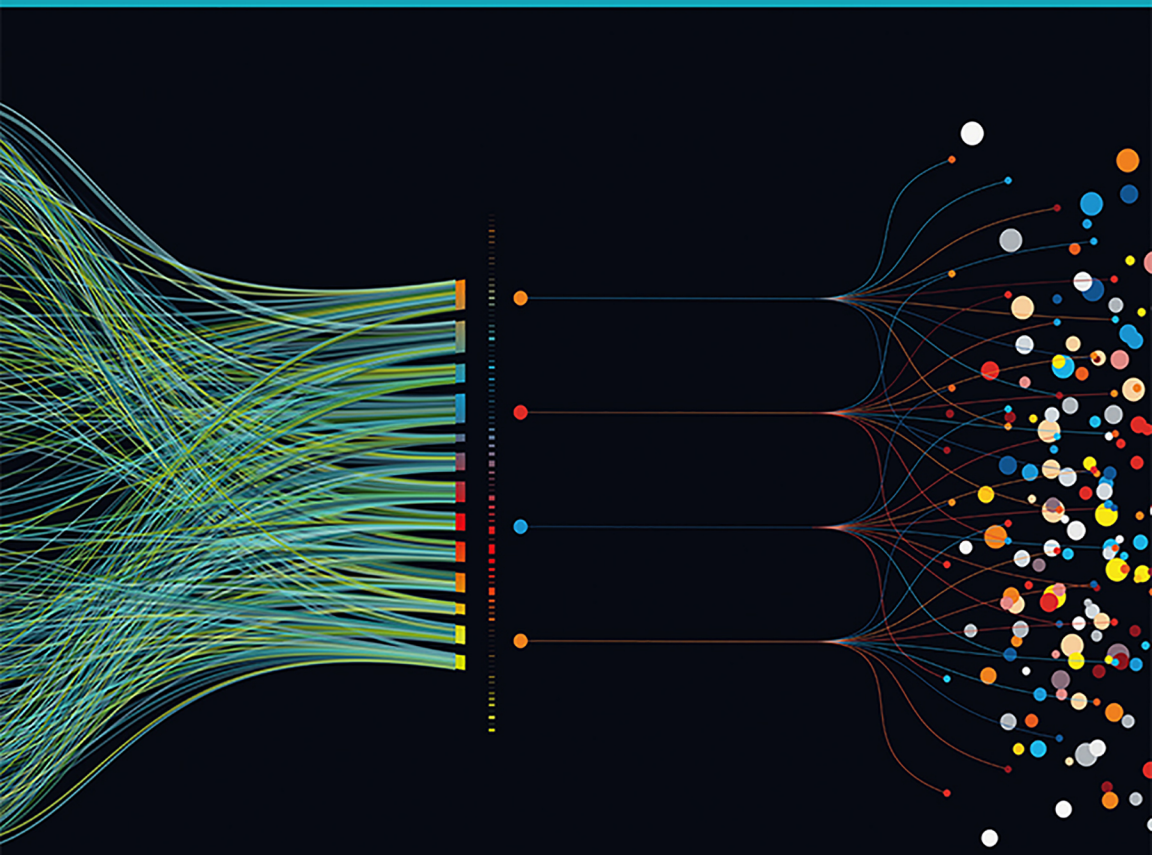

Antisocial, Narcissistic, and Borderline Personality Disorders

A New Conceptualization of Development, Reinforcement, Expression, and Treatment

Daniel J. Fox

ROUTLEDGE

"Daniel Fox, PhD, has written a highly sophisticated book that explores every facet of three personality disorders in great depth: antisocial, narcissistic, and borderline personality disorder. Designed for both clinicians and researchers, this detailed examination of these three personality disorders should prove to be a helpful asset in every professional's library."

Sherry Cormier, PhD, Licensed Psychologist

"Dr. Fox has written a book that broadens the utility of the alternative DSM-5 model of personality disorders to researchers and clinicians by providing a model of efficacy and understanding that anyone in the field would find beneficial. He addresses the developmental and dynamic underpinnings of these disorders (i.e., core structure), the more overt aspects (i.e., surface structure), the factors that lead to enduring psychopathology, and a successful treatment approach using a comprehensive model. Lastly, Dr. Fox examines the online behavior of those individuals with borderline, narcissistic, and antisocial personality and puts it into a useful context for researchers and clinicians. I highly recommend this book as a resource for all working with personality disorders."

Russ Wood, PhD, Licensed Psychologist

"I am glad to see that Dr. Fox has expanded his previous work on personality disorders. His current work addresses the DSM-5 traditional and alternative models of personality disorders. Since these models are often confusing and in need of clarification. He focuses on the antisocial, borderline and narcissistic types in speaking to the diagnostic and therapeutic issues. For those of us that have worked with persons with personality disorders, it is often difficult to identify personality disorders because of the overlapping of symptoms within and at times between the three clusters found in the DSM-5 traditional model. Fox explains the new alternative dimensional model and adds to the conceptualization and structure by incorporating additional models of psychopathology. The integrative model is comprehensive in addressing impairment and severity of pathology across diagnostic therapeutic interventions. Fox explains various therapeutic alerts in working with these three personality disorders, addressing levels of functioning, pathological behaviors, pervasiveness and stability, and makes suggestions for treatment innovations, and provides case studies for each disorder. Dr. Fox's new work is an integrative theory helping to explain personality disorders and assists providers with a map for diagnosis, treatment and intervention. He even includes online behaviors for the three personality disorders. I find that this integrative

model has relevance to other disorders including depressive and anxiety disorders. This work will become a valued addition to one's professional library and likely text for courses addressing the diagnosis and treatment of antisocial, borderline and narcissistic personality disorders. The model will add to the understanding of personality disorders with new research paradigms."

Roy H. Tunick, EdD, Professor Emeritus, West Virginia University;
Past President of West Virginia Psychological Association

Antisocial, Narcissistic, and Borderline Personality Disorders

This book provides a framework for scholars and clinicians to develop a comprehensive and dynamic understanding of antisocial, narcissistic, and borderline personality disorders, by seeing personality as a dual, as opposed to a singular, construct.

Converging the two separate research and clinical diagnostic systems into a wholistic model designed to reach reliable and valid diagnostic conclusions, the text examines adaptive and maladaptive personality development and expression, while addressing the interpersonal system that keeps the pathology from extinguishing. Each chapter will discuss core and surface content, origin and symptom manifestation, system and pathology perpetuation, and online behavior expression, concluding with practical guidance on treatment success and effective approaches.

Seasoned and tyro researchers and clinicians will be challenged to explore the utility of the DSM-5 alternative model of personality disorders and apply it to further the understanding of these complex, and often destructive, disorders.

Daniel J. Fox, PhD, is a licensed psychologist in Texas, international speaker, and multi-award-winning author. He has been specializing in the treatment and assessment of individuals with personality disorders for over 20 years in the state and federal prison system, universities, and in private practice.

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To my three heartbeats Lydia, Alex, and Sebastian.
I would not be able to achieve my dreams without you.

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About the Author

Daniel J. Fox, PhD, is a licensed psychologist in Texas, international speaker, and multi-award winning author. He has been specializing in the treatment and assessment of individuals with personality disorders for over 20 years in the state and federal prison system, universities, and in private practice. His specialty areas include personality disorders, ethics, burnout prevention, and emotional intelligence. He has published several articles in these areas and is the author of *The Clinician's Guide to Diagnosis and Treatment of Personality Disorders,* the award winning *Antisocial, Borderline, Narcissistic and Histrionic Workbook: Treatment Strategies for Cluster B Personality Disorders,* the award winning *The Narcissistic Personality Disorder Toolbox: 55 Successful Treatment Techniques for Narcissistic Spectrum Clients, Their Partners, and Their Children,* and *The Borderline Personality Workbook: An Integrative Program to Understand and Manage Your BPD*.

Dr. Fox has been teaching and supervising students for over 15 years at various universities across the United States, some of which include West Virginia University, Texas A&M University, University of Houston, Sam Houston State University, and Florida State University. He has worked in the state and federal prison system, is an adjunct assistant professor at University of Houston, as well as maintaining a private practice that specializes in the assessment and treatment of individuals with complex psychopathology and personality disorders. Dr. Fox has given numerous workshops and seminars on ethics and personality disorders; personality disorders and crime; treatment solutions for treating clients along the antisocial, borderline, narcissistic, and histrionic personality spectrum; emotional intelligence; managing mental health within the prison system; and others. Dr. Fox maintains a website of various treatment interventions focused on working with and attenuating the symptomatology related to individuals along the antisocial, borderline, narcissistic, and histrionic personality spectrum (www.drdfox.com).

Chapter 1

Introduction

Personality and Its Structure

Personality is an internal, psychological construct that determines how an individual views and makes sense of events, interacts with others, and creates expectations as to how the world functions. The complexity of this construct has led to many different approaches and conceptualizations of personality, leaving many challenged and confused about its make-up and influence on the individual as a whole (Allport, 1937).

Out of the attempt to understand and lessen this confusion, researchers attempted to identify general personality traits which, when pulled together, create a personality profile. This profile is designed to assist others in understanding an individual's view of self and the world and in predicting how an individual will respond when confronted with various situations and stressors (Allport, 1968; Costa & McCrae, 1992; Mischel, 2004).

Research on personality traits has continued concurrent to the search for the function, structure, and organization of personality, in order to explain one's distinctiveness from others, one's view of the world, and one's variability in behavioral response often seen in practice and "the real world" (Cervone, 2004; Mischel, 2004). These bifurcated endeavors created what is often called *the research-to-practice gap,* or a notable disparity between the findings of empirical research and implementation in clinical or daily practice. These discrepancies are evident in the fields of psychology, personality, medicine, and countless others that examine individual differences in the makeup of how a person views the self, others, and situations (DeAngelis, 2010; Kessler, 2008; Mallonee, Fowler, & Istre, 2006). Although they share a common goal, the roads of research and practice

continue to lack the overlap needed to draw a deeper and greater understanding of the study and expression of human function and response. Bridging the research-to-practice gap will lessen the confusion inherent in the understanding of personality and its aberration, thus moving the fields of personality research and practice forward, while enhancing its applicability.

By pulling together these critical factors into a single conceptualization that captures the structure of personality and its impact on the individual, researchers and clinicians will be better equipped to address the research-to-practice gap. This book aims to provide this singular and comprehensive framework for a deeper and clearer understanding of aberrant and unimpaired or "normal" personality that will advance research, practice, and applicability.

Core and Surface Structure of Personality

The first step to narrowing the research-to-practice gap is to explore the architecture of personality and to recognize its core and surface structure. Extant theories of personality structure have circuitously touched on personality architecture but failed to apply it more comprehensively to personality. Beck's model of cognition (1995, 1999) illustrates this very point. The model identifies three levels: core beliefs, intermediate beliefs, and automatic thoughts and images. *Core beliefs* are theorized to be entrenched, or deep and influential, in how an individual interprets, appraises, and responds to situations. Beck (1995) describes how *intermediate beliefs* influence unspoken attitudes, rules, expectations, or assumptions, and *automatic thoughts or images* are at a "superficial" or top level, reflecting how the individual verbally responds or thinks about a particular situation. These three components are theoretically structural, in that core beliefs comprise the foundation, intermediate beliefs are at the second level, and automatic thoughts and images are the top, or surface, level.

Beck is not alone in his structural conceptualization of internal mechanisms that influence an individual's response. Mischel (2004) describes the contents of memory and a "motivated meaning system" (p. 9) that guides the individual's interpretations of situations, which impacts the person–situation interaction in one's environment.

Beck and Mischel's theories are sound, but they only address part of the aspect of the inner workings of personality. Whereas Beck (1995) sees beliefs and thoughts and Mischel (2004) sees memory and meaning as a means to examine personality to explain behavior, it is the combination of these two approaches that provides a more unified, but still incomplete, framework. While these conceptualizations certainly help to explain how past experiences, thoughts, and cognitive appraisal or meaning influence how someone sees the self, others, and situations and drive behavior, the critical component of emotions is left out.

Table 1.1 The Five-Factor Model

Openness to Experience	Imaginative, Creative, Unique, and Curious
Conscientiousness	Hard-working, perseverant, well-organized, and punctual.
Extraversion	Talkative, active, affectionate, and optimistic.
Agreeableness	Trusting, lenient, soft-hearted, and good-natured.
Neuroticism	Worry-prone, self-conscious, feels inadequate, and hypochondriacal.

Akin to cognitive theories, emotions factor into the structure of personality at all levels and have thus been the subject of much study in personality research. In particular, researchers have focused heavily on the stability of emotions across environments and experiences, which adds to the understanding and predictability of a behavioral response (DeYoung, Peterson, & Higgins, 2002; Friedman & Schustack, 2016). Much of this research has been examined from a standpoint of compartmentalization – emotions as one component and beliefs, thoughts, memories as another.

Attempts to reconcile this compartmentalization have been made using the trait approach, such as the well-known five-factor model (FFM; Block, 1995; Costa & McCrae, 1995; Paunonen & Jackson, 2000). The FFM, which includes openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism, is the almost universal method most often applied to do this. Trait descriptions of each of the five factors are listed in Table 1.1.

The FFM has been applied to the conceptualization of individual differences in human functioning and provides a valuable framework for the understanding of personality disorders and their structure (Costa & Widiger, 1994; Trull & Widiger, 2013).

Disordered Personality and Its Structure

Before delving into the approach toward a structure of personality pathology discussed in this text, it is first necessary to contextualize the history of personality disorder, as characterized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Readers interested in a more comprehensive history of the development of the DSM, from its inception to the present, are referred to Blashfield et al. (2014).

When the first edition of the DSM (American Psychiatric Association (APA), 1952) was published, there were five classification systems for psychiatric

conditions in use in the United States. This variability in approach, conceptualization, and use prompted the APA to create a unified and conclusive diagnostic system (Fischer, 2012). This first edition defined personality disorder as "a behavioral reaction… [that] may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes primarily a pattern of action or behavior" (p. 13). According to this definition, a disordered personality is characterized by behavioral responses driven by internal and external factors. This definition, even back in 1952, loosely identified the structural component of personality via "internal and external stresses," but, without deeper definition, added complexity and confusion in its understanding and application.

In 1968, the DSM-II (APA, 1968) was published with the aim of consolidating the criteria between the DSM and the World Health Organization's International Classification of Disease (ICD), which was in its eighth edition at the time (Fischer, 2012). In this edition of the DSM, personality disorders have their own section titled: Personality Disorders and Certain Other Non-Psychotic Mental Disorders. Definitionally, personality disorders in the DSM-II were "characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms" (pp. 41–42). This definition was changed markedly from the first DSM, moving away from a structural perspective, while recognizing the developmental aspect of personality, noting the degree to which personality disorders are "life-long patterns, often recognizable by the time of adolescence or earlier."

The DSM-III (APA, 1980) was published in 1980, and the criteria were revamped in many ways under the direction of Robert Spitzer, criteria prominent researcher from the New York State Psychiatric Institute (Fischer, 2012). The DSM-III was a major departure from the previous versions, leading it to be highly controversial. One such critique was that the DSM-III nebulously defined the concept of "dysfunction" bringing into question the entire approach of the manual (Wakefield, 1992, 1999). Notably, the DSM-III moved in the direction of empirically based and operationally defined mental disorders, which set the foundation for modern approaches to diagnosis (Fischer, 2012; Mayes & Horowitz, 2005). This edition also saw the birth of the multiaxial system, which was composed of five axes, listed as follows:

Axis I: Clinical Disorders
Axis II: Personality Disorders or Mental Retardation
Axis III: Medical or Physical Conditions
Axis IV: Contributing Environmental or Psychosocial Factors
Axis V: Global Assessment of Functioning.

The expectation was that every client would be assessed on the five axes, which would provide a greater understanding and recognition of the pathology present in the individual. In regard to personality disorders, the multiaxial system

would presumably increase the accuracy of diagnosis, as research had identified that "preexisting personality disturbance" increased the likelihood of developing and exhibiting diagnoses identified on Axis I. Furthermore, it was presumed that the identification of personality pathology, in addition to Axis I conditions, would inform illness trajectory and response to treatment (Frances, 1980). What this edition did was not only illuminate the developmental component associated with personality disorders by being on Axis II but also separated them out from other disorders, such as depression, anxiety, and schizophrenia. This created concerns and questions about the degree of actual separation of personality disorders between the "Axis I: Clinical Disorders" (Røysamb et al., 2011).

The DSM-III (1980) also focused more on traits than on psychoanalytic conceptualizations, as were features of both previous editions. The DSM-III outlined a distinction between personality *traits* and personality *disorders,* noting:

> Personality *traits* are enduring patterns, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts. It is only when *personality traits* are inflexible and maladaptive and cause either impairment in social or occupational functioning or subjective distress that they constitute *Personality Disorders*.
>
> (p. 305, APA, 1980)

This definition of personality from a trait perspective recognized that traits are expressed outwardly while having internal workings. It further specified that the degree of impairment must reach a particular, although relative, threshold of "social or occupational functioning or subjective distress," or socioeconomic dysfunction, to warrant classification as a disorder.

Only seven years after the publication of the DSM-III (APA, 1980), the DSM-III-R was released with the intent to provide revised criteria that pulled together information from researchers and clinicians and provided new diagnostic categories (Fischer, 2012). Although many changes were made in the DSM-III-R (APA, 1987), the trait-based definition of personality disorders remained unchanged. The personality disorder clusters (A, B, and C) first appeared in the DSM-III-R (APA, 1987) as an attempt to simplify the eleven personality disorders recognized at the time. The three clusters were intended to classify the personality disorders using more global conceptualizations to help steer clinicians and researchers toward particular personality disorders. Cluster A was deemed the "odd or eccentric" cluster and included schizoid, schizotypal, and paranoid personality disorders; Cluster B was deemed the "dramatic, emotional, or erratic" cluster and included antisocial, borderline, histrionic, and narcissistic personality disorders; and Cluster C was deemed the "anxious or fearful" cluster and included avoidant, dependent, obsessive-compulsive, and passive-aggressive personality disorders (APA, 1987).

The application and use of the cluster system was met with much skepticism as to its validity and applicability (Schopp & Trull, 1993) and, although the clusters were first used in the DSM-III-R (APA, 1987), a description and purpose for their use were not listed until the DSM-IV (APA, 1994). The three clusters (A, B, and C) were purported to allow for a dimensional model perspective, in that the clusters "may also be viewed as dimensions representing spectra of personality dysfunction on a continuum with Axis I mental disorders" (APA, 1994, p. 634).

Even with this addition of a proposed dimensional slant to the understanding of personality disorders, the DSM-IV (APA, 1994) continued the same trait based, categorical approach originally devised in the DSM-III (APA, 1980) for the bulk of personality disorder explanation and description. The DSM-IV (APA, 1994) had few changes to personality disorders and other criteria compared to the DSM-III-R (Fischer, 2012). Six years later, the DSM-IV Text Revision (DSM-IV-TR; APA, 2000) was released as a means to provide updated information pertaining to research that had been conducted between 1992 and 1998, but the criteria were largely left unchanged (Fischer, 2012).

The consistency of the criteria since the DSM-III intertwined with changes in the understanding of personality disorders throughout the DSM editions illustrates the complexity of these constructs, as well as the ongoing attempt to understand trait related expressions and what motivates them. It would be over a decade until the publication of a new edition that would venture to challenge this view and conceptualization of personality disorders.

So many changes were put into place with the fifth edition of the DSM (APA, 2013) that a Roman numeral was no longer deemed appropriate to denote the edition, and instead the Arabic numeral "5" was put in its place. One of the biggest changes of the DSM-5 was the removal of the multiaxial system. This was done as a result of research that found that (1) the distinction between medical and psychiatric diagnosis was nebulous, (2) the psychosocial and environmental problems listed on Axis IV were used inconsistently by both clinicians and researchers, and (3) the Global Assessment of Functioning or Axis V had poor psychometric and clinical validity (APA, 2013; Kress, Barrio Minton, Adamson, Paylo, & Pope, 2014; Røysamb et al., 2011).

Unique and unprecedented, two views and approaches to personality disorders are included in the DSM-5 (APA, 2013). The established personality disorders and criteria-defined categorical model from the DSM-IV were maintained in Section II, and the newly proposed model, which utilizes more of a dimensional basis and view, was added in Section III. The new approach was labeled the "Alternative DSM-5 Model for Personality Disorders" and placed in Section III, "Emerging Measures and Models" (APA, 2013), as it lacked sufficient clinical utility to merit inclusion in the Diagnostic Criteria and Codes section at the time of publication (Section II; Oldham, 2015).

Research has been conducted to ferret out the benefits of the alternative model when compared to the Section II categorical model. Results illustrated greater clinical and research utility when using the alternative model as compared to the categorical model (Bastiaens, Smits, Hert, Vanwalleghem, & Claeset, 2016; Boland, Damnjanovic, & Anderson, 2018; Morey & Benson, 2016). Livesley (1998) expressed discontent with the categorical model that has remained throughout the research and practice community since its publication. These complaints include a lack of substantial theoretical or experimental reasoning for the identification of personality disorder categories, failures to support the categorical conceptualization of personality disorders with research findings, lack of support for the structural organization of the diagnostic categories that exist within the categorical model with statistical results, and the limitations to reliability and validity due to data collection methods and evidence that predicts external personality variables. The aim in developing the alternative model was to overcome these deficits and meet the needs of researchers and clinicians.

The Alternative DSM-5 Model for Personality Disorders

The new "alternative" model steps outside the definition previously used and characterizes personality disorders as "impairments in personality *functioning* and pathological personality *traits*." (APA, 2013, p. 761). By challenging the traditional view of personality pathology that focused largely on traits, the updated view focuses on both functioning *and* traits, which enhances the degree of utilization and understanding of personality impairment. Critically, the alternative model more closely mirrors the structure and nature of both personality and personality disorders. The two central determinants to identify a personality disorder using the alternative model are as follows: elements of personality dysfunction, classified as "moderate or greater impairment in personality (self/interpersonal) functioning" (Criterion A) and the presence of one or more pathological personality traits (Criterion B; APA, 2013, p. 761). A "level of functioning" scale ranging from "Little to no impairment" to "Extreme impairment" is also provided to help identify the degree of personality dysfunction.

Elements of Personality Functioning

Criterion A of the alternative model recognizes that "disturbances in self and interpersonal functioning constitute the core of personality psychopathology" (APA, 2013, p. 762). The core components of personality functioning are divided into four elements that all personality disorders have in common: Identity, Self-direction, Empathy, and Intimacy (Roche, 2018). As a baseline, these constructs

are initially described from an unimpaired standpoint, consistent with the alternative diagnostic model's dimensional approach.

According to this model, the self is composed of identity and self-direction. Identity is conceptualized as how a person experiences him/herself as separate from others with well-defined boundaries, a belief in and accurate valuation of his/her own worth and abilities, and control over a range of emotions. Self-direction is described as the ability to pursue clear and important goals, to utilize constructive and prosocial internal principles to manage behavior, and the possession of insight into one's own character, actions, and motives.

The interpersonal component of personality functioning is made up of empathy and intimacy. The empathy component includes understanding and feeling for another person's experiences and drives, tolerating alternative viewpoints, and recognizing the impact one's behavior has on others. The intimacy element is described as being able to emotionally connect to others for a period of time, wanting and being able to be close to another person, and behaving in a manner that conveys consideration of others and sharing of his/her feelings.

Criterion A, as described earlier, does not include the potentially pathological nature of personality core content in its definition, as each specific personality disorder has a unique core content which contributes to the dysfunctional expression of the specific disorder. As such, this initial explanation provides a framework to assess the deviation from an unimpaired or "normal" personality perspective to provide a baseline for the more self-destructive and interpersonally damaging personality disorder types. The case example below is provided to illustrate those elements described in Criterion A, which can be used as an unimpaired baseline of personality.

Case Study Baseline Personality: Marcus

Marcus recently graduated college and has been saving up to buy his first car. He feels like he is ready to "take on the world" now that he is out of school and is preparing to move to a new city, with his significant other of five years. His significant other has struggled to graduate college and found math to be her hardest subject. Marcus, being good in math, offered to help her and he would often adjust his schedule to make sure they could study together so that she could pass her classes and they could graduate together. When Marcus thinks about his relationship, his accomplishments, and all he has achieved, he is proud of himself. He recognizes those who helped him achieve his short-term and long-term goals and often tells them how much he appreciates their help and commitment to him.

The Level of Personality Functioning Scale

The four constructs that make up Criteria A are operationalized as existing on a continuum by using the Level of Personality Functioning Scale (LPFS) to identify

Table 1.2 Level of Personality Functioning Scale and Related Degree of Impairment

Level of Impairment	*Degree of Impairment*
0 = Little or no impairment	The individual can see his/her uniqueness and separation from others, and has continuous and controlled positive self-esteem. The individual at this level identifies and attempts to achieve practical goals, is able to clearly understand other peoples' experience and motivations, and is able to sustain several positive and continuous relationships.
1 = Some impairment	The individual's boundaries are somewhat nebulous when strong emotions are activated causing emotional distress, and he/she is conflicted about goal attainment. The individual at this level has some difficulty in seeing others' viewpoints and understanding their experience but can develop relationships with limited fulfillment.
2 = Moderate impairment	The individual unnecessarily depends on others for self-definition and goals that are aimed to garner external approval. The individual is focused on others but only to the extent that it impacts him/herself and can establish relationships, but these relationships tend to lack emotional depth.
3 = Severe impairment	The individual has a poor conceptualization of the self and may over-relate to others, impairing boundaries while struggling to develop and follow through on goals. The individual has difficulty comprehending thoughts, feelings, and behaviors of others and struggles with the ability to connect to others to form satisfying relationships.
4 = Extreme impairment	The individual believes others are harmful but sees little separation between the self and harmful others. Goals are impractical and irrational based upon his/her ability to achieve those goals. The individual is impaired to understand and learn from others' thoughts, feelings, and behaviors. Social engagement is disconnected, chaotic, or typically adverse.

the degree of personality dysfunction (APA, 2013). The LPFS identifies five levels that include: 0 = Little or no impairment, 1 = Some impairment, 2 = Moderate impairment, 3 = Severe impairment, and 4 = Extreme impairment. Table 1.2 provides a summarization of the LPFS and the related degree of impairment at each level.

Measuring the Level of Personality Functioning

An instrument was developed by Morey (2017) called The Level of Personality Functioning Scale-Self Report (LPFS-SR). This is an 80 item self-report measure to assess the four interrelated core personality components that make up Criteria A in the alternative model.

The measure is given to the client before meeting with the clinician and the client is asked to rate how well each item generally describes him/her. Hopwood, Good, and Morey (2018) explored the LPFS-SR and concluded that the measure is valid to assess personality pathology.

Pathological Personality Traits

Criterion B of the alternative model identifies 25 pathological personality trait facets that have been organized into five general trait domains: negative affectivity, detachment, antagonism, disinhibition, and psychoticism (APA, 2013). These five domains are dimensional constructs, which are listed in Table 1.3. These constructs run from unimpaired and functional to impaired and pathological.

Within these five-dimensional constructs are the 25 trait facets that were derived from "…meta-analytic reviews and empirical data on the relationships of the traits to DSM-IV personality disorder diagnoses." (APA, 2013, p. 763). These trait facets can be conceptualized as surface expressions of the core content of personality pathology (Krueger, Derringer, Markon, Watson, & Skodol, 2012). These surface expressions will be referred to as surface content, as they are surface expressions of the core personality pathology content that manifests as behaviors, thoughts, emotions, memories, etc. Table 1.4 lists trait domains and related facets, or surface content.

The trait domains and facets were designed to be inclusive of all individuals and not just those who meet the criteria for a personality disorder. As such, domains and facets are characterized in dimensional terms ranging from unimpaired and

Table 1.3 Personality Disorder Trait Domains and Polar Opposites

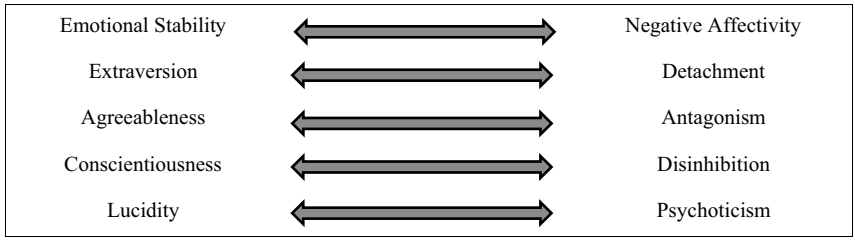

Table 1.4 Trait Domains and Related Facets

Surface Content (Trait Domains & Facets)
1. Negative affect (polar opposite is emotional stability): • Emotional lability • Anxiousness • Separation anxiety • Submissiveness • Hostility • Perseveration
2. Detachment (polar opposite is extraversion): • Withdrawal • Intimacy avoidance • Anhedonia (lack of enjoyment) • Depressivity • Restricted affect (limited emotional range) • Suspiciousness
3. Antagonism (polar opposite is agreeableness): • Manipulativeness • Deceitfulness • Grandiosity • Attention seeking • Callousness • Hostility
4. Disinhibition (polar opposite is conscientiousness): • Irresponsibility • Impulsivity • Distractibility • Risk taking • Rigid perfectionism
5. Psychotism (polar opposite is lucidity): • Unusual beliefs and experiences • Eccentricity • Cognitive and perceptual dysregulation

functional to impaired and pathological, as opposed to categorical indicators of being either present or absent.

The alternative model is quite different in conceptualization and use from the model known by most researchers and clinicians. This new model requires an adjustment to previously held notions of personality pathology, as it is unique to the understanding, assessment, and treatment of personality disorders. An example is provided below to help in understanding the application of this model.

The Application of the Alternative Model

Using the alternative model to diagnose Borderline Personality Disorder (BPD) requires two or more characteristic difficulties from Criteria A (i.e., identity, self-direction, empathy, and intimacy) that are present to a moderate, severe, or extreme level of impairment. The LPFS can be used to determine the degree of impairment. The four elements of the self and interpersonal functioning can be seen as core content related to BPD and can include: uncertainty of self-image and self-concept, being highly self-critical, feelings of emptiness, uncertainty as to career and personal goals, feelings of unworthiness, and tendency to see the world as ostensibly biased (APA, 2013; see DSM-5 Section III for complete list of characteristics). These core elements, or core content, drive the surface expression (i.e., surface content) of BPD, which are evident through the pathological personality traits as identified in Criterion B, including: unstable emotions, frequent mood changes, being highly emotionally reactive, experiencing intense and overwhelming anxiety and panic to stress, being fearful of past negative experiences, and possessing intense worry about negative possibilities. To meet criteria for BPD, the individual would need to exhibit at least four or more of the seven pathological personality traits, which we are calling surface content, and one of those must include impulsivity, risk taking, or hostility (APA, 2013).

Table 1.5 illustrates the core pathological content and the surface content BPD from the DSM-5, Section III (APA, 2013), followed by a case study to provide greater depth of understanding between the alternative model criteria and its presentation.

The Case of Sandy

Sandy is a 25-year-old female who has been in and out of treatment since her late teens following her first suicide attempt via overdose. She has been diagnosed with BPD. She does not meet criteria for any other mental health or medical related issues. She has continually denied a history of substance use and abuse. Sandy tends to feel alone, empty, abandoned, and worthless whenever she is by herself. Her mood often changes from fearful and anxious to sad and hopeless about finding someone she can connect with to "feel whole." When she meets someone new, she immediately feels connected to them and wants to be with him/her "every waking minute so I know they won't leave me." When she cannot get in contact with her boyfriend, she has thoughts of self-harm and may cut her arms and thighs to "relieve stress." When she feels disconnected or lost, she often defers to her boyfriend to help her make decisions and create goals for her no matter what they may be; she recently quit college because he told her she would be better at selling make-up over the internet than going to college.

When she encounters disappointments associated with her inability to achieve her goals, or when they do not work out as anticipated, she tends to become combative and verbally and physically aggressive with her boyfriend. Sandy is

Table 1.5 BPD Core Content and Surface Content

Core Pathological Content	*Surface Content*
1. Identity: • Variable and impaired self-image • Extreme and unwarranted self-criticism. • Continuous feelings of emptiness. • Under stress tendency to dissociate **2. Self-direction:** • Goals, aspirations, values, or career plans are variable and inconsistent. **3. Empathy:** • Impaired ability to identify feelings and needs of others due to interpersonal hypersensitivity (i.e., prone to feel insulted, injured, or disrespected). • Possesses a selective and distorted view of others characteristics or weaknesses that is negatively skewed. **4. Intimacy:** • Strong, variable, and contentious close relationships, filled with suspicion, neediness, and anxious obsession related to real or imagined abandonment. • Extremes of idealization and devaluation in close relationships that often alternate between over involvement and withdrawal.	**1. Negative affect (polar opposite is emotional stability):** • Emotional lability • Anxiousness • Separation anxiety **2. Detachment (polar opposite is extroversion):** • Depressivity **3. ANTAGONISM (polar opposite is agreeableness):** • Hostility **4. Disinhibition (polar opposite is conscientiousness):** • Impulsivity • Risk taking **5. Psychotism (polar opposite is lucidity):** • No considered diagnostic criteria but may be present in some cases.

often frustrated with others while simultaneously trying to please them and is frequently confused by the physical and emotional distance and their refusal to be as close to her as she wants to be to them. She has difficulty understanding this connection and is in constant fear of being harmed and cast off by those she wants to love her. This tends to cause her to feel overwhelmed cognitively and emotionally rejected, lessening her frustration tolerance and increasing her tendency to act out towards others in a broad range of environments, such as work and home.

Based on the above, Sandy meets criteria A (core content) and B (surface content) for BPD using the alternative model. However, criteria A and B would not be enough to diagnose Sandy with BPD using the alternative model as she would also have to meet criteria C through G of the General Criteria for Personality Disorder. According to the DSM-5 (APA, 2013), Criterion C includes inflexibility across various environments. In Sandy's case, for example, she displays impaired surface content in multiple environments, such as work and home (tends to feel cognitively overwhelmed and emotionally rejected, lessening her frustration tolerance and increasing her tendency to act out towards others in a broad range of environments) related to her core personality pathology (feel alone, empty, abandoned, and worthless whenever she is by herself). Criterion D entails stability over time as it relates to core and surface content issues and expression. In Sandy's case, she had been contending with her personality related concerns since her late teens. Criteria E and F include ruling out that the cause of the personality disordered issues is not due to another mental health concern or to substance abuse. In Sandy's case, she has not met criteria for another mental health, medical, or substance related disorder. Criteria G entails confirming that the personality disordered issues are not related to maturation or the combination of social or cultural factors. In Sandy's case, her issues of self-harm began in her late teens and have been stable and continuous, along with other BPD symptoms, into adulthood, and there are no social or cultural indicators, such as education, language, religion, or participation in social organizations that can better account for these symptoms and behaviors.

The case of Sandy illustrates the thoroughness of examining core content and surface content using the alternative model and how its use makes personality disorders and their related structure and expression better understood. However, personality disorders pose inherent problems in term of diagnosis, research, and treatment. Individuals with personality disorders typically meet criteria for other mental health disorders, such as depression or anxiety, as well as other comorbid personality disorders, which complicates the diagnostic process by making it confusing and challenging to render diagnoses that are reliable and valid for research and clinical purposes (Morey, Benson, Busch, & Skodol, 2015; Rottman, Ahn, Sanislow, & Kim, 2009).

The Confusion and Complexity of Personality Disorders

Most individuals will not fall into a specific personality disorder category, such as Narcissistic Personality Disorder, but are more likely to be diagnosed with Unspecified Personality Disorder, using the model in Section II for the DSM-5, or "Personality Disorder – Trait Specified" using the alternative model (APA, 2013; Kupfer & Reiger, 2010; Skodol et al., 2010).

As noted by several researchers (Haslam, Holland, & Kuppens, 2012; Oldham, 2015; Roche, 2018; Spitzer, First, Shedler, Westen, & Skodol, 2008; Tyrer et al., 2015), one of the inherent issues related to the complexity and confusion of personality disorder research and treatment was that the conceptualization was categorical. A categorical approach leads to errors in diagnosis and conceptualization, by encouraging the assumption that an individual with a particular personality disorder will process, react to, and interact with the world in a specific, diagnostically limited, and predictable manner. For example, all individuals with Narcissistic Personality Disorder will present with the same degree and presentation of entitlement. Both researchers and clinicians know this not to be the case. This limited perspective has hindered the understanding and conceptualization of personality disorders, which has impacted not only research but treatment as well. The alternative model was developed out of the recognition that personality disorders do overlap, are complex, and are constructs that are best understood using a dimensional perspective that increases reliability and validity (Chmielewski, Clark, Bagby, & Watson, 2015; Chmielewski, Ruggero, Kotov, Liu, & Krueger, 2017; Markon, Chmielewski, & Miller, 2011).

The Criteria Overlap and Diagnosis Perplexity

Criteria overlap, or the degree to which the same criteria or features (e.g., impulsivity) are present across the personality disorders, has been a longstanding problem in research and treatment, as it leads to diagnostic heterogeneity and confusion (Oldham, 2015). The alternative model was designed to remedy this problem by attempting to reduce the complexity and confusion by not only reducing the number of personality disorders from ten to six but also increasing the threshold that must be met, resulting in a more stringent basis for specific personality disorder diagnosis. Increasing this threshold leads to greater diagnostic specificity, as most individuals will fall under the "unspecified" or "other specified" categories, which is tantamount to the previously used "not otherwise specified" category (NOS; as used in the DSM-IV-TR and prior editions; APA, 2000) that has perpetuated longstanding diagnostic issues. These issues have remained because most individuals do not fit the criteria for a specific disorder, due to the presence and expression of subthreshold features of the disorder or multiple features of multiple disorders, as well as the complexity that is involved in making a reliable, valid, and clinically useful diagnosis (Kupfer & Regier, 2010; Rottman et al., 2009). Clark and colleagues (2015) demonstrated that most individuals with personality disorders are unlikely to meet criteria for one specific personality disorder. Instead, due to the complexity of personality pathology, which is poorly captured by the categorical model, individuals are better diagnosed using a broader diagnostic identifier, as is included in the alternative model.

