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The Personality Syndromes

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Key Points

- Personality refers to an individual's characteristic patterns of thought, feeling, behavior, motivation, defense, interpersonal functioning, and ways of experiencing self and others.
- Clinical knowledge accrued over generations has given rise to a taxonomy of familiar personality syndromes.
- Personality syndromes exist on a continuum of functioning from healthy to severely disturbed. There is no discontinuity between normal and pathological personality.
- Understanding personality syndromes requires an understanding of underlying personality processes such as inner conflicts, defenses, and motives.
- A diagnostic prototype is provided for each personality syndrome, which describes the syndrome in its "ideal" or pure form.
- A practical diagnostic method based on pattern recognition is provided, whereby clinicians consider the overall resemblance between patients and diagnostic prototypes.
- The personality constructs provide the broad strokes of clinical case formulations. They can explain and contextualize presenting symptoms and disorders.
- Each personality syndrome is a distinct pathway to depression and requires a different treatment focus.

Introduction

Personality is not about what disorders you *have* but about who you *are*. It refers to a person's characteristic patterns of thought, feeling, behavior, motivation, defense, interpersonal functioning, and ways of experiencing self and others. All people have personalities and personality styles.

While there are as many personalities as people, clinical knowledge accrued over generations has given rise to a taxonomy of familiar personality styles or types. Most people, whether healthy or troubled, fit somewhere in the taxonomy. Empirical research over the past two decades has confirmed the major personality types and their core features.[1–5]

Most clinical theorists do not view the personality types as inherently disordered. They are generally discussed in the clinical literature as personality types, styles, or syndromes—not "disorders." Each exists on a continuum of functioning from healthy to severely disturbed. The term "disorder" is best regarded as a linguistic convenience for clinicians, denoting a degree of extremity or rigidity that causes significant dysfunction, limitation, or suffering. One can have, for example, a narcissistic personality *style* without having narcissistic personality *disorder*.

The same personality dynamics give rise to both strengths and weaknesses. A person with a healthy narcissistic personality style has the confidence to dream big dreams and pursue them; they can be visionaries, innovators, and founders. A person with a healthy obsessive-compulsive style excels in areas requiring precise, analytic thinking; they may be successful engineers, scientists, or academics. A person with a healthy paranoid style looks beneath the surface and sees what others miss; they may be investigative journalists or brilliant medical diagnosticians. Our best and worst qualities are often cut from the same psychological cloth.

Many psychodynamically influenced clinicians accept the broad outlines of an organizing framework proposed by Otto Kernberg,[6,7] which combines the concept of personality type with a "severity dimension" reflecting level of personality organization (healthy, neurotic, borderline, psychotic).[8–9] For example, we can speak of a patient with narcissistic personality organized at a neurotic level or at a borderline level. The approach presented here is consistent with this framework. (For discussion of levels of personality organization, see Chapter 2, Levels of Personality Organization: Theoretical Background and Clinical Applications.)

The recognition that personality styles exist on a continuum of functioning was undercut by the *Diagnostic and Statistical Manual of Mental Disorders*[10] (DSM) beginning with the publication of DSM-III.[11] To shoehorn personality styles discussed in the clinical literature into a categorical taxonomy of disorders, the framers of the DSM described them in pathological form, in some cases ratcheting up the severity to the point of caricature.[3,4] The DSM also disregarded the underlying personality processes at the core of the personality styles, such as internal conflict, defenses, and motives. It focused instead on outward behavior and readily observable symptoms. Thus, the DSM borrowed terminology and concepts from the clinical, chiefly psychoanalytic literature (obsessive-compulsive, narcissistic, paranoid, and so on) but disconnected them from the larger body of clinical knowledge.

Clinicians who are expert in treating personality have a working knowledge of personality syndromes that is richer, deeper, and more complex than the depictions in the DSM[8,9,12,13] and in some cases diverges from it.[3] This chapter provides an overview of the personality syndromes as understood by expert clinicians and verified by empirical research. The descriptions provided here go beyond overt behavior and symptoms and address the personality processes that underlie them. For many patients, they can provide roadmaps for effective treatment.

Diagnosis as Pattern Recognition

Each personality syndrome discussed in this chapter is represented by a paragraph-length description called a diagnostic prototype, which describes the personality syndrome in its "ideal" or pure form.[4,14–15] These diagnostic prototypes are evidence based. They were derived empirically, based on a national sample of N = 1,201 patients described by their clinicians using the Shedler-Westen Assessment Procedure (SWAP). They reflect empirically observable characteristics of actual patients, not just theoretical conjecture.

Naturally occurring diagnostic groupings were identified using statistical clustering methods, which largely confirmed the personality syndromes described in the clinical literature. The SWAP items (descriptive statements) that best describe each personality syndrome were likewise identified empirically, then arranged as paragraphs to create the diagnostic prototypes.[4] (The SWAP instrument is described in Chapter 4, Integrating Clinical and Empirical Approaches to Personality: The Shedler-Westen Assessment Procedure (SWAP). The instrument is available at https://swapassessment.org.)

The diagnostic prototypes have the advantage of being empirically based and also preserving the richness and complexity of accrued clinical knowledge. To make a personality diagnosis, a clinician rates the overall resemblance or match between a patient and a diagnostic prototype from 0 (no match) to 5 (very good match). Higher scores indicate more resemblance to the diagnostic prototype and more severity. The diagnostic prototypes are presented in Boxes 1.1 to 1.10 and the rating scale is included with each prototype.

If categorical diagnosis is desired for compatibility with the DSM-5 or International Classification of Diseases (ICD-10) diagnostic system, scores of 4 and 5 indicate a personality disorder diagnosis, and a score of 3 indicates traits or features of a disorder. Thus, if a patient receives a score of 5 for narcissistic personality and 3 for obsessive-compulsive personality, the categorical (DSM format) diagnosis is narcissistic personality disorder with obsessive-compulsive traits.

The premise of this approach is that a configuration or pattern of interrelated psychological characteristics defines a personality syndrome, not the presence or absence of separate characteristics. *Recognizing a personality syndrome is pattern recognition*, much as recognizing a face depends on pattern recognition, not tabulating separate features.[4,14,15]

Prototype matching provides reliable and valid diagnoses and works with the cognitive decision processes of clinicians, which rely on pattern recognition. It systematizes what expert clinicians already do in practice. In a consumer-preference study, psychologists and psychiatrists preferred this method of personality diagnosis to the DSM diagnostic system and to dimensional trait models of personality.[16]

Developing a Treatment Focus

In recent years, many clinicians have been trained to focus on presenting problems and DSM Axis I disorders (such as depression or generalized anxiety) and view them as encapsulated conditions separate from personality. Treatments that target specific DSM disorders implicitly assume all patients with a given DSM diagnosis have the "same"

condition and will respond to the same interventions. Clinicians learn the hard way that things are rarely so simple.

Most often, the problems that bring people to mental health treatment are not encapsulated problems. They are woven into the fabric of their lives. They are em-embedded in, and inseparable from, the person's characteristic patterns of thinking, feeling, behaving, coping, defending, and relating to others: in other words, personality. This is true whether or not the person has a diagnosable "personality disorder." The patient needs the clinician to grasp something psychologically systemic about who they *are*, not just what disorders they *have,* to help them understand why they are repeatedly vulnerable to certain kinds of suffering and how to change it.

Meaningful and lasting change generally comes not from focusing on symptoms, but on the personality patterns that underlie them. Knowledge of personality styles provides a map of the personality terrain that expert clinicians navigate. Thus, each personality syndrome is not just description, but shorthand for the broad strokes of a clinical case formulation that can provide a treatment focus and address the underlying causes of many patients' suffering. The penultimate section of this chapter, Personality and Clinical Case Formulation, revisits this topic.

The Personality Syndromes

This section describes the major personality syndromes as understood by clinical theorists and confirmed by empirical research. The diagnostic prototypes and rating scales in Boxes 1.1 to 1.10 can be used for day-to-day clinical diagnosis.

Depressive Personality

Despite its omission from the DSM, depressive personality is the most common personality syndrome seen in clinical practice.[2] It is a personality syndrome in every sense of the term: an enduring pattern of psychological functioning evident by adolescence and encompassing the full spectrum of personality processes.

