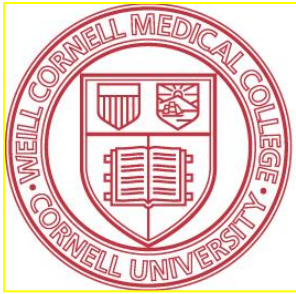


Weill Cornell Medical College

Clinical Assessment Strategies for Personality Pathology

John F. Clarkin, PhD

Build on Yesterday; Link to Specialized Treatments Today

- Yesterday:
  - Lee Anna Clark: Importance of severity ratings of domains of dysfunction
  - Paul Moran: The predictive power of simple ratings of mild, moderate and severe personality dysfunction
  - Raises the questions for the clinicians: mild, moderate, severe in what domains of functioning? How to assess these domains? Clinicians don't treat "traits" but behaviors and attitudes in particular settings in their lives
- Today:
  - Clinical assessment of the patient as a link to a specialized (DBT, Schema) or integrated treatment or structured clinical management

Centrality and Importance of Assessment (Wright & Zimmermann, 2015)

- "Rigorous science and effective treatment both rest on a foundation of valid and reliable assessment and diagnosis."
- "In the consulting room, assessment and diagnosis should provide useful information for clear communication among professionals and to patients, establishing prognosis and ultimately deciding whether and, if so, how to treat."
- "Patients with severe PDs often lead chaotic lives and have a fragmented or diffuse sense of self that can become embodied in a frenzied assessment process and a muddled clinical picture."

PERSONALITY TRAITS AND FUNCTIONING

Two Dominant Approaches to PERSONALITY in Psychology

- Dispositional or trait theory approach: goal is to characterize people in terms of a comprehensive but small set of stable behavioral dispositions
- Processing approach: personality as a system of mediating units (expectancies, goals, motives) and psychological processes (cognitive-affective units) that interact with the situation

Mischel & Shoda, 1999

Trait Theory

- Traits are conceptualized as enduring dispositions that express themselves in relatively consistent ways across contexts and time, providing the building blocks of personality (McCrae & Costa, 1997)
- Traits in DSM-5, section III are based on the Five Factor Model modified to capture severity: negative affectivity, detachment, disinhibition, antagonism, and psychoticism
- However, none of the major empirically supported treatments for personality disorder target pathological trait dimensions as their primary mechanisms of change
- Trait dimensions must be understood in their superordinate cognitive-affective representational structures that influence the expression of those traits in the specific environment of the patient (Meehan & Clarkin, 2015)

Cognitive-Affective Processing System (CAPS) (Mischel, 2004)

- The personality system contains mental representations (cognitive-affective units) whose activation leads to behavioral consistencies that characterize the person
- These cognitive affective units include the person's representations of the self, others, situations, and enduring goals, expectations and beliefs, feeling states, and memories of people and past events
- Individuals differ stably in this network of interconnections or associations. Differences in the chronic accessibility of the CAUs and in the distinctive organization of interrelationships among them
- Personality components do not operate in isolation, but organized hierarchically in terms of their importance for the functioning and priorities and goals of the person as a whole

CAPS Model of Personality

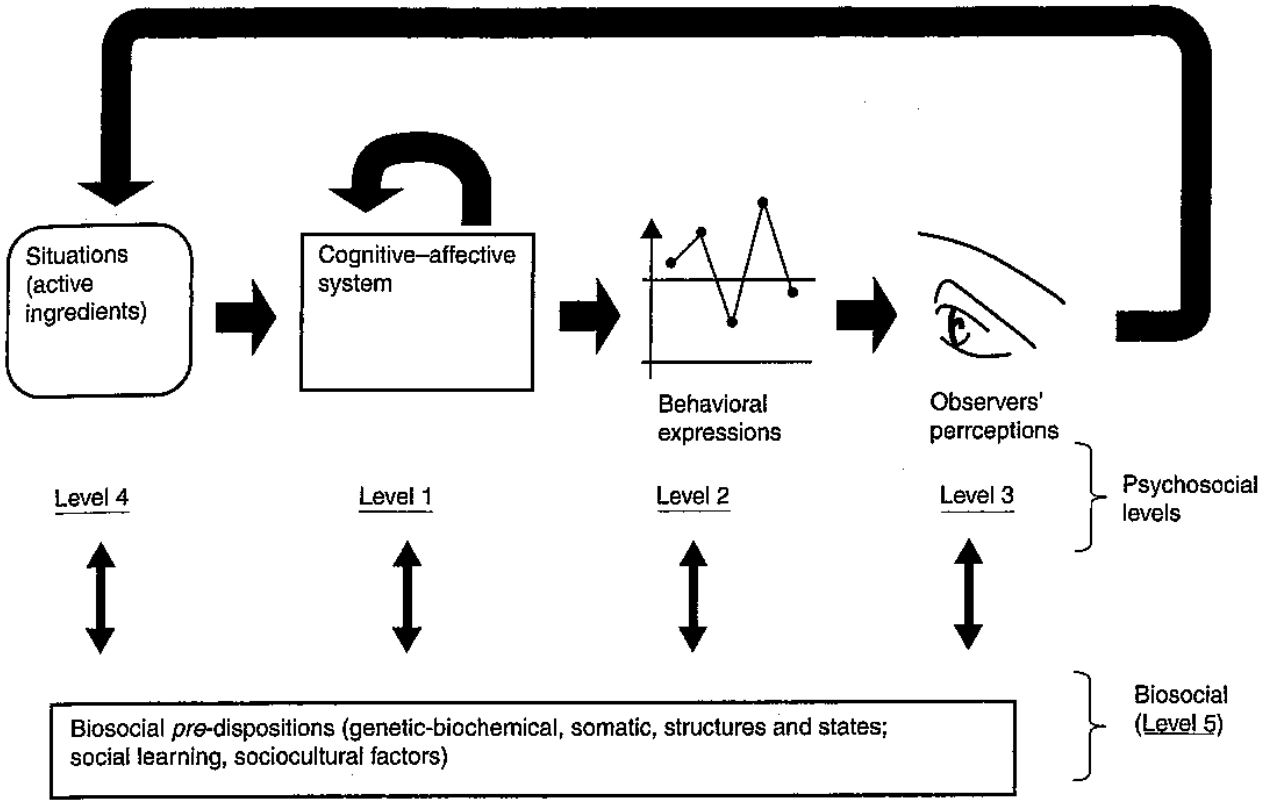


FIGURE 7.4. Personality stability and invariance: Five levels of analysis. From Mischel and Shoda (1995, p. 262). Copyright 1995 by the American Psychological Association. Adapted by permission.

