist will likely find significant factors of importance in the results of other assessments. A routine battery of assessments should include all of the assessments in either the *Personal Matrix* or a relationship *Matrix* (for those individuals who are in a significant relationship). Of greatest importance to the therapist are the results from the *Personal Crisis Inventory*, *Addictions and Dependency Scale*, and the *Foundations Assessment*.

If this seems like a daunting task, the therapist should rest assured: It is.

Complex Cluster Elevation #1
Cluster A / Cluster B

In this individual's particular case, they have two Clusters substantially elevated. Those Clusters are Cluster A and Cluster B.

The prognosis for successful counseling efforts with this Complex Cluster Elevation is difficult to predict. Success in counseling will largely be based on two factors: 1) The ability of the therapist to gain the acceptance of the client; and, 2) the client's willingness to change. If the client embarks on a course of blaming others for their own inadequacies, then the prognosis is very poor. The therapist must make every effort to enforce to the client that these personality patterns have been set during the earlier stages of life and are not the result of external influences of other people.

The propensity of the client will be to blame others for personality inadequacies. The client will also have a serious problem engaging softer emotions. Those emotions are excluded (largely or completely) from the emotional state of the individual. Those emotions will be needed in any significant effort to counsel this individual. If the individual is unable to

engage those emotions, the prognosis for counseling these personality issues is dismal.

Triggers that Typically Precipitate a Full Personality Disorder

There are multiple "trigger events" that will move this Complex Cluster Elevation toward a full personality disorder. The therapist must remember that this elevated situation already represents a destabilized personality structure, and, thus, a number of the characteristics listed below will already be present in the personality structure of the individual – even without a full personality disorder. Also, a Complex Cluster Elevation will move toward full personality disorder more readily.

Potential events that will trigger disorders in this individual include a variety of relationship events. Those may be an *interpersonal relationship crisis*, *efforts to avoid real or imagined abandonment* and *relationships in general with the opposite gender*. Other factors may also precipitate a full personality disorder. Those include *a significant personal quarry* or *crisis-based evaluation of self*, and *confrontation with social standards and rules*.

Behavioral Characteristics

The combination of these two Clusters results in self-focusing behavior characteristics. These individuals feel threatened by external reality, especially with people whom they *must* interact.

These individuals are defensive much of the time when dealing with other people. They strongly resist external influences on their behaviors. Their defensiveness may turn to aggression, if they feel overly threatened. As a rule, they are conceited, self-assured, self-centered and hypersensitive (but will not readily admit it). Their chronic tension from perceived threats may make them irritable and short-tempered.

They are prone to impulsiveness and may be inattentive to others due to their self-focus. Their self-focus makes them prone to impatience. They want what they want immediately.

They might be considered a bit eccentric. Their speech and logic patterns may be somewhat hard to follow, even incoherent at times. These individuals might be self-destructive either consciously or unconsciously.

Interpersonal Behaviors

The combination of these two Clusters reveals an interpersonal style that is distrustful. The core of the distrust appears to be fueled by a deep-seated fear.

This individual will avoid intimacy. Their relationships will all be superficial. This is even true of the marriage relationship. This individual will never trust another human being enough to risk emotional vulnerability.

At the core, they distrust everyone. Thus, they are irresponsible in relationships. They often have a reckless disregard for others and routinely use others to indulge themselves. They suffer from social apprehension, which at least leaves them socially aloof and may lead to efforts to totally isolate themselves socially. Their greatest desire is to be left alone.

They are rejection sensitive, which may be the reason that they would rather abstain from relationships. Their fear of abandonment may leave them interpersonally explosive and antagonistic. They will usually fluctuate between idealizing another person and condemning that same person over a short period of time.

Cognitive Traits

The combination of these two Clusters engenders a cognitive style that is rigid, inflexible, and often illogical.

These individuals would never admit to being cognitively rigid, inflexible or illogical. Often, these individuals appear to be intelligent at fist glance. And most likely, they think they are.

But, key elements of true intelligence are missing from the cognitive abilities of these individuals. They are cognitively distracted and their thinking can be scattered. They often avoid facts and data choosing rather to defend previously established belief systems, even when those systems are not totally logical.

Their intolerance makes them self-important, and can lead them to impulsive cognition. They are externally motivated and their thinking and communication may be derailed by external queues. Although they will not readily admit it, they are highly suggestible and tend to set unrealistic goals. Their thinking style is often expansive and may lead them to take a certain amount of liberty with facts.

Emotional Behaviors

The combination of these two Clusters results in a constricted affective pattern. Emotion is mechanical, except for hostility, anger and rage. Softer emotions are usually rejected, even considered as a threat.

Anger, rage and jealousy are the only significant emotions that are not mechanical and artificially produced. All other emotional states are cold and shallow. Sometimes, softer emotions demonstrated by others may confuse or disturb this individual. These individuals may react to those emotions with aggression or even anger.

This presents a significant issue in any type of intimate relationship – especially marriage. When a spouse attempts to display softer emotions, these individuals will typically cut off their spouse from expressing the softer emotions. This creates a constant tension in the relationship and results in an emotional situation that leaves the spouse without any viable means of relating in a vulnerable manner.

Due to the inability to express and recognize softer emotions, these individuals are usually non-empathetic. They are not

usually able to accept and internalize the vulnerable emotions of other people. They often view individuals who express those emotions as weak and pathetic. This prevents any type of true and lasting relationship of vulnerability between these individuals and others that they might call friends.

These individuals may be predisposed to depressive states.

Attachments to Others

The combination of these two Clusters results in an attachment style that is fear-based.

These individuals probably exhibit significant feelings of unworthiness. There are probably significant issues of trust related to other people. This results in a substantially negative view of other people. These individuals will sometimes use others to meet their own needs without reciprocation. Most attachments are externally-based and are devoid of significant emotional vulnerability.

Complex Cluster Elevation #2
Cluster A / Cluster C

In this particular case, these individuals have two Clusters substantially elevated. Those Clusters are Cluster A and Cluster C.