People with depressive personalities are chronically vulnerable to painful affect, especially feelings of inadequacy, sadness, guilt, and shame. They have difficulty recognizing their needs, and when they do recognize them, they have difficulty expressing them. They are often conflicted about allowing themselves pleasure. They may seem driven by an unconscious wish to punish themselves, either by getting into situations destined to cause pain or depriving themselves of opportunities for enjoyment. A psychologically insightful observer might describe the person as their own worst enemy.

Where there is an enemy, there is often anger and aggression. One underlying psychological theme in depressive personality is internal attacks against the self. The person is angry, defends against experiencing anger, and instead directs it at themselves in the form of self-criticism, self-deprivation, and self-punitiveness. The relevant SWAP item is, "Has trouble acknowledging or expressing anger toward others and instead becomes depressed, self-critical, self-punitive, etc." In short, the person treats themselves like someone they despise.

Clinicians can easily miss the patient's anger and aggression because people with depressive personalities tend to be overtly agreeable and put others' needs first,

including the clinician's needs. If psychotherapy is to bring about meaningful psychological change, anger must be recognized, experienced, and explored in the therapy relationship.

A second psychological theme involves separation, rejection, and loss. The person may be preoccupied with, and painfully vulnerable to, disruptions in interpersonal relationships. They fear being abandoned and left unprotected and uncared for. As a result, they avoid interpersonal conflict and have difficulty asserting themselves. Undue people-pleasing and helpfulness protect against disapproval or rejection. In psychotherapy, they suppress legitimate criticisms and dissatisfactions for fear of hurting the clinician's feelings or damaging the therapy relationship. Instead of communicating their needs and wants, they accept what is offered and make do. This can lead to a relationship dynamic in which the clinician thinks things are going swimmingly and the patient does without, thereby recreating the patient's dysfunctional relationship pattern in the therapy relationship.

This pattern may have roots in relational disruption or insufficient emotional availability of a caretaker in early development, leaving the person feeling emotionally empty and incomplete, and believing their deprivation was caused by their own badness. Some patients have a pervasive sense that someone or something essential to their well-being has been lost and can never be recovered. These feelings can crystalize around, and be amplified by, subsequent experiences of loss. Rewards and pleasures that are realistically available may be experienced as a pale shadow of what was lost or could have been. Such patients may need the clinician's help to mourn what has been lost before they can invest emotionally in what life can offer now.

For some patients with depressive personalities, themes of unconscious anger and self-attack predominate. For others, themes of separation and loss predominate. These themes have been discussed in the clinical and research literature in terms of introjective (self-critical) and anaclitic (dependent) depression.[17,18] Both themes may be present in any blend.

Depressive personality is the most common personality style among people drawn to the mental health professions.[19] Clinical practitioners have endless opportunity to care for others instead of themselves, be unduly helpful, and fault themselves for falling short of unrealistic, self-imposed standards.

See Box 1.1 for the depressive personality prototype.

Anxious-Avoidant Personality

The term "Avoidant Personality Disorder" is used by the DSM and is more familiar to clinicians, but the hyphenated term "anxious-avoidant" more accurately and telegraphically conveys the essence of this personality syndrome.

People with anxious-avoidant personalities are, first and foremost, anxious. Anxiety pervades their experience of themselves and their world. They ruminate and dwell on perceived dangers and past mistakes. Their predominant emotions are anxiety, shame, and embarrassment. They defend against sources of anxiety by avoidance. The problem is that the sources of anxiety are everywhere, including within. Ultimately, avoidant responses become bars in a psychological prison, constricting and limiting freedom of thought, feeling, choice, and action. As a result, people with anxious-avoidant personalities lead constricted lives and tend to adhere to familiar routines. Despite their avoidant

Box 1.1 Depressive Personality Prototype

Summary statement: Individuals with depressive personality are prone to feelings of depression and inadequacy, tend to be self-critical or self-punitive, and may be preoccupied with concerns about abandonment or loss.

Individuals who match this prototype tend to feel depressed or despondent and to feel inadequate, inferior, or a failure. They tend to find little pleasure or satisfaction in life's activities and to feel life has no meaning. They are insufficiently concerned with meeting their own needs, disavowing or squelching their hopes and desires to protect against disappointment. They appear conflicted about experiencing pleasure, inhibiting feelings of excitement, joy, or pride. They may likewise be conflicted or inhibited about achievement or success (e.g., failing to reach their potential or sabotaging themselves when success is at hand). Individuals who match this prototype are generally self-critical, holding themselves to unrealistic standards and feeling guilty and blaming themselves for bad things that happen. They appear to want to "punish" themselves by creating situations that lead to unhappiness or avoiding opportunities for pleasure and gratification. They have trouble acknowledging or expressing anger and instead become depressed, self-critical, or self-punitive. They often fear that they will be rejected or abandoned, are prone to painful feelings of emptiness, and may feel bereft or abjectly alone even in the presence of others. They may have a pervasive sense that someone or something necessary for happiness has been lost forever (e.g., a relationship, youth, beauty, success).

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

defenses, anxiety still leaks out through a variety of channels, which can include somatic symptoms and concerns.

People with anxious-avoidant personalities are fearfully avoidant not only of the external, interpersonal world but also their own internal world. The former is manifested in social avoidance, self-consciousness, and social awkwardness. The latter is manifested in inhibition and constriction of emotional life and desire. They are motivated to avoid perceived harm, not to pursue their desires.

The challenge in psychotherapy is that patients with anxious-avoidant personality are avoidant in psychotherapy, too. They are likely to steer clear of difficult topics, change the subject when their thoughts lead in disturbing directions, and fend off the clinician's efforts to explore psychological experience beyond the most familiar, well-worn grooves. This creates a dilemma for clinicians: If they don't confront avoidant defenses, therapy will accomplish little; if they do, the patient may quit or shut down. Effective treatment involves a balancing act of support and confrontation. The clinician should help and

Box 1.2 Anxious-avoidant Personality Prototype

Summary statement: Individuals with anxious-avoidant personality are chronically prone to anxiety, are socially anxious and avoidant, and attempt to manage anxiety in ways that limit and constrict their lives.

Individuals who match this prototype are chronically anxious. They tend to ruminate, dwelling on problems or replaying conversations in their minds. They are more concerned with avoiding harm than pursuing desires, and their choices and actions are unduly influenced by efforts to avoid perceived dangers. They are prone to feelings of shame and embarrassment. Individuals who match this prototype tend to be shy and self-conscious in social situations and to feel like an outcast or outsider. They are often socially awkward and tend to avoid social situations because of fear of embarrassment or humiliation. They tend to be inhibited and constricted and to have difficulty acknowledging or expressing desires. They may adhere rigidly to daily routines, have trouble making decisions, or vacillate when faced with choices. Their anxiety may find expression through a variety of channels, including panic attacks, hypochondriacal concerns (e.g., excessive worry about normal aches and pains), or somatic symptoms in response to stress (e.g., headache, backache, abdominal pain, asthma).

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support the patient to put words to previously unarticulated feelings and fantasies. When they respond to situations (both inside and outside therapy) with fearful avoidance, they should be pressed for details about the presumed dangers ("And what would happen then?") so they can be examined in the light of day. When a secure working alliance is established, the clinician should encourage the patient to face feared situations and experiences in incremental steps. See Box 1.2 for the anxious-avoidant personality prototype.

Dependent-Victimized Personality

The term "Dependent Personality Disorder" is used by DSM, but the hyphenated term "dependent-victimized" communicates a core feature of the personality syndrome: the tendency to put oneself in harm's way. People with this personality syndrome are drawn to relationships in which they are mistreated, exploited, or abused.

People with dependent-victimized personalities are characterized by intense dependency, leading them to subordinate their needs to those of others in order to maintain desperately needed attachments. This leaves them vulnerable to mistreatment and exploitation. The person experiences the attachment relationship as essential to their

existence and seems prepared to go to any length to preserve it, including agreeing to things they find objectionable and things that may be self-destructive. Externally, they are ingratiating, passive, and submissive. Internally, they experience themselves as unworthy, undeserving, and bereft without the connection to and approval of the other person. In severe cases, existence outside the relationship, however self-destructive, may seem unimaginable. Because of an inner experience of deep unworthiness, they may experience a person who demeans them as the only one who can understand them.