Route to Finding Invariance in Personality

- Find invariance in personality by taking into account the situation and its meaning for the individual
- The invariance can be seen in the stable interactions and interplay between them
- Research shows that:
  - behaviors are highly variable across different situations
  - Individuals show temporal stability in their behavior within particular situations
- The pattern of variability from one type of situation to another is not random

Assessment of Personality/Pathology Influenced by CAPS Theory (Mischel & Shoda, 1999)

- Organized pattern and sequence of activation of cognitive-affective mental representations
- Behavioral expressions of individual's processing
- Perceptions of self across situations
- Particular environments the individual seeks out and constructs

Normal Personality (Kernberg, 2004)

- Personality is the dynamic integration of all the behavior patterns derived from temperament, character, internalized value systems, and cognitive capacity.
- Normal personality is characterized by:
  - Integrated concept of the self and an integrated concept of significant others
  - A broad spectrum of affect dispositions, capacity for affect and impulse control, and capacity for investment in work and values
  - Integrated and mature superego
  - Appropriate and satisfactory management of libidinal and aggressive drives

Normal Personality
(Pankseep & Bavin, 2012)

- Mammalian brain has at least 7 affective systems
- “Regulation of RAGE, developing the capacity to counteract PANIC/GRIEF (by forming warm social attachments), negotiating FEAR adaptively, enjoying a capacity for PLAY, fulfilling one’s LUSTful strivings gracefully, and approaching life with optimistic anticipation, compassion, and forgiveness are essential elements for good mental health.” (Pankseep & Bavin, 2012, p 92)

APPROACHES TO PERSONALITY PATHOLOGY

Personality Pathology: DSM 5

- Definition of personality disorder:
  - An enduring pattern of inner experience and behavior (cognition, affectivity, interpersonal functioning, impulse control) that deviates markedly from expectations in the culture
  - Enduring pattern is inflexible and pervasive
  - Enduring pattern leads to significant distress or impairment in social, occupational functioning
  - The pattern is stable and of long duration
- Ten categorical diagnoses and NOS

Limitations of the Categorical Approach to Personality Disorder

- Enormous heterogeneity among individuals with the same categorical diagnosis
  - Dissimilar symptom pictures
  - Dissimilar trait features
  - Within individual heterogeneity

Empirical Evidence Does Not Support the 10 Category Structure of DSM 5

- A review of multiple factor analytic studies of DSM-IV PD at the criterion level do not replicate the categorical structure of DSM (Wright & Zimmermann, 2015)
- The only PDs that were replicated across studies as coherent latent dimensions were Obsessive-Compulsive and Schizotypal PD
- Across studies BPD criteria were interrelated with criteria from every other PD
- Borderline symptoms are at the core of personality pathology rather than expressing a specific content domain (Turkheimer, Ford, & Oltmanns, 2008)

General and Specific Factors in Personality Pathology (Sharp, Wright, Fowler, et al, 2015)

- Literature fails to support the DSM's putative structure of six distinct personality disorders
- Growing interest in models that evaluate general factors that account for both common variance shared across diagnoses and unique sources of variance that may represent more specific forms of psychopathology
- These authors tested the latter idea with a bifactor model on N=966 inpatient adults

General and Specific Factors (Sharp et al, 2015)

- Clear specific factors with strong average loadings emerged for three PD types: antisocial, schizotypal, and narcissistic
- BPD items loaded most strongly on the general factor

General Factor Items (Sharp et al. 2015)

Identity disturbance (BPD)	Failure to conform (ASPD)
Affective instability (BPD)	Deceitfulness (ASPD)
Empty (BPD)	Impulsivity (ASPD)
Self-harming impulsivity (BPD)	Social anxiety (SZTPD)
Interpersonal instability (BPD)	Needs admiration (NPD)
Suicidality (BPD)	Envious (NPD)
Avoids abandonment (BPD)	Preoccupied with rejection (AVPD)
Intense anger (BPD)	Must be liked (AVPD)
Transient dissociation (BPD)	Views self as inept (AVPD)
Disregard for safety (ASPD)	No risks or new activities (AVPD)

Interpretation

- Personality pathology is composed of a general factor that captures common variance in diverse expressions of personality pathology
- Like stated in DSM-5, Section III, personality pathology involves problems in self-functioning and in interpersonal functioning
- Another possibility is that the general factors represents “severity”
- Both are compatible with Kernberg’s formulation of PD pathology along a severity continuum with the quality of an individual’s mental representation of self and others (object relations) as a central component of this continuum.

DSM-5 Section III
Beutler's Empirical Approach
Linehan's Continuing Assessment
Assessment of Mentalization
Object Relations Theory and Crucial Dimensions

REVIEW OF REPRESENTATIVE ASSESSMENT SYSTEMS

1. DSM-5, Section III: General Criteria for Personality disorder

- A. Moderate or greater impairment in self/interpersonal functioning
- B. One or more pathological personality traits
- C. Inflexible and pervasive
- D. Relatively stable across time
- E. Not better explained by other disorders
- F. Not attributable to physiological effects (drugs, other)
- G. Not better understood as normal for stage of development or environment

Criterion a: Rating of Self Functioning

Identity	Self-Direction
Awareness of unique self	Reasonable self goals
Relatively intact sense of self	Inhibited or conflicted about goals
Depends on others for identity; vulnerable self esteem	Goals are means to gain approval; goals too high
Lack of identity; emptiness; sense of despair	Difficulty establishing or achieving goals

