chapter 1

Why Integrated Treatment?

General Principles of Therapeutic Change

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There is now solid evidence that personality disorders can be treated effectively. Prior to about 1990, treatment was dominated by various psychoanalytical therapies. Studies of treatment outcome were sparse, and therapeutic nihilism prevailed. Therapeutic developments were largely derived from observations of patients in long-term psychoanalytical therapy. Although these observations yielded a valuable understanding of the importance of such factors as a structured approach, the treatment contract, consistency, and the treatment alliance, there were few methodologically sound outcome studies to help the clinician to plan treatment. The situation changed in the 1990s with the development of a several manualized therapies.

Although this second phase in the evolution of personality disorder treatment was characterized by the emergence of specialized therapies for borderline personality disorder (BPD) and their systematic evaluation in randomized controlled trials (RCTs), the phase was ushered in with the publication of a more general work—Beck and colleagues' volume on cognitive therapy (Beck, Freeman, & Associates, 1990), which paved the way for new treatment options. Shortly afterward, randomized controlled outcome studies began to appear, led by Linehan, Armstrong, Suarez, Allmon, and Heard's (1991) investigation of dialectical behavior therapy (DBT), a landmark development that demonstrated the feasibility of evidence-based treatments for personality disorder. Other therapies rapidly became available so that, as we write,

at least seven specific manualized therapies have been shown to be effective in at least one reasonably methodologically sound evaluation. These include DBT (Linehan, 1993), cognitive therapy (Davidson, 2008), cognitive analytic therapy (Ryle, 1997), mentalizing-based therapy (MBT; Bateman & Fonagy, 1999, 2001), transference-focused psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 1999, 2006), schema-focused therapy (SFT; Young, Klosko, & Weishaar, 2003), and systems training for predictability and problem solving (STEPPS; Blum et al., 2008).

These developments are cause for optimism. Now a rich array of therapies apparently provide the clinician with a range of treatment options, although most studies were on patients with BPD—with the exception of a few studies on DSM-IV Cluster C disorders (Arnevik et al., 2008; Muran, Safran, Samstag, & Winston, 2005) and some recent studies dealing with all forms of personality disorder (Bamelis, Evers, Spinhoven, & Arntz, 2014; Clarke, Thomas, & James, 2013). The current *zeitgeist* tends to imply that therapists should use one or more of these evidence-based therapies. This approach is encouraged by advocates of specific treatments, who often argue that their treatment is the most empirically validated or in some way more comprehensive than the rest. This volume was motivated by a different perspective: the conviction that the treatment of personality disorders is entering a third phase characterized by greater concern with integrating treatment principles and methods across therapies, the use of eclectic and pragmatic treatment strategies, and the emergence of more modular and transdiagnostic approaches focusing on specific domains of personality pathology rather than global diagnoses. For want of a better term, we refer to this approach as *integrated modular treatment* (IMT). We suggest that individual patients present with a unique array of problems spanning multiple domains of functioning and that treatment should utilize an integrated array of strategies and techniques to address these diverse impairments. With this approach, domains of impairment such as symptoms, problems with emotion and impulse regulation, interpersonal patterns and self-identity problems, and overall severity of dysfunction are the focus of intervention, rather than a more globally conceptualized categorical disorder.

We recognize that integrated therapy is a rather soft and overused term; the proponents of various specialized therapies commonly claim that theirs is an integrated approach despite the fact that most are based on a single theoretical model and a relatively limited repertoire of interventions that reflect the assumptions of the underlying model. Here we use the term *integrated* to refer to an approach that combines an eclectic array of treatment principles, strategies, and methods drawn from all effective treatments and uses them in a targeted way to treat specific impairments. Later, we discuss the idea of integrated treatment in more detail. For now, we note our conviction that the time is ripe to integrate treatments: Outcome does not differ substantially across therapies, and the field is recognizing that personality disorders are complex conditions with a multifaceted psychopathology and a multidimensional biopsychological etiology. These developments challenge continued reliance on

treatments based on one-dimensional models of specific personality disorders that assume a single impairment and hence rely upon a limited set of treatment methods.

