Personality Disorders: A Dimensional Defense Mechanism Approach

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Categorical disease models of personality disorder currently dominate in the DSM-IV-TR and ICD-10 diagnostic systems. In preparation for DSM-V, these models have been questioned in light of evidence and widely held beliefs that disorders of personality are extreme variants of normal personality. Unfortunately, problems arise in trying to produce a dimensional model of abnormal and normal personality, such as how aspects of normal personality can be applied to personality disorders, and the all-important issue of precisely what aspect of normal personality is overextended in these disorders. In contrast to other approaches, a dimensional model based on defense mechanisms is easily applied to personality disorders, eliminates the need for complex scales, retains the notion of entities with which clinicians are familiar, provide useful therapeutic strategies, and clearly specify what aspect of normal personality is overextended. It also allows for the addition of new personality disorders.

KEYWORDS: personality; personality disorder; defense mechanisms; borderline personality disorder

INTRODUCTION

Disorders of personality are widely believed to be extreme variants of normal personality rather than categorical diseases (Bernstein, Iscan & Maser, 2007). Current diagnostic methods represented by the DSM-IV-TR (First, Frances & Pincus, 2002) and ICD-10 (WHO, 2007), constitute categorical disease models. In preparation for DSM-V, efforts are being made to prepare a dimensional model that will have utility for clinicians. A major focus is to transform well-validated instruments for assessing the so-called normal personality into a dimensional model of abnormal personality (Mullins-Sweatt, Smit, Verheul, Oldham & Widiger, 2009).

While at first glance this approach seems logical and potentially

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illuminating, there are several major problems. One issue concerns how well dimensions of normal personality, as measured by these instruments can be applied to personality disorders. For example, how do extremes of one of the most well-established dimensions of normal personality, extroversion-introversion (Costa & McCrae, 1992) relate to disordered personality? Extreme extroversion might somewhat relate to histrionic personality disorder, but not fully, and extreme introversion might apply more to anxiety disorders than personality issues. Another common dimension of normal personality, responsiveness to the environment, does not produce any personality concern on the stability side. On the responsive side, extreme variants represent neuroticism, a personality type predisposing individuals to multiple mental health problems without specificity for a particular personality disorder. This same concern applies to virtually all dimensions of the normal personality.

A second problem concerns how to amalgamate normal personality measures into a tool for assessing abnormal personality. This approach blends personality dimensions from different normal personality assessment instruments. In some cases even the instrument scales are blended (Widiger & Simonsen, 2005). However, combining different personality dimensions from well-validated scales does not necessarily produce a valid and reliable instrument. There has to be extensive testing of any agreed-upon instrument to establish its validity and reliability in both normal and abnormal personality settings because the dimensional approach must apply to everyone. This process may take years. Furthermore, the first problem, of how well aspects of normal personality apply to disordered personality, remains an obstacle.

The clinical utility of any process for assessing and rating abnormal personality is a third major obstacle in establishing a dimensional model of personality disorder (First, 2005; Verheul, 2006). Very few clinicians outside the research setting are likely to add a complex personality scale to their assessment processes, and this is particularly the case for psychiatrists, who are unaccustomed to using scales. Any assessment process recommended must be easy to apply and give clinicians the sense that it really adds to understanding. A complex scaling system based on the amalgamation of normal personality scales will almost certainly seem weighty and uninformative to most clinicians.

A fourth problem concerns how well any proposal fits with clinical reality. The personality categories now used, such as Narcissistic Personality Disorder, retain meaning that clinicians are unlikely to relinquish. Clinical logic went into developing these categorical approaches. Applying

a system that removes the essence of diagnoses is not likely to sit well with clinicians. It is easy to see a scenario in which clinicians will struggle to fill insurance forms using the new approach, while cognitively and practically relying on the old method. This scenario represents the ultimate detachment of research and clinical streams. To avoid such an occurrence, clinicians must see the new approach as not only fitting with the old, but also adding something useful.