Criterion a: Rating of Interpersonal Functioning

Empathy	Intimacy
Accurately understands others; aware of own impact on others	Multiple satisfying and enduring relationships; strives for cooperation
Compromised in ability to appreciate others	Some limitation on depth and satisfaction in relationships
Excessively self-referential; unaware or unconcerned about self effect on others	Connections largely superficial; cooperates for personal gain
Limited in understanding others; unaware of own impact on others	Capacity for lasting and positive relations impaired; experiences fear and rejection in intimate relations

Criterion B: Personality Traits

- Negative affectivity
- Detachment
- Antagonism
- Disinhibition
- Psychoticism

Limitations to the Diagnostic System

- Neither DSM-5 nor ICD-10/11 provides sufficient information to articulate a treatment plan for the individual patient
- What additional information is necessary to devise a treatment plan, i.e., level of care, foci of intervention, sequence of change, treatment strategies and techniques needed for change

Centrality of Self and Other Functioning

- DSM-5 is not the leader, but is catching up in recognizing the centrality of self and other functioning in personality and its disorders
- The centrality of self and other functioning has long been recognized in object relations theory (Kernberg, 1984)
- Social neurocognitive science (Frith & Frith, 2007) is exploding with new information about the neurobiological systems involved in self and other interaction (Lieberman, 2007)

2. Systematic Treatment Selection: Importance of Non-Diagnostic Factors (Beutler & Groth-Marnat, 2003)

- By extensive review of treatment literature, Beutler et al have isolated:
  - Four key (non-diagnostic) patient variables: functional impairment, coping style (internalizing vs. externalizing), trait like reactance (resist or accept external influence), and subjective distress
  - Six treatment dimensions: intensity, format, mode, focus (insight vs. symptom focus), therapist directiveness, affect regulation
- Fit between patient variables and treatment dimensions leads to therapeutic alliance and change;
  - e.g., therapist adjusts level of directiveness and guidance to the patient's ability to tolerate external influence (resistance level)
  - Use of symptom removal and/or insight related interventions corresponds to how patient acquires and adapts to new information (coping style)

3. DBT: Continuing Assessment With Diary Card (Linehan, 2015)

- Standard assessment (assess patient difficulties, determine treatment intensity and type, orient to skills training, developing collaborative commitment, and developing treatment alliance)
- Most distinctive: use of a diary card focuses the patient on self-destructive behaviors that are foci of intervention and use of skills learned in the therapy
- The patient who uses the diary card is pulled into a detailed focus on selected behaviors and when they occur
- The examination of the diary card between patient and therapist allows a collaborative attention to the problem events

4. Assessment in Mentalization Based Treatment (MBT)

- Mentalization:
- In the clinical interview, the assessor can probe for the patient's ability to mentalize in four polarities (Luyten et al, 2012):
  - Ability to perceive and self-correct initial impressions based on external appearances
  - Ability to integrate knowledge about self and others without undue focus on self
  - Ability to integrate both cognitive and affective knowledge of self and others
  - Ability to mentalize in both stressful and non-stressful conditions

5. Object Relations Theory: Levels of Personality Organization (Kernberg & Caligor, 2005)

- Personality pathology is conceptualized as a combination of categorical types (e.g., borderline, narcissistic) on a continuum of severity.
- Organization of the personality is seen as having three levels of severity: neurotic organization, high level borderline organization, low level organization
- Severity of identity-identity diffusion, defenses, reality testing, aggression, moral values determines the level of organization

Semi-Structured Interview: STIPO-R (Clarkin, Caligor, Stern, & Kernberg, 2015)

- Identity
  - Capacity to invest in work, studies, leisure activities
  - Coherence and continuity in sense of self
  - Representation of others
- Object relations
  - Interpersonal relations
  - Intimate and sexual relationships
  - Internal investments in others
- Defensive operations
- Aggression
  - Self-directed aggression
  - Other-directed aggression
- Moral values

Identity

- Investment in work
  - How important is work to you? Would you say you are ambitious with respect to work and career?
- Investment in free time
  - On weekends, or in your free time, what interests do you pursue?
- Sense of self
  - Tell me about yourself…describe yourself so that I get a live and full picture of you
- Representation of others
  - Tell me about (most important person)…

Overall Rating of Identity

1. Consolidated identity
2. Some areas of deficit, e.g., mild superficiality or instability in sense of self
3. Mild to moderate instability or discontinuity in sense of self and others
4. Marked instability and superficiality in sense of self and others
5. Severe: contradictory, chaotic views of self and others

Object Relations

- Interpersonal relations
  - Do you have close friends? Tell me about your friendship…what do you share with one another?
- Intimate relations and sexuality
  - Have you been involved in any romantic relationships in the past 5 years?
  - Do you find it difficult to experience tender feelings while still enjoying sex?
- Internal working model of relationships
  - What is it like for you when people close to you are in need of comfort, or are in emotional distress?

Overall Rating of Object Relations

1. Durable, realistic, nuanced, satisfying object relations
2. Some degree of impairment in intimate relations
3. Attachments present but superficial, flawed, need fulfillment, limited empathy
4. Attachments few and flawed
5. Paucity of attachments, no capacity for empathy nor sustained interest in others