THE IMPLICATIONS OF OUTCOME STUDIES

The RCTs of specialized treatments that radically changed the treatment landscape have several shortcomings that need to be considered when applying their findings to treatment planning. Because evaluations are largely confined to treatments of BPD, findings have to be extrapolated to other disorders, although there is evidence that some treatments, such as SFT, are effective with other disorders (Bamelis et al., 2014). Nevertheless, even with BPD, most RCTs used small samples, which limit the generalizability of their findings (Davidson et al., 2006). Also, in some studies information on follow-up is limited, so it is not clear whether the effects observed at the end of treatment are lasting, although a few studies show that outcomes are stable (see Bateman & Fonagy, 2008). In all trials, a significant number of patients did not respond to treatment, raising the question as to whether they would respond to an alternative treatment or to integrated treatment tailored to their individual needs. Finally, randomized trials do not normally provide information about the mechanisms of change, especially whether change is due to methods and strategies specific to the treatments being investigated.

With respect to treatment selection, the important finding of these studies is the lack of evidence of clinically significant differences in outcome across therapies (Bartak, Soeteman, Verheul, & Busschbach, 2007; Budge et al., 2014; Leichsenring & Leibing, 2003; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Mulder & Chanen, 2013). Significant differences are sometimes reported, but these are often difficult to interpret. For example, a comparison of TFP (Clarkin et al., 1999) and schema-focused therapy (Young et al., 2003) suggested that schema-focused therapy produced fewer dropouts (a significant problem in the treatment of personality disorder) and better outcomes (Giesen-Bloo et al., 2006). However, differences were modest, the sample size was small, and questions have been raised about whether the two treatments were delivered in comparable ways (Yeomans, 2007). Overall, outcome studies suggest that there are few empirical grounds for selecting one evidence-supported approach over another. However, the specialized therapies are more efficacious than treatment as usual or treatment delivered by expert clinicians (Budge et al., 2014; Doering et al., 2010; Linehan, Comtois, et al., 2006). Although this finding appears to suggest that advantages accrue from using a specialized therapy, there are reasons to question this conclusion. Treatment as usual is a rather modest standard because it is limited to whatever routine care is available in the setting in which the study occurred, and in some settings this care may be limited. Differences between specialized treatments and treatment as usual are also decreasing with time, presumably

because treatment as usual is improving. Moreover, when specialized therapies are compared with well-specified, manualized general psychiatric care tailored to BPD, the results are different.

The four studies that have examined this issue failed to find substantial differences. Clarkin, Levy, Lenzenweger, and Kernberg (2007) compared TFP, DBT, and a supportive dynamic treatment over 1 year and found few differences across multiple outcome measures. A limitation of this study was a small number of participants. This limitation was overcome in a study by McMain and colleagues (2009), who compared DBT with general psychiatric management that included a combination of psychodynamically informed therapy and symptom-targeted medication management based on APA guidelines for treating BPD (American Psychiatric Association, 2001). The two treatments did not differ significantly in outcome. This finding is especially important because DBT is the most studied treatment for BPD and considered by many to be the treatment of choice. It should also be noted that at the end of each treatment, patients still had substantial problems (McMain et al., 2009; see also Kröger, Harbeck, Armbrust, & Kliem, 2013).

A comparison of MBT and structured clinical management also reported similar outcomes for the two therapies, although problems decreased slightly faster with MBT (Bateman & Fonagy, 2009). Subsequently, the same investigators (Bateman & Fonagy, 2013) examined whether severity, variously assessed as severity of comorbid psychiatric syndromes, severity of BPD (number of criteria met), number of co-occurring Axis II disorders, and severity of symptom distress, influenced outcome for MBT and structured clinical management. Although none of the severity criteria predicted outcome at the end of treatment, patients with more severe disorder indicated by two of the severity criteria (multiple Axis II diagnoses and symptom distress) did better with MBT. The other severity criteria did not have a differential effect on outcome. The authors cautiously raise the possibility that greater severity of personality pathology and symptom distress may predict greater benefit of MBT over structured clinical management. An interesting feature of this finding in terms of its implications for a unified treatment model is how the authors characterize the distinction between MBT and structured management. They state that structured clinical management is based on routine psychiatric practice that matches "the non-specialized features of MBT in terms of intensity, organization and pharmacological treatment" (Bateman & Fonagy, 2013, p. 221). Presumably, they consider the specialized features of MBT to be strategies and interventions that enhance mentalization capacity. However, it could be argued that mentalizing interventions of MBT are not specialized interventions confined to this mode of therapy but rather a highly effective way to operationalize an essential set of generic change mechanisms in the context of treating BPD. These generic mechanisms include change mechanisms that have consistently been shown to be critical components of effective therapies such as self-reflection, perspective taking, psychological mindedness, empathy, and various metacognitive processes. This raises the possibility that the

demonstrated efficacy of MBT arises from the consistent and structured application of an array of generic interventions rather than the use of mechanisms specific to the approach.