Subservience leads to anger and resentment, but overt anger must be suppressed because it threatens the attachment relationship they perceive as their lifeline. Disavowed anger and aggression leak out in the form of passive-aggressive behavior, which tends to elicit further mistreatment from others. These relationship patterns can play out in the therapy relationship via transference and countertransference. The patient may feel dependent on the clinician while passive-aggressively thwarting all efforts to help. Clinicians may initially respond to the patient's need with extra efforts to provide care, then find themselves becoming controlling or punitive after the patient has "helplessly" and repeatedly thwarted all their efforts. At this point, the therapy relationship comes to resemble the patient's other dysfunctional attachments. Understanding these patterns and how they come about can open the door to new ways of relating. See Box 1.3 for the dependent-victimized personality prototype.

Obsessive-Compulsive Personality

Obsessive-Compulsive personality is among the most familiar and easily recognized of the personality syndromes. On the surface, people with obsessive-compulsive personality are conscientious, meticulous, regimented, and cerebral. They have little access to their emotional life and are more comfortable in the realm of thoughts and ideas than the realm of feelings. Ask a person with obsessive-compulsive personality what they feel, and they will likely tell you what they *think*, often at length, with careful weighing of pros and cons, arguments and counterarguments.

Their intellectualized discourse does not, however, lead to a decision or plan of action. Instead, they may digress into minutia or get caught up in intellectualized abstraction. Their thought processes do not lead to emotional clarity because their unconscious function is to defend against feelings, impulses, and desires. When confronted with the need to make a personal choice, they are likely to vacillate and equivocate. For every pro, there is a con of equal and opposite weight.

Because they come across as robotic and emotionally inaccessible, one theorist described people with obsessive-compulsive personality style as "living machines."[20] But defenses are proportionate to the impulses they defend against. Under the conscious surface, the person with obsessive-compulsive personality is waging epic emotional battles.

At the core of obsessive-compulsive personality is a conflict between obedience and defiance.[12] Obedience—obeying the rules, deference to authority—is experienced as submission and humiliation. This leads to rage and the urge to defy and humiliate the other. Defiance leads to guilt and fear of punishment, which leads back to obedience. Mundane, everyday issues lose proportion. The decision to come early or late to an appointment takes on the proportions of an epic battle between submission and defiance.

Box 1.3 Dependent-victimized Personality Prototype

Summary statement: Individuals with dependent-victimized personality are highly dependent and fearful of being alone, tend to show insufficient concern for their own well-being to the point of jeopardizing their welfare or safety, and have difficulty expressing anger directly.

Individuals who match this prototype tend to be needy and dependent, fear being alone, and fear rejection or abandonment. They tend to be ingratiating or submissive, often consenting to things they find objectionable in an effort to maintain support or approval. They tend to be passive and unassertive and to feel helpless and powerless. They tend to be indecisive, suggestible or easily influenced, and naïve or innocent, seeming to know less about the ways of the world than would be expected. They tend to become attached to people who are emotionally unavailable, and to create relationships in which they are in the role of caring for or rescuing the other person. Individuals who match this prototype tend to get drawn into or remain in relationships in which they are emotionally or physically abused, or needlessly put themselves in dangerous situations (e.g., walking alone or agreeing to meet strangers in unsafe places). They are insufficiently concerned with meeting their own needs and tend to feel unworthy or undeserving. Individuals who match this prototype have trouble acknowledging or expressing anger and instead become depressed, self-critical, or self-punitive. They tend to express anger in passive and indirect ways (e.g., making mistakes, procrastinating, forgetting) that may provoke or trigger anger or mistreatment from others.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

Acquiescing to another's preference or insisting on one's own can feel like being annihilated or annihilating. Minor decisions become emotionally fraught. With so much at stake, fear, shame, and rage constantly threaten to break through.

The overtly observable features of obsessive-compulsive personality derive from this conflict. Conscientiousness and orderliness derive from fear of authority and punishment. Defiance and rage "leak out" in the form of critical attitudes, controlling behavior, oppositionality, power struggles, stinginess, procrastination, and inevitable pockets of messiness and disorder. Intellectualization and emotional constriction serve to keep the conflict outside awareness.

People with obsessive-compulsive personality benefit from exploratory, interpretive psychotherapy. They benefit from insight into their defenses against emotional life and their high cost vis-à-vis their relationships and capacity for spontaneity and joy. The

clinician should be alert to the patient's tendency to intellectualize and treat the clinician's comments as theories to ponder versus matters of immediate emotional import. For example, if the patient says the clinician's observation makes sense, the clinician might ask whether it just "makes sense" or whether they recognize it in themselves and feel it to be true. In this way, the clinician can draw attention to the patient's emotional life and the defenses that squelch it.

Obsessive-compulsive *personality* is different from obsessive-compulsive *disorder*, which is a distinct phenomenon requiring different treatment. See Box 1.4 for the obsessive-compulsive personality prototype.

Box 1.4 Obsessive-compulsive Personality Prototype

Summary statement: Individuals with obsessive-compulsive personality are intellectualized and overly "rational" in their approach to life, are emotionally constricted and rigid, and are critical of themselves and others and conflicted about anger, aggression, and authority.

Individuals who match this prototype tend to see themselves as logical and rational, uninfluenced by emotion. They tend to think in abstract and intellectualized terms, to become absorbed in details (often to the point of missing what is important), and prefer to operate as if emotions were irrelevant or inconsequential. They tend to be excessively devoted to work and productivity to the detriment of leisure and relationships. Individuals who match this prototype tend to be inhibited and constricted, and have difficulty acknowledging or expressing wishes, impulses, or anger. They are invested in seeing and portraying themselves as emotionally strong, untroubled, and in control, despite evidence of underlying insecurity, anxiety, or distress. They tend to deny or disavow their need for nurturance or comfort, often regarding such needs as weakness. They tend to adhere rigidly to daily routines, becoming anxious or uncomfortable when they are altered, and to be overly concerned with rules, procedures, order, organization, schedules, and so on. They may be preoccupied with concerns about dirt, cleanliness, or contamination. Rationality and regimentation generally mask underlying feelings of anxiety or anger. Individuals who match this prototype tend to be conflicted about anger, aggression, and authority. They tend to be self-critical, expecting themselves to be "perfect," and to be equally critical of others, whether overtly or covertly. They tend to be controlling, oppositional, and self-righteous or moralistic. They are prone to being stingy and withholding (e.g., of time, money, affection). They are often conflicted about authority, struggling with contradictory impulses to submit versus defy.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
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1 no match (description does not apply)	

Schizoid-Schizotypal Personality

The term "schizoid" is among the most confusing in the clinical literature, because different writers have used the same word to describe very different types of patients. Those impaired enough to be diagnosed with a DSM personality disorder have basic deficits in psychological capacities. They are characterized by impoverishments in interpersonal functioning, emotional life, and thought processes. The schizoid-schizotypal personality prototype presented here describes this deficit-based syndrome.

Psychoanalytic writers have also used the term "schizoid" to describe a very different and much healthier type of patient who does not suffer from such basic deficits, whose psychology is more conflict-based. These patients may have rich inner lives and deep capacity for empathy, even as they keep their distance from others. Their underlying psychological conflict is between longing for closeness and fear of engulfment, impingement, or overstimulation. (For discussion of this healthier, conflict-based version of "schizoid personality," see Chapter 17, Some Thoughts About Schizoid Dynamics.)

With respect to the more impaired (deficit-based) patients, research does not support the DSM distinction between schizoid and schizotypal personality disorders. The framers of DSM attempted to sharpen the boundaries between these diagnostic categories by emphasizing subsyndromal positive symptoms of schizophrenia in one (schizotypal) and subsyndromal negative symptoms in the other (schizoid). However, the distinction does not hold up empirically. Research with the SWAP instrument consistently identified a single diagnostic grouping with features of both schizoid and schizotypal personality disorders, hence the hyphenated term "schizoid-schizotypal."