6. A Framework for Conceptualizing Integrated Treatment (Livesley, Dimaggio, & Clarkin, 2015)

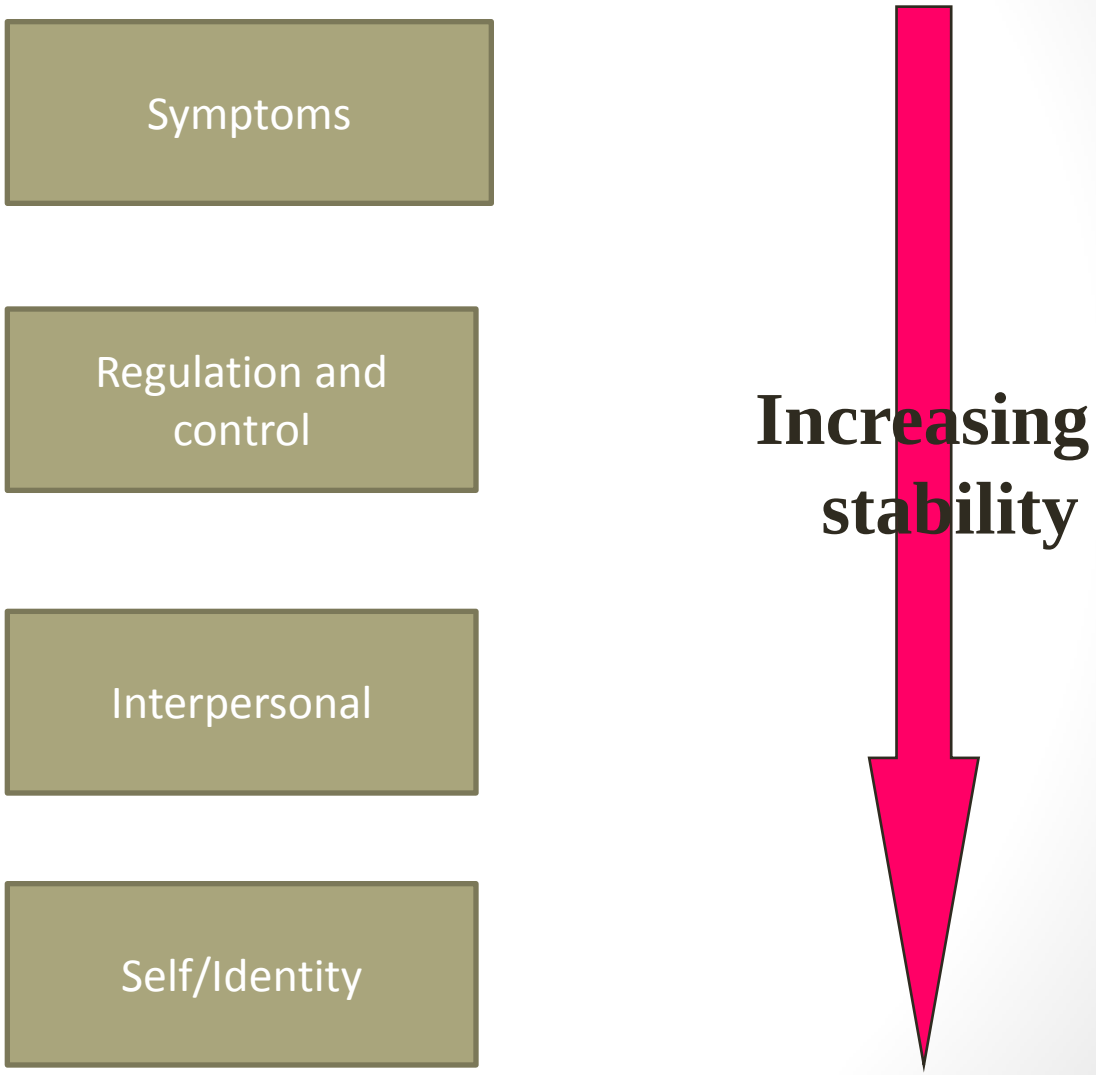
1. General and specific interventions
2. General treatment strategies
3. Domain-based use of specific treatment methods:

   Decompose personality pathology into four broad domains: symptoms, regulation, interpersonal, and self or identity

   Select specific treatment methods to treat each domain or sub-domain

1. Phases of change: Treatment is considered to progress through a series of phases with each phase focusing primarily on a different domain largely in the sequence: (1) symptoms and regulation, (2) interpersonal, and (3) self-identity

Domains and the Hierarchy of Change



Heterogeneity Among Personality Disorder Patients

- Personality disorder patients—and BPD patients in particular—are homogeneous in self and interpersonal functioning but heterogeneous in other domains
- We have focused on domains of:
  - Symptoms
  - Regulation and control
  - Interpersonal functioning
  - Self functioning

Domains of Dysfunction in 4 Patients with BPD Diagnosis

	Patient 1	Patient 2	Patient 3	Patient 4
Symptoms	Substance depen-dence; physical fights with boyfriend	No concerns	Alcohol depen-dence, physical fights	No concerns
Affect Regulation	Yelling, screaming, hitting	Constricted flat	Yelling, hitting, screaming	Labile mood, behavior under control
Reality Testing	Paranoid ideation	Paranoid ideation	No concerns	No concerns

Domains of Dysfunction in 4 Patients with BPD Diagnosis

	Patient 1	Patient 2	Patient 3	Patient 4
Inter-personal functioning	Conflicted; in romantic relationship, she cheats on partner; speaks to family when needs money	Isolated, no friends or romantic relations; relations with family conflicted	Extraverted; becomes close quickly then belittles, brief sexual encounters but no romantic relations	Submissive, tries to please all; romantic relation in which she is physically abused; few friendships
Self-functioning	Un-employed; supported by parents	Working in low-level job with college degree	Low level job, lives with parents	Low level job despite college degree

ALLIANCE BUILDING AND CONTRACT SETTING

Alliance Building Techniques in the Assessment Process (Hilsenroth & Cromer, 2007

- Longer and collaborative in-depth assessment that allows ample opportunity for the patient to voice concerns and explore cognitive and emotional aspects of these concerns
- Detailed exploration of patient's immediate concerns
- Seeking feedback from the patient on the process and experience of the assessment

As the Level of Severity Increases…

- Patients often appear in crisis, wishing to rush into treatment as a “magical” solution to their problems; use detailed assessment to slow the process down
- Obtain detailed information on how previous treatments ended
- Conduct the assessment with the negotiation of a treatment contract in mind

Structuring the Treatment (Links et al, 2015)

- Tasks: 1) articulating the goals of therapy; 2) roles of patient and therapist; 3) housekeeping (e.g., time and place of sessions, etc)
- Three ways patient's personality disorder impacts treatment frame and alliance:
  - Challenging the treatment frame
  - Require more time in order to effect a treatment alliance
  - Creation of alliance ruptures:
    - Recognize these metacommunications
    - Focus the patient on the immediate experience
    - Collaborate with patient in exploring the difficult behavior

Contract: Standard Content

Patient Responsibilities

- Attendance and participation
- Paying fee
- Reporting thoughts and feelings without censoring

Therapist Responsibilities

- Attending to the schedule
- Making every effort to understand and, when useful, to comment
- Clarifying the limits of the therapist's involvement – (for patients with earlier experiences of challenging boundaries)

Predicting Threats to the Treatment, and establishing parameters to address them

Contract: Specific Issues for the Individual Patient

- Expectations built up from previous treatments (e.g., therapist answered all your phone calls)
- How your previous treatment(s) ended?