Finally, Chanen and colleagues (2008) reported that cognitive analytic therapy was not significantly better than manualized good clinical care—a modular treatment package based on standard psychiatric management and a problem-solving approach combined with specific modules to address specific symptom clusters. The interesting feature of these studies is that they were conducted by investigators with different theoretical orientations using three different specialized treatments that were compared with three forms of general clinical care in three countries, Canada, the United Kingdom, and Australia. This lends confidence to the generalizability of the findings. Consistent with this interpretation is evidence that some specialized therapies are not more effective than supportive therapy. Jorgensen and colleagues (2013) compared the outcome of MBT and supportive psychotherapy in patients with BPD. Outcome assessed using multiple self-report measures and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) did not differ across groups. The only significant difference observed between groups was in therapist-rated global assessment of functioning, which was open to bias as it was not a blind rating. The failure to demonstrate greater efficacy for MBT was especially notable because treatment intensity differed substantially across groups, with the MBT group receiving 45 minutes of individual therapy and 90 minutes of group therapy per week, whereas the supportive therapy condition received only 90 minutes of group therapy every 2 weeks. In contrast, Bales and colleagues (in press) did not find differences in favor of day-hospital MBT versus other specialized psychotherapeutic treatments.

Evidence that the specialized therapies do not differ substantially in outcome either from each other or from good clinical care that largely relies on generic change factors and that supportive therapy is as effective as MBT suggests that nothing is gained by using a specialized treatment, a conclusion with major implications for conceptualizing and implementing treatment. It suggests that positive outcome is more a function of a structured approach and change mechanisms common to all effective treatments than to treatment-specific interventions. In this sense, the results of outcome of treatments for BPD converge with the results of psychotherapy outcomes generally: we have known for more than 40 years that outcome is similar across therapies (Beutler, 1991; Luborsky, Singer, & Luborsky, 1975), which suggests that different therapies share common elements associated with successful outcome (Castonguay & Beutler, 2006a, 2006b; Norcross & Newman, 1992). Personality disorders are unlikely to show a different pattern.

Nevertheless, the general factors may not be the whole story. Some treatment methods specific to a given therapeutic approach are also likely contribute to positive outcomes. The evidence on this point is not strong because outcome studies do not evaluate mechanisms of action. However, some older studies show evidence of domain specificity. Piper and Joyce (2001), reviewing

the literature on psychotherapy for personality disorder, noted evidence of differential effectiveness: Treatment methods that work for one domain do not necessarily work for another. Consistent with this conclusion is evidence that some therapies are better than others in treating specific impairments. For example, TFP appears to significantly increase reflective functioning compared with either MBT or supportive therapy. These considerations suggest that integrated treatment should not rely solely on a common-factors approach but also needs to incorporate specific methods to treat specific impairments or domains of psychopathology. Hence a guiding principle behind this volume is that treatment should start not from a narrowly focused, disorder-specific manual but from a detailed analysis or deconstruction of the patient's psychopathology into domains of dysfunction and that treatment methods should be selected on the basis of what works for the specific problems and domains that are the focus of therapeutic attention.