Patients who match the schizoid-schizotypal prototype lack close relationships and appear indifferent to human company or contact. They lack social skills and tend to be socially awkward or inappropriate. They may seem odd or peculiar in appearance or manner; something about them seems "off." They tend to think in concrete terms and have little capacity to appreciate metaphor, analogy, or nuance. They have difficulty making sense of others' behavior and likewise have little insight into their own. Despite apparent detachment, they suffer inwardly, often greatly, and experience themselves as outcasts and outsiders. A subset of schizoid-schizotypal patients shows substantial aberrations in thinking, reasoning, and perception, and their speech and thought processes may be digressive and circumstantial.

The schizoid-schizotypal grouping, identified empirically by statistical clustering methods, may not describe a homogeneous group of patients best understood in terms of personality. The patients share surface similarities, notably absence of close relationships and deficits in interpersonal functioning. In some cases, this may reflect personality. But other patients in this diagnostic cluster may have subclinical schizophrenic spectrum disorders and others may be on the autistic spectrum. Clinicians tempted to diagnose schizoid-schizotypal personality should consider carefully whether the patient's difficulties might be better accounted for by factors other than personality per se.

Psychotherapy for deficit-based schizoid-schizotypal patients is largely supportive. Close interpersonal connections and emotional intimacy may not be attainable goals, but patients can work toward more harmonious and frictionless coexistence. Therapy should support ego functions (executive function) and assist patients with reasoning, interpreting events, interpreting others' behavior, planning, judgment, and decision processes. See Box 1.5 for the schizoid-schizotypal personality prototype.

Box 1.5 Schizoid-schizotypal Personality Prototype

Summary statement: Individuals with schizoid-schizotypal personality are characterized by pervasive impoverishment of, and peculiarities in, interpersonal relationships, emotional experience, and thought processes.

Individuals who match this prototype lack close relationships and appear to have little need for human company or contact, often seeming detached or indifferent. They lack social skills and tend to be socially awkward or inappropriate. Their appearance or manner may be odd or peculiar (e.g., their grooming, posture, eye contact, or speech rhythms may seem strange or "off"), and their verbal statements may be incongruous with their accompanying emotion or non-verbal behavior. They have difficulty making sense of others' behavior and appear unable to describe important others in a way that conveys a sense of who they are as people. They likewise have little insight into their own motives and behavior, and have difficulty giving a coherent account of their lives. Individuals who match this prototype appear to have a limited or constricted range of emotions and tend to think in concrete terms, showing limited ability to appreciate metaphor, analogy, or nuance. Consequently, they tend to elicit boredom in others. Despite their apparent emotional detachment, they often suffer emotionally: They find little satisfaction or enjoyment in life's activities, tend to feel life has no meaning, and feel like outcasts or outsiders. A subset of individuals who match this prototype show substantial peculiarities in their thinking and perception. Their speech and thought processes may be circumstantial, rambling, or digressive, their reasoning processes or perceptual experiences may seem odd and idiosyncratic, and they may be suspicious of others, reading malevolent intent into others' words and actions.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

Antisocial-Psychopathic Personality

The DSM diagnosis of Antisocial Personality Disorder emphasizes criminality but largely ignores the personality processes and motives that define a personality syndrome. The empirically derived diagnostic prototype describes personality processes and more closely resembles the historical concept of psychopathy.[21–23] The hyphenated term "antisocial-psychopathic" serves as a bridge between the DSM construct and the clinical personality syndrome.

People engage in antisocial and criminal behavior for many reasons unrelated to personality pathology. Not all people who engage in criminal behavior (or meet DSM criteria for Antisocial Personality Disorder) have psychopathic personalities; not all people

with psychopathic personalities engage in criminality. In some walks of life, psychopathic traits are rewarded. People with antisocial-psychopathic personality styles, given the right opportunities, may become business or political leaders, not criminals, and pursue their ruthless agenda with social approval and even admiration.

People with antisocial-psychopathic personality lack an internalized moral system. What is right is what they can get away with. They are out for personal gain, take advantage of other people, and manipulate and deceive without guilt or inhibition. They show reckless disregard for others' rights, property, or safety. They experience little remorse for the harm they cause. On the contrary, they take sadistic pleasure in dominating and exercising power over others.

People with antisocial-psychopathic personality experience little anxiety, and they show minimal autonomic reactivity in response to aversive events. Many have a high need for stimulation and seek thrills, novelty, and excitement. They push limits and act impulsively, because impulses are not checked by anxiety, empathy, or an internalized moral system. Non-impulsive variants of antisocial-psychopathic personality also exist but are less common. In these variants, sadistic aggression is planned, deliberate, and coldly emotionless, in a way that has been described as "reptilian."

People with antisocial-psychopathic personality are motivated by self-interest, sensation seeking, and desire for power and dominance. Others may puzzle over the person's motive for manipulation or cruelty where there seems little to be gained. The reason is: because they can. Dominance and exerting power over another are their own rewards.

People with antisocial-psychopathic personalities have little interest in self-exploration and rarely come to treatment of their own accord. They come when they perceive some immediate personal advantage to doing so (for example, inducing the clinician to intercede on their behalf, or to get out of legal or other trouble). They are expert at convincing others they have turned over a new leaf, only to revert to the same behavior once they have gotten out of trouble. They understand power, not empathy, and are likely to perceive the clinician's sympathetic attention and compassion as a weakness to exploit. Prognosis is poor. Therapeutic leverage, to the extent there is any, comes from a position of power and dominance few clinicians are comfortable assuming. See Box 1.6 for the antisocial-psychopathic personality prototype.

Narcissistic Personality

The hallmark of narcissistic personality is the coexistence of feelings of grandiosity and feelings of inadequacy and emptiness. Grandiosity defends against and masks underlying feelings of inadequacy (but see the section on Malignant Narcissism for a possible exception).

When narcissistic defenses are working, patients with narcissistic personalities feel special and superior. They have an exaggerated sense of self-importance, feel privileged and entitled, expect preferential treatment, and seek to be the center of attention. Their inner life is dominated by fantasies of limitless success, power, glory, beauty, or talent. They tend to treat others as an audience (to witness their magnificence) or as extensions of themselves.

Idealization and devaluation are central defenses. When they idealize someone to whom they are connected, they feel special and important by association. When they devalue someone, they feel superior. They are relatively oblivious to others' actual

Box 1.6 Antisocial-psychopathic Personality Prototype

Summary statement: Individuals with antisocial-psychopathic personality exploit others, experience little remorse for harm or injury caused to others, and have poor impulse control.

Individuals who match this prototype take advantage of others, tend to lie or deceive, and to be manipulative. They show a reckless disregard for the rights, property, or safety of others. They lack empathy for other people's needs and feelings. Individuals who match this prototype experience little remorse for harm or injury they cause. They appear impervious to consequences and seem unable or unwilling to modify their behavior in response to threats or consequences. They generally lack psychological insight and blame their difficulties on other people or circumstances. They often appear to gain pleasure by being sadistic or aggressive toward others, and they may attempt to dominate significant others through intimidation or violence. Individuals who match this prototype tend to be impulsive, to seek thrills, novelty, and excitement, and to require high levels of stimulation. They tend to be unreliable and irresponsible and may fail to meet work obligations or honor financial commitments. They may engage in antisocial behavior, including unlawful activities, substance abuse, or interpersonal violence. They may repeatedly convince others of their commitment to change, leading others to think "this time is really different," only to revert to their previous maladaptive behavior.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

emotional experience unless it coincides with their own. Interpersonally, they have been described as having emotional transmitters but not receivers.

Grandiosity serves a defensive function, warding off and masking painful feelings of inadequacy, emptiness, smallness, anxiety, and rage. When narcissistic defenses fail, the person is at the mercy of these painful feelings and may lash out in rage or slump into depression and despair.

Deflated or depleted narcissists are less easily recognized than well-defended, grandiose narcissists (and not recognized at all by the DSM). However, they are common in clinical practice. Deflated narcissists are likely to be diagnosed with depressive disorders and may present as ashamed, defeated, and beaten down. When clinicians gain access to their internal world, they find the patient is preoccupied with fantasies of glory and aggrieved at a world that has failed to recognize their unique worth or provide the rewards to which they feel entitled. Behind a depressive presentation, one sometimes finds a deflated narcissist.

Effective treatment involves a careful balancing act, with a judicious blend of empathy and confrontation. Patients with narcissistic personalities benefit from empathic understanding of their underlying pain, insecurity, and vulnerability when these feelings are accessible. With the clinician's help, they can develop greater capacity to tolerate the feelings without resorting to grandiosity and devaluation. On the other hand, they benefit from tactful but systematic confrontation of narcissistic defenses, and exploration of the considerable cost of these defenses vis-à-vis relationships and their ability to find meaning and fulfillment in their lives.