The fifth problem is the major one, and its resolution guides the way for a novel and useful model of normal and abnormal personality. While it is generally accepted that disorders of personality represent extreme versions of normal personality, the question arises—what aspect of normal personality in an extreme form produces a personality disorder? Personality is often defined as something akin to enduring patterns of experiencing, acting, and interacting. A quick consideration clearly indicates that numerous behaviors fit into this category. Everyone has his or her typical ways of experiencing events, acting, and interacting. In a certain sense, the concept of personality might be so all inclusive as to be meaningless.

The extensiveness of the behaviors included as personality favors the idea of dimensions and within those dimensions, facets, to describe normal personality. Extending this concept to abnormal personality in a fashion that is meaningful to clinicians is extremely difficult, made even more so when we do not know which aspect(s) of so-called "normal personality" produces the abnormal personality. If we could identify the specific aspect(s) of normal personality that in an extreme form represents disorders of personality, we would have a simple and highly functional system. I propose that the aspect of normal personality that ties into abnormal personality is defense mechanisms. The concept of defense mechanisms often brings to mind classical Freudian processes protecting conscious system functioning from intolerable unconscious input. However, defense mechanisms are vastly more extensive in application, attenuating the impact of disturbing emotional occurrences and thereby enhancing evolutionary fitness (Nesse, 1998; Bowins, 2004, 2006, 2008; Valliant, 1994).

As resources diminish for psychotherapy training, and more specifically psychodynamic therapies, it is essential that clinicians focus on robust psychotherapeutic concepts. Once seen as a list of rigid, difficult-to-understand-and-apply defensive entities, psychological defenses are increasingly being viewed as adaptive and flexible responses to evolutionary derived challenges (Bowins, 2004, 2006, 2008; Valliant, 1994; Nesse 1998). For example, the evolution of human intelligence amplified primary and secondary emotions by making the underlying cognitive activating apprais-

als more intensive and extensive and the Amplification Effect (Bowins 2004, 2006). Amplified negative emotions (sadness and fear) foster depression and anxiety disorders, which in turn reduce fitness. Psychological defense mechanisms evolved to preserve fitness by safeguarding emotional functioning in an ongoing and flexible fashion. Given this flexible, ongoing process (as opposed to an inflexible mechanistic role), psychological defense mechanisms are extremely robust and pertinent. In line with this perspective I will now demonstrate why the categorical personality disorders applied in the DSM-IV-TR and ICD-10, actually represent extreme versions of normal defense mechanisms used by each of us. Borderline Personality Disorder (Emotionally Unstable Personality Disorder in ICD-10) represents a unique entity, with the personality disorder resulting from subjective trauma.

PERSONALITY DISORDERS AS EXTREME VARIANTS OF DEFENSE MECHANISMS

We all demonstrate characteristic ways of defending against disturbing emotional input to preserve psychological functioning. Without an extensive array of defense mechanisms, we would be as vulnerable psychologically to negative emotional input as our physical selves would be to pathogens in the absence of an immune system (Bowins 2004, 2006; Valliant, 1994). Like the immune system, we take defense mechanisms for granted and are not aware that they act moment to moment to protect us. These defenses are unobtrusive and barely noticeable when milder. However, in a more extensive form they can become very disturbing to others, as well as to the person demonstrating them. Clinicians can relate to this occurrence if they are able to conceive of defense mechanisms in a broader context than the traditional psychoanalytic role. By conceptualizing defense mechanisms on a spectrum from normal and unobtrusive to extensive and dramatic, entities associated with the categorical approach can be retained. The defense mechanism perspective also enables ongoing modification to incorporate extremes of different defensive styles that are not represented by current categorical personality descriptions. I will now briefly illustrate the possible defensive basis of each of the categorical personality disorders focusing mainly on DSM-IV-TR but also including ICD-10 categories.