CONCEPTUAL AND PRACTICAL LIMITATIONS OF SPECIALIZED THERAPIES

Thus far we have argued for integrated treatment based on the results of outcome research. However, an examination of the specialized treatments provides a second reason for pursuing integration: None of these treatments offer the range of interventions needed to treat all components of personality disorder. Each specialized treatment is based on a theory of personality disorder that is largely speculative but nevertheless determines the primary focus of treatment and the interventions used. A general limitation of these theories is the tendency to explain the diverse psychopathology of personality disorders in terms of a single primary impairment. Although this assumption has the advantage of providing the therapist with a clear conceptual approach, it neglects the contribution of other explanatory factors and runs the risk of neglecting other important intervention strategies. For example, the proposed impairments associated with BPD include affect dysregulation, maladaptive thinking, maladaptive schemas, conflicted relationships, primary problems with impulsivity, fragmented object relationships, impaired mentalizing capacity, and identity pathology. Because therapies differ in the assumed impairment, they emphasize different strategies and interventions. For example, because cognitive therapy emphasizes dysfunctional beliefs and maladaptive thinking, treatment primarily focuses on cognitive restructuring and the development of new beliefs and associated behaviors. In contrast, DBT (Linehan, 1993) assumes that affect regulation is the critical feature and hence focuses on developing emotional regulation skills. MBT (Bateman & Fonagy, 2004), on the other hand, considers impaired mentalizing to be the central problem and hence focuses primarily on enhancing mentalizing capacity on the assumption that this will promote affect regulation and more adaptive cognitive functioning.

However, even a cursory consideration of borderline pathology indicates that it involves maladaptive cognitions, emotion dysregulation, impaired mentalizing, and more. Personality pathology is complex spanning multiple domains of problems that include symptoms, emotion and impulse regulation, interpersonal pathology, maladaptive traits, situational or environmental problems, identity problems, and impaired metacognitive processes (Clarkin, 2008; Livesley, 2003). This suggests that evidence-based treatment needs to adopt a multidimensional model of personality disorder and a comprehensive array of interventions.

Our discussion of outcome studies and the limitations of contemporary treatments points to the need for a more unified approach that incorporates interventions based on change mechanisms common to all effective treatments and more specific interventions targeted to specific domains of psychopathology. This structure has implications for assessment. It implies that a global diagnosis based on current diagnostic categories is insufficient. In order to select appropriate interventions, personality disorder needs to be decomposed into different functional domains (see Livesley & Clarkin, Chapter 3, this volume). This reveals an additional benefit of integration: It accommodates the considerable heterogeneity among patients with a given disorder and permits treatment to be tailored to the individual (Livesley, 2012; Stone, 2010). The importance of tailoring treatment to the individual is illustrated by a recent outcome study of borderline and avoidant personality disorders (Gullestad et al., 2012) that assessed pretreatment mentalizing abilities. Patients with lower pretreatment mentalizing skills fared worst in day-hospital treatment than in individual therapy. The authors noted that poor understanding of mental states may make group therapy and day-hospital treatment too distressing and confusing, leading to poor outcome. Individual therapy was more effective because the use of individual therapy made it easier to manage the impaired mentalizing by providing a safer and more predictable environment (Gullestad, Johansen, Høglend, Karterud, & Wilberg, 2013).

PATHWAYS TO INTEGRATION

Integrated treatment may be organized in various ways depending on how integration is conceptualized and the way interventions from different therapies are combined. The model proposed here incorporates to varying degrees the three routes to integration that have traditionally been described in the general psychotherapy literature: common factors, technical eclecticism, and theoretical integration (Arkowitz, 1989; Norcross & Grencavage, 1989; Norcross & Newman, 1992). The common-factors approach seeks to identify principles of change common to all therapies and uses these principles to establish the basic structure of treatment. Technical eclecticism uses treatment methods from diverse treatment models without adoption of their associated theories. Most experienced clinicians show a degree of technical eclecticism—they use

methods that they have found to work even though they may not subscribe to the theoretical position on which they are based, an approach that Stricker (2010) calls *assimilative integration*. Theoretical integration is more complex. It seeks to combine the major components of two or more therapies to create a more effective model. The concern is not just to identify common change principles and blend diverse interventions to integrate underlying theories of therapeutic change (Norcross & Newman, 1992; Stricker, 2010).

We emphasize the common-factors approach based on similarity in outcome across specialized treatments and evidence that the common factors account for much of the change we see in patients. Within the current framework, interventions implementing generic change mechanisms form the basic structure of treatment that provides the consistency and structure needed for effective treatment. It will be apparent from earlier comments that we also espouse technical eclecticism and consider it necessary to comprehensive treatment of personality pathology. Hence we propose using a wide range of interventions drawn from all therapies without adopting the theories on which they are based. The challenge for eclecticism is how to select and combine diverse and even theoretically incompatible interventions. The solution that we advocate is to decompose personality disorder into different problem domains and select specific interventions to treat each domain based on empirical and rational considerations. We believe this provides a more effective and parsimonious way to treat personality disorder than to use a combination of specialized therapies. Theoretical integration involving the melding of different therapies is probably not feasible given current knowledge. As an alternative, a descriptive scheme is offered for decomposing personality disorder into components for treatment purposes (see Livesley & Clarkin, Chapters 2 and 3, this volume).