Functions of the Contract

1. Establish mutual understanding of problem and Define the REALITY of the relation
2. Define patient and therapist responsibilities
   - Protect the patient, the therapist, and the therapy
   - Minimize Secondary Gain
3. Protect the patient, the therapist, and the therapy
   - Protect the therapist's ability to think clearly
4. Providing a safe place for the patient's dynamics to unfold
5. Sets the stage for identifying and understanding patient's deviation from the contract
6. Provides an organizing frame so that the therapy can become an anchor in the patient's life

1. Clinical interview or semi-structured interview?
2. Essential domains of dysfunction
3. Threshold of personality disorder
4. Balance between current functioning and development history
5. Patient report and experience of patient by others
6. Need for ancillary information beyond the clinical interview

DECISION POINTS IN CLINICAL ASSESSMENT

1. Clinical Interview vs. Semi-structured Interview

- The clinical interview is the time-honored approach to assessment, with the advantages of interaction between patient and clinician that allows:
  - patient freedom to describe his/her difficulties,
  - clinician assessment of patient's pattern of thinking and interacting with the clinician
- A semi-structured interview based on DSM criteria (e.g., SCID-II, IPDE) assures coverage of areas of functioning, an approach to severity (number of criteria met), but focus on categorical disorders is limited

2. Severity of Selected Domains of Dysfunction

- A general rating based on failures in cooperating and coping with the interpersonal world (Parker et al, 2004)
- Severity rating based on distorted cognition, inappropriate affectivity, impaired interpersonal functioning, impulse control problems (Bornstein, 1998)
- Global Assessment of Functioning Scale (Widiger, Costa, & McCrea, 2002)
- Total number of DSM 5 PD criteria (Hopwood et al., 2011)
- The number of comorbid PDs (Bateman & Fonagy, 2013)
- Dimensional scores on Self and Other functioning, and dimensional scores of five traits (DSM 5, Section III)
- Beutler: Rating of empirically derived domains of dysfunction
- Profile from domains of functioning (STIPO-R, Clarkin et al, 2015)

What Domains of Functioning Deserve Emphasis?

- The categorical diagnosis of personality disorder without severity of domains of dysfunction cannot inform adequate treatment planning
- Domains of functioning prominent in this review:
  - Symptoms:
  - Aggression: against self and others
  - Moral values/antisocial attitudes and behavior
  - Quality of functioning in work and interpersonal relations, intimate relations
  - Self functioning: cognitive affective units, identity, mentalization

3. Does the Patient Cross the Threshold into Personality Disorder?

- The precise point at which personality difficulties become a disorder is not clear
- The severity of domains of dysfunction are essential to assessment and treatment planning

4. Focus: Current Functioning/ Past; Content/Process

- As severity of personality disorder functioning increases, there is need to focus treatment on present disturbed functioning
- Specialized treatments for severe personality pathology (e.g., DBT, MBT, TFP) focus on present dysfunction
- Therefore, assessment should focus primarily on current functioning, with secondary focus on the developmental history

5. Patient Report Compared to Other Observation

- Patient description of current difficulties, interpersonal problems, and conceptualization of self and others is crucial for understanding the patient
- As severity of patient personality functioning increases, the patient's report may be confusing and at time contradictory. Clinician's assessment of these contradictions is useful assessment information
- As severity of personality pathology increases, it calls for collateral information from former therapists and family members

6. Utility of Ancillary Questionnaires

- The clinical interview can be supplemented by the use of self-report questionnaires that focus on personality pathology
- Illustrative questionnaires:
  - Schedule for Nonadaptive and Adaptive Personality (SNAP) (Clark, 1993)
  - Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ) (Livesley & Jackson, 2009)
  - Personality Inventory for DSM-5 (PID-5) (Krueger, et al, 2012)

Within-in person variance

Flaws in randomized-clinical trials

FUTURE DIRECTIONS

Future Directions: Ecological Momentary Assessment (EMA)

- Seasoned clinicians are aware that the symptomatic expression of PD varies not only between patients but also within a patient across time (Wright & Zimmermann, 2015)
- Assessment must move outside the consulting room to sample individuals in their everyday life (Os et al, 2013)
- Experience sampling methodology (ESM), ecological momentary assessment (EMA) and ambulatory assessment (AA) sample an individual's behavior or experiences repeatedly in his or her natural environment

Interpersonal behavior: What is EMA?

