DISCUSSION QUESTION

Prior to beginning work on this discussion, read the Cohen, et al. (2013) and Wu, et al. (2007) articles and review the Evaluating Mental Health Patients (Links to an external site.)Links to an external site. and HumanMetrics Jung Typology Test (Links to an external site.)Links to an external site. websites.
For this discussion, you will be taking on the role of the intake counselor at a mental health facility. In this role, you will facilitate the evaluation of a client based on clinical personality assessments, mental status exam, and observations of the client to make recommendations to the treatment team consisting of the clinical psychologist, counselors, and case manager for the client. Carefully review the PSY615: Week Two Counseling-Based Personality Assessment Scenario (Links to an external site.)Links to an external site..

In your initial post, examine the personality assessment instrument used in the scenario and research a peer-reviewed article in the Ashford University Library on this personality assessment. Using the required articles and websites as well as your researched article to support your statements, describe the standard use of this personality assessment. Based on the scenario, evaluate the reliability, validity, and cultural considerations inherent to the personality assessment used and comment on the relevance of these elements within the scenario. Analyze and describe some of the potential ethical issues which might arise from the use of this personality assessment in the given scenario. Provide information from your research regarding the use of the personality measure, and assess the value of other possible instruments that could be added to create a more complete assessment of the client in the scenario.

USE FOR DISCUSSION

EVALUATING MENTAL HEALTH PATIENTS

A Forum About Interviewing and Diagnosis for Clinicians

By James Morrison, M. D.

Here's what I'm trying to do:

With the publication of DSM-5, there's another thousand pages (nearly) of material loose in the land concerning mental health diagnosis. Much of it (most of it) is complicated; some of it is contradictory. And all of it is subject to the interpretation of readers, who come to the project with a variety of backgrounds and levels of education, training, experience, and understanding. I intend these pages to present a forum for discussion of not just DSM-5, but mental health evaluation and diagnosis in general. (I'm limiting myself here, inasmuch as my primary focus will not be on treatment but on evaluation and interpretation of diagnostic signs and symptoms.) And at that, I'll stick mainly to the diagnosis of adults, though from time to time I will probably (inevitably) wander into the field of child and adolescent evaluation. I've even written a book (with Kathryn Flegel) that applies to kids.

You'll find a lot more on the "About DSM-5" page.

You can also email me with any questions or comments:
morrjame@ohsu.edu

Guilford has now released my newest book. It uses the stories of 26 new patients to explore further the material from several of my previous books.

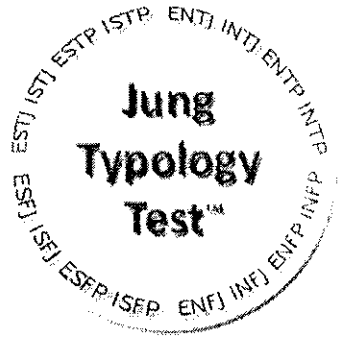
USE FOR DISCUSSION

Discover your personality type

This free personality test is based on Carl Jung's and Isabel Briggs Myers' typological approach (/personality/type) to personality. Discover your personality type.

Take the test! » (/cgi-win/jtypes2.asp)

(/cgi-win/jtypes2.asp)



Upon completion of the personality assessment questionnaire, you will:

- Obtain your 4-letter type formula according to Carl Jung's and Isabel Briggs Myers' typology (/personality/type), along with the strengths of preferences and the description of your personality type, communication and learning style,
- Discover careers and occupations most suitable for your personality type, along with examples of educational institutions where you can get a relevant degree or training,
- See which famous personalities share your type,
- Use the results of this test with the Jung Marriage Test™ (/relationship-match-test) to assess long-term compatibility with your romantic partner.

Go to test » (/cgi-win/jtypes2.asp)

business users - visit advanced version » (https://www.hrpersonality.com/)

What is Personality Type?

According to Jung's theory of psychological type, people can be characterized using the following three criteria:

- **Extraversion - Introversion**
- **Sensing - Intuition**

- **Thinking - Feeling**

Briggs Myers emphasized that the **Judging - Perceiving** relationship also influences characteristics of personality type...

Read more » (/personality/type)

USE FOR DISCUSSION

The 16 personality types described

ESTJ (/personality/estj)	**ISTJ (/personality/istj)**	**ENTJ (/personality/entj)**	**INTJ (/personality/intj)**
ESTP (/personality/estp)	**ISTP (/personality/istp)**	**ENTP (/personality/entp)**	**INTP (/personality/intp)**
ESFJ (/personality/esfj)	**ISFJ (/personality/isfj)**	**ENFJ (/personality/enfj)**	**INFJ (/personality/infj)**
ESFP (/personality/esfp)	**ISFP (/personality/isfp)**	**ENFP (/personality/enfp)**	**INFP (/personality/infp)**

More Personality Type Resources

- **Premium Career Development Report (http://www.personalityexplorer.com/)**
- Personality Type and Careers (/personality/career-choices)
- Communication Strategies (/personality/communication-strategies-for-different-types)
- Learning Styles (/personality/learning-styles)
- Leadership Style (https://www.hrpersonality.com/resources/effective-leadership)
- Determine Other People's Personality (/personality/how-to-determine-other-peoples-type)
- Personality Type and Fictional Characters (/westeros/)
- *New!* Humanmetrics Blog (/blog)

For Business Users: HRPersonality.com (https://www.hrpersonality.com/)

Jung's typology for organizations: pre-employment assessment, team building, personal and professional development of employees and more.

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* Humanmetrics Jung Typology Test™ instrument uses methodology, questionnaire, scoring and software that are proprietary to Humanmetrics, and shall not be confused with the MBTI®, Myers-Briggs® and/or Myers-Briggs Type Indicator® instrument offered by CPP, Inc. Humanmetrics is not affiliated with CPP, Inc.

USE FOR DISCUSSION QUESTION

PSY615: Week Two Counseling-Based Personality Assessment Scenario

PSYCHOLOGICAL EVALUATION

(Williamsburg Mental Health Center)

Jane Smith Date of Evaluation: 10/12/2013

Case No.: 12783A

Admission Date: 10/8/2013

PURPOSE FOR EVALUATION:

This is the second admission of a 32-year-old female to the Center. The client has 14 years of formal education and is employed as an administrative assistant at a local community college. She was admitted due to signs of major depression with possible psychotic features.

The purpose of this clinical evaluation is to assess the client's current mental well-being and the extent of her need for clinical intervention.

ASSESSMENT PROCEDURES:

The clinical psychiatrist on duty recommended the following assessments:

- Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
- Mental Status Examination
- Review of Prior Psychological Assessment
- Review of Prior Medical Records
- Clinical Interview

ASSESSMENT RESULTS:

Note: Typically, this section reports test results of all the recommended assessments. Here you are provided with the abbreviated results from the MMPI-2, the Mental Status Examination, Review of Prior Medical Records, and Clinical Interview.

Adjustment Level

Jane's elevated scores on Depression (T = 94) and Psychasthenia (T = 92) scales indicate her dissatisfaction with her life situation and feelings of hopelessness and inadequacy.

Symptoms

Jane appears to suffer from major depression, which is evident in her elevated Harris-Lingoes subscales on depression (D1, T = 101; D2, T = 89; D3, T = 80; D4, T = 99; and D5, T = 80). These scores and a high score on the Social Introversion scale (T = 79) indicate chance of suicidal

tendencies. She may withdraw from personal relationships and struggle with separation, which links to her depression.

Perceptions of Environment and People

Jane's elevated scores on Fears (T = 77) and Anxiety (T = 80) indicates that she does not feel safe or comfortable in most environments.

Reaction to Stress

Jane's elevated D1 subscale and low ego strength indicate that she is not able to cope well with stress, even under normal circumstances. Jane likely reacts to stress by withdrawing and isolating herself from the stressors.

Self-Concept

Jane's score on Low Self-Esteem (T = 89) is evidence of low ego strength and a poor self-concept.

Emotional Control

Jane seems to have a lack of emotional control with her depression. She appears to be struggling with feelings of hopelessness and despair. Elevations in level of depression should be monitored, particularly if the elevations extend over a long period of time.

Interpersonal Relationships

In addition to her depression, Jane's score on Social Introversion (t = 79) indicates she is aloof, ruminative, and withdrawn. Other indicators include elevated scores on Familial Discord (T = 72) and Family Problems (T = 83), which supports the evidence that she may have turmoil in the family.

Psychological Resources

Jane has attended college and appears intelligent. She has some satisfaction with work, so she knows that she is successful on some level. Her high score on Negative Treatment Indicators (TRT, T = 85) coupled with depression may indicate a negative attitude toward therapy.

Social Dynamics

Jane's parents are divorced and her home life was likely filled with conflict and dissention. Her parents were highly critical, which may be the source of her isolated introversion, anxiety, and depression.

Diagnostic Impressions

Jane's MMPI profile indicates that she suffers from major depressive disorder and she is at risk for suicidal tendencies. Jane may also have a bipolar personality and problems with mental processes, but she does not appear a danger to others at this time.

PSY615: Week Two Counseling-Based Personality Assessment Scenario

BACKGROUND INFORMATION:

The client is a 32-year-old, single white female who was previously admitted one year ago for possible suicidal ideation and major depression. She has an associate's degree and is currently working for a local community college as the administrative assistant for the dean of the business school. She does not have a record of suicide attempts or long-term hospitalization in a mental health facility. She is a single female with no family history of mental illness.

MENTAL STATUS EXAMINATION:

Observational conclusions of the patient's attitude were as follows:

Open and cooperative, and her mood was euthymic. Her affect was appropriate to verbal content and showed broad range. Her memory functions seemed grossly intact and she was able to recall events and factual information. Her thought process was intact, goal oriented, and well organized. The client indicated no evidence of delusions, paranoia, or suicidal/homicidal ideation. Her level of personal insight appeared to be good, as evidenced by ability to state her current diagnosis and by ability to identify specific stressors that precipitated the current exacerbation. Social judgment appeared good, as evidenced by appropriate interactions with staff and other patients in the center and by cooperative efforts to achieve treatment goals required for discharge.

USE FOR DISCUSSION

PERSPECTIVES

Understanding Self-mutilation in Borderline Personality Disorder

Joel Paris, MD

Self-mutilation is common in borderline personality disorder, but this pattern of behavior does not usually carry suicidal intent. Instead, it serves other functions, including regulation of dysphoric affect, communication of distress, expression of emotions, and coping with dissociative states. Multiple causal factors, including biological, psychological, and social risks, influence thresholds for self-mutilation. Management of this behavior can be informed by understanding its psychological functions. (HARV REV PSYCHIATRY 2005;13:179–185.)

Keywords: self-mutilation, borderline personality disorder

To examine the empirical and clinical literature on the origins of self-mutilation in borderline personality disorder (BPD), this review made use of both MEDLINE and PsycINFO databases, identifying all English articles between 1980 and 2004 containing one or more of the following keywords: self-mutilation, self-cutting, self-injury, or deliberate self-harm. Since the focus of the review was on patients with personality disorders, the search was limited to combinations of these keywords with either "personality disorder" or "borderline personality disorder." This procedure identified 113 publications, from which the review selected all empirical studies and systematic reviews (eliminating most case reports). These articles were then supplemented by relevant publications prior to 1980.

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DOI: 10.1080/10673220591003614

DEFINING THE CLINICAL PROBLEM

There are many difficult aspects of managing BPD, but self-mutilation is one of the most challenging. These patients can be a source of worry when they cut, burn, or hurt themselves. This review will focus on the pattern seen in BPD: repetitive, nonlethal self-injury without intent to die.[1]

The literature has used multiple and somewhat confusing descriptive terms to describe this pattern. "Self-mutilation" has been defined by Favazza[2] as "the deliberate nonsuicidal destruction of one's body tissue." Two other terms—"self-injury"[3] and "self-injurious behavior"[4]—have similar meanings. "Deliberate self-harm," defined as "the intentional injuring of one's own body without apparent suicidal intent,"[5] while seemingly similar, has been used in research to describe both self-poisoning and self-injury, while excluding repetitive self-cutting.[6] The term "parasuicide," defined as "any nonfatal, self-injurious behavior with a clear intent to cause bodily harm or death,"[7] has also been used in a broader way. To maximize clarity, this review will confine itself to the terms "self-mutilation" and "self-injury."