To address the complexity and lessen the confusion, the alternative model allows for the classification of "Personality Disorder-Trait Specified" (PD-TS), which can be used in those personality disorder cases that do not fall into one of the six specified personality disorder categories (i.e., antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders). This classification of PD-TS is designed to allow "clinicians to tailor the description of each individual's personality disorder profile, considering all five broad domains of personality trait variation and drawing on the descriptive features of these domains as needed to characterize the individual" (APA, 2013, p. 770). In addition to these broad domains, the individual must still possess moderate or greater impairment in at least two of the four Elements of Personality Functioning: identity, self-direction, empathy, and intimacy. This conceptualization provides greater depth of classification and utility as it promotes documentation of pathology in more specific terms (Clark et al., 2015; Schmeck, Schlüter-Müller, Foelsch, & Doering, 2013). For example, in the DSM-5, the diagnosis of Other Specified Personality Disorder seemingly encourages greater specificity but this actually asks the diagnostician to use other general terms, such as "mixed personality features" or "cluster B traits." This leads to an ill-fitted personality disorder distinction that provides minimal research and clinical utility. Using the PD-TS diagnosis streamlines the process by adding "descriptive elements" to explain the personality pathology issues and presentation of an individual.

The Case of Nebulous

Nebulous is a 35-year-old male who is seeking therapy for the first time for chronic anxiety, depression, and difficulty controlling his temper and behavior. He stated that he has always had trouble feeling good about himself and he feels nervous all of the time, except when he feels lethargic and angry. He reported that he wants to standout and be special because he deserves to be recognized, but finds it better to go with the flow and follow his peer group. He often calls himself a "coward" and "a weakling," as he feels a "real man" would define himself and not follow everyone else. When talking about himself, he tends to refer to failures and missed opportunities, such as in relationships and in procuring jobs. When discussing any success, he minimizes it by saying that "anyone" could have done the same, or better.

Nebulous has trouble understanding the motivation and behavior of others, and he attributes everything someone else receives to subterfuge on the part of the receiver. For example, his friend Paul recently got a job with a prominent technology company, and Nebulous had difficulty understanding how Paul got this job except by rationalizing that he must've gotten it by bribing his new boss with money or sex. Nebulous has a long history of short-term, tumultuous relationships in which he felt used and mistreated and occupationally, his longest

term of employment is three months. Nebulous has difficulty managing his anxiety, depression, and temper when his expectations are not met, but when asked, he has difficulty defining his expectations and wants to others. Nebulous would not meet criteria for any of the specifically identified personality disorders in the alternative model (i.e., antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders). However, his pervasive issues cause him significant socioeconomic dysfunction, have been present and stable over time, and his symptoms and behavior are not better explained by another mental illness or substance abuse. In this case, you would diagnosis him with PD-TS, Severe (anxiousness, hostility, depressivity, suspiciousness, grandiosity, and impulsivity), and he has core content impairment in multiple areas. His identity is impaired as evidenced by instability of self-esteem and self-appraisal and poor ability to regulate a range of emotional experiences. His self-direction is impaired by his poor ability to possess and follow through with coherent and meaningful short-term and life goals. His poor ability to self-reflect effectively, as well as his difficulty appreciating his friends' experiences and recognizing their motivations reflects impaired empathy. Using the LPFS, Nebulous' degree of impairment is in the Moderate range.

By encouraging exploration into core personality pathology and the related surface expressions of these functional impairments, the alternative model lessens the complexity and confusion that has plagued prior categorizations of personality disorders, thus helping those in the research and treatment community to better understand those who meet criteria for one of the six specific personality disorders, as well as those meeting the more likely trait specified types. Understanding the structure of what makes up personality and personality disorders is only part of the picture. How these constructs function in an interrelated manner is the next step to recognizing and possibly predicting an individual's surface structure behavior that is exhibited when core content is ignited by a stressor.

The Interrelated Structure of Personality Disorders

Personality Disorders are made up of a unique interrelated structure not seen in other types of mental illnesses. This structure is made up of core elements of personality, Criterion A, that drive surface structure expressions, also called pathological personality traits or Criterion B. In treatment and research settings, the goal is to examine and better understand how core content, Criterion A, influences particular surface content expression, Criterion B, resulting in the dysfunctional pathology that constitutes the particular personality disorder. Once this is achieved, researchers and clinicians can learn and develop more effective and targeted methods to ameliorate and manage symptom expression and to address the core features of personality dysfunction that drive these manifestations. This

is no easy task, as this complex interrelated structure has challenged the field of psychology and human understanding since its inception. This text aims to lessen this complexity and narrow the research and practice gap by using extant models of cognitive and affective processing and the alternative, dimensional model, in conjunction with a structured and interactive model of personality pathology. Lessening this gap through the use of these models will assist both researchers and clinicians who are challenged to disseminate and implement effective treatment approaches that clearly address and attenuate personality problems that plague both fields. These models address, and will attempt to lessen, the disparity between teaching and applying research and/or treatment skills to those who will one day explore and attempt to remedy personality dysfunction, as well as using a common and comprehensive language, illustrated through the use of these models, to better obtain and evaluate data derived from research, and clinical, settings.

The Cognitive-Affective Processing System

The Cognitive-Affective Processing System (CAPS) model (Mischel & Shoda, 1995) emerged to provide a framework in which to conceptualize behavior, in certain situations, for a given individual. This model outlines a network of mental representations that when activated lead to thoughts, feelings, memories, and other internal experiences that drive subsequent behavior (Higgins, 1990; Shoda & Smith, 2004). The goal of the CAPS model is to provide a means to conceptualize clinical cases and form treatment planning options to promote research and clinical practice that best serves to understand the intersection of personality and behavior (Shoda & Smith, 2004). The convergence of the CAPS model and personality disorders within this text addresses and expands upon this goal.

The CAPS model is founded on two basic tenets as outlined by Shoda, and colleagues (2014). First, it postulates that an individual's varying stream of thoughts, feelings, and behaviors reflect changes in what are called cognitive-affective units (CAUs). These CAUs are made up of thoughts and feelings, as well as conceptualizations of self-and-others, expectations and beliefs, goals and values, and self-regulatory strategies that a particular individual can potentially access and experience. Activation of these CAUs are in continual flux as time progresses and some of these changes are in response to external input. For example, smelling a perfume worn by a past significant other can bring about new thoughts and feelings that can cause previously activated thoughts and feelings about the individual or the perfume to fade; new thoughts and feelings usurp once very positive memories while the relationship was ongoing with negative feelings now that the relationship has ended. However, these changes are not always initiated by external input. Remembering a hurtful experience the individual had with that past significant other can bring up feelings, thoughts, and memories of disappointment and

discouragement that can lessen positive feelings the individual had been experiencing up until that time.

The CAPS model's second tenet is that individuals differ in regard to the unique behavioral reaction elicited by various internal and external factors that are impacted by the systemic make-up and interaction of their CAUs. This unique system drives as well as limits the activation of the specific cognitions, affects, and behaviors that are available as a result of individual's specific CAUs. For example, that same perfume worn by a previous significant other may elicit particular memories, both good and bad, of the lost relationship causing the individual to withdraw and choose be alone for a period of time to process the activated thoughts, feelings, and memories. However, someone else who smells that perfume may have positive memories, thoughts, feelings, etc. that prompts them to engage with others as they have accessed positive memories elicited by the perfume.

The CAPS model also takes into account that individuals react consistently in various situations as well. That same perfume worn by someone other than the previous significant other may elicit sadness whether at a party, at work, or with family due to the consistency of the systemic activation of the CAUs. It is the organization and interaction of the CAUs that make up the basic stable structure of the personality system and underlies the behavioral expressions that make the individual unique in not only the manner in which they encounter an initial stimulus or stressor, but the interaction of that individual's CAUs, leading to a high probability of predictable behavioral expression.

The CAPS Model and Personality

The CAPS model is ideal to understand the interrelated structure of personality, both impaired and unimpaired, as it provides a means to explain the stability in core content and surface structure. The CAPS model begins with the presence and impact of external stressors, which are experienced and interpreted on an individualized basis and can be characterized as one of the five stressor types: time-limited, environmental, blended, continuous, and historical (see Fox, 2019 for more information). As with all individuals, perception and response to stressors are individualized based upon past experience, current assessment of stressor, number of stressors present at the time, and the individual's degree of mental health, ranging from no impairment to extreme impairment. These and other factors should be taken into account when exploring and assessing stressors related to the individual and their impact on core and surface structure.

According to the CAPS model and the approach utilized in this text, stressors ignite the core content elements of personality resulting in an outward, or behavioral expression, of personality traits and facets (i.e., surface structure expression). Core

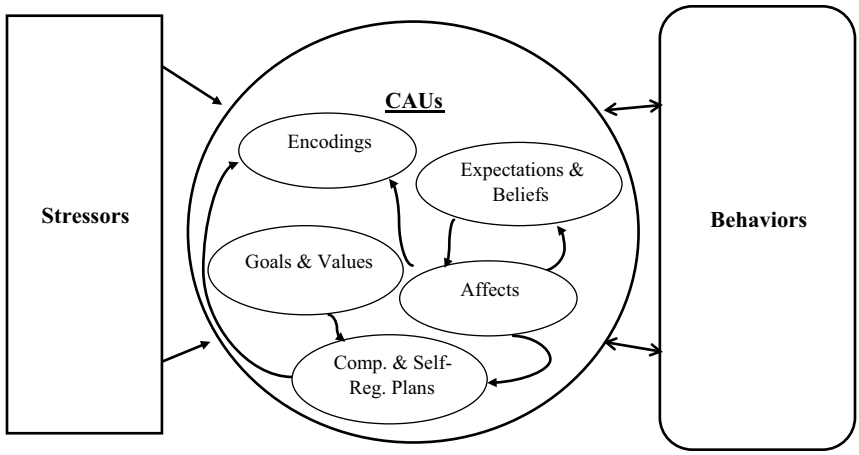

Figure 1.1 The CAPS model with CAUs.

content elements can be understood using the CAUs from the CAPS model, which drive surface structure expression of the individual's personality traits and facets.

According to Mischel and Shoda (1995, 2008), the CAPS model describes the intra-personal cognitive-affective and motivational processes, which, when activated by a stressor, contribute to a particular behavioral expression, as illustrated in Figure 1.1. Within this process, the individual utilizes an integrated network of CAUs to generate response patterns to these initial stressors.

The CAU network consistent of five components (Mischel & Shoda, 1995 and based in part on Mischel, 1973):

1. Encodings – categories or constructs of the self, others, and situations. Examples: People are selfish; I'm ignorant.
2. Expectations and Beliefs – pertain to the social world and self-efficacy related to specific behavior or competencies in various situations. Examples: I know I'm going to fail; I'm doomed to be lonely.
3. Affects – feelings, emotions, and affective responses and physiological reactions. Examples: I'm so angry right now my heart is beating a mile a minute; I'm frozen with fear.
4. Goals and Values – desirable and aversive outcomes and affective states that impact organization and motivation of behavior over time. Examples: I will seek treatment because I want to have control over my life; I want a better job to have a better life, so I'm going to school.
5. Competencies and Self-Regulatory Plans – behaviors and scripts about what one can do and plans and strategies to organize action to impact one's

internal state, behavior, and outcome. Examples: In therapy I'm learning to control my anger though using relaxation exercises and cognitive processing; I'm going to leave him when I have enough money to be away from this pain.

Research substantiates that the affective-evaluative reactions to initial stressors is mediated through CAUs to produce predictable and stable responses using *if… then…* profiles (Borkenau, Riemann, Spinath, & Angleitner, 2006; English & Chen, 2007; Mendoza-Denton & Mischel, 2007; Mischel & Shoda, 1995, 2008). *If… then…* profiles are based upon the individual's response to stressors that activate the mental processing of acquiring information and understanding it using thoughts, images, memory (cognitions) and emotions (affects), it is at this point that the CAUs are engaged. Once this activation has begun, a unique process unfolds within the individual that is composed of a network of associations that produces thoughts, emotions, or observable behaviors (Shoda, LeeTiernan, & Mischel, 2002). Using this framework, *If… then…* profiles posit that *if* the individual experiences situation A (composed of a stimulus or stressor), *then* he/she will respond with B (thoughts, emotions, or observable behaviors).

The If… Then… Case of Rita

Rita is a 45-year-old female who has worked at a local coffee shop for the last four months. She is up for her first quarterly review. Her supervisor Bill called her into his office and told her that her preparation time for the beverages is good, but her interaction style with the customers could be improved using more engaging terms, such as "how can I help you," "thank you, come again," and "you're welcome, see you next time." After Rita heard this, she stood up, raised her voice, and called Bill "a chauvinistic idiot who couldn't pour a cup of coffee to save to his life." She then turned, told Bill she quit, and walked out slamming the door behind her.

Rita has a history of serial unemployment due to her aversive reactions to suggestions, feedback, comments, and criticisms regarding her work performance; much like what happened with Bill. Rita's *if… then…* profile is as follows, *If* Rita receives feedback that is perceived as negative, she *then* responds in an aggressive manner.

The power of the *if… then…* profile is in its stability in predicting an individual's behaviors based upon the larger CAPS model components (Shoda & LeeTiernan, 2002; Shoda et al., 2002; Shoda, Mischel, & Wright, 1994), as illustrated in the example above with Rita. The CAPS model acknowledges that while there is considerable variation in stressors that the individual will encounter, the underlying cognitions and affects are stable. As such, according to this model, an individual's "behavioral signature of personality" can be revealed based upon the individual's personality core structure (Shoda et al., 1994).

Although the majority of research and application of the CAPS model has been on nonclinical samples (Mischel & Shoda, 1995; Shoda & LeeTiernan, 2002; Shoda et al., 2013), the model fits as a means to conceptualize psychopathology, including personality disorders (Eaton, South & Krueger, 2009; Huprich & Nelson, 2015).

The CAPS Model and Personality Disorders

Huprich and Nelson (2015) remarked on the applicability of the CAPS model to personality disorders stating, "…[the] CAPS model offers a comprehensive, integrative framework on which many theories of personality and pathology can be placed at the conceptual level." (p. 8). Further, the authors note the cross-theoretical nature of the CAPS model, in which "those models of personality disorders that have the most interest to personality disorder researchers and clinicians (e.g., psychoanalytic and psychodynamic, interpersonal, social-cognitive, trait, neurobiological) can be readily mapped into this framework." Absent of a constricting theoretical orientation and in line with a unifying approach of complex theories to enhance utility (Sternberg & Grigorenko, 2001), the CAPS model is deemed an effective framework for researchers and clinicians to understand personality as it provides a common language to further inquiry and intervention.

The CAPS model furthers the process of understanding by broadening the conceptualization of personality disorders, moving away from a steadfast trait-based approach to a "situation-inclusive paradigm" (Eaton et al., 2009). This view conceptualizes how an individual with a personality disorder may present particular adaptive or maladaptive responses by incorporating not only the stressors the make-up a given situations but also the underlying core content that makes up the personality disorder. The CAPS model, when considered in conjunction with and further applied to the personality pathology framework of the DSM-5's alternative model (APA, 2013), provides a more detailed and comprehensive personality disorder conceptualization. This is shown in Figure 1.2.

As illustrated in Figure 1.2, the DSM-5's alternative model to personality pathology maps well to the CAPS conceptualization of what drives behavior. In pathology, the CAPS model is initiated once the individual encounters a stressor, which can be time-limited, environmental, blended, continuous, and historical (Fox, 2019) The experience of a stressor ignites an internal response that drives the core pathological personality content of the self and interpersonal functioning, including intimacy, self-direction, empathy, and identity. In this way, CAUs can be conceptualized as interacting with core content drivers that, when ignited, result in the expression of surface structure behaviors that comprise the pathological personality trait domains and facets, such as negative affectivity, emotional lability, irresponsibility.

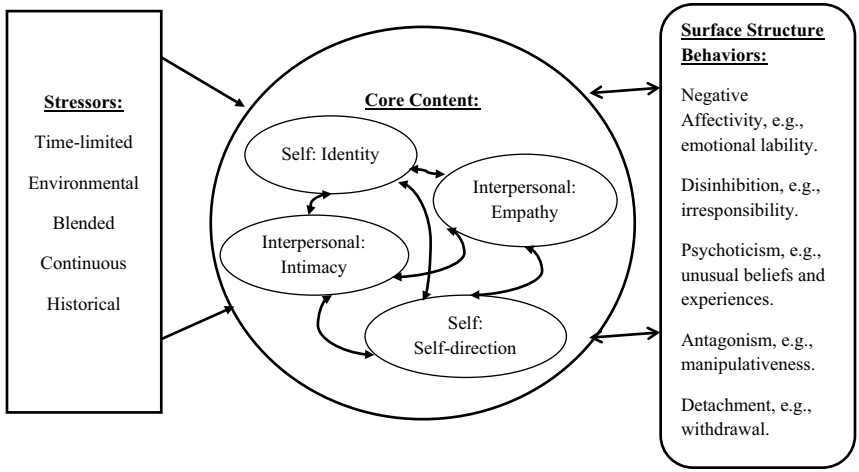

Figure 1.2 CAPS and DSM-5 alternative model.

The complexity of the CAPS model and the DSM-5 alternative model of personality disorders lies in the central intrapersonal processing, which includes CAUs and core content components. The CAUs are broad categories that are interrelated with the self and interpersonal functioning components that are stable within a given personality disorder. Taken together, CAUs and components of pathological functioning influence an individual's core content.

Using the general Elements of Personality Functioning from the DSM-5's alternative model (APA, 2013) as an example, under Self: Identity is the individual's ability to "experience oneself as unique, with clear boundaries between self and others." This conceptualization of identity fits into the CAUs system of encodings, expectations and beliefs, and affects. One's ability to see the distinction of the self as separate and unique fits with how one conceptualizes the self and others (encodings); One's social world and self-efficacy is impacted by how one sees the separation of self from others and the boundaries that make that distinction that impacts specific behaviors in various situations (expectations and beliefs); and one's recognition of the uniqueness and separation of the self from others relates to one's feelings, emotions, and affective responses and physiological reactions (affects).

The core personality psychopathology content of the Elements of Personality Functioning from the DSM-5 alternative model general functioning and the CAUs are listed in Table 1.6. Keywords are used to represent each component of the general Elements of Personality Functioning in the table, to see the unabbreviated description, consult the DSM-5, Section III, Criterion A (APA, 2013, p. 762).

Table 1.6 Elements of Personality Functioning and CAUs

Elements of Personality Functioning	*Cognitive-Affective Units*				
	Encodings	*Expectations and Beliefs*	*Affects*	*Goals and Values*	*Competencies and Self-Regulatory Plans*
Self: Identity Unique self and boundaries	X	X	X		
Self: Identity Stable self-esteem and self-appraisal	X	X			X
Self: Identity Ability to regulate emotional experience		X	X	X	X
Self: Self-direction Pursuit of meaningful goals		X		X	X
Self: Self-direction Positive behavioral standards				X	X
Self: Self-direction Productive Self-reflection	X	X		X	X

Table 1.6 (*Continued*)

Interpersonal: Empathy Recognition of other's experiences and motivations	X	X			
Interpersonal: Empathy Tolerance of different perspectives	X	X	X		X
Interpersonal: Empathy Understanding of one's behavior on others	X	X			X
Interpersonal: Intimacy Connection with others	X		X		X
Interpersonal: Intimacy Desire and capacity for closeness	X	X	X	X	X
Interpersonal: Intimacy Reciprocity of interpersonal behavior	X	X			X

As you can see from the table, some elements have a stronger relationship to some CAUs than others. *Expectations and Beliefs* and *Competencies and Self-Regulatory Plans* have the strongest relationship to the general Elements of Personality Functioning, with 10 related components for each. This suggests that general personality functioning, at the core content level, is impacted the most by the social world and self-efficacy. One's core content related to perceptions and beliefs about the social world, such as social scripts about what one can and ought to do, influence specific behaviors in various situations. Likewise, one's core content associated with self-efficacy influence one's ability to plan and strategize and to coordinate or organize action to alter one's internal state, behavior, and outcome.

Table 1.6 further illustrates which areas are least impactful to unimpaired Elements of Personality Functioning, such as *Affects* and *Goals and Values*, in the case of the example of those with unimpaired personality shown above. This does not mean that affects and goals and values are not important or impactful, but that they have less of an impact on those whose personality is not pathological; likely these individuals have a better controlled influence of these constructs. Affects and Goals and Values are those aspects that include feelings, emotions, and affective responses and physiological reactions, as well as desirable and aversive outcomes. These individuals experience affective variability but not to the adverse and intense level as those with pathological core content (e.g., affective instability). Extreme variation and intensity of affective experiences, as is seen in pathological personalities, adversely impact one's wants, principles, and ability to organize and motivate the self over time to influence change in situations and outcomes.

Incorporation of the CAPS and DSM-5 alternative model to personality pathology provides value to clinicians and researchers by further clarifying and conceptualizing the process from activating event to the expression of pathological personality traits, or surface structure. In addition, this combined model proves useful to guide treatment.

The CAPS Model and Treatment

Shoda and Smith (2004) discuss how the CAPS model relates to the treatment of a myriad of mental health and psychological concerns, such as marital discord, phobias, posttraumatic stress disorder, obsessive–compulsive disorder, and is deemed applicable to several treatment techniques and protocols already in-use, such as behavioral contracting, promoting acceptance and commitment, conflict resolution training, systematic desensitization, anxiety-reduction, and enhancement of self-efficacy.

The CAPS model has been proposed as an efficacious framework for treatment conceptualization and practice utilizing a wide variety of therapeutic modalities, including cognitive-behavioral, interpersonal, and psychodynamic therapies

(Huprich & Nelson, 2015; Shoda et al., 2013). The CAPS model recognizes the interplay between stimuli and stressors, the individual, and expressive behavioral responses, and proposes that if changes occur in one component of this process, other aspects are influenced as well; this is often seen, understood, and executed through the *if… then…* profiles (Shoda & Smith, 2004).

The symmetry between the CAPS model and the DSM-5 alternative model has been well explained. When adding a treatment component, the model develops an additional construct that impacts its flow, that now is representative of the individual's experience through the combined system, which we call the CAPS-5 Treatment Model. Figure 1.3 illustrates the CAPS-5 Treatment Model.

In addition, the CAPS-5 Treatment Model addresses one of the great concerns regarding the DSM-5 alternative model, which is that the alternative model is too complicated for clinicians, causing them not to use it (Oldham, 2015).

In this conceptualization, the CAPS-5 Treatment Model takes into account the influence of stressors on core personality content, while recognizing the impact that effective therapeutic intervention has on the outcome, when targeted at the interaction between surface structure expression and core content. This therapeutic addition, shown with the boxed T, illustrates the impact therapeutic interventions can have on the surface structure expression of core content. This is not a singular process, but rather an interactive or reciprocal process, as shown by the two-headed arrows. This mutual process recognizes that effective therapeutic intervention impacts surface structure behavior, but also influences the elements of personality core content, whether unimpaired or disordered. Acknowledging

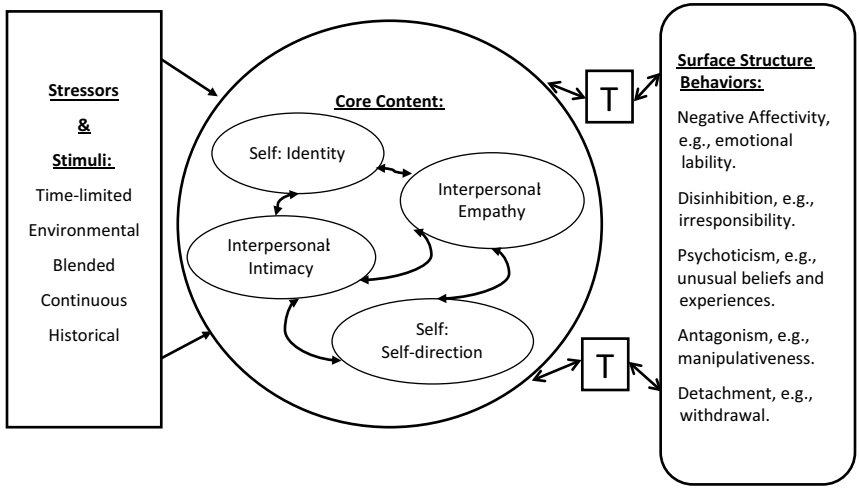

Figure 1.3 The CAPS-5 treatment model.

that dysfunction and treatment needs exist on a continuum, the CAPS-5 Treatment Model fits with treatment conceptualizations related to the dimensional structure of the DSM-5 alternative model. Taking a transdiagnostic approach, the CAPS-5 Treatment Model also aligns well with modern therapeutic conceptualizations that argue treatment should not be narrowed to the concept that "specific disorders call for specific treatment." Rather, flexibility in theory and technique, while emphasizing evidence-based approaches, should be included to fit both the client and the condition (Hopwood, 2018).

Hopwood (2018) outlines a five-step treatment approach to working with individuals with personality disorders that fits with the CAPS-5 Treatment Model. The first step is to determine the degree of impairment in the Elements of Personality Functioning, Criterion A, using valid measures, such as LPFS-SR (Morey, 2017).

The next step in Hopwood's (2018) clinical approach is to identify and determine the severity of the pathological personality traits, Criterion B, that are present. This can be achieved using the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012), for example. This inventory consists of 220 items, with a 4-point response scale, that are used to identify the 5 broad trait domains and 25 specific trait facets that pertain to Criterion B of the DSM-5 alternative model. This inventory has been found to be reliable and valid when used with a wide variety of clinical and nonclinical samples (De Caluwé, Verbeke, van Aken, van der Heijden, & De Clercq, 2018; Fossati, Krueger, Markon, Borroni, & Maffei, 2013; Wright et al., 2012). There are two additional forms of the PID-5, the short-form (PID-5-SF) with 100-items, which has been found to be reliable and valid (Maples et al., 2015) and a brief form (PID-5-BF) with 25-items, which has been found to be clinically useful and valid (Anderson et al., 2018). The PID-5-SF assesses the 5 domains and 25 traits facets; whereas, the PID-5-BF assesses the 5 trait domains only.

The third step includes assessing the individual's presenting challenges and issues, in order to create a targeted intervention strategy, while incorporating relevant assessment data. Targeted interventions will be designed to address core and surface content issues that are ignited by stimuli or stressors. It is at this point that the frequency of sessions and total duration of treatment is to be determined, as well periodic or regular progress monitoring sessions to evaluate change and target new areas for treatment as they may arise.

Once these previous steps are completed, the clinician disseminates the information that has been gathered to the client and the related individuals. It is at this stage that consent for treatment is obtained, and explicit details should be provided pertaining to therapeutic disruptions, such as missed sessions, crises, hospitalizations, and so on, if and when these issues arise to prepare not only the client but the related individuals as to how these issues will be handled for the safety of the client and the continuation of treatment.

The final step of this approach is to include routine assessments of therapeutic movement, such as a lessening or exacerbation of core and surface content. This can be achieved through the use of a variety of psychological assessment measures, including but not limited to the PID-5, PID-5-SF, PID-5-BF.

It is noted that the greater the severity of impairment, the more flexibility and modifications will be required to tailor the treatment to the client going forward. This level of impairment can be identified in the first step using the LPFS-SR preparing the treatment provider to make modifications in the areas of treatment setting, level of involvement from friends and family, the regularity of progress monitoring and treatment planning, and the level of supervision and consultation for providers. For example, with higher risk clients, modifications might include: in-patient or intensive care and the application of a high degree of structured treatment planning, such as outlining treatment sessions, crisis interventions and resources, and a personal safety plan. Some cases may call for a multifaceted, systems-oriented approach, which includes all those involved in the client's therapeutic experience, such as treatment providers, family members, and others who provide support. For treatment providers, modifications could involve: routine consultation sessions to discuss transference and countertransference reactions; continual evaluation of the utility of the insight-oriented, supportive, and change-oriented strategies that impact the therapeutic dynamic and progress; and, as is also valuable to family and support givers, focusing on clear communication, boundaries, and awareness of possible manipulation.

The CAPS-5 Treatment Model and the outlined steps above are proposed to help close the research and practice gap by illustrating the use of research data to drive therapeutic outcomes, as well as new and effective ways to conceptualize and treat personality disorders.

Concepts to Be Addressed

This book will explore several aspects of antisocial personality disorder, narcissistic personality disorder, and borderline personality disorder. These particular disorders were chosen as a focus of exploration as they are amongst the most prevalent personality disorders seen in treatment and are the most researched, compared to other personality disorders included within the DSM-5 alternative model. As such, emphasis on these three historically Cluster B conditions has the greatest likelihood of further attenuating the gap between personality pathology research and clinical practice (Dixon-Gordon, Peters, Fertuck, & Yen, 2017; Kacel, Ennis, & Pereira, 2017; Porter & Risler, 2014; Waugh et al., 2017; Wygant et al., 2016). Each chapter is dedicated to one personality disorder and will have five main sections.

The first section of each chapter, titled *Core and Surface Content*, will include: a brief history of the disorder, a detailed explanation of the DSM-5 alternative model as it relates to that disorder, and an examination into how each personality disorder type fits into the CAPS model. Each chapter will further discuss how the application of the DSM-5 alternative model is advantageous for these specific conditions. Additionally, chapters will explore how the CAPS conceptualization aptly captures and helps to better understand the dysfunctional interpersonal systems inherent in personality pathology that have been constructed to perpetuate the core and surface structure that make up the particular personality disorder type.

The next section within each chapter, titled *Origin and Symptom Manifestation*, will explore the origin and expression of core and surface content utilizing the biopsychosocial model (Engel, 1977), or from a biological, psychological, and social vantage point. The biopsychosocial model has previously been applied to the personality disorders being explored in this book (Paris, 1993). This book will revisit and expand upon these prior applications in order to gain greater understanding into each type's development and expression.

As our society becomes more socially electronic to attempt to connect to one another, those with personality disorders continue to perceive other individuals, feedback, criticisms, environments, and situations through the lens of their unimpaired or disordered personality (Azucar, Marengo, & Settanni, 2018). Each chapter will also include an examination of the core elements of personality and the pathological personality traits that manifest online and how each impacts online behavior and the internet community as a whole, titled *Online Behavior Expression*.

The fourth section, titled *Treatment Success and Effective Approaches*, will cover efficacious treatment approaches for each disorder, in addition to factors that promote and degrade treatment success. Therapeutic approaches for each of the three personality disorders will be explored using the CAPS-5 Treatment Model and Hopwood's (2018) step-by-step treatment approach.

In the final chapter, the focus will be on the direction of personality disorder research and the possible future concerns and challenges that clinicians and researchers might face when working with and studying personality pathology. In addition, this chapter will discuss ways to continue to lessen the complexity and confusion of personality disorders by using the concepts included in this book.

Chapter 2

Antisocial Personality Disorder

Antisocial personality disorder (ASPD) is a term used to describe those who perpetrate acts that illustrate the darker side of humanity. It is used to describe those who engage in violence, aggression, manipulation, and deceit, while exhibiting and experiencing callousness, lack of restraint, blunted emotions, disregard for rules and norms, and indifference toward the welfare of others. Those individuals who possess the traits that make up ASPD cause significant societal and interpersonal destruction and that includes destruction of property, physical and emotional abuse, and loss of life. Due to the havoc that individuals with ASPD tend to cause, ASPD has been the subject of extensive study in efforts to better understand and describe those who exhibit these traits.

Over the centuries, the condition which is now called ASPD has held a variety of names including moral derangement (Rush, 1812), moral insanity (Prichard, 1835), sociopathy (Lykken, 1985), and psychopathy (Patrick, 2006). While other terms have become antiquated, psychopathy has stood the test of time and is most often researched in conjunction with, or as a more severe variant of ASPD, existing on the end of the broader ASPD continuum (Adshead & Jacob, 2012; Coid & Ullrich, 2010; Hare & Neumann, 2008; Patrick, 1997). The main distinction between ASPD and psychopathy is that ASPD is best understood as a behaviorally focused diagnosis, that is included in the DSM whereas psychopathy is not, and psychopathy includes personality features, such as callousness, egocentricity, and low anxiousness for example (Lilienfeld, 1998) In this chapter, ASPD will be examined within the context of the DSM-5 alternative model. Psychopathy,

conceptualized as this more extreme variant, will be discussed within the framework of the DSM-5 alternative model as a specifier "with psychopathic features."

It is noted that there is a greater degree of research conducted on the more extreme form of ASPD, psychopathy, than ASPD alone. As this book is designed to bridge the research-to-practice gap, the following chapter will examine and address issues related to the more global construct ASPD, which is specifically included in the DSM-5 (American Psychiatric Association (APA), 2013) alternative model. However, to completely ignore psychopathy would do a disservice by failing to address the full spectrum of ASPD; thus, psychopathy examined as it relates to the more global construct of ASPD. It is important to examine psychopathy as it relates to the more global construct of ASPD.

History of ASPD

Clinicians and researchers have attempted to understand the motivations and expressions of antisocial behaviors for centuries. In 1806, Philippe Pinel used the term "insanity without delirium" to identify individuals who would repeatedly engage in violent behavior toward themselves, or others, despite the absence of cognitive impairment. In 1835, Benjamin Rush, who is considered the "Father of American Psychiatry," described individuals who possessed socially deviant behaviors as having "moral alienation of the mind" and suffering from "moral derangement." He noted that these individuals would use obscene language when agitated, were identified as "kleptomaniacs," abused alcohol and drugs, and were prone to impulsive suicidal gestures. These examples can be seen as the beginning of a research and practice-based approach to the study of aberrant and amoral behavior that is harmful to self, others, and society that will later be factors associated with ASPD.

While research and psychiatric exploration of these individuals continued, no clear designation or term about the individuals who engage in these antisocial behaviors had yet prevailed. This is exemplified by Henry Maudsley (1874), a British psychiatrist, who addressed the 1967 abduction, murder, and dismemberment of an 8-year old girl by Fredrick Baker, a 24-year old man. Maudsley noted that "the impulsive character of the crime, the quiet and determined ferocity of it, the savage mutilation, his equanimity immediately afterwards, and his complete indifference to his fate – all these indicated an insane organization" (p. 163). Noting all of these findings, Baker was not found insane or to meet the qualification of moral insanity (Jones, 2017). What researchers, clinicians, and those in law enforcement were encountering then was described and identified but still remained nebulous. Maudsley describes then what we now understand to be the antisocial personality:

> Notwithstanding prejudices to the contrary, there is a disorder of the mind, in which, without illusion, delusion, or hallucination, the

> symptoms are mainly exhibited in a perversion of those mental faculties which are usually called the active and moral powers — the feeling, affection, propensities, temper, habits, and conduct. The affective life of the individual is profoundly deranged, and his derangement shows itself in what he feels, desires, and does. He has no capacity of true moral feeling; all his impulses and desires, to which he yields without check, are egoistic; his conduct appears to be governed by immoral motives, which are cherished and obeyed without any evident desire to resist them. There is an amazing moral insensibility. The intelligence is often acute enough, being not affected otherwise than in being tainted by the morbid feeling under the influence of which the persons think and act; indeed they often display an extraordinary ingenuity in explaining, excusing, or justifying their behaviour, exaggerating this, ignoring that, and so coloring the whole as to make themselves appear the victims of misrepresentation and persecution.
>
> (pp. 171–172)

Cesare Lombroso (1911), as well as others, attempted to gain greater understanding of antisocial pathology by discerning its root cause. Lombroso embraced the moral insanity identifier and took steps to further the understanding and application of this term. He did so by identifying two types of criminal characteristic types: "born criminals" (akin to those with moral insanity) and "criminaloids." According to Lombroso's typology, born criminals possess a deeper and ingrained criminal genetic characterological structure (atavism and epilepsy), which included low cranial capacity, retreating forehead, highly developed frontal sinuses, great frequency of Wormian bones (additional small bones sometimes found between the cranial sutures of the bones of the skull), early closing of the cranial sutures (fibrous bands of tissue that connect the bones of the skull), the simplicity of the sutures, the thickness of the bones of the skull, enormous development of the maxillaries (upper fixed bone of the jaw) and zygotomata (cheekbone), prognathism (skeletal base where either of the jaws protrudes beyond a predetermined imaginary line in the coronal plane of the skull), obliquity of the obits (separate or uneven eye sockets), greater pigmentation of the skin, tufted and crispy hair, and large ears. The individuals he identified as criminaloids are separated from the born criminal as they do not have biological anomalies, confesses fault more easily, sincerely, and more often. They value the respect of society, may influence others to perpetrate illegal acts removing the criminaloid from liability and being labeled a criminal, and may present as a good upstanding citizen.

The term "moral insanity" was often used and misused and eventually became a "waste-basket" for conditions and maladies that did not fit into neat and classifiable categories (Partridge, 1930). It was eventually usurped in 1891 by the term "psychopathic inferiority," introduced by J.L.A. Koch and used to describe "all

mental irregularities, whether congenital or acquired, that influence a man in his personal life and cause him, even in the most favorable cases, to seem not fully in possession of normal mental capacity" (Pastar, Petrov, Krizaj, Bagaric, & Jukic, 2010, p. 466). Koch broke down psychopathic inferiority into three main categories: hereditary, acquired, and hereditary-acquired. These categories were further subdivided into disposition, burden, and degeneration to reflect the degrees of psychopathic inferiority (Gutmann, 2006). See Table 2.1 for descriptions of Koch's psychopathic inferiority categories. Koch's theory was a step forward as it recognized the contribution of both hereditary and environmental (or acquired) aspects to mental functioning, including aberrant antisocial behaviors.

