Rainer Sachse

Personality Disorders

A Clarification-Oriented Psychotherapy Treatment Model

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About the Author

Rainer Sachse is Head of the Institute for Psychological Psychotherapy (IPP) in Bochum, Germany. He studied psychology from 1969 to 1978 at the Ruhr University of Bochum, Germany, and went on to gain his doctorate in psychology and a postdoctoral qualification for a full professorship, and later becoming a professor of clinical psychology and psychotherapy. At the end of the 1990s, Prof. Sachse developed a dual action theory of personality disorder which led to the creation of clarification-oriented psychotherapy, a therapy approach which he continues to use and develop today. His main areas of interest are personality disorders, psychosomatics, clarification-oriented psychotherapy, and behavioral therapy, and he has written extensively about these themes.

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Foreword

Personality disorder has been increasingly identified as a mental condition that influences the treatment and recovery of patients both in medical psychiatric and in psychodynamic and cognitive behavioral treatments. Despite significant research, personality disorders still remain relatively underrecognized and misperceived in both psychiatric and psychological evaluations, either due to the predominance of primary comorbid disorders, such as mood, trauma, substance misuse, or eating disorders, or because of insufficient strategies for distinguishing and integrating personality-based function into assessment and treatment. In addition, the shortage of general, effective guidelines for identifying and approaching personality disorders has left many clinicians and therapists to their own devices when facing these problems with their patients. Some personality disorders are significantly influenced by deficits in neuropsychological processing, by attachment patterns, and by trauma, in addition to cognitive and interpersonal patterns, while others can be identified primarily in terms of psychological processing and relational motivation and regulation.

This volume provides a most instructive and comprehensive outline for identifying and treating clients with these personality disorders, which first and foremost present with problems in psychological and relational functioning. It fills a significant gap through its aim to create an integrative strategy for clarification and for motivating patients to seek to change. The author presents a well-organized approach, including detailed descriptions of each disorder and their array of functional patterns, with thorough therapeutic strategies for a broad range of problems in different phases of the treatment.

The clarification-oriented psychotherapy approach focuses on self-regulation and motivation in interpersonal interactions and relationships. By identifying motives and schemas, the author provides constructive and informative strategies for therapists to understand and manage the complexity of patients' internal and interpersonal functioning, which can otherwise easily distract therapists and invite unconnected or misguiding perceptions of patients' mental functioning. The informative and detailed therapeutic guidelines can help direct therapists' efforts to identify and clarify patients' complex motives and the different behavioral and intentional aspects of their functioning, and these guidelines include specific examples that are anchored in a solid theoretical frame of reference. In addition, the author identifies the co-occurring normal aspects of personality functioning within the framework of psychopathology, as well as subcategories of disorders that present with a range of behaviors and levels of functioning. This is very important for alliance building and for engaging patients' sense of agency and motivation toward change and improvement.

In sum, this is a very well-structured, informative, and readily accessible book that provides unique and valuable guidelines for therapists treating those with personality disorders, with a clarification- and schema-focused approach. Given the integration of empirical studies

with detailed clinical descriptions of each disorder, this is a useful and inspiring resource, and it is to be hoped that this book can be made available to therapists and clinicians in many countries.

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Chapter 1

Essential Basic Concepts of Personality Disorders

1.1 Introduction

The concept of personality disorders (PDs) has a long history, and in consequence, widely differing ideas have developed around it. These ideas vary greatly from one another and are barely compatible (e.g., see Benjamin, 1996, 2003; Clarkin & Lenzenweger, 1996; Derksen, 1995; Fiedler, 2007; Fowler et al., 2007; Magnavita, 2004; Oldham et al., 2005).

Recent developments of this concept suggest that PDs should be conceived of as based on two factors: One should first conceptualize generally what PDs in fact are in a psychological sense, and then, on the basis of this general concept, one should clearly define the characteristics of the individual disorders (see Livesley, 1998, 2001; Livesley & Jackson, 1992, 2009; Livesley & Jang, 2005; Livesley et al., 1994, 1998; Hentschel, 2013). Some considerations of this are also dealt with in the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders,* fifth edition (DSM-5; APA, 2013).

The concept of PDs presented here adopts an equivalent approach: A general model of the psychological functioning of PDs is introduced, with the individual disorders then being elucidated on the basis of this model. Moreover, therapeutic implications are derived from the general as well as specific models (see Döring & Sachse, 2008a, 2008b).

The purpose of this book is not to trace and discuss conceptual developments, however. Rather it is to illustrate a **treatment concept of PD** – that is, the concept of **clarification-oriented psychotherapy** (COP; in German: *klärungsorientierte Psychotherapie*, or KOP). For this purpose, essential basic concepts of the approach to PDs will be emphasized to reveal the ideas that are suggested for the concept described here.

1.2 The Term *Personality Disorder*

It was initially suggested that there were some disorders that were very comprehensive, profound, and treatment-resistant. As a result, these disorders were seen as **disorders of the overall personality** (see Kernberg, 1978; Kretschmer, 1921; Schneider, 1923).

