

Suggested APA style reference:

Sperry, L. (2008, March). *Identifying and managing the personality-disordered client in everyday counseling practice*. Based on a program presented at the ACA Annual Conference & Exhibition, Honolulu, HI. Retrieved June 27, 2008, from <http://counselingoutfitters.com/vistas/vistas08/Sperry.htm>

Identifying and Managing the Personality-Disordered Client in Everyday Counseling Practice

Len T. Sperry

Florida Atlantic University.

Sperry, Len T. is Professor of Mental Health Counseling at Florida Atlantic University. He is the author of *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders, 2ed* and *Cognitive Behavior Therapy of DSM-IV-TR-Personality Disorders, 2ed*.

Based on a program presented at the ACA Annual Conference & Exhibition, March 26-30, 2008, Honolulu, HI.

Clients with personality disorders can present significant challenges in counseling practice. Personality disorders are persistent patterns of personality that have become inflexible and maladaptive patterns of perceiving, thinking, feeling and acting. While it is theoretically possible, but very difficult, to change personality dynamics in short-term counseling, it is more realistic and easier to “manage” them. To work effectively in such counseling contexts, counselors must be able to quickly identifying personality-disordered patterns and then implement interventions that manage them so that short-term goals can be achieved. This paper describes a diagnostic strategy for rapidly identifying personality disorders and an effective intervention strategy for managing or *indirectly* changing personality-disordered cognitions and behaviors. Case material illustrates this

second strategy.

Identifying Personality Disorders

There are two dimensions that are helpful in identifying personality disorders. The first dimension involves core features. While healthy, adaptive personality patterns reflect responsibility, cooperativeness, and self-transcendence—all ‘markers’ of social interest, less healthy and maladaptive personality patterns are characterized by irresponsibility, lack of cooperation, and self-interest. Thus, the presence of irresponsibility, lack of cooperation, and self-interest are the core features of all personality disorders. Cloninger (2000) make a convincing case for the centrality of the core features of personality disorders.

The second dimension reflects the unique presentation and specific DSM criteria for specific personality disorders. This dimension involves activity level and movement. Millon and Everly (1985) has proposed a useful model for conceptualizing this dimension of personality disorders. The model is based on basic elements of Adler’s (1956) personality typologies, i.e., levels of activity: active vs. passive and movement: toward (dependent), away from (detached), against (independent), toward and against (ambivalent). By combining these basic elements eight basic personality styles—and related personality disorders- can be derived. These are: the antisocial personality (active–independent); the histrionic personality (active–dependent); the passive-aggressive personality (active–ambivalent); the avoidant personality (active-detached); the narcissistic personality (passive-independent); the dependent personality (passive-dependent); the obsessive-compulsive personality (passive–ambivalent); and the schizoid personality (passive–detached). Millon (1984) considers the borderline, schizotypal, and paranoid personalities to be pathological extensions of the various eight basic styles. For example, the borderline personality represents a pathological or decompensated extension of the histrionic, dependent, or the passive-aggressive personality, while the paranoid personality is the pathological extension of the antisocial, narcissistic or obsessive-compulsive personalities. It is important to note that movement and activity level reflect an individual personality style. It is only when this style is habitually maladaptive and inflexible, i.e., marked by irresponsibility, lack of cooperation, and self-interest, that personality style is considered disordered.

So, how can this conceptual approach be used in everyday clinical practice? First, the counselor gathers information about the core features. It takes only a short time, about five minutes, to elicit the presence or absence of responsibility, cooperativeness and self-transcendence in an individual’s life history. Second, irrespective of whether these core features of a personality disorder are noted, the clinician then considers both the individual’s relational movement and activity level. For example, if the individual has a history of characteristically moving toward others in an active fashion, the histrionic personality disorder is likely. The final step is to consider the extent to which the individual meets the formal DSM criteria for histrionic personality disorder and then

specify the diagnosis, if warranted. Obviously, if the initial inquiry indicates that the individual exhibits social interest, i.e., is responsible and cooperative, the histrionic personality style rather than the personality disorder would be correctly identified.