Self-mutilation began to be discussed in the psychiatric literature only several decades ago, in a series of clinical reports and reviews[8–13] that described patients who repeatedly, but superficially, cut their wrists. Repeated self-mutilation has been found to be associated with serious psychopathology, most particularly mental retardation, schizophrenia, and personality disorders,[14–16] and it is especially common in BPD.[1]

Self-mutilation associated with major mental disorders needs to be distinguished from similar behaviors occurring in more normative or situational settings. Thus, self-mutilation has been documented in historical data, particularly in relation to religious practices.[17] It has also been described in community populations,[6,18,19] although such reports do not distinguish between occasional self-mutilation and repetitive behavior. Finally, self-injury has been described as being common among prison inmates with personality disorders;[20] it is not known whether this behavior continues after release from confinement.

FUNCTIONS OF SELF-MUTILATION IN BPD

Why do patients with BPD injure themselves? The crucial point is that the intent of self-mutilation is not necessarily "suicidal." In a study comparing 30 suicide attempters with cluster B personality disorders and a history of self-mutilation to a matched group of 23 suicide attempters with cluster B personality disorders and no history of self-mutilation, Stanley and colleagues[21] found that while self-mutilators were more chronically suicidal and more impulsive, most were aware that wrist cutting is not life threatening. Similarly, in a study of 75 BPD patients, Brown and colleagues[22] found that self-cutting was described as a means to relieve dysphoria, while overdosing was described as motivated by a need to escape difficult life situations. The independence of self-mutilation and suicidal intent in BPD patients is further supported by a five-year prospective follow-up of 37 borderline patients,[23] which found that changes in self-harm and suicide attempts over time were not correlated. Although about 10% of patients with BPD eventually end their lives by suicide, most completions occur late in the course of the illness.[24] Moreover, while "deliberate self-harm" (in general) is associated with higher rates of completion,[25] suicide is not predicted by self-mutilating behavior.[24] Thus, the term "suicidal" is not appropriate as a descriptor for self-mutilation.[26]

Although self-injury often lacks suicidal intent, it can perform other psychological functions, several of which have been suggested in the BPD literature. The first (and most often discussed) is that self-injury can provide relief from negative mood states.[27,28] Since self-mutilation tends to reduce dysphoria resulting from stressful life events, it can become a habitual method of dealing with psychological distress. In such cases the behavior comes to function like an addiction; Linehan[28] has suggested that this effect derives from its very success in reducing dysphoria. These mechanisms are not necessarily unique to patients with BPD and may not even be unique to humans; self-injury has been observed in other species as a response to stressful circumstances.[29]

Second, distraction is another mechanism by which self-mutilation can reduce distress in BPD. As described by Linehan,[28] physical injury tends to refocus the patient's attention away from mental pain to physical pain.

A third function of self-mutilation in BPD is that it can be used to communicate distress and obtain care from other people—significant others as well as therapists.[30,31] While many patients are initially secretive about self-injury,[32] the presence of visible scars or burn marks (particularly in the summer months) eventually tends to bring the behavior to the attention of other people.

A fourth potential function is that self-mutilation can be used to express emotions in a symbolic fashion.[26,27] Some patients describe cutting as a self-punishment related to guilty feelings or as a way of expressing anger that cannot be communicated in another way.[33]

A fifth function of self-mutilation derives from its connection with dissociative phenomena.[34–37] BPD patients may experience dissociation as dysphoric or may be in a dissociated state when they cut.[35] In this context, the sight of blood can remind patients that they are really alive. Scores on scales measuring dissociation are consistently higher in BPD patients who self-mutilate.[36,37] In these states of mind, cutting may not even be painful. Several studies have found that self-mutilators are relatively insensitive to pain,[38–42] a phenomenon that has been hypothesized to be related to the production of endogenous opioids.[1,43]

BPD PATIENTS WHO DO, AND DO NOT, SELF-MUTILATE

Self-mutilation is seen in about half of all patients with BPD.[36,43] We need to explain why only some patients with BPD injure themselves. Unfortunately, there have been only a few studies comparing patients with and without this behavior.

A first level of explanation is that patients with lower levels of functioning are more likely to self-mutilate. Self-injury in BPD has been shown to have a strong association with multiple comorbidities and illness severity.[44]

A second level of explanation derives from the relationship of self-mutilation to impulsive traits.[45,46] Affective instability and impulsivity have been seen as the primary traits underlying BPD.[47] Affective instability describes rapid shifts of moods in relation to environmental cues.[48] Linehan[28] applies a similar concept, emotion dysregulation, in which emotions are more intense and take longer to return to baseline. Affective instability is also found, however, in personality disordered patients who do not self-mutilate.[49] To understand the role of self-injury in BPD, one has also to consider the influence of impulsive traits. Although self-mutilation can sometimes be planned, the

tendency to use action to reduce inner distress is a key aspect of impulsivity[50]—a central characteristic of patients with BPD.[51,52]

In support of this mechanism, Simeon and colleagues[43] reported that self-injury in personality disorders is associated with overall high levels of impulsivity. This trait is one that has been shown to be heritable,[52] and impulsive behaviors, including self-mutilation, are associated with variations in neurobiological functioning, most particularly central serotonergic dysfunction.[53–55] For example, in a study comparing personality disordered patients who self-mutilated to those who did not, self-injury was associated with abnormal paroxetine binding.[43] Also, in a behavioral genetics study of personality dimensions in community and clinical populations,[56] self-harm emerged from factor analysis as a distinct trait dimension having a heritable component.

A third factor in self-mutilation derives from its relationship to life experiences, particularly childhood adversities. Self-mutilation in BPD is associated with a history of abuse in childhood,[57,58] and it has been suggested that self-injury might even be a marker for such abuse.[34] These associations can probably best be accounted for, however, by latent variables. Sexual abuse, physical abuse, and neglect are equally common in the childhood of patients with BPD who do not self-mutilate as in those who do.[34,57] Moreover, meta-analyses indicate that the relationship between childhood trauma and BPD is only of moderate strength.[59] While there is some relationship between traumatic histories and impulsivity,[60] the other key trait behind BPD, affective instability, lacks a strong relationship to trauma.[61] Finally, impulsive traits have been shown to be heritable.[62] Thus, the real association is most likely between childhood trauma and BPD, rather than with any specific symptom of the disorder.

A fourth possible explanation as to why some patients with BPD self-mutilate and others do not derives from the social environment—in particular, from learning (through imitation) of behaviors observed in other patients or in the media. Thus, patients who have not previously cut themselves may begin to do so after a hospital admission in which they have had the chance to observe such behavior.[14,63] This process, termed "social contagion,"[64] has been shown to influence the development of other impulsive disorders.[65]

CLINICAL IMPLICATIONS FOR MANAGING SELF-MUTILATION IN BPD

Self-mutilation is a troubling symptom, but understanding its functions for patients can help with management. Also, once therapists realize that self-injury does not usually carry a great risk for completed suicide, they can feel more comfortable treating patients in an outpatient setting.

This issue has not always been fully understood in the clinical community. Self-mutilation is one of the symptoms that often leads patients with BPD to be hospitalized.[66] Yet it makes little sense to hospitalize such patients in order to prevent them from committing suicide, if that is not the real purpose of their actions; although hospitalization can provide short-term relief for distress, doing so has little to do with safety. There are also problems with admissions that become repetitive, since responding consistently to self-injury with hospitalization can be reinforcing for some patients.[67] Instead, therapists might think of self-mutilation as an expectable part of the territory one traverses in treating patients with BPD. Finally, there is no evidence that hospitalization prevents suicide in this population, even among patients who seriously want to die.[67]

If one of the primary functions of self-injury is to reduce dysphoria, then therapy needs to identify the causes of that dysphoria and to help patients find better ways of dealing with emotions. These goals are the underpinnings of Linehan's[28] dialectical behavior therapy (DBT), which is specifically designed to target parasuicidal behaviors by improving emotion regulation. Controlled trials in several settings[68–70] have shown that self-mutilation in BPD can be reduced by DBT within a year of treatment, yielding results significantly better than treatment as usual. While other forms of cognitive-behavioral therapy (CBT) have been proposed for BPD,[71,72] they have not yet been subjected to empirical testing. In a randomized controlled trial, Tyrer and colleagues[73] found that manualized CBT was equivalent to treatment as usual for the treatment of recurrent "deliberate self-harm."

Other models, such as psychodynamically oriented outpatient therapy, might achieve many of the same results, as has been suggested by two meta-analyses.[74,75] There have been few empirical tests of psychodynamic therapy for patients with BPD, but findings from a randomized controlled trial of "mentalization-based treatment" (MBT), designed to reduce impulsive behaviors in BPD by increasing self-observation, have been encouraging.[76–78] MBT obtained a significant reduction in suicidal and parasuicidal behaviors within 18 months, as compared to treatment as usual. Although the main trial was conducted in the context of day treatment, preliminary evidence suggests that therapy is also effective in outpatient settings.[79] Finally, a recent comparative study of DBT versus "treatment by [BPD] experts," which showed some advantage for DBT in reducing overdoses, also showed that many forms of psychotherapy are effective in reducing self-mutilation.[80]

Self-mutilation has been a target not only for psychotherapy, but also for pharmacological interventions. A variety

of agents has been studied, including low-dose neuroleptics,[81–84] selective serotonin reuptake inhibitors (SSRIs),[85,86] mood stabilizers,[87–90] and naltrexone.[91] In a controlled study that focused specifically on the effects of SSRIs on self-mutilation, high doses were effective in many cases, but patients had difficulty tolerating side effects.[85] It is likely that these drugs work through a common mechanism, in that they all reduce levels of impulsivity.[92,93] Clinicians need to keep in mind, however, that while pharmacological agents can be helpful, one rarely sees remission in BPD.[93]

Above and beyond controlled clinical trials, practical methods for addressing self-mutilation in BPD have been suggested by experts working with this group of patients.[27,28,94] The general principles common to these approaches are consistent with existing research on self-injury in BPD.

First, one need be concerned, but not alarmed, when patients cut themselves. If patients who self-mutilate are distressed, therapists need to empathize with that distress. While being careful not to invalidate the patient's inner experience, a clinician's response to a patient's report of self-injury can be calm and neutral, using comments such as "you must have been very upset to have done that."

Second, therapy needs to focus on modifying the traits of affective instability and impulsivity that lie behind self-mutilation. Thus, to give up their addiction to cutting, patients need to stand outside their intense emotions and impulsive responses in order to modulate them. Therapists of all orientations[27,28,94,95] have recommended that clinicians understand and address the life events and emotions that have led to self-mutilation. Here the response can be: "Let's understand how this happened." Linehan[28] uses behavioral analysis to reconstruct the precipitants of episodes, and similar approaches have been described in other forms of therapy.[27] In the cognitive tradition, "decentering" has been developed for the management of impulsive symptoms in related conditions, such as bulimia nervosa.[96] Decentering involves teaching patients to observe their emotions rather than being taken over by them. This concept is similar to Bateman and Fonagy's[78] construct of "mentalization," which describes the ability to observe self and others accurately, even when emotions and impulses are strong.

Third, therapy can deal with more distal causes of self-mutilation, including patterns of maladaptive functioning rooted in schemas derived from early experience.[27,71] The evidence reviewed here does not support any simple correspondence between self-mutilation and specific childhood adversities. In line with the principles of developmental psychopathology,[97] this behavioral pattern is most likely an endpoint of many adversities, reflecting interactions between temperament, adult life experiences, and social influences.

Finally, any theory of self-mutilation needs to explain why it tends to be more frequent in younger patients with BPD, and then decreases over time.[93] Follow-up studies of patients with BPD[98–104] show that most recover, no longer meeting criteria for BPD; part of this process involves remission from self-injury. In some cases, the behavior stops at a much earlier stage.[103] It is notable that both psychotherapeutic[28] and psychopharmacological interventions[92] reduce self-mutilation, even before other symptoms remit.

These findings support a treatment plan in which BPD patients are managed symptomatically while working actively to make the recovery process proceed more rapidly.[93] Clinicians can also be reassured that however alarming the patterns of self-mutilation they treat, this behavior rarely continues over many years.

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ASSIGNMENT

Prior to beginning work on this assignment, review Chapter 3 in your textbook and the HumanMetrics Jung Typology Test website, and read the Choca (1999), Paris (2005), and Westen (1998) articles.