Countertransference reactions include feeling disengaged, deskilled, or competitive with the patient (when devalued), or tempted to join them in a mutual admiration society (when idealized). The clinician's countertransference provides a window into the patient's relationship patterns and the responses they elicit from others. It is important to recognize and explore the relationship patterns as they arise in the therapy relationship, instead of simply repeating the patterns with a new person. People with narcissistic personalities may be most receptive to psychotherapy in mid-life or later, when fantasies of extraordinary success and glory have failed to materialize and they are forced to confront life's realistic limits. See Box 1.7 for the narcissistic personality prototype.

Malignant Narcissism

Malignant narcissism is a variant of narcissistic personality that has gained public attention in recent years. It is, in fact, the intersection of narcissistic personality and antisocial-psychopathic personality, blending the characteristics of both. Malignant narcissism has also been described by clinical theorists as narcissism suffused with sadistic aggression.[6] It is not sufficient for the malignant narcissist to feel important and special; it is necessary for someone else to be demeaned or vanquished. The syndrome could plausibly be called "psychopathic narcissism" or "narcissistic psychopathy," but malignant narcissism is the historically and clinically familiar term.

When psychopathic deception, exploitation, sadistic aggression, and externalization combine with narcissistic grandiosity and self-importance, the result can be especially destructive. When there is no internalized moral system to counteract grandiose strivings, others' needs, rights, and well-being become irrelevant. Other people are used and discarded without guilt or remorse. Harmful consequences and disastrous outcomes are always someone else's fault.

Externalizing blame can have toxic effects on others and is often discussed by nonprofessionals as "gaslighting." The item in the SWAP assessment instrument that addresses externalization is: "Tends to blame own failures or shortcomings on other people or circumstances; attributes his or her difficulties to external factors rather than accepting responsibility for own conduct or choices." The psychological processes that give rise to gaslighting are straightforward. The underlying logic is something like, "The world exists for my aggrandizement and my personal benefit. I am not responsible for my actions or the harm they cause. *You* are responsible."

In extremis, people with severe malignant narcissism may appear to lose touch with reality. This comes about when external events starkly contradict their grandiose, defensively constructed self-image. It is as though the person, forced to choose between revising their self-image and revising reality, opts to revise reality. They may demand that others in their orbit also accept their revised version of reality.

Box 1.7 Narcissistic Personality Prototype

Summary statement: Individuals with narcissistic personality are grandiose and entitled, dismissive and critical of others, and often show underlying signs of vulnerability beneath a grandiose façade.

Individuals who match this prototype have an exaggerated sense of self-importance. They feel privileged and entitled, expect preferential treatment, and seek to be the center of attention. They have fantasies of unlimited success, power, beauty, or talent, and tend to treat others primarily as an audience to witness their importance or brilliance. They tend to believe they can only be appreciated by, or should only associate with, people who are high-status, superior, or "special." They have little empathy and seem unable to understand or respond to others' needs and feelings unless they coincide with their own. Individuals who match this prototype tend to be dismissive, haughty, and arrogant. They tend to be critical, envious, competitive with others, and prone to get into power struggles. They attempt to avoid feeling helpless or depressed by becoming angry instead, and tend to react to perceived slights or criticism with rage and humiliation. Their overt grandiosity may mask underlying vulnerability: Individuals who match this prototype are invested in seeing and portraying themselves as emotionally strong, untroubled, and emotionally in control, often despite clear evidence of underlying insecurity or distress. A substantial subset of narcissistic individuals tend to feel inadequate or inferior, to feel that life has no meaning, and to be self-critical and intolerant of their own human defects, holding themselves to unrealistic standards of perfection.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

In empirical research with the SWAP instrument, items addressing underlying inadequacy and inferiority did not emerge as descriptors of malignant narcissism.[24] It is unclear whether underlying feelings of inadequacy are not a component of malignant narcissism or were not evident to the clinicians who provided the data. It seems likely that when personality dynamics are predominantly narcissistic, underlying inadequacy is present, even if not readily observable; when personality dynamics are fundamentally antisocial-psychopathic, it may not be.

Depending on the blend of narcissism and psychopathy, people with malignant narcissism may or may not be amenable to psychotherapy. Where narcissism predominates and psychopathic traits are secondary, psychotherapy may be helpful, albeit difficult. When psychopathy predominates, prognosis is poor, for the same reasons it is poor for antisocial-psychopathic personality. There is little therapeutic leverage when patients lack an internalized value system or a basic capacity for mutuality.

Paranoid Personality

Patients with paranoid personalities are chronically suspicious, angry, and hostile. They read malevolent intent into others' words and actions and are quick to assume others mean them harm. They hold grudges, dwell on slights, and react to perceived threats with rage and aggression. They see their difficulties as externally caused and lack insight into their own role in shaping events.

At the core of paranoid personality is the defense of projection. People with paranoid personalities are filled with aggression and rage, which they project onto others and (mis)perceive as originating from them. People with paranoid personalities experience the world as cold, hostile, and dangerous because they see their own hostility wherever they look.

Paranoid personality style is found at healthy and neurotic levels of personality organization but is more often seen at borderline levels of organization, at least in clinical populations. Often underappreciated in the clinical literature (and neglected in the DSM) is the extent of cognitive and perceptual disturbances in patients with paranoid personalities. They tend to show disturbances in thinking, above and beyond paranoid ideas. Their perceptions and reasoning can be odd and idiosyncratic, and they may become irrational in the face of strong emotion. While the role of cognitive and perceptual disturbances has been historically underappreciated, it is perhaps not surprising given the pervasiveness of paranoid projection, which necessarily requires some confusion about what is internal versus external and what is reality versus fantasy.

Clinicians' strong emotional reactions to patients with paranoid personality give them a small taste of the fear and rage the patients experience chronically and seek to manage through externalization and projection. The clinician should assist the patient with reality testing when necessary, and help the patient recognize and find more adaptive ways to manage their anger and aggression. An overly friendly or sympathetic stance on the part of the clinician is likely to arouse the patient's suspicion and intensify paranoid thinking. A matter-of-fact stance, even to the point of brusqueness, is generally more effective. See Box 1.8 for the paranoid personality prototype.

Hysteric-Histrionic Personality

The terms "hysteric" and "histrionic" evoke an era of patriarchy and gender inequality and are offensive to many, with reason. There is, however, a difference between the term and the phenomenon. Regardless of the label, a personality syndrome does exist. It is described repeatedly in the clinical literature and emerges in empirical research using statistical clustering methods. Objections to terminology should not blind us to the clinical phenomenon. Nomenclature is beyond the scope of this chapter, which addresses clinical issues.

Before DSM-III introduced the diagnosis of histrionic personality disorder, the term "hysteric" was used to describe higher-functioning people with this personality style and "histrionic" was used for more disturbed patients (such as those in the borderline range of functioning). The hyphenated term "hysteric-histrionic" encompasses higher- and lower-functioning variants of the personality syndrome and provides a bridge between the DSM construct and the extensive clinical literature.

Box 1.8 Paranoid Personality Prototype

Summary statement: Individuals with paranoid personality are chronically suspicious, angry and hostile, and may show disturbed thinking.

Individuals who match this prototype are chronically suspicious, expecting that others will harm, deceive, conspire against, or betray them. They tend to blame their problems on other people or circumstances, and to attribute their difficulties to external factors. Rather than recognizing their own role in interpersonal conflicts, they tend to feel misunderstood, mistreated, or victimized. Individuals who match this prototype tend to be angry or hostile and prone to rage episodes. They tend to see their own unacceptable impulses in other people instead of in themselves and are therefore prone to misattribute hostility to other people. They tend to be controlling, to be oppositional, contrary, or quick to disagree, and to hold grudges. They tend to elicit dislike or animosity and to lack close friendships and relationships. Individuals who match this prototype tend to show disturbances in their thinking above and beyond paranoid ideas. Their perceptions and reasoning can be odd and idiosyncratic, and they may become irrational when strong emotions are stirred up, to the point of seeming delusional.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

Hysteric-histrionic personality is a multifaceted syndrome encompassing the full spectrum of personality processes. On the surface, people with hysteric-histrionic personality styles exemplify gender stereotypes. They present as stereotypically feminine or masculine, like a leading lady or leading man in a stylized Hollywood movie. They are emotional and dramatic. They use their physical attractiveness and sexuality to gain attention. They are flirtatious, seductive, and sexually provocative. They may lead people on and make romantic conquests. They tend to become involved in romantic triangles involving rivals. They can charm and captivate members of the other sex (when both are heterosexual) but may annoy or threaten members of the same sex. Their emotions can seem simultaneously intense and shallow. They can develop intense infatuations which they describe as love, and lose interest when a new prospect arrives.