The prognosis for successful counseling efforts with this Complex Cluster Elevation is difficult to predict. Success in counseling will largely be based on two factors: 1) The ability of the therapist to gain the acceptance of the client: and, 2) the client's willingness to change. If the client embarks on a course of blaming others for their own inadequacies, then the prognosis is very poor. The therapist must make every effort to enforce to the client that these personality patterns have been set during the earlier stages of life and are not the result of external influences of other people.

The propensity of the client will be to blame others for personality inadequacies. The client will also have a serious problem engaging softer emotions. Those emotions are excluded (largely or completely) from the emotional state of the individual. Those emotions will be needed in any significant effort to counsel this individual. If the individual is unable to

engage those emotions, the prognosis for counseling these personality issues is dismal.

Triggers that Typically Precipitate a Full Personality Disorder

There are multiple "trigger events" that will move this Complex Cluster Elevation toward a full personality disorder. The therapist must remember that this elevated situation already represents a destabilized personality structure, and, thus, a number of the characteristics listed below will already be present in the personality structure of the individual – even without a full personality disorder. Also, a Complex Cluster Elevation will move toward full personality disorder more readily.

Potential events that will trigger disorders in these individuals include a variety of relationship events including an *interpersonal relationship crisis*, *the prospect of being alone*, and *demands for and of close personal relationships* (including intimacy). Others factors that may precipitate a disorder include *demands for social appearances*, *expectations of self-reliance*, and *a significant personal quarry*.

Behavioral Characteristics

The combination of these two Clusters leads to erratic behavioral characteristics. All of the following characteristics may be possible. However, these individuals will probably choose a certain pattern that may exclude some of these traits. Even in that case, all of these characteristics are possible.

These individuals may resist external influences to change. They may be defensive toward those who influence a change. Since these individuals are significantly focused on external influences (and resist internal queues), the therapist should understand that these individuals will probably resist any efforts to get them to accept responsibility for their problems. Their external focus will cause them to blame others for all of their problems. There will be a substantial inability to accept that they

themselves might be responsible for their problems. This individual may suffer from chronic tension due to perceived external environmental threats.

Social withdrawal and non-assertiveness are predominant in some cases as a mechanism to resist external influences. When confronted with external influences that they must deal with, these individuals may be aloof, passive and compliant. Other times, these individuals may react to external influences with aggression or even hostility. Either tactic is an effort to shut off the external influences so that they do not need to be dealt with.

The individual may appear to be lethargic and inattentive. They may have incoherent speech and logic patterns. While they are dependable, there may be elements of perfectionism.

Interpersonal Behaviors

The combination of these two Clusters results in an avoidance of true emotionally interactive relationships. These individuals will always hold back something from a relationship, even relationships such as marriage. They will usually not allow themselves to become emotionally vulnerable. That prospect is not considered as "safe" due to their depreciated self-image.

These individuals will likely interact with others in a manner that allows them to avoid intimacy, even in the most intimate of relationships. Although these individuals can engage in a long-term and consistent relationship, that relationship will be significantly superficial and will not allow for complete integration of the emotional element of an intimate relationship. This is largely due to their rejection sensitivity. This presents a problem for the spouse of these individuals since the spouse will not be able to engage in a fulfilling relationship of emotional sensitivity and vulnerability.

Rejection sensitivity may lead to a constant need for assurance from others. In order to prevent rejection, they may be pleasing and self-sacrificing. At the same time, they may deeply distrust others. Their self-sacrificing behavior is an effort to reduce the potential for rejection. These individuals may be

socially apprehensive or – in extreme cases – may even engage in attempts to isolate themselves socially. When they do engage in social situations, they may be socially aloof and desire to be left alone. Finally, in some cases, this individual may be unsatisfied with the performance of others.

Cognitive Traits

The combination of these two Clusters reveals a cognitive style that is substantially rigid, biased and somewhat illogical. These individuals are often not able to completely assess facts and process data to change their current preconceived beliefs.

Oftentimes, the cognition of these individuals will be scattered. They are often cognitively distracted. These individuals often attempt to reaffirm and reinforce preconceived beliefs and ideas rather than focusing on data and facts to make decisions. When confronted with obvious facts that contradict preconceived beliefs and ideas, these individuals will likely react with some form of hostility to protect their preconceived beliefs and ideas.

Thinking and communication are easily derailed by external influences. These individuals may display heightened perceptions, but in other cases they may suffer the opposite characteristic of unperceptiveness. In short, there is often a cognitive disturbance of perception with these individuals. They may tend to minimize difficulties. They often suffer from low self-esteem. These individuals usually have a constricted thinking style and often show too much attention to detail.

Emotional Behaviors

The combination of these two Clusters results in a constricted emotional style. This individual is largely unable to focus on softer emotions and they prefer harsher emotions. Hostility is the core of their emotional behaviors.

The emotional style of these individuals is substantially cold and aloof. Most of the time their emotions are constricted, not

allowing a full range of healthy emotion. Routinely, they avoid softer emotions. They have significant difficulty expressing a full range of deep feelings of intimacy. This fact disrupts significant relationships where a whole range of emotions are expected, including marriage.

In the marriage relationship, these individuals will make attempts to cut off the softer emotions in their spouse. They may feel threatened by those emotions. They may also be confused by those emotions since they do not regularly allow themselves to experience and express those emotions. Individuals who are capable of a full range of emotions will be viewed as weak. This actuality leaves the spouse in an emotional void unable to express themselves in a healthy manner. These individuals will likely attempt to cut off any conversations that involve the spouse expressing emotions found undesirable or threatening to this individual. If the spouse is able to express an emotion that the individual finds undesirable, this individual will likely negate that emotion by immediately expressing some emotion of their own.

The primary emotions of this individual will be harsher emotions. Those emotions will include a range of hostilities, including anger, rage and jealousy. This may be a fear-based reaction related to the fear of abandonment. Thus, the logic is that if they don't risk intimacy they can avoid the pain of potential future rejection. This methodology results in insecurity and anxiety within the individual.

At times, they may be confused or disturbed by some emotions of others and may even react to the emotions of others with hostility. Significant feelings of emptiness and loneliness are usually the result. This leaves these individuals with a core emotional state that centers on anger and hostility. Since they are usually not able to engage in realistic introspection, they will blame others for their emotional state. This, in turn, aggravates the hostility within the person.