For this assignment, choose a historically important figure or a character from a movie, novel, or TV show, then address the following in your paper:

- Examine your figure or character from the perspective of Jung's theoretical approach to personality and describe your chosen figure or character based on the dichotomous facets of personality as defined by Jung.
- Evaluate the current Myers-Briggs Type Indicator (MBTI) personality instrument, which is based on Jung's theories, and provide your impression of your chosen figure or character through the major facets of the MBTI.
- Analyze how ethical issues might affect the implementation of MBTI personality assessment in the setting native to your chosen figure or character.
- Assess the MBTI and its use to provide results on your chosen figure or character and describe the efficacy and reliability of this assessment as it relates to your chosen person.
- Summarize and present your opinion about how well this theory describes the person in question. Provide research to support your claims.

The Personality Analysis

- Must be three to five double-spaced pages in length (not including title and references pages) and formatted according to APA style as outlined in the Ashford Writing Center (Links to an external site.)Links to an external site..
- Must include a separate title page with the following:
  - Title of paper
  - Student's name
  - Course name and number
  - Instructor's name
  - Date submitted
- Must address the topic of the paper with critical thought.
- Must use at least three peer-reviewed sources, including a minimum of three from the Ashford University Library. These may include the required articles for the assignment.
- Must document all sources in APA style as outlined in the Ashford Writing Center.
- Must include a separate references page that is formatted according to APA style as outlined in the Ashford Writing Cente

USE FOR ASSIGNMENT

4

CASE FORMULATION AND PERSONALITY DIAGNOSIS: TWO PROCESSES OR ONE?

DREW WESTEN

Clinical formulation and diagnostic formulation often seem like entirely separate, if not contradictory, enterprises, particularly with respect to the assessment of personality and its pathology. Clinical case formulation always presupposes a theory of personality because the questions one asks and the hypotheses one forms about a patient's personality depend on what one thinks personality is and how it relates to overt symptomatology. The categories and criteria embodied in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV*; American Psychiatric Association, 1994), by contrast, were deliberately selected to be as theory neutral as possible. As a result, clinicians, who always operate from theory, often find them irrelevant to clinical formulation and practice. Does it matter whether a patient meets criteria for histrionic personality disorder or only manifests four of the requisite criteria?

In this chapter I argue that one of the problems with the current diagnostic system is precisely that it separates the processes of formulation and diagnosis, that this drives a wedge between clinical practice and research, that this need not be the case, and that quantified clinical judg-

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Making Diagnosis Meaningful: Enhancing Evaluation and Treatment of Psychological Disorders, edited by J. W. Barron

ments can in fact be translated into clinically and empirically valid personality diagnoses. I begin by addressing some of the costs and benefits of diagnosis, focusing on the diagnosis of personality and personality disorders. I then suggest that the link between case formulation and diagnosis is *functional diagnosis* (i.e., assessment of discrete but interacting personality functions) and suggest three questions that organize a systematic case formulation: What are the person's motives; psychological resources; and experience of the self, others, and relationships? A fourth related question is, How is each of these aspects of the person's personality developed? I conclude with a brief discussion of a psychometric procedure for translating reliable clinical judgments about personality functioning into diagnoses, which can be adapted for clinical practice in a way that systematizes and organizes clinical thinking rather than overrides it for the purpose of arriving at what may seem like an arbitrary diagnostic categorization.

WHY DIAGNOSE? THE COSTS AND BENEFITS OF DIAGNOSING PERSONALITY

I begin with a case example, which I use throughout the chapter to illustrate some of the relevant issues. Throughout the chapter, the case description and formulation are indented, so that by the end of the chapter the reader can assess the adequacy of the model of case formulation being proposed by rereading the material in italics as if it were an initial evaluation summary. For simplicity, I describe the patient at the beginning of treatment.

> The patient, Mr. D., was a man in his early 20s who came to treatment for lifelong problems with depression, anxiety, and feelings of inadequacy. Mr. D. was a kind, introspective, sensitive man who nevertheless had tremendous difficulty making friends and interacting comfortably with people. He was constantly worried that he would misspeak, would ruminate after conversations about what he had said and the way he was perceived, and had only one or two friends with whom he could interact comfortably. Sex for Mr. D. was fraught with conflict. He was in a 2-year relationship with a woman who was emotionally and physically distant, whom he saw twice a month and with whom he rarely had sex. Before her, his sexual experiences all had been anxiety provoking and short-lived in every sense. His associations to memories of these sexual experiences were replete with classically Freudian imagery, such as his fantasy that he would "accidentally" touch the woman's anus and be repulsed, that her vagina seemed "torn up," and that his desire was really for a man. Mr. D. came from a working-class family in Boston and had lost his father, a police officer, when his father was killed in a gunfight when Mr. D. was 4 years old. He was reared by his mother and later a stepfather, who seemed relatively kind and benign.

He described his mother as basically loving, but she herself had a history of depression that seemed more chronic than episodic.

Using the *DSM–IV*, Mr. D. would not receive a personality disorder (PD) diagnosis, even though he clearly had enduring, maladaptive ways of thinking, feeling, and behaving (i.e., the kinds of personality problems that require therapeutic attention). On Axis I he meets criteria for dysthymic disorder, has subclinical symptoms of an anxiety disorder, and could be diagnosed with a male erectile disorder. On Axis II he would come close to meeting criteria for depressive personality disorder, which is not an official diagnosis. He has some avoidant features but clearly does not meet criteria for that disorder. Using the two axes, then, one can capture much of his depression, some of his anxiety, some of his social anxiety, and a description of some of his sexual problems. The interconnections among these problems, however, cannot be captured; they appear as discrete symptoms. His chart diagnosis would be nondescriptive:

Axis I: dysthymic disorder; male erectile disorder; r/o anxiety disorder not otherwise specified;
Axis II: deferred;
Axis III: deferred;
Axis IV: social isolation, job dissatisfaction;
Axis V (Global Assessment of Functioning): 65.

I believe this is a relatively typical case in terms of what the *DSM–IV* captures and fails to capture.

The Problems of Diagnosis

Diagnosis, particularly as embodied in the *DSM* approach, has a number of problems, costs, and limitations. One with which every introductory psychology student is familiar is the problem of labeling. The classic version of this concern was the labeling theories of the 1960s, which focused on the stigma of psychiatric diagnosis, notably schizophrenia. A more contemporary concern is that labels activate schemas, and schemas carry connotations that can lead clinicians to see what they expect or to react affectively to patients diagnosed with disorders for which they have particular countertransference problems (e.g., the reactions of many clinicians to patients with borderline personality disorder [BPD]). Additionally, diagnosis today is frequently used in the service of anxiety reduction by psychiatric residents and other mental health professionals who are not being adequately trained to understand their patients' dynamics and instead are compensating by focusing their attention on finding the right category into which to place their patients. These problems associated with psychiatric labeling, however, point more to problems with clinicians and training than with diagnosis per se. They suggest that as clinicians we need to be

aware of schematic biases and our issues with particular kinds of patients, address difficulties we might have in sitting with "not knowing," and avoid training programs that teach about categories instead of people.

Other problems, however, are more serious. One is the "so what" question. Suppose we decide that Mr. D. has a dysthymic disorder, and perhaps make the diagnosis of depressive personality disorder even though it is currently only in the appendix to the diagnostic manual. Clinically, what does this add to the knowledge, garnered in the first 5 min of the first interview, that he has been depressed most of his life? Does it guide us psychotherapeutically? Does it suggest a particular medication? Suppose, instead, we decide that he has an avoidant personality disorder with depressive features rather than a depressive personality disorder with avoidant features. So what? These are the kinds of diagnostic questions on which most PD research is currently focused, which is probably why most clinicians, sadly, do not read PD research.

Another related problem is the issue of comorbidity. The *DSM* approach, following a model that *does* pass the "so what" test in other areas of medicine (e.g., knowing that a patient has hypothyroidism rather than anemia has clear treatment implications), places individuals into categories. The problem for the classification of PDs is the high comorbidity of PDs both within and across the two axes. With respect to Axis I comorbidity, empirically, a substantial percentage of patients with Axis II disorders are comorbid for Axis I pathology and vice versa (Green & Curtis, 1988; Shea, Glass, Pilkonis, Watkins, & Docherty, 1987). The whole notion of Axis I–Axis II "comorbidity" may be largely artifactual, brought about by an artificial distinction between one axis originally intended to be more episodic and biogenic and the other more chronic and psychogenic. Unfortunately, nature was not so kind as to separate episodic, biological disorders from chronic, psychological or "functional" pathology. Schizophrenia and bipolar disorder are the best examples of disorders with high heritability, but schizophrenia is often chronic, as are some forms of bipolar disorder, and relapse in each is related in part to psychosocial variables such as the amount of hostile criticism and overinvolvement patients receive from their families (Hooley, 1987; Miklowitz et al., 1991). Furthermore, many of the PDs undoubtedly have biological diatheses, particularly schizotypal PD, which appears to be best categorized as a schizophrenic spectrum disorder and is found in the biological relatives of schizophrenic patients.

In this respect, consider Mr. D. Does it really make sense to scatter his symptomatology over two axes, like ashes over the Grand Canyon? All the problems with which he presented are chronic, but the extent to which they reflect biological or environmental etiological factors is unclear. Making matters more complicated, many aspects of his pathology are not represented on either Axis, such as his sexual conflicts, his passivity, and his

chronic feelings of inferiority that do not appear to be part of any particular PD and are found in many patients who have personality problems not severe enough to merit an Axis II diagnosis. Indeed, this latter point represents another clear problem with Axis II, which fails to include or categorize a large percentage of psychotherapy patients with "neurotic" personality pathology that slips between the axes (for empirical data, see Westen, 1997a). In a recent study, Westen and Arkowitz (1998) found that fully 60% of patients treated in clinical practice for enduring maladaptive personality patterns cannot be diagnosed on Axis II.

Within Axis II, comorbidity is even more of a problem. Research consistently shows that most patients with PDs fit criteria for multiple disorders (Bell & Jackson, 1992; Morey, 1988; Oldham et al., 1992), so that if a patient has any PD, he or she likely receives three or four PD diagnoses, at least with the research instruments widely in use. This has led some observers (Widiger & Frances, 1994) to suggest a shift from categorical to dimensional diagnosis. This could be accomplished by giving the patient a rating for each PD, leading to a diagnostic profile rather than a categorical diagnosis (e.g., on a scale from 1 to 7, Mr. D. would receive a 6 on depressive PD, a 3 on avoidant PD, a 1 on BPD, etc.). Alternatively, as Widiger and Frances and others have proposed, Axis II could be abandoned in favor of rating patients using the Five Factor Model (FFM) of personality (Goldberg, 1993; John, 1990; McCrae & Costa, 1990). The FFM was derived from self-reports and distinguishes five dimensions of personality on which individuals vary: neuroticism, extraversion, conscientiousness, agreeableness, and openness to experience. From this perspective, people with PDs are nothing but individuals who fall on the extreme ends of these dimensions. Mr. D. would no longer receive a diagnosis of depressive PD with avoidant features; instead, he would score high on neuroticism and introversion.

From a clinical perspective, neither the current categorical model nor the dimensional alternative seems to provide an adequate solution to the problem of personality diagnosis. In fact, each seems to confound a substantive issue with a scaling issue. Clinically, the question is not, Does the patient cross the threshold for avoidant PD? or How high does the patient score on neuroticism? The relevant clinical question is, Under what circumstances do which cognitive, affective, motivational, and behavioral patterns and their interactions get triggered in ways that lead to distress for the patient or those around him or her? As I show later, this is a functional question, not a scaling question, and it is one that neither Axis II nor the FFM (particularly with its reliance on self-reports) is prepared to answer. It is a question that deals with the dynamic interaction of psychological processes, intrapsychically and intersystemically. Both categorical and dimensional diagnostic systems share a major problem of trait theories criticized years ago by Mischel (1968) with which personality psy-

chologists have wrestled for nearly three decades (e.g., Funder & Colvin, 1991; Kenrick & Funder, 1988), namely that they fail to specify the eliciting conditions for personality processes and instead describe traits as qualities that are relatively fixed over time and across situations. Clinically, many patients have problems with authority, but these do not emerge with cats, dogs, peers, or subordinates and cannot easily be summarized with adjectives on a checklist or with categorical diagnoses.

The Benefits of Diagnosis

These are some strong arguments against diagnosis, particularly as instantiated in the *DSM–IV*. Diagnosis also, however, has considerable benefits. One is communication between clinicians. To describe a patient with a 10-page discursive evaluation summary is not parsimonious, nor can clinicians learn about more general processes typical of certain types of patients (e.g., those with BPD, antisocial PD, anorexia, etc.) without some form of categorization. Elimination of diagnosis would result in articles with titles such as, "Developmental History in Patients Who Show Evidence of Splitting, Difficulty Maintaining Relationships, Self-Mutilation, Inconstant Representations, Poorly Modulated Affect, and Sundry Other Symptoms." Clearly, diagnosis allows communication among mental health professionals about patients who share certain features, however fuzzy the categories are around the edges.