Gutmann (2006) notes Koch's influence on forensic psychiatry with the recognition of diminished capacity and its need to be applied to the criminal code for individuals who fit into the psychopathic inferiority categories, as well as providing not merely punishment but treatment for these individuals. This opened the door to more than just housing those with psychopathic inferiority, but attempting to treat them as well.

Adolf Meyer (1904) generally followed Koch's classification of psychopathic inferiority but distinguished psychopathic cases from psychoneurotic disorders. Meyer drew clear distinctions between genetic or physical origins and psychogenic origins and tended to believe that the latter was more influential to explain neuroses (Meyer, 1904). Meyer postulated that neurosis, or neuroses, was different from psychosis in that only a part of the personality was involved. He further regarded neurotic patients as adversely impacted by unrealistic expectations and the inability to accept themselves as they were. American psychiatry continued

Table 2.1 Koch's Categories of Psychopathic Inferiority

Hereditary Psychopathic Disposition Tension and high sensitivity. Mildest form that eventually turned into "normality."	**Hereditary Psychopathic Burden** Peculiar, egocentric, compulsive, and highly impulsive.	**Hereditary Psychopathic Degeneration** Seen mostly in impaired cognitive functioning or in moral behavior, or both. Believed to turn into psychosis.
Acquired Psychopathic Disposition Mild "psycho-vegetative symptoms of fatigue" (p. 211)	**Acquired Psychopathic Burden** Neurasthenia - exhaustion of the central nervous system's energy reserves; often seen in individuals working in sedentary occupations.	**Acquired Psychopathic Degeneration** A group of heterogeneous syndromes and disorders, from what is now called epilepsy to alcohol use disorder.

this line of thinking for some time until the term "inferiority" was eventually removed, as it was found to be pejorative. This term was replaced with "constitutional psychopathic state" and "psychopathic personality" in the early part of the 20th century (Millon, Simonsen, & Birkec-Smith, 1998).

Moving from the end of the 19th century into the 20th century, many authors, medical professionals, and researchers subscribed to degeneration theory, which posited that humans are returning to an earlier, worsened and impaired, state of existence, as evidenced by depraved human behavior. Emil Kraepelin subscribed to this approach but was critical of its ubiquity and noted that an individual's degeneration could not simply be identified based upon one's physical appearance (Hoff, 2015). He introduced what we now identify as pathological personality types using the general term "psychopathic personalities." Kraepelin's psychopathic personalities included four types: (1) "Morbid liars and swindlers" who were charming, deceitful, and fraudulent con artists, who lacked responsibility and loyalty to others; (2) "criminals by impulse" who were urged by the inability to control themselves and were arsonists, rapists, and kleptomaniacs; (3) "professional criminals" who appeared well-mannered and socially appropriate, but covertly calculating, manipulative, and self-serving; and (4) "morbid vagabonds" who were purposeless, lacking in self-confidence, and irresponsible. In 1915, Kraepelin revised his psychopathic personalities by removing "professional criminals" and adding four additional types: excitable – these individuals share characteristics similar to today's conceptualization of borderline personality disorder –eccentric, antisocial, and quarrelsome (Crocq, 2013; Kraepelin, 1915).

Schneider, a German psychiatrist who wrote extensively on the symptoms and diagnosis of schizophrenia and psychopathic personalities, published the influential "The Psychopathic Personalities" in 1923, where he identified a variety of pathological personality types, which he termed "psychopathic" in nature. Schneider's ten types included: the hyperthymic (exceptionally positive temperament), the depressive, the insecure, asthenics (sensitive), the explosive, the weak-willed, the fanatical, as well as those who are recognition-seeking, those with labile mood, and those who are emotionally-blunted (Schneider, 1923). Kraepelin's seven psychopathic personality types identified individuals who were seen as problematic to society; whereas Schneider identified individuals with atypical personality that were markedly depressed or insecure using the term "psychopathic" generally to encompass a wide range of abnormal personality types, not just individuals with antisocial personality characteristic and expressive behaviors (Crocq, 2013). Crocq (2013) credits Schneider with the perspicacity to recognize personality as a dimensional construct ranging from unimpaired personality to pathological personality, a feature that will eventually be resurrected in the alternative model in Section III in the DSM-5 (APA, 2013). Before exploring the ASPD dimensional model, ASPD throughout the editions of the *Diagnostic and Statistical Manuals* (DSM; APA, 1952, 1968, 1980, 1987, 1994, 2000, 2013) will be examined.

The DSM and ASPD

The groundbreaking work of the American psychiatrist Hervey Cleckley laid the early and profound stepping stones to the first edition of the DSM and what would later be identified as ASPD. Cleckley's *The Mask of Sanity* is the seminal early work on psychopathy, with multiple revised editions throughout the subsequent years (1941, 1976). Cleckley (1941) identified 21 diagnostic features of psychopathy which are often cited as foundational in the formulation of the DSM-I "sociopathic personality disturbance" with a subcategory of antisocial reaction (Millon, 2011). Sociopathic personality disturbance generally described individuals who are "ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relation with other individuals" (APA, 1952; p. 38). Emphasis on callousness and irresponsibility is where the DSM-I's sociopathic personality disturbance and Cleckley's psychopathy overlap (Gurley, 2009), and that is the often the root of the confusion between ASPD and the term psychopathy continues. The DSM-I attempted to provide greater definition of its sociopathic personality disturbance by adding three subclassifications that are listed in Table 2.2.

Table 2.2 Subclassifications of Sociopathic Personality Disturbance, DSM-I (APA, 1952)

Antisocial reaction	These individuals are "chronically antisocial" always in trouble, failing to learn from past experience or punishment, and lacking loyalty to other people, groups, or norms and standards. They are unsympathetic, pleasure seeking, immature emotionally, and lacking in sense of responsibility and judgement, along with a tendency to "rationalize their behavior so that it appears warranted, reasonable, and justified." (p. 38). This subclassification is likened to "constitutional psychopathic state" and "psychopathic personality."
Dyssocial reaction	These individuals show open neglect for social rules and are often in conflict with them due to living in "an abnormal moral environment" (p. 38). Although these individuals may have strong loyalties, they tend to be towards their own predatory, criminal, or other deviant group. This subclassification is likened to "pseudosocial personality" and "psychopathic personality with asocial and amoral trends."
Sexual deviation	These individuals are to be distinguished from those with schizophrenia and obsessional reactions and is meant to include "pathological behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation)" (p. 39). This subclassification is likened to "psychopathic personality with pathologic sexuality."

Revisions of the DSM-I, resulting in the DSM-II (APA, 1968), were representative of the shift in the APA from a psychoanalytic perspective to more of a biological framework and etiology (Pickersgill, 2012). However, this edition was not well received due to concerns about the reliability with which criteria were being applied. This doubt regarding the reliability led to further mistrust as to the validity of the "sociopathic personality disturbance" diagnosis, and the manual as a whole (Ogloff, 2006; Spitzer, Endicott, & Robins, 1978).

In regard to ASPD, the DSM-II (APA, 1968) merged Cleckley's (1941) description of psychopathy and the first edition's sociopathic personality disturbance to create the global term "antisocial personality." This more global conceptualization took into consideration the behavioral and affective components of both origins (APA, 1968, p. 43):

> This term is reserved for individuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups, or social values. They are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalizations for their behavior. A mere history of repeated legal or social offenses is not sufficient to justify this diagnosis.

Due to perceived misuse and complaints surrounding the DSM-II, the authors of the DSM-III (APA, 1980) developed more specific criteria that were created for research purposes by Feighner and colleagues (1972) and Spitzer, Endicott, and Robins (1978). With respect to ASPD, the DSM-III (APA, 1980) criteria addressed specifically the individual's severe and chronic irresponsibility, poor work history, relationship infidelity or instability, financial irresponsibility, impulsiveness, irritability, aggressiveness, and violation of the rights of others. In addition, it acknowledged the importance of behaviors during childhood, requiring that three or more of the following be present before age 15: truancy, expulsion or suspension from school, delinquency, running away, lying, rule violations, starting fights, repeated casual sex, substance abuse, theft, vandalism, and school grades below the individual's ability (APA, 1980). By requiring the presence of childhood antecedents, the validity of the ASPD diagnosis was enhanced (Lahey, Loeber, Burke, & Applegate, 2005; Loeber, Burke, & Lahey, 2002).

The revisions of the DSM-III successfully improved diagnostic reliability, but problems arose regarding behaviorally specific criteria that were included in the other personality disorders (Widiger & Trull, 1987). There were further concerns that the criteria were too general, such that individuals were being misclassified as having ASPD due to frequent interactions with criminal courts and coming from a "disadvantaged" group (Pickersgill, 2012; Widiger, Frances, Spitzer, & Williams, 1988). Criticism

regarding the DSM-III criteria also centered around its lack of inclusion of the psychopathy features identified by Cleckley (1941), such as low anxiousness, arrogance, lack of remorse and empathy, and superficial charm (Gurley, 2009; Widiger, 2006).

The next edition of the DSM followed approximately seven years later and was the first revised edition (DSM-III-R; APA, 1987). Due to inconsistencies and a lack of clarity in the diagnostic system, the APA convened a work group to revise DSM–III, leading to the DSM–III–R (Fischer, 2012). Within the purview of ASPD, Cleckley's criterion of lack of remorse was added to the criterion set in response to the criticism surrounding its prior omission (Gurley, 2009; Widiger et al., 1988). This addition illustrates the influence psychopathy had, and continues to have, on the construct of antisocial personality (Pickersgill, 2012).

In developing the criteria for ASPD in the DSM-IV (APA, 1994), two aspects were considered: greater emphasis on traits of psychopathy and simplifying the criteria without changing the diagnosis or adversely affecting diagnostic reliability (Widiger et al., 1996). Changes included deleting two criteria, parental irresponsibility and failure to sustain a monogamous relationship for more than one year, and moving contempt for the feelings of others, superficial charm, and lack of empathy to the Associated Features section (Pickersgill, 2012). Confusion between ASPD and psychopathy continued into the DSM-IV. In particular, authors note that "the pattern [of antisocial traits] has also been referred to as psychopathy, sociopathy, or dissocial personality disorder," highlighting the myriad of titles that have been used to name this condition (APA, 1994, p. 645). Further, readers are reminded that features such as lack of empathy, inflated self-appraisal, and superficial charm may be critically valuable in distinguishing ASPD from psychopathy, particularly in cases where criminal and/or aggressive acts are likely to be "nonspecific," such as prison or forensic settings (APA, 1994, p. 647). This acknowledgement serves to contrast ASPD and psychopathy, dividing characteristics largely on behavioral and social-emotional lines, respectively.

The conceptualization within the DSM-IV was seen as problematic and confusing to many of those in the field perceiving two sets of diagnostic criteria for ASPD, one focused solely on antisocial and criminal behaviors and another encompassing these behaviors, as well as providing inferences regarding personality (Hare, 1996). Failure to discern psychopathy from ASPD can have real-world consequences, as noted by Robert Hare (1996). For example, Hare noted the prevalence of individuals on death row who were misperceived as psychopaths, when in actuality there was a higher likelihood that these individuals "merely meet criteria for ASPD, a disorder that implies tenuous implications for treatability and the likelihood of violent reoffending" (p. 40). The following edition of the DSM, DSM-IV-TR (APA, 2000), made a minimal attempt to address this very issue when it updated the associated features "to clarify that features that are part of the traditional conception of psychopathy may be more predictive of recidivism in setting (e.g., prisons) where criminal acts are likely to be nonspecific" (p. 842).

Approximately thirteen years later, the DSM-5 (APA, 2013) has two systems of classifying personality diagnoses: one in Section II, which houses the traditional categorical approach that has been largely criticized and present since the DSM-III (APA, 1980), and one in Section III, which contains a hybrid dimensional model intended to address and remedy these criticisms and increase utility, known as the alternative model. As noted in Chapter 1, utilizing the dimensional approach has been found to add to the conceptualization and understanding of the distinction between personality disorders, including ASPD (Bastiaens et al., 2016; Strickland, Drislane, Lucy, Krueger, & Patrick, 2013).

ASPD and the Alternative Model

The alternative model, as it relates to ASPD, not only enhances conceptualization and utility of the disorder but also provides a clearer distinction between the global core content and trait facets between ASPD and psychopathy (Wygant et al., 2016). The DSM-5 alternative model has a specifier, "with psychopathic features," to assist with the identification of related additional traits that include low anxiousness, low withdrawal, and high attention seeking. High attention seeking and low withdrawal make up the social potency (assertiveness and dominance) component social potency (assertiveness and dominance) and low anxiousness makes up the stress immunity (emotional stability/resilience) component (APA, 2013).

Within the DSM-5 alternative model, ASPD is conceptualized by pathology within the core content elements of personality that impact the self and interpersonal functioning listed in Table 2.3. To meet criteria for ASPD, the individual

Table 2.3 ASPD Core Pathological Content (Criterion A)

1. Identity	The individual displays an inability to understand that another person's view or opinion may be different from their own. The individual's self-worth and confidence are derived from personal gain, power, or pleasure.
2. Self-direction	The individual sets goals based upon personal gratification and lacks personal values, beliefs, and views that conform to legal or cultural norms of ethical behavior.
3. Empathy	The individual is without interest in the feelings, needs, or anguish of others. He or she is without guilt or compassion after hurting or harming another.
4. Intimacy	The individual is incapable of reciprocal close relationships, due to the relationship being primarily based on manipulation, deceit, or coercion of others. Individual may engage in subjection or bullying to control others.

must possess difficulties in two or more of the four areas identified (Identity, Self-direction, Empathy, and Intimacy) within Criterion A (core content).

Meeting Criterion A is only half of the ASPD picture, as the individual must also meet the qualification for Criterion B, which addresses personality variables that are specific to the condition (APA, 2013). The individual must possess six or more of the seven pathological personality trait facets (detailed below) that are organized within the five, over-arching trait domains (i.e., Negative Affectivity, Antagonism, Detachment, Psychoticism, and Disinhibition). It is worth noting that Criterion B trait facets only fall within two of the five trait domains, Antagonism and Disinhibition, reflecting the robust nature of the model in distinguishing ASPD from psychopathy (see Strickland et al., 2013 for more on this issue). The identified pathological personality traits for Criterion B for ASPD are listed in Table 2.4.

The majority of research pertaining to ASPD and the DSM-5 alternative model has been on Criterion B (Wygant et al., 2016). Research supports using the DSM-5 alternative model in lieu of the traditional categorical model, found in Section II, to explore ASPD and psychopathy, as it has shown valid and reliable

Table 2.4 ASPD Surface Content (Pathological Personality Traits)

1. Manipulativeness	To meet this criterion, the individual must use deception repeatedly to influence or control others and deliberately entice, allure, "smooth talk," or attempt to gain favor with another to achieve one's ends.
2. Callousness	To meet this criterion, the individual must be without consideration for the feelings or problems of others, be without regret or shame about the adverse or damaging effects of one's actions on others, and possess and display hostility and cruelty.
3. Deceitfulness	To meet this criterion, the individual must engage in and have a history of deceit cheating, lying, or deceiving someone, giving false or misleading information about oneself, and exaggerate and spout untruths regarding events.
4. Hostility	To meet this criterion, the individual must often and continually feel and express anger and petulance to minor affronts and offense with cruel, offensive, or retaliatory behavior.

(*Continued*)

Table 2.4 (*Continued*)

5. Risk taking	To meet this criterion, the individual must participate in dangerous, risky, and potentially self-damaging activities, needlessly and with disregard for penalties in an effort to mitigate boredom while paying little to no attention or awareness to the individual's actual abilities and how this could cause harm to the self.
6. Impulsivity	To meet this criterion, the individual must rapidly respond to stimuli without plan or regard for the outcome and have impairment developing plans and following through.
7. Irresponsibility	To meet this criterion, the individual must possess and exhibit disdain and neglect for financial and other obligations or commitments and have disrespect for, and a history of reneging on, promises, arrangements, and responsibilities.

outcomes, and even more powerful relationships have been found when research has included the "with psychopathic features" specifier (Anderson, Sellbom, Wygant, Salekin, & Krueger, 2014).

The use and application of the DSM-5 alternative model to arrive at an ASPD diagnosis is illustrated in the case of Teresa below. Following the case study will be a breakdown of Criterion A and B and how it relates to this specific case.

The Case of Teresa

Teresa is a 32-year-old female, who has been in and out of prison multiple times for theft, fraud, and assault. Teresa has a history of stealing the identity of the customers who pay with credit cards at the restaurants she has worked as a server. Her longest period of employment is two months, as she tends to get fired after confrontations with her bosses or customers who complain about her attitude or performance, or after she is told what to do. The last time she stole customers' identity information, she was proud of herself as she collected 29 names and credit card numbers and sold them to her neighbor who used the information to open fake accounts so he and Teresa could go on a "shopping spree." When her neighbor sold some of the information and kept the money for himself, Teresa retaliated by stealing his car and selling it to a friend. When her neighbor confronted her about this and threatened to call the police, she began flirting with

him, attempting to seduce him. When he was not receptive, she punched him in the face multiple times and threatened to hurt his girlfriend if he said anything. Teresa was eventually arrested, as the person who bought the car was pulled over by police and did not have proper registration and identified Teresa as having sold him the stolen car. When Teresa was interviewed by police regarding the theft, she was remorseless, offended, and agitated. When asked why she did not seem to show any concern about stealing from her friend, she said,

> I don't feel anything about it and I couldn't care less. If the car was so important to him, he should've taken better care of it and not let people take it. He needed to be taught a lesson and given a beat down. Consider him schooled and beaten.

Teresa qualifies for all four Criterion A elements of ASPD: *Identity*, *Self-direction*, *Empathy*, and *Intimacy*. Teresa meets the *Identity* criterion as stealing the identities of her customers and her neighbor's car made her feel empowered and she was offended and agitated when her inappropriate act was pointed out to her; the *Self-direction* criterion is met as her goal is to get money by stealing the identity of others from those whom she has waited on, and she is without regard for the privacy of the customers' financial information or the laws against identity theft; she meets the *Empathy* criterion as she has no guilt or remorse for the financial and personal impact caused by those whose identity she has stolen to open credit card accounts, or for her friend having his car stolen and sold to someone else; and she meets the *Intimacy* criterion as she exploits others such as her neighbor to sell the identity information she gathers, and when her plan goes awry, she uses violence, seduction, and threats to coerce him into not reporting her for stealing and selling his car.

Teresa qualifies for Criterion B of ASPD as she meets criteria for all seven of the pathological personality traits. She meets the criterion of *Manipulativeness* when she tries to seduce her neighbor after he tells her he is going to report his car stolen; she meets the criterion of *Callousness* as she is remorseless about stealing the customers' identity, stealing her neighbor's car, and punching her neighbor and threatening his girlfriend; she meets the criterion for *Deceitfulness* as she has engaged in, and been incarcerated, multiple times for theft and fraud; she meets the criterion for *Hostility* as she punched her neighbor when he confronted her about the theft and she is often fired for confronting others when presented with negative feedback; she meets criterion for *Risk taking* as she has no regard for possibly going back to prison for stealing the credit card information and her neighbor's car; she meets criteria for *Impulsivity* as she steals her neighbor's car and sells it after she feels slighted and tricked, and when her neighbor does not respond as expected to her seduction, she hits him and threatens to harm his girlfriend; and finally, she meets criteria for *Irresponsibility* as she does not honor the implicit

trust placed in her to have her customers' credit card information, and her history of short-term serial employment which is due to her disrespect by confrontations, complaints, and attitude toward customers and bosses.

Using the DSM-5 alternative model, the researcher or clinician can identify Teresa as meeting criteria for ASPD, but this provides insight into only a fraction of the depth and complexity of this disorder. The Cognitive-Affective Processing System (CAPS) model assists to further the understanding of the structure, function, expression, and possible treatment approaches of the ASPD spectrum.

ASPD and the CAPS Model

Using the CAPS model, additional valuable and useful data can be derived to assist researchers and clinicians in studying and working with individuals along the ASPD spectrum. As outlined in Chapter 1, the CAPS model provides a framework to recognize the process of how initial stressors activate the core content elements of the impaired personality, which ultimately drive surface structure expression of pathological personality traits and facets. Core content elements can be understood using the Cognitive-Affective Units (CAUs) within the CAPS model. Figure 2.1 illustrates the merging of ASPD and the CAPS model.

Stressors are specific to individuals; the degree of reaction and cognitive-affective processing that follows is specific to the personality make-up or type of personality disorder (Eaton et al., 2009). Stressors tend to fall within one or

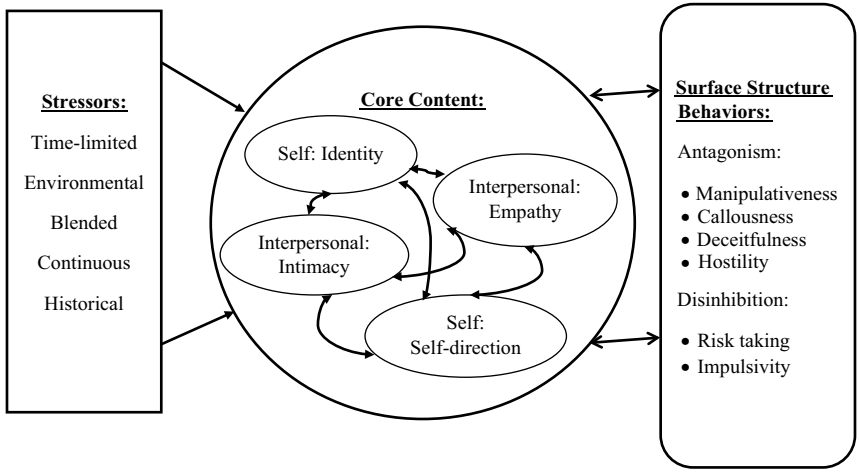

Figure 2.1 ASPD and CAPS model integration.

more of the following categories: time-limited, environmental, blended, continuous, and historical. Individuals along the ASPD spectrum tend to appraise and perceive stimuli in a distorted manner, leading to misperception of events as perceived threats, manipulation, or malice. Such misperceptions further lead to a distorted and dysfunctional cognitive-affective processing of the initial events (Brinkley, Schmitt, & Newman, 2005; Gawda, 2013; Hiatt et al., 2002; Lorenz & Newman, 2002). This pattern of appraisal and perceptual bias causes the ASPD spectrum individual to develop a tendency to inaccurately assess the stressor and misperceive the situation. Subsequent engagement of the CAUs within the CAPS model that are associated with the ASPD spectrum individual's core content become activated on a distorted premise that may inadvertently reinforce the perceptual bias as the cognitive process continues.

Once the CAUs are activated, they interact within an interrelated network with core content elements of personality functioning in a unique manner specific to ASPD. The core personality psychopathology content of ASPD from the DSM-5 alternative model and the related CAUs are listed in Table 2.5. Keywords are used to represent each component of ASPD in the table; to see the unabbreviated description, consult the DSM-5, Section III, Criterion A (APA, 2013, p. 764).

As you can see from the table, some elements have a stronger relationship to some CAUs than others for those along the ASPD spectrum. *Encodings*, *Expectations and Beliefs*, and *Affects* have the strongest relationship to the DSM-5 alternative model Criterion A impairment in personality functioning, with seven related components for each. This suggests that ASPD, at the core content level, is impacted most by issues perceived to impact the self, others, and situations, the social world and one's self-efficacy as it pertains to situational behavior, and affective responses and physiological reactions.

Table 2.5 further illustrates which area is least impactful to impaired ASPD personality functioning, *Competencies and Self-Regulatory Plans*. This fits the conceptualization of individuals along the ASPD spectrum, as they tend not to plan, strategize, or organize their behavior to impact their internal state or desired outcomes. This is also consistent with findings that those along the ASPD spectrum tend to have distorted and dysfunctional cognitive-affective processing, in conjunction with an difficulty in regulating or coordinating behaviors and emotions, which results in a tendency to respond more intensely to encodings, expectations and beliefs, and affects (Brinkley et al., 2005; Gawda, 2013; Hiatt et al., 2002; Lorenz & Newman, 2002). The CAU of *Goals and Values* is not as impactful as *Encodings*, *Expectations and Beliefs*, and *Affects,* as it is weakly associated with ASPD core content. Again, this matches with the conceptualization of those along the ASPD spectrum, as *Goals and Values* are not as strong of a driving force in the production of surface structure expressions. Rather, how the individual encodes or interprets, what he or she expects and believes, and how he or she emotionally reacts to encountered stressors, is the most critical driver of surface structure.

Table 2.5 ASPD and CAUs

Elements of Personality Functioning	*Cognitive-Affective Units*				
	Encodings	*Expectations and Beliefs*	*Affects*	*Goals and Values*	*Competencies and Self-Regulatory Plans*
Self: Identity Self-centeredness	X		X	X	X
Self: Identity Self-worth tied to power and profit	X	X		X	X
Self: Self-direction Goals rooted in gratification of self		X		X	X
Self: Self-direction Value, beliefs, and views are illegal or against cultural norms	X	X	X	X	
Interpersonal: Impaired empathy for other's experiences and motivations	X	X	X		
Interpersonal: Little to no empathy or tolerance for different perspectives	X	X	X		
Interpersonal: Impaired empathy to understand one's behavior on others	X	X	X	X	
Interpersonal: Impaired intimacy in one's connection with others	X	X	X		
Interpersonal: Impaired interest and capacity for closeness			X		
Interpersonal: Impaired reciprocation of interpersonal behavior			X	X	X

The ASPD surface structure expression of pathological personality traits is likely to match those identified by the DSM-5 alternative model, but the manner and degree in which they are expressed is very individualized. Before describing the *if… then…* profile of an individual along the ASPD spectrum, several key factors must be considered. These include where on the ASPD spectrum the individual falls (i.e., Little or no, Some, Moderate, Severe, or Extreme Impairment), the stressor that ignited the CAPS model sequence and those CAUs that were subsequently activated, any comorbidity or dual diagnosis issues that may be present (i.e., substance abuse, a mood or thought disorder), and the collection of coping strategies, maladaptive and adaptive, from which the individual is able to pull. These considerations will assist in gaining a better understanding of the ASPD spectrum individual to produce an even more reliable predictive picture using the *if… then…* profile sequence.

When we examine the *if… then…* profile of the individual along the ASPD spectrum and consider the factors that make up this profile, we are better able to outline the individual's response pattern. Through over use, the individual's CAPS model is reinforced and solidified, and this pattern, grounded in antagonism and disinhibition, makes treatment more difficult. For example, an ASPD spectrum individual experiences an environmental stressor when he does not get the payment he expected for his work and subsequently feels disrespected and angry. *If* this ASPD spectrum individual feels disrespected and angry, he *then* responds with verbal aggression towards the underpaying individual. This *if… then…* sequence is likely characteristic of the individual and consistent with the CAPS model theory (Shoda & LeeTiernan, 2002; Shoda et al., 2002; Shoda, Mischel, & Wright, 1994), as when this individual encounters a stressor and he feels disrespected and angry, we might expect him to respond with verbal aggression. This *if… then…* profile is outlined in Figure 2.2.

According to the CAPS model, it is the combination of the stimulus type, the core content personality elements that place him along the ASPD spectrum, the cognitions and affects that make up the individual's CAUs, and the surface structure personality traits expression that produces the predictable and stable

Figure 2.2 ASPD *if… then…* profile.

if… then… sequence response (Borkenau et al., 2006; English & Chen, 2007; Mendoza-Denton & Mischel, 2007; Mischel & Shoda, 1995, 2008).

Pathology Perpetuation

All individuals exist within an interpersonal system that supports their beliefs, perceptions, and behavioral expressions. This system is composed of, and maintained by, social norms. Social norms can be defined as a group, or social situations and standards that influence the individual's perception and judgement (Sherif & Sherif, 1953). Additionally, social norms, or group norms, regulate attitudes and behaviors that embody a particular group, which can serve to differentiate it from other groups (Hogg & Reid, 2006). For example, when an individual enters an elevator, he does not stand right next to someone else if space is available, he does not stand facing the others in the elevator, and he does not push all the buttons for all the floors. Engaging in any of these behaviors is likely to produce societal pressures to conform to the norms to give space when available, face front, and only press the button of the floor you plan to exit on.

Social norms are critical components of an individual's interpersonal system and have been found to be influential in the engagement and perpetuation of antisocial behavior, beliefs, and patterns (Brendgen et al., 2000; Farrington, 2004; Heinze, Toro, & Urberg, 2004; Monahan, Steinberg, & Cauffman, 2009).

Social norms can be used to understand an individual's interpersonal system and how it perpetuates and supports the core content and surface structure pathology that one along the ASPD spectrum possesses and exhibits. Many individuals along the ASPD spectrum associate with individuals who either directly or indirectly support antisocial beliefs, behaviors, and patterns within the individual's social norm group. For example, the ASPD individual uses illegal drugs and she is likely to associate with others who use illegal drugs, which supports this behavior as her social norm group. Using the CAPS model and the DSM-5 alternative model, the perpetuation of ASPD spectrum pathology can be explored at a deeper level.

Combining these frameworks helps to better explain the intractable nature of core and surface content related to the ASPD spectrum individual. As noted previously in this chapter, individuals along the ASPD spectrum tend to perceive stressors as threatening, manipulative, or malicious, by means of distorted and dysfunctional cognitive-affective processing (Brinkley et al., 2005; Gawda, 2013; Hiatt et al., 2002; Lorenz & Newman, 2002). The ASPD spectrum individual is likely to encounter encouragement from his or her environment and interpersonal system to challenge these distortions, particularly if the individual's socially accepted norms are consistent with or promote said distortions. The discrepancy between stressor perception and stressor reality, if unchallenged, ignites the self

and interpersonal elements of one's core content. Intrapersonally, these might include one's egocentrism, deriving personal power and pleasure from manipulation or inflicting harm onto others.

Interpersonally, for example, these include impaired empathy and lack of remorse from harming others when acts of wrongdoing are performed, as well as the encouragement of exploitation and the use of dominance to maintain control. When core content is ignited, without interpersonal or intrapersonal correction, influence, or dissonance, what follows is the engagement of surface structure behaviors, or pathological personality traits, that include manipulation, callousness, deceitfulness, hostility, risk-taking behaviors, impulsivity, and irresponsibility. The parameters of the ASPD individual's social norms are made up and regulated by the individual's interpersonal system, which leads to intense pressure and dissonance from those within that group to remain within expected limits (e.g., deviant behavior). This pressure and dissonance serve to maintain homeostasis and re-establish control over behavior (Bisin & Verdier, 2001; Fox, Kaplan, Damasio, & Damasio, 2015; Immordino-Yang, McColl, Damasio, & Damasio, 2009). These parameters and social group norms create an interpersonal systematic loop that perpetuates personality pathological core content and surface structure expression. This is illustrated in The Case of Jeremy below.

The Case of Jeremy

Jeremy is a 23-year-old male with an extensive history of felony and state convictions for theft, robbery, wire fraud, assault, and drug possession. These crimes would provide him with a sense of pride for being the breadwinner and reinforced him identifying himself as a "gangster" and one with the power to take and get what he wants, when he wants it.

Jeremy's mother, father, and brother have also been incarcerated multiple times for similar crimes. Jeremy's girlfriend, Loren, indirectly profits from his crimes through having disposable cash and easy access to drugs. Jeremy's friends also have criminal histories and have been in and out of prison for a wide variety of state and federal charges. Jeremy was recently released from prison after serving 13 months for robbery and, while he was incarcerated, Loren gave birth to his daughter. While in prison, Jeremy participated in various self-help groups, earned his GED, and made a promise to himself to not go back to engaging in criminal behavior, in order to be a role model for his daughter. Within the first few days after Jeremy's release, his friends called, texted, and came over his house to tell him about different, illegal, ways he could make some "quick and easy money." Jeremy felt determined to stay out of prison and lead a life without crime. As part of his probation, he has to work at a local department store making $9.00 an hour. His friend often made fun of him having to go to work for eight hours to earn so little.

His parents, brother, and Loren all accuse him of not taking care of his family because he is earning so little money and now, they have to live on a budget.

Jeremy felt intense pressure and stress as he would try to resist the temptation to go back to crime. One particular night, Loren wanted to be taken out to dinner and a movie, but Jeremy was not able to afford it. An argument ensued and she called one of Jeremy's friends, who took her to the movies and a fancy dinner. Jeremy was enraged and felt that his sense of self was being attacked, his manhood questioned, and his sense of intimacy with Loren, his daughter, and his family was ruptured. The ignition of his core content (e.g., self-esteem derived from personal power, self-esteem derived from personal gain and power, lack of remorse after hurting or mistreating another, etc.) drove him to call a friend of his and agree to commit an armed robbery of a liquor store. During the robbery, Jeremy was still enraged about how his family and friends perceived him as weak and useless. These thoughts continued to re-ignite his core content, and in his rage, he shot and killed a customer who had nervously dropped her wallet. Jeremy did not see her nervousness, but rather saw her behavior as a sign of disrespect. He had distorted her dropping the wallet to mean that she questioned his manhood and his ability to dominate and control the situation. Jeremy and his accomplice were arrested hours later at his home. As he was being placed in the police car, Loren came home and saw him. She looked at him and simply nodded. Jeremy knew what that nod meant and he felt his reputation and respect had been restored.

As the case study illustrates, the pressure to comply with social norms within one's interpersonal system are intense. Deviation from these norms disrupts the homeostasis of the individual's interpersonal system that adds continual and intense pressure on the individual to return to homeostasis, the systems normalized and expected behavior. In the case of Jeremy, his return to antisocial beliefs, behaviors, and patterns normalized his interpersonal system decreasing his pressure and dissonance, while also adding to his distorted sense of self and intimacy with Loren, his family, and his friends.

The interpersonal system, and the social norms of that system, whether prosocial or antisocial or a mixture of the two, is a powerful influence on pathology development, expression, and perpetuation. While important, social norms and mores are not the only significant factor. The development and maintenance of core content personality elements, and the expression of these elements through surface structure beliefs, behaviors, and patterns is also influenced of a myriad of etiological factors, including biology and environment.

Biopsychosocial Model and ASPD

The manifestation of ASPD spectrum core content elements and surface structure beliefs, behaviors, and patterns is best viewed by using the biopsychosocial

model, as first conceptualized by Engel (1980). This current epidemiological theory recognizes that pathology results from a combination, rather than isolation, of multiple sources and risk factors (Mausner & Kramer, 1986). The biopsychosocial model acknowledges that multiple etiological factors can be associated with the development of pathology, and that by looking at these factors in combination provides a more complete account or understanding of individual outcomes, over and above viewing individual factors separately. This approach provides the most comprehensive explanation for the development and expression of personality pathology, including traits and diagnosable disorders (Paris, 1993).

Paris (1993) explains the value of considering the interplay between biological, social, and psychological factors to explain personality traits that exacerbates, impairs functioning, and also works in concert with other traits to create a personality disorder. He writes:

> Biological factors determine the specificity of personality disorders, and psychological and social factors are the strongest determinants of whether an underlying predisposition leads to an overt disorder. Psychological risk factors increase the likelihood of the development of personality disorders, but they need not by themselves produce disorders because in the absence of other risk factors, children may be sufficiently resilient to compensate for psychological insults. Social influences can act either as protective factors against personality disorder that buffer the effects of biological and psychological risk, or as risk factors in their own right.
>
> (Paris, 1993, p. 262)

This recognition of the interchange between biological, social, and psychological factors on the development of personality disorders was enlightening at the time. This guide to conceptualization helped pave the way for future researchers and clinicians to understand and recognize the myriad of factors at work in the development personality disorder pathology.

Examining ASPD spectrum personality pathology through the lens of the biopsychosocial model provides a valuable framework to identify critical risk factors that increase the likelihood of an individual developing ASPD. The genetic and biological factors associated with ASPD spectrum personality pathology indicate that the heritability of ASPD is estimated at 69%, estimated equivalence to Borderline Personality Disorder (Glatt, Faraone, & Tsuang, 2008). Rates of ASPD spectrum personality pathology are higher amongst first degree relatives of persons with the disorder (Cloninger, Gottesman, & Mednick, 2009). Rhee and Waldman (2002), after conducting a meta-analysis of 51 twin and adoption studies to estimate the heritability of antisocial behavior, found that the combination of genetic and environmental influences on antisocial behavior is significant,

that shared environmental effects were larger for parent and teacher ratings of antisocial behavior as compared to the children's self-report, and no significant difference was found between males and females in regard to the degree of genetic and environmental differences.

Researchers and clinicians recognize that a genetic predisposition for antisocial behaviors does not equate to developing or meeting criteria for ASPD. A comprehensive review, conducted by Raine (2002), explored the biopsychosocial effects on antisocial and violent behaviors from several key areas, including genetics, psychophysiology, obstetrics, brain imaging, neuropsychology, neurology, as well as the role of hormones, neurotransmitters, and environmental toxins. Findings revealed that biological and social factors, when pulled together, illustrate an exponential increase in antisocial behavior. This finding fits into the biopsychosocial model, as it illustrates that it is not just one component which dictates ASPD behavioral expression, but a combination of factors. Further, it is noted that it is not just the mere presence or absence of a factor that results in the presence or absence of pathology, but rather that status on a continuum of risk and protective factors influences status along a complex dimension of personality pathology.