According to current psychological concepts (Fiedler & Herpertz, 2016; Millon, 2011), one must still assume that these disorders are complex, and that owing to their specific psychological

constellations, they remain relatively difficult to treat (see O'Donohue, Fowler, & Lilienfeld, 2007). However, the disorder at issue is not necessarily considered a disorder of the personality. Instead, it has become clear that features which characterize a PD are often already present in a lighter form in almost every person and are largely considered as normal and ordinary. As a result, more severe forms appear to be only extreme forms of ordinary psychological occurrences (Fiedler, 2007) and therefore are variations of a norm that are not necessarily considered as pathological.

In this context, a tendency in psychology could be observed to depathologize and normalize PDs. However, it is still obvious that these disorders generate great costs for the person concerned and that it makes sense to treat them therapeutically. Nonetheless, it is important to refrain from stigmatizing those affected. Unlike Emmelkamp and Kamphuis (2007), we do not view PDs as a "chronic psychiatric disorder . . . characterized by pathological personality traits" (Sachse, Sachse & Fasbender, 2010, 2011; Sachse, Fasbender, Breil, & Sachse, 2012).

It is essential to see PDs as an extreme form of ordinary, normal psychological processes, which generate such great costs for the person concerned that psychotherapy is useful.

Therefore, in this book clients with PD will not be classified or designated as infantile, immature, pathological, seriously disturbed, or temperamentally deficient. It is important to get away from such negative evaluations (this is important to create a good therapeutic relationship with the client!). Furthermore, such a diagnosis may affect the therapist's stance and interventions. Basically, it would make sense to dispense with the term *personality disorder* and replace it with *interaction disorder*. However, since the term has been adopted into the language, it is easier to stay with the term personality disorder as long as one knows what is intended by it.

1.3 Style and Disorder

Individuals with a minor personality style exhibit characteristics of a psychological entity in a mild form, whereas individuals with a major clinical disorder exhibit these characteristics in a severe form.

An important implication of this approach is the assumption that there are no distinct criteria according to which a style becomes a disorder. Basically, there are no empirically valid criteria which specify precisely when a style becomes a disorder (see Caspar et al., 2008; Foster & Campbell, 2005, 2007; Krueger et al., 2007; Livesley et al., 1994; Ronningstam, 2005; Samuel & Widiger, 2011; Watson, 2005; Widiger & Samuel, 2005; Widiger & Simonsen, 2005; Widiger et al., 2005). Thus, during the process of psychotherapy, it is sensible to negotiate with the client as to whether they consider their disorder to be so disruptive that therapy is indispensable.

1.4 Making Diagnoses

An important aspect of depathologization is that one does not make diagnoses of PD to label people: If one makes an official diagnosis (i.e., one that is passed on to the authorities), one

should always be aware that it can certainly be used against the client, and one should be careful about this. For internal communication between professionals, that is, in supervision, diagnoses serve exclusively to help understand exactly what the client's disorder is in order to be able to deal constructively with the client.

The sole purpose of diagnosis is to derive meaningful therapeutic measures to help the client (Sachse, 2017).

Therefore, it makes sense in principle that a therapist
- gives a diagnosis,
- is aware of the fact that this is always a more or less well-proven hypothesis – that is, a working hypothesis for the purposes of psychotherapy,
- establishes a diagnosis as early as possible in the process (and as a first hypothesis),
- never overlooks a client's PD.

And in this case, it may well make sense to speak, for example, of narcissism as a disorder, although the client only exhibits a style: Because it can be helpful even then to be sufficiently prepared for games, motivational problems, etc.

In general, it appears to be expedient to consider a personality style or a disorder in the therapy process – that is, to diagnose it and to consider it in the therapeutic procedure if
- aspects of the style or disorder cause the costs the client does not want to incur, and/or
- aspects of the style or disorder become relevant in therapeutic interaction – for example, by leading to manipulative behavior that significantly influences interactions with the therapist.

As a rule, however, even mild styles are relevant, so therapists should generally
- be mindful of PDs,
- be capable of quickly detecting and validly diagnosing any PD,
- be able to handle the PD in a constructive manner.

1.5 Resources

When treating PDs, the focus is no longer solely on deficits, but moves toward the client's **resources.** It becomes more and more obvious that PD always implicates resources: The clients are, due to their schemas, very sensitive regarding certain information, they are competent in certain actions, etc. Most of the time, the problem is not that they do not have any resources but that they are unwilling or unable to use them constructively.

These resources are good therapeutic tools, if one wants to change schemas, develop alternative action patterns, etc.: In the modification phase of the therapy, the orientation of these resources can be very helpful. Plus, the focus on resources helps to get away from the tendency to pathologize and stigmatize the client.

This approach also has consequences for the definition of **therapeutic objectives**. Healing as an objective is not useful (aside from not being even realistic), because clients do not have to abandon all aspects of their personality. Clients just have to learn to use their resources more