Managing the Personality-Disordered Client

Direct vs. Indirect Change Strategies

It has long been assumed that real change in the lives of personality-disordered individuals only occurs when personality structure or core beliefs and schemas are *directly* addressed and changed. The basic direct change strategy or equation in psychodynamic psychotherapy involves four processes: clarification, confrontation, interpretation, and working through leading to insight and subsequent behavior change (Greenson, 1967). The basic direct change strategy in conventional Cognitive Therapy (CT) and CBT is very similar to the psychodynamic equation except that cognitive restructuring “replaces” interpretation. In psychodynamic psychotherapy the “working through,” process involves the repetitive and incremental exploration and interpretation of resistances that prevent intellectual and emotional insight from leading to increased functioning, while in CT and CBT it refers to the progressive “chipping away” of maladaptive elements of core beliefs and schemas. For example, the process of “working through” of the core belief: “I have always been inadequate and have never felt worthless” involves the incremental modification of that belief to a point that it is more realistic and adaptive, i.e., “I am basically adequate and worthwhile, although sometimes I may not feel or act as if I am.” Achieving such major changes in personality structure and schemas is often time intensive, demanding, and difficult, particularly with personality-disordered individuals. Such change may require three or more years of intensive treatment for clients who are fully engaged in the treatment process and are highly motivated (Gunderson, Gratz, Neuhau, & Smith, 2005). Because of such stringent requirements, it may be more realistic to “manage,” i.e., *indirectly* address such personality structures and schemas rather than directly address them. Such an indirect change strategy is less intensive and much less threatening to the client. As a result there is considerably less resistance. In place of “working through” and interpreting resistances or restructuring core beliefs, this indirect strategy “works around” these instead. In CT and CBT terms this means focusing on automatic and intermediate beliefs in the here-and-now rather than directly confronting and changing core beliefs and schemas formed in early life. In addition, such an indirect change strategy is well suited for brief counseling encounters.

An Indirect Change Strategy

Cognitive Behavior Analysis System of Psychotherapy (CBASP) is an indirect change strategy. CBASP is a form of CBT that was developed by McCullough (2000) that combines behavioral, cognitive and interpersonal methods to help clients focus on the consequences of their behavior and to use problem solving for resolving both personal

and interpersonal difficulties. CBASP was initially targeted for the treatment of clients with chronic depression, one of the most treatment-resistant mental conditions. A national, multi-site study found CBASP to be a more effective treatment than conventional CBT or medication (Keller, et al, 2000).

The basic strategy of CBASP involves a situational analysis wherein clients discover why they did not obtain a desired outcome by evaluating thoughts and behaviors which interfere with achieving what they wanted. Because there is often a mismatch between what personality-disordered clients want and what actually occurs in their lives, CBASP has proven effective in managing all of the personality disorders, including borderline personality disorder (Driscoll, Cukrowicz, Reardon, & Joiner, 2004).

There are two phases in CBASP treatment: elicitation and remediation. The elicitation phase consists of 6 steps which are framed by specific questions:: How would you describe the situation? How did you interpret the situation? Specifically, what did you do and what did you say? What did you want to get out of the situation, i.e., what was your desired outcome? What was the actual outcome of this situation? And, finally: Did you get what you wanted?

During the remediation phase, behaviors and interpretations or cognitions are targeted for changed and revised so that the client's new behaviors and cognitions will contribute and result in their desired outcome. First, each of the client's interpretations of the situation is assessed to determine whether it helped or hindered the achievement of the desired outcome. Next, each of the client's behaviors is similarly analyzed to determine whether or not it helped or hindered in the attainment of the desired outcome.

Essentially, CT and other CBTs are direct change strategies in which core maladaptive beliefs and schemas are modified through cognitive restructuring, while CBASP is an indirect strategy that replacing problematic behaviors and intermediate-level beliefs with more helpful behaviors and beliefs. In CT and other CBTs the counselor' role is to engage clients in actively confronting their core schemas. In CBASP the counselor' role is to gently inquire about whether specific behaviors and thoughts help or hurt the clients in getting what they want. Not surprisingly, clients experience this process as considerably less therapist directive and less threatening. Since personality-disordered individuals tend to resist others' efforts to change them, they are less likely to resist this strategy. The following case example and transcription describes this intervention.