Ecological momentary assessment

- Ambulatory assessment
- Experience sampling method

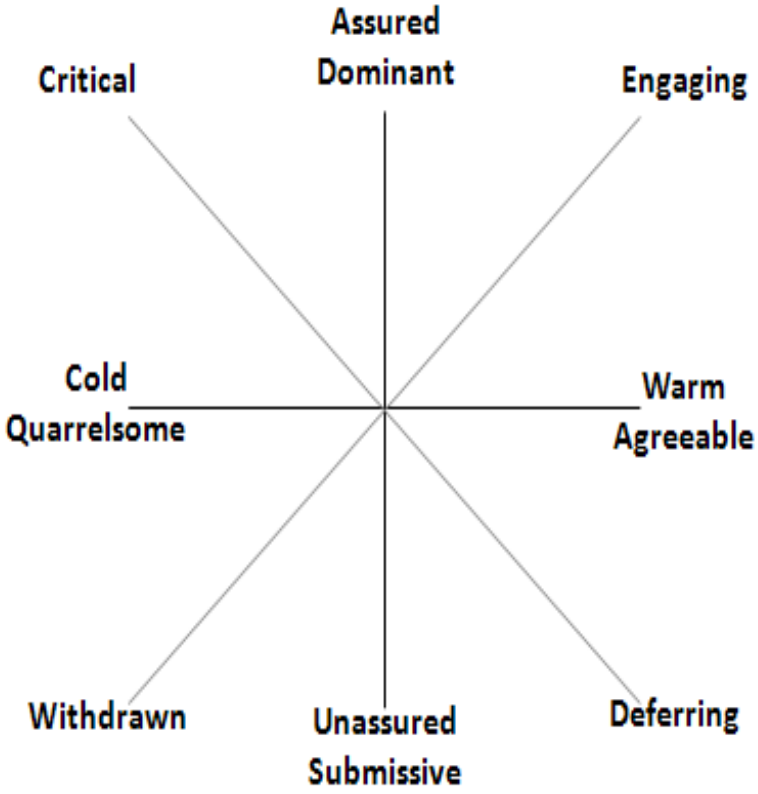
- Repeated self-report measure
- In the participant real-world environment
- In "real-time" (current or recent thoughts, emotions, behaviors)

- Trigger:
  - Random = e.g. 6 times/day
  - Event = e.g. after a social interaction of more than 5 minutes
  - Time = before going to bed

Trull & Ebner-Priemer, 2009

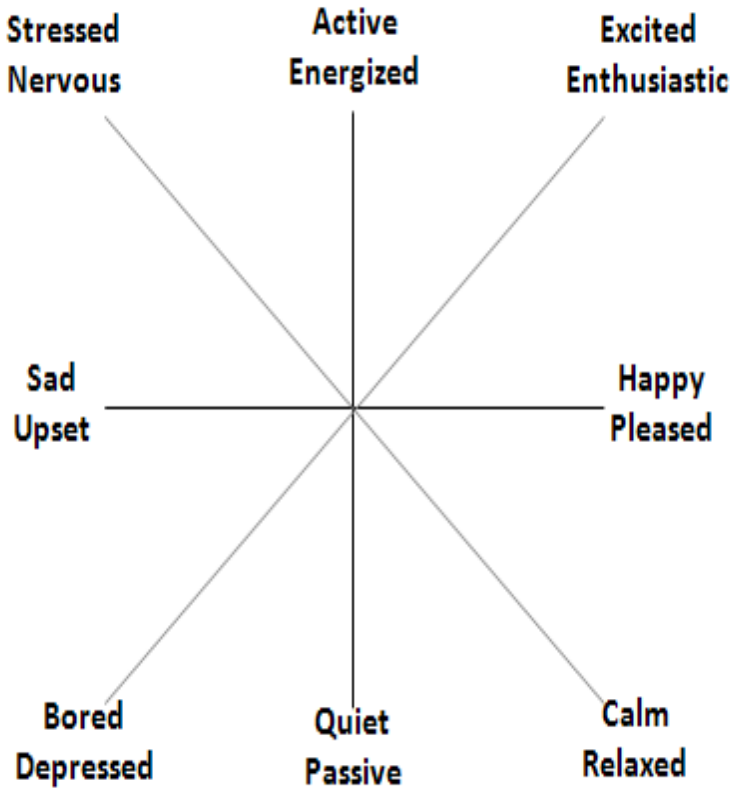
EMA Measures: Daily Assessments (3x/day)

- Interpersonal Behavior
- How did YOU behave in this social situation?
- How did THE OTHER PERSON behave in this social situation?
  - Perception of self and other; an object relation
- Rated using the Interpersonal Grid (Moskowitz & Zuroff, 2005)



EMA Measures: Daily Assessments (3x/day)

- Affect
  - An important component of the object relation dyad
- How did YOU feel in the social interaction?
- How do you think THE OTHER PERSON felt in the social interaction?
- Rated using the Affective Circumplex (adapted from Russell, 1980)

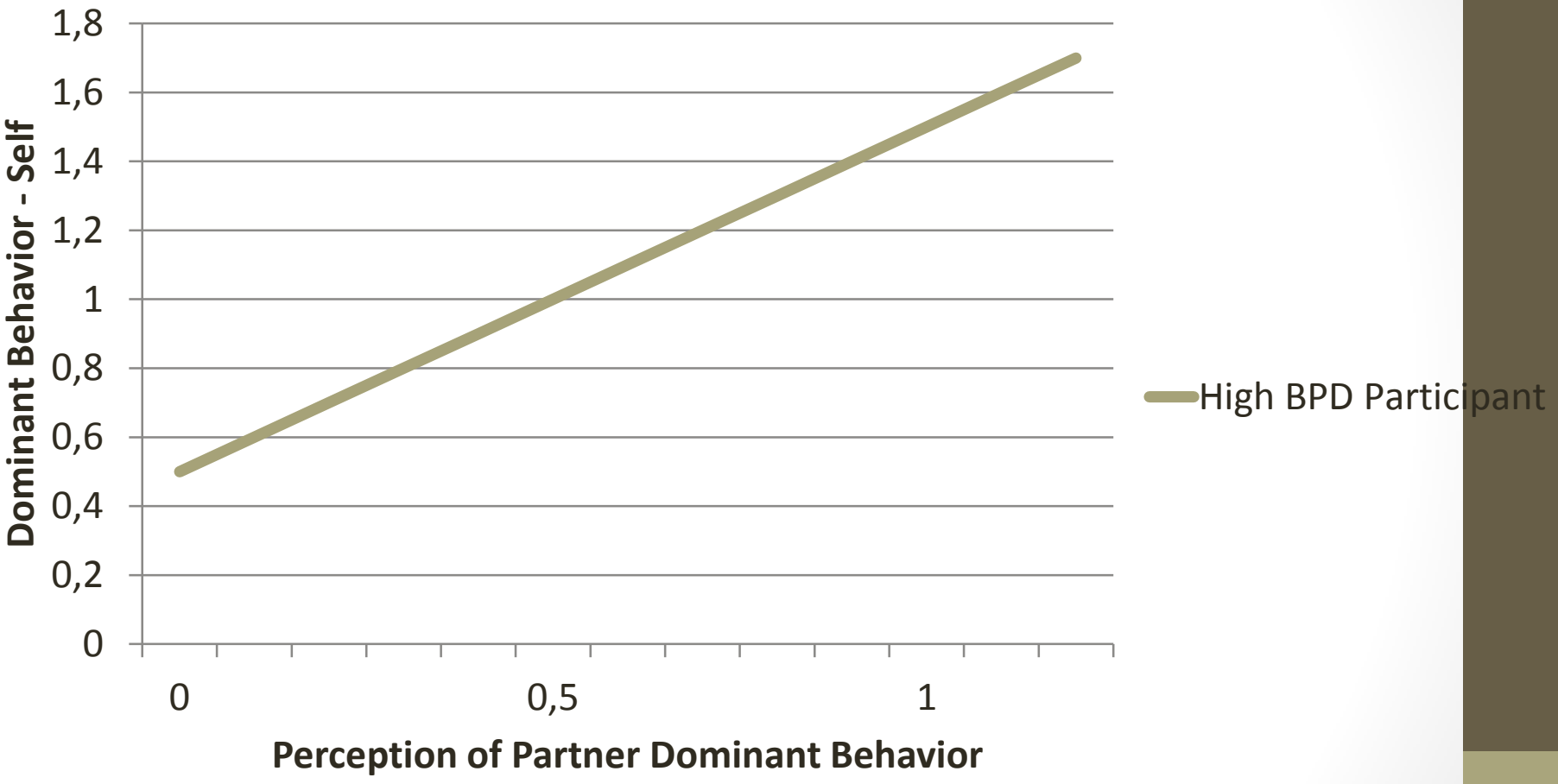


EMA Study: Preliminary Results

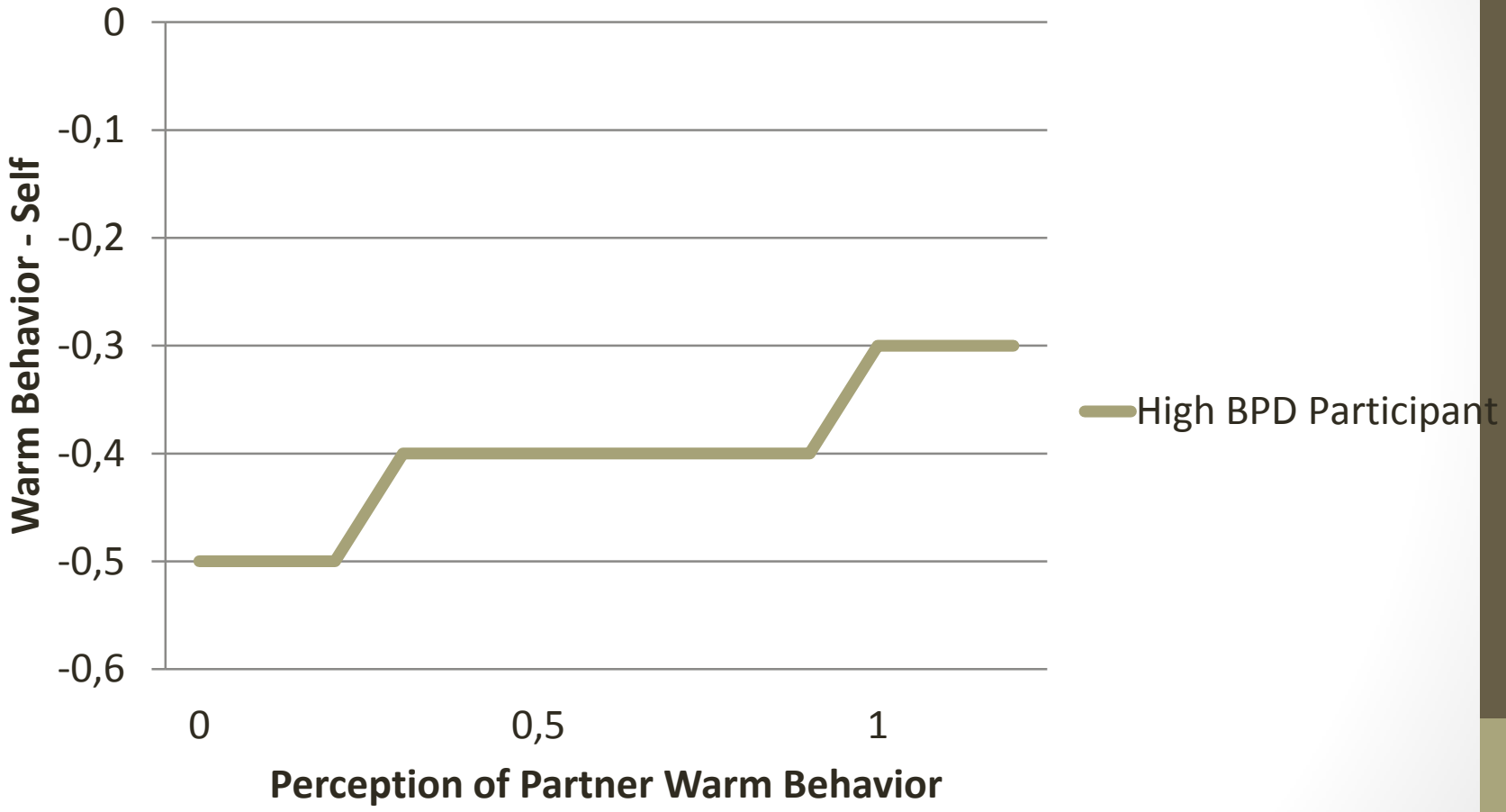
(Cain, Meehan, De Panfilis, & Clarkin, in preparation)