These individuals are apparently not capable of true empathy. Empathy involves the ability to feel the emotions of another person and to internalize those emotions, as if they were their own. Since these individuals negate certain softer emotions as

unsafe or weak, they will be unable to accept those emotions for empathetic consideration. They cannot engage in those emotions themselves leaving them with no ability to feel those emotions for someone else. This presents a critical issue for intimate relationships such as marriage since these individuals largely abandon the spouse emotionally.

Attachments to Others

Regarding this Complex Cluster Elevation, the most primary motivation for attachment to others is fear-based. It appears that this motivation is centered on feelings of unworthiness. Vulnerability presents a significant threat that must be cut off. These individuals may use others to meet their own needs but they are not usually able to equally reciprocate. Attachments will be significantly external in their orientation. The prospect for close, interpersonal relationships based on emotional vulnerability is not very likely. The prospect for a dynamic and healthy emotionally vulnerable marriage is dismal.

Complex Cluster Elevation #3
Cluster B / Cluster C

In this individual's particular case, they have two Clusters substantially elevated. Those Clusters are Cluster B and Cluster C.

The prognosis for successful counseling efforts with this Complex Cluster Elevation is difficult to predict. Success in counseling will largely be based on two factors: 1) The ability of the therapist to gain the acceptance of the client: and, 2) the client's willingness to change. If the client embarks on a course of blaming others for their own inadequacies, then the prognosis is very poor. The therapist must make every effort to enforce to the client that these personality patterns have been set during the earlier stages of life and are not the result of external influences of other people.

The propensity of the client will be to blame others for personality inadequacies. The client will also have a serious problem engaging softer emotions. Those emotions are excluded (largely or completely) from the emotional state of the individual. Those emotions will be needed in any significant effort to counsel this individual. If the individual is unable to

engage those emotions, the prognosis for counseling these personality issues is dismal.

Triggers that Typically Precipitate a Full Personality Disorder

There are multiple "trigger events" that will move this Complex Cluster Elevation toward a full personality disorder. The therapist must remember that this elevated situation already represents a destabilized personality structure, and, thus, a number of the characteristics listed below will already be present in the personality structure of the individual – even without a full personality disorder. Also, a Complex Cluster Elevation will move toward full personality disorder more readily.

Potential events that will trigger disorders in these individuals include a variety of relationship events including *demands for and of close personal relationships*, *efforts to avoid real or imagined abandonment*, and *a relationship with the opposite gender*. There are also personal issues that may precipitate a personality disorder including *a personal evaluation of self*, *demands for social appearances*, *expectations of self-reliance*, and *the prospect of being alone*. Finally, *a confrontation with social standards and rules* may trigger a personality disorder.

Behavioral Characteristics

The combination of these two Clusters is somewhat illogical. The therapist should understand that behaviors associated with this Complex Cluster Elevation may be somewhat erratic.

The common behavioral characteristics include impulsiveness and self-centered behaviors. These individuals will prefer to withdraw socially. If left alone, they will usually appear aloof, passive, compliant, and non-assertive.

When forced into social situations, however, they may become hypersensitive, impatient, and irritable. They may even become aggressive in an effort to push others away and to be left alone. They will likely appear conceited and very self-assured.

They are potentially perfectionistic and may be potentially self-destructive either consciously or unconsciously.

Interpersonal Behaviors

The combination of these two Clusters results in erratic interpersonal traits. On one hand, these individuals may be self-centered and antagonistic – even explosive. Yet, at the same time, they may be compliant and self-sacrificing. The therapist should be aware of the potential erratic nature of their interpersonal relating style.

At first sight, these individuals may appear very self-centered, antagonistic, and distrustful. In some cases, they may display a reckless disregard for others. They may be interpersonally explosive and irresponsible in interpersonal relationships. They may use others to indulge themselves and may appear manipulating toward others. Deeply, they may be unsatisfied with the performance of others.

While these traits are all aggressive traits, these individuals may display more passive interpersonal traits. Those traits will not be displayed to everyone, but mostly to those that are closest to them. These traits include a constant need for assurance from others, a desire to please others, and a self-sacrificing attitude. The self-sacrificing attitude will only present itself at times that these individuals are feeling overtly rejection sensitive and they feel that they may be abandoned. These individuals are intolerant of being alone.

Cognitive Traits

The combination of these two Clusters presents some significant potential for erratic thinking styles. These individuals are substantially external in their orientation. They display an exaggerated sense of self-importance. This exaggerated sense of self-importance will likely be a mask to cover their excessively low self-esteem.

This Cluster combination is characterized by impulsiveness, inflexibility and intolerance. These individuals can be highly suggestible, are not totally analytical (although they will probably deny it), and they tend to take liberty with the facts. These individuals can set unrealistic goals.

They are expansive and exaggerated in their thinking styles at times. At other times, however, their erratic thinking style leads them to a constricted thinking style. At times, they have heightened perceptions while in other cases they may suffer the opposite characteristic of unperceptiveness. In short, these individuals may suffer from a cognitive disturbance of perception. At times, they minimize difficulties. At other times, they show too much attention to detail, which ends up maximizing difficulties. These individuals may believe they are powerless to change their behaviors

Emotional Behaviors

The combination of these two Clusters results in an emotional style that includes an aversion to deep emotions. These individuals will likely have significant problems expressing softer emotions and they may have significant difficulties with anyone who displays those emotions. Typically, these individuals will not risk true intimacy.

Their emotional style will most likely be shallow. They do not usually display a healthy and complete range of emotion. Softer emotions are usually not displayed and those emotions are usually rejected or even scorned when seen in others. For these individuals, emotion that is not hostility-based is usually mechanical and superficial. The primary emotions that these individuals are willing to display are hostility, anger, and rage.

In the marriage relationship, these individuals will make attempts to cut off the softer emotions in their spouse. They may feel threatened by those emotions. They may also be confused by those emotions since they do not regularly allow themselves to experience and express those emotions. Individuals who are capable of a full range of emotions will be viewed as weak. This

actuality leaves the spouse in an emotional void. These individuals will likely attempt to cut off any conversations that involve the spouse expressing emotions found undesirable or threatening to this individual. If the spouse is able to express an emotion that the individual finds undesirable, this individual will likely negate that emotion by immediately expressing some emotion of their own.