A second benefit has to do with communication with patients. As clinicians, we rarely present our patients with a diagnosis. Rather, if we provide initial diagnostic feedback at all (which I believe we should), we offer a brief narrative, clinical formulation at the end of an evaluation period, which describes what we have seen and what we think might be helpful. For example, after spending three sessions with a patient with BPD, I might say something along the following lines:

> It seems like we've identified some central issues for us to work on. One is that you often feel overwhelmed, like your feelings are out of control. When you feel this way, sometimes you'll break off a relationship that you'll later wish you hadn't, sometimes you'll cut yourself, and sometimes you'll drink too much. A second issue is that deep down, you seem like you don't really trust that people will love you and treat you well. And this seems related to your feelings about yourself—when you feel bad about yourself, you feel totally bad, like there's nothing about you but badness and that you don't deserve any better.

This can be useful to patients because it takes what feels like a morass of feelings, symptoms, and concerns and puts them into a manageable, coherent form and lets them know that the clinician has some understanding of them and how to proceed.

On some occasions, however, actually telling a patient his or her diagnosis can be therapeutically indicated. This is often the case with patients with posttraumatic stress disorder, who frequently fear they are going crazy and have no idea that their symptoms are a typical, understandable, and treatable response to psychological trauma. Although using a diagnostic label is rarely indicated with PD patients, who will generally feel labeled rather than understood (and for good reason), in some cases giving the patient a diagnosis can be helpful. When I was nearing the end of my internship many years ago, I was assigned a severely disturbed borderline patient for evaluation and brief treatment (because I was leaving the agency). She presented with a foot-high stack of psychiatric records since the time of her initial contacts with mental health professionals as a runaway 20 years earlier. I knew she had written away for all prior records and that she would do the same with anything I wrote, so I decided to go over my evaluation summary with her, including the diagnosis. It was one of the most therapeutic encounters I have ever had with a patient with BPD. She was struck not only by the dynamic interpretations of a series of events from her history but also by the fact that she was not alone and crazy and that a class of people existed who shared similar problems. Her first response after the session was to go to the bookstore, to buy some books on BPD (she found Kernberg especially helpful), and to learn about herself.

Third, diagnosis is essential with some disorders, such as schizophrenia or bipolar disorder, for which treatment decisions depend on accurate diagnosis. A diagnosis of BPD can be useful as well because the presence of this PD has predictive value vis-à-vis the use of various medications for depression (see, e.g., Gunderson, 1986). Knowing whether a patient who has behaved antisocially actually has the constellation of variables associated with antisocial PD or is acting out a neurotic conflict also is clinically important.

A fourth way in which diagnosis is useful is for research purposes, which should ultimately feed back into clinical knowledge. A case in point is the etiology of BPD. For years the only etiological theories were based on reconstructions in psychoanalytic treatment, notably Kernberg's (1975) suggestion that patients with borderline personality organization have a constitutional overabundance of aggressive drive and several less clearly specified hypotheses about pathogenic mother–child interactions in the preoedipal years (e.g., Mahler, Pine, & Bergman, 1975). Once the third edition of the *DSM* created a PD axis, however, measures began to arise to operationalize diagnoses, notably BPD, which led to research relevant to its etiology. On the basis of this research, clinicians now know that a history of sexual abuse is unusually common in the developmental histories of patients with BPD (Herman, Perry, & Van der Kolk, 1989; Ogata et al., 1990; Westen, Ludolph, Misle, et al., 1990) and that it probably contributes, along with constitutional factors and the quality of attachment rela-

tionships in childhood, to the development of the disorder. Without a diagnosis, we might well be continuing to argue about whether sexual abuse plays any role in the disorder, with no basis for choosing among competing theories except for the authority of those who expound them.

Diagnosis has one final utility: It is impossible to do without. Diagnosis is simply a technical form of categorization, and people cannot navigate their way through the world without concepts and categories. Any therapist who claims simply to sit with the patient and experience the person "as he or she is" is cognitively naïve. Schemas can lead us astray, but they are essential for thought. Clinicians have to be able to tell whether a patient is psychotic, and they use all kinds of implicit and explicit rules to do so. This is simply how the human brain works. Categories represent observed (or taught) regularities in the world. Without them, every case would be entirely new, and clinicians would have to reinvent a theory of personality for every patient. Even the most stalwart constructivists implicitly assess the way their patients feel, how they handle their feelings, the extent to which they have a good hold on reality, and so forth. This implies assimilation of aspects of patients' behavior to preexisting schemas. The question is how to make those schemas clinically useful and more likely to sharpen our understanding of our patients rather than obscure who they are.

FUNCTIONAL ASSESSMENT OF PERSONALITY

The issue, then, is not whether to give up diagnosis but how to reframe the diagnostic process so that it is maximally useful. One way to make diagnosis more meaningful when assessing personality is to begin with a *functional assessment*, or *functional diagnosis*—an assessment of how the individual tends to function cognitively, affectively, and behaviorally under certain conditions relevant to psychological and social adaptation. This means assessing pathology as well as health because helping a patient requires knowledge of his or her adaptive capacities as well as areas of dysfunction. The kinds of descriptive diagnoses made on Axis II can and should be derivative of a functional assessment because once a clinician has thoroughly assessed a patient's personality functioning, a simple prototype-matching procedure can automatically produce a descriptive diagnosis.

Elsewhere (Westen, 1995, 1996) I have argued that three sets of variables, defined by three questions, provide a relatively comprehensive roadmap of personality that can guide personality assessment: First, what does the individual wish for, fear, and value and to what extent are these motives conscious and mutually compatible? Second, what are the individual's

psychological resources for adapting to internal and external demands? Third, what is the individual's capacity for engaging in intimate relationships, and how does the individual experience the self, others, and relationships? The interaction of the processes included under these three broad rubrics defines the individual's personality, as he or she pursues motives and responds to experiences with characteristic ways of thinking, feeling, and behaving. From a clinical perspective, a fourth question is developmental: How did these various processes emerge, and at what junctures and in what ways did development go awry?

This view of personality is dynamic and systemic in two senses. First, it views personality as the interaction of psychological processes activated under specific conditions, not as the possession of certain traits to particular degrees. One can, and should, be able to measure each of the variables defined by the model, but assigning people to static categories or ascribing to them relatively static traits is not the goal of assessment because doing so misses the dynamics at the heart of the patient's personality functioning. Second, this view does not consider situational demands as being entirely independent of personality characteristics. The environment people experience is not generally independent of their actions (see Wachtel, 1987), and the way they respond is often conditional, depending in part on the presence of certain activating conditions, not automatically and inflexibly elicited regardless of the circumstances (Westen, 1997b).

In this section, I flesh out each of these questions and the variables that constitute them (see Exhibit 4.1), again using Mr. D. as an example. Although delineation of these variables drew extensively from research across personality, clinical, and developmental psychology, the first three questions address, respectively, the concerns of classical psychoanalytic theory; ego psychology; and object relations theory, relational theories, and self psychology. The fourth cuts across all three. All four questions, although theory laden, are close to clinical data and together represent a codification of the kind of assessment most skilled clinicians intuitively make, although the effort here is to systematize those dimensions in a way that is both clinically and empirically sound.

Question 1: What Does the Person Wish for, Fear, and Value, and to what Extent Are These Motives Conscious and Mutually Compatible?

The first question regards motivation: What does the individual wish for, fear, and value? To put it another way, what representations of desired, feared, and valued states has the patient come to associate with a substantial enough degree of affect that these representations guide behavior as goal states? These affectively imbued representations can be conscious, un-

EXHIBIT 4.1
Domains of Personality Functioning in a Comprehensive Assessment

I. Motives
   a. Fears
   b. Wishes
   c. Values
   d. Conflicts among fears, wishes, and values
   e. Consciousness of dominant motives
   f. Notable compromise formations
II. Psychological resources
   a. Cognitive functions
      1. Intellectual functioning, verbal and nonverbal skills, memory
      2. Cognitive style
      3. Coherence or disorder of thought processes
      4. Expectancies and belief systems
   b. Affective experience
      1. Intensity of affective experience
      2. Variability or lability of affect
      3. Tendency to experience positive and negative affect
      4. Tendency to experience particular affects
      5. Consciousness of affective experience
      6. Capacity for experiencing ambivalent emotions
   c. Affect regulation
      1. Conscious coping strategies
      2. Defenses
      3. Repertoire of affect-regulatory behavior
   d. Behavioral resources
III. Experience of the self and others and capacity for relatedness
   a. Cognitive structure of representations of self and others
      1. Complexity
      2. Differentiation of different representations from each other
      3. Integration of diverse elements
   b. Affect tone of relationship schemas
   c. Capacity for emotional investment in relationships
   d. Capacity for investment in values and moral standards
   e. Understanding of social causality
   f. Dominant interpersonal concerns: chronically activated interpersonal wishes, fears, and schemas
   g. Management of aggressive impulses
   h. Social skills and interpersonal behavior
   i. Self-structure
      1. Sense of self-continuity or coherence; sense of self as a thinker, feeler, and agent; experience of self as being continuous over time
      2. Conscious and unconscious representations
      3. Self-with-other schemas
      4. Self-esteem
      5. Feared, wished-for, ought, and ideal self-representations
      6. Self-presentation
      7. Identity
IV. Development
   a. Developmental level (maturity) of various psychological processes
   b. Temperament
   c. Salient developmental experiences

conscious, or somewhere in between (such as acknowledged but only in alternation, or recognized with considerable clinical probing and support), and they may be congruent or conflicting. They also may be combined to produce compromise formations (see Brenner, 1982), which simultaneously address multiple motives, some or all of which may be unconscious. Recent empirical evidence (summarized by Westen, in press; see Bargh, 1997; McClelland, Koestner, & Weinberger, 1989) supports the long-held clinical view that motives can be either conscious or unconscious, that conscious motives can differ substantially from their unconscious counterparts, and that motives (e.g., the desire to perceive the self accurately and the desire to maximize self-esteem) can conflict and be combined unconsciously to produce compromise responses.

A comprehensive assessment of an individual's motivational structure would, of course, be impossible because it would involve mapping every connection between thought and feeling in the individual's mind; rather, the major aim of assessment of this domain of personality is to understand the broad sweep of his or her recurring motives, particularly those involved in symptom formation and maintenance:

> Mr. D. was torn by competing motives to succeed and to fail. On the one hand, he desperately wanted to succeed, in part to match up to a fantasy ideal of his dead father, in part to please his mother and stepfather, and in part simply because he had internalized much of the achievement orientation of U.S. culture. On the other hand, he appeared compelled to find ways to fail, and careful examination of his motives in such circumstances led to wishes to be passive and cared for, fears that he would fail that led him to avoid efforts to succeed that seemed to him "doomed," and conflicts around his masculinity [apparently related in part to his father's death at a young age] that left him reluctant to take on a more "agentic" role that he associated with manliness [and ultimately death].
>
> Mr. D. was equally conflicted about his relational wishes. On the one hand, he wanted to be closer to people, but he was frightened that he would be rejected and was afraid of his own anger in relationships. Thus, instead of actually engaging with people, he would often have a running commentary with them in his mind, often filled with aggressive content, which served as a compromise among his wishes to connect, his wishes to express his rage at what felt like constant rejection and humiliation, and his fears of getting involved. Sex was a particular battleground for conflicting motives for Mr. D., who once again wanted to connect emotionally, wanted to satisfy his physical desires, and wanted to feel like a man but was paralyzed by conflicting motives. As noted earlier, he associated female genitals with danger and was both drawn to and repulsed by anal fantasies. [I am not speaking theoretically here; he was explicit in describing those fantasies and corresponding fears, with no suggestion necessary on my part.] He also

had homosexual fantasies that would sometimes intrude during moments of arousal, which was distressing to him.

Question 2: What Psychological Resources (Cognitive, Affective, and Behavioral Dispositions) Does the Individual Have at His or Her Disposal?