For people with hysteric-histrionic personality, facts and reason take a backseat to emotion. Their reactions tend to be based on feelings, not reason. If you ask a person with hysteric-histrionic personality what they think, they are likely to tell you how they feel. Their cognitive style tends to be glib, global, and impressionistic; they miss details and gloss over inconsistencies.[25] They come across as naïve and seem to know less about the ways of the world than might be expected. Their beliefs can seem cliché or stereotypical, as if taken from storybooks or movies. They tend to be suggestible. Their impressionistic cognitive style is unrelated to intelligence and serves a defensive function.

People with hysteric-histrionic personality do not look too closely at details or connect too many dots, for fear of seeing and knowing too much.

At the core of hysteric-histrionic personality are conflicts around gender and power. Unconsciously, they see their own gender as weak, defective, or inferior. They see the other gender as powerful, exciting, and frightening, and they are unconsciously envious. They use sexuality as a way to turn the tables and gain power over the other gender. Such use (or misuse) of sexuality helps to ward off feeling of weakness, powerlessness, and fear. They may flaunt their sexuality in exhibitionistic ways to counteract underlying shame, fear, and envy. Genuine sexual intimacy and satisfaction are difficult for the same reasons; it is hard to experience deep connection while feeling shamefully defective or frightened by one's partner. When underlying psychological conflicts cannot find expression in thoughts and words, they may find expression through somatic symptoms (conversion symptoms). Beneath the dramatic presentation and sexualization is a fear of being abandoned and left uncared for, and a yearning to be cared for and protected. Their tragedy is that they long for a caring relationship but find sexual relationships instead.

Patients with hysteric-histrionic personalities respond well to psychotherapy and benefit from both its exploratory, interpretive aspects and its relational aspects. The dependability of the therapist and safety of the therapeutic frame provide a context for self-exploration and insight into conflicts around gender, power, and sexuality. At the same time, the therapy relationship provides a new and different relationship template, one in which a therapist of the other gender is neither seductive nor seducible, and a therapist of the same gender is neither ineffectual nor competitive. Therapists should let the patient lead, allowing them to explore their needs, feelings, wishes, fears, and conflicts at their own pace. The patient does not need an authority figure explaining their experience to them; they benefit from exploring and explaining it to themselves. A didactic stance on the part of the therapist may reinforce feelings of defectiveness and powerlessness.

When both parties are heterosexual, high-functioning hysteric-histrionic patients may charm therapists of the other gender and annoy those of the same gender, at least initially. It is helpful to remember the patient unavoidably brings their relationship patterns into the therapy relationship, and this is what makes it possible to explore the thoughts, feelings, and experiences that underlie them. More disturbed patients (in the borderline range of functioning) with hysteric-histrionic personality may alarm and exasperate therapists with flagrant seductiveness or acting out in place of talking and reflecting. See Box 1.9 for the hysteric-histrionic personality prototype.

Borderline-Dysregulated Personality

The term "borderline" dates back to a time when psychiatric classification distinguished primarily between neurotic and psychotic disturbance based on intact versus impaired reality testing. Over time, clinical writers began describing patients on the "border," who seemed neither neurotic nor psychotic. The diagnostic construct has evolved, but the term "borderline" remains. The hyphenated term "borderline-dysregulated" retains the familiar term and highlights the emotional dysregulation that is a hallmark of the personality syndrome.

People with borderline-dysregulated personality have been described as "stably unstable."[26] There is a pattern of instability in emotional life, self-concept, and relationships.

Box 1.9 Hysteric-histrionic Personality Prototype

Summary statement: Individuals with hysteric-histrionic personality are emotionally dramatic and cognitively impressionistic, sexually provocative, and interpersonally suggestible, idealizing of admired others, and paradoxically both intensely and superficially attached.

Individuals who match this prototype are emotionally dramatic and prone to express emotion in exaggerated and theatrical ways. Their reactions tend to be based on emotion rather than reflection, and their cognitive style tends to be glib, global, and impressionistic (e.g., missing details, glossing over inconsistencies, mispronouncing names). Their beliefs and expectations seem cliché or stereotypical, as if taken from storybooks or movies, and they seem naïve or innocent, seeming to know less about the ways of the world than would be expected. Individuals who match this prototype tend to be sexually seductive or provocative. They use their physical attractiveness to an excessive degree to gain attention and notice, and they behave in ways that seem to epitomize gender stereotypes. They may be flirtatious, preoccupied with sexual conquest, prone to lead people on, or promiscuous. They tend to become involved in romantic or sexual "triangles" and may be drawn to people who are already attached or sought by someone else. They appear to have difficulty directing both tender feelings and sexual feelings toward the same person, tending to view others as either virtuous or sexy, but not both. Individuals who match this prototype tend to be suggestible or easily influenced, and to idealize and identify with admired others to the point of taking on their attitudes or mannerisms. They fantasize about ideal, perfect love, yet tend to choose sexual or romantic partners who are emotionally unavailable or who seem inappropriate (e.g., in terms of age or social or economic status). They may become attached quickly and intensely. Beneath the surface, they often fear being alone, rejected, or abandoned.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

Core features include affect dysregulation, splitting, identity diffusion, projection, projective identification, and insecure attachment.

People with borderline-dysregulated personality have difficulty regulating affect. Their emotions can change rapidly and unpredictably and spiral out of control, leading to extremes of despair, anxiety, agitation, and rage. They experience episodes of deep depression in which they lose access to any glimmer of hope. They are often filled with rage, and they are prone to destroy relationships with hateful, rage-filled outbursts. Poor impulse control is an ongoing problem and leads to ill-considered actions and self-destructive behavior.

Splitting refers to compartmentalizing good and bad perceptions, feelings, and experiences, leading the person to experience self and others as all good or all bad. (The term "dichotomous thinking" in dialectical behavioral therapy also refers to this phenomenon.) Splitting results in extreme, wildly fluctuating views of self and others, depending on which "compartment" the person is experiencing. When distressed, people with borderline-dysregulated personality lose the capacity to see others as complex, three-dimensional human beings. Instead, they become one-dimensional heroes, saviors, victims, villains, and abusers.

The person may see certain people as all good ("good objects") and others as all bad ("bad objects"), or their experience of the same person may swing between contradictory extremes. This leads to unstable and chaotic relationships. For example, a person with borderline-dysregulated personality may see the clinician as a savior, until they disappoint. Then they may see the clinician as a "bad person" and attack them for their callousness or incompetence. Such shifts from idealization to devaluation are often precipitated by perceived criticism or rejection.

Splitting also refers to compartmentalized, contradictory experiences of self. The person may vacillate between experiencing themselves as a good person and as someone evil and rotten to the core. Self-concept depends on which of multiple, contradictory self-representations is being experienced. Shifts between different self-representations bring corresponding shifts in emotional state and keep the person on an emotional roller-coaster. Affect dysregulation and splitting therefore go hand in hand.

Because disparate self-representations are not integrated into a coherent whole, people with borderline-dysregulated personality have difficulty maintaining a consistent, stable sense of self ("identity diffusion"). Their attitudes, values, and self-concept are unstable and changeable. They may shift with relationships, circumstances, or emotional state. The person may present in strikingly different ways on different occasions, often to the consternation of clinicians. If they are feeling good, they may be blithely unconcerned that they were recently suicidal. If depressed, they may feel no connection to any part of themselves they have ever experienced as positive.