Narcissistic Personality Disorder

Although Borderline Personality Disorder often evokes the most negative reaction from many clinicians, patients with Narcissistic Personality

Disorder can be the most difficult to treat. Any comment that the individual might misconstrue as a personal slight produces a so-called narcissistic injury, triggering anger and frequently, a failure to return to therapy. While narcissism has different dimensions, one crucial aspect to consider is that in a lesser form it is a defense we all use. Essentially, narcissism as a defense mechanism involves compensating for weakness with strengths. For example, if an individual is trying to impress a potential partner but is somewhat tongue tied, he might rely upon his appearance (assuming he is attractive). Likewise, if a suitor speaks very well but is not very physically attractive, it is likely he will talk a lot when trying to impress the prospective partner. In the case of Narcissistic Personality Disorder there are highly significant weaknesses and intense over-compensation. Fenichel (1945) was one of the first to note this compensatory relationship, indicating that excessive striving for achievement derives from defective self-esteem. The research-based division of narcissists into vulnerable and grandiose reflects the two sides of the self-esteem coin (Dickinson & Pincus, 2003; Rovik, 2001).

Psychotherapy treatment for Narcissistic Personality Disorder frequently ends poorly, a very typical scenario even for highly experienced therapists. Applying a defense mechanism approach can substantially improve outcomes. As pertains to practical guidelines, discuss with the Narcissistic Personality Disorder patient how people routinely use strengths to compensate for weaknesses. Perhaps start with the example, if your right foot is injured you will put more weight on your left. Then progress to more psychological aspects of functioning, followed by a discussion of how the person uses strengths to compensate for insecurities. Review the strengths and insecurities that are relevant. Besides massaging the individual's ego by emphasizing that this narcissistic strategy requires strengths, this approach fits very well with the person's experience. Explore how the patient reacts with hurt when something touches his insecurity. Repeatedly emphasize how he over-compensates with strengths because of the extent of his insecurity. As therapy progresses and the patient's insecurity is shored up, the compensation diminishes. Over time the patient becomes more like the rest of us, using strengths in a reasonable and limited way to compensate for weaknesses. In applying this approach I have had far fewer narcissists self-eject from therapy, and many have progressed surprisingly well, even seeking literature on narcissism.

Histrionic Personality

This particular form of personality disorder seems to be encountered in a pure form less often than many other disorder types. The colorful and dramatic behavior can represent the manipulation and deception of Antisocial Personality Disorder or be an expression of a hypomanic or manic state. To the extent that histrionic personality disorder stands in its own right, it probably, like narcissism, provides compensation for insecurities, but it is different in that it is designed to impress people and gain attention. The person is using actual (or perceived) interpersonal strengths to compensate for self-esteem deficiencies that might (or might not) be restricted to the interpersonal sphere.

Antisocial Personality Disorder (Dissocial Personality Disorder in ICD-10)

Debate exists as to what this entity really represents. Although some researchers believe that there is an actual defect in sociopaths, there is compelling evidence that antisocial behavior is an adaptive trait providing an enhanced ability to acquire resources through deceit (Harpending & Sobus, 1987; Mealey 1995). It represents a relatively rare instance of frequency dependent selection, meaning that when present in a distinct minority of the population, deception of this magnitude can be adaptive, the advantage declining when the behavior occurs at a higher frequency because too many people become aware of the manipulation and are on their guard for it (Mealey 1995). Factor analyses of the Psychopathy Checklist-Revised, the primary scale for assessing sociopathic behavior, reveals two main dimensions of antisocial personality disorder, namely emotional detachment and antisocial behavior (Patrick, Cuthbert & Lang, 1994). The emotional detachment dimension includes interpersonal items, such as superficial charm, grandiosity, lying and manipulativeness, affective shallowness, and the absence of remorse or empathy. Detachment from, and indifference to, the feelings and welfare of others is a hallmark of the condition (Intrator, 1997), which has been described as a "mask of sanity" in which language and conceptual reasoning are intact but dissociated from affect (Patrick et al., 1994). Dissociation, as one of the classical defense mechanisms involving an actual separation of mental processes, is secondary only to acting out as a defensive style demonstrated by sociopaths (Vaillant, 1994). It is the main defense mechanism for individuals involved in less violent "white-collar crime" activities.