The second question includes several subdimensions, largely centering on the individual's cognitive and affective patterns. The first set of dimensions pertains to the cognitive resources at the individual's disposal. When clinicians assess patients, they try to evaluate several aspects of cognitive functioning. One is intellectual functioning, such as the degree to which the individual can process information efficiently using verbal and visual modes. Contemporary theories of intelligence emphasize multiple intelligences and the uses to which people put their intellectual processes in solving problems (Chen & Gardner, 1997; Gardner, 1983; Sternberg, 1985, 1997). Clinical assessment of intelligence similarly entails a functional assessment of the way individuals think relative to the tasks that confront them. A dynamically informed cognitive assessment also focuses on the role of motives in channeling intellectual processes, on the extent to which the individual's affects disrupt them, and in general on the interaction of affect, motivation, and reasoning.

Another cognitive variable is cognitive style (Shapiro, 1965), such as the global, impressionistic, hysterical style that usually co-occurs with defenses such as repression, pseudonaïveté, or denial of obvious but unpleasant ideas, and the analytical, miss-the-forest-for-the-trees, obsessional style, which is usually accompanied by defenses such as intellectualization and inattention to affect. Similar concepts of cognitive style emerged independently in other empirical literatures, such as research on field dependence (Berry, 1976), although a dynamic understanding focuses more on cognitive–affective interactions. An additional cognitive variable, first studied by psychoanalytic ego psychologists, is the degree to which an individual's thought processes are intact or disordered (see Allison, Blatt, & Zimet, 1968; Johnston & Holzman, 1979; Rapaport, Gill, & Schafer, 1945). Finally, cognitive assessment requires attention to cognitive content as well as process, that is, to prominent schemas and beliefs (see, e.g., Beck, 1976, 1993; Weiss & Sampson, 1986). Cognitive therapists pay attention to the more conscious aspects of these schemas, whereas psychodynamic clinicians attend more to unconscious schemas or representations, although the focus of psychodynamic clinicians on such cognitive processes is often obscured by their use of the word *fantasies* to refer to all manner of psychological contents, from the wishful beliefs most people colloquially understand as fantasies, to childhood constructions of reality such as "my father died because I got angry at him." (To the extent that these cognitive

contents encode interpersonal information, they attain a salience highlighted by the third broad question, to be discussed shortly.) Research that distinguishes explicit thought and memory (consciously retrievable and manipulable information) from implicit cognitive processes (such as information encoded along associational networks, which is inaccessible to consciousness; see Holyoak & Spellman, 1993; Schacter, 1992) suggests the need for careful attention to cognitive processes at different levels of consciousness because the two systems of thought (implicit and explicit, unconscious and conscious) are psychologically and neurologically distinct (see Westen, in press).

Another domain of psychological resources is composed of the individual's chronic affective tendencies. Individuals differ in a number of affective dimensions, many of which have been studied empirically, including affective lability (i.e., the extent to which they fluctuate from one emotional state to another), affect intensity (i.e., the extent to which emotions are strong; Larsen & Diener, 1987), the extent to which they chronically experience pleasant and unpleasant affects (Buss & Plomin, 1984), the extent to which they experience specific affects such as shame and guilt (see Watson & Clark, 1992; Watson & Tellegen, 1985; Westen, 1994), their comfort with conscious awareness of affect (see Pennebaker, 1989), and, as emphasized by Kernberg (1975, 1984) and subsequently examined empirically (e.g., Baker, Silk, Westen, Nigg, & Lohr, 1992; Sincoff, 1992), their ability to recognize and experience conflicting affective states and appraisals simultaneously (i.e., the capacity for ambivalence).

An important domain of affective functioning that is currently receiving more widespread attention by psychologists is affect regulation, which refers to the conscious and unconscious procedures used to maximize pleasant and minimize unpleasant emotions (see Dozier & Kobak, 1992; Mayer, Salovey, Gomberg-Kaufman, & Blainey, 1991; Westen, 1985, 1994; Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997). People regulate affects in many ways, using conscious coping strategies (e.g., anticipation, cognitive reframing, self-distraction, suppression, humor, etc.), unconscious defenses (see Perry & Cooper, 1989; Vaillant, 1992), and behaviors aimed at altering reality to eliminate an aversive situation or at altering the affect directly (e.g., by ingesting drugs or alcohol; Haan, 1977).

Finally, assessment of psychological resources includes an assessment of the way the individual chronically tends to behave, which is the domain of personality most often assessed by personality psychologists who endorse the FFM. Although many aspects of behavior are learned, temperament clearly plays an important role in influencing general tendencies, such as activity level, extraversion, and impulse regulation (i.e., the capacity to delay impulse and action). Too often, dynamic therapists assume that if they address motives and conflicts, behavior will change. Sometimes addressing a conflict (e.g., ambivalent feelings about becoming successful) will

produce dramatic changes in skills (e.g., study or work skills). At other times, however, even a skill deficit (e.g., problematic social skills) that originally had its origins in conflict (e.g., avoiding the discomfort associated with interacting with a capricious or inept attachment figure) will not remit with dynamic work because it has become a functionally autonomous behavioral pattern. As Bandura (1977, 1986) has demonstrated, people will not show competent behavior unless they not only have relevant motives and positive expectancies about the likely outcome of producing the behavior but also the skills to carry it out.

> Mr. D., with respect to cognitive resources, was verbally intelligent, although his conflicts about success inhibited him from expressing much of his ability to think with words occupationally. Instead, he worked for several years as a cabinetmaker, where he developed skills that instead made use of his considerable motoric intelligence. His cognitive style was obsessional, in that he would often ruminate on details of conversations, minor mistakes in cabinet construction, and the like. He showed no signs of disordered thinking. A number of cognitive constructions, many of which are addressed by Question 3 [e.g., beliefs about his father's death, beliefs about his inadequacy, etc.], influenced his mood and behavior. With respect to affective resources, he had access to a range of emotions and was not particularly labile affectively, although his emotions could at times be strong. He tended to experience more negative than positive affect, especially depression and anxiety, and he was often angry but uncomfortable with expressing it. He tended to use obsessional defenses such as intellectualization but also had a number of adaptive coping strategies at his disposal, such as his ability to rely on emotional support from his therapist, parents, and a limited number of close friends. His behavioral style was passive, relatively slow-moving, introverted, and complex with respect to impulse regulation because he was often inhibited or reflective before taking action but would sometimes show breakthroughs of poorly regulated impulses [as when he would buy an expensive piece of carpentry equipment with little forethought about how he would pay for it].

Question 3: How Does the Person Experience the Self and Others, and to What Extent Can the Individual Enter Into Intimate Relationships?

The third question, regarding interpersonal functioning, forms the content of object relations theory, including self psychology. The term *object relations* refers to the cognitive, affective, and motivational processes that underlie the capacity for maintaining intimate relationships. Several dimensions of object relations are empirically distinguishable and have been examined in patients, normal adults, children, and adolescents (see

Westen, 1991; Westen, Lohr, Silk, et al., 1990; see also Blatt & Lerner, 1983; Stricker & Healey, 1990). These dimensions include the cognitive structure of representations of people (complexity, differentiation, and integration), the affect tone of relationship schemas (i.e., the extent to which the individual expects relationships to be destructive or enriching), the capacity for emotional investment in relationships (i.e., the transcendence of a need-gratifying orientation to others), moral development, the capacity for understanding why people do what they do, the ability to regulate and appropriately express aggression, the dominant interpersonal concerns (fears, wishes, and cognitive constructions) that repetitively emerge in the individual's relationships and are manifest in narratives of interpersonal encounters (in psychotherapy hours or on projective tests), and social skills. Another set of variables involves aspects of self (for a more detailed delineation, see Westen, 1992; Westen & Cohen, 1992), including the coherence of the individual's sense of self; the nature of chronically recurring self-representations or self-schemas; self-esteem; feared, wished-for, and ideal self-representations that serve as standards or guides for behavior (see Higgins, 1990; Strauman, Lemieux, & Coe, 1993); and what Erikson (1963) referred to as identity, which includes both the sense of self, representations of self, the recognition of one's selfhood by the social milieu, and an emotional weighting of elements of self (e.g., roles) the individual experiences as self-defining.

Mr. D., like many patients, demonstrated a much more complex, multifaceted picture with respect to his object relations than is often afforded by unidimensional stage theories that place an individual at a single developmental level, such as fixated at a hypothesized rapprochement stage (see Westen, 1989, 1990):

> Mr. D.'s representations of people were often fairly complex; he rarely showed signs of splitting, was generally clear about whose feelings were whose, and was able to recognize people's strengths as well as their feelings, even when he was angry or upset. The affective quality of his representations of others was mixed. He did not expect malevolence from others and was able to experience pleasure in the small number of close friendships he had developed over the years, but his experiences with people had left him with somewhat negative views of what he could expect to happen in relationships [which were not altogether unrealistic given his experiences and anxieties in interacting with them]. He wanted to connect with people, was able to care about others, and had a well-developed, if sometimes harsh, superego. He also had a relatively solid understanding of why people do what they do, although at times he had trouble using this knowledge in concrete social situations. He had difficulty with regulation of aggression and would frequently be passive or self-punitive rather than appropriately assertive, which contributed to a lingering hostile fantasy life and a tendency at times to behave passive aggressively. His dominant inter-

personal concerns centered around rejection, shame, and aloneness. He had the skills to interact with people, but he was frequently inhibited by his anxiety from doing so and would often find himself tongue-tied, especially with women. He had no difficulties experiencing himself as coherent (i.e., he had no dissociative tendencies), but he chronically felt inadequate and perceived himself as failing to meet his own and his parents' standards for achievement. He often voiced identity concerns directly, wondering what he was going to do with his life, where he would fit in, and feeling adrift without either meaningful work or love relationships that were sustaining.

Question 4: How Do These Processes Develop?

The final question is one of development. A distinguishing feature of psychodynamic theory has always been the assumption that to understand any adult phenomenon one must understand its genesis. Although theorists have often erred in assuming that all pathological variants represent fixation or regression points along normal developmental continua, they have emphasized that to understand why an individual is behaving in a way that seems maladaptive or unintelligible, one should ask several questions: Does this behavior (e.g., throwing tantrums in an older child, ending relationships precipitously when they are momentarily ungratifying in an adult) resemble the behavior of younger children? What events transpired during development that made this individual vulnerable? When did the individual first behave this way, and what problem was this behavior an attempt to solve? Underlying these questions is the view that people often find themselves saddled as adults with ways of seeking pleasure, regulating unpleasant affects, and construing events that were forged in childhood. Because these thoughts, motives, and affect regulation strategies became automatic or unconscious through repeated use, and because consciousness of some of them may have produced discomfort, they may not have been appropriately revised in light of adult circumstances and cognition.

Thus, case formulation requires attention to ways in which people have maintained response tendencies that are no longer adaptive (or may never have been adaptive). A thorough case formulation also attends to two other developmental questions. First, what are the temperamental contributions to enduring personality dispositions, and how are constitutional factors implicated in the etiology of the patient's symptoms? Research in behavioral genetics has shown that many aspects of personality, such as negative affectivity and introversion–extraversion, are highly heritable (see, e.g., Kagan & Snidman, 1991; Plomin, Chipuer, & Loehlin, 1990; Tellegen, Lykken, Bouchard, Wilcox, & Rich, 1988). A second developmental dimension involves salient developmental experiences, such as parental behavior, parental loss, neglect, and abuse. A growing body of re-

search on attachment establishes the role of attachment patterns, as early as the first 12 months of life, in shaping later social adjustment (Bretherton, 1990; Lyons-Ruth, Connell, Grunebaum, & Botein, 1990; Sroufe & Fleeson, 1986). Adolescent drug use and abuse, as well as personality characteristics such as rigidity or manipulativeness, can be predicted from mothers' interactions with their preschool children (Shedler & Block, 1990). Research has similarly documented links between experiences such as abuse, neglect, and disruptions in caretaking throughout childhood with later interpersonal pathology and personality disorders (see Tizard & Hodges, 1978; Westen, Ludolph, Block, et al., 1990).

Understanding a given individual's personality requires examination of the way temperament and life experiences interact to shape his or her development in the domains outlined under the first three questions (i.e., motives, psychological resources, and experience of self and others). For example, an event such as sexual abuse may have a differential impact on various psychological processes. In one individual it may lead to malevolent expectations of relationships but not to global alterations in cognitive functioning. In another, it may lead to a disruption in verbal intelligence caused by a defensive shutting down of semantic knowledge as a way of constricting associative memory.