The cumulative effect of biological, psychological, and social factors comprising the biopsychosocial model influences all aspects of the CAPS model and the alternative DSM-5 model. Initially, the interaction between biopsychosocial risk and protective factors impacts the manner in which an individual interprets and thus is affected by a stressor. Factors that can influence the development of this maladaptive pattern include a genetic predisposition for antisocial behaviors, growing up in an abusive or safe environment, or witnessing and engaging in violent or prosocial behaviors. These genetic, environmental, and social components impact the ASPD core content that directly influences one's self identity and self-direction as well as one's interpersonal intimacy and empathy; for example, egocentrism, goal setting focused on personal gratification, lack of concern for others' feelings, needs, or degree of suffering, and inability to participate in reciprocal intimate relationships.

The sequence results in surface structure expression of traits that are specific to the individual. This combination of the biopsychosocial, CAPS, and DSM-5 alternative models are similar to the process model of biosocial model of antisocial behavior, as proposed by Baker, Bezdjian, and Raine (2006). This model, while focused on the interaction between biological and social forces that contribute to antisocial behavior, also recognizes the influence of psychological functioning, including psychophysiology, neuropsychology, and psychosocial factors (e.g., physical and sexual abuse, neglect, extreme poverty, foster home placement, having a criminal parent, severe family conflict, etc.). The biosocial model outlines the progression from basic processes (genetics and environment), to risk factors (biological and social risks), to biosocial interaction, to protective factors and prevention, and finally to the outcome of antisocial behavior.

Examining the development of ASPD using this combined process model provides a comprehensive lens into the development of ASPD core content elements and surface structure traits and expression.

Online Behavior and ASPD Personality Expression

As examined in Chapter 1, the internet is a unique setting where one encounters various stimuli and stressors that impact personality core content elements that drive surface structure behaviors. The activation and sequence from stressor to behavior is consistent with the CAPS and DSM-5 alternative models. The internet provides fertile ground for antisocial behaviors, and ASPD surface structure expression, due to the unlimited access to stimuli and stressors in the form of blogs, ecommerce sites, wiki websites (sites that allow others to collaborate and write content), comment sections and message boards, and social networking sites (e.g., Facebook, LinkedIn, Twitter).

Antisocial behaviors are not uncommon online and have been linked to the personality surface structure expressions that make up ASPD. Criminal activities in the form of computer crimes, such as virus writing, identity fraud/theft, and website defacing, have been associated with both violent and nonviolent off-line antisocial behavior (Seigfried-Spellar, Villacís-Vukadinović, & Lynam, 2017). However, criminal activity is not the only antisocial expression found online. Online aggression, harassment, and bullying have been found to have an impact on increasing anger and sadness, as well as adversely influencing social and emotional development in adolescents (Akbulut, Sahin, & Eristi, 2010; Li, 2005; Raskauskas & Stoltz, 2007).

The majority of antisocial behaviors that are performed online have been examined using the construct of The Dark Triad, comprised of the personality types of Machiavellianism, narcissism, and psychopathy (Paulhus & Williams, 2002; Williams, McAndrew, Learn, Harms, & Paulhus, 2001). While the triad was designed to include non-pathological individuals who possess "socially malevolent character traits with behavior tendencies toward self-promotion, emotional coldness, duplicity, and aggressiveness," research has examined the triad using both clinical and subclinical populations (Furnham, Richards, & Paulhus, 2013; Paulhus, & Williams, 2002, p. 557). Recently, an additional personality trait, "everyday sadism," has been added, resulting in the new Dark Tetrad (Buckels, Jones, & Paulhus, 2013; Chabrol, Van Leeuwen, Rodgers, & Séjourné, 2009; Furnham et al., 2013). The four personality components of the Dark Tetrad will be examined throughout this section.

Machiavellianism is the use of tactical flattery and deceit in order to manipulate other individuals for personal gain. Individuals who exhibit this trait tend to be cynical and clever manipulators, who are unfazed by the exploitation of

others (Geis & Moon, 1981). Narcissism within The Dark Triad refers to individuals who exhibit grandiosity, entitlement, and self-importance. They tend to see themselves as unique and are hypersensitive to insults (Furnham et al., 2013). This is largely consistent with the conceptualization of narcissistic personality disorder in the DSM-5 (APA, 2013). Narcissistic antisocial behavior typically manifests as bragging, interpersonal insincerity or game playing, and selfishness in romantic relationships (Foster, Shiverdecker, & Turner, 2016; Vazire & Funder, 2006). Psychopathy is the most sinister component and includes high levels of impulsivity; thrill-seeking; interpersonal coldness; and little to no impulse control, remorse, or empathy (Baughman, Dearing, Giammarco, & Vernon, 2012; Hare, 1996; Lilienfeld & Andrews, 1996).

The Dark Tetrad includes both clinical and non-clinical conceptualizations of psychopathy. Those high in trait psychopathy within this construct fall into the subcategory of the "successful psychopath," as these individuals tend to possess higher levels of autonomic responsivity and executive functioning, while possessing archetypal characteristics, such as being superficially charming, devoid of disabling anxiety, and tend to be articulate, guiltless, callous, self-centered, and purposeless (Lilienfeld, Watts, & Smith, 2015; Mullins-Nelson, Salekin, & Leistico, 2006). These individuals are considered to be outside of forensic and criminal populations and are thus best suited to serve as examples for the application of the Dark Tetrad conceptualization, as they may interact freely with others online, unlike incarcerated populations.

Everyday sadism is the fourth trait in The Dark Tetrad and has been described as cruelty that occurs in daily life, such as in watching violent films, watching or participating in brutal sports, and playing video games with cruel content (Buckels et al., 2013). Research has found that those who scored higher on a measure of sadistic personality had a greater preference for the visceral experience of killing bugs (e.g., putting bugs into a "bug-crunching machine"). Furthermore, individuals scoring high on this trait tended to increase attacks, expend more energy and time to hurt that other person they are competing against in the computer game, particularly once they realized the other individual would not fight back (Buckels et al., 2013).

The traits that make up the Dark Tetrad have been found to be predictive of online antisocial behavior that includes trolling, dishonest self-promotion, cyberaggression, cyberstalking, and cyberbullying (Abell & Brewer, 2014; Craker & March, 2016; Sest & March, 2017; Smoker & March, 2017). Trolling has been found to be linked to online antisocial behaviors and the Dark Tetrad. Trolling is online behavior that is deliberate, aggressive, deceptive, and purposefully inflammatory (Buckels, Trapnell, & Paulhus, 2014). For example, going into a chatroom designed for those of a particular political party and promoting an opposing one, or posting a knowingly false news or research article to cause a disruption. The Dark Tetrad traits are predictive of engaging in trolling behavior.

Specifically, psychopathy and everyday sadism have been found to be significant predictors of trolling on several SNS, such as Tinder and Facebook (Buckels et al., 2014; Craker & March, 2016; March, Grieve, Marrington, & Jonason, 2017). In addition, it has been found that online trolling by those high on psychopathy is more likely when the victims are considered popular, weaker, and possessing less self-esteem (Book, Costello, & Camilleri, 2013; Hare, 2006; Lopes & Yu, 2017).

Manipulation of information for self-promotion is common in online communities, such as Facebook (Nadkarni & Hofmann, 2012; Pempek, Yermolayeva, & Calvert, 2009). Machiavellianism, as conceptualized in the Dark Tetrad, is positively associated with self-promotion behaviors in both males and females. Females high in Machiavellianism tend to engage in dishonest self-promotion and relational aggression, which includes posting embarrassing content about a friend when angry with them or engaging in other forms of online behavior to make another feel ashamed, embarrassed, or guilty. For men, those who scored high on Machiavellianism tend to engage in more self-promotion by means of posting status updates and tagging oneself in pictures to enhance attractiveness and social network size (Abell & Brewer, 2014; Austin, Farrelly, Black, & Moore, 2007).

Antisocial behavior online can also manifest in the form of cyber-aggression, cyber-bullying, or cyber-stalking. Cyber-aggression is defined as intentional harm to an individual or group by electronic means that are purposefully offensive, derogatory, harmful, or unwanted (Grigg, 2010). For example, sending someone a text message saying, "You're fat and nobody likes you," or starting a rumor about someone on Facebook. The Dark Tetrad trait of psychopathy has been found to be the strongest predictor for engaging in cyber-aggression on Facebook among 14 to 18-year-olds. Machiavellianism and narcissism were also associated with engaging in this behavior but presence of these traits is not predictive (Pabian, De Backer, & Vandebosch, 2015). Kurek and colleagues (2019) found that sadism was directly predictive of cyber-aggression, but psychopathy, narcissism, and Machiavellianism only became predictive of cyber-aggression as online disinhibition increased. This illustrates that as individuals can shield their identity, they are at a greater likelihood to show emotional coldness, duplicity, aggressiveness, and to brag about themselves.

Cyberstalking is another form of online ASPD spectrum behavior that is defined as the deliberate, repeated, and malevolent following or harassing of another person online. This may include continuous remote surveillance, threats toward the identified victim, and repeated contacts with that victim, despite an expressed or implied interest from the victim of no-further contact (Coleman, 1997; Smoker & March, 2017). Results indicate that all personality traits associated with The Dark Tetrad are significant predictors of intimate partner cyberstalking (Smoker & March, 2017).

Cyberbullying is described as continuous, deliberate, and injurious online behaviors demonstrated against perceived weaker individuals (Patchin & Hinduja,

2015). Cyberbullying has been linked to callousness and uncaring due to related lack of empathy, remorse, guilt and minimal concern for one's own behavior and impact on others. The presence of callous and unemotional traits also may increase as individuals feel more disinhibited online, leading to cyberbullying perpetration (Wright, Harper, & Wachs, 2019). Cyberbullying is significantly associated with sadism, as individuals high in sadism tend to engage in this behavior and get a personal satisfaction out of seeing their victims suffer (van Geel, Goemans, Toprak, & Vedder, 2017). Narcissism, Machiavellianism, and psychopathy have also been positively related to cyberbullying; however, only psychopathy has been found to be related to offline bullying, such as physical, verbal, racial/ethnic, indirect, and sexually oriented behavior (Goodboy & Martin, 2015).

The Dark Tetrad and the DSM-5 Alternative Model

Trolling, dishonest self-promotion, cyber-aggression, cyberstalking, and cyberbullying are all linked to, or predicted by, the personality components that make up The Dark Tetrad. The personality traits that comprise The Dark Tetrad map onto the identified pathological personality traits of ASPD found in the DSM-5 alternative model. Table 2.6 shows a summary of this relationship.

With respect to the DSM-5 alternative model's ASPD pathological traits, extant research has demonstrated relationships between Machiavellianism and manipulativeness (Bacon & Regan, 2016; Belschak, Muhammad, & Den Hartog, 2018), callousness (Jones & Paulhus, 2010), deceitfulness (Lyons, 2019), hostility (Jones & Neria, 2015; Pabian et al., 2015), and risk taking (Jones, 2016), but not impulsivity (Malesza & Ostaszewskil, 2016) or irresponsibility (Grigoras & Wille, 2017). The narcissism trait within The Dark Tetrad is positively associated with all of the DSM-5 alternative model's ASPD pathological traits, including impulsivity (Krizan & Herlache, 2018; Paulhus & Williams, 2002), risk taking (Foster, Reidy, Misra, & Goff, 2011), and irresponsibility (Kernberg, 2007).

Table 2.6 The Dark Tetrad and DSM-5 ASPD Pathological Traits

ASPD Traits	*Machiavellianism*	*Narcissism*	*Psychopathy*	*Sadism*
Manipulativeness	X	X	X	
Callousness	X	X	X	X
Deceitfulness	X	X	X	
Hostility	X	X	X	X
Risk taking	X	X	X	
Impulsivity		X	X	X
Irresponsibility		X	X	

Psychopathy, or the more aptly identified "successful psychopath," within The Dark Tetrad maps onto all aspects of the pathological personality traits that make-up ASPD in the DSM-5 alternative model. Psychopathy has been found to be predictive of manipulativeness, callousness, deceitfulness, hostility, risk taking, impulsivity, and irresponsibility (Baughman et al., 2012; Goodboy & Martin, 2015; Lilienfeld & Andrews, 1996; Paulhus & Williams, 2002). Everyday sadism has been found to be positively associated with callousness (Paulhus, 2014; Pfattheicher & Schindler, 2015), hostility (Buckels et al., 2013; Pfattheicher & Schindler, 2015), and impulsivity (March et al., 2017). After an extensive search, data could not be found linking sadism with manipulativeness, deceitfulness, risk taking, or irresponsibility. This may be due to a relative paucity of these traits in those who possess a high degree of sadism, as they may tend to be more upfront and direct in regard to inflicting pain and displeasure on others (lacking a need for manipulation or deceit), may possess a lower inclination for risk taking as enjoying the suffering of others does not require personal risk, and enjoying or inflicting pain on others may be irrespective of responsibly honoring obligations, agreements and promises.

The Dark Tetrad and ASPD have many commonalities and areas of divergence. The more researchers and clinicians understand these constructs and aberrant personality trait expressions, the more likely they are to identify and develop suitable means of treatment to attenuate the direct destruction and collateral damage often caused by those along the ASPD spectrum.

Treatment Success and Effective Approaches

The search for efficacious treatment for those along the ASPD spectrum is longstanding, with few encouraging results. Many intervention studies that have been conducted with individuals along the ASPD spectrum suggest that interventions are ineffective or are associated with high rates of recidivism (Harris & Rice, 2006; Wilson, 2014). Furthermore, a meta-analysis that examined over 120 studies concluded that mandated treatment was ineffective in reducing recidivism and increasing treatment adherence, particularly provided in correctional settings; alternatively, voluntary treatment was superior to mandated treatment in terms of outcome, regardless of treatment setting (Parhar, Wormith, Derkzen, & Beauregard, 2008). Some researchers have concluded that while individuals with ASPD may be treatment resistant to some forms of Cognitive-Behavioral Therapy, behavioral interventions – in the form of reward and contingency learning – may provide some benefit (Brazil, van Dongen, Maes, Mars, & Baskin-Sommers, 2018; Byrd, Loeber, & Pardini, 2014).

The symmetry between the CAPS model and the DSM-5 alternative model has been well explained. When adding a treatment component, the model develops

an additional construct that impacts its flow, that is representative of the individual's experience through the combined system, which we call the CAPS-5 Treatment Model; see Chapter 1 for the complete model and explanation. Hopwood's (2018) five-step treatment approach to working with individuals with personality disorders and the CAPS-5 Treatment Model can readily be applied to ASPD.

The first step is to determine the degree of impairment in the ASPD Elements of Personality Functioning, Criterion A, using valid measures, such as The Level of Personality Functioning Scale-Self Report (LPFS-SR; Morey, 2017) or the Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders (SCID-5-AMPD; Bender, Skodol, First, & Oldham, 2018) Module I. These measures illustrate the ASPD spectrum individuals' core content as it pertains to Identity, Self-Direction, Empathy, and Intimacy.

The next step in Hopwood's approach to identify and determine the severity of the pathological personality traits, Criterion B, that are present can be applied to the ASPD spectrum individual. Assessment of severity can be accomplished by using measures such as the Personality Inventory for DSM-5 (PID-5; Krueger, Derringer, Markon, Watson, & Skodol, 2012), the SCID-5-AMPD Module II, or the DSM-5 Clinicians' Personality Trait Rating Form (PTRF; APA, 2011). These measures can be used to assess each of the 25 proposed pathological personality traits subsumed by the five trait domains: negative affectivity, detachment, antagonism, disinhibition, and psychoticism. Specifically to ASPD, the individual is likely to show elevations within Antagonism that include Manipulativeness, Callousness, Deceitfulness, and Hostility and within Disinhibition that includes Risk taking, Impulsivity, and Irresponsibility. It is important to recognize that these are probable areas of elevations for individuals along the ASPD spectrum; however, it is also possible that, due to the variability in personality pathology, other elevations specific to the individual being assessed are also likely. Individual elevations in other domains must be identified as part of the treatment process.

Next, one would need to target an appropriate intervention strategy for ASPD spectrum individuals. Any intervention should include principles from The Risk-Need-Responsivity (RNR) model to address presenting challenges and issues in order to provide a practical structure on how to organize and deliver programs to a correctional population. The RNR model has been utilized in the treatment of offenders in Canada, the U.K, New Zealand, and Australia for almost 30 years (Andrews, Bonta, & Hoge, 1990). It is often used to reduce criminal behavior, which is common among ASPD individuals, and assists in offender rehabilitation by identifying both dynamic and static factors that contribute to re-offending. While geared towards criminal offenders, the RNR model can also be used to address those who exhibit ASPD personality behavioral patterns (Bonta & Andrews, 2007). The RNR model centers on three pillars: identifying and addressing (1) risk factors (e.g., substance abuse, unemployment), (2) areas of criminogenic needs (e.g., characteristics, traits, problems, or issues of an

individual that directly relate to the individual's likelihood to re-offend and commit another crime), and (3) responsivity factors (e.g., need for excitement, shallow affect; Andrews & Bonta, 2010; Andrews, 1990).

When incorporated with relevant assessment data about the ASPD spectrum individual gathered in steps 1 and 2, the RNR model assists the clinician in determining appropriate targets of treatment. For example, the RNR level of risk entails determining the likelihood the individual is going to engage in criminal behaviors, or exhibit ASPD surface structure behaviors. Need entails determining the service targets associated with characteristics, traits, problems, or issues that directly relate to the likelihood the individual will re-offend or engage in criminal conduct. Again, this model focuses on the criminal offender, and its use here is generalized to include those with a higher probability of engaging in general antisocial behaviors, such as those individuals along the ASPD spectrum. Table 2.7 illustrates major and minor risk/need factors related to the RNR, as delineated by Bonta & Andrews (2007).

The factors listed in the major and minor category assist the clinician in assessing the presences and severity of issues to be addressed, as well as the likelihood the individual will engage in criminal or ASPD surface structure behaviors that disrupt the treatment process and prognosis. When this information is pooled together with the previous two steps in Hopwood's model, the clinician is provided a detailed picture of the ASPD spectrum individual not typically seen or utilized in treatment settings. The responsivity component in the RNR model refers to the utilization of cognitive social learning interventions (Andrews & Bonta, 2010; Andrews, 1990; Bonta & Andrews, 2007) that can be incorporated into the next step of this treatment sequence.

The information from the previous steps is best used to identify and target interventions to address core and surface content issues that are ignited by stressors to help determine the frequency of sessions and total duration of treatment. Next, cognitive social learning interventions can be employed to address a variety of surface structure concerns, such as reducing depressive symptoms and thoughts, increasing prosocial behavior, and lessening specific antisocial behaviors and cognitions (Andrews & Bonta, 2010).

The fourth step entails disseminating the information that has been gathered to the client and any other related individuals. An agreement to proceed with treatment would be obtained and explicit details should be provided pertaining to the "rules of treatment." This information is valuable to not only prepare the client but also other individuals who are affected by his or her treatment (e.g., spouses, children). These rules should also outline how safety issues as they pertain to the client will be managed, such as threats of suicide. Preparing for treatment disruption and how it will be managed is also be explained to the client, as treatment with individuals along the ASPD spectrum can be disrupted in a variety of ways. These can include the individual threatening the clinician or other staff, acting out aggressively or violently, substance abuse or relapse, being incarcerated or jailed

Table 2.7 Major and Minor Risk/Need Factors

Major	Antisocial personality pattern	The individual exhibits impulsive, sensation seeking, aggressive and irritable demeanor.
	Pro-criminal attitudes	The individual justifies criminal behavior and holds a negative perspective of the legal system.
	Social supports for crime	The individual interacts with a network of individuals who commit crimes and lacks association with prosocial others.
	Substance abuse	The individual is positive for past or present abuse of drugs and/or alcohol.
	Family/marital relationships	The individual has poor and inconsistent parental monitoring and disciplining, as well as tumultuous family relationships.
	School/work	The individual is deficient in academic or employment performance and has a low level of satisfaction related to this domain.
	Prosocial reactional activities	The individual has an absence of prosocial recreational and leisure activity involvement.
Minor	Self-esteem	The individual has little confidence in his/her worth or abilities.
	Unclear feelings of distress	The individual experiences nebulous feelings of anxiety and sadness.
	Major mental disorder	The individual meets criteria for schizophrenia or bipolar disorder.
	Physical health	The individual has a physical deformity or nutrient deficiency.

during the course of treatment, and loss of housing and employment (National Institute for Health and Clinical Excellence, 2010).

The final step of this approach includes routine evaluation of therapeutic progress to assess the attenuation or exacerbation of core and surface structure issues. Several of the assessment measures mentioned previously in this section could be used to complete this step. Information from ongoing and periodic monitoring is necessary to gauge changes in core and surface structure issues and major/minor risk and need factors. Assessment of response to intervention requires an understanding of fluctuations in these features over time and as a result of intervention, and allows for the identification of new areas for treatment that may arise.

Working with individuals along the ASPD spectrum has many inherent challenges. Both clinicians and researchers should be aware that individuals that are further along the ASPD spectrum, high-moderate to extreme (psychopathy included), may not benefit from treatment, may be reluctant to participate, or may possess an ulterior motive not revealed to the clinician until weeks or months later. These challenges do not mean that all individuals along this spectrum should not receive treatment. Rather treatment approaches, such as the one discussed here, and research and clinical models, such as the one articulated in this chapter, should be considered to frame and enhance understanding of this challenging personality type to foster more accurate conceptualization and efficacious treatment.

Chapter 3

Narcissistic Personality Disorder

Narcissistic Personality Disorder (NPD) is a complex and challenging construct for both clinicians and researchers, due in large part to widespread misunderstanding and the relative rarity of the condition. This chapter will examine the issues inherent in NPD and will present NPD in a framework that lessens these challenges, thereby increasing clinical understanding and facilitating programs of research. First, it is necessary to disentangle the construct of entitlement which is associated with, and often confused with, NPD.

Entitlement and NPD are often inappropriately used interchangeably in many settings. These include books, magazines, and movies, but also in clinical and research settings. Entitlement refers to a trait, while the other, NPD, refers to a clinical disorder with core content components and behavioral expressions that lead to socioeconomic dysfunction. These terms are related but have vastly different meanings and implications. Because they are connected, this does not obviate the fact that entitlement can certainly cause impairment in various domains, but at what point is a single trait a full disorder? Never, but this is the inherent curse of the term entitlement and the NPD classification confusion.

The trait of entitlement is often confused with the larger and more comprehensive construct of narcissism or the more destructive, and rare, NPD. All traits are on a spectrum of severity from mild to extreme, which relates to the degree of adaptive and maladaptive influence and impact. A severity level of moderate and above of entitlement, identified as maladaptive entitlement, impairs growth and functioning in individuals who possess this trait. Maladaptive entitlement

is when one has a global sense of being more deserving of personally favorable outcomes over others, having expectations of special treatment without the need or desire to reciprocate, and the belief that one is deserving of special treatment and exemptions from typical social consequences and expectations (Campbell, Bonacci, Shelton, Exline, & Bushman, 2004; Emmons 1984; Raskin & Terry 1988). This maladaptive form of entitlement has been linked to the need to possess power over others and the exploitation of others, in addition to being less forgiving, more likely to demand and exact revenge, and more likely to abuse others when in a supervisory position. Likewise, maladaptive entitlement has been associated with exhibitionism and conduct issues (Barry, Frick, & Killian, 2003; Daddis & Brunell, 2015; Exline, Baumeister, Bushman, Campbell, & Finkel, 2004; Piff, 2013; Wheeler, Halbesleben, & Whitman, 2013; Whitman, Halbesleben, & Shanine, 2013).

Despite these associations, entitlement is not a completely maladaptive and singular construct. Two types of entitlement have been identified: excessive and exploitative entitlement (deemed maladaptive) and adaptive and positive entitlement (Candel & Turliuc, 2017). The maladaptive type, discussed previously, has been linked to psychopathy, neuroticism, poor work ethic, low self-esteem, impaired social empathy, as well as low agreeableness, conscientiousness, morality, altruism, cooperation, and sympathy (Ackerman & Donnellan, 2013; Candel & Turliuc, 2017; Credo, Lanier, Matherne III, & Cox, 2016; Greenberger, Lessard, Chen, & Farruggia, 2008; Krizan & Herlache, 2018; Lessard, Greenberger, Chen, & Farruggia, 2010; Miller, Lewis, Huxley, Townsend, & Grenyer, 2018). The association between maladaptive entitlement and these psychosocial features is central to the confusion and entanglement with the more pathological and dysfunctional NPD. The antithesis, adaptive type of entitlement, has been positively associated with self-esteem, well-being, extraversion, and friendliness (Ackerman & Donnellan, 2013; Kriegman, 1983). For example, adaptive and positive entitlement provides the motivation to ask for what the individual needs and wants and to assert oneself to have their standards met.

The trait of entitlement is one example of the complexity that drives the misunderstanding of NPD. As with all traits and disorders, as outlined by the dimensional model of personality pathology, NPD exists on a spectrum. In this chapter, several facets will be explored and elucidated to provide greater understanding of this disorder, those individuals along its spectrum, and its larger impact on society.

The History of Narcissism and NPD

The term narcissism is based upon the Greek mythological figure Narcissus, who after rejecting the advances of the nymph Echo, was punished to fall in love with himself in a pool of water. As Narcissus pined away, gazing at his own reflection,

he changed into a flower that bears his name, the Narcissus (Graves, 1990). In 1911, Otto Rank published the first psychoanalytic paper to address vanity and narcissism (Millon, Millon, Meagher, Grossman, & Ramnath, 2012). In 1914, Freud conceptualized the expression of narcissism as the repression of any information or emotion that lessens the individual's sense of self, as well as recognizing it as a dimensional construct that extends from a balanced self-concept to an obsessed one of self-grandiosity (Freud, 1957).

Horney (1939/1966) advanced the conceptualization of narcissism and defined it as self-inflation and love, and admiration for the value of self that has no equal. Horney's view converged with Freud's approach in that narcissism stems from loveless caregivers, and he postulated that if parents did not love children for their 'real selves', they would compensate by creating inflated versions of themselves to seek admiration and attention. Horney (1939/1966) believed that the outward display of self-love was illusory and that narcissism is derived from an inability to honestly love oneself or anyone else. This was a divergence from Freud, who postulated that narcissists are unable to love others because they love themselves too much.

Continuing the exploration into narcissism and personality, Kernberg (1967, 1970) used the term "narcissistic personality structure," recognizing the dimensional aspect by acknowledging the depth to which narcissism can exist, ranging from normal to pathological. The term "narcissistic personality disorder," was first used by Kohut (1968) to describe long-term characterological functioning as a mechanism against perceived threats and fear. While both Kernberg (1967) and Kohut (1968) were interested in narcissism from the standpoint of providing treatment and agreed on its manifestation, particularly in individuals who possessed a healthier form of the disorder, they disagreed on the etiology of narcissistic personality.

Proposed Origins of NPD

Kernberg (1975, 1986) proposed that parental rejection, devaluation, and an emotionally invalidating environment combined with the parental inconsistencies or self-absorbed parenting (interacting with their children to only meet the parents' own needs) resulted in the development of narcissism. As a result of this parenting style, the child withdraws and creates a pathological self-grandiosity that includes the following aspects, illustrated in Figure 3.1.

As illustrated in Figure 3.1, the child initially interacts with the world in an authentic fashion, until the child realizes its needs are not going to be met. In response to this realization, the child creates a fantasized environment of self and others. The child's retreat into this fantasy world exacerbates the extent to which she perceives the outside world as a harsh and dangerous place, and thus solace is found in further distortion of self and other. As will be demonstrated later, the

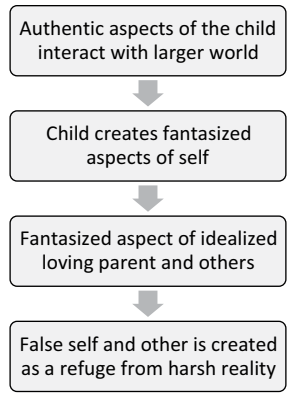

Figure 3.1 Kernberg's pathological grandiosity developmental process.

development of this fantasized world becomes an integral part of the core content of the self that is then expressed via surface content of narcissistic beliefs, behaviors, and patterns. This expression is the beginning of the splitting of the self that provides the foundation for the critical aspects of the NPD spectrum individual that is later evidenced by subjective feelings of emptiness, a continuous desire for admiration and thrills, and shame.

Kohut (1966, 1972, 2011) proposed that the child creates two systems of "narcissistic perfection" to compensate for unavoidable maternal deficiencies, such as impaired empathic responsiveness. As a result of maternal behaviors that convey "all that is good is within the child and that everything bad is external," the child creates a *grandiose self* in an attempt to stabilize and mitigate disruption of this internalized view. The fledgling NPD spectrum individual subsequently develops an image of the idealized parent, called the *idealized parental imago*, which is a mechanism to protect the child's well-being by bestowing an external object with unlimited power, strength, and goodness. Inevitably, the actual object, typically the parental image or figure, fails to meet the expectations, revealing that the world is uncertain, frightening, and painful.

Another theory of narcissistic development is Millon's (1981) social learning theory of narcissism. This theory purports that narcissism develops not out of parental devaluation but as a result of parental overvaluation. Due to this, the child is treated as a unique person, given an abundance of attention, and led by parents to believe that he or she is lovable by being perfect. However, due to this unrealistic over-evaluation of the self, the future NPD spectrum individual creates illusions of the self as perfect and overly deserving, despite evidence or effort substantiating these beliefs. Over time, the child presumes similar treatment

from others and utilizes arrogant and demanding strategies in attempts to elicit positive reactions when his or her parents are unavailable. This strategy creates a tendency to take others for granted and to take advantage of others for self-benefit to get one's narcissistic needs met. Consistent with Millon's (1981) social learning theory, empirical research has demonstrated that when individuals are overly indulged in childhood, they are at a greater likelihood to develop NPD traits. Further, research has found that children who experience overvaluation are less self-sufficient (Capron, 2004; Otway & Vignoles, 2006), which may indicate a tendency to utilize maladaptive narcissistic strategies to compensate for fear of having to manage issues on one's own.

Perception of parents also plays a part in the development of NPD. Research has found an increased likelihood of the development of narcissist traits in adulthood in children who perceive their parents as being warm but controlling and manipulative. This finding is particularly true for children who identify mothers as indulgent and authoritarian (Cramer, 2011; Horton, Bleau, & Drwecki, 2006).

Three features related to the development of NPD have been proposed by Benjamin (1996). The first is that the fledgling NPD spectrum individual grew up with a parent who was selfless, and was thus provided limitless love and adoration, which created a child that lacks understanding regarding the parent's separate feelings and needs. Due to this, the child learns that the parent is there solely to delight in the child's presence and fails to learn that other people have feelings, needs, and concerns outside of their own. The second main feature entails the parent approaching the child in a "deferential and nurturant" manner that inspires egotism in regard to expectations that one is entitled to obsequious and nurturing treatment from everyone. As a result, if the fledgling NPD spectrum individual does not receive such treatment, the child is emotionally shaken and agitated. The final developmental feature is the "ever-present threat of a fall from grace" (p. 146). Because it is rare that the fledgling NPD spectrum individual is truly gifted (as it is more likely that the individual is average in skill or ability), the child becomes disgruntled with the parent. The result is feelings of dissonance and dissatisfaction in the child due to a recognition of conflicting views between how one is perceived and treated by the parent and how one is perceived and treated by the "real world." Thus, an internalized view of being truly unique or perfect is combined with extreme stress, and when failure occurs, it is linked to shame and despair. The internal workings of the NPD individual are best described as follows:

> Since the narcissist's self-concept stems from internalization of unrealistic adoration, the substitution of disappointment or criticism for love is devastating. The NPD is demolished, empty, and terribly alone. He or she can 'dish it out' but is not equipped to 'take it'
>
> (Benjamin, 1996, p. 147)

NPD Prevalence

NPD tends to have a lower prevalence rate than many other personality disorders in both community and clinical settings, which is contrary to the beliefs of those in the general public (Torgersen, 2009; Zimmerman, Rothschild, & Chelminski, 2005). The discrepancy between beliefs of rampant narcissism and actual prevalence is linked to the previous discussion of the confusion between entitlement, a more prominent trait, and NPD. The prevalence of NPD in the DSM-5 is "based on DSM-IV definitions" (APA, 2013, p. 671) and is projected to be between "0% and 6.2% in community samples" (p. 671). The DSM-5 (APA, 2013) states that between half and two-thirds of individuals diagnosed with NPD are male. According to an epidemiological survey of the United States, the lifetime prevalence rate of NPD is 6.2%, of which 7.7% are male and 4.8% are female (Stinson et al., 2008). Using the Alcohol Use Disorder and Associated Disabilities Interview Schedule – DSM-IV Version (AUDADIS-IV PD; Grant et al., 2004), NPD was found to be the 5th most prevalent personality disorder, comprising 2.2% of diagnoses in a community sample, behind avoidant personality disorder (AVD, 6.4%), paranoid personality disorder (PPD, 5.1%), obsessive-compulsive personality disorder (OCPD, 4.7%), and borderline personality disorder (BPD, 3.9%; Crawford et al., 2005).

Twenge and Campbell (2009) estimate that in the last two decades the prevalence of NPD has more than doubled in the United States, and that 1 in 16 individuals have some components of significant NPD traits. This finding was unique for two reasons: First, not only is it very rare for NPD spectrum individuals to enroll and participate in treatment but also the concerns that brought them there in the first place were unexpected given the nature of this condition. These issues included loneliness, distress, poor social functioning, inability of others to meet their needs, divorce, unemployment, and subsequent depression (Miller, Campbell, & Pilkonis, 2007; Ronningstam, 2011; Zimmerman et al., 2005).

Thus far, we have discussed numerous etiological theories associated with the development and origin of NPD. An additional etiological consideration is attachment theory, which, when incorporated with these other models, brings a critical lens to the conceptualization and understanding of this complex personality disorder.

Attachment and NPD

Attachment theory, and the identified secure and insecure attachment types, has been frequently utilized as a central component through which to explore impaired and unimpaired personality development (Blatt & Levy, 2002). Secure attachment has been seen as a critical part of the foundation and development of "healthy narcissism," as it permits the individual to create a bonded, well-integrated, and

consistent sense of self (Kohut, 1971, 1977). Research has examined attachment types and narcissism, but most of the research has explored this dynamic focusing on the identified NPD subtypes: covert/vulnerable and overt/grandiose. Briefly, covert or vulnerable narcissism is characterized by defensive, hypersensitive, and anxious preoccupation with competence while concealing an underlying sense of importance; whereas, overt or grandiose narcissism is characterized dominant, self- assured, exhibitionistic, and aggressive presentation and behaviors (Dickinson & Pincus, 2003; Russ, Shedler, Bradley, & Westen, 2008; Wink, 1991). These subtypes are explored in greater detail below.

Individuals who meet criteria for the overt or grandiose type of narcissism tend to be classified as having a more secure (high self-esteem and high sociability) or dismissing (high self-esteem and low sociability) attachment style, illustrating a stance of positive self-appraisal and a denial of interpersonal distress. Those with the covert or vulnerable narcissistic type have a fearful (low self-esteem and low sociability) or preoccupied (low self-esteem and high sociability) attachment style, which indicates a negative view of self. Individuals with covert/vulnerable narcissism may be more likely to say derogatory or negative things about themselves, to experience interpersonal distress, and to avoid relationships (Dickinson & Pincus; 2003; Foster & Trimm, 2008; Smolewska & Dion, 2005). Early parenting style and types of attachment have been linked with trait narcissism and NPD such that authoritarian parenting and secure attachment are positively associated with overt or grandiose narcissism. Alternatively, permissive and responsive parenting and covert or vulnerable narcissism were negatively related to secure attachment but positively related to preoccupied attachment (Cramer, 2019).

NPD Subtypes

In general, there are few pure personality archetypes. In fact, most personality types are more likely a mixture of variants of one major type with one or more secondary or minor subtypes (Millon et al., 2004). NPD is no exception, as multiple subtypes have been identified. According to Millon and colleagues (2004), there are four subtypes of NPD, which are listed in Table 3.1.

These four subtypes are not mutually exclusive, and individuals tend to show varied traits of the different subtypes. While some may exemplify one subtype over another, for others, aspects of various subtypes may only be exhibited under certain conditions, such as stress, or with certain people, such as partners, friends, or coworkers.

In addition to the four subtypes proposed by Millon (2004), Russ and colleagues (2008) also identified three subtypes related to NPD. These subtypes include grandiose/malignant, fragile, and high-functioning/exhibitionistic. The grandiose/malignant subtype exploits others with no consideration for the impact

Table 3.1 Millon's Four Identified NPD Subtypes

Unprincipled (antisocial features)	Conscience is malformed and this individual tends to engage in immoral, deceitful, misleading, controlling, and malicious behaviors and conceptualizations.
Amorous (histrionic features)	Lack of interest in authentic intimacy. These individuals are sexually seductive, coquettish, intensive pleasure seekers, along with the tendency for pathological lying and cheating.
Compensatory (negativistic/ avoidant features	Due to feelings of failure, inferiority, and low self-esteem the individual creates an illusion of superiority that exudes positive self-worth.
Elitist (prototypical features)	Harbors feelings of "specialness," entitlement, and authority related to pseudo-achievements while seeking an idealized life that exemplifies "special status" and advantage by association with other "special" individuals.

or welfare of those being taken advantage of. Their grandiosity is a core feature of their personality structure, which is in opposition to the classic view of compensating for weak self-esteem and vulnerability. In the fragile narcissist subtype, grandiosity and feelings of inadequacy are fused and manifests in a vacillating self-concept that runs from extreme superiority to extreme inferiority. Grandiosity in this subtype is often exhibited as a defense mechanism in response to perceived threat to one's already tenuous self-esteem. The final subtype is the high-functioning/exhibitionistic variant. This subtype is characterized by grandiosity, competitiveness, and attention-seeking or sexually provocative behaviors. Individuals with this subtype may be more likely to use eloquence, high-energy, interpersonal adaptivity, and achievement orientation to get one's needs met.