These individuals probably have a significant fear of abandonment. They are typically insecure and have issues with anxiety or anxiety disorders. Their lack of ability to engage in a true intimate relationship often leaves them with feelings of emptiness and loneliness. These individuals may tend toward depression and depression-like syndromes.

Attachments to Others

Attachments related to this Complex Cluster Elevation are fear-based. They are also external. These individuals suffer from significant personal feelings of unworthiness.

These individuals have a substantially negative view of others. They often use others to meet their own needs. They are usually wary of the individuals that they are using. Since they usually are not able to connect with deep emotions, the potential for close interpersonal relationships based on emotional vulnerability is not very probable.

Complex Cluster Elevation #4
Cluster A / Cluster B / Cluster C

In this particular case, all three Clusters are substantially elevated. These individuals will display an erratic personality style that will be very difficult to counsel. Since Complex Cluster Elevation is so broad, it is nearly impossible to determine a pattern related to the way these individuals will act and react to the environment around them. A few common elements can be projected in a very general manner.

The therapist should understand that this is likely a prolonged counseling situation. Aiding individuals with a Complex Cluster Elevation that includes all three Clusters will take considerable effort and time. The therapist will need to keep the client focused and motivated to deal with their issues. If relationship issues are also present, that fact will complicate matters even more.

The prognosis for successful counseling efforts with this Complex Cluster Elevation is less than promising. The complexity of the situation and the time involved in resolving issues will mitigate against success. Success, however, is possible with a motivated client and a therapist who is able to keep the client on task.

Success in counseling will largely be based on two factors: 1) The ability of the therapist to gain the acceptance of the client; and, 2) the client's willingness to change. If the client embarks on a course of blaming others for their own inadequacies, then the prognosis is very poor. The therapist must make every effort to enforce to the client that these personality patterns have been set during the earlier stages of life and are not the result of external influences of other people. In this case, if the client cannot understand those issues in a short period of time, the likelihood of success diminishes greatly. The propensity of the client will be to blame others for personality inadequacies.

The client will also have a difficult time engaging softer emotions. Those emotions are excluded (largely or completely) from the emotional state of the individual. Those emotions will be vital in any significant effort to counsel this individual. If the individual is unable to engage those emotions in a short period of time, the prognosis for counseling these personality issues is dismal.

Triggers that Typically Precipitate a Full Personality Disorder

In the case where all three Clusters are elevated, individuals are already in crisis – whether a technical personality disorder can be diagnosed or not.

A host of relationship issues may act as triggers that lead to a full personality disorder. However, there are a number of other issues that can also lead to a full personality disorder. The therapist should understand that there is no good predictor for the onset of any personality disorder when a personality is this disordered.

Behavioral Characteristics

Since this Complex Cluster Elevation includes a vast number of individual personality styles, it is hard to definitively project the behavioral patterns that these individuals may display. The

therapist should understand that the behavioral traits detailed below are only potentials and clients may realistically present traits that are only marginally associated with the details presented here.

Probably the most general scope of behaviors that can be expected is broadly related to erratic, eccentric, self-centered and self-focused behaviors. This is the driving force of this Complex Cluster Elevation. There are also chronic fears of emotional relationships and abandonment that drive the personality structure.

The therapist should understand that this personality disorganization will make it quite difficult to proceed logically and productively in any counseling situation. These individuals will resist the intimate communication that is necessary for true healing. They will also reject many of the suggestions of the therapist.

These individuals will resist external influences. They will likely be very defensive and will not easily drop their guard. When confronted, they may become aggressive. The therapist will likely note a chronic tension due to the perceived external threats of the therapeutic environment. They will most certainly blame others for their personal problems and the therapist will need to engage a constant battle to get them to own their own ills.

When left to themselves, these individuals will usually be non-assertive, aloof, passive, compliant, and may even be very dependable. This is due to their desire to be left alone and to avoid confrontation at all cost.

Personally, they are usually lethargic, inattentive to others, impulsive, irritable, conceited, self-assured, impatient, and hypersensitive. They tend toward social withdrawal so that they do not need to engage in any type of confrontation. All confrontation may be perceived as a threat.

At times, they may be incoherent in their speech and logic patterns. They may have perfectionistic tendencies. Finally, there is some possibility that they can be self-destructive. This self-destructive tendency may be suicidal. However, the self-destructive tendencies may be much broader in scope. The self-

destructiveness may be conscious or unconscious in nature. It may even be associated with a consistent pattern of success and then failure in relationships.

Interpersonal Behaviors

The impetus that drives the interpersonal relationships of individuals with elevation of all three Clusters is an avoidance of true and deep intimacy in relationships. This individual has serious apprehension related to any significant interpersonal interaction that might require deep emotional or intimate contact.

These individuals will avoid intimacy. Most, if not all, of their interpersonal relationships will be superficial. They may even show a reckless disregard for other people. There will be a general irresponsibility in most interpersonal relationships. These individuals will generally use others to indulge themselves. In order to fulfill their own needs, they may fluctuate between idealizing other people and then condemning those same people a short time later. This cycle may be repeated a number of times with the same individual.

This individual will likely be socially apprehensive. If that apprehension is extreme enough, they may engage in complete or partial social isolation. When forced into a social situation, they will probably remain socially aloof. When in a social situation, they will desire to be left alone. It is common for these individuals to desire to leave as soon as they arrive in a social gathering.

Since the whole personality structure of these individuals centers around a substantial fear of rejection, they will demonstrate significant rejection sensitivity. It is likely that they will not directly express this fear overtly to many people. However, the signs associated with rejection sensitivity will be evident. This will include distrust of others. To quench the feelings of potential rejection, these individuals will likely seek out one or two people that they feel they can trust. They will seek constant assurance from those individuals. They may be intolerant of being completely alone. This intolerance, however,

will only be fulfilled by the very trusted few in the individual's life.

This individual is quite self-centered. When they are confronted, they will become antagonistic. They may become interpersonally explosive when they are pressed into a confrontation that they do not have control over.