Dissociation represents one of the major classes of psychological defense mechanism, extending along a spectrum from mild, everyday expres-

sions, such as absorption, to extensive, amnestic events and personality fragmentation (Bowins 2004, 2006). The sociopathic variant of dissociation consists of emotional detachment and diminished responsiveness to emotional stimuli.

Antisocial behavior represents a specialized form of dissociation (Bowins, 2004). A special form of dissociation might have developed from the general dissociative template, given the resource-enhancing nature of antisocial behavior that is derived from the ability to cheat and cope with violence (where having the ability to hurt others and kill without remorse is adaptive). Antisocial individuals, such as contract killers, have an exceptional ability to encapsulate emotions (Schlesinger, 2001). With the presence of the additional factor—antisocial behavior—the sociopath can manipulate others to better his or her position in terms of resource acquisition. Antisocial Personality Disorder might then represent a specialized and extensive version of a major defense mechanism—dissociation—that operates on a continuum. Given its evolutionary role in deriving benefit from deceit and manipulation, and the correspondingly strong stand-alone genetic basis, this condition is not amendable to psychotherapeutic improvement.

Avoidant Personality Disorder (Anxious Personality Disorder in ICD-10)

The tendency to avoid painful, harmful, and unpleasant scenarios is a fundamental defensive strategy. Although approaching some potentially dangerous situations offers the potential for great reward, being overly prone to approaching such situations would have been very costly in our evolutionary context, often reducing fitness. Fundamental aspects of motivation that have seemingly become incorporated into human personality are the Behavioral Inhibition System (BIS) and Behavioral Activation System (BAS), which are very ancient general motivational systems with the former regulating sensitivity to threat and non-reward cues, and guiding inhibition or avoidance responses (Gray, 1987; Fowles, 1988), and the latter being approach oriented and based on positive appetitive incentive. A strong genetic loading for behavioral inhibition manifests early in life, and high BIS is associated with harm avoidance and anxiety disorders, particularly the social version (Gray 1987; Biederman, et al 2001). High levels of anxiety naturally entail inhibition of behavior, for example, as in socially anxious person being fearful of speaking out in a group and hence, remaining silent.

As with most personality traits, there is a spectrum of BIS sensitivity, and those highly prone to it are naturally more likely to avoid threatening

or unpleasant stimuli. Viewing Avoidant Personality Disorder as an extension of a natural BIS-related tendency to avoid threatening, dangerous, and unpleasant circumstances is very conceptually and practically compelling. In the presence of BIS-activating factors, normal avoidance shifts to pathological avoidance. Addressing BIS and BAS in therapy, with a focus on diminishing the influence of the former and increasing that of the latter, represents a novel intervention strategy. To do this, describe the influence of these two motivational systems, and provide examples of how BIS dominates the patient's behavior. The emphasis is on how some avoidance is very adaptive but an excess deprives the individual of BAS-related rewards. Explain to the patient that to diminish the influence of BIS, a person must learn to distinguish real from apparent threat, and approach when there is no actual threat and a potential for reward. A person with Avoidant Personality Disorder focuses only on threats and not potential rewards; it is important to get him or her to appreciate the reward potential in various scenarios. As unpleasant (but not dangerous) circumstances are faced, and rewards achieved, functioning improves. The patient learns that in most cases the fear is worse than the reality, and this motivates further approach behavior. In effect, BIS-related motivation is diminished and BAS-related motivation is intensified and expanded, transforming pathological avoidance into normal defensive avoidance.

Dependent Personality Disorder

Homo sapien evolution has instilled in us the value of social contacts and reliance upon others. Lacking the strength and "body weaponry" of many other species, early humans had to rely on a social way of life in hunting/gathering groups. Practically, this entailed engaging in reciprocal exchanges and honoring debts as well as calling in obligations. Each person was integrally connected to the social group by these exchanges, and failure to reciprocate and repay debts resulted in ostracism (Glantz & Pearce, 1989). Partial ostracism meant being restricted from important resources while complete ostracism involved ejection from the hunting/gathering group, leading to almost certain death, or at the very least greatly reduced evolutionary fitness in the absence of mates. Hence, we evolved to be quite dependent on other people, with social behaviors satisfying this dependency embedded in personality. Reinforcing the dependent tendencies of Homo sapien is the long period of parental care required. Divisions of labor in more complex forms of social organization, such as agriculture, could only have further strengthened our dependency needs.

