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Personality Disorders as Maladaptive Variants of Common Personality Traits: Implications for Treatment

Thomas A. Widiger, Ph.D.

Personality disorders are inadequately described by the diagnostic categories of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (APA, 1994). This inadequacy is discussed with respect to the heterogeneity among persons with the same diagnosis, the substantial co-occurrence of personality disorder diagnoses, the arbitrary distinction from normal personality functioning, and the inadequate coverage. Optimal treatment decisions should be informed by a more precise description of each individual's unique constellation of adaptive and maladaptive personality traits. The dimensional five-factor model of personality is offered as an alternative. Empirical support and illustrative case examples are provided.

INTRODUCTION

Personality disorders are of substantial clinical importance (Widiger & Sanderson, 1996). Each of the latest editions of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has given special attention to the diagnosis of personality disorders by placing them on a separate, distinct axis (APA, 1994) in part because personality disorders affect significantly the occurrence, expression, course, and/or treatment of most other mental disorders, as well as themselves being the focus of clinical treatment (Shea, Widiger, & Klein, 1992). In addition, many patients will meet the criteria for at least one personality

Address correspondence to Thomas A. Widiger, Ph.D., 115 Kastle Hall–Psychology, University of Kentucky, Lexington, Kentucky 40506-0044.

disorder and very few patients will fail to have maladaptive personality traits.

Yet, personality disorders are among the most problematic of diagnoses (Overholser, 1989). Maser, Kaelber, and Weise (1991) surveyed clinicians in 42 countries. "The personality disorders led the list of diagnostic categories with which respondents were dissatisfied" (Maser et al., 1991, p. 275). There are many reasons for this dissatisfaction, including the variability among persons who receive the same diagnosis, substantial co-occurrence, the arbitrary distinction from normal functioning, and the inadequate coverage (Widiger, 1993; Widiger & Sanderson, 1995). Each of these problems will be discussed briefly in turn.

LIMITATIONS OF DIAGNOSTIC CATEGORIES

Heterogeneity of Cases

A mental disorder diagnosis should suggest the presence of a relatively distinct behavior pattern. However, it is apparent that this rarely occurs for personality disorders. Only the most prototypic cases have all of the defining features; most cases vary in the extent to which they resemble the prototype (Widiger, 1993). The typical case is not a prototypic case; prototypic cases are in fact atypical (Blashfield & Haymaker, 1988).

A DSM-IV personality disorder diagnosis does provide useful information but it can also contribute to inaccurate and misleading stereotyping. "There is a tendency, once having categorized, to exaggerate the similarity among nonidentical [cases] by overlooking within-group variability, discounting disconfirming evidence, and focusing on stereotypic examples of the category" (Cantor & Genero, 1986, p. 235). Not all borderlines are alike, and they should not all be treated in the same manner (Clarkin, Hull, Cantor, & Sanderson, 1993). They vary in the extent to which they are characteristically angry, impulsive, anxious, vulnerable, depressed, oppositional, manipulative, and/or irresponsible, and this heterogeneity will have substantial implications for treatment (Stone, 1993).

Co-Occurrence Among Personality Disorder Diagnoses

The expectation (or at least hope) in DSM-IV is that only one personality disorder would be present for each patient (Gunderson, 1992). Guidelines for differential diagnosis are provided to facilitate the determination of which individual personality disorder is the correct choice. For example, DSM-IV indicates that "both Dependent Personality Disorder

and Borderline Personality Disorder are characterized by fear of abandonment; however, the individual with Borderline Personality Disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with Dependent Personality Disorder reacts with increasing appeasement and submissiveness" (APA, 1994, p. 653). However, a problem for DSM-IV is that persons who meet the criteria for one PD usually meet the criteria for another (Widiger & Trull, in press). There will be many cases of persons with a borderline personality disorder who react with appeasement and submissiveness, and persons with a dependent personality disorder will at times react with rage, emptiness, and/or demands.

The occurrence of multiple diagnoses is not particularly surprising. Normal personalities are rarely so distinct that only one word or term is sufficient to describe them. An adequate description of any one individual requires a variety of trait terms. I have been unable to use just one word to describe adequately the complexity and nuances of the personalities of the persons that I know well. The same can be said for persons with clinically significant maladaptive personality traits.