Because of their self-centered focus, they may use a variety of methods to gain attention and focus on their efforts. This will only be engaged, however, if there is no possibility of confrontation with others. They may be exhibitionists, desiring everyone else to recognize their accomplishments. They may also be manipulating. This is an effort on their part to prove to themselves that they are in control of their external environment; and, thus, they have nothing to fear.

Although they may seek to please others, that effort is again simply an effort to draw the center of attention to themselves. They may use self-sacrificing behaviors for this same purpose. Ultimately, however, they will be terminally dissatisfied with the performance and the actions of other people.

Cognitive Traits

This combination of Clusters results in a constricted cognitive style that the therapist will find to be challenging to deal with in the counseling setting. Although these individuals will likely present themselves with an exaggerated sense of self importance, that exaggerated sense of self importance is actually a method used to cover up a deep-seated lack of self-worth.

The likelihood is that this individual will initially appear quite intellectual and somewhat intelligent. However, the cognitive nature of these individuals is likely scattered, distracted, impulsive, inflexible, and intolerant. These factors defy the appearance of intelligence that may first be presented.

These individuals are probably expansive and exaggerated in their thinking style. They may be highly suggestible and not totally analytical. They may take liberty with facts, especially if those facts disrupt their preconceived beliefs. They tend to set

unrealistic goals and minimize difficulties associated with the goals that they have set. Often, they show too much attention to detail.

Since this individual is externally oriented, there will be a belief that they are powerless to change their behaviors. They tend to be biased, even in the face of compelling facts that contradict their preconceived belief structure. External forces that attempt to disrupt their core beliefs will usually be met with some form of hostility or anger-based emotional response. These individuals will make decisions based on preconceived beliefs and ideas rather than focusing on data and facts to make decisions. Thus, thinking and reasoning are easily derailed by external influences that contradict preconceptions. This, again, is a component of the fear-based mentality.

These individuals may suffer from a cognitive disturbance of perception. That disturbance may take one of two different structures. (Occasionally, it may vacillate between both structures.) These individuals may be unperceptive, attempting to cut off any external influences that might confront their belief systems. In the same regard, and for the same reason, they may have heightened perceptions. In any case, there will likely be a significant disturbance of perception.

Emotional Behaviors

The emotional state of these individuals is driven (again) by the fear-based structure that is so predominant in their personality. The primary fear associated with this personality structure is a fear of abandonment. Consequently, the emotional expressions of these individuals will be shallow, mechanical, and superficial. They may tend toward depression or depression-like syndromes. They may be cold, emotionally aloof, and they may lack a sense of humor.

The core emotions that these individuals will overtly and consistently exhibit are considered safe emotions to them. Their emotional range is seriously constricted. Only the harder emotions like anger, hostility, rage, and jealousy will be

exhibited voluntarily. Softer emotions will not be voluntarily expressed. In fact, they will likely be rejected.

Therefore, when this individual encounters these softer emotions in others that encounter may lead to a number of reactions in the individual. They may be confused by the softer emotions because they themselves do not understand them. They may be disturbed by those emotions, since they do not understand them. In certain situations where these individuals are in a situation that demands that they interact with the softer emotions, the demand for interaction may result in their exhibition of anger, rage, disgust, or some other hostile emotion. This will be in an effort to stop the softer emotion (which they will recognize as a threat). This prospect will greatly inhibit the possibility of a long-lasting and healthy marriage relationship. This individual is largely incapable of having true empathy.

The general emotional state of this individual leaves them feeling insecure, lonely and empty. Anxiety states may be heightened in this individual.

Attachments to Others

The attachment style of individuals with an elevation in all three Clusters is substantially uniform. Attachment to other people (especially in the most intimate relationships) is fear-based. These individuals have deep-seated feelings of unworthiness and consistent fears about rejection. They are never able to deeply attach to another person although they consistently use other people to meet their own needs.

Because of their fear of rejection, they are wary of the individuals with whom they have any type of relationship. The more substantial the relationship, the more they will exhibit fear in that relationship. There will always be issues of trust, even if those issues are never directly verbalized to anyone. They have a significantly negative view of other people.

In extreme cases, these factors may result in dissociative symptomology, especially in social situations.

These individuals, driven by fear, are unable to internalize any relationship. This includes marriage. All relationships will be externally based and kept outside of their emotional realm. They cannot express deep feelings of attachment. They are usually uncomfortable with those who express those feelings. The potential for any interpersonal attachment based on emotional vulnerability is not probable. Relationships will be engaged in to quench their internal fear of separation.

APPENDICES

Defense Mechanism Checklist

The following list may be photocopied and used as a quick checklist during counseling sessions. This information can then be transferred into the *MARET Counseling and Assessment Software Program.*

Level #1 Defense Mechanisms

_____ **Anticipation –** Experiences emotional reactions in advance. Anticipates consequences and considers realistic alternatives.

_____ **Affiliation –** Able to turn to others for help/support. Able to share problems without making someone else responsible.

_____ **Altruism –** Dedication to meeting needs of others even when faced with a stressing event.

_____ **Humor –** Emphasizes the amusing/ironic aspects of current stressing events.

_____ **Self-assertion –** Non-coercive/non-manipulative expression of feelings and thoughts.

_____ **Self-observation –** Able to reflect on own thoughts, feelings, motivations, and behavior and respond appropriately.

_____ **Sublimation –** Channels potentially maladaptive feelings/impulses into socially acceptable behavior.

_____ **Suppression –** Able to intentionally avoid thinking about disturbing problems, wishes, feelings or experiences.

Level #2 Defense Mechanisms

_____ **Displacement –** Transfers feelings and/or responses from an appropriate object to a less threatening object.

_____ **Dissociation –** Breakdown in usually integrated functions of consciousness, memory, perception of self or the environment. May involve sensory/motor behaviors (e.g. events and emotions are no longer *associated*).

_____ **Intellectualization –** Excessive use of abstract thinking or intellectual reasoning to minimize emotional discomfort.

_____ **Isolation of Affect –** Separation of ideas from feelings originally associated with them. Only cognitive elements remain.

_____ **Reaction Formation** – Substitution of "real" behaviors and thoughts with those that are not from the client's reality.