> Mr. D.'s history suggests likely contributions of both biological and experiential events to his psychopathology. His mother was chronically depressed, which suggests a biological diathesis, a psychosocial diathesis, or both. In fact, depression ran throughout her family, even in cousins with whom she had minimal contact, suggesting a biological contribution. Given the high comorbidity rates of depressive and anxiety disorders, Mr. D.'s anxiety—and his tendency to experience negative affective states more generally—probably had origins in part in temperament. This temperamental vulnerability was likely exacerbated by experiences that could lead to distress and pathogenic representations of self and relationships in even a temperamentally more resilient child, such as his mother's chronic depression and his father's violent death. Given the age at which he experienced both (the former from as early as he could remember) and the immaturity and egocentrism of much preschool thought, he was likely to have constructed an understanding of the causes of the misery in his family that put his own actions and fantasies at center stage. Precisely how and why he developed such negative self-representations and social anxiety is unclear, although tendencies of this sort can be self-reinforcing. As an adult, for example, he developed negative expectancies and a conditioned anxiety response to sexual situations after his first sexual encounters, which involved erectile failures. This only increased his anxiety, which appeared to have been spurred initially by unbidden images and anxiety-filled fantasies and associations to sexuality.

FROM FUNCTIONAL DIAGNOSIS TO DESCRIPTIVE DIAGNOSIS

The material in italics describing Mr. D. throughout this chapter, as scant as it is, probably seems to most readers considerably richer and more descriptive than his *DSM–IV* diagnosis, and, at first glance, the two appear unrelated. In fact, however, a descriptive diagnosis can be derived from a functional diagnosis, so that the advantages of the former (e.g., communication among clinicians, research on etiology, etc.) can be garnered without the limitations. I conclude by briefly describing a procedure by which such a translation can be made for both empirical and clinical purposes.

Jonathan Shedler and I have spent the past several years developing a Q-sort instrument for assessing personality dynamics and pathology called the Shedler-Westen Assessment Procedure (SWAP-200; Shedler & Westen, 1996). A Q-sort is a scaling procedure that has been receiving increased use in personality research because of its ability to translate clinical or quasi-clinical judgments into quantified narrative statements (see Block, 1978). As in other Q-sorts, the statements that make up the SWAP-200 Q-sort are written in clear language with minimal jargon (to avoid multiple interpretations of the construct being assessed) and are printed on notecards, one per card. The task for the observer (a clinician, interviewer, or coder who has watched an interview) is to sort the cards into eight piles, numbered 0–7, to indicate the degree to which each statement describes the patient. Thus, items in Pile 7 are absolutely defining of the individual's personality, whereas those in Pile 0 do not describe the individual at all.

This procedure yields a narrative description of the patient in descending order of diagnosticity (from Pile 7 downward), as well as a quantified assessment of the patient's personality, because each statement now has a number attached to it, from 0 to 7. Although the statements in the SWAP-200 were not designed explicitly to assess the dimensions of personality delineated here, we did attempt to cover these domains. Initial validity and reliability studies have been promising (see Shedler & Westen, 1996), and we have recently completed a study of 797 patients with PDs who were described by a random national sample of psychologists and psychiatrists from the registers of the American Psychiatric Association and the American Psychological Association, which has allowed us to examine empirically the statements that appear best to describe patients with each of the PDs listed in the *DSM–IV* to ascertain using cluster analytic methods whether alternative ways of categorizing patients with PDs might be more useful, and examine the relation between various genetic and developmental history variables (e.g., familial alcoholism, abuse, loss; Question 4) and personality characteristics (Questions 1–3; Westen & Shedler, 1998a, 1998b). The SWAP-200 can be used to provide a quantified narrative description of the personality characteristics of any patient, provided that the observer (such as the patient's therapist) knows the patient well

enough to do so (which we have operationally defined as a minimum of five sessions' contact).

Consider the statements that would receive highest placement (Piles 6 and 7) in the sort for Mr. D. (in no particular order):

- Has difficulty acknowledging or expressing anger.
- Tends to be anxious.
- Tends to feel helpless; feels own wishes or actions have little effect.
- Is empathic; is sensitive and responsive to other peoples' needs and feelings.
- Tends to feel ashamed or embarrassed.
- Is articulate; can express self well in words.
- Tends to be shy or reserved in social situations.
- Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it.
- Appears to associate sexual activity with danger (e.g., injury, punishment, contamination, etc.), whether consciously or unconsciously.
- Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.
- Experiences a specific sexual dysfunction during sexual intercourse or attempts at intercourse (e.g., inhibited orgasm or vaginismus in women, impotence or premature ejaculation in men).
- Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
- Tends to think in abstract and intellectualized terms, even in matters of personal import.
- Tends to avoid social situations because of fear of embarrassment or humiliation.
- Tends to be passive and unassertive.
- Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
- Tends to feel unhappy, depressed, or despondent.

The following items would receive moderately high placement (e.g., Piles 4 and 5) but would not be in the most diagnostic piles:

- Has moral and ethical standards and strives to live up to them.
- Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
- Tends to be self-critical; seems intolerant of own human defects.

- Tends to fear rejection or abandonment by those who are emotionally significant.
- Tends to be critical of others.
- Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.
- Is unsure whether he or she is heterosexual, homosexual, or bisexual.
- Lacks a stable image of who he or she is or would like to become (e.g., attitudes, values, and goals may be unstable and changing).
- Tends to be ingratiating or submissive (e.g., may consent to things he or she does not agree with or does not want to do in the hope of getting support or approval).
- Tends to be conflicted about authority (e.g., may feel he or she must submit, rebel against, win over, defeat, etc.).
- Tends to act impulsively, without regard for consequences.
- Tends to abuse alcohol.
- Tends to feel like an outcast or outsider; feels as if he or she does not truly belong.
- Tends to oscillate between undercontrol and overcontrol of needs and impulses (i.e., needs and wishes are expressed impulsively and with little regard for consequences, or else disavowed and permitted virtually no expression).
- Is creative; is able to see things and approach problems in novel ways.
- Tends to see normal sexual experiences as somehow revolting or disgusting.
- Appreciates and responds to humor.
- Tends to be angry or hostile (whether consciously or unconsciously).
- Tends to be overly needy or dependent; requires excessive reassurance or approval.

Several aspects of this characterization of Mr. D. are noteworthy. First, the procedure offers a rich portrait of the patient's personality dynamics and psychopathology. Any competent clinician reading these statements would have a sense of what Mr. D. is like as a person and what issues call for therapeutic attention. Second, the virtue of the Q-sort method is that it turns clinically meaningful statements into quantifiable items on which two observers can agree. We have found, for example, that the interrater reliability for the combined scores of two coders observing the same loosely structured clinical interview on a given patient is .75 and that this profile of statement scores correlates, on the average, with the treating clinician's Q-sort description of the patient (r = .54). What the Q-sort procedure

essentially allows clinicians to do is to make a case formulation using a common language, so that any two well-trained clinicians should be able to provide case formulations on a patient that are not only qualitatively but quantitatively highly similar.

Third, the SWAP-200 description of Mr. D., unlike his *DSM–IV* diagnosis, provides a portrait of both his strengths and weaknesses, which allows the clinician to know what needs to be done, what does not, and what strengths can be called on in the service of treatment. Fourth, it provides a clearer sense of diagnosis in patients such as Mr. D. who have clear personality pathology but not a PD. The high placement of health items—such as Mr. D.'s capacity for empathy or for making use of information that is threatening but potentially useful—makes clear that Mr. D. may be depressed, anxious, and sexually conflicted but that he does not have a PD despite areas of maladaptation.

Fifth, this system does not define a patient's diagnosis in terms of the presence or absence of a small number of symptoms (e.g., four of seven symptoms of avoidant PD). Rather, it provides a broad profile of attributes, ranging from those that are extremely true of the patient, through those that are moderately true, through those that are not true at all. In so doing, it allows the clinician to make 200 discriminations about the patient (because the Q-sort has 200 items) rather than trying to decide whether he or she meets a small number of criteria for a disorder that may itself be somewhat arbitrarily defined. The Q-sort procedure also does not require that clinicians make dichotomous (present or absent) choices about variables (e.g., social anxiety, depression, rejection sensitivity, etc.) that are continuous in nature. Particularly useful about this method of diagnosis is that it allows for more sophisticated research about treatment and treatment outcome. Not only can researchers use this instrument to determine precisely which aspects of personality change with which kind of treatment after what average duration, but they also can use it to construct scales—which are nothing more than lists of statements—that can indicate to clinicians which patients might benefit from particular kinds of interventions. For example, by examining a large sample of depressed patients who responded to selective serotonin reuptake inhibitors (SSRIs) and comparing them with a sample that did not, one can develop a profile of the personality characteristics of patients whose symptoms are most likely to "listen to Prozac." This would have been useful for Mr. D., who, in fact, responded well to treatment with SSRIs.

A final aspect of this Q-sort description is particularly important from the perspective of the present chapter: It can be translated directly into a descriptive diagnosis by a process of prototype matching. For research purposes, one can correlate a patient's Q-sort profile with the obtained aggregated profile of a large sample of patients with various disorders to determine the extent to which the patient resembles patients with each disorder.

Thus, if Mr. D.'s profile correlates highly with the average profile of a group of 40 patients with depressive PD but only moderately with that of a sample of avoidant patients, one can describe his pathology with confidence in terms of the degree of match, and with precision in terms of the size of the correlation. In our cluster analytic study, we found a category of "neurotic depressives" with which Mr. D.'s profile would correlate highly. For clinical purposes, clinicians can intuitively perform the same operation on the basis of their experience by comparing the profile of statements that are descriptive of their patient with other patients they have worked with to arrive at an Axis II diagnosis. The advantage of this method clinically is that the diagnosis flows directly from the functional assessment.

CONCLUSION

In recent years, the gap between clinicians and researchers has been increasing, particularly with respect to the diagnosis of personality (Westen, 1997a). The elimination of neurotic character patterns from official psychiatric discourse, the development of structured interviews that diverge from clinical practice, the attempt to describe personality patterns without reference to personality theories, and a variety of other trends have led many clinicians to consider the official nosology and research using it irrelevant to clinical practice.

We need not eliminate Axis II in favor of a five-factor model of personality based on self-reports. And we need not, and should not, ghettoize some of the most important aspects of personality and its dynamics, such as defenses, to appendixes in the various editions of the DSM, leaving an eviscerated official diagnostic system. These options will not work because they eliminate from the assessment of personality precisely what, from a clinical perspective, personality is all about: the tendency to respond cognitively, affectively, and behaviorally under certain specifiable circumstances in ways that define both the individual's enduring dispositions and aspects of his or her character that he or she could profitably change.

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USE FOR Assignment

PERSPECTIVES

Understanding Self-mutilation in Borderline Personality Disorder

Joel Paris, MD

Self-mutilation is common in borderline personality disorder, but this pattern of behavior does not usually carry suicidal intent. Instead, it serves other functions, including regulation of dysphoric affect, communication of distress, expression of emotions, and coping with dissociative states. Multiple causal factors, including biological, psychological, and social risks, influence thresholds for self-mutilation. Management of this behavior can be informed by understanding its psychological functions. (HARV REV PSYCHIATRY 2005;13:179–185.)

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To examine the empirical and clinical literature on the origins of self-mutilation in borderline personality disorder (BPD), this review made use of both MEDLINE and PsycINFO databases, identifying all English articles between 1980 and 2004 containing one or more of the following keywords: self-mutilation, self-cutting, self-injury, or deliberate self-harm. Since the focus of the review was on patients with personality disorders, the search was limited to combinations of these keywords with either "personality disorder" or "borderline personality disorder." This procedure identified 113 publications, from which the review selected all empirical studies and systematic reviews (eliminating most case reports). These articles were then supplemented by relevant publications prior to 1980.

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DEFINING THE CLINICAL PROBLEM

There are many difficult aspects of managing BPD, but self-mutilation is one of the most challenging. These patients can be a source of worry when they cut, burn, or hurt themselves. This review will focus on the pattern seen in BPD: repetitive, nonlethal self-injury without intent to die.[1]

The literature has used multiple and somewhat confusing descriptive terms to describe this pattern. "Self-mutilation" has been defined by Favazza[2] as "the deliberate nonsuicidal destruction of one's body tissue." Two other terms—"self-injury"[3] and "self-injurious behavior"[4]—have similar meanings. "Deliberate self-harm," defined as "the intentional injuring of one's own body without apparent suicidal intent,"[5] while seemingly similar, has been used in research to describe both self-poisoning and self-injury, while excluding repetitive self-cutting.[6] The term "parasuicide," defined as "any nonfatal, self-injurious behavior with a clear intent to cause bodily harm or death,"[7] has also been used in a broader way. To maximize clarity, this review will confine itself to the terms "self-mutilation" and "self-injury."