The combination of general factors and technical eclecticism determines the basic structure of treatment. It implies the use of two broad kinds of intervention modules: general modules based on interventions that operationalize general change mechanisms common to all therapies and more specific modules composed of interventions that target more specific impairments, such as emotion dysregulation, violent behavior, deliberate self-harm, and submissiveness.

OVERVIEW OF THE VOLUME

The overarching goals of this book are to foster integrated treatments for personality disorders and to stimulate a professional climate and discussion of clinical integration because we think such a development is timely. Outcome research points to the feasibility of integration, and nosological research increasingly emphasizes the general features of personality disorder and its severity as opposed to particular personality disorder types. At the same time, interest is growing in transdiagnostic approaches to diagnostic classification

based on domains of impairment that cut across traditional diagnostic entities (Cuthbert & Insel, 2013; Doherty & Owen, 2014), an approach that is congenial to our emphasis on domains of personality dysfunction and the selection of interventions based on domains rather than global diagnoses. The authors we approached to contribute to this volume were all willing to abandon the idea that their approach is the best and to contribute to a larger enterprise of exploring the domains of dysfunction in patients with personality disorder and exploring various treatment approaches. This willingness suggests to us that the spirit of integration is alive and well. We also attempt to provide a template to guide clinicians in applying an integrated approach to assessment and treatment and to facilitate the teaching of an integrated treatment approach in training programs for mental health professionals.

We have organized this book with these ideas in mind. Part I, "Conceptual Framework and Treatment Principles," provides the reader with the rationale for integration and a general framework for organizing treatment. In Chapter 2, W. John Livesley and John F. Clarkin describe a general framework that distinguishes between general treatment modules based on the common-factors approach to integration and specific treatment modules. Each module consists of a set of interventions for treating a specific problem or problem domain.

Part II, "Assessment, Treatment Planning, and the Treatment Contract," deals with assessment, formulation, treatment planning, and establishing the treatment contract. The emphasis that IMT places on tailoring treatment to the problems and impairments of individual patients and on linking interventions to specific problems requires a more detailed evaluation than a simple categorical diagnosis. These issues are addressed in Chapter 3 by W. John Livesley and John F. Clarkin, who describe a three-stage diagnostic assessment covering severity, clinically important traits, and domains of personality impairment. In Chapter 4, Clarkin and Livesley then discuss how this information can be used to construct a formulation and plan treatment. This chapter also deals with the important problem of how to match domains of personality pathology with treatment modules and how to sequence the use of specific intervention modules. The chapter also introduces the important point that integration is ultimately something that occurs in the mind of the therapist, who arrives at a comprehensive formulation that is used to select appropriate treatment methods based largely on clinical judgment. In Chapter 5, Paul S. Links, Deanna Mercer, and Jon Novick set the stage for treatment by examining strategies for developing a treatment contract, a crucial issue in treating personality disorder: All effective therapies stress the importance of the contract as something that is essential to providing the structure needed to establish a consistent treatment process.

In Part III, "General Change Principles and Mechanisms," Sumru Tufekcioglu and J. Christopher Muran (Chapter 6) discuss diverse aspects of the therapeutic relationship in treating personality disorder. They offer a relational theory of the person as a context for understanding the therapeutic

alliance and explore in depth the critical issue of how to manage breakdowns to the therapeutic alliance. The next two chapters explore different aspects of the treatment of impaired metacognitive functioning and the role these problems play in disordered personality. In Chapter 7, Anthony W. Bateman and Peter Fonagy discuss mentalization as a core impairment of personality disorder and show how enhancing mentalizing capacity is fundamental to effective therapy. This theme of metacognitive processes generally is continued in Chapter 8 by Giancarlo Dimaggio, Raffaele Popolo, Antonino Carcione, and Giampaolo Salvatore. In describing the nature and treatment of impaired metacognitive functions, they introduce the important idea of using analysis of specific events or scenarios to facilitate different aspects of change. The first three sections flesh out a broad framework for implementing integrated treatment by providing an approach to treatment that can readily be structured to meet the needs of individual patients and the clinician's preferred mode of working.

Part IV, "Treating Symptoms and Dysregulated Emotions," covers strategies for treating diverse aspects of personality pathology. This section is not intended to provide comprehensive coverage of all components of personality disorder but rather to illustrate how different methods can be used within an integrated framework. To this end, we invited authors to describe their approach to treatment and to show how this could be delivered within a unified model. The sequence of these chapters roughly approximates the sequence in which different problems and impairments are treated.

The section begins with Chapter 9, in which Paul S. Links and Yvonne Bergmans discuss the management of suicidal and other crises. They develop a practical and integrated framework by comparing and contrasting the way crises are managed in DBT and general psychiatric management. Kenneth R. Silk and Robert O. Friedel then address the use of medication in treating personality disorder in Chapter 10. After reviewing the evidence on the benefits of medication, they discuss strategies for integrating the use of medication with psychotherapy. This is an important issue because many patients with personality disorder also receive medication, and it is important that this is delivered in a way that is consistent with an integrative approach and that facilitates psychotherapeutic work.

Chapter 11, by W. John Livesley, describes the treatment of emotional dysregulation using a modular strategy that is based on an analysis of the structure of emotional dysregulation and the patient's subjective experience of intense, unstable emotions. A four-module strategy is proposed, with each module consisting of an eclectic set of interventions that target an component of emotional dysregulation from different perspectives with the aim of increasing understanding of emotions and the nature of emotional experiences, enhancing emotional awareness, improving emotional self-regulation, and increasing emotion processing capacity. The following two chapters discuss other aspects of treating emotional dysregulation, providing additional perspectives that may contribute to a more unified framework. Robert L. Leahy,

in Chapter 12, describes a metacognitive model of emotion and introduces the idea of emotional schemas—thoughts and ideas about the emotion aroused by events and how these schemas influence both the appraisal of events and the subsequent processing of emotional responses. Strategies and techniques for restructuring emotional schemas are discussed in the context of different forms of personality disorder. The chapter concludes by illustrating the use of these strategies in treating a case of BPD. In Chapter 13, Paolo Ottavi, Tiziana Passarella, Manuela Pasinetti, Giampaolo Salvatore, and Giancarlo Dimaggio consider the role of mindfulness in treating personality disorder, especially its value in treating the ruminative tendencies observed in many patients. After considering the ways standard mindfulness protocols need to be modified for use with patients with severe personality pathology, they outline specific strategies and techniques and discuss their applications in specific cases.

In Part V, "Treating Interpersonal and Self Functioning," the focus changes. The section begins with Chapter 14, in which Nicole M. Cain and Aaron L. Pincus discuss the management of interpersonal pathology. They use interpersonal theory as the basis for proposing the concept of interpersonal signature to describe and explain adaptive and maladaptive social behavior and then consider how this framework can be applied to to identifying and treating the disturbed interpersonal relationships that characterize personality disorder. In Chapter 15, Thomas R. Lynch, Roelie J. Hemple, and Lee Anna Clark discuss the treatment of a less commonly treated form of disorder—social withdrawal and emotional constriction. They argue that treatments should not assume that patients have the capability for effective emotional responding and hence emphasize the need for skills-based approaches, suggesting that the overcontrolled forms of emotional dysregulation are likely to benefit from interventions designed to reduce inhibitory control and increase flexible responding. Their perspective complements Dimaggio and colleagues' earlier discussion of the management of the treatment narrative in emotionally constricted individuals (see Chapter 8). Stephen C. P. Wong discusses the challenging problem of treating aggression and violent behavior in individuals with psychopathic traits. The two-component structure of psychopathy is used to discuss treatment of the interpersonal and more behavioral components of psychopathy using an integrated approach that combines elements of both the treatment of personality disorder and the more structured approaches to treating risk commonly used by forensic and correctional treatment services.