_____ **Repression** – Expelling of disturbing wishes, thoughts, or experiences from consciousness. Emotions may remain.

_____ **Undoing** – Words or behaviors designed to negate/make amends symbolically for unacceptable thoughts, feelings, or actions.

Level #3 Defense Mechanisms

_____ **Devaluation** – Attributes grossly exaggerated negative qualities to self or others.

_____ **Idealization** – Attributes grossly exaggerated positive qualities others.

_____ **Omnipotence** – Projection of the image that one possesses special powers or abilities. Superior to others.

Level #4 Defense Mechanisms

_____ **Denial** – Refusing to acknowledge some painful aspect of external reality or subjective experience that would be apparent to others.

_____ **Projection** – Individual falsely attributes to another person their own unacceptable feelings, impulses, or thoughts.

_____ **Rationalization** – Conceals the true motivations for thoughts, actions, or feelings through the elaboration of reassuring or self-serving but incorrect explanations.

Level #5 Defense Mechanisms

_____ **Autistic Fantasy** – Excessive daydreaming as a substitute for human relationships, more effective action, or problem solving.

_____ **Projective Identification** – Projection of feelings, impulses, or thoughts onto another. Eventually, those feelings, impulses or thoughts are fulfilled in the party upon whom they have been projected.

_____ **Splitting** – Compartmentalizing opposite affects. Not able to see good and bad in something at the same time.

Level #6 Defense Mechanisms

_____ **Acting Out** – Physical action taken in response to internal reflections or feelings. Acted out behavior is a direct response to the internal affective cues.

_____ **Apathetic Withdrawal** – Withdrawal from any attempts to deal with internal or external stressing events of emotional states. The person gives up.

_____ **Help Rejecting Complaining** – Making repeated requests for help. When help is offered, it is rejected.

_____ **Passive Aggression** – Indirect and unassertive aggression toward others. Overt and visible compliance masks covert resistance, resentment and hostility.

Level #7 Defense Mechanisms

_____ **Delusional Projection** – Projection with the added component of belief that the event or situation being projected is part of objective reality when in fact it is not.

_____ **Psychotic Denial** – Denial with the added component of belief that the event or situation being denied can be verified to be false (e.g. denies wife has died and continues to hear/see her).

_____ **Psychotic Distortion** – Internal efforts to reshape the external world with hallucinations and delusions. Creation of a new reality.

Glossary

AUTOMATIC THOUGHTS – The *thoughts* or *thinking* patterns that *automatically* "dictate" or regulate an individual's behavior patterns are called *automatic thoughts*. Many times, *automatic thoughts* are subconscious and don't reach the awareness of an individual. The therapist, however, will be able to bring the *automatic thoughts* to the conscious level by discussing the reasons that a client commits specific behaviors. The justification that a client uses to do specific things will reveal the subconscious *automatic thoughts* that regulate their behaviors. *Automatic thoughts* usually cause "automatic" behaviors.

During the therapy process the therapist must locate a client's *automatic thoughts* and eliminate them through cognitive assessment of the *automatic thoughts* with the client. The therapist should only engage the *automatic thoughts* of a client when the therapist feels that the client is ready and willing to engage and eliminate those *thoughts*. Premature engagement and elimination of *automatic thoughts* may be too threatening for the client.

AXIS I DISORDERS – The DSM-IV-TR contains a diagnostic methodology that involves five different *Axis* categories in which specific diagnoses can be placed. Three of those *Axis* categories are important for the pastor. The first of those categories is called *Axis I Disorders*.

Axis I Disorders are disorders which are mental, emotional, or psychological in nature. Those disorders, however, are not diagnosable personality disorders. *Axis I Disorders* cover a wide range of issues including *Substance Related Disorders, Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorders, Eating Disorders and Sleep Disorders*.

AXIS II DISORDERS – DSM-IV-TR *Axis II Disorders* are *Personality Disorders*. The DSM-IV-TR contains specific criteria for diagnosis of each of the ten recognizable personality disorders. See the definition for *Personality Disorder*.

AXIS III DISORDERS – *Axis III Disorders* are medical in nature (e.g. heart condition). While the DSM-IV does not contain diagnosis of medical conditions, those already-diagnosed conditions are placed on *Axis III* since any medical condition may influence the counseling of an individual. It is best for the therapist to be aware of all conditions that might be affecting an individual.

For example, the individual who has been diagnosed with terminal cancer will have that diagnosis indicated on *Axis III*. While the therapist will not treat the cancer, the therapist will treat the mental and emotional issues that are presented by the cancer. Information recorded on this *Axis* may be very helpful for the therapist.[98]

The *Axis III* diagnosis category is for the therapist's information and not so that the therapist might treat the medical issue.

CLIENT – Anyone who engages in any form of counseling or therapy whether individual or group related is a *client*. This individual is formally involved in the process of working through issues with a therapist. The term *client* is more

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[98] The *MARET Counseling and Assessment Software* program allows a therapist to record multiple diagnoses on each *Axis*. Therefore, the therapist will have immediate access to information that is relevant to *Axis III* medical conditions.

appropriate than other terms (e.g. counselee) since it is a more neutral term and does not place an undue "defectiveness" on the individual who is seeking help. The therapist should move away from any terminology that would indicate or cause the individual to believe that they are defective.

COUNTERTRANSFERENCE – *Countertransference* is the process of the therapist transferring feelings, emotions, or any other reactions to the client in response to the client's feelings, emotions, or behaviors during the therapy process.

Sometimes *countertransference* is a good thing. Many times it is not. Moreover, if a therapist is not immediately cognizant that *countertransference* is occurring, the *countertransference* may derail the therapy process even leading to therapist behaviors and emotional encumbrances that are damaging to the therapist and the client. The therapist must always be aware that *countertransference* is occurring and make the decision to express it or suppress it based on the needs of the client.

An appropriate form of *countertransference* may be the true and heartfelt expression of therapist grief related to a dire situation that the client is encountering (e.g. a dying spouse). It is appropriate for a therapist to engage a client at this emotional level since it is beneficial to the client to receive such heartfelt expressions.