Self-mutilation began to be discussed in the psychiatric literature only several decades ago, in a series of clinical reports and reviews[8–13] that described patients who repeatedly, but superficially, cut their wrists. Repeated self-mutilation has been found to be associated with serious psychopathology, most particularly mental retardation, schizophrenia, and personality disorders,[14–16] and it is especially common in BPD.[1]

Self-mutilation associated with major mental disorders needs to be distinguished from similar behaviors occurring in more normative or situational settings. Thus, self-mutilation has been documented in historical data, particularly in relation to religious practices.[17] It has also been described in community populations,[6,18,19] although such reports do not distinguish between occasional self-mutilation and repetitive behavior. Finally, self-injury has been described as being common among prison inmates with personality disorders;[20] it is not known whether this behavior continues after release from confinement.

FUNCTIONS OF SELF-MUTILATION IN BPD

Why do patients with BPD injure themselves? The crucial point is that the intent of self-mutilation is not necessarily "suicidal." In a study comparing 30 suicide attempters with cluster B personality disorders and a history of self-mutilation to a matched group of 23 suicide attempters with cluster B personality disorders and no history of self-mutilation, Stanley and colleagues[21] found that while self-mutilators were more chronically suicidal and more impulsive, most were aware that wrist cutting is not life threatening. Similarly, in a study of 75 BPD patients, Brown and colleagues[22] found that self-cutting was described as a means to relieve dysphoria, while overdosing was described as motivated by a need to escape difficult life situations. The independence of self-mutilation and suicidal intent in BPD patients is further supported by a five-year prospective follow-up of 37 borderline patients,[23] which found that changes in self-harm and suicide attempts over time were not correlated. Although about 10% of patients with BPD eventually end their lives by suicide, most completions occur late in the course of the illness.[24] Moreover, while "deliberate self-harm" (in general) is associated with higher rates of completion,[25] suicide is not predicted by self-mutilating behavior.[24] Thus, the term "suicidal" is not appropriate as a descriptor for self-mutilation.[26]

Although self-injury often lacks suicidal intent, it can perform other psychological functions, several of which have been suggested in the BPD literature. The first (and most often discussed) is that self-injury can provide relief from negative mood states.[27,28] Since self-mutilation tends to reduce dysphoria resulting from stressful life events, it can become a habitual method of dealing with psychological distress. In such cases the behavior comes to function like an addiction; Linehan[28] has suggested that this effect derives from its very success in reducing dysphoria. These mechanisms are not necessarily unique to patients with BPD and may not even be unique to humans; self-injury has been observed in other species as a response to stressful circumstances.[29]

Second, distraction is another mechanism by which self-mutilation can reduce distress in BPD. As described by Linehan,[28] physical injury tends to refocus the patient's attention away from mental pain to physical pain.

A third function of self-mutilation in BPD is that it can be used to communicate distress and obtain care from other people—significant others as well as therapists.[30,31] While many patients are initially secretive about self-injury,[32] the presence of visible scars or burn marks (particularly in the summer months) eventually tends to bring the behavior to the attention of other people.

A fourth potential function is that self-mutilation can be used to express emotions in a symbolic fashion.[26,27] Some patients describe cutting as a self-punishment related to guilty feelings or as a way of expressing anger that cannot be communicated in another way.[33]

A fifth function of self-mutilation derives from its connection with dissociative phenomena.[34–37] BPD patients may experience dissociation as dysphoric or may be in a dissociated state when they cut.[35] In this context, the sight of blood can remind patients that they are really alive. Scores on scales measuring dissociation are consistently higher in BPD patients who self-mutilate.[36,37] In these states of mind, cutting may not even be painful. Several studies have found that self-mutilators are relatively insensitive to pain,[38–42] a phenomenon that has been hypothesized to be related to the production of endogenous opioids.[1,43]

BPD PATIENTS WHO DO, AND DO NOT, SELF-MUTILATE

Self-mutilation is seen in about half of all patients with BPD.[36,43] We need to explain why only some patients with BPD injure themselves. Unfortunately, there have been only a few studies comparing patients with and without this behavior.

A first level of explanation is that patients with lower levels of functioning are more likely to self-mutilate. Self-injury in BPD has been shown to have a strong association with multiple comorbidities and illness severity.[44]

A second level of explanation derives from the relationship of self-mutilation to impulsive traits.[45,46] Affective instability and impulsivity have been seen as the primary traits underlying BPD.[47] Affective instability describes rapid shifts of moods in relation to environmental cues.[48] Linehan[28] applies a similar concept, emotion dysregulation, in which emotions are more intense and take longer to return to baseline. Affective instability is also found, however, in personality disordered patients who do not self-mutilate.[49] To understand the role of self-injury in BPD, one has also to consider the influence of impulsive traits. Although self-mutilation can sometimes be planned, the

tendency to use action to reduce inner distress is a key aspect of impulsivity[50]—a central characteristic of patients with BPD.[51,52]

In support of this mechanism, Simeon and colleagues[43] reported that self-injury in personality disorders is associated with overall high levels of impulsivity. This trait is one that has been shown to be heritable,[52] and impulsive behaviors, including self-mutilation, are associated with variations in neurobiological functioning, most particularly central serotonergic dysfunction.[53–55] For example, in a study comparing personality disordered patients who self-mutilated to those who did not, self-injury was associated with abnormal paroxetine binding.[43] Also, in a behavioral genetics study of personality dimensions in community and clinical populations,[56] self-harm emerged from factor analysis as a distinct trait dimension having a heritable component.

A third factor in self-mutilation derives from its relationship to life experiences, particularly childhood adversities. Self-mutilation in BPD is associated with a history of abuse in childhood,[57,58] and it has been suggested that self-injury might even be a marker for such abuse.[34] These associations can probably best be accounted for, however, by latent variables. Sexual abuse, physical abuse, and neglect are equally common in the childhood of patients with BPD who do not self-mutilate as in those who do.[34,57] Moreover, meta-analyses indicate that the relationship between childhood trauma and BPD is only of moderate strength.[59] While there is some relationship between traumatic histories and impulsivity,[60] the other key trait behind BPD, affective instability, lacks a strong relationship to trauma.[61] Finally, impulsive traits have been shown to be heritable.[62] Thus, the real association is most likely between childhood trauma and BPD, rather than with any specific symptom of the disorder.

A fourth possible explanation as to why some patients with BPD self-mutilate and others do not derives from the social environment—in particular, from learning (through imitation) of behaviors observed in other patients or in the media. Thus, patients who have not previously cut themselves may begin to do so after a hospital admission in which they have had the chance to observe such behavior.[14,63] This process, termed "social contagion,"[64] has been shown to influence the development of other impulsive disorders.[65]

CLINICAL IMPLICATIONS FOR MANAGING SELF-MUTILATION IN BPD

Self-mutilation is a troubling symptom, but understanding its functions for patients can help with management. Also, once therapists realize that self-injury does not usually carry a great risk for completed suicide, they can feel more comfortable treating patients in an outpatient setting.

This issue has not always been fully understood in the clinical community. Self-mutilation is one of the symptoms that often leads patients with BPD to be hospitalized.[66] Yet it makes little sense to hospitalize such patients in order to prevent them from committing suicide, if that is not the real purpose of their actions; although hospitalization can provide short-term relief for distress, doing so has little to do with safety. There are also problems with admissions that become repetitive, since responding consistently to self-injury with hospitalization can be reinforcing for some patients.[67] Instead, therapists might think of self-mutilation as an expectable part of the territory one traverses in treating patients with BPD. Finally, there is no evidence that hospitalization prevents suicide in this population, even among patients who seriously want to die.[67]

If one of the primary functions of self-injury is to reduce dysphoria, then therapy needs to identify the causes of that dysphoria and to help patients find better ways of dealing with emotions. These goals are the underpinnings of Linehan's[28] dialectical behavior therapy (DBT), which is specifically designed to target parasuicidal behaviors by improving emotion regulation. Controlled trials in several settings[68–70] have shown that self-mutilation in BPD can be reduced by DBT within a year of treatment, yielding results significantly better than treatment as usual. While other forms of cognitive-behavioral therapy (CBT) have been proposed for BPD,[71,72] they have not yet been subjected to empirical testing. In a randomized controlled trial, Tyrer and colleagues[73] found that manualized CBT was equivalent to treatment as usual for the treatment of recurrent "deliberate self-harm."

Other models, such as psychodynamically oriented outpatient therapy, might achieve many of the same results, as has been suggested by two meta-analyses.[74,75] There have been few empirical tests of psychodynamic therapy for patients with BPD, but findings from a randomized controlled trial of "mentalization-based treatment" (MBT), designed to reduce impulsive behaviors in BPD by increasing self-observation, have been encouraging.[76–78] MBT obtained a significant reduction in suicidal and parasuicidal behaviors within 18 months, as compared to treatment as usual. Although the main trial was conducted in the context of day treatment, preliminary evidence suggests that therapy is also effective in outpatient settings.[79] Finally, a recent comparative study of DBT versus "treatment by [BPD] experts," which showed some advantage for DBT in reducing overdoses, also showed that many forms of psychotherapy are effective in reducing self-mutilation.[80]

Self-mutilation has been a target not only for psychotherapy, but also for pharmacological interventions. A variety

of agents has been studied, including low-dose neuroleptics,[81–84] selective serotonin reuptake inhibitors (SSRIs),[85,86] mood stabilizers,[87–90] and naltrexone.[91] In a controlled study that focused specifically on the effects of SSRIs on self-mutilation, high doses were effective in many cases, but patients had difficulty tolerating side effects.[85] It is likely that these drugs work through a common mechanism, in that they all reduce levels of impulsivity.[92,93] Clinicians need to keep in mind, however, that while pharmacological agents can be helpful, one rarely sees remission in BPD.[93]

Above and beyond controlled clinical trials, practical methods for addressing self-mutilation in BPD have been suggested by experts working with this group of patients.[27,28,94] The general principles common to these approaches are consistent with existing research on self-injury in BPD.

First, one need be concerned, but not alarmed, when patients cut themselves. If patients who self-mutilate are distressed, therapists need to empathize with that distress. While being careful not to invalidate the patient's inner experience, a clinician's response to a patient's report of self-injury can be calm and neutral, using comments such as "you must have been very upset to have done that."

Second, therapy needs to focus on modifying the traits of affective instability and impulsivity that lie behind self-mutilation. Thus, to give up their addiction to cutting, patients need to stand outside their intense emotions and impulsive responses in order to modulate them. Therapists of all orientations[27,28,94,95] have recommended that clinicians understand and address the life events and emotions that have led to self-mutilation. Here the response can be: "Let's understand how this happened." Linehan[28] uses behavioral analysis to reconstruct the precipitants of episodes, and similar approaches have been described in other forms of therapy.[27] In the cognitive tradition, "decentering" has been developed for the management of impulsive symptoms in related conditions, such as bulimia nervosa.[96] Decentering involves teaching patients to observe their emotions rather than being taken over by them. This concept is similar to Bateman and Fonagy's[78] construct of "mentalization," which describes the ability to observe self and others accurately, even when emotions and impulses are strong.

Third, therapy can deal with more distal causes of self-mutilation, including patterns of maladaptive functioning rooted in schemas derived from early experience.[27,71] The evidence reviewed here does not support any simple correspondence between self-mutilation and specific childhood adversities. In line with the principles of developmental psychopathology,[97] this behavioral pattern is most likely an endpoint of many adversities, reflecting interactions between temperament, adult life experiences, and social influences.

Finally, any theory of self-mutilation needs to explain why it tends to be more frequent in younger patients with BPD, and then decreases over time.[93] Follow-up studies of patients with BPD[98–104] show that most recover, no longer meeting criteria for BPD; part of this process involves remission from self-injury. In some cases, the behavior stops at a much earlier stage.[103] It is notable that both psychotherapeutic[28] and psychopharmacological interventions[92] reduce self-mutilation, even before other symptoms remit.

These findings support a treatment plan in which BPD patients are managed symptomatically while working actively to make the recovery process proceed more rapidly.[93] Clinicians can also be reassured that however alarming the patterns of self-mutilation they treat, this behavior rarely continues over many years.