The within-group variation of NPD has many facets, but the two subtypes that have stood the test of time and research scrutiny include the Vulnerable-Sensitive type (i.e., covert) and Grandiose-Exhibitionistic (i.e., overt; Wink, 1991). Both types demonstrate features such as conceitedness, self-indulgence, and disregard for others, but the Vulnerable-Sensitive type tends to be introverted, defensive, anxious, and vulnerable to life's challenges, while the Grandiose-Exhibitionistic type tends to be extraverted, self-assured, exhibitionistic, and aggressive.

Exploring these two subtypes of narcissism has significantly advanced the understanding of NPD core content and expression. Those with overt narcissism tend to possess higher self-esteem, pleasure-based motivation, have weaker behavioral inhibition, more positive self-regard due to being reward focused, moderately insensitive to punishment, and have greater life satisfaction. When met with barriers to success or desires, those with overt narcissism are more likely to experience feelings of restlessness and impatience. Covert narcissism, alternatively, has

been associated with impaired goal-directed motivation and engagement, due to a lack of internal stimulation. Individuals with this variant tend to possess lower self-esteem, desire-based motivation, greater inhibition, and report less life satisfaction, when compared to those with overt narcissism (Foster & Trimm, 2008; Rose, 2002; Wink & Donahue, 1997).

Overt and covert narcissism are the prevailing subtypes as of this writing. These two subtypes assist those within research and clinical settings to better understand and work with individuals along the NPD spectrum. Falling behind the trend of subtype identification and distinction, the DSM largely focuses on overt or grandiose narcissism. However, some effort is being made to include covert narcissism in the DSM-5 alternative model under specifiers, "Other traits of Negative Affectivity (e.g., depressivity, anxiousness)" that can be used to record more vulnerable or covert traits (APA, 2013, p. 768). It may appear to be minimal, but this is a step in the direction of providing a more comprehensive acknowledgement and consideration of the dimensional pathology related to NPD and those with narcissistic traits.

The DSM and NPD

NPD first appeared in the DSM-III (APA, 1980). To have met criteria for this disorder, one must have exhibited a grandiose sense of self-importance or uniqueness; exhibitionism; preoccupation with fantasies of success, power, intelligence, attractiveness, or ideal love; rage, shame, humiliation, or emptiness in response to criticism or defeat; possessed feelings of entitlement; interpersonal exploitiveness; over-idealization and devaluation of others; and a lack of empathy. No empirical studies were included to develop this definition in the DSM-III. Rather, diagnostic criteria were devised by a committee of psychiatrists and psychologists who considered extant writings of the time (Levy, Reynoso, Wasserman, & Clarkin, 2007).

The DSM-III-R criteria saw the addition of a fixation on feelings of envy and the belief that one's problems are unique (APA, 1987), while the criterion of vacillation between feelings of idealization and devaluation was deleted, due to significant overlap with BPD (Widiger, Frances, Spitzer, & Williams, 1988). The most distinguishing criterion to differentiate individuals with NPD from those with other personality disorders, and other psychiatric disorders, was grandiosity and grandiose fantasies. This was defined as a belief in one's uniqueness and superiority with an unrealistic overvaluation of one's own abilities (Ronningstam & Gunderson, 1990). In the DSM-IV (APA, 1994), the criterion pertaining to those who exhibit rage, shame, humiliation, or emptiness in response to criticism or defeat was removed and the criterion related to fixation on feelings of envy was revised to include attributing envy to others. New to this edition was criteria related to the demonstration of arrogance and self-important behaviors or attitudes (Ronningstam & Gunderson, 1990).

A national sample of psychiatrists and psychologists was asked to match disorders with the criteria to which they belonged based on the disordered symptom criteria from the DSM-IV (Linde & Clark, 1998). Results illustrated that 70% of the time, practitioners incorrectly assigned the NPD criterion "interpersonally exploitive" to antisocial personality disorder (ASPD); however, they correctly assigned "grandiosity and lack of empathy" as consistent with NPD criteria 97% of the time, suggesting that grandiosity and lack of empathy are viewed as essential core concepts in NPD. No changes were made from the DSM-IV (APA, 1994) to the DSM-IV-TR (APA, 2000), or to the Section II criteria in the DSM-5 (APA, 2013) related to NPD.

Benjamin (1996) identified a link between the NPD spectrum individual's interpersonal history and the expression of DSM criteria. The "total NPD" is identified as an individual who meets all of the criteria listed in the DSM. According to Benjamin, several of the traits of NPD, as captured in the diagnostic criteria, are rooted in the fledgling NPD spectrum individual's childhood experience of unconditional love and adoration, for example, the expanded view of self-importance (Criterion 1), preoccupation with fantasies of unlimited success (Criterion 2), need to be linked to individuals who are seen as special (Criterion 3), need for continuous attention and adoration (Criterion 4), and sense of entitlement (Criterion 5) that developed into manifestation of arrogant behaviors and views (Criterion 9). Due to the selflessness that ran synchronously with the continual praise, empathy failed to develop (Criterion 7). Exploitation is bred from passive nurturance and the stress of meeting expectations of perfectionism that caused the fledgling NPD spectrum individual to be sensitive and vigilant to anything that might taint that image, resulting in envy (Criterion 8) and egotistical (Criterion 9) behaviors.

Several issues have been raised regarding DSM-5, Section II, NPD diagnostic criteria. The most predominant concern is that the criteria largely focus on the presentation of the overt or grandiose type, while disregarding many aspects of the covert or vulnerable type (as discussed previously). Further, it has been argued that the DSM-5 Section II criteria overlooks the etiological components that produce impaired or unimpaired NPD, and the degree of its behavioral expression (Cain, Pincus, & Ansell, 2008; Levy, 2012; Pincus & Lukowitsky, 2010; Ronningstam, 2012). These concerns were addressed in the DSM-5 alternative model's approach to NPD.

NPD and the Alternative Model

Consistent with the dimensional model outlined in the DSM-5, Section III (APA, 2013), Criterion A for NPD includes moderate or greater impairment in the

domains of Identity, Self-direction, Empathy, and Intimacy. For Criterion B, only two pathological personality traits must be present: grandiosity and attention seeking. To qualify for an NPD diagnosis, all other facets of personality impairment must be met under the General Criteria for Personality Disorder in Section III. These include pervasive and stable maladaptive trait expression that begins in adolescence or early adulthood; maladaptive behavior that is not better explained by another medical or mental health condition, such as head injury, schizophrenia, or substance use; and lastly, maladaptive behavior is not an expected part of the individual's development or sociocultural environment.

Compared to the traditional model (DSM-5, Section II, and prior editions), there is greater evidence for the validity for the alternative, dimensional model, as it more comprehensively captures pathological narcissism by including covert, or vulnerable, and overt, or grandiose traits (Fossati, Krueger, Markon, Borroni, & Maffei, 2013; Miller, Widiger, & Campbell, 2010; Ronningstam, 2009; Wright et al., 2013). Recognizing both subtypes of NPD has a direct bearing on clinical settings, as the alternative model's conceptualization provides greater utility for clinicians. Clients along the NPD spectrum are more likely to enter treatment when they are in a covert or vulnerable state, as compared to an overt or grandiose one, since the latter inhibits treatment-seeking (Ellison, Levy, Cain, Ansell, & Pincus, 2013). Using the Section II criteria, which fails to consider aspects related to both subtypes, the clinician risks only recognizing a small segment of individuals who are along the NPD spectrum (Miller, Gentile, Wilson, & Campbell, 2013). Thus, the DSM-5 alternative model is deemed more comprehensive, as it recognizes pathological personality structure as a dual construct, Criterion A (core content) and Criterion B (pathological traits), and conceptualizes the spectrum of personality from impaired to unimpaired (Di Pierro, Costantini, Benzi, Madeddu, & Preti, 2019; Krueger & Markon, 2006).

Within the DSM-5 (APA, 2013) alternative model, NPD is conceptualized as pathology within the core content elements of personality that impact the self and interpersonal functioning. These are listed in Table 3.2. Per Criterion A, to meet criteria for NPD, the individual must first possess at least moderately severe impairments in two or more of the four areas identified. These four domains are detailed in Table 3.2.

Criterion B identifies only two pathological traits that both fall within the Antagonism domain to be classified as NPD using the alternative model. The identified pathological personality traits for Criterion B for NPD are listed in Table 3.3.

The application of the DSM-5 alternative model and NPD is illustrated in The Case of Paul below.

Table 3.2 NPD Core Pathological Content

1. **Identity**	To meet this criterion, the individual's self-esteem and self-conceptualization is based upon continual comparison to others, while perceived value of self is either extremely high or low, and the value of self- dictates how well one can govern emotions.
2. Self-direction	To meet this criterion, the individual sets goals based upon obtaining acceptance from others, possesses unreasonably high or low standards that reflect the individual's unique or deserving nature, and lacks insight into what motivates the self.
3. Empathy	To meet this criterion, the individual's ability to perceive or acknowledge the emotions and rights of others is impaired, while being hyper-vigilant to others' responses but only to the degree that it impacts the individual, and influence on others is grossly over- or underestimated.
4. Intimacy	To meet this criterion, the individual's relationships are frivolous and lack depth serving only to regulate self-worth and the individual has little interest in their partner beyond gain for self.

Table 3.3 NPD Surface Content (Pathological Personality Traits)

1. Grandiosity	To meet this criterion, the individual must possess overt or covert feelings of privilege, be egocentric and hold the belief of betterment above others, and illustrate this by being patronizing and disdainful toward others.
2. Attention seeking	To meet this criterion, the individual must engage in behaviors to elicit attention from others, while being the central focus of that attention and continually striving for admiration.

The Case of Paul

Paul is a 44-year-old male who has a long history of serial employment. After graduating with his master's degree in cybersecurity from Brown University, Paul has held 13 jobs in four years. He procured his most recent position working at a well-known social media company. He chose this position, and all the others, as he wanted to earn six figures as a Network Security Engineer and for his friends, family, and acquaintances to be aware of his "intellectual prowess." Paul has had difficulty in his previous positions, primarily because he perceives his coworkers to be incompetent. He becomes embarrassed by their failure to follow through on orders he has given them, which then leads to him yelling and pounding his fists on the desk, resulting in his termination. He was fired from his last job at another

well-known online media company after yelling at his supervisee and grabbing him by the arm to force him to return to his desk. Paul believes all of his past and present coworkers, supervisees, and bosses are plotting against him in order to make him look bad. Many of them do not respond as he feels they "should" when he discusses his master's degree from Brown University; he is often heard saying, "Brown is Ivy League, in case you didn't know." Paul often posts on social media about his jobs, cars in the parking lot that illustrate the company's wealth and power, and his physique, as well as exaggerating his accomplishments regarding awards and recognitions. Every social media post includes the Brown University symbol. If Paul did not get enough likes or comments, he condemns others on social media for being dull, idiotic, simple, or "unworthy" of following him.

After Paul was fired from his last job and had difficulty finding another, he felt hurt and began to question his competence and ability. This caused him to be even more easily agitated and volatile. He had read that many CEOs and powerful executives had attended therapy, so he sought out a therapist mentioned in one of the articles. As he entered the therapist's office, he walked around looking at the diplomas and pictures on the wall, and said, "Don't worry Doc, I'm just making sure you're qualified to work with me." As he examined the items on the wall, he was acutely aware of the therapist's unwavering, neutral expression, which frustrated Paul. When offered to sit down, Paul replied, "I'm good, I can stand." He then explained how his employers hire ignorant workers to work with him in order to make him look bad, or to sabotage any success he could possibly have, because they are threatened by his education and intellect. Over the course of therapy, Paul recalled countless stories of how he would get coworkers fired or transferred because they did not meet his standards of excellence. During one session, Paul explained how he was romantically involved with several coworkers, who "were too stupid to keep their mouths shut or see what they had to lose, until they lost me." Paul specifically recalled, with no remorse, how one supervisee was fired due to their inappropriate working relationship. She was a single parent with three young children who ultimately had to move in with family out of state.

Paul qualifies for all four Criterion A elements of NPD: *Identity*, *Self-direction*, *Empathy*, and *Intimacy*. The following will describe as Paul's characteristic difficulties as they relate to the descriptions in the DSM-5 alternative model of NPD. In the *Identity* domain, he chooses places of employment that bolster his self-esteem and to show proof of his "intellectual prowess," his outbursts that have led to his termination due to embarrassment when he perceives that incompetent coworkers fail to follow through on his "orders," and he believes his employers are threatened by his education and intellect, and purposely hire bad supervisees and coworkers to sabotage his success. The *Self-direction* criterion is met as: he chooses to only work at well-known companies and his decision to attend an Ivy League university was to garner admiration and approval from others. Further, he possesses poor insight into his own motivations; while in treatment, Paul recalled countless stories of how he would get coworkers fired or transferred because they did not

meet his standards. In terms of *Empathy*, Paul is acutely aware of and annoyed by the therapist's neutral gaze and expression as he examines her qualifications and pictures on the office wall, not considering how the therapist may feel being evaluated in this way. He shows no remorse for, or recognition of, the difficulty a coworker he was romantically involved with experiences when she loses her job and has to move out of state with her children. Lastly, the *Intimacy* criterion is met as Paul repeatedly blames his failed romantic working relationships on his ex-partners and belittles their intelligence for not seeing the value he thinks he brought to the relationship. He tends to show only superficial concern for his romantic partners and he has little to no interest in how they feel in the relationship, or the consequences of being involved in a failed relationship with him (i.e., losing employment).

Paul also qualifies for Criterion B of NPD as he meets criteria for *Grandiosity* and *Attention seeking*. The *Grandiosity* criterion is met because: he believes his coworkers do not respond with appropriate adulation when he tells them about his degrees; he told his therapist that he was looking at the diplomas and pictures on the wall to assess if she is suitable and deserving to provide services to him; and he believes that his employers purposefully hire incompetent workers to make him look bad or to sabotage his success due to resentment related to his education and intellect. For *Attention seeking,* he often posts on social media about his jobs, his physique, his accomplishments, and to show off the expensive cars in the parking lot, thereby associating himself with the company's wealth and power; every social media post includes the Brown University symbol to let others know the prestige of where he went to school; and if he does not get praise, he condemns others for their lack of insight and intelligence to recognize him on social media.

Using the DSM-5 alternative model, the researcher or clinician can identify Paul as meeting criteria for NPD, but this provides only a fraction of the depth and complexity of this disorder. The Cognitive-Affective Processing System (CAPS) model allows better understanding of the structure, function, expression, and possible treatment approaches that could be used with those along the NPD spectrum.

NPD and the CAPS Model

The CAPS model provides a framework to recognize the process from initial presence and impact of stressors, to the activation of NPD core content elements identified in the DSM-5 alternative model, that work concurrently with the Cognitive-Affective Units (CAUs) within the CAPS model, and results in the surface structure expression of NPD pathological personality traits and facets. Figure 3.2 illustrates the merging of NPD and the CAPS model.

As mentioned in the first chapter, stressors tend to fall within one or more of the following categories: time-limited, environmental, blended, continuous, and historical (Fox, 2019). Stressors tend to be unique in terms of the degree of impact

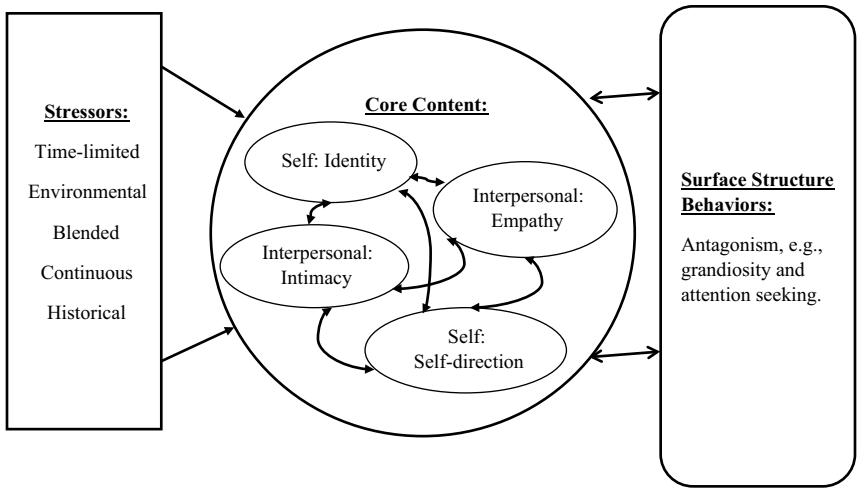

Figure 3.2 The merging of NPD and the CAPS model.

on the individual as they relate to personality make-up or type of personality disorder (Eaton, South, & Krueger, 2009). Individuals along the NPD spectrum are likely to find particular instances stressful, such as social evaluation, lack of appropriate environmental response to their perceived uniqueness, and difficulties related to overestimation of their intelligence, attractiveness, and competence, as well as shortsightedness and adverse consequences related to opportunism to illustrate their positive self-image (Edelstein, Yim, & Quas, 2010; Gabriel, Critelli, & Ee, 1994; Paulhus & John, 1998; Wallace & Baumeister, 2002). Each of these instances could fall into one, or several, of the identified stressor types. Once these stressors are encountered, the individual's Cognitive-Affective Units (CAUs) within the CAPS model associated with the NPD spectrum individual's core content is activated. These include those aspects of identity, self-direction, empathy, and intimacy that are specific to those along the NPD spectrum.

Once the CAUs are activated, they interact within an interrelated network with core content elements of personality functioning in a unique manner specific to NPD. The core personality psychopathological content of NPD from the DSM-5 alternative model and the related CAUs are listed in Table 3.4. Keywords are used to represent each component of NPD in the table, to see the unabbreviated description consult the DSM-5, Section III, Criterion A (APA, 2013, p. 764).

For those along the NPD spectrum, some elements have a stronger relationship to certain CAUs than others. *Encodings*, *Expectations and Beliefs*, and *Competencies and Self-Regulatory Plans* have the strongest relationship to the DSM-5

Table 3.4 NPD and CAUs

Elements of Personality Functioning	*Cognitive-Affective Units*				
	Encodings	*Expectations and Beliefs*	*Affects*	*Goals and Values*	*Competencies and Self-Regulatory Plans*
Self: Identity Refer to others to define self and self-esteem	X	X			
Self: Identity Overstated or understated assessment of self	X		X		X
Self: Identity Self-esteem determines degree of emotional control	X		X		X
Self: Self-direction Goals rooted in approval from others				X	X
Self: Self-direction Personal standards too high or too low based upon extreme view of self as unique or deserving	X	X		X	X

Table 3.4 (*Continued*)

Self: Self-direction Lack of insight into own motivations	X				
Interpersonal: Empathy Recognition of needs or feelings of others is impaired	X		X		
Interpersonal: Empathy Hyper-vigilant to others reactions only as it relates to perception of self	X		X	X	
Interpersonal: Empathy Impact of behavior on others is over- or underestimated	X	X		X	
Interpersonal: Intimacy Relationships lack emotional depth and are contingent upon gratification to self	X			X	
Interpersonal: Intimacy Lack of interest in learning about others' experiences, unless related and beneficial to self	X	X	X	X	

alternative model Criterion A. Each of these heavily weighted CAU categories relates to the individual's strong need for internal and external management of narcissistic needs, expectations, beliefs, behaviors, and scripts. The regulation of these internal and external forces factors into management of the self and interpersonal relationships. *Encodings* has the strongest relationship to core NPD content, as the individual along the NPD spectrum relies heavily on mental categories and constructs in order to relate to the self, others, and situations to keep oneself safe and secure, as well as to maintain one's narcissistic core of self and interpersonal interaction. However, this is not the only central CAU component, as the NPD spectrum individual is also strongly influenced by *Expectations and Beliefs* and *Competencies and Self-Regulatory Plans* to maintain the narcissistic self. Expectations and beliefs directly relate to narcissistic schemas that these individuals rely on throughout their life to make sense of, and to organize, behavioral scripts and organizational strategies to manage outcome and one's internal states (Beck, Freeman, & Davis, 2015; Huprich & Nelson, 2015).

Table 3.4 also illustrates the areas that are less impactful for an individual along the NPD spectrum, *Affects* and *Goals and Values*. Individuals along the NPD spectrum place little value on feelings, emotions, and affective responses or physiological reactions (Maccoby, 2000). Further, individuals along the NPD spectrum are also less likely to place emphasis on *Goals and Values*, which is consistent with research that illustrates that those along the NPD spectrum are driven by goals that increase wealth and standard of living, promote an exciting lifestyle, and lead to being perceived as influential and prestigious, while placing little value and interest in earning enough income to be comfortable and assisting others who may need it (Roberts & Robins, 2000). These conclusions do not mean that feelings, emotions, affective responses, and physiological reactions and lofty goals, or goals that bring the "bling," are not of importance. These affects and goals do not have the same degree of impact on surface structure expression as those that confirm and sustain the core content elements of NPD, which includes *Encodings*, *Expectations and Beliefs*, and *Competencies and Self-Regulatory Plans*.

The final sequence in the CAPS model is the surface structure expression of the pathological personality traits and facets. For NPD, this includes grandiosity and attention seeking behaviors. The behavioral expression often seen in an NPD spectrum individual can be best explained using the *if… then…* profile. This provides insight into not only the overall frequency of given behaviors but also the pattern of situational responses of that distinctive profile. This makes it possible to predict, with increased reliability, the NPD spectrum individual's behavior across situations. For example, an NPD spectrum individual experiences a time-limited stressor when she does not get the accolades she feels she deserves for her work. This perceived lack of sufficient praise causes her to feel insulted and ignored. *If* this NPD spectrum individual perceives to be insulted and ignored, she *then* responds with complaints to her boss and her boss's boss about how she

is not treated appropriately and often overlooked for her skills. Further, perhaps she demands to be recognized at the next awards dinner in front of all of her other coworkers. This *if… then…* sequence is likely characteristic of that individual, as it is likely to occur in each instance of perceived slights. The sequence is also consistent with the CAPS model theory (Shoda & LeeTiernan, 2002; Shoda, LeeTiernan, & Mischel, 2002; Shoda, Mischel, & Wright, 1994), because when this individual encounters a stressor and feels insulted and angry, her predictable response is to complain, angrily recite her skills to her boss and her boss's boss, and demand public recognition of her skills. This *if… then…* profile is outlined below (Figure 3.3).

According to the CAPS model, it is the combination of the presence of the stressor, the activation of core content personality elements that places her along the NPD spectrum working in concert with the cognitions and affects that make up the individual's CAUs, leading to the expression of surface structure personality traits creating the predictable and stable *if… then…* sequence response to the stressor (Borkenau, Riemann, Spinath, & Angleitner, 2006; English & Chen, 2007; Mendoza-Denton & Mischel, 2007; Mischel & Shoda, 1995, 2008).

Pathology Perpetuation

There are a number of unique factors that contribute to the perpetuation of narcissistic pathology in individuals along the NPD spectrum. These individuals, like all individuals, exist within an interpersonal system that typically substantiates their beliefs, perceptions, and behavioral expressions. This system is usually composed of, and maintained by, social norms; however, there is a preponderance of evidence that illustrates that narcissistic pathology is driven more by intrinsic, or intrapersonal, factors, such as a self-serving bias (Campbell, Bush, Brunell, & Shelton, 2005; Campbell, Reeder, Sedikides, & Elliot, 2000; Grijalva, & Zhang, 2016; Rose & Campbell, 2004; Warach, Josephs, & Gorman, 2018), self-deception (Levi & Bachar, 2019; Lewis, 2018), and an internal locus of control (Baldegger, Schroeder, & Furtner, 2017).

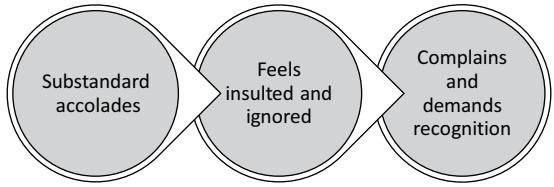

Figure 3.3 NPD *if… then…* profile.

Individuals along the NPD spectrum are often less influenced by extrinsic or interpersonal factors due to the fact that they tend to have little interest in relationships that are warm, close, or intimate (Campbell, Brunell, & Finkel, 2006; Campbell & Miller, 2011) and possess lower levels of empathy towards others (Hepper, Hart, Meek, Cisek, & Sedikides, 2014; Ritter et al., 2011; Ronningstam, 2016), commitment to others (Campbell & Foster, 2002), communion with others (Gebauer, Sedikides, Verplanken, & Maio, 2012; Morf, Horvath, & Techetti, 2011; Sakellaropoulo & Baldwin, 2007; Sedikides, Campbell, Reeder, Elliot, & Gregg, 2002), caring (Campbell, Rudich, & Sedikides, 2002; Jordan, Giacomin, & Kopp, 2014), and selflessness (Campbell, Foster, & Finkel, 2002) than those that are not.

The agency model of narcissism, proposed by Campbell et al. (2006), remains the best conceptualization of the perpetuation of narcissistic core content elements and surface structure expression. Agency refers to the individual as a solitary unit with motivations focused on enhancing the functions or needs of the self, such as increasing one's sense of self-worth (Bakan, 1966). Agency, as it relates to the NPD spectrum and the agency model of narcissism, pulls together aspects related to esteem management to achieve "narcissistic esteem" through agency seeking (asserting dominance and degree of competitiveness), self-regulation (effort to feel good, special, successful, and important), and self-conscious emotions (motivate and serve to regulate an individual's thoughts, feelings, and behaviors), which is driven by an offensive/approach orientation (looking for opportunities for self-enhancement; Campbell, 1999; Miles, Smyrnios, Jackson, & Francis, 2019; Morf & Rhodewalt, 2001; Paulhus, 2001; Raskin, Novacek, & Hogan, 1991; Rose & Campbell, 2004; Tracy & Robins, 2004).

The agency model begins with the recognition of the basic tenants of narcissism, which includes the factors of narcissistic agency mentioned above (e.g., agency seeking, self-regulation, etc.). It is here that intrapsychic strategies are used to maintain core content elements of NPD self and self-direction, such as self-serving bias, fantasies of power, and inflated view of skills, with little emphasis on genuine and reciprocal empathy and intimacy. These strategies are employed, but also reinforced, by NPD spectrum surface structure beliefs and behaviors, such as inflated confidence, condescension toward others, and extraversion to gain attention. Surface structure beliefs and behaviors are used to achieve particular NPD-spectrum-reinforcing outcomes, such as self-promotion and to obtain attractive status symbol partners, which reinforces core content elements. Through this agency model, narcissistic esteem is achieved and reinforced in a cyclical manner, thus perpetuating narcissistic pathology. This is illustrated in the Case of Diane below.

The Case of Diane

Diane is a 24-year-old female who recently started a YouTube channel about fashion trends and the latest styles of bathing suits. She has always been interested in fashion and she frequently goes to the beach "to be seen" wearing the latest trends.

In her videos, she would talk about how particular name brand bathing suits emphasize particular aspects of her body and how wearing name brands shows off her sense of style and importance. She further bolstered her self-esteem by presenting herself as a leading expert in bathing suit trends, claiming she could always identify "who looks good in what." Her YouTube channel received a lot of attention and many of the comments to her videos were very flattering and encouraging, which drove her to make more and more videos. Negative comments were quickly deleted and the composers were sent scathing emails outlining their "ignorance." Several of Diane's videos had gone viral (i.e., spreads rapidly through a population by being frequently shared with a number of individuals), which had gained the attention of bathing suit designers and marketing agencies.

Diane spent most of her time planning, making, editing, posting, reacting to, and promoting her videos. When she first started making videos, her boyfriend would help her, but as she gained more popularity and publicity, she outgrew his "homegrown attempts," and she hired a cameraperson and other "professional personnel" to help her. She started spending less and less time with her boyfriend. After not seeing her for two weeks, he told her that he missed her, wanted her to help her succeed, and asked to spend more time with her. She responded by saying "I don't and won't have time for those who don't move me forward and up." After this, she stopped taking his calls and responding to his texts and emails. They never "officially" broke-up, they just never spoke again.

Diane soon received invitations to attend fashion shows, go to celebrity parties, and be seen with well-known models and sports figures, and other "important" people. Diane loved the attention and praise. She was sociable, outgoing, agreeable, and endearing to those she believed could help her career, all the while feeling that it was well-deserved as she had worked hard, looked good, and was getting the admiration she deserved from the people with the ability to recognize her worth and skills. While at the home of a fashion executive, Diane attempted to film a bathing suit video by his pool. He objected to this and told her it was inappropriate, particularly without his permission. Diane became enraged, yelled at the executive, told him of her status within the industry, and commented on his short-sightedness in failing to recognize her importance. The executive subsequently ceased all contact with her, which she interpreted as him being threatened by her rising fame and influence.

Diane soon began dating a basketball star, and she would encourage him to take her to the hottest places and introduce him to his friends and agents. While at a trendy club, Diane asked a well-respected agent for his card because Diane was considering becoming his client. When the agent told Diane he was not interested in representing her, Diane retorted, "some stars are too bright for *mid-level* agents" and walked away. Over time, Diane worked harder and harder to maintain her believed deserved level of recognition and status. She began spending more money and going into debt to film in more exotic locations that showed off

her suits and skills at identifying trends, spending more time with A-list celebrities that reflected her perceived worth, ignoring her friends and family, and continuing to seek out other "fashion influencers," who were also unique enough to understand her and her deserved fame.

The Case of Diane illustrates the tenets of the agency model of narcissism and how it is central to the perpetuation of NPD core elements and surface structure behaviors. Diane is not strongly influenced by conventional social norms or interpersonal relationships. Rather, she is driven by her intrinsic perceptions of value, and not the actions and reactions of those around her, what is considered socially acceptable, or the "right thing to do." This is illustrated by her impaired insight into her inappropriate behavior at the executive's house. When others challenge Diane's perception of herself, or disagree with her views and values, she discounts these external sources, relying on intrinsic or intrapersonal factors to keep her narcissistic esteem intact. Diane is driven to continue to achieve the level of attention and status she feels she deserves, which justifies her view of self. When contrary evidence is shown to her, she rebuffs it as false or unworthy of her consideration. This cycle continues to reinforce her narcissistic view of self and perpetuates her NPD surface structure behavior that is a reaction to the activation of her NPD core content. This example exemplifies how narcissistic pathology is perpetuated in those individuals along the NPD spectrum.

Biopsychosocial Model and NPD

The exploration and identification of the interaction of biological, psychological, and social factors provide a vantage point to gain greater understanding into the components that lead to the development and expression of various personality disorders. These complex disorders are not simply the manifestation of biological components and responses to external risk factors, but exist within a system of psychological and social influences that impact the individual who is at a biological and psychological risk to display traits that are consistent with what have been identified as personality disorders (Paris, 1993).

While limited empirical research directly applying the biopsychosocial model to NPD has been conducted, its development has been examined through the exploration of a combination of biological, psychological, and social factors. Pulling this data together allows for a unified biopsychosocial picture of NPD.

The heritability estimate for NPD is 77% in clinical samples and 24% in the general population (Torgersen et al., 2000, 2008). Even with such strong heritability estimates, there is a paucity of studies that examine the various biological components associated with NPD. Drawing from neuroanatomy research, NPD has consistently has been linked with functional impairments in the insular cortex, which is associated with a wide variety of emotional and sensory perceptions and

processes including emotional awareness and recognition (Gu, Hof, Friston, & Fan, 2013; Zaki, Davis, & Ochsner, 2012), unfairness (Kirk, Downar, & Montague, 2011), trust and cooperation (King-Casas et al., 2008), norm violations (Xiang, Lohrenz, & Montague, 2013), and empathy (George & Short, 2018; Gu et al., 2012, 2013). Though each are connected to interpersonal deficits in NPD, research has demonstrated the strongest links between empathy impairment and NPD.

Using meta-analyses, researchers have demonstrated decreased gray matter volume in the left anterior insula in those with NPD when compared to controls (Fan et al., 2011; Schulze et al., 2013). When conducting whole-brain analyses on those with NPD, compared to healthy controls, results illustrated reduced grey matter volume in the paralimbic region of the brain, specifically the rostral and medial cingulate cortex and dorsolateral and medial sections of the prefrontal cortex (Schulze et al., 2013). These structural brain abnormalities suggest a link to impaired emotional empathy, a core content element of NPD, but it would be ill-conceived to believe that the identified neurological abnormalities discussed only impact and impair empathy in those along the NPD spectrum.

From a psychosocial perspective, research has shown that those along the NPD spectrum have impaired emotional reasoning when facing overwhelming fear. This emotional processing deficit drives poor decision-making and exacerbates other psychiatric conditions (Ronningstam, 2016). The perception of unfairness or inequity, an emotional reasoning process, has been related to NPD. Specifically, the perception of unfairness, self-esteem, and entitlement has been linked to degree of perceived attractiveness of the partner (Rohmann, Bierhoff, & Schmohr, 2010) and the tendency to perceive compensation below the level at which they feel they deserve (O'Reilly, Doerr, Caldwell, & Chatman, 2014). Individuals with higher degrees of narcissism are likely to trust others (Ackerman, & Donnellan, 2013; Kong, 2015) and cooperate less (Campbell et al., 2005). Lastly, several studies have found that individuals along the NPD spectrum have a tendency to violate norms of appropriate behavior (Adams, Florell, Burton, & Hart, 2014; Barry, Chaplin, & Grafeman, 2006; Twenge & Campbell, 2003). These studies did not directly examine the neurological, anatomical, or genetic differences in their samples, but conclusions suggest a connection worthy of future research between the perceptions and behaviors characteristic of NPD and neurological alterations in the insular cortex.

The CAPS and DSM-5 alternative model provide a comprehensive perspective of the interaction effect and the influence that biological, psychological, and social components have on individuals along the NPD spectrum. From the research discussed thus far, we can postulate that when an individual along the NPD spectrum encounters social risk factors or stressors, such as family or romantic disruption, unexpected and unplanned unemployment, or rapid social change, the insular cortex and paralimbic region are activated in a unique way that influences the

CAUs, activating the interrelated network of core content elements of personality functioning in a unique manner specific to NPD. This central activation drives surface structure behaviors of grandiosity and attention seeking. This complex process fits with the interdisciplinary framework proposed by Engel (1977, 1980) and expanded on by Paris (1993) that there are multiple etiologies and influences that cause the expression of NPD and other personality disorders.

The following example is provided to illustrate the process from initial exposure to a stressor to NPD trait expression. An individual along the NPD spectrum is suddenly laid off from work, as the company is laying off employees to hiring younger ones for less money. This individual with NPD is likely to misinterpret this, failing to see that the company's move was financial and not a personal attack. This misinterpretation could be related to deficits in the interpretation of emotionally laden events as processed in the insular cortex and paralimbic region. This individual has little to no concern for the others who were also laid off and thinks only of himself and how the act is unfair, which reinforces the lack of trust in the company. The individual's CAUs are activated leading to the perception that the company is inferior and the self is superior (encodings), the conceptualization that he should be too special and valued to be impacted by the layoffs (expectations and beliefs). Subsequently, the individual engages in behavioral scripts and schemas that support the NPD ideology of uniqueness, specialness, and worthiness of praise (competencies and self-regulatory plans). In concert with the CAUs, the core content elements of NPD are activated: identity (e.g., inflated self-appraisal), self-direction (e.g., personal standards unreasonably high in order to see oneself as exceptional), empathy (e.g., impaired ability to recognize or identify with the feelings and needs of others), and intimacy (e.g., mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain). The interaction within the individual's core content structure drives the surface structure response, which is likely to result in poor emotional control, leading to social norm violation. This could include acting out angrily in public or seeking public retribution from the company.

NPD surface structure behavior, and the process that occurs prior to its expression, is not only exhibited in "the real world" but in the virtual one as well.

Online Behavior and NPD Personality Expression

Narcissism is a trait often seen, and believed to be exacerbated, online (Twenge & Campbell, 2009). There is a preponderance of research that examines the connection between NPD core content elements and surface structure behaviors that are expressed online. It has been speculated that the online environment, particularly social networking sites (SNSs), have a strong appeal to those along the NPD spectrum (Fox & Rooney, 2015). The manifestations of NPD personality expression online will be explored here.

The internet is an ideal environment for NPD spectrum behaviors to be expressed. As in the physical environment, pathological traits and surface structure behaviors are exhibited when core content elements are ignited by stressors. The online environment provides a multitude of stressors and challenges to one's NPD spectrum beliefs about oneself, others, and the world. The internet has been called a "narcissistic accelerator" that exacerbates the individual's weak impulses, encourages acting out, and emboldens the creation of an alternate persona. These behaviors feed the need for grandiose expression, which can lead to sexual infidelity (Seiden, 2001), to cite just one measured outcome. Whereas another study found that individuals identified with a high degree of narcissism tended to use profanity and aggressive language to get attention online (DeWall, Buffardi, Bonser, & Campbell, 2011).

Research conducted by Brailovskaia and Bierhoff (2016) examined subtypes of narcissism, overt and covert, and online behavior. They found that higher narcissism, regardless of subtype, was predictive of greater SNS activity, as indicated by the number of online friends, status updates, and uploaded photos to Facebook. Further, those higher in narcissism visited their Facebook page more often and spent more time on the SNS than those lower in narcissism. The researchers reasoned that the commonality of subtypes in online behavior was due to it being a place where false personas that feed the concept of self can be created, as opposed to "real-world" interactions. In the "real world," overt/grandiose narcissists get their needs met by drawing attention to themselves through interaction within their physical social environment; whereas covert, or vulnerable, narcissists are at a disadvantage in the physical world, due to shyness and social anxiety, but can overcome these stressors in the virtual environment.

Several studies have examined narcissism and SNS, such as Facebook, and found that these sites create an environment where the narcissistic individual can project their ideal self to counter an imbalanced sense of self. Imbalanced self-image is a fluctuating relationship between grandiosity and efficacy, variable self-esteem, and a sense of vulnerability. This cyclical reinforcement of impression management can increase the likelihood of social media addiction (Buffardi & Campbell, 2008; Malik & Khan, 2015; Manago, Graham, Greenfield, & Salimkhan, 2008; Marshall, Lefringhausen, & Ferenczi, 2015; Mehdizadeh, 2010; Zhao, Grasmuck, & Martin, 2008). Halpern, Valenzuela, and Katz (2016) found that individuals further along on the narcissistic spectrum are more likely to take selfies (e.g., a photograph that one has taken of oneself, typically one taken with a smartphone or webcam and shared via social media). They also found that as levels of narcissism increase over time, per self-report from NPD spectrum individuals, the rate of sharing images of themselves and SNS use increased as well. Demographically, addictive use of the internet and social media to feed the narcissistic ego and lessen negative self-concept has been found to be more likely in those who are single, female, younger than 35 years of age, and have less education and lower income (Andreassen, Pallesen, & Griffiths, 2017). Social media

addiction and narcissism are best understood and explored within the context of the Dark Triad/Tetrad.

The Dark Tetrad, NPD, and the DSM-5 Alternative Model

The majority of studies that examine NPD spectrum elements and traits use The Dark Triad (Paulhus & Williams, 2002; Williams, McAndrew, Learn, Harms, & Paulus, 2001) or Dark Tetrad (Buckels, Jones, & Paulhus, 2013; Chabrol, Van Leeuwen, Rodgers, & Séjourné, 2009; Furnham, Richards, & Paulhus, 2013). The Dark Triad is composed of three personality types: Machiavellianism, narcissism, and psychopathy. This was later expanded to the Dark Tetrad, which includes Machiavellianism, narcissism, psychopathy, and everyday sadism. Going forward, only the term Dark Tetrad will be used.

Within the Dark Tetrad, narcissism is defined as a "subclinical version" of the DSM's NPD but still includes grandiosity, entitlement, seeing oneself as unique, self-important, and a tendency to be hypersensitive to vulnerability. Research has utilized both subclinical and clinical populations to explore narcissism within the Dark Tetrad (Furnham et al., 2013).

Narcissism within the Dark Tetrad, along with trait self-objectification (e.g., depersonalized and judged as an object with solely sexual worth), was related to greater social networking use, greater number of photos and selfies posted, and more photo editing (Fox & Rooney, 2015). Dark Tetrad narcissism was also found to be associated with the tendency to engage in higher cyberstalking in women (Kircaburun, Jonason, & Griffiths, 2018). The authors of this study suggested that this behavior may be driven by a fear of missing out (FOMO) on what the identified other may have shared or posted online, or used to send a message to the stalked individual that their every action online is being watched. Surprisingly, with respect to the Dark Tetrad, narcissism was not a predictor of trolling behaviors (i.e., online behavior that is deliberate, aggressive, deceptive, and purposefully inflammatory) on Facebook. Empirical evidence found that trolling behavior was negatively related to narcissism (Buckels, Trapnell, & Paulhus, 2014), which was attributed to the high degree of self-absorption often seen in narcissism and a lack of interest in what others are doing on Facebook (Craker & March, 2016).

The identified personality traits that makeup The Dark Tetrad fit with all of the identified pathological personality traits of NPD found in the DSM-5 alternative model. Table 3.5 shows a summary of this relationship.

The construct of narcissism within the Dark Tetrad shares similar facets of grandiosity and attention seeking that comprise the DSM-5 alternative model traits of NPD. Additionally, antagonism is the broad trait domain that houses the two trait facets of NPD within the DSM-5 alternative model, and it is one of the strongest common underlying elements of the Dark Tetrad (Derefinko & Lynam, 2006; Furnham et al., 2013).

Table 3.5 The Dark Tetrad and DSM-5 NPD Pathological Traits

NPD Traits	*Machiavellianism*	*Narcissism*	*Psychopathy*	*Sadism*
Grandiosity	X	X	X	X
Attention seeking	X	X	X	X

Treatment Success and Effective Approaches

Individuals along the NPD spectrum, particularly those considered moderate or above, bring to treatment several considerable challenges. NPD spectrum individuals tend to be some of the most high-functioning but also the most impaired and intractable individuals seen within various treatment settings (Caligor, Levy, & Yeomans, 2015). Typically, the classic narcissistic picture is not what is presented initially in treatment, as individuals along the NPD spectrum often enter treatment when they are in a vulnerable state, exhibiting covert traits that include wariness, hypersensitivity, and anxious preoccupation with competence, as opposed to a grandiose state, exhibiting overt traits that include perfectionism, mastery, and attention seeking (Ellison et al., 2013). This presentation for treatment makes it considerably more difficult for the mental health provider to recognize pathological narcissistic traits until a degree of narcissism is restored, subsequently resulting in the exhibition of grandiose traits. This shift in presentation complicates treatment planning and often causes the mental health provider to have to change treatment targeted beliefs, behaviors, and patterns from an individual who was initially perceived to be sullen, fearful, and uneasy to one that is resistant, grandiose, and without self-perceived flaws. This adjustment in identified problems becomes a challenge to the mental health provider to balance the tendency to prematurely terminate treatment, with providing encouragement and empowerment, while building recognition and insight into the NPD spectrum individual's problematic beliefs, behaviors, and patterns (Ronningstam & Weinberg, 2013).

Specific treatment guidelines and approaches for NPD spectrum individuals tend to be based upon case studies, theoretical formulations, and clinical experience due to the inherent resistance of these individuals to identify weaknesses and their lack of empathy to build greater understanding of self and other (Campbell & Miller, 2011; Levy, Reynoso, Wasserman, & Clarkin, 2013). This is consistent with treatment for most personality disorders, for which there is a dearth of evidence-based interventions, except for BPD (Bateman, Gunderson, & Mulder, 2015; Hopwood, 2018; discussed in the next chapter). It has been suggested that the most beneficial approach to treatment of individuals along the NPD spectrum is an integrative and unified approach (Magnavita, 2012), as there is no single, most efficacious intervention for treating NPD. Ronningstam and Weinberg (2013) identify multiple treatment modalities applicable to treat NPD with the

notation that no one treatment has been found to be superior or more reliable. These include psychoanalysis, psychoanalytic psychotherapy, psychodynamic psychotherapy, transference-focused psychotherapy, schema-focused therapy, metacognitive interpersonal therapy, and group therapy and couples therapy. The authors also list modalities originally designed for BPD, which can be augmented and applied to NPD: dialectical behavioral therapy (DBT) and mentalization-based therapy. Another intervention not listed above is cognitive-behavioral therapy (CBT), as described by Behary and Davis (2015), that is applicable to those individuals with NPD from clinical signs and symptoms to common challenges and clinician self-care.

The CAPS-5 Treatment Model and Hopwood's (2018) five-step treatment approach to working with individuals with personality disorders will be delineated to assist both the researcher and clinician in conceptualizing NPD treatment. The first step of Hopwood's (2018) five-step treatment approach is to determine the degree of impairment in Criterion A, the NPD Elements of Personality Functioning, using valid measures, such as The Level of Personality Functioning Scale-Self Report (Morey, 2017) or the Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders (SCID-5-AMPD) Module I (Bender, Skodol, First, & Oldham, 2018). These measures help to identify the NPD spectrum individual's core content as it pertains to Identity, Self-Direction, Empathy, and Intimacy, which will assist the mental health provider in identifying the level of core content severity that could adversely impact the success of the CAPS-5 Treatment Model.

The next step in Hopwood's (2018) approach is to identify and determine the severity of the pathological personality traits, Criterion B, that are present and can be applied to the NPD spectrum individual using the Personality Inventory for DSM-5 (PID-5; Krueger, Derringer, Markon, Watson, & Skodol, 2012), the Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders (SCID-5-AMPD) Module II (Skodol, First, Bender, & Oldham, 2018), or the DSM-5 Clinicians' Personality Trait Rating Form (PTRF; American Psychiatric Association, 2011). The PID-5 illustrated strong associations between the Antagonism domain and both vulnerable and grandiose forms of narcissism (Wright et al., 2013). Additionally, it was found that the PID-5 performed well in accounting for a large portion of the variance for the grandiose and vulnerable factors as they relate to the grandiosity and attention seeking NPD facets of the DSM-5 alternative model (Miller, Lynam, & Campbell, 2016). Miller et al. (2013) examined the relationship between grandiose and vulnerable traits of NPD and the DSM-5 NPD alternative model to determine if these subtypes are captured equally. Results concluded that Criterion A descriptions of self and interpersonal dynamics (e.g., "exaggerated self-appraisal inflated or deflated, or vacillating between extremes," "emotional regulation mirrors fluctuations in self-esteem," and "over- or underestimate of own effect on others")

favor both subtypes. However, the two required pathological traits, grandiosity and attention seeking, ostensibly favor the overt subtype. This was substantiated using the PID-5, which "accounted for 63% of the variance in the grandiose narcissism factor compared with 19% of the variance in the vulnerable narcissism factor" (p. 288).

No studies could be found that examined the NPD DSM-5 alternative model's trait facets using the SCID-5-AMPD or the PTRF. The DSM-5 alternative model identifies only two pathological personality traits: Grandiosity and Attention Seeking. At this point in the process, the mental health provider, using the CAPS-5 Treatment Model, should determine the degree of interpersonal and intrapersonal impact associated with these identified surface structure traits and how they will facilitate or derail treatment.

The mental health provider should then consider the severity of narcissistic impairment. Kernberg (2009) delineates three severity levels of NPD. which translate well into this treatment approach conceptualization and intervention. These three severity levels fit with the conceptualization of the CAPS-5 Treatment Model as it considers both core content elements and surface structure behavior, and it illustrates an aggregate of steps 1 and 2 from Hopwood's approach. Kernberg's severity levels are listed in Table 3.6.

The next step is to identify an intervention strategy for NPD spectrum individuals by incorporating the information from the previous steps related to core content and surface structure expression within the CAPS-5 Treatment Model. The following intervention is specifically designed for individuals along the NPD spectrum and incorporates this author's clinical experience and intervention strategies (Fox, 2018) along with recommended guidelines outlined by Critchfield and Benjamin (2006).

Initially, a therapeutic and collaborative relationship must be built and maintained. This will be impacted by the severity of the narcissism and presenting problems that motivated the individual to seek treatment. Most individuals along the NPD spectrum are reluctant to seek treatment unless prompted by an outside entity, significant dissonance exists related to their life, blockades to goals and strives for accomplishments become present such as acute financial, vocational, or personal crises or loss, and/or a comorbid disorder that may include bipolar disorder, depression, anxiety, substance abuse, posttraumatic stress disorder, or suicidality (Ronningstam & Weinberg, 2013). Next, the mental health provider needs to combine and tailor treatment interventions to fit the individual, such as addressing, changing, and giving up maladaptive patterns; identifying motivations for change; assessing narcissistic reactions from stress to rage; digging deeper into narcissistic motivations; lessening symptomatology that enhances personal empowerment; learning adaptive strategies to manage acting out and destructive behaviors; and building social potency and lessening dependency on narcissistic reinforcing strategies (Fox, 2018).

Table 3.6 Kernberg's Severity Levels of Narcissism

"Neurotic" level	Individuals who possess this degree of narcissism are often hyper-vigilant about actions of self and other but at a functional level. The degree of neuroticism impacts long-term intimate relationships and long-term professional and work communication and interpersonal involvement. Treatment of narcissistic personality structure may or may not be the focus of treatment. Prognosis is good.
"Typical syndrome" level	Individuals who possess this degree of narcissism have an excessive degree of self-centeredness, intensive dependency on admiration from others, excessive fantasies of success and grandiosity, along with avoidance of evidence in reality that is contrary to view of self, as well as greediness and exploitation of others for one's own gain, devaluation of others while continually demonstrating unreliability and shallowness of emotions, and lack of empathy. These individuals show severe and chronic failure in their work and profession, as well as in their efforts to establish or maintain intimate romantic relationships. Treatment of narcissistic personality structure is required to mitigate impairment to self and others. Prognosis is questionable.
"Overt borderline or antisocial" level	Individuals who possess this degree of narcissism possess all of the characteristics of the previous "typical syndrome" level, while also exhibiting a widespread intolerance for anxiety and impulse control and impaired ability in the "capacity for productivity or creativity beyond gratification of survival needs" (p. 105). Not all individuals will exhibit borderline-like features, as some will show antisocial features. This type of narcissism is called "malignant narcissism." The antisocial features include severe antisocial behavior, paranoia, and aggression directed toward self and other. These individuals tend to exhibit severe and chronic failure in their work and profession, and in their ability to establish or maintain intimate relations. Treatment of narcissistic personality structure is required to attenuate damage to self and others. Prognosis is poor.

The third and fourth guidelines proposed by Critchfield and Benjamin (2006) entail emphasizing support, empathy, and validation for the individual to move forward, while attending to beliefs, behaviors, and patterns that disrupt therapeutic progression of attenuating narcissistic pathology. Next, the mental health provider needs to utilize a flexible, problem-solving approach to the many problems that NPD spectrum individuals encounter. The guidelines then suggest that the treatment provider be engaged in the therapeutic process as an active participant. Here, CBT can be used to construct dialogues between schema modes (i.e., facets of the self that include specific schemas, or coping responses, that have not fully combined with other facets, such as angry child, over-compensator, etc.) and assess the cost and benefit of utilizing a new coping strategy (see Behary & Davis, 2015). Alternatively, the mental health provider can use DBT to address the emotional dysregulation and self-destructive urges inherent in NPD (see Reed-Knight & Fischer, 2011). Lastly, guidelines suggest instilling a sense of hope and encouraging the motivation to change as the individual challenges core content and utilizes new and adaptive surface structure behaviors.

The next step in Hopwood's personality disorder treatment approach entails giving the information that has been gathered to the client and any other related individuals. This needs to be handled "with kid gloves" when relaying treatment and diagnostic information to the individual along the NPD spectrum. Typically, the individual is going to be resistant, hypersensitive, defensive, and fault-finding in regard to the data and treatment options. The best course of action is to describe the issues and trajectory of treatment in a manner that illustrates what is best for the client, and how diagnosis and treatment will help the NPD spectrum individual achieve his/her goals of mastery and success. For example, the mental health provider can describe the benefit of learning emotional regulation skills as a means to master situations by recognizing and controlling not only the NPD spectrum individual's emotions but the emotions in the situation, and how this help the individual look good (attention seeking) and be seen as a unique and influential problem solver (grandiosity). Also, at this juncture, an agreement to proceed with treatment should be obtained. Additionally, the "rules of treatment" should be explained to the client and associated individuals, including how issues will be handled related to safety and the continuation of treatment.

The final step of this approach includes routine assessments of therapeutic progress to assess the attenuation or exacerbation of core and surface structure issues. Several of the assessment measures mentioned previously in this section could be used to complete this last step.

Individuals along the NPD spectrum bring with them many therapeutic challenges. Central and specific to NPD treatment is the high likelihood of premature termination (Bennett, 2015). The likelihood of treatment continuation and successful outcome is associated with the degree of narcissistic impairment, with moderate severity and above having a decreased probability of success. Factors

related to grandiose narcissism (e.g., hostility, projection of difficulties onto others, spitefulness, and envy) have been linked to client-initiated termination (Gamache, Savard, Lemelin, Côté, & Villeneuve, 2018). This does not mean that individuals along the NPD spectrum cannot, and do not, benefit from therapeutic intervention. Therapeutic success is often achieved when NPD spectrum clients are motivated to explore their core content, to work to adjust their maladaptive patterns, and to change how they see and interact with the self, others, and the world in which they exist.

Chapter 4

Borderline Personality Disorder

Borderline personality disorder (BPD) is the most studied, clinically evident, and treated personality disorder but also the most misunderstood, controversial, and stigmatized (Bradley, Conklin, & Westen, 2007; Sheehan, Nieweglowski, & Corrigan, 2016; Sperry, 2016). Adding to this is the disparate view between research and treatment realms and the comorbidity that exists in those individuals along the BPD spectrum. This chapter will examine BPD and these aspects to clarify these misunderstandings while advancing them and building a bridge between research and clinical engagement with those along the BPD spectrum.

There is little debate that the stigma associated with BPD adversely impacts perception, accurate diagnosis, management and treatment availability for this disorder. It is not uncommon for mental health providers to refer to individuals along the BPD spectrum, typically moderate and above in severity, as "the worst of the worst," "untreatable," "liars and manipulators," and countless other pejorative and degrading terms. There are multiple concerns associated with holding these views, the least of which is that they are unwarranted and based upon outdated conceptualizations. Hollywood and other forms of "entertainment" have presented individuals along the BPD spectrum in the most disparaging light, for example, Glenn Close in *Fatal Attraction*, Winona Ryder in *Girl, Interrupted*, Ryan Gosling in *Blue Valentine*, and Jim Carrey in *The Cable Guy* to name but a few. These films show individuals along the BPD spectrum that encompass typically the extreme upper 5% (estimated based upon severity of symptom expression). Using such limited and skewed perceptions would add to the bias toward

any disorder. For example, imagine only being exposed to the most extreme 5% of cases with depression. These individuals would be seen as intractable, unmotivated, disengaged, chronically suicidal, and resistant to treatment. Over time, this conceptualization of depression would be tantamount to the bias and stigma impacting those along the BPD spectrum.

The stigma associated with BPD has been well documented. Pearl, Forgeard, Rifkin, Beard, and Björgvinsson (2017) found that those with a high likelihood of BPD had greater levels of internalized stigma (awareness of/and agreement with negative stereotypes about mental illness) at the initial phase of treatment, which was believed to be indicative of the stigmatization of those along the BPD spectrum in the public and treatment domains; interestingly, participants along the BPD spectrum had reduced levels of internalized stigma following treatment. Several researchers have found that those with BPD are perceived more negatively than those with other stigma-producing disorders, such as schizophrenia and affective disorders (Forsyth, 2007; Fraser & Gallop, 1993; Markham & Trower, 2003).

Mental health providers who subscribe to the stigmatization are likely to have negative reactions, adding to an environment that lessens the probability of developing an effective treatment relationship, creating emotional and social distance, impaired empathy toward the client, lowered belief in clients ability to get well, and distorted views of the client as being controlling, relentless, treacherous, manipulative, and more in control of their behavior than other clients with other disorders, all of which contribute to premature termination (Aviram, Brodsky, & Stanley, 2006; Forsyth, 2007; Fraser & Gallop, 1993; Markham & Trower, 2003; Sansone & Sansone, 2013). Knaak and colleagues (2015) took on the task to lessen the stigma associated with BPD by providing a 3-hour training course on attitudes and behavioral intentions of those along the BPD spectrum and dialectical behavior therapy (DBT). Results were promising, showing that the intervention improved attitudes and behavioral intentions towards those along the BPD spectrum.

The impact of mental health professionals' and researchers' view of those along the BPD spectrum is longstanding and problematic, but this can be remedied through building genuine insight and understanding, in conjunction with providing a means through which to successfully work with these individuals. This chapter will provide this much needed information and supply an intervention approach that is clearly articulated, useful, and directed toward those along the BPD spectrum.

The History of BPD

First introduced in the 1930s, the diagnosis of "borderline" was used to identify patients who seemed to be experiencing a mild form of schizophrenia, believed to be on the *borderline* between neurosis and psychosis (Stern, 1938). Stern

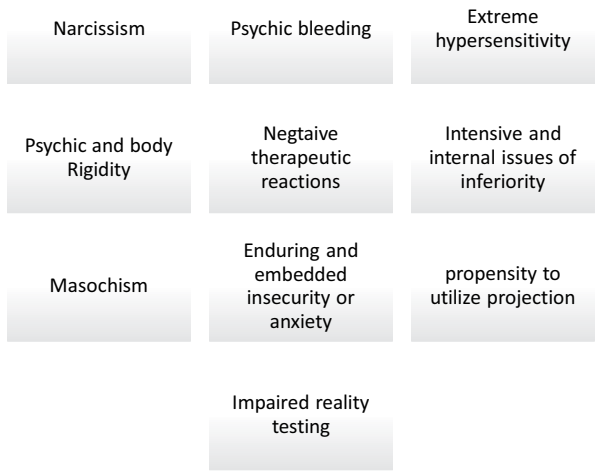

Figure 4.1 Stern borderline type character traits.

identified several character traits and reaction formations that make up the "borderline type." These are listed in Figure 4.1.

Many of these issues are still considered a core component of BPD today, such as extreme sensitivity, inferiority, insecurity and anxiety, and impaired reality testing. For approximately the next 15 years, the term "borderline" remained dormant until it was expanded to include not only those patients who were not psychotic but those that presented with psychosis but still did not qualify for a schizophrenia diagnosis (Knight, 1953). Knight (1953) articulates the conceptualization of BPD at the time in the summary of his seminal article titled *Borderline states*:

> Far more important, however, than arriving at a diagnostic label is the achievement of a comprehensive psychodynamic and psychoeconomic appraisal of the balance in each patient between the ego's defensive and adaptive measures on the one hand, and the pathogenic instinctual and ego-disintegrating forces on the other, so that therapy can be planned and conducted for the purpose of conserving, strengthening, and improving the defensive and adaptive functions of the ego
>
> (p. 12)

Kernberg (1967) expanding on the borderline concept by noting the prevalence of enduring patterns of unstable feeling, thinking, and behaving, as well as the

impaired experiencing self and others while contending with realities that are perceived as dissonant. He further tended to see these patients as possessing a *borderline personality organization* that was due to poor identity formation, utilization of primitive defense mechanisms (i.e., splitting), and the transient breakdown of reality perception when under stress. Kernberg (1975, 1984) is credited with the continued interest in borderline personality, especially within the psychoanalytic community of the time.

The first empirically based study associated with borderline syndrome patients was conducted by Grinker, Werble, and Drye (1968). This study produced the first criterion set that included failures of self-identity, tendency for emotionally dependent relationships, depression and loneliness, and propensity for anger expression. The understanding of the BPD spectrum continued to separate borderline syndrome from psychosis. This was done through finding that those with borderline syndrome tended to have experienced shorter psychotic episodes, greater impairment associated with dissociative episodes, and more intense anger, but less anxiety (Gunderson, Carpenter, & Strauss, 1975). Gunderson, "the father of the borderline diagnosis", and Singer (1975) published a descriptive review of patients with BPD and noted that the description varied based upon who was describing them and in what context and how samples and data were gathered. To minimize confusion, they identified six criteria related to the diagnosis. These are listed in Table 4.1.

To further lessen confusion and build understanding of BPD, the focus continued on the distinction between those with borderline pathology and other mental health issues. This revealed seven related criteria, similar but expanded upon from those identified in 1975: low achievement, impulsivity, manipulative suicide, heightened affectivity, mild psychotic experiences, high socialization, and disturbed close relationships (Gunderson & Kolb, 1978). From these seven criteria, The Diagnostic Interview for Borderline Patients (DIB) was created to assist in the diagnosis of those with borderline pathology by assessing five related areas: social adaptation, impulse/action patterns, affects, psychosis, and interpersonal relations (Gunderson, Kolb, & Austin, 1981). To find common ground and lessen

Table 4.1 Gunderson and Singer Borderline Features

Intense affect that is habitually depressed or hostile
A history of impulsive behavior
A degree of social adaptivity
Brief psychotic experiences
Loose thinking in unstructured situations
Vacillation in relationships between transitory superficiality and intense dependency

the confusion associated with the "various borderline conditions," efforts were being undertaken to enhance diagnostic accuracy and lessen treatment confusion using Gunderson and colleagues' results and the DIB, which would later be utilized in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) BPD category (Spitzer, Endicott, & Gibbon, 1979).

The only change to BPD from the DSM-III to the DSM-5, Section II, which is essentially a cut and paste from the DSM-III, is the addition of text added to the course noting the change in prognosis to "good" in the DSM-IV-TR (American Psychiatric Association (APA), 2000). Contrary to the published criteria and conceptualization of BPD in DSM-III and onward, efforts remained steadfast and focused on improving methods as the subsequent sections of this chapter will illustrate. It is the recognition and building of insight and understanding into the evolution of the BPD spectrum that will decrease the stigmatization, lessen confusion, and foster greater research and clinical interventions as illustrated in the pages ahead.

Proposed Origins of BPD

There are many theories as to the origin of BPD. Several studies have been conducted that examine BPD within families that confirm that BPD "breeds true" (Links, Steiner, & Huxley, 1988). This refers to BPD being more common in first-degree relatives than in controls (Belsky et al., 2012; Sansone & Sansone, 2009; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1988). Results have shown that individuals diagnosed with BPD who have a relative with the same diagnosis are five times more likely to be diagnosed with the disorder (Gunderson, 1994). BPD has been found to have a heritability component between 0.52 and 0.69 (Torgersen et al., 2000), while more recent studies indicate a heritability estimate of those diagnosed with BPD at .46, with .54 contribution of non-shared unique environmental factors (Skoglund et al., 2019).

It is of greater benefit and utility to examine specific traits that make up BPD, as opposed to looking at BPD as a diagnostic whole, due to global aspects lending themselves to greater interpretation and definition, such as difficulty in relationships, whereas specific traits, such as impulsivity, are better demarcated. The conceptualization of BPD as an extreme presentation of temperament or associated traits such as impulsivity, neuroticism, affective instability, depression, anxiety, and interpersonal relationship disturbance has been found to show strong familial lineage and can be used as a means of discrimination between BPD and other mental health disorders (Few et al., 2016; Paris, 2003; Skodol et al., 2002; Witt et al., 2017; Zanarini et al., 2004). The heritability of specific borderline traits ranges between 0.44 and 0.53 for anxiousness, affective lability, submissiveness, insecure attachment, cognitive dysregulation, and identity problems (Skodol et al., 2002).

Distel and colleagues (2008) studied BPD features in twins from three countries – the Netherlands, Belgium, and Australia – with a total sample of 5,496 twins. Results showed that genetic influence accounted for 42% of the variation in both genders. This result is not in isolation, as Bornovalova, Hicks, Iacono, and McGue (2009) examined the heritability and course of BPD over a 10-year span. Their sample consisted of adolescent female twins starting at age 14 from the Minnesota Twin Family Study that showed stability of BPD traits from age 14 to 17 years but a decline from adolescence to adulthood. After the age of 17 years, the traits began to "decline significantly at each assessment point" (p. 1348). However, the authors noted that although there is a decline in the degree of trait expression, the identified genetic factors contribute to BPD trait stability. The authors also showed moderate heritability of BPD traits.

A growing area of research has utilized neuroimaging to study the etiology of BPD. It has been found that individuals with BPD are hyper-reactive to emotional stimuli, which manifests in heightened activation of the amygdala (Donegan et al., 2003). This is supported by additional research that illustrates bilateral decreases in hippocampal and amygdala volumes when compared to individuals without BPD (Hall, Olabi, Lawrie, & Mcintosh, 2010). The brain response of individuals with BPD, when presented with emotional faces, becomes activated in both control and BPD patients, but those with BPD tend to show a greater activation in the areas that assist in the processing of facial features that are emotionally salient, such as the middle and inferior temporal cortical areas (Guitart-Masip et al., 2009).

Origins beyond biological components have also been found to be associated with BPD. Childhood abuse has been found to be a possible etiology of BPD (Herman, Perry, & Van der Kolk, 1989). The connection between BPD and specific childhood maltreatment in the form of sexual abuse has been found to have prevalence rates in those who develop BPD between 36.5% to 68% (Elzy, 2011; Herman et al., 1989; Kuo, Khoury, Metcalfe, Fitzpatrick, & Goodwill, 2015; McGowan, King, Frankenburg, Fitzmaurice, & Zanarini, 2012; Menon, Chaudhari, Saldanha, Devabhaktuni, & Bhattacharya, 2016).

Several factors associated with abuse have been found to contribute to the degree of impairment related to BPD symptoms, such as severity of abuse, age of onset of abuse, and number and types of abuse (Ibrahim, Cosgrave, & Woolgar, 2018; MacIntosh, Godbout, & Dubash, 2015; Zanarini et al., 2002). Studies have also shown that multiple instances of trauma, as opposed to a singular event, appear to have a greater relationship to the development of BPD (Kuo et al., 2015; Weaver & Clum, 1993). Abuse is not the only identified and studied precursor of BPD.

Abuse alone is not enough to be *the* causal factor. The familial environment has also been identified as a significant component in the development of BPD. Studies have repeatedly identified severely dysfunctional family environments

as contributing factors to BPD; these environments included: neglect, conflict, hostility, chaotic unpredictability, parental mental illness, and abnormal bonding with parents who provided a mix of neglect and overprotective responses (Frank & Paris, 1981; Giffin, 2008; Robertson, Kimbrel, & Nelson-Gray, 2013; Soloff & Millward, 1983; Tackett, Balsis, Oltmanns, & Krueger, 2009; Zanarini, 2000). Familial chaos, disrupted attachments, multiple caregivers, parental neglect, alcohol and drug abuse, and affective instability have also been found to be related precursors (Dahl, 1985; Fruzzetti, Shenk, & Hoffman, 2005; Golomb et al., 1994; Gunderson & Phillips, 1991; Ogata et al., 1990). These dysfunctional family environments have consistently been found in the histories of those along the BPD spectrum, as these individuals grew up in families that featured neglect, conflict, hostility, chaotic unpredictability, and abnormal bonding with parents who provided a mix of neglect and overprotective responses (Frank & Paris, 1981; Giffin, 2008; Links et al., 1990; Soloff & Millward, 1983). However, confounds between genealogical pathology are likely to be present when it comes to the study of family environment.

Marsha Linehan (1993), a leading researcher in modern conceptualizations and treatments of BPD, identified three types of emotionally invalidating families related to the fledgling BPD spectrum individual, listed in Table 4.2.

These identified invalidating environments feed emotional dysregulation, driving the child to act out emotionally, which then causes the invalidating environment and those within it to apply more stress and pressure for the fledgling BPD spectrum individual to have greater control, which further drives maladaptive emotional actions and reactions (Linehan, 1993).

Table 4.2 Linehan's Invalidating Family Types

Chaotic	Parental substance abuse or other mental illness is present. Parents are largely absent and little time and attention is paid to the child. Financial problems are present and the child's needs are disregarded and invalidated.
Perfect	Negative emotions are stifled and displays of these emotions are discouraged or punished. Child learns through invalidating interactions and statements that it is inappropriate to express emotion and that emotions and subsequent lack of control of these emotions indicate a flaw within the fledgling BPD spectrum individual.
Typical	Emphasis is placed on cognitive control over emotions, while overlooking the child's difficulty in regulating and expressing emotions. Clear and sharp boundaries between self and others and achievement and mastery are the only accepted criteria for success. This importance on emotional control intertwined with lack of support is invalidating.

Linehan (1993) went on to describe two common parenting errors associated with these environments. First, is a shaping error. In this error, the child is expected to be able to display behaviors beyond their capacity; this is followed by excessive punishment and insufficient responses in the form of maladaptive modeling, instruction, coaching, cheerleading, and reinforcement. This causes the child to act out emotionally in an effort to end punishment by creating intensive and adverse consequences that lead the parents or caregivers to give up at trying to control the child. The second error is the reinforcement of "extreme expressive behaviors" (p. 59), while stifling the more moderate expressive behaviors. This patterns inadvertently creates a sequence of behaviors seen in adult BPD spectrum individuals: unexpected or aversive conditions occur leading to an increase in passive and helpless behaviors; if thwarted, punished, or insufficient, the individual engages in extreme emotional behavior or extreme passive and helpless behavior, leading to a host of identified BPD characteristics, such as self-harm and emotional instability, that continue as the child ages.

Additional precursors to the development of BPD include parental separation and loss (Bandelow et al., 2005; Links et al., 1988; Reich & Zanarini, 2001; Soloff & Millward, 1983). There is an extensive amount of research that illustrates that individuals along the BPD spectrum have childhood histories that include long separations from, or permanent loss of, one or both parents. These histories of loss distinguish this group from those diagnosed with schizophrenia, depression, and other personality disorders (Bradley, 1979; Frank & Paris, 1981; Links et al., 1988; Soloff & Millward, 1983; Zanarini et al., 1988). Crawford, Cohen, Chen, Anglin, and Ehrensaft (2009) examined data to determine if long-term maternal separations (parental divorce, childhood hospitalizations, parental hospitalization) in early childhood, younger than 5 years old, were predictive of later BPD symptoms. Results from this large community sample of participants found a relationship between early separations and BPD symptoms in children, as well as adults. BPD symptoms were higher in children with early separations and declined slower than expected when compared to those without early separations. These results support the iconic study by Bradley (1979), who investigated the histories of 14 children who had experienced early separations from their mother for at least one month before age five, and concluded that they were at an increased risk for BPD due to infant-mother bond disruption.

Zanarini and Frankenburg (1997) propose the tripartite model of BPD etiology. According to their model, three inter-related factors are necessary for BPD to develop. The first is a traumatic childhood that gives rise to sorrow, rage, shame, and/or terror. The second is a vulnerable or "hyperbolic" temperament; hyperbolic temperament is defined as a quickness to take offense, that one subsequently attempts to manage by demanding that others notice and pay attention to one's inner pain. Due to continuous circuitous and covert attempts that fail to achieve this goal, the individual accuses those others as being "insensitive,""stupid," or "malevolent." The third and final factor is the presence of "triggering events," either

singular or multiple, that are within the "normal" developmental process or are traumatic in nature. These events build up and eventually ignite BPD pathology; without such events the individual may appear erratic and dramatic but not to the level of disordered functioning.

The pathogenic hypothesis, proposed by Benjamin (1996), provides an explanatory trajectory for the fruition of BPD symptomology. First, the fledgling BPD spectrum individual is raised within a chaotic family environment made up of "terrible fights, affairs, abortions, infidelity, drunken acting out, suicide attempts, murders, imprisonment, disowning, and illicit births" (p. 118). During peaceful, non-calamitous moments, the fledgling BPD spectrum individual feels empty, bored, and dreary. There is a steady lack of constancy; the fledgling BPD spectrum individual's world is in constant unrest heavily interspersed with chaos and instability. Traumatic abandonment experiences make up the second factor of this development, which includes hours or days of being left alone without a sense of safety, protection, companionship, or materials for positive activities. Benjamin (1996) gives the example of the fledgling BPD spectrum individual being locked in a room alone while the parent is out on a date, being locked in a basement for alleged misbehavior, or being accessible for sexual abuse or sadistic religious rituals. Due to this time spent in isolation or being left with an abusive or neglectful "supervisor" or "caretaker," the fledgling BPD spectrum individual associates this with the belief that one is a bad person. Due to the hurt and pain associated with sexual abuse, the probability that the fledgling BPD spectrum individual will engage in self-mutilation is increased, due the confusion between pleasure and pain. Abuse also teaches the fledgling BPD spectrum individual to alternate from idealization to devaluation. The devaluation disrupts the fledgling BPD spectrum individual's ability to accurately test reality and make sound judgments, causing one to become confused and disoriented.

The physical or sexual abuse occurred when the fledgling BPD spectrum individual was unprotected and alone. The family ideals maintained that independence is bad and that dependency and compassionate misery with the family are good make up the third feature of Benjamin's hypothesis. Due to this, the fledgling BPD spectrum individual learned while growing up that loyalty to the chaos and maladjustment equaled pleasure and "peace." From this originates the tendency to self-sabotage when good things begin to happen, such as school, a relationship, therapy, or a new job. Self-sabotage is the consequent of two possible sources: the first is the internalization of the abuser, or a jealous parent or sibling, who implements revenge or causes pain that is a recapitulation of earlier instances of abuse. The second source is when the fledgling BPD spectrum individual learns that one needs to be sick in order to be cared for, because as one gets better or healthier, one will be "ejected" from treatment. The final aspect is that the fledgling BPD spectrum individual learns that to gain love and concern from family or loved ones, one must experience misery, sickness, and debilitation.

BPD Prevalence

Population prevalence rates for BPD are estimated to be between 1.0% and 5.9% (APA, 2013; Gross et al., 2002; Lenzenweger, Loranger, Korfine, & Neff, 1997; Torgersen, Kringlen, & Cramer, 2001). Within primary care settings, it is estimated to be approximately 6%; in outpatient mental health clinics, it is estimated to be approximately 10%; and in psychiatric inpatients, it is estimated to be approximately 20% (APA, 2013). However, a large cross continental study, conducted by Zanarini and colleagues (2011), examined BPD prevalence using a sample composed of 6,330 11-year-old children in England and 34,653 adults in America and revealed rates for those who met criteria for BPD, based upon DSM-IV criteria, to be 5.9% for adults and 3.2% for children. This study also found that BPD is less common in those aged 11–12 years than those who are 18 years of age and older. This result is believed to be due to poor reliability in children compared to older individuals but also that symptom manifestation had not occurred at the time of data collection. Lastly, this study found that females reported affective symptoms, while males reported more impulsive symptoms, which leads to misdiagnosis and classification. This difference in symptom presentation is one of the central issues related to confusion and misunderstanding associated with gender, prevalence and BPD.

Research examining the prevalence of BPD found that a preponderance (76%) of individuals diagnosed with BPD are female, with a gender ratio of 3:1 (Widiger & Weissman, 1991). This finding, which is actually a misperception, has been perpetuated time and time again and has been a highly influential factor in the perception that females have BPD traits and subsequently receive the diagnosis more often than males. This gender misconception is also reported in the DSM-5, "Borderline personality disorder is diagnosed predominantly (about 75%) in females" (APA, 2013, p. 666), but other research proves its falsity. Community studies have consistently shown equal prevalence of BPD among men and women (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Lenzenweger, Lane, Loranger, & Kessler, 2007; Paris, 2010; Zanarini et al., 2011). Several theories have been postulated to explain this seemingly inherent and intractable gender distortion related to BPD. Going back to the original conceptualization of diagnostic criteria addition to the DSM-III, Kaplan (1983) noted gender bias associated with several personality disorders, including BPD, which includes that masculine-based assumptions were utilized to determine "healthy" or "crazy" behaviors and that females who over-conformed to particular sex-role stereotypes would be found to be pathological. Widiger (1998) identified several factors that lead to gender bias that can be attributed to BPD: sampling bias, diagnostic criteria and constructs bias, diagnostic threshold bias, diagnostic criteria application bias, and assessment instrument bias.

Becker and Lamb (1994) examined gender bias in a mental health provider sample by sending a survey to social workers, psychologists, and psychiatrists to assign diagnoses to hypothetical case studies, differentiated by gender only, where the client met criteria for either BPD or posttraumatic stress disorder. Results illustrated a gender bias in that clinicians rated females higher for the applicability of BPD criteria than male clients, though both scenarios met criteria for BPD. It is critical for researchers and clinicians in every domain to be aware of the potential for gender bias when making a diagnosis or drawing a participant pool, particularly those working with or studying BPD.

Attachment and BPD

A link has been identified between early separation and attachment disturbance in the development of psychopathology in individuals of all ages (Mikulincer & Shaver, 2007). Early separation (Bradley, 1979; Crawford et al., 2009) and attachment disturbance (Fonagy, 2000; Sable, 1997) have also been associated with the development of BPD. A strong association was found in a review of 13 empirical studies that examined individuals along the BPD spectrum and found that these individuals were more likely to have unresolved or preoccupied and fearful attachment types (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004). These results fit with conceptualizations of relationships and connections to others as those individuals along the BPD spectrum tend to approach attachment relationships in a manner that is inconsistent, need based, and peppered with fear intensive interactions. This is done in an attempt to draw the perceived attachment object closer while simultaneously fearing that closeness, loss of it, or possessing a lack of worth to deserve it.

These interactions, patterns, and other attachment-driven conceptualizations can be traced to internal working models. Bowlby (1958, 1973) theorized that internal working models represent how the individual sees the world and others, and that these models organize personality development and influence the trajectory and conceptualization of future relationships. When development is disrupted and internal working models become disordered, due to the caregiver's unpredictable, frightening, and/or abusive behavior towards the individual, a possible foundation for later BPD surface structure symptomatology is created (George & West, 1999). These internal working models create a foundation that malevolence is a likely outcome in "emotionally charged complex attachment relationships" (Fonagy, 2000, p. 1136) for those along the BPD spectrum. Additionally, distorted internal working models have been found to result in the inability to predict, understand, process, and adjust in response to the actions and reactions of significant others leading to the development and identification of insecure attachment types (Liotti, 2000; Lyons-Ruth & Jacobvitz, 1999; Main, Kaplan, & Cassidy, 1985). In a study of 99 individuals who were "reliably

diagnosed" with BPD, results illustrated that approximately 90% were classified as having an avoidant (29.2% of the sample), preoccupied (25.8% of the sample), or fearfully preoccupied (44.9% of the sample) attachment type. Those within the preoccupied type exhibited greater distress and behavioral response to real or imagined abandonments; those with the avoidant type had higher ratings on inappropriate anger; and those with the fearfully preoccupied attachment type showed higher ratings on identity disturbance (Levy, Meehan, Weber, Reynoso, & Clarkin, 2005).

Studies have consistently found an association between attachment and romantic relationship disturbance related to individuals along the BPD spectrum, particularly those moderate and above in severity (Agrawal et al., 2004; Blatt & Levy, 2003; Bouchard, Sabourin, Lussier, & Villeneuve, 2009; Hill et al., 2008). Hill and colleagues (2011) examined attachment, relationship dysfunction, and BPD using a sample of women from North West England who had participated in a previous study on child maltreatment, interpersonal functioning, and depression and another sample from an outpatient clinic who were currently in treatment. Results showed that insecure attachment, specifically preoccupied attachment, was related to romantic dysfunction and BPD in both samples.

Attachment goes beyond just the connection to other people. Hooley and Wilson-Murphy (2012) explored BPD and attachment to transitional objects, such as stuffed animals, using a nonclinical sample of 80 adults (61 females and 19 males). Results showed the most intense attachment to transitional objects were in those along the BPD spectrum. This same group also reported a history less parental care, caregivers who were more controlling, greater relationship anxiety, and more childhood trauma experiences. It has been found that individuals along the BPD spectrum have a greater tendency to endorse having a transitional object while in-patient or at home, and finding it a source of self-soothing whether in the hospital or at home (Cardasis, Hochman, & Silk, 1997). The draw of transitional objects for those along the BPD spectrum is not surprising, as these individuals often have difficulty with their own internal resources to self-soothe when they encounter relationship or attachment stress or separation (Adler, 1993).

BPD Subtypes

The question of subtypes and BPD is not an uncommon one and one that has received some attention by researchers or clinicians over several decades. It should be noted that the DSM-5, as well as earlier versions do not discuss or address subtypes, and tends to focus on the more general features of the disorder. The search pertaining to BPD subtypes has been conducted from many vantage points and methods, including affect, interpersonal, and of course personality characteristics, using longitudinal studies and finite mixture modeling to name a few. The

identification of various subtypes illustrates the myriad of issues encountered by researchers and clinicians studying this complex condition. Bradley, Zittel Conklin, and Westen (2005) attempted to explore this issue in adolescent males and females, but they did not have enough male participants to perform required statistical analysis to draw conclusions for males. Results identified four subtypes for females labeled as high-functioning internalizing, histrionic, depressive internalizing, and angry externalizing that are subsets of the larger diagnosis, BPD. Using mental health provider data related to patients with BPD and their affective regulation and experience, three BPD subtypes were identified and labeled as internalizing-dysregulated, externalizing-dysregulated, and histrionic-impulsive (Conklin, Bradley, & Westen, 2006). Withdrawn–internalizing, severely disturbed–internalizing and anxious–externalizing subtypes were identified in a different study using demographic and clinical and psychological variables, such as age, coping strategies, comorbid diagnosis, suicide attempts and self-harm (Digre, Reece, Johnson, & Thomas, 2009). This study also found that functioning and treatment impact and outcome were related to the various subtypes: reduced levels of dissociation was found in the withdrawn–internalizing subtype; significant reduction in depressive levels by the anxious–externalizing subtype; and no significant improvement was found in the severely disturbed–internalizing subtype.

Four additional subtypes were identified based upon reactive and regulative temperament dimensions: low anxiety, inhibited, high self-control, and emotional disinhibited (Sleuwaegen et al., 2017). The individuals identified with the "low anxiety" subtype were found to have significantly lower levels of anxiety and interpersonal sensitivity, but higher antisocial personality trait scores and were identified as having low punishment sensitivity and low avoidance when compared to the other subtypes. The individuals identified with the "inhibited" subtype were found to possess avoidant, obsessive-compulsive, and depressive personality features and were less likely to express emotions, be less hostile, but were more likely to internalize, as well as be identified as having low sensitivity and approach to reward. The "high self-control" subtype was found to expend considerable effort to control oneself and utilize more adaptive coping strategies and to experience fewer clinical and personality disorder symptoms than the other subtypes. The final subtype is the "emotional disinhibited" subtype and fits the classic archetype of individuals with BPD, such that they have intense emotions and poor impulse control, high anxiety, are interpersonally sensitive, and possess histrionic personality disorder typology.

Affective components are not the only identifying factors used to identify BPD subtypes. Interpersonal functioning has also been explored as a means to identify subtypes using the Circumplex Model of Interpersonal Behavior and two distinct subtypes were identified and labeled as "autonomous" and "independent," which were stable at a four-month follow-up (Leihener et al., 2003). In another study, vindictive, moderate submissive, nonassertive, exploitable, and socially avoidant

were identified as five distinct subtypes based upon interpersonal distress, interpersonal differentiation, and severity of global symptoms (Salzer et al., 2013).

Lenzenweger, Clarkin, Yeomans, Kernberg, and Levy (2008) also identified three distinct subtypes labeled Group 1, 2, and 3, using finite mixture modeling with 90 participants (7 males and 83 females), age 18–50 years based upon the work of Kernberg and Caligor (2005). The groups differed in degree of paranoia, antisocial personality features, and aggression which was consistent with Kernberg's theory of BPD organization (1967, 1975). Group 1 was identified as nonaggressive, non-paranoid, and non-antisocial BPD patients as they had less negative emotions and childhood physical abuse, and better social and work functioning; Group 2 was identified as nonaggressive and non-antisocial, but paranoid BPD patients tended to affiliate and feel close to others less often (a likely product of the paranoia) and reported higher rates of childhood sexual abuse; and Group 3 was identified as aggressive, antisocial, and non-paranoid BPD patients as they were characteristically antisocial and aggressive with poor behavioral control and tended to be impulsive and psychopathic, as well as having poorly integrated positive and negative parts of the self, resulting in an incoherent sense of self that is distressing to the individual.

Using similar methods employed by Lenzenweger and colleagues (2008), Hallquist and Pilkonis (2012) examined a mixed clinical and nonclinical sample of 362 adults and identified four subtypes: angry-aggressive, angry-mistrustful, poor identity and low anger, and "prototypical" (individuals who exhibited low levels of aggression, antisocial behavior and mistrustfulness, but moderate levels of inappropriate anger).

Millon (2011) identifies six subtypes that make up his UBC spectrum; based upon Millon's theory and approach, this is most similar to the term and conceptualization of "BPD spectrum" more commonly used today. The UBC spectrum represents personalities that range from unstable styles (the Dissatisfied Unstable Personality Style and the Unpredictably Unstable Personality Style – mild level severity and manifesting no more than two or three of the DSM-IV borderline criteria), borderline types (the Impulsive Borderline Personality Type and the Petulant Borderline Personality Type – mid-level severity and exhibiting four or five DSM criteria), and cyclophrenic disorders (Discouraged Cyclophrenic Personality Disorder and Self-Destructive Cyclophrenic Personality Disorder - most severe and displaying five or more of the DSM criteria). Individuals long this spectrum are often "emotionally dysfunctional" and possess a "maladaptively ambivalent polarity orientation" (p. 890).

The Dissatisfied Unstable Personality Style tends to harbor abandonment fears, possess a sense of worthlessness and emptiness, which fosters a sense of dissatisfaction with life that is validated by abandonment experiences in chaotic interpersonal relationships that exacerbate dissatisfaction and depression. Suicidal ideation and attempts as well as self-mutilation are related to poor self-image and

utilized as a means to shock and control others. The Unpredictably Unstable Personality Style is characterized by a desire to fuse with another, intertwined with conflict about losing sense of self within that relationship. The other in the relationship is often idealized as a magical romantic figure which creates dependence on that individual leading to complete dependency for self-esteem and self-worth. Due to this paradox, the individual sabotages the relationship which creates a continuous cycle of chaos, and the means to manage such chaos is to never let any relationship be too stable.

The Impulsive Borderline Personality Type is representative of extreme efforts to cope with various events which foster, deepen, and perpetuate the individual's difficulties. Due to lack of attainment of the attention and reward they desire, they intensify their efforts through seductiveness and irresponsibility, possibly falling back on histrionic strategies of extreme hyperactivity, capriciousness, and distractibility. At times, they may appear boastful and "manic" with an insatiable need for social engagement and excitement. Those with antisocial features may engage in spontaneous destructive and irresponsible acts along with failure to consider more reasonable options paired with resistance to the consequences of their behavior. A cycle is often created that originates with attention solicitation that is strongly linked to esteem and self-worth, but when they fail to achieve this goal they experience periods of hopelessness and self-deprecation followed by worry and anxiety, subsequent to emptiness and abandonment ultimately leading to a deeply dysphoric outlook until attention seeking is resumed to restore their sense of self and value. The Petulant Borderline Personality Type is characterized by being extremely unpredictable, restless, irritable, and impatient, along with a tendency to complain. These individuals are defiant, dissatisfied, unhappy, pessimistic, stubborn, easily disenchanted and insulted. They harbor envy for others and feel unappreciated and unrecognized. This type is at an increased probability for psychotic episodes compared to the other types and styles discussed. Although angry and seemingly misanthropic, these individuals desire affection and love, but fear it at the same time. This push and pull towards affectional needs goes against their very sense of self, and this desire and fear for connection, which is perceived as dependency, makes it so they are unlikely to have secure relationships and their needs go unsatisfied on a regular basis.

Individuals who are representative of Discouraged Cyclophrenic Personality Disorder tend to be compliant and submissive with a lack of initiative, be chronically in a state of dysphoria, and avoid competition. They desperately seek attachment to another and when this does not work out, their sense of self becomes questionable and they desperately move on to seek security in another, but due to their lack of inner resources and solidified self-doubts, they are driven to connect to any other person willing to have them. When they do, they respond by completely rejecting their own autonomy and individuality just to be with this person. Due to the level of insecurity, these individuals find daily tasks arduous, and this

difficulty builds their inner doubt and loneliness which feeds futility. This increases the possibility of suicide and self-mutilation which is an act to restore control over their self-hatred or to punish themselves for their bad behavior. Self-Destructive Cyclophrenic Personality Disorder is characterized by continuous vacillation in all aspects of life. Being with another equals complete dependency, while not being with another is total emotional destitution. This inner drive to connect is often resented, creating anger that is expressed in an intropunitive way, exhibited through depressive or masochistic traits. Interestingly, these individuals are able to present a veneer of sociability and conformity, appearing deferential to others. They tend to go out of their way to ingratiate themselves through their drive to meet others' expectations and their seemingly serious-mindedness to solve issues and perform. Periods of severe depressive episodes, chronic anxiety, and somatic complaints are common, and these individuals are typically intropunitive, agitated, angry, and impulsive due to difficulties to maintain their image of perceived respectability and responsibility. Typical pattern is one that is self-destructive and self-deprecating in behavior and attitude, and risk of suicide is chronic.

The various subtypes of BPD are vast and often overlap. This can create confusion. To attenuate this, all subtypes discussed are listed in Table 4.3. The benefit of subtype identification is the inherent examination of the BPD spectrum, as symptom presentation and degree of intrapersonal and interpersonal impact are explored and considered, whether in a research or clinical setting.

The DSM and BPD

Due to the focus on psychoanalytic literature, the term BPD was not included in the first or second edition of the DSM (Paris, 1999). However, similar personality types were identified. In DSM-I (APA, 1952), the "emotionally unstable personality" is tantamount to BPD, which is described as:

> In such cases the individual reacts with excitability and ineffectiveness when confronted by minor stress. His judgment may be undependable under stress, and his relationship to other people is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety.
>
> (p. 34)

This description fits with the emotional lability often seen in those along the BPD spectrum and recognizes the inconsistent responses to stressors, as well as the underlying emotions that drive intensive behavioral reactions.

The DSM-II (APA, 1968), the personality disorder "explosive personality (Epileptoid Personality Disorder)" is listed under Personality Disorder and

Table 4.3 BPD Subtypes

Authors and Year of Publication	*Subtypes Identified*
Bradley et al. (2005)	High-functioning internalizing Histrionic Depressive internalizing Angry externalizing
Conklin et al. (2006)	Internalizing-dysregulated Externalizing-dysregulated Histrionic-impulsive
Digre et al. (2009)	Withdrawn–internalizing Severely disturbed–internalizing Anxious–externalizing
Sleuwaegen et al. (2017)	Low anxiety Inhibited High self-control Emotional disinhibited
Leihener et al. (2003)	Autonomous Independent
Salzer et al. (2013)	Vindictive Moderate submissive Nonassertive Exploitable Socially avoidant
Lenzenweger et al. (2008)	Group 1 Group 2 Group 3
Hallquist and Pilkonis (2012)	Angry-aggressive Angry-mistrustful Poor identity and low anger Prototypical
Millon (2011)	Dissatisfied unstable personality style Unpredictably unstable personality style Impulsive borderline personality type Petulant borderline personality type Discouraged cyclophrenic personality disorder Self-destructive cyclophrenic personality disorder

Certain Other Non-Psychotic Mental Disorders and is comparable to BPD and is described as:

> This behavior pattern is characterized by gross outbursts of rage or of verbal or physical aggressiveness. These outbursts are strikingly

> different from the patient's usual behavior, and he may be regretful and repentant for them. These patients are generally considered excitable, aggressive and over-responsive to environmental pressures. It is the intensity of the outbursts and the individual's inability to control them which distinguishes this group.
>
> (p. 42)

This description acknowledges the vast outpouring of anger and frustration in verbal and physical forms and the ensuing regret following the explosion. The description goes further in paralleling how the field conceptualizes individuals along the BPD spectrum by identifying their tendency to be irascible and excitable, along with their inability to control such behavior derived from emotional vicissitudes.

In the subsequent 12 years leading up to the DSM-III (APA, 1980), research was done to develop criteria for these clinically challenging individuals using their mental status, history, interpersonal relationships, defense mechanisms, and other aspects of personality functioning in addition to research that further isolated characteristics of these individuals; they were often not psychotic, but angry and demanding, and posed difficulties during the interview and treatment process (Grinker et al., 1968; Gunderson & Kolb, 1978; Perry & Klerman, 1978, 1980). These research studies led to the proposed and accepted diagnosis of BPD, which first appeared in the DSM-III (APA, 1980).

In the DSM-III, the eight criteria included impulsivity or unpredictability, unstable and intense interpersonal relationships, inappropriate and intense anger or lack of control of anger, identity disturbance, affective instability, intolerance of being alone, physically self-damaging acts, and chronic feelings of emptiness or boredom. Based upon these criteria, the BPD diagnosis tended to be given to those individuals who were more interpersonally unstable and affectively labile (Adams, Bernat, & Luscher, 2001), but the DSM-III criteria were useful in that it could successfully distinguish BPD from other disorders that were once confused with BPD, such as schizophrenia, affective disorders, and other personality disorders, except histrionic and antisocial (Pope, Jonas, Hudson, Cohen, & Gunderson, 1983).

Using the DSM-III criteria along with the Revised Diagnostic Interview for Borderline Patients (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1990), seven features were found to be particularly robust and specific to BPD irrespective of the control group used or the gender of the BPD individual. These included quasi-psychotic thought (odd thinking/unusual perceptual experiences and non-delusional paranoia), self-mutilation, manipulative suicide efforts, abandonment/engulfment/annihilation concerns, demandingness/entitlement, treatment regressions, and counter transference difficulties (Zanarini et al., 1990). The DSM-III and its revolutionary criteria-based approach opened

new ground for researchers and clinicians, but issues with BPD remained. Particularly, issues included difficulty distinguishing BPD from other mental health issues, such as Histrionic Personality Disorder. To address these limitations, a method for diagnostic efficiency was proposed (Pfohl, Coryell, Zimmerman, & Stangl, 1986). Diagnostic efficiency is a proposed method for weighing diagnostic criteria differently and considering different symptom combinations as well as single symptoms and diagnostic overlap in an advantageous manner to identify true-positives, true-negatives, and false-positives, and false negatives (Meehl & Rosen, 1955; Widiger, Hurt, Frances, Clarkin, & Gilmore, 1984). Using this approach, considerable variation of BPD specific features was found and it was recommended that one feature should not be assessed singly but included within a wider scope that encompasses the other features of this disorder _(Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983). These were not problems only with the DSM-III but continued into the publication of the DSM-III-R (APA, 1987).

The DSM-III and DSM-III-R criteria were lacking due to the failure to include the tendency for those along the BPD spectrum to experience paranoid or dissociative episodes. To remedy this, transient, stress-related paranoid ideation or severe dissociative symptoms were added to the DSM-IV criteria (Sperry, 2003). Even with an additional criterion, presumably to provide greater utility and accuracy for the diagnosis, only moderate support for content validity was found using factor analysis, revealing three domains comprising the criteria set: interpersonal and identity instability, impulsivity, and identity instability (Blais & Norman, 1997). In several studies that examined the diagnostic efficiency of the DSM-IV BPD criteria, it was found that the presence of suicidality or self-injury was the most predictive of BPD two years later, and that affective instability had the greatest negative predictive power for BPD, showing it had the greatest exclusionary utility (i.e., it served as the best rule-out criterion; Grilo, Becker, Anez, & McGlashan, 2004; Grilo et al., 2001, 2007). Additional research examining the DSM-IV criteria of BPD found that criterion nine, transient, stress-related paranoid ideation, or severe dissociative symptoms, had the poorest diagnostic efficiency (Blais, Hilsenroth, & Fowler, 1999). Considering all of the diagnostic issues related to the DSM-IV and BPD, one might believe that major changes were about to occur with the subsequent publication.

In the next edition, the DSM-IV-TR, the only significant change was to the "course" of BPD stating that "contrary to many clinicians' perceived notions, the prognosis for many individuals with Borderline Personality Disorder is good" (APA, 2000, p. 842). Other than this, the criteria remained the same as that in the DSM-IV. In 2013, the DSM-5 was published and BPD was featured in Section II, which housed the original criteria from the DSM-IV, as well as being included in Section III, the Alternative DSM-5 Model for Personality Disorders (APA, 2013).

BPD and the Alternative Model

The conceptualization of BPD within the DSM-5 Section III (APA, 2013) model includes impairment in Identity, Self-direction, Empathy, and Intimacy at a moderate or greater severity, this constitutes Criteria A. For Criteria B, four or more pathological personality traits must be present from the following: emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk taking, and hostility. To qualify for a BPD diagnosis, all facets of personality impairment must also be met under the General Criteria for Personality Disorder in Section III. These include pervasive and stable maladaptive trait expression that begins in adolescence or early adulthood; the maladaptive behavior is not better explained by another medical or mental health condition, such as head injury, schizophrenia, or substance use; and lastly, the maladaptive behavior is not an expected part of the individual's development or sociocultural environment.

Research has found continual support for the identified BPD pathological personality traits and use of the DSM-5 alternative model of personality (Anderson, Snider, Sellbom, Krueger, & Hopwood, 2014; Evans & Simms, 2018; Fowler et al., 2018; Miller, Morse, Nolf, Stepp, & Pilkonis, 2012; Yam & Simms, 2014). Bach, Sellbom, Bo, and Simonsen (2016) sought to determine if the Section III PD model can successfully differentiate those with BPD from "healthy controls" and other individuals with PDs. Results illustrated that the DSM-5 Section III traits of Emotional lability and suspiciousness, and partly depressivity and risk taking reflect core trait features of BPD. Emotional lability and suspiciousness (perceived to be linked to paranoid ideations and sensitivity to harm and mistreatment) were found to be specifically associated with BPD. Depressivity assisted in the distinction between BPD from the healthy controls as it is made up of lower order facets of Guilt and shame, low self-esteem, pessimism, and self-Harm. Risk taking was found to be a unique construct to BPD when compared to other individuals identified as having a PD due to the tendency of those with BPD to engage in dangerous, risky, and self-damaging behaviors. It should be noted that no individuals were identified as having Antisocial Personality Disorder (ASPD) in the non-BPD group, which is associated with the risk taking trait.

Gunderson and colleagues (2018) identified advantages of the DSM-5 alternative model over the categorical, Section II, model: (1) it focuses on the self and interpersonal psychopathological factors that assist in the distinction of BPD from other PDs and mental health conditions and (2) it links BPD trait structures of normal and abnormal personality by combining the boundary components that make up BPD that assist in the distinction of pathological from non-pathological functioning. Although these advantages for changing the definition of BPD are substantial, reasons for moving slowly are also apparent.

Table 4.4 BPD Core Pathological Content

1. Identity	To meet this criterion, the individual's self-esteem and self-conceptualization are limited and poorly constructed and tends to be connected to intense self-criticism, as well as feelings of emptiness along with a high probability to dissociate when under stress.
2. Self-direction	To meet this criterion, the individual has a history of inconsistency in goals, aspirations, values, and career plans.
3. Empathy	To meet this criterion, the individual's ability to perceive or acknowledge the emotions and rights of others is impaired and linked to the tendency to feel slighted, insulted, or rejected very easily, as well as the tendency to see others in a negative light with the perceived intent to be harmed.
4. Intimacy	To meet this criterion, the individual's relationships are composed of intense tumult due to mistrust, dependency, and anxiety associated with fixations on real or imagined abandonment, along with the tendency to see those the individual is in relationships with as a hero (idealized) or a zero (devalued) and to be intensely involved or physically and emotionally removed from those close relationships.

The DSM-5 (APA, 2013) alternative model conceptualizes the pathology of BPD within the core content elements of personality that impacts the self and interpersonal functioning. These are listed in Table 4.4. To meet criteria for BPD, the individual must first be found to possess impairments in two or more of the four areas identified (Identity, Self-direction, Empathy, and Intimacy) within Criterion A to a severity level of moderate or greater.

Criterion B identifies seven trait facets (Emotional lability, Anxiousness, Separation insecurity, Depressivity, Impulsivity, Risk taking, and Hostility) from three trait domains: Negative Affectivity, Disinhibition, and Antagonism. The individual must have four or more of the seven pathological personality traits. BPD is the only personality disorder within the alternative model that pulls from three trait domains; for example, Antisocial Personality Disorder pulls from two trait domains – Disinhibition and Antagonism, and Narcissistic Personality Disorder pulls from only one trait domain – Antagonism. In addition, to qualify for BPD, the individual must exhibit one or more of the following traits: Impulsivity, Risk taking, or Hostility. The identified pathological personality traits for Criterion B for BPD are listed in Table 4.5.

The use and application of the DSM-5 alternative model and BPD is illustrated in The Case of Vicki below. Following the case study will be a breakdown of Criteria A and B and how it relates to this specific case.

Table 4.5 BPD Surface Content (Pathological Personality Traits)

1. Emotional lability	To meet this criterion, the individual must often experience emotional instability and mood fluctuations, as well as being prone to emotionally intense and disproportionate responses to events and circumstances.
2. Anxiousness	To meet this criterion, the individual must frequently experience extreme uneasiness, tension, or panic to relational stress, as well as grave concern regarding the negative impact of past adverse experiences and intense fear of additional harmful occurrences in the future. The individual also tends to experience vigorous distress regarding the possibility of having an irreparable emotional breakdown and complete loss of control.
3. Separation insecurity	To meet this criterion, the individual must house intense rejection or detachment from identified significant others intertwined with trepidation of exorbitant dependency and absolute loss of autonomy.
4. Depressivity	To meet this criterion, the individual must experience sadness, misery, and/or hopelessness often, while having difficulty recovering from these mood states, as well as intense negativity about the future, inescapable shame, inferiority, and suicidal ideation or attempts.
5. Impulsivity	To meet this criterion, the individual must have a history of capricious behavior subsequent to an unexpected provocation without consideration of the consequences and little to no planning and execution of how to manage it. The individual also tends to possess an intense drive to inflict self-harm when experiencing emotional agony.
6. Risk taking	To meet this criterion, the individual must participate in nonessential high-risk, hazardous, and likely self-damaging activities without consideration of the consequences, as well as refutation and disregard for the personal danger involved.
7. Hostility	To meet this criterion, the individual must harbor intense feelings of outrage and respond with fury and rage to minor insults and perceived disrespect.

The Case of Vicki

Vicki is a 24-year-old female with serial unemployment due to difficulty getting along with her bosses and co-workers as she feels they are "out to get me, prevent me from succeeding, and they all hate me." Vicki was fired from her last job at a coffee shop because she stopped showing up because she knew her boss was just waiting to fire her and that no one there liked her. She based this on an instance where she incorrectly made a coffee for a customer, and the customer brought it back to the counter and asked a co-worker (who was standing closer to the customer at the time) to make it again. Following this incident, Vicki became so distraught she walked away from the "coffee line" (where beverages are made), went into the restroom, cried profusely, began slapping her face, and had a panic attack. She stayed in the restroom for 20 minutes, until a co-worker talked to her through the door, helped her calm down, and asked her to come out, which she did. Her boss then asked her if she needed help, which she scoffed at and abruptly left and went home knowing she would be fired at any minute.

Vicki has a long history of changing her opinions, clothing, viewpoints, and goals to please others around her and to feel like she fits in, but she continually feels "out of place" and alone if not in a relationship. Due to this, she condemns herself for not being likeable. Her mother would often rebuke her saying, "You change your mind more than you change your socks." This was usually followed by a long list of mistakes, errors, and reasons why "no man is gonna love you." Vicki often feels alone and disconnected, even when she is with others. When asked how she feels, she will often say she is "a hole that cannot be filled." She has been involuntarily committed three times following suicide attempts and arrested two times for assault and domestic violence. Vicki is often highly agitated and easily provoked. When asked about her anger, she says "I am brimming with rage that if it ever got out, I'd lose my mind and probably kill myself."

Vicki has been dating Ron for nine months. When they first met, she felt that she had found her soulmate, the one that would give her all the answers and finally make her feel "whole." She wanted to spend every moment with Ron. Ron worked full-time at a car dealership, and Vicki would wait for him out front to have a break or bring him lunch every day. She neglected her own job to make sure she was there for Ron but also to make sure he did not run off and leave her. Due to this continual fear, she would drive by the dealership multiple times per day to try and see him, and to see if he was talking with other women. She would text and try to FaceTime him multiple times during the day. When he did not respond immediately, she would get in her car and drive by the dealership, or try to watch him from across the street because she knew he was cheating on her; though she had no actual evidence. When Vicki would ask him why he did not answer her calls and texts, he would say it is because he is working and cannot

always answer the phone if he is working with a customer. Vicki began screaming at him, calling him a liar, and demanding to know who the woman at work was that he had fallen in love with. Vicki continued to accuse Ron over the next several weeks and he eventually ended their relationship, which led her to stop eating, staying in her room all day for several days, and eventually cutting her legs. She ended up being admitted to an in-patient facility.

Vicki qualifies for all four Criterion A elements of BPD: *Identity*, *Self-direction*, *Empathy*, and *Intimacy*. She meets the *Identity* criterion as she possess an unstable self-image as she tends to change her opinions, clothing, viewpoints, and goals to please others around her to try to feel like she fits in, condemns herself for not being a better fit for others to like her, and she experiences chronic feelings of emptiness. She meets the *Self-direction* criterion as she has multiple goals and is inconsistent in her aspirations, values, and career goals. The *Empathy* criterion is met as she perceives others as selectively biased towards her, such as in the coffee shop with the customer, her co-worker, and her boss. She failed to consider the position her behavior put her co-worker and boss in, who are trying to tend to customers, when she abruptly went into the restroom and they had to stop and check on her due to her being in the restroom for 20 minutes crying, hitting herself, and having a panic attack. Additionally, she fails to consider how Ron feels having his significant other constantly call him at work, accuse him of infidelity, and scream and yell at him. The *Intimacy* criterion is met as she tends to believe that Ron is going to leave her and that he is being unfaithful due to his failure to immediately respond to texts and FaceTime calls, though she has no actual proof other than her *knowing* he is cheating on her.

Vicki qualifies for most of the Criterion B pathological traits of BPD as she meets criteria for *Emotional lability*, *Anxiousness*, *Separation insecurity*, *Depressivity*, *Impulsivity*, and *Hostility*. Vicki does not meet criteria for *Risk taking*. The *Emotional lability* criterion is met as she runs into the restroom crying, slapped her face, and worked herself up into a panic attack when the customer asks someone else to make the correct coffee. The *Anxiousness* criterion is met when Vicki becomes so anxious over the coffee episode and runs into the restroom, she is highly anxious about Ron talking with other women and needs to see and know what he is doing at all times, and she is highly anxious about Ron leaving her which fits with her mother's statement that a man is not going to love because of her issues. The *Separation insecurity* criterion is met when she is consumed by fear of rejection related to Ron leaving her, cheating on her, talking to other women, as well as the belief that he is her soulmate and that he will provide all of her answers, and the intense belief that he will make her "whole," and cure her emptiness. The *Depressivity* criterion is met as she often feels alone if not in a relationship, she has depressive episodes when relationships end, feelings of inferiority as other prevent her from succeeding, feels alone and disconnected even when she is with others, and she often says she is "a hole that cannot be filled." In addition, Vicki

has made multiple suicide attempts and has had four in-patient admissions related to these attempts. The *Impulsivity* criterion is met when she becomes so distraught she goes into the bathroom for 20 minutes crying and is upset, she texts and FaceTime calls Ron continually, and she drives by his work to check on him. The *Hostility* criterion is met when Vicki scoffs at her bosses attempt to assess how she is doing and help her, she is often highly agitated and easily provoked, described her anger by saying, "I am brimming with rage that if it ever got out I'd lose my mind and probably kill myself," she has been arrested two times for assault and domestic violence, and interacts with Ron in a very angry and hostile manner about his believed infidelity and their relationship.

Using the DSM-5 alternative model, researchers and clinicians can identify Vicki as meeting criteria for BPD, but this provides only a fraction of the depth and complexity of this disorder. The Cognitive-Affective Processing System (CAPS) model assists to further the understanding of the structure, function, expression, and possible treatment approaches that could be utilized in regard to those along the BPD spectrum.

BPD and the CAPS Model

Valuable data can be derived using the CAPS model in conjunction with the DSM-5 alternative model to assist researchers and clinicians in studying and working with individuals along the BPD spectrum. The CAPS model provides a framework to recognize the process from initial presence and impact of stressors, to the activation of BPD core content elements identified in the DSM-5 alternative model, that work concurrently with the Cognitive-Affective Units (CAUs) within the CAPS model, which results in the surface structure expression of BPD pathological personality traits and facets. Figure 4.2 illustrates the merging of BPD and the CAPS model.

Stressors tend to fall within one or more of the following categories: time-limited, environmental, blended, continuous, and historical (Fox, 2019) and tend to be unique in the degree of impact to the individual as they relate to personality make-up or type of personality disorder (Eaton et al., 2009). Individuals along the BPD spectrum have been found to be particularly vigilant and sensitive to stressors of perceived rejection, abandonment, disagreement with another of high perceived value (i.e., romantic partner, boss/teacher, friend, etc.), and interpersonal situations that depict possible threat to one's survival, such as a possible intruder in the home, being trapped in a situation, and the approach of a threatening figure (Berenson, Downey, Rafaeli, Coifman, & Leventhal Paquin, 2011; Berenson et al., 2016; Coifman, Berenson, Rafaeli, & Downey, 2012; Hepp, Lane, Wycoff, Carpenter, & Trull, 2018; Limberg, Barnow, Freyberger, & Hamm, 2011; Sauer, Arens, Stopsack, Spitzer, & Barnow, 2014). Linehan (1993) identified several

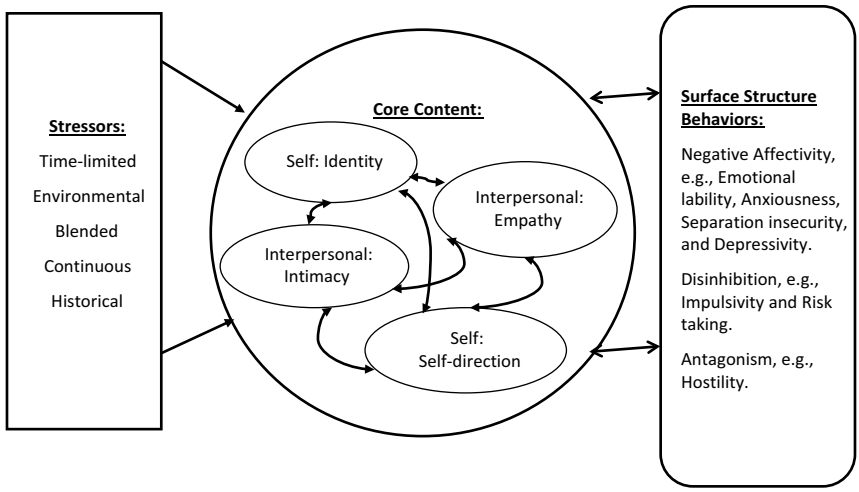

Figure 4.2 The merging of BPD and the CAPS model.

areas of specific stressors for those with BPD in her theory, these include: social isolation, problematic peer relationships, poor individuation from parent, and invalidation of emotions.

Chaudhury and colleagues (2017) examined the changes in affect in individuals with BPD using Ecological Momentary Assessment (EMA) in response to specific stressors and coping strategies. They found that painful reminders of something from the past was identified as a particularly intensive daily stressor and that frequent stressors often included feeling neglected and facing an interpersonal disappointment. The authors surmised that "the frequency of daily stressors suggests that individuals with BPD, with or without concurrent depression, face substantial pain and distress in their everyday lives" (p. 7). Lastly, this study identified coping strategies that were often employed by those with BPD to include keeping busy, finding perspective, and positive thinking, which can assist in treatment guidelines and approaches to working with those along the BPD spectrum that will be discussed later in this chapter.

One, several or all stressors mentioned previously fall into multiple stressor categories identified in Figure 4.2. Once these stressors are encountered, the individual's CAUs associated with the BPD spectrum individual's core content is activated. These include those aspects of identity, self-direction, empathy, and intimacy that are specific to those along the BPD spectrum.