To depend on others to varying degrees is a perfectly normal defensive

strategy, and we consider someone very abnormal who has no need to rely on others. With Dependent Personality Disorder there is an excess reliance on people, to the point where the person cannot function alone. As with Avoidant Personality Disorder, anxiety plays a prominent role, encouraging the person to cling to others rather than face being independent. By taking a therapeutic stance of encouraging and modeling independence, these individuals can learn to face responsibility and not fear the consequences. As rewards build from their more independent actions and fears subside, they can gradually shift to a level of dependence on others that is within the normal range of the continuum.

Obsessive-Compulsive Personality Disorder (Anankastic Personality Disorder in ICD-10)

Much like Avoidant Personality Disorder and Dependent Personality Disorder, Obsessive-Compulsive Personality Disorder relates to anxiety. One of the fascinating aspects of Obsessive-Compulsive Disorder might be referred to as the Anxiety Paradox: While the intrusive and ego-dystonic aspect of obsessions generate anxiety, compulsive behavior can often contain and restrain anxiety (Storch, Abramowitz, & Goodman, 2008). For example, worries about the natural randomness and messiness of life can be managed by compulsive thoughts and actions emphasizing neatness, order, and symmetry. In some cases obsessions and compulsions might even represent a stepping down of anxiety, comparable to power in electrical lines. Initially, free-floating, anxious thoughts are funneled into circumscribed obsessions and then contained and restrained by compulsive thoughts and actions. For example, a fear of death or serious illness might be limited to thoughts of becoming infected by a type of germ, which are contained by ritualistic behavior, such as touching doors in a fashion designed to reduce the likelihood of contamination. From an analytic perspective, guilt-related anxiety is managed and contained by obsessive-compulsive behavior via excessive application of the undoing defense mechanism (Fenichel, 1945).

Compulsive behavior in a mild form may actually be adaptive based on its ability to contain and restrain anxiety, and is part of our normal defensive capacity. For example, clinicians who contain the potential threat of litigation or actions from governing colleges by being rigorous in obtaining information and compiling notes, almost always fare much better emotionally and practically when a problem arises. There are many sources of threats, both actual and potential, in day-to-day life, and having a mechanism to contain these anxiety-inducing inputs is highly adaptive.

Not surprisingly, obsessive-compulsive experiences and symptoms have been reported in 90% of healthy adults and children (Boyer & Lienard, 2006). Unfortunately, the benefit of obsessive-compulsive behavior falls off rapidly at the moderate-to-extreme level, and this greatly restricts a person's capacity to cope with stress and change. A useful approach in treating Obsessive-Compulsive Disorder is to stress the value of the lesser degrees of compulsive behavior in containing and restraining diffuse sources of anxiety. The concept of eliminating all obsessive-compulsive type behavior is often frightening to the patient, and unrealistic when viewed (at least in part) as a normal defense. Having the patient scale back on obsessive thoughts and compulsive behaviors, while supporting those that contain and restrain reasonable sources of anxiety, is much more likely to succeed than completely eliminating such behavior.

Paranoid Personality Disorder

Paranoid Personality disorder is characterized by cognitive distortions of delusional intensity, based largely on the classical defense of projection. Projecting one's own negative features onto others fosters suspicion. To a limited extent, suspiciousness is adaptive and is an effective defense against deception by those with antisocial tendencies. However, when the suspicious perceptions and beliefs represent cognitive distortions of delusional intensity, a disorder that impairs adaptation is present. Given that the belief is delusional in intensity, psychotherapy is not effective. Antipsychotic medication, if accepted, can eliminate the delusional aspect and diminish suspiciousness to normal levels.