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EVOLUTION OF MILLON'S PERSONALITY PROTOTYPES

In 1969, Millon proposed 8 personality prototypes that could be conceptualized at lower levels of severity than the level of the personality disorders. These personalities were fit into a theoretical system that emphasized the strength of the interpersonal attachment and the mode of accommodation. Disorders such as schizophrenia

and depression were pictured as a decompensation of the basic personality. This article traces the evolution of Millon's theory from the original inception, through the influence of the 3rd and 4th editions of the Diagnostic and Statistical Manual of Mental Disorders, and onto its present form. Now visualized as resulting from 3 polarities, the model has expanded the number of personalities to include 3 additional prototypes.

Through a book entitled Modern Psychopathology (1969), Theodore Millon proposed a new classification for emotional or psychiatric disorders. The foundation of the system was made up of eight personality prototypes borrowed from the psychiatric nosology that was current at the time, the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II; American Psychiatric Association, 1952). The innovation was the way Millon described and conceptualized the eight prototypes in the 1969 book and in another book that followed shortly thereafter (Millon & Millon, 1974).

First, Millon (1969) wrote less pathological versions of personality disorders of the DSM-II, creating "personality patterns of mild severity" (p. 220). In each case, he set his descriptions to characterize three elements for each of the eight personality patterns: behaviors, self-perceptions, and intrapsychic processes.

Second, Millon fit his personality prototypes into a logical and coherent classification scheme. To organize the eight personality prototypes, Millon focused on the kind of interpersonal relationships that the individual typically established and the mode with which the person achieved his or her accommodation with the environment. As Figure 1 shows, Millon used the tendency toward interpersonal attachment or dominance to produce four different options (left column of the figure). Two modes of accommodation (active and passive) were added to each of the interpersonal choices to create the basis for the eight personality prototypes.

Although the concept of interpersonal styles is easily understood, the concept of the modes of adaptation is more elusive and merits an additional explanation. Adaptation to the environment can be seen as a process of changing those aspects we can change and accepting those aspects we cannot change. Millon proposed that individuals have a natural tendency toward one or the other of these two modes of adaptation. The proclivity of the personalities with the active mode is to attempt a change of the environment, whereas the inclination of the passive personalities is to adjust to the realities of the environment without change.

The reasons why different personalities use a particular mode of adaptation differ. The passive mode of the dependent personality, for instance, results from an individuals's belief that he or she is inferior and would not be personally able to make any significant changes in his or her environment. The passive mode of the narcissistic personality comes from the opposite belief, the conviction that he or she is so special that the individual does not need to make the effort it takes to alter the environment. The active mode of the histrionic personality is generated by the need to obtain attention from others, whereas the active mode of the antisocial is tied to the assumption that the world is a competitive setting where no one is totally trustworthy (Millon, 1995).

The third major innovation proposed by Millon in 1969 was the expansion of the eight basic personalities to take into account the level of dysfunction or severity. Millon believed that as the severity of the symptomatology increases, the distinctive flavor of the different personality styles is attenuated. As a result of this process, the distinction between the active and the passive mode becomes blurred, and the clinical picture of individuals with different personalities becomes less unique. Figure 2 shows this process in graphic form. The theory explained schizophrenia, bipolar affective disorder, and the paranoid delusional syndrome as decompensations of the individual's personality structure. These disorders were seen, as a result, as severe personality disorders. In other words, at the milder level, the inability to establish a relationship with others leads to a schizoid or avoidant personality. More extreme cases become more peculiar and fit the description of the

schizotypal personality. When the breakdown of interpersonal relationships is further exacerbated, the person develops the more severe psychopathology of schizophrenia or the complete dysfunction referred to by Millon as the terminal personality. The application of the same idea to the other styles led to the cycloid and paranoid personalities, as well as the cyclophrenic and the paraphrenic.

For the sake of completion it should be mentioned that, in addition to the personality disorders, Millon proposed three other groups of disorders in his classification system. The symptom disorders included anxiety, psychophysiologic, sociopathic, and psychotic disorders. Under pathological behavior reactions, Millon recognized transient situational reactions and circumscribed learned reactions. Finally, Millon used the label of biophysical defects to cluster disorders that are a direct result of brain dysfunction.

During the decade that followed the publication of his book, Millon was influential in the development of a new psychiatric classification system, the groundbreaking third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980). Although there were some differences between the Millon personalities and those of the DSM-III (Widiger & Sanderson, 1987; Widiger, Williams, Spitzer, & Frances, 1985), the conceptualizations of the personality prototypes in the two systems were generally compatible. The creation of multiple axes for the DSM-III, with one axis designed to hold the personality makeup of the individual, was loyal to Millon's separation of personality and other types of psychopathology. It is noteworthy, on the other hand, that the DSM-III did not visualize schizophrenia, bipolar affective disorder, or the paranoid delusional disorder as decompensations of the personality.

Continued efforts to improve psychiatric nosology soon led to a revision of the DSM-III. The possibility of including two additional personality disorders, the sadistic and the masochistic personalities, was widely discussed. These disorders were included in the appendix of the revised nosology, the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev. [DSM-III-R]; American Psychiatric Association, 1987). Eventually those disorders were voted down but not before Millon became convinced of the usefulness of the prototypes. To accommodate the new prototypes Millon added a discordant element to the detachment and dominance that had been used to characterize the different personalities in the previous version of the model. As with the other factors, the discordant element has a passive variant (the masochistic or self-defeating personality) and an active variant (the sadistic or aggressive; Millon, 1987).

In addition to the new prototypes, Millon revised some of his descriptions to increase the compatibility between the Millon personalities and those of the DSM-III (Millon, 1987). Most notably, the mood instability of the cycloid personality was deemphasized in favor of some of the elements introduced in the DSM-III as part of the borderline personality, such as the impulsive acting out. The name of this particular prototype was also changed to borderline.

Finally, an attempt was made during this period of time to fit all of the Millon prototypes into a circumplex. The resulting circle (Millon, 1987) used two dimensions to map all of the personalities. The affiliation dimension of the y axis offers autonomous and enmeshed as poles; the emotionality dimension is represented by the x axis with the attributes of impassive and expressive as extremes.

Further development took place when the possibility of adding a depressive personality disorder was discussed in preparation for the next revision of the DSM, the work that led to the fourth edition (DSM-IV; American Psychiatric Association, 1994). Although the prototype was eventually relinquished to the appendix of the DSM-IV as an entity in need of further study, Millon (1994) liked the concept and added this prototype to his list.

The next milestone in the development of Millon's (1990) creativity occurred when he expanded his theory to take evolutionary concepts into account. Millon's use of evolutionary concepts to complemen this theory is discussed in another article and goes beyond the scope of this effort. However, the ideas about evolution seemingly led him to reformulate the foundation of his personality styles (Millon, 1995).

Millon now uses three polarities (see Figure 3) to explain the basic differences between his personality prototypes. One of these polarities, the adaptation mode polarity (active-passive), was already described. The replication strategy polarity (self-other) contrasts the drive toward self-actualization with the need to have regard for others. Personalities emphasizing the self (the narcissistic and the antisocial) are confident and assertive, and seem to have their own ideas on how to conduct their lives. In contrast, the personalities emphasizing others (the dependent and the histrionic) rely on other people for meeting their needs and are invested in the welfare of others.

The third polarity is the survival aim polarity, contrasting the pursuit of pleasure to the avoidance of pain. According to Millon (1995), some personality styles strive to enhance life, seeking new experiences and pursuing pleasure and fulfillment. People with these personalities (e.g., narcissistics, histrionics, antisocials) seek more than life preservation. In contrast, other personalities (e.g., avoidant, compulsive) emphasize the avoidance of danger above everything else, even at the expense of constricting their existence.

A personality prototype may be strong, weak, or neutral in any particular element of any of the polarities. Being strong on a particular element of a polarity does not imply a good attribute, but simply indicates a tendency toward some style of behavior.

Using the three sets of polarities, Millon was able to characterize each of the personality prototypes. The schizoid personality, for instance, is strong in the passive polarity but it is weak in the pleasure, the pain, and the other polarity. As Figure 4 illustrates, however, the mapping becomes quite complex. Millon (1995) simplified that complexity by emphasizing the polarity of greatest deficiency in grouping the personality prototypes, as shown in Figure 5.

As in 1969, Millon currently proposes severity as another variable. Borrowing concepts from Kernberg's (1984) work on personality dysfunction, Millon now discusses the personality structure. The level of severity that was labeled borderline in 1969 is now referred to as involving a defective personality structure; progressively higher levels of dysfunction are characterized as reflecting a decompensated or a terminal personality structure. Figure 6 offers the mapping of the current Millon personalities at the four levels of dysfunction.

Although Millon still feels that personalities can decompensate into a schizophrenic-like disorder, now that disorder is labeled decompensated schizotypal instead of schizophrenia. The decompensated disorders can further decay into the terminal disorder, as had been proposed earlier. The idea that personality disorders can evolve into an affective disorder has been abandoned. The other change is the recognition that the avoidant, narcissistic, and antisocial personalities can decompensate into a borderline personality disorder (Millon, 1995).

Millon's personality prototypes have both a categorical and a dimensional nature. The dimensional aspect allows us to conceptualize an individual as being stronger or weaker in any of the categorical dimensions. Thus, even when two persons are both histrionic, the two of them may be differentiated if one is more histrionic than the other. Additionally, real-life people often demonstrate more than one of the personality prototypes. The person who is mostly compulsive but also has avoidant elements will appear noticeably different from the person who combines the compulsive and the negativistic prototypes.

Descriptions of personality profiles that take into account more than one personality have been used to interpret the self-report inventories based on Millon's theory (see Choca & Van Denburg, 1997; Craig, 1993). Using that kind of information, Millon recently expanded his descriptions to characterize subtypes of the different prototypes. Among schizoid individuals, for instance, Millon discusses an affectless schizoid who--in addition to being schizoid--is compulsive, or a remote schizoid who is both schizoid and avoidant. Whether the person is an amorous, unprincipled, or compensatory narcissist depends on whether histrionic, antisocial, or negativistic elements accompany the narcissistic traits. The latest edition of Millon's (1995) book on personality disorders recognizes 61 such subtypes.

Finally, Millon refined his characterization of the different prototypes into clinical domains that address four different levels: the behavioral, phenomenological, intrapsychic, and biophysical levels. Functional and structural aspects may be recognized in any of the four levels. As depicted in Table 1, these clinical domains address all of the areas required for the characterization of the antisocial prototype.

This article summarized the gains in depth and complexity that the Millon model has made during the 30 years it has been in existence. The addition of evolutionary concepts has enriched greatly what the theory had to offer. In achieving that gain, the theory lost some of the simplicity of the original model. The current system of polarities is so intricate that few practitioners may have enough of a command of the system to be able to use the polarities productively. Perhaps that is the fate of any psychological theory as it matures in its attempt to reflect the complex intricacies of human nature.

Viewing the developments of the Millon theory from the perspective of the DSM, there are some areas that have gained consonance, whereas other areas seem more divergent. An example of the former has been the abandonment of the idea that affective disorders (the cycloid personality, cyclophrenia) represent dysfunctional aspects of the personality. On the other hand, Millon's model has acquired three personality prototypes that are not recognized by the official nosology. It should be obvious, however, that the official nosology is itself unstable and transitional.

As Hirschfeld (1993) eloquently pointed out, there is no way to define what is currently included under Axis II of the DSM. If this axis is eventually defined as containing the lifelong tendencies of the individual, then Millon's additional prototypes and the concept of decompensated personality disorders may very well guide further developments in the field. I would favor including only personality styles on Axis II, prototypes that are commonly seen in a nonpsychiatric population and that are not, in and of themselves, pathological. If we were to take that direction, it would be Millon's original breakthrough and his 1969 creation of patterns of mild severity that will be most useful to us.

In terms of empirical support for Millon's model, factorial studies have shown that the Millon personality prototypes emerge nicely from the items included in the second and third editions of the Millon Clinical Multiaxial Inventory (Choca, 1997; Choca, Retzlaff, Strack, Mouton, & Van Denburg, 1996). No one has been able to show, however, that higher order factors resembling the Millon polarities are part of the structure of any of his tests. Millon (1998) explained that his theory is not a factorial theory and that his personality prototypes do not have the orthogonal type of structure that can emerge nicely from factor analytic studies. Future research, however, must find a way of validating his concepts if the theory is to be seen as more than some interesting ideas.

TABLE 1 Clinical Domains of the Antisocial Personality Prototype (Millon, 1995)

Legend for Chart: