Rainer Sachse

Personality Disorders

A Clarification-Oriented Psychotherapy Treatment Model

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About the Author

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

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Foreword

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

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

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

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

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

Elsa Ronningstam, PhD
Harvard Medical School, Harvard University, Cambridge, MA

Contents

Chapter 1

Essential Basic Concepts of Personality Disorders

1.1 Introduction

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

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

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

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

1.2 The Term *Personality Disorder*

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

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

Chapter 2

Characteristics of Personality Disorders

2.1 Introduction

As a kind of advanced organizer, essential general characteristics of PDs are summarized in this section (also in distinction to Axis I disorders): Thus, the question is, what characterizes clients with PD and what are the particular features they bring into the therapy?

2.2 Ego-Syntony and Ego-Dystony

Fiedler (2007) spotlighted the aspect of ego-syntony: A disorder is **ego-syntonic** if the person concerned does not perceive essential aspects of the disorder as disruptive, problematic, and necessitating change; moreover, these aspects are perceived as part of the self – as part of one's identity. By contrast, a disorder is **ego-dystonic** if the person perceives essential aspects of it as disruptive: The person does not want to suffer these aspects of their disorder and experiences them as foreign and necessitating change.

Contrary to Axis I disorders, which are usually ego-dystonic, PDs are usually ego-syntonic: the degree of ego-syntony depends on the type and severity of the disorder (e.g., avoidant PD is a little ego-syntonic, whereas obsessive-compulsive PD is highly ego-syntonic).

2.3 Motivation for Change

The degree of motivation to change strongly depends on the ego-syntony (motivation to change is the tendency to actively want to change aspects of oneself).

Motivation to change implies that

- The person realizes that their belief system produces costs;
- That these costs are relevant, and they do not want these costs;
- That changing can reduce costs and make objectives attainable;
- That these costs are self-produced, and that the client must actively pursue their objectives. (Sachse, Langens, & Sachse, 2012)

Chapter 3

What Is Clarification-Oriented Psychotherapy?

3.1 Introduction

Since both the theory of PDs and the therapeutic strategies described here are based on a concept of therapy from COP, we would like to give a brief overview here of what is meant by COP. This will make the concepts presented easier to understand. COP is a psychologically well founded, highly empirically validated form of psychotherapy that pursues two major lines of approach.

One of these lines of approach relates to clarification: On the basis of a trustful therapist–client relationship actively established by the therapist, the real motives of the client that they are presently unaware of are clarified with a view to eliminating the client's state of alienation. Further, clarification also aims at representing and clarifying dysfunctional client schemas that are co-determining the problems encountered.

The second major task of COP deals with processing and modifying these clarified schemas therapeutically, which enables the client to behave more constructively and flexibly during their daily routines, exhibit less or no disturbing symptoms, better face up to everyday situations both cognitively and affectively, thus leading to a more satisfied self-regulative life.

The key objective of COP focuses on (re)establishing functional self-regulation (Baumann & Kuhl, 2005). The client should be put in a position that enables them to access their motives, appropriately deal with situations, and take decisions that both comply with and face reality, and which are compatible with their motives. Moreover, the client should be able to process information and make decisions without disturbances caused by any dysfunctional schemas, symptoms, or unreasonable behavioral costs.

3.2 Aspects of Clarification-Oriented Psychotherapy

To accomplish the objectives listed in the previous section, COP comprises a number of subdomains that involve tasks therapists have to cope with and that require their expertise to be brought to bear in various different fields.

Chapter 4

General Psychological Function Model for Personality Disorders

4.1 Introduction

In this section, a general psychological function model for PDs is presented: the **model of dual action regulation**. This model specifies which psychological variables matter for PD, how these variables interact, and what kind of consequences result from these interactions (see Sachse, 1997a, 2000a, 2001a, 2001b, 2002, 2004a, 2004b, 2004c, 2005, 2006a, 2006b, 2013a, 2014a, 2016a; Sachse, Sachse, & Fasbender, 2010). The dual action regulation model represents a theoretical framework for PDs.