Most clinicians, however, do provide only one diagnosis per patient (Gunderson, 1992; Westen, 1997) perhaps because it is not particularly meaningful to say that a patient suffers from three or four comorbid personality disorders, each having its own distinct etiology and pathology (Lilienfeld, Waldman, & Israel, 1994). It is perhaps as meaningful to say that a person has both a borderline and an antisocial personality disorder as to say that a person has both a normal and a borderline personality. Persons may have borderline and antisocial personality traits, and may have borderline and normal (adaptive) personality traits, but they have just one personality. It would be simpler and more meaningful to say that a person suffers from one personality disorder characterized by varying degrees of borderline, antisocial, and paranoid traits than to state that the patient is suffering from three different, comorbid personality disorders (Oldham et al., 1992; Tyrer & Johnson, 1996).

Differentiation from Normal Personality Functioning

It is stated in DSM-IV that personality disorders involve personality traits that result in "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 1994, p. 633). However, the thresholds for the individual diagnoses do not in fact identify or demarcate that point at which personality traits result in clinically significant impairments (Westen, 1997). Persons with five of the eight DSM-IV criteria for a dependent personality disorder are more impaired than per-

sons with four criteria, but the decision to require five was not based on any empirical data or even expectation that five criteria identifies that point at which dependent personality traits result in any significant impairments. For example, dependency provides a vulnerability to episodes of depression (Bornstein, 1993) but the diagnostic threshold for DSM-IV dependent personality disorder has no relationship with that point at which this vulnerability is most likely to occur (Overholser, 1991). Persons with just three of the dependent criteria (e.g., feels helpless when alone because of exaggerated fears of being unable to care for oneself, unrealistically preoccupied with fears of being left alone, and needs others to assume responsibility for most major areas of life; APA, 1994) will experience significant impairments secondary to their dependent personality traits.

The failure of the DSM to provide clinically meaningful thresholds has been evident in a number of studies (Widiger & Sanderson, 1995). For example, Overholser (1991) demonstrated empirically that just moderate levels of dependency can result in significant depressive symptomatology. He therefore suggested that persons with only a few of the dependent criteria "were more appropriately classified as dependent than nondependent" (p. 252). McGlashan (1987) was similarly concerned with the relationship of borderline personality disorder to depression. He needed a comparison group of depressives without borderline personality disorder and therefore obtained depressed persons who did not meet the DSM-III criteria for borderline personality disorder. However, these persons had on average three of the borderline criteria. They were diagnosed as not having a borderline personality disorder but did in fact have clinically significant borderline traits. Characterizing them as not having a borderline personality disorder was inaccurate and misleading.

Coverage

DSM-IV contains 10 personality disorder diagnoses: avoidant, antisocial, borderline, dependent, histrionic, narcissistic, obsessive-compulsive, paranoid, schizoid, and schizotypal (APA, 1994). However, the most common diagnosis in general clinical practice is personality disorder not otherwise specified (Widiger & Sanderson, 1995), used when the clinician determines that the person does have a personality disorder but fails to meet the diagnostic criteria for any one of the 10 officially recognized diagnoses. Most clinicians find the DSM-IV diagnostic categories to be inadequate in describing the maladaptive personality traits of their patients (Clark, Watson, & Reynolds, 1995).

Compelling arguments have indeed been made for many additional personality disorder diagnoses, including (but not limited to) self-defeating (Cooper, 1993), sadistic (Spitzer, Fiester, Gay, & Pfohl, 1991), pleonexic or machiavellian (Nikelly, 1992), depressive (Phillips, Gunderson, Hirschfeld, & Smith, 1990), malevolent (Hurlbert & Apt, 1992), and negativistic (Millon, 1993). The 10 officially recognized diagnoses fail to cover fully the possible manner and range of clinically significant maladaptive personality traits (Westen, 1997).

The DSM-IV diagnostic system also fails to acknowledge the presence of adaptive personality traits in persons with a personality disorder. These additional traits are necessary for a comprehensive and treatment relevant description of a patient's personality. For example, persons with a dependent personality disorder will have a number of additional personality traits beyond simply those that are necessary for the diagnosis, many of which may be quite relevant to treatment responsivity, such as a disposition toward open-mindedness or conscientiousness (Millier, 1991). Personality traits that contribute to adaptive, healthy functioning and treatment responsivity can be as important to treatment decisions as the maladaptively dysfunctional traits.

THE FIVE-FACTOR MODEL ALTERNATIVE

The model of personality classification that I use in my clinical practice is the Five-Factor Model (FFM; McCrae & Costa, 1990), as it appears to address the limitations with the DSM-IV diagnostic categories noted above.

The FFM describes five broad domains of personality: (1) neuroticism (or negative emotionality) versus emotional stability; (2) extraversion (or positive emotionality) versus introversion; (3) openness to experience (or unconventionality) versus closedness to experience; (4) antagonism versus agreeableness; and (5) conscientiousness (or constraint) versus negligence (McCrae & Costa, 1990; Tellegen & Waller, in press). Each of these broad domains can be differentiated into underlying facets. Table 1 presents facets of the FFM, as identified by Costa and McCrae (1995). For example, the facets of neuroticism include anxiousness, impulsiveness, depression, angry hostility, vulnerability, and self-consciousness, and the facets of agreeableness (vs. antagonism) are trust (vs. mistrust, suspiciousness), modesty (vs. arrogance), altruism (vs. exploitation), compliance (vs. oppositionalism, aggression), tender-mindedness (vs. tough-mindedness, low empathy), and straightforwardness (vs. deception, manipulation).

There is substantial empirical support for the FFM description of personality, including a consistency in structure across diverse cultures

Table 1. Five-Factor Model of Personality: Domains and Facets[a]

Neuroticism

N1: *Anxiousness:* fearful, apprehensive vs relaxed, unconcerned
N2: *Angry Hostility:* bitter, angry vs even-tempered
N3: *Depressiveness:* pessimistic, glum, despondent vs. optimists
N4: *Self-Consciousness:* timid, embarrassed vs self-assurred, glib, shameless
N5: *Impulsiveness:* tempted, reckless vs controlled, restrained
N6: *Vulnerability:* fragile, helpless vs stalwart, brave, fearless

Extraversion (vs. Introversion)

E1: *Warmth:* affectionate, attached vs cold, aloof, reserved, indifferent
E2: *Gregariousness:* sociable, outgoing vs withdrawn, isolated
E3: *Assertiveness:* enthusiastic, forceful vs unassuming, quiet, resigned
E4: *Activity:* active, energetic, vigorous vs passive, lethargic
E5: *Excitement-Seeking:* adventurous, rash vs cautious, monotonous, dull
E6: *Positive Emotions:* high-spirited vs placid, anhedonic

Openness vs. Closedness to Experience (or Unconventionality)

O1: *Fantasy:* imaginative, dreamer, unrealistic vs practical, concrete
O2: *Aesthetic:* aesthetic vs unaesthetic
O3: *Feelings:* emotionally responsive, sensitive vs unresponsive, constricted
O4: *Actions:* novelty seeking, eccentric vs routine, habitual stubborn
O5: *Ideas:* curious, odd, peculiar, strange vs pragmatic, rigid
O6: *Values:* broad-minded, tolerant vs traditional, dogmatic, biased

Agreeableness (vs. Antagonism)

A1: *Trust:* trusting, gullible vs skeptical, cynical, suspicious, paranoid
A2: *Straightforwardness:* honest, confiding vs cunning, manipulative, deceptive
A3: *Altruism:* giving, sacrifical vs selfish, stingy, greedy, exploitative
A4: *Compliance:* cooperative, docile vs oppositional, combative, aggressive
A5: *Modesty:* self-effacing, meek vs confident, boastful, arrogant
A6: *Tender-Mindedness:* concerned, compassionate, empathic vs callous, ruthless

Conscientiousness

C1: *Competence:* efficient, perfectionistic vs lax, negligent
C2: *Order:* organized, methodical, ordered vs haphazard, disorganized, sloppy
C3: *Dutifulness:* dutiful, reliable, dependable, rigid vs casual, undependable
C4: *Achievement-Striving:* purposeful, ambitious, workaholic vs aimless
C5: *Self-Discipline:* industrious, devoted, dogged vs negligent, hedonistic
C6: *Deliberation:* reflective, thorough, ruminative vs careless, hasty

[a]Derived from Costa and McCrae (1992), Tellegen and Waller (in press), and Trull and Widiger (in press).

(McCrae & Costa, 1997), stability across time (Costa & McCrae, 1994), and convergence across a diversity of methods of assessment, including self, peer, and spousal ratings (McCrae & Costa, 1987). Its assessment and vali-

dation (e.g., normative data) are beyond the scope of this particular paper, as this discussion is confined largely to its application and relevance to psychotherapeutic treatment, but details regarding this research are available in a number of review articles and texts (Costa & McCrae, 1995; Widiger & Trull, 1997).

It is apparent from the descriptors provided in Table 1 that each of the DSM-IV personality disorders can be understood from the perspective of the FFM (Widiger, Trull, Clarkin, Sanderson, & Costa, 1994). For example, the angry hostility, excessive vulnerability, extreme anxiousness, impulsivity, and depressiveness from neuroticism, along with facets of antagonism (e.g., manipulation and oppositionalism), describe quite well the borderline personality disorder (Clarkin et al., 1993; Widiger, 1993). Tough-mindedness (e.g., lack of empathy), aggressiveness, deception, and manipulation from the domain of antagonism, coupled with fearlessness, self-assurance, recklessness, and impulsivity from the domain of neuroticism, and negligence and hedonism from the domain of conscientiousness, describe well the psychopathic (antisocial) personality disorder (Widiger, in press). The major traits of each of the personality disorders have a precise representation within the FFM, including the suspiciousness of the paranoid (a facet of antagonism), the self-consciousness of the avoidant (a facet of neuroticism), and the arrogance of the narcissistic (a facet of antagonism). A number of studies, sampling from a variety of populations and using a variety of measures of the FFM and personality disorders, have indicated a close association of the FFM with models of personality disorder (e.g., Clark, Vorhies, & McEwen, 1994; Clarkin et al., 1993; Costa & McCrae, 1990; Schroeder, Wormworth, & Livesley, 1992; Soldz, Budman, Demby, & Merry, 1993; Trull, 1992; Wiggins & Pincus, 1989).

The FFM also allows for the consideration of maladaptive personality traits not recognized within the DSM-IV (Stone, 1993), such as alexythymia (i.e., closedness to feelings) and biased, prejudicial attitudes (i.e., closedness to ideas and values). Each of the two poles of the thirty facets of the FFM includes a maladaptive variant at its most extreme expression, with more adaptive variants toward the mild and moderate ranges of expression. For example, skepticism (within the trust-mistrust facet of agreeableness-antagonism) is a largely adaptive trait. Its more extreme variant would be suspiciousness. Opposite to skepticism is the disposition to be trusting, which is again largely adaptive, but its more extreme variant is gullibility.

It is not the case that each of the domains of the FFM, each of the facets within each domain, and each of the poles of each facet, are equivalent with respect to their degree of adaptivity and maladaptivity. It would be a substantial coincidence of nature for this to occur. Neuroticism will be more closely associated with maladaptivity than extraversion or uncon-

ventionality, and high neuroticism will be more maladaptive than low neuroticism. Nevertheless, each trait, particularly in its most extreme variant, will be associated with some degree of maladaptivity. For example, most persons would desire to be low in feelings of vulnerability, self-consciousness, and anxiousness. However, excessively low neuroticism provides the fearlessness, glib and superficial charm, and indifference to signs of threat or danger that are fundamental to the personality disorder of psychopathy (Lykken, 1995; Widiger, in press).

The mild to moderate levels of each trait will usually (but not always) be associated with adaptive behaviors. The FFM then provides the ability to describe a person's adaptive and maladaptive traits within one model of personality. The FFM will describe the extent to which the patient is open-minded, warm, empathic, considerate, honest, conscientious, gregarious, relaxed, and self-assured, along with the extent to which the patient is suspicious, deceptive, exploitative, withdrawn, cold, reckless, pessimistic, or aggressive. The recognition of these traits not only provides a more accurate, vivid, and precise description, but they are also quite important to treatment (Fagan, 1994; Sanderson & Clarkin, 1994). For example, patients who are characteristically open-minded will tend to be more receptive to change, and patients who are conscientious will tend to be reliable, responsible, and diligent in their effort to change (Miller, 1991). The FFM provides a much more precise and treatment relevant description of personality than is provided by the gross and stereotypic labeling of the DSM-IV diagnostic categories.

The FFM includes the important traits of personality because it was developed empirically for just this purpose. The FFM was developed on the basis of the compelling rationale that the most important traits of personality would be identified through an empirical (lexical) analysis of the language (Saucier & Goldberg, 1996). The English language has been in use and development for a substantial period of time. The personality traits that people consider to be the most important in describing themselves and others will naturally be encoded into the language in the course of its usage across its long history of development. The relative importance of a trait would be indicated by the number of terms that have been developed to describe its various nuances and range of expression, and the structure of the traits would be evident by the relationship among the terms. It is certainly possible, but unlikely, for a brilliant theorist to discover important personality traits that have not been recognized over the long history of human speech, thought, and interaction. To the extent that a theorist is describing an important dimension of personality, it should be evident within the FFM and, in fact, alternative models of personality have con-

sistently been identified as a subset or constellation of FFM facets (McCrae & Costa, 1990).

An additional attraction of the FFM is that its language and terms are, for the most part, straightforward and atheoretical. A criticism of the FFM has been the absence of a particular theoretical model to provide the explanation for the etiology of its domains and facets (Block, 1995). For example, the FFM itself offers no explanation for the existence and etiology of the domain of neuroticism, nor does it suggest a specific therapeutic intervention for the alteration of one's level of neuroticism. It simply indicates the presence of and describes the major facets of this domain of functioning.

This criticism, however, is somewhat ironic, given the aspiration of the DSM-IV diagnostic system to be atheoretical, or at least theoretically neutral (APA, 1994). It is desirable and advantageous for a model of personality description not to be wedded to a particular theoretical perspective. The DSM-IV and the FFM are to be used by persons with a wide variety of theoretical orientations, including psychodynamic, neurochemical, cognitive-behavioral, and interpersonal-systems perspectives. There is no single form of treatment for the many mental disorders within DSM-IV, nor is there a specific form of treatment for personality change. It is, of course, impossible to be entirely atheoretical, but classification systems can be distinguished in part by the extent to which they are compatible or incompatible with one or more theoretical models. Benjamin (1993), Beck, Freeman, and Associates (1990), and Cloninger, Svrakic, & Przybeck (1993) have much to offer to our understanding of the etiology and treatment of maladaptive personality traits. However, pharmacologically-oriented clinicians will find Benjamin's (1993) analytic dimensions of self-emancipation and self-love to be foreign, at best, and object-relational clinicians will have a comparable difficulty with the clinical utility of the neurotransmitter-based temperaments of Cloninger et al. (1993). On the other hand, clinicians from these diverse perspectives do find it relatively easy and useful to describe the extent to which patients are antagonistic, introverted, or suspicious.

A theoretically neutral perspective is also realistic, as the etiologies of borderline, psychopathic, and other personality traits are complex, multifactorial, and at times even idiosyncratic to individual cases. There are many different contributing and interacting factors for each respective personality disorder (e.g., Bornstein, 1993; Lykken, 1995), and persons with the same disorder will at times have followed a different path to its development. Treatment of these maladaptive personality traits should be equally flexible and eclectic (Stone, 1993).

ILLUSTRATIVE EXAMPLES

Many case studies and clinical applications of the FFM have been published (e.g., Bruehl, 1994; Corbitt, 1994; Fagan, 1994; Fagan et al., 1991; MacKenzie, 1994; Miller, 1991). Two additional cases are provided in this paper to offer illustrations of some of the issues raised above.

Billy Ray

Billy Ray was a 26 year-old lawyer who sought treatment for cocaine abuse. He did not meet the DSM-IV criteria for any of the officially recognized personality disorders. My clinical diagnosis was personality disorder, not otherwise specified, with antisocial personality traits. Figure 1 provides the FFM description of his personality, as well as for a prototypic antisocial and psychopathic personality disorder diagnosis (more detailed discussions of these disorders are presented elsewhere; Widiger, in press; Widiger & Lynam, in press).

Figure 1 illustrates the important differences between the antisocial and psychopathy diagnoses (Hare, Hart, & Harpur, 1991), notably the inclusion in the diagnosis of psychopathy of such traits as glib charm (i.e., N4, excessively low self-consciousness), fearlessness (N6, low vulnerability), low anxiousness (N1), arrogance (A5), and low empathy (A6, tough-mindedness). Billy Ray, however, had few of the facets of low conscientiousness that are emphasized in both diagnoses (e.g., C3, irresponsibility), nor was his exploitation (A3) expressed through overt criminal activities. He also lacked a physical aggressiveness (A4). As a result, he failed to meet the DSM-IV criteria for antisocial personality disorder (APA, 1994). However, he did have many clinically significant psychopathic personality traits, notably the exploitativeness (A3), deception (A2), glib charm (N4), impulsivity (N5), manipulation (A2), and lack of empathy (A6). These traits were of considerable importance in fully understanding his personality and his many social and occupational setbacks and failures. Nevertheless, in combination with his high levels of competence (C1), organization (C2), and achievement-striving (C4), he characterized in part what has been described in the clinical literature as the successful psychopath (Widiger, in press; Widiger & Hicklin, 1995).

Billy Ray indicated that his nickname at work was "The Shark," a nom de plume that he wore with considerable pride despite its negative connotations. Everyone expected that Billy Ray would succeed, but often at the expense of his competitors, colleagues, and even friends. He was charming, brave, assertive, cagy, shrewd, calculating, confident, unsentimental, ambitious, and, "when necessary," ruthless. He did not feel that these traits were at all problematic or undesirable, as they were instrumental to his occupational success. There was indeed some truth to this belief, but he did not (yet) appreciate the shallowness of his personal relationships, the risks that resulted from his confident fearlessness, and the mounting danger of his manipulation, exploitation, and, at times, overt cheating of others (Widiger & Hicklin, 1995).

His motivation for treatment was facilitated by the importance he gave to achievement and competence (Miller, 1991). He knew that he did not have the complete package for success. He lacked the necessary dutifulness, discipline, restraint, and self-control (i.e., facets of conscientiousness and low neuroticism). He was troubled particularly by his inability to resist temptations. His cocaine abuse was not the only manifestation of his characterologic impulsivity. He gambled and frequented strip clubs. These were not egregiously pathologic behaviors, but they were very problematic to his aspirations and legal career.

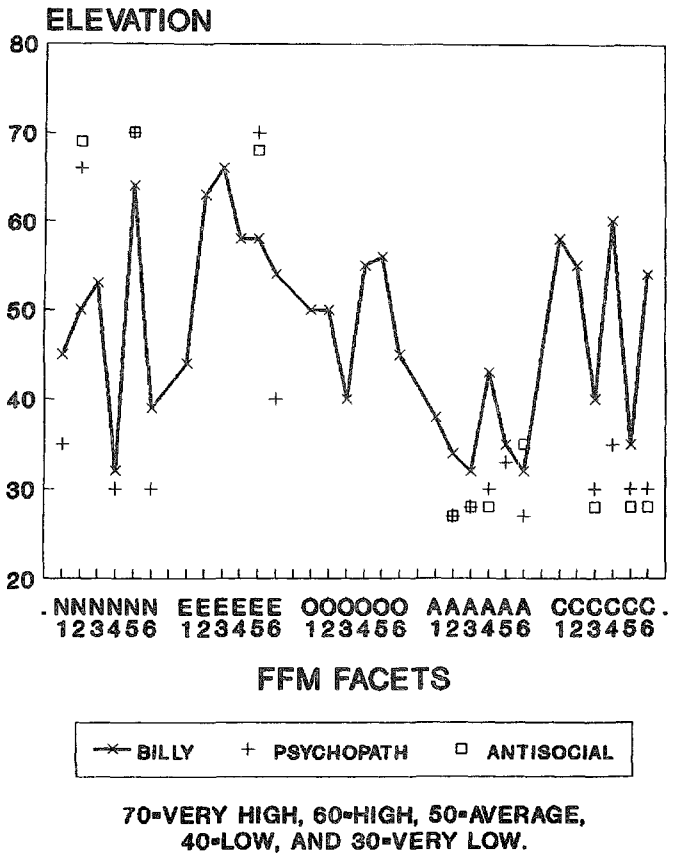

Fig. 1. FFM personality description: Billy and the psychopathic & antisocial personality disorders.

Treatment was initially cognitive-behavioral (Beck et al., 1990), capitalizing on his emphasis on competence, order, and achievement (i.e., high conscientiousness). As suggested by Miller (1991), persons who are characterized by high conscientiousness are "willing and able to cooperate with treatment, if the mode of treatment is otherwise suitable for them" (p. 431). I also used (or fed) his competitive ambition by challenging him to develop an organization and structure that would constrain his drug usage. Billy's high need for achievement was perhaps the major motivation for change. Psychopathic persons are notoriously unmotivated for and unresponsive to psychotherapy. However, I did not appeal to Billy's minimal

desire for growth or moral self-improvement. I appealed to his ambition and drive for success that were as fundamental to his personality as his maladaptive psychopathic traits. We developed personal mantras that he would repeat to himself to challenge himself to resist temptations whenever they arose. These mantras might have sounded superficial to others, but they were effective, meaningful, and even inspirational to Billy.

Billy's cynicism, deceptiveness, manipulativeness, and low empathy did complicate his treatment substantially, as is the case for most persons with a diagnosis of psychopathy (Widiger & Hicklin, 1995). A sincere rapport and clinical attachment were difficult to achieve, and were perhaps never obtained. These maladaptive traits were addressed initially by accepting (or simply ignoring) them. I did not criticize or morally condemn his reckless impulsivity. He could still use cocaine (at least initially) but only under specified conditions. At times, I even pretended to admire his successful exploitations. This was not particularly genuine on my part, and it is risky to suggest an approval, pleasure, or collusion in the pathology of the patient. Nevertheless, I often find that it is necessary to initially accept the personality of a patient, to initially go downstream with the maladaptivity, in order for the person to become comfortable in expressing and eventually questioning his or her personality. My acceptance of Billy allowed him to be himself, to not feel defensive, and to recognize, at his own time, the maladaptivity of his personality without losing face.

As we traced the historical roots of his impulsivity (the personality trait that he could recognize as being problematic), he gradually became more cognizant of other difficulties and problems that had pervaded his life. He had been twice divorced, with both relationships ending in substantial acrimony and conflict; he had been investigated briefly during law school for a suspicion of cheating; and he had narrowly escaped a charge of sexual harassment at work. He had no difficulty in obtaining girlfriends, but this was because he had no difficulty deceptively charming and seducing women. None of his past girlfriends had ever remained his friend. His personal, academic, and occupational history was littered with victims of his exploitation. He did not feel especially ashamed or remorseful. He was more proud than embarrassed, but he did acknowledge being troubled by the eventual consequences of his actions, such as the failure to sustain any long-term relationships, the acrimony and conflicts that inevitably developed, and the many close calls when he was caught "bending the rules." He gradually recognized, in the context of the accepting therapeutic relationship, that his life path was leading nowhere, at least with respect to personally meaningful relationships. His motivation to address his subthreshold psychopathic traits did lack some depth, as it was again motivated

in part by his desire (or need) to succeed, but it was at least sufficient motivation to hewn the rougher edges to his personality.

Donna

Donna was a 32 year-old female who sought treatment after her third divorce. She failed to meet the full DSM-IV diagnostic criteria for any officially recognized personality disorder, yet it was apparent that it was her personality traits that had been problematic to her marriages. Her clinical diagnosis was personality disorder, not otherwise specified, with borderline personality traits. Figure 2 presents her FFM profile, as well as the profile of a prototypic borderline personality disorder (more detailed discussions of the borderline personality disorder from the perspective of the FFM are presented elsewhere: Bruehl, 1994; Clarkin et al., 1993; Widiger et al., 1994).

Donna's most problematic personality traits were her angry hostility (N2), a cynicism and skepticism that bordered on suspiciousness (A1), and an argumentativeness (A4). However, these traits were offset by her empathy (A6), gregariousness (E2), warmth (E1), sociability (E2), generosity (A3), and concern for others (A6). She wanted very much to get along with others, to develop close friendships and attachments, but she would inevitably contaminate these relationships with her anger, bitterness, mistrust, and argumentativeness. She had no difficulty initiating, obtaining, and developing relationship; she just couldn't maintain them.

An excellent sign for her potential responsivity to treatment was her openness to an exploration of her feelings (O3), fantasies (O1), and ideas (O5) (Miller, 1991; Sanderson & Clarkin, 1994). She was indeed quite reflective, inquisitive, and open to change. She did not need to be challenged to change, but was instead openly receptive to self-reflection and self-criticism. She already had within her personality the necessary motivation for successful treatment.

My approach in this instance was primarily an exploratory, insight-oriented psychotherapy (Stone, 1993). Persons characterized by high openness to feeling and ideas are perhaps particularly well-suited for exploratory, insight-oriented psychotherapy (Clarkin & Sanderson, 1994; McCrae & Costa, 1990). Donna indeed traced her anger, cynicism, and bitterness in large part to being raised by an inconsistent, alcoholic father. Throughout her childhood, he would often encourage and nurture a very close, emotional attachment to him, but then suddenly and inexplicably detach and withdraw. He eventually left her mother for a younger woman when Donna was in the ninth grade. He tried to maintain an involvement with her, but she had grown weary and mistrustful of his "on-again, off-again" love. Her disappointment and bitterness were also fueled by the overt resentment and anger of her mother who continually reminded her of his faithless love. As she eventually acknowledged in therapy, "this 'boulder on my shoulder' has been very difficult to remove." "I wanted so much to get close to him again, to forgive and forget, but I haven't forgotten and there is too much to forgive." Forgiving one's parents for their failures is indeed difficult, but it was in part because she could not let go that many persons thereafter

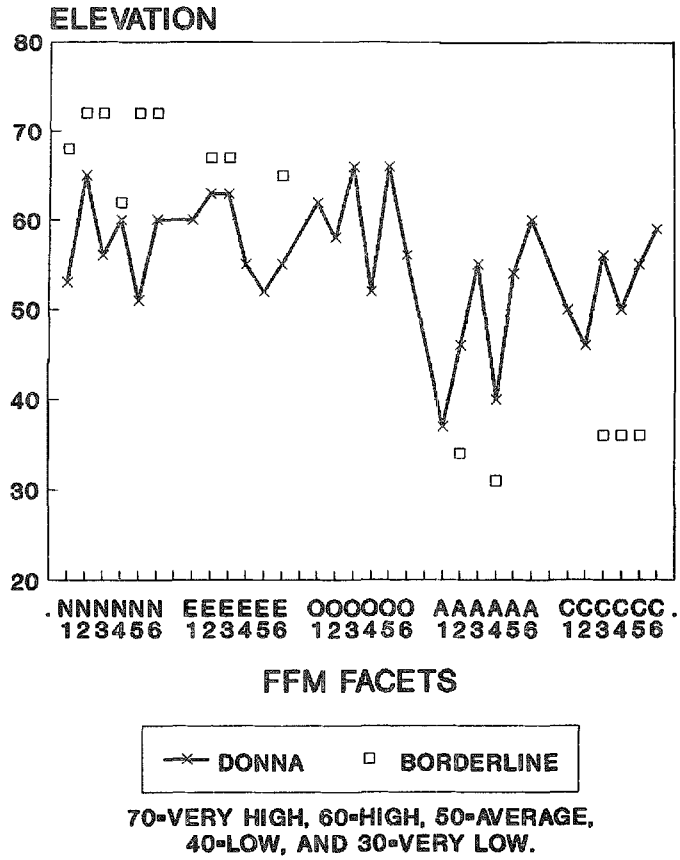

Fig. 2. FFM personality description: Donna and the borderline personality disorder.

became the victims of her bitterness, mistrust, and anger (Pattison, 1965; Worthington & DiBlasio, 1990). As one husband said, "you have a very good reason to be angry and bitter, but not toward me." Donna would in fact continually recreate her victimization, and refuel her bitterness, by pushing and testing persons so hard that they would eventually lash out against her.

Treatment was not particularly successful in fully healing her wounds, but she did grow to appreciate that her manner of relating to others had been developed within a pathologic family environment. These insights were facilitated substantially by her openness to exploring her feelings,

thoughts, and fantasies. A personality disorder diagnostic label (e.g., borderline) would not have recognized this strength of her personality. Donna gradually became more successful in recognizing when her feelings of resentment were overdetermined by her past experiences, in addressing overt conflicts without exploding in anger, and in letting herself develop an attachment to someone without a concomitantly rising tide of suspicion and mistrust.

SUMMARY AND CONCLUSIONS

The optimal description of a patient's personality is provided by a classification that is comprehensive in its coverage of *both* adaptive and maladaptive personality traits and that is specific to an individual's idiosyncratic constellation of personality traits. Most persons will have some maladaptive personality traits, and most persons with clinically diagnosed personality disorders will have at least some adaptive, useful personality traits. The personalities of persons and patients can not be described by simply one word, term, or diagnosis. Optimal treatment decisions should be informed by a more accurate and precise description of each individual person's adaptive and maladaptive traits as provided, for example, by the dimensional, five-factor model of personality.

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