Schizotypal Personality Disorder

This disorder is not represented in ICD-10, and there is confusion regarding what this condition represents, one possibility considers it as a milder version of schizophrenia characterized by significant positive symptoms. It does not appear to represent a prodromal phase of schizophrenia because this phase is characterized by negative symptoms (Hemmingsen, Madsen, Glenthoj & Rubin, 1999), and schizotypal behavior persists indefinitely. A feasible defensive aspect derives from a much more mainstream defensive process. The cognitive aspects of psychosis, such as delusions and related alterations in thought form, represent extreme cognitive distortions (Bowins 2004). One of our major evolved psychological defense templates consists of positive cognitive distortions occurring in a spectrum from mild to extreme (Bowins 2004, 2006). Mild positive cognitive distortions characterize good mental health, for example, putting a "sugar coating" on events, seeing things through rose-colored glasses,

placing a self-enhancing spin on occurrences, and favorable attribution biases. So-called mature classical defenses, including humor and altruism, represent mild positive cognitive distortions. Moderate cognitive distortions include excessive fantasy involvement, magical thinking, and overvalued ideas, as well as intermediate classical defenses. More extreme cognitive distortions cross into the realm of psychosis, with delusional thinking and immature classical defenses such as schizoid fantasy. There is an inverse relationship between the degree of cognitive distortion and maturity level of the defense, with more mature ones involving a mild attenuation of unpleasant reality and immature variants greatly distorting reality (Bowins 2004). Substantial challenges to coping capacity often require moderate positive cognitive distortions and even brief activation of more extreme cognitive distortions. Schizotypal Personality Disorder might represent a personality-based expression of more extreme positive cognitive distortions. Support for the positive nature of delusional cognitive distortions, is provided by the ego-syntonic aspect of delusions with a person fighting for instead of against them.

Schizoid Personality Disorder

Unlike individuals with Avoidant Personality Disorder—who like contact with people but are often fearful of it—individuals with Schizoid Personality Disorder are truly asocial. What this represents is also unclear. It might be a milder and/or purer version of the deficit state of schizophrenia, but without psychosis. Frequently, those with Schizoid Personality Disorder lead very limited lives and demonstrate some degree of psychosis when under significant stress, thus reinforcing the perspective that it is a variant of schizophrenia. However, the verdict is out on this one. Given that contact with people can be more draining than rewarding with deceit, game playing, and interpersonal politics to contend with, it could be the case that limited isolation is protective. Many people appreciate the anonymity of our modern urban landscape and actively seek alone time, emphasizing how some degree of isolation is a valued defensive strategy. Those with Schizoid Personality Disorder extend isolation to the extreme. This disorder of personality might also represent over-application of the immature classical defense of schizoid fantasy, much as paranoid personality disorder is based on the defense of projection.

THE SPECIAL CASE OF BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder (BPD) is equivalent to Emotionally Unstable Personality Disorder, Borderline Type, in ICD-10. In contrast to

other personality disorders, BPD does not primarily represent an extreme variant of normal defense mechanisms. Instead, defense mechanisms appropriate at an early stage of personality development are repeated despite their inappropriateness, and the regulation of defense mechanisms is impaired. A crucial factor behind these disturbances in personality development appears to be trauma experienced during the span from birth to the late teens/early twenties. Outside of this timeframe, a trauma likely results in Post-Traumatic Stress Disorder.

Controversy exists as to whether or not trauma is necessary for the development of BPD. A recent review by Gunderson (2009) concluded that trauma is not necessary and does not account for much of the etiological variance. In contrast to this perspective, clinical experience and strong research evidence indicate that trauma is strongly linked to BPD (Landecker, 1992; Bandelow, Krause, Wedekind, Broocks, Hajak & Ruther, 2005). A review of the literature relevant to this debate is beyond the scope of this paper; however, a few points are worth mentioning. For example, much of the research focuses on what researchers decide is traumatic. The crucial aspect is what the person experiences as traumatic. Considering only objectively damaging occurrences, such as sexual or physical abuse, misses a great deal of what might actually traumatize a person (Levy, 2000). People experience potentially traumatic occurrences in different ways. For example, those higher in reactivity on the responsiveness-emotional stability dimension of normal personality likely suffer more from any given objective level of trauma.