4.2 Dual Action Regulation Model

4.2.1 Introduction

The dual action regulation model is based on the assumption that PDs may be understood as relationship disorders (or, in other words, interaction disorders). To be sure, PDs are indeed complex disorders involving disturbances in behavior, reasoning, feelings, certain patterns of information processing, etc. However, it can be assumed that dysfunctional beliefs about relationships, dysfunctional intentions regarding interactions, and dysfunctional types of relationship structuring constitute the core of the disorder (Figure 2).

The model is called the dual action regulation model, because it is proposed that there are two action levels:

- the **motive level**, or level of authentic action regulation;
- the **level of disfunctional schemas**
- the **maneuver level** (or "game"-level), or level of manipulative or nontransparent action regulation

At the motive level, the person pursues their actual motives and objectives, their approximation objectives – that is, those objectives whose achievement will bring positive affects and satisfaction. These effects satisfy the motive and result in a long-term satiation of the motive, whereby their relevance decreases. At this level, the person acts authentically – that is to say,

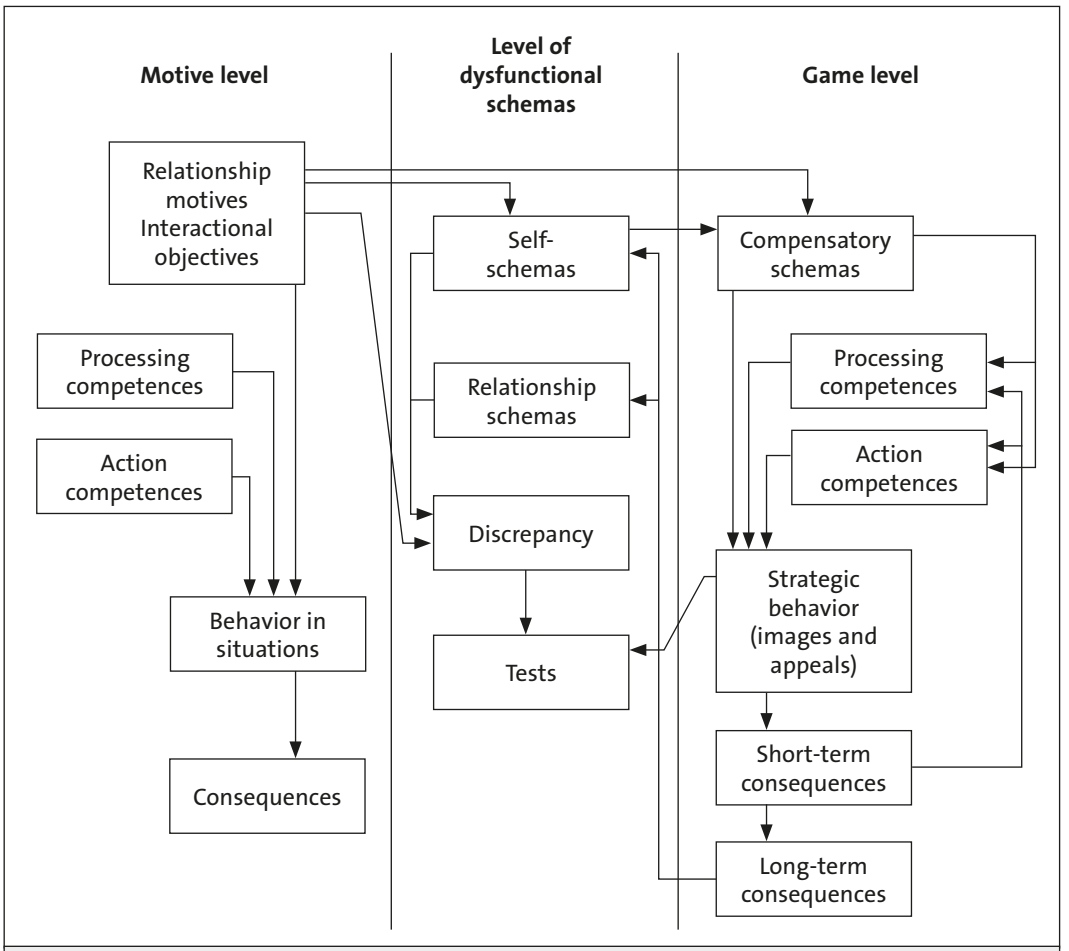

Figure 2
The dual action regulation model.

the person acts in such a way that the interaction partner is able to recognize their objectives. The person means what they say, and their behavior is consistent with their motives.

At the game level (maneuver level), the person is already pursuing interactional objectives which do not represent their real motives but are explicit, often extrinsically motivated objectives, in the sense of being for the purpose of avoidance (i.e., avoiding particular themes or questions). The norms and rules followed usually do not represent what the person actually wants and what would actually satisfy them. In this sense, the person does not even act authentically. They also delude their interaction partner. They will communicate images of themselves that are either exaggerated or simply untrue (see the subsection Game Behavior: Images and Appeals, in Section 4.2.4). By transmitting these images, they more or less systematically deceive the interaction partner. On the basis of those images, the interaction partner is compelled to act in response to their appeals. As the interaction partner trusts these images of the person and accepts them, they will therefore act on the basis of false assumptions. They will be compelled to perform actions they would not have done without the images (i.e., without

Chapter 5

Diagnostic Features of Personality Disorders

5.1 Introduction

An essential question is what kind of psychological aspects of their disorder are relevant indicators and thus defining features of PDs, and which features qualify for a diagnosis of PD. In this section, these essential aspects of PDs as deduced from the dual action regulation model will be discussed. These features can be assessed by therapists in therapy sessions. As these features appear in the interactional behavior with therapists, the client can hardly falsify them intentionally; The therapist's assessment in this respect is thus fairly reliable (see Sachse, Sachse, & Fasbender, 2011).

5.2 Relationship Motives

People with PD are always characterized by the fact that they have certain relationship motives which rank and stay high in their motive hierarchy. Narcissists, for example, are characterized by a central appreciation motive, whereas histrionic PD clients have a central importance motive. Any PD can be characterized by a set of relevant relationship motives. These aspects of PDs are described in more detail later in Chapter 7.

5.3 Dysfunctional Schemas

People with PD feature characteristic, dysfunctional schemas: both self-schemas and relationship schemas. **Dysfunctional self-schemas** are schemas which include negative assumptions about the self. Narcissistic PD clients make typical assumptions such as

- "I am not ok."
- "I am a failure."
- "I am not competent."

Chapter 6

Therapeutic Strategies for Clients With PD: Consequences of the Model

6.1 Introduction

Basic therapeutic strategies can be derived from the dual action regulation model and are based on the therapeutic concept of COP (Sachse, 2003, 2004d, 2006e, 2007a, 2008a, 2008b, 2013b, 2014b, 2015a, 2016c; Sachse, Breil & Fasbender, 2009; Sachse & Fasbender, 2010, 2013; Sachse, Fasbender, & Breil, 2009; Sachse & Langens, 2014a, 2015; Sachse, Langens, & Sachse, 2012; Sachse & Rudolf, 2008; Sachse & Sachse, 2009, 2011; Sachse, Sachse, & Fasbender, 2011). These are represented below.

6.2 Therapy Phases

We work from the assumption that the therapy of clients with PD should take place in phases. Any therapy phase is characterized by certain therapeutic key aspects: In each phase, the therapist follows certain therapeutic process objectives involving particular strategies. As these objectives are achieved, the therapist proceeds to the next phase, in which they focus on new objectives including other therapeutic strategies. Certainly, these phases cannot be exactly defined, and to some extent their transitions are fluid: When therapists have already achieved subgoals regarding certain issues, they may start addressing the objectives of the next phase while still working on the remaining objectives. Furthermore, the therapy phases do not take place linearly: It may be necessary for a client to go through certain phases several times.

In addition, a therapist may work on many client schemas at the same time, but the phases being processed for a given schema may differ. Schema X, for example, is not embarrassing for the client, and thus the therapist and client are already in Phase 4 with this schema, whereas schema Y is difficult for the client, so that in that case, therapist and client are only concentrating on Phase 1.

Following phase sequences has proven successful in evaluations of therapy success. Experience has shown that it is important to stick to the order of process objectives to achieve

Chapter 7

Types of Personality Disorders

7.1 Introduction

An essential question is how to summarize and classify different PDs. The DSM (APA, 1994, 2013) distinguishes between three clusters: However, there is the major disadvantage that they are neither empirically founded nor comprehensibly and theoretically deducted. The clusters combine disorders which resemble each other superficially at the most, but otherwise are highly heterogeneous. In the opinion of the author of this present work, the DSM clusters cannot be understood to be a useful summary of PDs.