Inappropriate *countertransference* would include the following: 1) Anger as a response to a client's expression of *transferred* emotion; 2) any emotional or behavioral response that is unhelpful for the client and is not therapeutically advantageous; 3) acceptance and/or promotion of a client's romantic, erotic, or sexual advances, feelings, emotions, or behaviors; or 4) any behaviors, feelings or emotions that are done for the gratification of the therapist.

It is not uncommon for the therapist to exhibit inappropriate *countertransference* when issues arise that the therapist has not dealt with themselves. The therapist must resist these urges at all expense. See the definition of *Transference*.

DECOMPENSATION – *Decompensation* is the breakdown of the defensive system that an individual has placed around them to protect them from the stressors that they are or may encounter. The person uses the maladaptive defenses as a *compensation* for not dealing with stressors properly. An individual who has consistently used a maladaptive defense mechanism (or a series of mechanisms) will likely face *decompensation* when that defense mechanism breaks down and no longer allows them to be shielded from external reality.

In this case, the individual must face an external stressor "head on" without the usual defenses that they have used in the past. *Decompensation* usually poses a significant problem since without the defense mechanism in place, the individual is faced with the stark realities of life that they have tried to avoid.

Decompensation may result in a number of reactions from a significantly disordered individual. 1) They may learn new and more appropriate means of dealing with external reality that brings about growth and healing; 2) they may resort to use of other maladaptive defense mechanisms that replace the defense mechanisms that *decompensated*; 3) they may experience *Axis I Disorders*; 4) they may experience a full *Personality Disorder*; 5) and/or, they may fall into a psychotic reaction of some type.

The therapist must be aware of the maladaptive defense mechanisms that an individual is using. The therapist must also be aware that during the counseling process those defense mechanisms will likely *decompensate*. At that point, the therapist needs to lead the individual toward more appropriate defenses to face reality.

DEFENSE MECHANISMS – The DSM-IV-TR lists seven different categories of *defense mechanisms*. Six of those categories contain *defense mechanisms* that are less than optimal. The seven categories list *defense mechanisms* that range from optimal in their functionality to completely dysregulated. Those *defenses* that are dysregulated involve substantial or complete loss of reality testing abilities.

Defense mechanisms are internal means by which an individual deals with stressing events. A *defense mechanism* is

the method that a person uses to resolve the inner (usually emotional) conflict that a stressing event poses.

Healthy *defense mechanisms* allow an individual to face the reality of the stressor and deal with it in such a manner that the client is able to lessen the emotional impact of the stressor without diminishing the reality associated with the stressor. The more a client diminishes reality while using *defense mechanisms*, the more unhealthy and potentially damaging the *defense mechanism* is.

The therapist must be aware of the possibility of the *decompensation* of *defense mechanisms* during the therapy process. As an individual encounters the reality of their stressors, there is a strong possibility that they will suffer the *decompensation* of their *defense mechanisms*. The goal of the therapist should be to replace the maladaptive *defense mechanisms* with more appropriate *defense mechanisms* that allow the individual to face reality without ignoring it or distorting it.

DSM-IV-TR – The DSM-IV-TR is the *Diagnostic and Statistical Manual of Mental Disorders*. It is currently in its fourth generation (i.e. *IV*). And, the most recent version of the DSM-IV has gone through a Textual Revision (i.e. *TR*). The DSM-IV is published by the *American Psychiatric Association*. This *Manual* is the officially recognized *Manual* for exploration of and diagnosis of all disorders that are mental, emotional, or psychological in nature.

Traditionally, these topics have not been widely used, learned, or accepted in the pastoral setting. This presents a significant problem and a gross inadequacy in pastoral counseling practice.

The problem presented by this lack of acceptance and knowledge of the DSM materials limits a pastor's understanding of the whole scope of potential issues that a client may be facing. A client may indeed be facing much more severe issues than a pastor is aware of because of a lack of knowledge.

And therein lies the inadequacy. The pastor who is unaware of all of the potential issues that a client may be facing will not

be able to adequately treat or counsel the individual. In fact, the form of therapy administered in this void of knowledge may be more damaging to the client than it is helpful. Thus, *MARET Systems International* has endeavored to educate pastors regarding these issues so that the pastor can have all of the tools necessary to adequately counsel individuals. *MARET's Educational Series Course #2* covers the issue of the DSM-IV-TR in adequate detail for pastoral counseling.

PERSONALITY CONTINUUM – When using the technical diagnostics of the DSM-IV-TR, a personality is either in a state of disorder or it is not. While that information is helpful to the therapist when an individual is in a state of disorder, the information is useless when a person is not in a state of disorder. We are left with no information that shows us a "picture" of the individual's personality structure.

Consequently, the psychological community is increasingly viewing personality as a *continuum* rather than disorder versus non-disorder. This *continuum* allows us to include an entire range of personality characteristics that reveal everything from optimal functioning to traits associated with disorder (and everything in between).

This methodology gives the therapist a much more complete view of the personality structure of the individual. It also allows us to recognize negative elements in a personality structure that have not manifested in a crisis but that may manifest during a crisis.

The *MARET Counseling and Assessment System* contains a comprehensive and professional assessment module that determines the dominant and subdominant personality styles of an individual. That assessment module also screens an individual for technical DSM-IV *Personality Disorder*. This information will give the therapist a great advantage in the counseling office. This tool is even more useful when the therapist is working in any form of couples' therapy.

PERSONALITY DISORDER – The DSM-IV-TR contains diagnostic criteria for ten specific *Personality Disorders*. All *Personality*

Disorders are characterized by a pervasive and persistent pattern of maladaptive behavior. Minimum criteria must be met according to DSM-IV standards for a diagnosis to be made. *Personality Disorders* are also characterized by onset at or about the beginning of adulthood. All *Personality Disorders* are recorded on *Axis II*.

PERSONALITY STYLE – The concept of a *Personality Disorder* is very rigid. Either an individual meets the minimum criteria for diagnosis or they do not. If they do not meet the minimum criteria for diagnosis, then a *Personality Disorder* may not be diagnosed.

That information, however, is only helpful to us if a person meets the minimum criteria for diagnosis. In order to better understand a client, some individuals in the psychological community have devised a method to assess the general *style* of an individual's personality. That *style* shows the optimally functioning traits of a personality on a continuum that also displays the disorder traits at the other end of the spectrum.