Primitive forms of projection are a hallmark of borderline-dysregulated personality. Split, disavowed representations of self and others and the feelings associated with them are projected wholesale onto other people with conviction and certainty. The projections often involve intensely negative emotions like anger, spite, hate, envy, and disgust. The person regards their projections as facts, not perceptions. It can be disorienting and maddening to others, including clinicians, to be seen and treated repeatedly as someone they are not.

Projective identification takes the defense of projection a step further. In addition to projecting disavowed parts of themselves, the person works to induce and evoke the feelings they have projected with such vehemence, so that the other person comes to feel and act in accord with the projection. Borderline-dysregulated patients are masterful in bringing this about, although they do not do it consciously. Clinicians describe experiences of not being able to think their own thoughts or feel their own feelings, as if their minds have been colonized by something alien.[27] Under the sway of projective identifications, clinicians may find themselves filled with hatred for their patient or impelled to cross professional boundaries to rescue them.

The transfer of thoughts and feelings from patient to clinician that occurs in projective identification is not mysterious or mystical. Observable behavior on the part of the

patient pulls, pushes, coaxes, and coerces the clinician into their assigned role, although the clinician may be unaware of this as it is occurring. Generally, countertransference comes first, and understanding emerges after the fact.

Borderline-dysregulated patients with a history of abuse are prone to enacting scenarios involving shifting roles of abuser, victim, and rescuer.[27,28] Through processes of projection and projective identification, clinician and patient can inhabit any of the three roles. A common scenario begins with the patient in the role of victim and the clinician in the role of rescuer. As the patient's needs and demands escalate, the clinician overextends themselves to the point of feeling persecuted and victimized by the patient (for example, taking late night phone calls, allowing sessions to run overtime, not collecting fees). The clinician may become controlling and punitive as they try to reestablish boundaries, moving into the abuser role. Ideally, clinician and patient can examine the patient's shifting experience of self and other and how these role relationships are recreated in the therapy relationship, instead of just reenacting them with a new person.

Finally, people with borderline-dysregulated personality have insecure or disorganized attachment styles and are hypersensitive to rejection. They are needy and dependent, become attached quickly and intensely, yet anticipate rejection and abandonment. They are desperate to be cared for, but their concept of "caring" involves unrealistic levels of availability and attunement that no one can provide. When the other person inevitably falls short, they become enraged and lash out. This dynamic is captured by a pithy book title: *I Hate You—Don't Leave Me*.[29]

A number of therapy models have been developed for borderline-dysregulated personality and are described in other chapters. Work with borderline-dysregulated patients can be fast, furious, chaotic, and confusing. One supervisor likened it to "tumbling helplessly in a clothes dryer," never knowing what is coming or from where. In the early stages of treatment, the clinician's role may simply be to accept and tolerate the confusion, remain engaged with the patient, and maintain the treatment frame. A clear theoretical model provides direction and helps contain the clinician's anxieties.

All therapy models emphasize attention to boundary issues, attention to what is happening in the therapy relationship, and active management of behaviors potentially destructive to the therapy and the therapy relationship. Because borderline-dysregulated patients are prone to crises, therapy can easily be derailed if crisis management rather than work on underlying psychological issues becomes the focus. Therapy models for borderline-dysregulated personality include regular consultation and support for therapists, to help manage intense countertransference.

Borderline-dysregulated personality can be viewed as a personality syndrome in its own right (when no other personality syndrome is salient) or as a level of personality organization associated with any other personality syndrome. For example, a patient who matches the descriptions for narcissistic personality and borderline-dysregulated personality can be described as having narcissistic personality organized at a borderline level; a patient who matches the descriptions for paranoid personality and borderline-dysregulated personality can be described as having paranoid personality organized at a borderline level; and so on. This organizing framework brings considerable clarity to diagnostic formulations. See Box 1.10 for the borderline-dysregulated personality prototype.

Box 1.10 Borderline-dysregulated Personality Prototype

Summary Statement: Individuals with borderline-dysregulated personality have impaired ability to regulate their emotions, have unstable perceptions of self and others that lead to intense and chaotic relationships, and are prone to act on impulses, including self-destructive impulses.

Individuals who match this prototype have emotions that can change rapidly and spiral out of control, leading to extremes of sadness, anxiety, and rage. They tend to "catastrophize," seeing problems as disastrous or unsolvable, and are often unable to soothe or comfort themselves without the help of another person. They tend to become irrational when strong emotions are stirred up, showing a significant decline from their usual level of functioning. Individuals who match this prototype lack a stable sense of self: Their attitudes, values, goals, and feelings about themselves may seem unstable or ever-changing, and they are prone to painful feelings of emptiness. They similarly have difficulty maintaining stable, balanced views of others: When upset, they have trouble perceiving positive and negative qualities in the same person at the same time, seeing others in extreme, black-or-white terms. Consequently, their relationships tend to be unstable, chaotic, and rapidly changing. They fear rejection and abandonment, fear being alone, and tend to become attached quickly and intensely. They are prone to feeling misunderstood, mistreated, or victimized. They often elicit intense emotions in other people and may draw them into roles or "scripts" that feel alien and unfamiliar (e.g., being uncharacteristically cruel, or making "heroic" efforts to rescue them). They may likewise stir up conflict or animosity between other people. Individuals who match this prototype tend to act impulsively. Their work life or living arrangements may be chaotic and unstable. They may act on self-destructive impulses, including self-mutilating behavior, suicidal threats or gestures, and genuine suicidality, especially when an attachment relationship is disrupted or threatened.

5 very good match (patient ***exemplifies*** this disorder; prototypical case)	**Diagnosis**
4 good match (patient ***has*** this disorder; diagnosis applies)	
3 moderate match (patient has ***significant features*** of this disorder)	**Features**
2 slight match (patient has minor features of this disorder)	
1 no match (description does not apply)	

Personality and Clinical Case Formulation

It should be clear that personality syndromes are not merely descriptive constructs, like DSM diagnoses; they are explanatory. The descriptions of the personality syndromes explicate underlying psychological processes that leave people vulnerable to a range of mental health problems. Mental health problems do not arise in a vacuum. More often than not, they arise in the matrix of personality dynamics.

The personality syndrome descriptions provide the broad strokes of clinical case formulations. They can provide a treatment focus and direct the clinician's attention to

psychological processes underlying presenting symptoms and diagnoses. They are broad strokes because they are simplifications, especially when applied to people at higher (healthy and healthier neurotic) levels of functioning. People at higher levels of functioning have greater psychological flexibility and commonly show a blend of personality styles. Even so, it is possible to recognize areas where specific personality dynamics (depressive, obsessive-compulsive, narcissistic, and so on) prevail. "Purer" examples of personality styles are generally seen at lower levels of personality organization.

Clinical case formulations articulate cause and effect. For example, the person with depressive personality defends against anger, which finds indirect expression through self-criticism and self-punitiveness. The person with narcissistic personality inflates themselves to ward off underlying feelings of inadequacy and emptiness, but their defensively constructed self-image cuts off authentic connection with self and others. The person with borderline-dysregulated personality cannot reconcile contradictory perceptions and feeling states, and so vacillates between them. The person with paranoid personality sees their own projected hostility everywhere they look, and so experiences the world as cold and cruel.

Such statements describe cause-and-effect relationships that can form the nucleus of individualized, patient-specific case formulations that give treatment direction and focus. Without a coherent case formulation, treatment can devolve into a haphazard "spaghetti-on-the-wall" process, with the clinician trying one intervention after another, hoping something will "stick." It can also devolve into aimless, directionless "supportive therapy" in which the therapist has essentially given up on meaningful change. To recognize a personality syndrome is to begin to articulate a clinical case formulation.

Personality Pathways to Depression

The most common mental health diagnoses, at least in North America, are depressive disorders. Many depressed patients experience only minimal relief from symptom-focused treatments, or experience relief but then relapse. Depression is often considered a chronic condition. In many cases, it may appear chronic because the personality processes that give rise to it have never been addressed in psychotherapy.

Nearly all of the personality syndromes can be pathways to depression and require their own distinct treatment focus. I will briefly describe how several of the personality syndromes create vulnerability to depression and will touch even more briefly on some treatment implications. My purpose is to illustrate connections between personality processes and depression, not provide specific instructions for conducting treatment, which would require a book in its own right, or several.

Depressive Personality

Depressive personality refers to enduring personality dynamics, not mood state. People with depressive personalities may or may not experience clinical depression, and people with recurring or chronic depression may or may not have depressive personality styles.