The subsequent three chapters offer different perspectives on treating the self and identity problems associated with personality disorder. This is an important domain of personality pathology that has not always received the attention it warrants, although it has recently been given greater prominence by the current emphasis on the general features of personality disorder as opposed to specific diagnoses. This prominence is reflected in the DSM-5, Section 3, proposed definition of personality disorders as a combination of chronic interpersonal dysfunction and self-identity problems. The theme is introduced in Chapter 17, by Giancarlo Dimaggio, Raffaele Popolo, Antonino

Carcione, Giampaolo Salvatore, and William B. Stiles, who discuss ways to elaborate and enrich patients' self-narratives. This is an important topic. The self-systems of most patients are poorly developed, and many lack an adaptive self-narrative to guide action and give direction and purpose to their lives and to help promote more adaptive personality functioning. The chapter discusses the importance of self-narratives or scripts to place the issue in the broader context of overall personality functioning before examining the kinds of problems observed in the life scripts of patients with personality disorder. This discussion sets the stage for presenting strategies for constructing more adaptive scripts. An eclectic approach is used that combines narrative methods, metacognitive strategies, and behavioral exposure and behavioral experiments.

Chapter 18, by John F. Clarkin, Frank Yeomans, Chiara De Panfilis, and Kenneth N. Levy, examines the challenge of constructing a more adaptive self-system from a different perspective—that of object relations theory—that conceptualizes identity and interpersonal functioning as intertwined structures and processes arising from the same interactional matrix. The authors suggest that some of the concepts and procedures emphasized by object relations therapy, including a focus on the patient–therapist relationship, could be useful components of an integrated treatment that addresses both the disturbed behavior and the disturbed internal world associated with severe self-pathology. In the final chapter to examine self and identity problems, Giampaolo Salvatore, Raffaele Popolo, and Giancarlo Dimaggio offer a complementary approach to integrating the disjunctions existing in the self-states and inner experience of patients with severe personality disorder. Rather than focusing on the use of the patient–therapist relationship as a vehicle for integration, Salvatore and colleagues examine the way the ongoing reformulation of a case during treatment may be used to promote integration of separate and disparate self-states. Throughout the volume, reference has been made to the importance of formulation in planning and delivering treatment and the need to revise the formulation throughout therapy as new information becomes available. Viewed from this perspective, the formulation is a blueprint both for therapy and for constructing a more adapive self-script. Collaborative work in reformulation allows the patient to revise and reconstruct the formulation so that it becomes the basis for an autobiographical self-narrative.

Our experience in editing this volume and working with authors with diverse theoretical orientations and interests is that psychotherapy integration is difficult and challenging. We anticipate that the reader who wishes to practice integrated treatment will also find it challenging, at least initially. However, we also believe it necessary to improving treatments for personality disorder. Consequently, we gave considerable thought to what else we could do as editors to help the reader to assimilate the ideas discussed. This deliberation led to the inclusion of a case, in Part VI, "Integration," that illustrates an integrated approach in the treatment of a specific patient with multiple problems so that the reader can see how the therapist struggled with integrating different intervention strategies (Chapter 20). Although we have placed this

at the end of the book, the reader may find it helpful to peruse this earlier. Finally, in Chapter 21, we attempt to synthesize the main ideas.

There are similarities but also major differences between what we are advocating here and what the major empirically supported treatments have done for patients with personality disorders. We are suggesting a unified approach to any patient with a personality disorder, not just one of the specific categories of personality disorder. We agree with the major treatment designers about the need to provide the therapist with a unified conception of psychopathology to guide treatment. In contrast to the major treatments that focus on a single concept (e.g., affect dysregulation, mentalization, internal object relations, or interpersonal schemas), we use a framework based on domains of dysfunction in these patients. The authors in this volume have indicated the major domains of dysfunction that they encounter in their work. Although the logical empirical approach to the single-focus therapies is to compare their approaches with treatment as usual or with a competing treatment, our approach would have to be examined at the level of the individual patient and the success or failure with the domains of dysfunction relevant to that patient.

We have considered the integration of multiple strategies and techniques for domains of dysfunction in patients with a personality disorder diagnosis limited to the individual-treatment format. We have not examined integration as applied to marital, family, or group treatment formats, nor to treatments with multiple modalities, such as a day-hospital approach. This first focus seemed appropriate, as the individual format alone or combined with group format (e.g., DBT) has enjoyed the most empirical investigation. Finally, in the spirit of what has been articulated so far, we are not intending to develop a manualized treatment (with a three-letter name) leading to a randomized clinical trial with dedicated followers for our approach.

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