- EMA "Case Study"
- Examined the EMA data from 1 participant who scored high on the PAI-BOR items
  - PAI-BOR T-score = 80 (clinically significant)
  - Female participant, age = 21, ethnicity = African American
  - Most of her social interactions were with her boyfriend of 6 months
    - For this case study, we are only looking at her interactions with her boyfriend over the 1 week period
      - Out of 21 data points (3x/day for 1 week), 14 social interactions were with her boyfriend
      - Other social interactions were with mother, brother, co-worker, friend

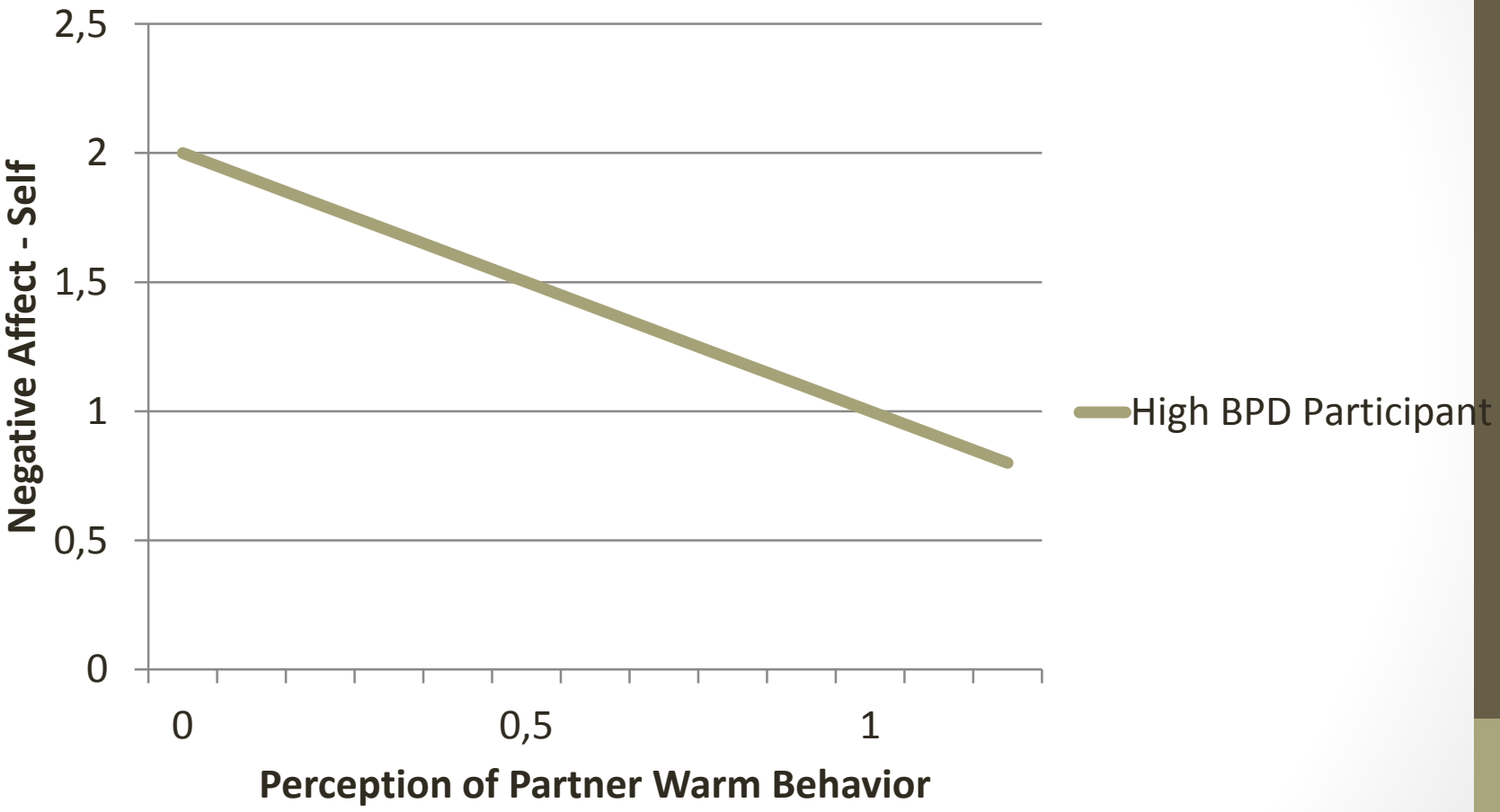
Self-Other Dominance: As perception of boyfriend dominance increases, her dominance increases



Self-Other Warmth: She is low, increases with boyfriend warmth



Interaction Between Negative Affect-Self Rating an Perception of Partner Warmth



Existing RCTs on Treatment of BPD

- Heterogeneity of domains of dysfunction in patients selected by the BPD diagnosis
- Lack of severity ratings as moderator variable
- Very little information on the mechanisms of change

In Conclusion…

- The clinical interview is the most practical, flexible method for assessment and treatment structuring
- Empirical approaches do not support the categories of personality disorder as defined in DSM 5
- Dimensional ratings (severity) of domains of dysfunction are essential for treatment planning, including foci of intervention and levels of care
- Every comprehensive treatment must address 1) symptoms of self-harm, 2) affect dysregulation, 3) interpersonal functioning, 4) self and other representations
- Assessment interview is the beginning of a treatment alliance
- As severity of personality dysfunction increases, there is an increasing need to negotiate a treatment contract
- EMA approaches are attempts to get us closer to the patients' perceptions, motivations, and behavior in their specific environment

For Further Information:

- W. J. Livesley & J.F. Clarkin, Diagnosis and assessment in W.J. Livesley, G. Dimaggio, & J.F. Clarkin (Eds.), Integrated Treatment for Personality Disorder: A Modular Approach. New York: Guilford.
- Clarkin, J.F., Meehan, K., and Livesley W.J., Clinical assessment of personality dysfunction in Livesley, W.J. (Ed.) Handbook of Personality Disorder, 2nd Edition, in press.

Thank you for your attention