Difficulty recognizing needs and desires can lead to clinical depression. It is difficult to meet your needs when you do not know what they are. Failure to meet basic emotional

needs leads to depletion and depression. Work in psychotherapy should focus not just on expressing unrecognized and unarticulated needs, but on recognizing the psychological processes that interfere with recognizing them. The clinician should be alert to subtle ways the patient steers away from needs and desires, and help them articulate the fears that lead them to steer away.

Anger directed at the self can lead to depression. Being berated, punished, and scorned causes pain, and this is equally true when the person doing the punishing is oneself. To stop the self-torment, the person must recognize and consciously experience the anger they habitually disavow. This process cannot be merely academic or intellectual; the anger must be experienced in the "here and now" of the therapy relationship. The therapist should be alert to indirect indications of irritation or disappointment, or their absence where they might be expected, and actively invite them into the therapy relationship. "I'm sorry I was late" is not an invitation to explore disappointment or anger; "I notice you didn't say how it felt when I was not here" *is* an invitation.

Patients who have not internalized a reliably available caretaker remain dependent on others for emotional care and are vulnerable to depression when left to rely on their own internal resources. They benefit from experiencing and internalizing a relationship with an attuned and reliably available therapist. Brief therapies with arbitrary session limits can be destructive. Instead of helping them repair early experiences of relational disruption or loss, they can force the patient to relive them.

Avoidant Personality

Emotional well-being requires engagement in the world and at least a modicum of enjoyment and pleasure. People with anxious-avoidant personality styles cut themselves off from emotional sustenance through fearful avoidance. Their living space can become too restricted to meet basic needs, leading to depletion and depression. To make matters worse, the person finds little respite from their anxieties even when they avoid feared situations, because perceived dangers are internal as well as external. The effort to keep anxieties at bay is emotionally depleting and exhausting.

Therapy must help the patient confront what they avoid, internally and externally. They remain vulnerable to depression so long as their lives remain too constricted to meet their emotional needs, and so long as they devote their energies to avoiding harm at the expense of pursuing desires.

Obsessive-Compulsive Personality

People with obsessive-compulsive personalities are engaged in an ongoing internal conflict, which they defend against by constricting and inhibiting emotional awareness and expression. Unfortunately, it is impossible to selectively inhibit negative emotions. The defenses that inhibit shame, fear, and rage also inhibit spontaneity, joy, excitement, desire, and pleasure. Life becomes monotonized, routinized, and pleasureless.

Desires are forbidden, and when the person does pursue desire, it gives rise to so much guilt that they cannot enjoy it. Constant squelching of needs and desires, and excessive devotion to work and productivity at the expense of leisure and enjoyment,

lead to depletion and depression. Underlying shame, humiliation, and rage constantly threaten to erupt, which can leave the person with a background feeling of impending doom.

Effective psychotherapy explores defenses against emotional life and allows the patient to discover through lived experience in the therapy relationship that emotion and desire can be met with acceptance and interest, not horror, and can be expressed without bringing about punishment, retaliation, or catastrophe.

Narcissistic Personality

People with narcissistic personality are inherently vulnerable to depression. One source of vulnerability is a chronic gap between grandiose expectations and what the world affords. Rewards that come the person's way fall short of those to which they feel entitled and are therefore devalued. Instead of feeling satisfaction and pleasure, the person ends up feeling disappointed and aggrieved. The gap between expectation and reality never closes, leading to dejection, hopelessness, and despair.

There is likewise a chronic gap between self-expectations and capabilities. The narcissistic person fantasizes about unlimited success, power, beauty, or talent. Instead of experiencing satisfaction and pride in legitimate accomplishments—which could provide a basis for realistic self-esteem—they perpetually feel they have fallen short.

Finally, their defensively constructed self-image represents a barrier to genuine intimacy and can cut them off from love and meaningful connection with others.

Effective psychotherapy can help these patients understand how they devalue life's pleasures, devalue their own legitimate abilities, and cut themselves off from intimate connections that make life meaningful and make its hardships bearable (including the connection potentially available with the therapist). If they develop enough trust in the therapy relationship, they may allow themselves to reveal the parts of themselves they experience as shameful and inadequate and keep hidden away. They may then slowly internalize the therapist's more accepting and benign view of their fundamental humanness. Ultimately, they must grieve the loss of the perfect person and perfect world of their fantasies, in order to live as they person they are in the world that is.

Paranoid Personality

People with paranoid personality are vulnerable to depression because they experience the world as cold, cruel, and hostile. They feel embattled and surrounded by enemies and dangers on all sides. They experience the world as hostile because they project their anger and aggression and see their own hostility wherever they look. The chronic experience of being embattled, persecuted, and excluded leads to depressive states. Additionally, the person is deprived of meaningful attachments and emotional support because they keep others at a distance, and their hostility and suspicion make others want to keep their distance.

Psychotherapy may help the person recognize that the aggression they experience as external emanates from within, understand its sources and its role as protection against deeper injuries, and understand their own role in creating hostile and adversarial interactions.

Borderline-Dysregulated Personality

People with borderline-dysregulated personality experience episodes of dark, deep depression. Their severe depressive states seem to encompass the entirety of their being. There can be a pervasive feeling that everything about them and everything about their world is dark and hopeless and always has been and always will be. The person may feel irreparably damaged, evil, or rotten to the core. Positive self-representations and experiences seem inaccessible.

These severe depressive states are rooted in splitting. At healthier levels of personality organization, good and bad self-representations and feeling states are integrated into a coherent whole and naturally modify and modulate one another. But when self-representations are split and compartmentalized, the current self-representation and feeling state is experienced as *all there is*. When painful feeling states are not modulated by other experiences, they are felt in their rawest form.

Other factors also contribute to severe depressive states. Identity diffusion, or difficulty maintaining a coherent and stable sense of self, leads to painful feelings of emptiness. Recurring relationship patterns in which the person relives experiences of helplessness and victimization lead to depression. Unstable relationships and rageful responses to others can leave them without emotional support when they need it most. Impulsive, ill-considered choices and actions can bring painful consequences.

Some therapy approaches emphasize management of dysregulated emotional states (for example, by learning and practicing self-regulation skills). Others address and work to change the underlying psychological processes that cause the dysregulated states. This requires creating a sturdy reflective space in which the patient's intense emotional reactions can be contained, examined, and understood.

Conclusion

The purpose of diagnosis is to provide more helpful treatment. When presenting complaints and diagnoses are rooted in personality dynamics, as they often are, meaningful change means addressing personality dynamics. Because personality dynamics tend to fall into recognizable patterns, personality diagnosis is largely a matter of pattern recognition. Clinicians who recognize these patterns have a tremendous advantage in navigating the clinical landscape. For example, they will recognize underlying psychological processes that create vulnerability to suffering, the defenses they are likely to encounter, and the roles they themselves are likely to be cast in (via transference and countertransference) as treatment unfolds. Treating patients without an understanding of personality syndromes is like navigating without a map.

The eleven personality syndromes described in this chapter reflect not only clinical knowledge accrued over generations of practice experience but also the findings of empirical research. The typology itself—the eleven diagnostic groupings or classifications—is derived via statistical clustering methods applied to large clinical samples. The core diagnostic features of the syndromes, summarized in the diagnostic prototypes, are also empirically derived. Clinicians who use this diagnostic system can be confident they are utilizing an evidence-based approach.

Perhaps most important, each personality syndrome provides the broad strokes of a clinical case formulation that therapist and patient, working together, can fill in,

Box 1.11 Resources for Clinicians and Researchers

- swapassessment.org.
  This is where to access the SWAP assessment instrument. Clinicians can complete an assessment online and receive a comprehensive assessment report with personality diagnoses, clinical case formulations, and treatment recommendations. There is an extensive bibliography with links to downloadable reprints.
- swapassessment.org/prototypes.
  This is a three-page quick reference guide (pdf file) containing all the diagnostic prototypes. It is available as a free reference resource to facilitate personality diagnosis in day-to-day clinical practice.

elaborate upon, and revise as new understandings emerge. This kind of case formulation gives treatment direction and focus that can lead to meaningful and lasting change for many patients.

For additional resources for clinicians and researchers review Box 1.11

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