In recent years, a great deal of neuropsychological research has been done into PDs. The results have shown that there are PDs showing strong to very strong functional neuropsychological deficits, and many PDs that do not show any such disturbances. These aspects are useful when making a first distinction among different PDs.

7.2 Pure and Hybrid Personality Disorders

Disorders without (noteworthy) functional neuropsychological deficits can be seen as purely psychologically interpretable disorders (or **pure disorders**): Pure PDs can be understood as relationship disorders functioning as indicated by the dual action regulation model. These disorders do not comprise any other disorder aspects.

Disorders that can only be ascribed to some extent to psychological factors (such as schemas, interaction games, etc.) and in which considerable neuropsychological aspects are involved (e.g., neuropsychological regulation deficits, control deficits, information processing deficits) are called **hybrid disorders**. The term *hybrid* emphasizes that psychological as well as neuropsychological factors induce the disorder, so that hybrid disorders can only be partly understood as PDs, because only parts of the disorder are considered to be interaction disorders. Disorders of this type have additional disorder aspects that cannot be interpreted as interaction disorders – for example, aspects of an emotion regulation disorder or an information processing disorder. The considerations usually associated with PDs apply to these disorders only in part or with restrictions; other therapeutic procedures that are not at all linked with PDs are additionally indicated.

The pure PDs are:

- Narcissistic PD
- Histrionic PD

Chapter 8

Narcissistic Personality Disorder

Nothing is so common-place as the wish to be remarkable.
Oliver Wendell Holmes

8.1 Description and Types of NPD

One characteristic of **narcissistic personality disorder** (NPD) is that it can be subdivided into three subtypes (Sachse, Sachse, & Fasbender, 2011): **successful narcissism** (SNPD), **failed narcissism** (FNPD), and **unsuccessful narcissism** (UNPDs). First of all, a general description of NPD will be given, followed by a characterization of these subtypes (see Döring & Sachse, 2008a, 2008b; Sachse, 2000a, 2001b, 2004b, 2006f, 2007c, 2008b, 2014d, 2015b, 2016e, 2016f; Sachse & Fasbender, 2013; Sachse & Müller, 2016; Sachse, Sachse, & Fasbender, 2011; Sachse & Schirm, 2015).

Generally speaking, SNPD persons are successful, strong-willed, and capable of roping in other people for their purposes (Akhtar, 1996; Horowitz, 1996; Levy et al., 2007; Millon, 1996; Ronningstam & Gunderson, 1996). On the other hand, NPD clients exhibit a high level of self-doubt and emotional vulnerability and are sensitive to criticism.

Conspicuous characteristics of NPD persons are described by Millon (1996) and Ogrodniczuk (2013) as well as Ronningstam (1996, 2000, 2005, 2010, 2011; Ronningstam & Gunderson, 1996). SNPD clients are viewed as people who are self-assured in an exaggerated way and in general are quite successful, able to get their own way, recruit others for their purposes, etc. (see Akhtar, 1996; Döring & Sachse, 2008a, 2008b; Horowitz, 1996; Levy et al., 2007; Millon, 1996; Ronningstam & Gunderson, 1996).

However, there are two problems linked with how NPD has been viewed hitherto:

1. NPD clients are often regarded as persons who exclusively exhibit a feeling of greatness; more often than not aspects of self-doubt, vulnerability, depressiveness, and negative self-esteem are overlooked (see Gabbard, 2009; Heisel et al., 2007; Levy et. al., 2007; Pimentel, 2007; Ronningstam, 2009; Russ et al., 2008); but these must be seen as an integral attribute of narcissism.
2. The disorder is usually understood to refer to the so-called successful narcissists while other subtypes of NPD are ignored (see Russ et al., 2008).

With our conception, we aim at establishing as comprehensive as possible a picture of NPD, as well as discussing the therapeutic consequences resulting therefrom.

When making a closer analysis of what characterizes NPD persons, it turns out that former definitions mainly refer to **successful narcissists** while the fact that not all NPD persons