Once the CAUs are activated, they interact within an interrelated network with core content elements of personality functioning in a unique manner specific to BPD. The core personality psychopathological content of BPD from the DSM-5 alternative model and the related CAUs are listed in Table 4.6. Keywords are used

Table 4.6 BPD and CAUs

Elements of Personality Functioning	*Cognitive-Affective Units*				
	Encodings	*Expectations and Beliefs*	*Affects*	*Goals and Values*	*Competencies and Self-Regulatory Plans*
Self: Identity Poorly developed and variable self-image paired with self-condemnation	X	X	X	X	X
Self: Identity Chronic feelings of emptiness	X	X	X		X
Self: Identity When under high stress may dissociate	X		X		
Self: Self-direction Variable goals, hopes, morals, or career plans	X	X		X	X
Interpersonal: Empathy Recognition of needs or feelings of others is impaired due to being overly sensitive	X	X	X		
Interpersonal: Empathy See others as biased towards the self because of perceived weaknesses or flaws	X	X	X		
Interpersonal: Intimacy Conflicted relationships due to mistrust, dependency, and anxiety related to abandonment	X	X	X	X	X
Interpersonal: Intimacy Tendency to perceive significant others as a hero and savior or a zero and a villain	X	X	X	X	X

to represent each component of BPD in the table, to see the unabbreviated description consult the DSM-5, Section III, Criterion A (APA, 2013, p. 764).

Particular elements have a stronger relationship to some CAUs than others for those along the BPD spectrum. *Encodings*, *Expectations and Beliefs*, and *Affects* have the strongest relationship to the DSM-5 alternative model Criterion A elements of personality functioning. These three CAU categories relate to the individual along the BPD spectrum in the manner in which one views the self, others, events, and situations within an internal and external context but also considers the presumption or conjecture by which they operate, as well as the beliefs about the world in which they function, or experience and react with dysfunction, and the intensity in which they experience affective states. This result is supported by previous research that has illustrated that those along the borderline spectrum have significantly lower levels of emotional awareness, less capacity to manage variable emotional states, impaired accuracy at recognizing facial expressions of emotion, and more intense responses to negative emotions (Carpenter & Trull, 2013; Linehan, 1993; Schmahl et al., 2014; Selby & Joiner, 2009; Unoka, Fogd, Füzy, & Csukly, 2011). As individuals along the BPD spectrum are often driven by emotions associated with the perception of harm from the outside world, it is not surprising to see that the CAUs are grounded in affect and perception of self, other, events, and situations. Schema therapy and modes also helps to explain this finding. Young and colleagues (2003) identified five central modes (a mode is a temporary mindset that includes both your present emotional state and how you are managing it) related to borderline personality dysfunction that explains the greater emphasis and impact of encoding, expectations and beliefs, and affects that determine how these individuals see and interact with the world due to their CAUs. These modes include (1) abandoned and abused child, (2) angry and impulsive child, (3) the detached protector, (4) the punitive parent, and the missing component of (5) the healthy adult. Each of these modes impacts the individual in adverse ways, producing disrupted perceptions of other, events, and situations, as well as the self.

The CAUs with the least influence includes *Goals and Values* and *Competencies and Self-regulatory Plans*, as seen in Table 4.6. This fits with the conceptualization of BPD that goals and values and behavioral scripts and plans would have less of an influence than those more strongly associated with affective states, expectancies, and how one sees self and the world. Inherent in those along the BPD spectrum is the tendency to have impaired problem-solving ability, particularly when it relates to interpersonal situations, which has been attributed to poor emotional regulation (Kremers, Spinhoven, Van der Does, & Van Dyck, 2006). As this finding illustrates, emotional dysregulation and poor self-regulation strategies are primary sources of impairment that adversely impact perception that precedes goal and value construction and plans, as well as strategies for organizing actions to affect outcomes, behaviors, and internal states.

The final sequence in the CAPS model process is the surface structure expression of the pathological personality traits and facets, which for BPD includes emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk taking, and hostility. The behavioral expression often seen in an individual along the BPD spectrum can be best explained using the *if… then…* profile. This provides understanding into the pattern of situational responses specific to that individual's distinctive profile of behaviors when core content is triggered by stressors. This makes it possible to predict, with increased reliability, the BPD spectrum individual's behavior across situations.

For example, an individual along the BPD spectrum experiences multiple continuous stressors that include difficulty maintaining employment, financial difficulty, and relationship stress. The combination of these stressors is a continual taxing of resources, which when drained make it difficult to utilize adaptive and healthy coping strategies and driving the individual to engage in default maladaptive behaviors. These maladaptive behaviors include acting out aggressively, isolation, self-harm, and increased alcohol consumption. Initially, it appears that this individual responds in a precarious manner due to the most obvious stressor, the relationship tumult, but when this is put into an *if… then…* profile, the individual's behavior becomes more predictable. *If* the BPD spectrum individual experiences serial unemployment, *then* financial stress, and *if* that causes a heightened sense of vulnerability and fear (Anxiousness), the individual is *then* likely to respond to others, their significant other in this case, with screaming, yelling, and perhaps physical violence (Impulsivity and Hostility) that drives that individual to either permanently or temporarily end the relationship fulfilling a continual fear (Separation insecurity). *If* the relationship is in flux, the individual *then* engages in isolation (Depressivity), which *if* it reaches a particular degree, leads to self-harm behaviors (i.e., cutting or head banging) and increased alcohol consumption (Risk taking). In this example, the *if… then…* profile has multiple layers leading to a longer sequence from initial incident to response behavior. It is unlikely that this individual would utilize new maladaptive, or other, response patterns but remain behaviorally consistent, as this is often seen in most individuals due to perception of seeing most situations in a similar framework (Sherman, Nave, & Funder, 2010). This supports the presumption of the *if… then…* sequence that behavioral response is highly characteristic of an individual, which adds to the applicability of the CAPS model theory (Shoda & LeeTiernan, 2002; Shoda, LeeTiernan, & Mischel, 2002; Shoda, Mischel, & Wright, 1994) of stability and predictability in human behavior. The *if… then…* sequence is listed in Figure 4.3.

Based upon the CAPS model, it is the combination of the presence of the stressor, or in this case stressors, which activates core content personality elements that place the individual along the BPD spectrum while working in concert with the cognitions and affects that make up the individual's CAUs. This leads to the expression of surface structure personality traits creating the predictable and stable

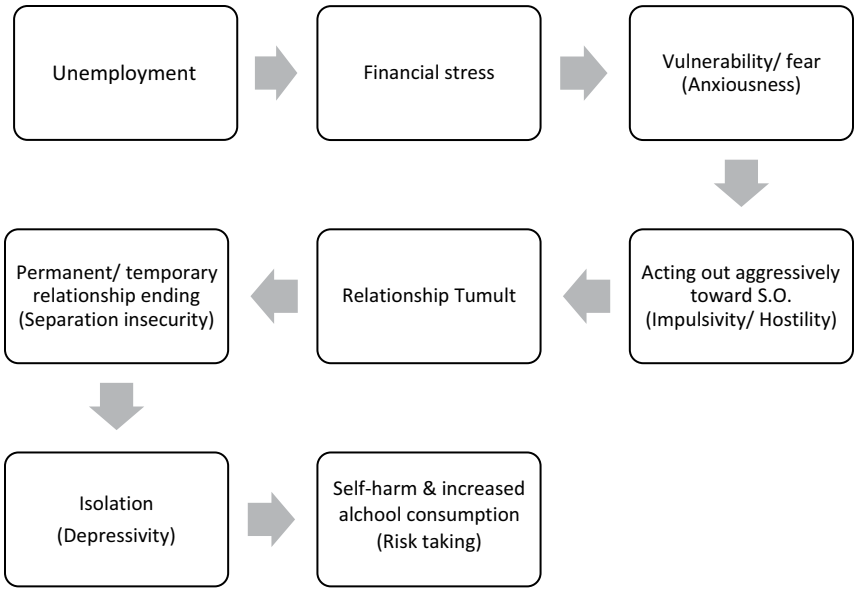

Figure 4.3 BPD *if… then…* profile.

if… then… sequence response to the stressor (Borkenau et al., 2006; English & Chen, 2007; Mendoza-Denton & Mischel, 2007; Mischel & Shoda, 1995, 2008).

Pathology Perpetuation

The interpersonal system in which all individuals exist is designed to support their beliefs, perceptions, and behavioral expressions. This system is composed of, and maintained by, the self-system proposed by Harry Stack Sullivan (1953a, b). Though this approach is not specific to BPD, it fits very well as an explanatory framework for pathology perpetuation. The self-system is a collection of the self-perceptions that work to protect the individual from information that would cause anxiety or dissonance leading to a reevaluation of those original self-perceptions. Sullivan postulated that anxiety (or dissonance) is the product of interpersonal relations, originally formulated from the relationship between the caretaker and the infant that manifests later in life by threats to one's perceptions and security. To avoid or minimize actual or potential anxiety or dissonance, the individual adopts varying degrees of protective measures and supervisory controls over their behavior. One learns, for example, that one can evade punishment by conforming to their caregivers' wishes. Another example would be that the individual

learns to draw love and concern, a lessening of anxiety and dissonance, when they relinquish their autonomy and accept the misery and sickness given to them by their caregivers (see Benjamin, 1996 for a more detailed explanation of this BPD origin process). These strategies are specific to the individual and form the self-system that perpetuates certain forms of beliefs, behaviors, and patterns (i.e., "I'm worthless," engaging in self-harm, and frequent impulsive and destructive behavior in response to perceived abandonment) while also forbidding other forms (i.e., "I have value," engaging in self-care, and practicing mindfulness in times of stress) seen in those who possess personality disorders or pathological personality traits.

The self-system is also designed to exclude information that is incompatible with the present organization of the self, and it resists and fails to recognize rewards from alternative experiences. As the individual develops and the self-system grows in complexity and independence, it distorts the making of balanced judgments of one's own beliefs, behaviors, and patterns and glosses over clear contradictions between the "real" person and the self-system's conceptualization. As the individual encounters more instances of anxiety and dissonance, the more influential their self-system becomes and the more disconnected it ends up being from other aspects of that individual's personality. This results in the creation of a more comprehensive picture that substantiates the self-system's characterization of the individual that meets the conceptualization of the self and the world in which the individual exists. Sullivan's self-system, the CAPS model, and the DSM-5 alternative model provide a framework for understanding the perpetuation of BPD spectrum pathology.

Research on individuals along the BPD spectrum has indirectly substantiated Sullivan's self-system. Those along the BPD spectrum have a disparate perception of self as compared to their actual self (Arntz et al., 2003; Parker, Boldero, & Bell, 2006; Vater, Schröder-Abé, Schütz, Lammers, & Roepke, 2010; Winter, Bohus, & Lis, 2017). When compared to "healthy controls," individuals with BPD were more likely to ascribe undesirable self-relevant feedback and tended to rate themselves less favorably (Korn, La Rosée, Heekeren, & Roepke, 2016). This tendency towards negative self-description and assessment coincides with other research that illustrates that those along the BPD spectrum are likely to possess a negative self-evaluation bias (Miller, 1994; Rüsch et al., 2007, 2011; Winter et al., 2015). These findings support Sullivan's claims that accepting new, perhaps better balanced, information would cause an increase in anxiety or dissonance, and to avoid this, the BPD spectrum individual resists evidence that is contrary to the conceptualization of the self and gravitates toward information and individuals who substantiate the originally held negative view of self.

The self-system is further supported by the interpersonal circle, as those that make up the individual's circle support, directly or indirectly, the individual's psychopathology by not only being within the circle, but by not self-selecting out of it either, as "healthy others" tend to do. Over time, the individual may seemingly

attempt, usually unsuccessfully, to create an interpersonal circle that lessens anxiety and dissonance, but due to the pathological aspect of the self, this system ends up actually promoting BPD pathology. Components associated with interpersonal disruption include impulsiveness, emotion dysregulation, hypermentalization (a social-cognitive process of mentalizing errors that occur through the overinterpretation or overattribution of intentions or mental states to others), reduced inhibitory control, threat sensitivity, rejection sensitivity, and disagreement, sadness, and hostility (Bertsch et al., 2017; Dixon-Gordon, Gratz, Breetz, & Tull, 2013; Euler et al., 2019; Hepp et al., 2017; Sharp et al., 2013). These factors continue to play out between the BPD spectrum individual and those within the interpersonal circle leading to the continuation of BPD pathology. The self-system and the BPD spectrum are described in the section "The Case of Billy."

The Case of Billy

Billy is a 26-year-old male who recently moved back in with his mother after completing an intensive treatment program designed to help those with BPD. Billy's father left the family when Billy was 5 years old and had not been seen or heard from since. Billy's mom often brought this up to him, blaming him for his father leaving. Billy's mom was often neglectful of him and put her wants and needs before his. When Billy went out for Little League, his mom refused to bring him because the times were inconvenient, so he would get rides from friends' parents or teachers. One day while a teacher was taking him to Little League, the teacher sexually assaulted him and told him to not tell anyone as no one would believe "a broken kid like you." Billy did tell his mom, who refused to believe him, and then when he showed her the bruises and marks, she said he probably asked for it and refused to report the assault. Throughout Billy's development, he was often told he would not amount to anything and whenever he would get hurt or cry, or show any negative emotion, he would be punished and ridiculed for not "being a man."

Billy has had multiple relationships throughout adolescence and into young adulthood, and each relationship was tumultuous, with him in a dependency role, fearing the loss of his significant other, or "soulmate." He would do anything he could to please them, assume their needs, continually call and text them, and would vacillate between extreme nervousness, tension, and panic to feeling down, hopeless, and pessimistic when the relationship did not meet his expectations. Billy's most recent relationship was with Sandra, with whom he moved in after knowing her for three weeks, as he felt she was his soulmate. He felt connected to her in a unique way; though he tends to say this about all of his previous partners. Shortly after moving in together, Sandra would sometimes not be seen or heard from for days at a time. When she was home, she would receive multiple calls from

other men and when Billy would ask about them, she would rebuke him and tell him how little of a man he was and how he was not up to satisfying her, so she had to look elsewhere. This would drive Billy to try even harder to please her. When Billy would get angry with her, he would yell, scream, and punch himself. Their arguments would end in physical confrontations, with Sandra calling the police and Billy being charged with domestic violence, and his mother having to bail him out of jail several times.

Billy has few friends and a limited social circle. His closest friend is Tyler, who borrows money from him often and has been known to not respond or ignore him when a better opportunity arises. Billy is often trying to please Tyler and be his "best friend," but Tyler gets frustrated with Billy easily because Billy is "moody" and intense in his reactions, and will sometimes want to do "crazy stuff, like drive fast on the highway and close his eyes to try and be funny." When Billy cannot reach Tyler or Sandra he feels "like a hole that is endless and can never be filled."

While in college, Billy met Margaret and felt that she was his soulmate. She was kind and attentive to him and would listen to his stories about his upbringing and his mom and feeling lonely due to not knowing his dad. Margaret would encourage Billy to try new things, healthy things, to help him feel good about himself. Billy would text and call her repeatedly throughout the day and night. When she attempted to explain that the texting and calling was excessive but time with him was important, and that time with her friends was also important. Billy took this as a sign she was manipulating him, not seeing him as important, and that she was just waiting to one day abandon him and break his heart, and that she was going to cheat him out of a happy life. During the discussion, Billy became enraged, threatened to harm her, and she left and told him never to contact her again. Billy interpreted this to mean that she never loved him to begin with and that she was going to abandon him someday anyway, so good riddance. After this break-up, Billy went into a deep depression and sought treatment for the first time.

Billy had been in and out of treatment since college. He had been given multiple diagnoses and prescribed a wide variety of medications, but none seemed to attenuate his anxiety, depression, emptiness, abandonment, or impulsive behaviors. Before Billy returned home, he completed an intensive treatment program for individuals with BPD. After completion of the program, Billy moved in with his mother so he could save some money and try to start over. He was using strategies to control his behavior, building his sense of self, discovering his likes and wants, and believing that he had value and was worthy of being treated with respect. Although he felt awkward and uncomfortable (dissonance) about these new beliefs, behaviors, and patterns, he was determined to help himself.

Having nowhere else to go, Billy moved back in with his mom. She would berate him and make fun of him for being so weak he had to have someone else help him. After weeks of this, Billy sought help from Tyler who agreed to meet

with him to talk about his troubles but never showed up, and then Billy contacted Sandra who was warm and loving, what he always wanted, but after spending a few days with her, she returned to receiving calls from other men, intermittently disappearing, and berating him. Eventually this lead to Billy experiencing a resurgence of emptiness and abandonment which led to his anxiety, depression, and impulsive behaviors. Although he was feeling worse than when he initially finished treatment, he would say that "I feel like my old self again" and had returned to eagerly trying to please Tyler and Sandra, and his other maladaptive patterns. Having done this, Billy's dissonance subsided although he was back to his old unhealthy patterns and ways of meeting his expectations and of those within his interpersonal circle.

The Case of Billy illustrates how the self-system is central to the perpetuation of BPD spectrum core content elements and surface structure behaviors. Billy's early experiences shaped his core content and built his perceptions of self which assisted in populating his interpersonal circle with those who either directly or indirectly perpetuated his BPD pathology. When confronted with alternative information and individuals, such as the treatment program and Margaret, he is initially receptive but he experiences anxiety and dissonance that drives him to go back to his maladaptive behaviors, which causes him to "feels like [his] old self again," lessening the anxiety and dissonance he experienced doing things differently.

Biopsychosocial Model and BPD

The interaction of biological, psychological, and social factors provides a vantage point to gain greater understanding into the components that lead to the development and expression of various personality disorders, including BPD. Personality disorders are not simply the manifestation of biological components and responses to external risk factors but exist within a system of psychological and social influences that impact the individual who is at risk to display maladaptive traits that are consistent with what is identified as a personality disorders (Paris, 1993). No single specific trajectory or component has been identified to account for the culmination of behaviors and traits that make up BPD. Individuals along the BPD spectrum have been found to be influenced by parental style, parental mental illness, trauma, abuse, and neglect (Davis, 1997; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Macfie, 2009; Paris, 1994; Zanarini et al., 2002). Due to the lack of a singular BPD antecedent, it stands to reason that it is the interaction between biological (e.g., genetic) and psychosocial factors (e.g., abuse), which provides the most comprehensive explanation for the development of BPD.

The biosocial theory postulated by Linehan (1993) proposes that BPD is a disorder of emotional dysregulation that manifests when interpersonal interactions coincide with biological vulnerabilities within specific environments. This

emotional dysregulation results when the BPD spectrum individual experiences heightened emotional sensitivity, an inability to self-regulate strong emotional urges to respond, and a slow return to emotional baseline. This impaired emotional responding is due to a complex interplay between emotion-linked cognitive processes, biochemical and physiological intrapersonal components, facial and muscle reactions, action urges, and emotion-linked actions. The specific environment that Linehan identifies is the invalidating environment. This environment consists of inaccuracy (parent contradicts the child's emotional state), misattribution (parent ascribes the cause of the child's unacceptable emotions as invalid and inappropriate), discourages negative emotions (child learns to make few demands for help or support from the parent or environment, instead learning extreme self-reliance), and oversimplification (child's problems are minimized and can simply be solved by trying harder). Linehan's theory sets the stage of understanding the multiple routes, influences, and underlying components that when combined manifest into BPD.

Research has shown through family studies that first-degree proband relatives of individuals along the BPD spectrum are 10 times more likely to have been treated for BPD and Major Depressive Disorder than first-degree proband relatives of those with schizophrenia (Loranger, Oldham, & Tulis, 1982). More recent studies support a genetic component associated with BPD with heritability being between .40 and .60 (Torgersen et al., 2000, 2008). Individuals with BPD have been found to also have neurological identifiers, such as reduced volume in the amygdala and hippocampus (Schmahl, Vermetten, Elzinga, & Bremner, 2003; Weniger, Lange, Sachsse, & Irle, 2008). A significant frontal and prefrontal hypermetabolism in patients with BPD when compared to "healthy" controls was found using PET scans, illustrating a fronto-limbic dysfunction (Juengling et al., 2003; Salavert et al., 2011). Exploring the fronto-limbic dysfunction further, studies have shown that those individuals with BPD display alterations in fronto-limbic activity to the processing of fear stimuli, which is identified in increased amygdala response and weakened emotion-modulation of anterior cingulate cortex activity (Holtmann et al., 2013; Minzenberg, Fan, New, Tang, & Siever, 2007). These findings illustrate support for the contention that individuals along the BPD spectrum have a fronto-limbic dysfunction, but biological underpinnings are only a part of the biopsychosocial model.

Multiple psychological and social factors have been identified that contribute to the manifestation and severity of BPD core and surface content. Physical, sexual, and emotional abuse, and physical and emotional neglect have been found to be psychosocial antecedents to BPD core and surface structure content (see Carr, Martins, Stingel, Lemgruber, & Juruena, 2013 for more information). Zanarini and colleagues (2010) explored the course of psychosocial functioning in individuals along the BPD spectrum. Results illustrated that individuals with BPD are challenged to attain and maintain good psychosocial functioning, which

was defined as having at least one relationship with weekly contact, no elements of abuse or neglect, and were considered to be close by the patient, as well as performing well vocationally, being vocationally involved full-time, and able to sustain performance for at least 50% of the time at school or work. Vocational functioning was particularly challenging for these individuals over the 10-year study, when compared to social functioning.

It has been proposed that the psychosocial functioning of those along the BPD spectrum is chronically impaired (Skodol et al., 2005), but more recent studies have found that remission of BPD symptoms was not a critical factor for good interpersonal or vocational functioning; instead an anxiety disorder, Major Depressive Disorder, or a Substance Use Disorder was predictive of poor psychosocial functioning (Soloff & Chiappetta, 2018). These conflicting results may be due to looking at surface structure components only, such as anxiety, emotional lability, depression, substance use, etc. and neglecting to look at core content. A study that examined a common core content issue for those along the BPD spectrum – emptiness – found this component to be associated with dysfunctional behaviors, impulsivity and self-harm, and poor psychosocial improvement (Miller, Lewis, Huxley, Townsend, & Grenyer, 2018). This finding and those discussed previously provide support for the biopsychosocial perspective of BPD as a more comprehensive approach to the understanding of this complex disorder.

The combination of the biopsychosocial, CAPS and DSM-5 alternative models enhances the understanding of those individuals along the BPD spectrum. The grouping of these models considers the biological, psychological, and social components but adds a new lens that focuses on the personality elements and traits involved in how these individuals perceive, process, comprehend, and act and react to not only core issues that have biopsychosocial aspects, but their surface structure expressions are well.

Several stressors have been identified that are of particular relevance to those along the BPD spectrum, such as perceived rejection, abandonment, disagreement with another of high perceived value (i.e., romantic partner, boss/teacher, friend, etc.), social isolation, problematic peers relationships, invalidation of emotions, and interpersonal situations of perceived threat (Berenson et al., 2011; Berenson et al., 2016; Coifman et al., 2012; Hepp et al., 2018; Limberg et al., 2011; Linehan, 1993; Sauer et al., 2014). When an individual along the BPD spectrum encounters one of these identified stressors, their fronto-limbic system is engaged that influences the CAUs, activating the interrelated network with core content elements of personality functioning in a unique manner specific to BPD. This central activation drives surface structure behaviors of emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk taking, and/or hostility. This complex process fits with the interdisciplinary framework proposed by Engel (1977, 1980) and expanded on by Paris (1993) that there are multiple etiologies and influences that cause the expression of BPD and other personality disorders.

Online Behavior and BPD Personality Expression

As discussed previously, online behaviors and interaction patterns are consistent with individuals' personality make-up, and BPD is not obviated from this. The internet provides an environment composed of stimuli and stressors that ignite core content driving surface structure behavior. This sequence is concordant with the CAPS and Alternative DSM-5 models discussed.

There is a limited body of research into the use and misuse of the internet and social networking sites and BPD. Studies have found a relationship between internet addiction and impulsivity (Cao, Su, Liu, & Gao, 2007; Dalbudak et al., 2013b; Mazhari, 2012), unstable interpersonal relationships (Ko, Yen, Yen, Lin, & Yang, 2007; Milani, Osualdella, & Di Blasio, 2009), and personality characteristics that resemble those individuals along the BPD spectrum. These include greater difficulty in identifying and describing feelings, possessing and displaying a high degree of hostility, irritability, aggressiveness, indecisiveness, and obsessive-compulsive traits, as well as depressive and anxious symptoms, novelty seeking, less emotional stability, and the exhibition of impaired self-directedness and a low degree of cooperation (Dalbudak et al., 2013a; Yang, Choe, Baity, Lee, & Cho, 2005). In a sample of those with various mental health disorders and internet addiction, BPD was found in 14% of the sample, commensurate with ADHD, but behind only generalized anxiety disorder and social anxiety, which was 15% (Bernardi & Pallanti, 2009).

Those with severe BPD symptoms, and disturbed and unconsolidated identity as well as a lack of identity tended to have a higher occurrence of internet addiction, significant depression, and suicidality at one-year follow-up (Chen, Hsiao, Liu, & Yen, 2019). Beyond addiction to the internet, those along the BPD spectrum attempt to meet their needs in other ways online. For those along the BPD spectrum, the internet has been linked to tension reduction and disinhibition, and is often seen as a coping resource for negative emotions, such as depression (Wu, Ko, Tung, & Li, 2016). Although seen as a haven of assistance and support, internet addiction was also found to occur most often in those with BPD, followed by narcissistic and antisocial personality disorders (Black, Belsare, & Schlosser, 1999). This was substantiated by the finding that out of 556 students with Internet addiction, there was significantly higher frequency of those with borderline, narcissistic, avoidant, and dependent personality disorder features (Wu et al., 2016). When broken down by gender and internet addiction in this same study, males tended to show a higher frequency of narcissistic personality disorder features, and females tended to show a higher degree of BPD features.

Interpersonal relationships are central and critical to those along the BPD spectrum, and the internet provides fertile ground for attempting to meet this need but also mimics the tumult often seen in their "in-person" relationships. Individuals with BPD were found to have significantly more ex-romantic partners

in their social networks and were more likely to cease contact with 33% of those within their social network in the past year, compared to 9% of those without an identified personality disorder (Clifton, Pilkonis, & McCarty, 2007), illustrating the ephemeral and unbalanced nature of their relationships. Moreau, Laconi, Defour, and Chabrol (2015) examined problematic Facebook use in those they labeled the "borderline" group (those that scored above the mean on borderline traits, depressive symptoms, social anxiety, and sensation seeking) and found that these individuals showed more problematic Facebook use, and that social anxiety and depressive symptoms appeared to play a particularly strong role. In a study composed of "internet users," individuals with "borderline-specific cognitions" tended to use online chats, instant messengers, and blogs more often and were 15 times more likely to affirm that "living is generally easier online" (Blumer & Renneberg, 2010, p. 60).

The exhibition of BPD pathology online is not only related to adults but has been found in those along the developmental trajectory of this challenging disorder. Fledgling BPD individuals, adolescents with BPD features, were found to engage in cyberbullying behaviors and to respond to social interactions using cyber forms of aggression more often (Stockdale, Coyne, Nelson, & Erickson, 2015).

Although the research on BPD and internet activities and behavior is limited, research is prolific on internet use and misuse and the many surface structure issues those along the BPD spectrum often contend with. These issues include depressive symptoms (Błachnio, Przepiórka, & Pantic, 2015; Morgan & Cotton, 2003; Ryu, Choi, Seo, & Nam, 2004), social anxiety (Prizant-Passal, Shechner, & Aderka, 2016; Shepherd & Edelmann, 2005; Weinstein et al., 2015), suicidal ideation (Dunlop, More, & Romer, 2011; Yang, Tsai, Huang, & Peng, 2011), loneliness (Demir & Kutlu, 2016; Nowland, Necka, & Cacioppo, 2018; Skues, Williams, Oldmeadow, & Wise, 2016), and negative mood states (Casale, Caplan, & Fioravanti, 2016; Shaw & Black, 2008). In addition, it provides an environment that can be misused as a result of impulsivity (Savci & Aysan, 2015; Wilson, Fertuck, Kwitel, Stanley, & Stanley, 2006) and risk-taking behaviors (Dir & Cyders, 2015; Durkee et al., 2016), two traits often seen in those along the BPD spectrum. These findings support, admittedly indirectly, the use and misuse of the internet by those who are along the BPD spectrum, but also that the internet is a means in which to avoid or contend with surface structure issues pertaining to borderline personality pathology (Wölfling, Müller, & Beutel, 2013).

The results in this section illustrate the perception and lure of the internet as a resource and environment for those with BPD to attempt to manage surface structure behaviors. The internet can also be used as a medium for treatment intervention as well. Rizvi, Dimeff, Skutch, Carroll, and Linehan (2011) conducted a pilot study to empirically test the utility of a mobile phone application as an adjunct tool to "standard DBT." The sample consisted of 22 individuals

enrolled in "standard DBT outpatient treatment programs" (p. 591) and were provided with the DBT Coach (the smartphone application). Results found that the participants were highly satisfied with the DBT Coach and that the "Use of the DBT Coach resulted in a significant decrease in the intensity of the emotion identified as causing the most distress as well as urges to use substances following completion of the coaching session" (p. 597). Furthermore, results showed a decrease in depressive symptoms, psychological distress, and urge to use substances. This study illustrates the importance of technology and its ubiquitous influence on all people, including those along the BPD spectrum, as well as opening new avenues for treatment.

Treatment Success and Effective Approaches

BPD is a treatable disorder. This statement that has been supported by research and experienced by clinicians for many years, but the stigma of BPD being untreatable remains intractable (Gunderson & Hoffman, 2016). Interestingly, but not well-known to many within and outside the mental health field, the efficacy of treatment for BPD is well documented, typically involving two to three hours per week for one or more years with a trained mental health professional using an efficacious intervention, such as DBT (Linehan, 1996), Mentalization-based therapy (Batman & Fonagy, 2016), or Transference-focused psychotherapy (Doering et al., 2010; Giesen-Bloo et al., 2006; Levy et al., 2006). These are not the only treatments that have been found to successfully treat BPD and those along this spectrum. Utilizing a general psychiatric management approach that includes meeting at least once a week and that addresses the individual's interpersonal relationships, which may include family intervention and medication, has also been found to be effective (APA, 2001; Gunderson, 2009).

It has also been found, but largely unknown, that those along the BPD spectrum are likely to experience significant reductions in symptoms over time, even when not in treatment, if stable support is present and the individual can avoid interpersonal stressors successfully. At six-year follow-up, 75% of individuals diagnosed with BPD who had been hospitalized previously had a remission in symptoms, 50% had remission rates at four years, with a recurrence of symptoms in less than 10% of the sample (Zanarini, Frankenburg, Hennen, & Silk, 2003). In another study, it was found that these individuals experience remission rates, defined as no more than two diagnostic criteria being met for 12 months, of approximately 45% at two years and 85% at 10-years, with a relapse rate of approximately 15% (Gunderson et al., 2011). Although it may appear from these results that therapeutic intervention is unnecessary, the foundational skills to develop a stable support system and identify those others to incorporate into one's interpersonal circle that cause less stress is often lacking in individuals along the

Table 4.7 The Seven Common BPD Treatment Principles

1. One central mental health provider
2. Structure of the therapeutic intervention
3. Support for the client and validation of the individual's extreme pain and fear along with the installation of hope
4. Client must be engaged in the therapeutic process and be motivated to change
5. Mental health provider is an active participant in the therapeutic process and builds insight into beliefs, behaviors, and patterns
6. Prepare and manage self-harm and suicidal thoughts, threats, and gestures
7. Mental health provider must be aware of their own weaknesses, challenges, and strengths, and seek and participate in ongoing supervision or consultation

BPD spectrum, hence why those along the BPD spectrum are high treatment seekers (Bender et al., 2001, 2006).

Gunderson's principles listed in Table 4.7 fit very well into The CAPS-5 Treatment Model and Hopwood's (2018) five-step treatment approach to working with individuals with personality disorders and will be described below to assist both the researcher and clinician to conceptualize BPD treatment. Incorporating these models and approaches initially requires that a primary clinician be identified or selected by the organization, the client, or by other means to administer assessments and work with the client throughout this process. The first step of Hopwood's (2018) five-step treatment approach is to determine the degree of impairment in Criterion A, the BPD Elements of Personality Functioning, using valid measures, such as The Level of Personality Functioning Scale-Self Report (LPFS-SR; Morey, 2017) or the Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders (SCID-5-AMPD) Module I (Bender, Skodol, First, & Oldham, 2018). These measures help to identify the BPD spectrum individuals' core content as it pertains to Identity, Self-direction, Empathy, and Intimacy, which will assist the mental health provider in identifying the level of core content severity that is present as the individual moves through The CAPS-5 Treatment Model.

The next step in Hopwood's (2018) approach is to identify and determine the severity of the pathological personality traits, Criterion B, that are present and can be applied to the BPD spectrum individual using the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012), SCID-5-AMPD SCID-5-AMPD Module II (Skodol, First, Bender, & Oldham, 2018), or the DSM-5 Clinicians' Personality Trait Rating Form (PTRF; APA, 2011). Results indicate that the PID-5 can be used successfully to identify BPD dimensional traits in the DSM-5 alternative model (Fowler et al., 2018; Hopwood, Thomas, Markon, Wright, & Krueger, 2012;

Sellborn, Sansone, Songer, & Anderson, 2014), as well as the PTRF (Amini, Pourshahbaz, Mohammadkhani, Ardakani, & Lotfi, 2014). The mental health provider, using The CAPS-5 Treatment Model, should determine the degree of interpersonal and intrapersonal impact associated with these identified surface structure traits and how they will facilitate or derail treatment.

Utilizing the information gathered from the previous two steps related to core content and surface structure expression, the mental health provider should identify an intervention strategy for the BPD spectrum individual that fits within The CAPS-5 Treatment Model, which is Hopwood's third step. It is at this stage in the process that Gunderson's principles (2011) largely come into play, as listed in Table 4.7.

Within this step, the remainder of Gunderson's principles are utilized, starting with the implementation and structure of the particular intervention chosen by the organization, the mental health provider, etc. The approach may encompass DBT, Mentalization-based therapy, Transference-focused psychotherapy, or general psychiatric management. Within each of these modalities, support and encouragement for the client, while empathizing with the complex interpersonal and intrapersonal issues the individual is contending with, is relayed in an empathic manner.

Often overlooked, but critical, is principle 4, the degree of motivation in the client for change. The Stages of Change can be employed here to identify where in the process the individual is, such as the precontemplation, contemplation, preparation, action, or maintenance phase (see Prochaska & DiClemente, 1983, for more information). The University of Rhode Island Change Assessment (URICA; McConnaughy, DiClemente, Prochaska, & Velicer, 1989; McConnaughy, Prochaska, & Velicer, 1983) can be used to assess an individual's readiness and motivation for change. The URICA was used to assess suitability of applying the stages of change to those meeting criteria for BPD and participating in a group DBT program (Soler et al., 2008). Results showed that where the individual was within the stages of change was significantly related to drop out and approach to treatment. Those in the precontemplation stage were likely to drop out of treatment prior to completing all DBT group sessions; whereas, those in the contemplation and action stage (a composite of these two scales), or action stage alone, showed a higher degree of effort and attitude to confront their issues associated with BPD.

The mental health provider then applies principle number 5, which includes building insight into maladaptive and adaptive beliefs, behaviors, and patterns that keep BPD core content and surface structure in place and perpetuates pathological approaches to self, others, and the world. The mental health provider must also be aware of the degree of likelihood and probability of an individual along the BPD spectrum to engage in non-suicidal self-injury (NSSI), suicide attempts, and the rate of completed suicides within this population; Gunderson's principle number 6. It has been estimated that 50% to 90% of adults with BPD engage in

NSSI (Wedig et al., 2012; Zanarini et al., 1990; Zanarini, Laudate, Frankenburg, Wedig, & Fitzmaurice, 2013; Zanarini et al., 2008), 46% to 92% engage in suicide attempts (Zanarini et al., 2008), and approximately 8% complete suicide (Pompili, Girardi, Ruberto, & Tatarelli, 2005). Knowledge and support in managing these issues encompass the last of Gunderson's principles, which is that the mental health provider be aware of weaknesses, challenges, and strengths, and pursue and participate in ongoing supervision or consultation throughout the treatment process.

Returning to Hopwood's personality disorder treatment approach, the penultimate and fourth step entails giving the information that has been gathered to the client and any other related individuals. This needs to be handled with empathy and compassion when relaying treatment and diagnostic information to the individual along the BPD spectrum. The mental health provider must be aware, and clearly discuss, how to handle missed sessions and consequences. For example, after what number of sessions is treatment discontinued or paused, with an explanation of when and how to resume? An agreement to proceed with treatment should be obtained relating to the "rules of treatment" to explain to the client, and associated individuals, how issues will be handled related to these issues and safety of the individual.

The final step of this approach includes routine assessments of therapeutic progress to assess the attenuation or exacerbation of core and surface structure issues. Several of the assessment measures mentioned previously in this section could be used to complete this last step.

Working with individuals along the BPD spectrum can be challenging, but very rewarding as well. The stigma of this disorder is one that is longstanding, but also inaccurate. The mental health community must increase their own awareness and let go of the prejudice regarding BPD and those individuals who possess traits and meet criteria for the full disorder. The late John Gunderson said it best in his book, *Beyond Borderline* (Gunderson & Hoffman, 2016):

> Seldom does an illness, medical or psychiatric, carry such intense stigma and deep shame that its name is whispered, or a euphemism coined, and its sufferers despised and even feared. Perhaps leprosy or syphilis or AIDS fits this category. Borderline Personality Disorder (BPD) is such an illness. In fact, it has been called the "leprosy of mental illness" and the disorder with "surplus stigma." It may actually be the most misunderstood psychiatric disorder of our age.
>
> (p. 1)

It is time to move beyond this fallacy.

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