In the *MARET Counseling and Assessment System*, the *personality style* is categorized using the same names as the *Personality Disorders*. It reveals both optimal functioning and disorder traits. Thus, the therapist can easily realize the full range of possibilities that might be manifested when an individual is under crisis.

PSYCHOSIS – *Psychosis* is the diminishing of a client's reality testing abilities to the degree that the client is no longer able to recognize or encounter facts from observable reality that are commonly accepted by other individuals. *Psychosis* distorts reality, negates reality, or creates reality that does not really exist. This may involve hallucinations – both auditory and visual. Hallucinations, however, are not the only means by which an individual may experience a failure in reality testing abilities. Gross distortion of facts and ideas of reference to reality may also be *psychotic* in nature.

A few examples will help clarify the definition of *psychosis*.

"*I know that my wife is not dead because she was in the house last night. We sat on the couch and had a discussion*." This individual is obviously suffering from both visual and auditory hallucinations since his wife is indeed dead. "*I talked with a person the other day and I realized that they were not really human. During our discussion I realized that they were a space alien posing as a human*." This individual is suffering from a *psychotic delusion*. There was no real hallucination but there was a distortion of reality to the point where reality no longer existed as true reality.

An individual faced with the *decompensation* of significantly maladaptive *defense mechanisms* might experience a *Brief Psychotic Episode* (an *Axis I Disorder*). Other individuals may have more lasting *psychotic* symptoms that indicate more serious issues including various forms of *Schizophrenia*.

Various forms of anti-psychotic medications are used sometimes to lessen *psychotic* symptoms. Brain chemistry may play a key role in *psychotic* symptoms. Longstanding use of significantly maladaptive *defense mechanisms* may also move an individual toward *psychosis*. The role of an abusive home of origin may be a key indicator in the prevalence of and tendency toward *psychotic* symptomology. This is especially true of unresolved cases of significant sexual abuse.

ROLE-PLAYING – *Role-playing* is a therapeutic technique that can be very useful in the counseling process. It is most effectively used in situations where a client is not able to encounter the outside world with a "real world" experiment or assignment.

When, for example, an individual is fearful of social interaction, it would be nonproductive (and potentially explosive) for the therapist to simply tell the client to go out into the world and engage in some social activity. The client is most likely not going to do the homework assignment. If they do, the likelihood of failure is significant. In the case of failure, the client will be much more apprehensive to doing any more real world experiments.

Much more appropriately, the therapist can *role-play* a social interaction in the office where the client feels more comfortable. This process may take a number of sessions for the client to feel comfortable enough to actually go out and experiment in real social situations.

When *role-playing* is engaged, the client's fears and apprehensions can be addressed immediately. The therapist will be able to assess the real inhibitors to social interaction. Those issues can all be cognitively addressed and resolved in the safe setting of the counseling office.

Role-playing may be used for a variety of situations that prohibit or restrict the client in their "real world."

THERAPIST – A *therapist* is any individual in any setting that is affecting the processes of *therapy* for a *client* who is in moral, ethical, emotional, relational, or psychological distress or conflict. See the definition of the term *Therapy*.

THERAPY – Pastors have traditionally refrained from using the term *therapy* related to their counseling efforts. They have usually not considered nor called themselves *therapists*. This is most unfortunate. There seems to be an inappropriate assignment of this term to the "professional" and licensed psychotherapist.

The term *therapy*, however, comes from the Greek word *therapeuo* – which means "to heal." Any pastor who takes on a counseling case is actively attempting to bring *healing* to an individual. Thus, there should be no reason that a pastor should not use the terms *therapy* and *therapist* when counseling an individual in conflict or crisis.

It is the desire of *MARET Systems International* to develop the abilities of pastors so that they can feel adequately trained in most counseling settings. This should give the pastor a renewed confidence that they are indeed bringing *healing* to those that they counsel.

One caveat is in order regarding the usage of the terms *therapist* and *therapy*. In some States in the United States there may be restrictions in place that prohibit certain unlicensed psychological professionals from using one or both of those

terms. Every pastor should check their local laws and regulations prior to actually using those terms so that the pastor might be in compliance with State and local laws.

TRANSFERENCE – The client *transfers* a feeling, belief or behavior onto the therapist. For example, the client may have significant anger toward their spouse that they are unable to express to the spouse. The client is able, however, to *transfer* that anger to the therapist.

Sometimes *transference* results in the client expressing their emotions directly to the therapist regarding the "real" issue. In this case, the client may exhibit their anger about the spouse by yelling about the behavior of the spouse to the therapist. "*He always does this or that and it makes me so mad*!" In this case, the client has appropriately connected the anger to the appropriate subject and has *transferred* it to a surrogate "object" (e.g. the therapist). At this point, the therapist must help the client refine their anger and aid the client in placing it on the proper "object" (the spouse).

Other times, the client will use a form of *displacement* in the *transference* process. If the client is unable to confront their inner feelings regarding their spouse, they may get angry with the therapist regarding another issue that has come up in therapy. While the internal processes of the client are subconsciously generating anger regarding the spouse, the anger that will be displayed to the therapist will be associated with the therapeutic relationship. The client may be angry with the therapist as a *displacement* for their anger toward the spouse. In this case, the client finds this to be a "safer" place to display their anger. When the therapist encounters this type of *transference*, the therapist must explore the anger and help the client *transfer* it to the proper subject first. Then the therapist can work toward proper *placement* of the anger on the spouse.

This form of *transference* is usually used when a client is threatened by the thought of *placing* the anger on the proper subject. If the therapist is not careful, the therapist may engage in unhealthy *countertransference* at this point. Rather than recognizing that the client is *displacing* their anger, the therapist

may react with their own anger or other emotions that will prohibit the client and the therapist from discovering the true source of the client's anger.

The therapist is forewarned that in some cases clients will *transfer* feelings of affection toward the therapist. This is especially true when the individual is in a crisis marriage situation, when the client has a personality structure that is somewhat dependant, or the therapeutic relationship is structured in such a way that the client recognizes the therapist as a "savior" or a rescuer. The therapist must avoid this form of unhealthy countertransference at all cost.

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