Case Illustration

Jenny is an 18 year old single male college student with debilitating social anxiety. She meets DSM-IV-TR criteria for Avoidant Personality Disorder as well Social Phobia. While she can tolerate most solitary and family activities, she experiences a considerable anxiety in situations which involve activities involving "outsiders"--her reference to others she does not know well--such as those in her classes, her dormitory and in other

social situations. Being around others has been since childhood but has increased since she has been away from home. Because she was home schooled by her mother she has had minimal contact with others until leaving for college. She is being seen in short-term counseling at the University Counseling Center and has a contract for 15 sessions. In her third session she agreed to a between session assignment to make eye contact and greet someone on campus that she had not met before. Here is a short excerpt from that session in which Jenny describes what happened.

Client: I went to the university bookstore the other day, and when I was going through the checkout line, I said hello to the cashier and asked her how she was doing.

Therapist: What were your interpretations or thoughts when you were in that situation?

Client: One of my thoughts was "I'm not normal because I am here alone."

Therapist: Okay. So one of your interpretations in this situation was "I'm not normal because I am here alone." and your SUDS rating for this thought was 85. This seems to be a good interpretation for us to focus on. What were your behaviors in that situation?

Client: While I was trying to talk, I kept my head down the entire time and looked at the floor, except when I looked at her and made eye contact. So I said "hi" and asked her how she was doing. It probably was barely audible.

Therapist: Did the cashier respond?

Client: Yes. She said she was doing fine. But then I couldn't think of anything else to say and then I looked down and didn't say anything else.

Therapist: So your behaviors in this situation were to keep your head down and look at the floor and not to talk to anyone except when you greeted the cashier. O.K. So, what outcome did you expect?

Client: To get some things at the bookstore and make eye and greet someone without being too anxious.

Therapist: What actually happened?

Client: I was able to make eye contact with the cashier and ask her how she was doing but I was really nervous and uncomfortable.

Therapist: Did you achieve what you were hoping to?

Client: Sort of. I was able to look at the cashier and ask her how she was doing. But I still

experienced a lot of anxiety and I couldn't think of anything else to say to her.

Therapist: Good. Let's go back through your interpretations to see which ones were helpful and hurtful to you in getting your expected outcome of making eye contact with someone and greeting the person, while tolerating any anxiety. Your first interpretation was, "I am not normal because I am here alone." Do you think that thought was helpful or hurtful to you in this situation?

Client: Hurtful.

Therapist: Why?

Client: Because I kept my head down and didn't speak to anyone because they would look at me and think I was weird because I was alone and because I was talking to them.

Therapist: Can you think of any thoughts, then, that you could replace the hurtful thought with that would be helpful to you in this situation?

Client: I am normal.

Therapist: Good. How do you think that would have helped you?

Client: Well, if I kept telling myself that I was normal and was not weird for being there alone, and that it's okay to feel anxious, I may have been more likely to have kept my head up and made eye contact with someone. I probably would have been more likely to say hello to someone.

Therapist: So your interpretation "I am not normal because I am here alone" was hurtful to you because it made you keep your head down and not speak to anyone while you were in the bookstore, except when you spoke to the cashier, and then you still experienced a lot of anxiety, which made you feel more uncomfortable. If you replaced that interpretation, then, with "I am normal and I am not weird for being here alone, and it's okay to feel anxious" you would have experienced less anxiety or been more accepting of it, and you would have been more likely to keep your head up and speak to others. Is that right?

Client: Yes.

Therapist: Then let's move on to your behaviors. One of your behaviors in this situation was to keep your head down the entire time, except when you made eye contact with the cashier. Do you think this was helpful or hurtful to you in achieving your desired outcome?

Client: Hurtful. I probably would have been more likely to make eye contact with other

people and maybe even say hi if I didn't look down the entire time.

Therapist: But you were able to make eye contact and speak to the cashier. How was it hurtful, then?