Children in particular are more sensitive to trauma given their less developed cognitive structures, global undifferentiated thinking, and great dependence on parental figures (Levy, 2000). "Even objectively harmless events can become major traumas in the absence of ways to cope with them. Traumatization depends so much on the child's view of the event" (Anguyal, 1965, p. 118-9). Although children might be more vulnerable to the effects of trauma, adults are also susceptible, and very subjective factors play an instrumental role in the development of long-lasting psychological aftereffects. Hence, any consideration of whether or not, and to what extent, trauma is linked to BPD needs strongly to consider the subjective experiencing of trauma. Even with the highly objective trauma, including violence, sexual abuse, separation from parents, parents divorcing, severe childhood illness assessed by Bandelow et al. (2005), only 6.1% of patients with BPD *did not* report any severe traumatic occurrence compared to 61.5% of the normal control group. Interestingly, Gunderson (2009) referenced this study to support the perspective that trauma is not

necessary for the development of BPD. One of the other two studies referenced by Gunderson (2009)-Fossati, Madeddu & Maffai (1999)-only focused on sexual abuse.

If trauma is linked to the development of BPD, then the diverse range of behavior seen within the disorder may be explained by effects of the trauma on defense mechanisms. Traumatic experiences encountered in the earlier years of life often "freeze" personality development at the stage in which the traumatic event occurred (Massie & Szajnberg, 2006; Spates, Waller, Samaraweera & Plaisier, 2003). Defense mechanisms of that stage persist despite their inappropriateness (Cramer & Block, 1998; Finzi-Dottan & Karu, 2006). Classic defense mechanisms described in the psychoanalytic literature occupy a continuum from least to most mature (Vaillant, 1977; Vaillant, 1994). The level of maturity describes both the adaptive value of the defense mechanism and the age when it is most commonly expressed (Vaillant, 1977). For example, acting out to protect against emotional stress is most commonly expressed in childhood and is a grossly inadequate defense mechanism when applied in adulthood. In a protective response to trauma, a child applies age-appropriate, yet immature defense mechanisms to such an extent that these defenses come to characterize personality (Cramer & Block, 1998). Interestingly, there is evidence that immature defenses might provide children with more protection from trauma than do mature and intermediate defenses (Warren 2002).

Those with BPD rely heavily on various immature defense mechanisms, such as splitting and idealization/devaluation (Kernberg, 1976; Bond, Paris & Zweig-Frank, 1994; Landecker, 1992). Kernberg (1976) indicated that more maladaptive and image-distorting defense mechanisms characterize BPD. Furthermore, intense, long-term use of immature defenses contributes to the development of BPD (Bond et al., 1994). Conceptualizing much of borderline behavior as excessive reliance on defense mechanisms dominant during early development assists in understanding the patient's behavior. It also provides a practical therapeutic approach, in the form of working directly with the immature defense mechanisms. For example, start therapy by reviewing with the patient how we all use defense mechanisms, explaining that because of early life trauma, individuals may continue to repeat defenses that are not so helpful. Describe how acting out adverse emotional states through self-harm and suicidal gestures is less constructive than learning to identify, verbalize, and elaborate these states. Explain how rather than splitting members of the support team, recruiting their combined assistance is much more adaptive. Help the

patient develop a more consistent picture of the therapist as opposed to an image in which the therapist is great one minute and awful the next, emphasizing how it improves the relationship. Given the "frozen" nature of the defense profile in BPD, it takes time and a lot of work to get these patients to shift their defensive styles, but it does occur.

Trauma has an additional—and in many ways more profound—impact on defense mechanisms in that it impairs regulation (Finzi-Dottan & Karu, 2006). At some level, mostly unconscious or preconscious, the brain selects a defensive strategy or strategies for the occasion, and regulates the application in terms of intensity and time frame. In BPD extremely deficient regulation is the norm, with a failure to apply any defensive strategy at times leading to intense emotional distress, extreme overuse of immature defenses, and inadequate cessation of the defense/s when the threat is past. Figuratively, it is like a child is at the helm of the defense mechanism regulatory apparatus. Perhaps it is the case that defense mechanism regulation itself "freezes" at the stage in which the trauma occurred. By setting an example for the patient regarding how to manage situations in the therapeutic relationship, a therapist can indirectly assist in improving the regulation of defense mechanisms. Therapists who sway too much with the patient—expressing anger and resentment when the person acts out or being overly relieved and friendly when the patient is "nice"—do not assist in this regulation. Providing a stable, professional, and supportive therapy structure with clear limits and boundaries helps the patient regulate defense mechanisms and relevant behavior.

CONCLUSION

Conceiving of personality disorders as extensions of normal defensive processes provides a simple and clinically useful dimensional approach to these disorders. It resolves the issue of exactly what aspect of normal personality produces personality disorders when present in an extreme form. It also preserves the "old" categorical concepts that most clinicians are unlikely to relinquish fully (or perhaps even partially). Furthermore, it avoids the complexity and problems associated with linking other aspects of normal personality structure to personality disorders. Direct links to normal personality traits, such as extroversion/introversion and how open or closed a person is to experience, do not have to be attempted. On the other hand, these traits might be viewed as variables influencing the defense mechanisms upon which an individual relies. For example, a person who is highly closed to experience is more likely to rely on the defenses of avoidance or dependence than someone very open to experi-

ence. Someone who ranks high on conscientiousness will be more likely to rely on an obsessive-compulsive defensive approach.

By focusing on the defensive aspects of normal personality, amalgamating normal personality instruments into a valid and reliable instrument applicable to both normal and abnormal populations becomes unnecessary. Clinicians not used to working with what will inevitably prove to be a fairly complex rating instrument, will be very thankful that the defense mechanism approach can be applied without the use of scales. Of critical importance defense mechanisms conceptualized and applied in a flexible and progressive fashion have a clear and direct role in both the manifestation and treatment of personality disorders, unlike most other aspects of normal personality. This fit will make the approach more palatable to clinicians, and provide for clear therapeutic interventions.

An additional major advantage to a defense mechanism approach is flexibility in adding personality disorders to the existing list. Extreme variants of any defense mechanism can theoretically and practically produce a personality disorder. As a simple example, extensive denial produces what might well be considered a personality disorder, given that ongoing and unreasonable use of denial impairs the person's ability to function in many areas of life. Likewise, a person who intellectualizes everything has essentially removed emotions from the equation, and will find it very difficult to make even the simplest of decision where there is not a clearly objective correct course. One of the most common personality "disorders" encountered by clinicians is not even recognized as such—the "difficult" patient. Every clinician has experienced people who are contrary, disagreeable, and argumentative. In a milder form this represents a normal defense mechanism designed to individualize personality. Both young children and teenagers go through phases of distinguishing themselves from their parents by being contrary, disagreeable, and argumentative. This process while "difficult" for the parents actually helps the person develop a distinct character. Later in life having your own unique character and resisting the personality of others enhances self-esteem and is necessary for adequate functioning in interpersonal relationships. However, if carried too far the "difficult" defense alienates people and isolates the person.

Changing any established paradigm is never easy as there is a human tendency to adhere to the status quo. This aspect of normal personality will prompt some readers to outright reject the defense mechanism approach to personality disorders presented here. However, momentum is building for a change from a categorical to dimensional method of conceptualizing

personality disorders. While there are numerous forms that this change might take, it will ultimately be clinicians who decide if the system is workable. Strategies for directly linking normal personality variants and scales to abnormal personality in a dimensional format appear to be overly complex and cumbersome, and will largely eliminate the categories clinicians are familiar with. Applying a defense mechanism dimensional approach has several advantages including being vastly more straightforward, retaining the notion of categories clinicians are familiar with, and conceptual simplicity blended with advanced therapeutic strategies. Although identifying and working with defense mechanisms is not without its challenges, a dimensional defense mechanism approach is highly psychotherapy compatible, and without any doubt psychotherapy will remain the mainstay of treatment for personality disorders.

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