Client: While I was looking at the ground, I just kept thinking about how I wasn't normal and that I just wanted to leave. If I had my head up and looked at other people, I might have been distracted and not thought those things over and over again.

Therapist: So, what behavior would have been helpful to you in this situation?

Client: To keep my head up. I probably wouldn't have thought negatively as much and would have been more likely to make eye contact with others and to even speak to people in the grocery store.

Therapist: So in this situation, if you would have thought to yourself "I am normal and I am not weird for being here alone, and it's okay to feel anxiety" instead of, "I am not normal because I am here alone, and I shouldn't feel anxiety," and if you would have kept your head up instead of looking at the ground the entire time you would have been more likely to get your entire DO, which was to make eye contact and greet someone while feeling less anxiety and better tolerating the anxiety you did feel, right?

Client: Yes.

Case Commentary

Utilizing this strategy, the counselor was able to therapeutically process one or two problematic situations per session while following up on Jenny's between session assignments. Progress was noted and the emphasis in the next three sessions was on relating to others in Jenny's immediate environment. By the seventh session Jenny was feeling more comfortable being around others in her dorm and classes. In the subsequent eight sessions the focus was on dating and relational behavior. In a review of progress during the fifteenth session, Jenny and the counselor agreed that she was considerably and more able to relate to others with considerably less anxiety. While she still manifested avoidant behavior in some situations, she no longer met criteria for either Social Phobia or Avoidant Personality Disorder. The counseling contract was renewed for 10 more weekly sessions, until the end of the academic year.

It should be noted that Jenny was able to identify and process both behaviors and interpretations in this as well as subsequent sessions. Had she been more severely disordered, the CBASP strategy might have been modified at the outset, i.e., her counselor might have emphasized only overt behaviors initially, whereas more focus on interpretations is possible with less disordered individuals earlier in the treatment process.

(Driscoll, Cukrowicz, Reardon, & Joiner, 2004).

Concluding Note

This paper has described strategies for identifying personality disorders and indirectly changing or managing them. The indirect strategy described here is effective in short-term, even single session, counseling encounters with personality-disordered behaviors.

This indirect change strategy can also be utilized in longer term counseling for reducing client treatment-interfering behaviors, distress, and impaired functioning. Furthermore, it can also be utilized in conjunction with cognitive restructuring, interpretation, and other personality change strategies.

References

- Adler, A. (1956). The individual psychology of Alfred Adler. H. Ansbacher & R. Ansbacher (Eds.). New York: Harper & Row.
- Cloninger C.R. (2000). A practical way to diagnosis of personality disorders: A proposal. *Journal of Personality Disorders, 14*, 99-108.
- Driscoll, K., Cukrowicz, K., Reardon, M. & Joiner, T. (2004). *Simple treatments for complex problems: A flexible cognitive behavior analysis system approach to psychotherapy*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Gunderson, J., Gratz, K., Neuhaus, E., & Smith, G. (2005). Levels of care in treatment. In J. Oldham, A. Skodol, & D. Bender (eds.). *The American Psychiatric Publishing textbook of personality disorders*. pp. 239-256. Washington, DC: American Psychiatric Publishing.
- Greenson, R. (1967). *The technique and practice of psychoanalysis. Vol. 1*. New York: International Universities Press.
- McCullough, J. (2000). *Treatment for chronic depression: Cognitive behavioral analysis system of psychotherapy*. New York: Guilford.
- Millon, T. & Everly, G. (1985). *Personality and its disorders: A biosocial learning approach*. New York: Wiley.
- Sperry, L. (2002). From psychopathology to transformation: Retrieving the developmental focus in psychotherapy. *Journal of Individual Psychology, 58*, 398-421.
- Sperry, L. (2003). *Handbook of the diagnosis and treatment of DSM-IV-TR personality*

disorders. Second edition. New York: Brunner-Routledge.

Sperry, L. (2006). *Cognitive behavior therapy of DSM-IV-TR personality disorders: Highly effective interventions for the most common personality disorders. Second edition.* New York: Routledge.

VISTAS 2008 Online

As an online only acceptance, this paper is presented as submitted by the author(s). Authors bear responsibility for missing or incorrect information.