Journal of Psychotherapy Integration
2015, Vol. 25, No. 1, 49–57

1053-0479/15/$12.00 http://dx.doi.org/10.1037/a0038771

SPECIAL COMMENTARY

Integrated Treatment for Personality Disorders: A Commentary

Kenneth N. Levy and J. Wesley Scala
Pennsylvania State University

Despite the articulation and growing evidence for shared properties in effective psychotherapies (Castonguay, 2000; Wampold, 2001) and the value of integrated protocols (Krueger & Glass, 2013), the training and the provision of psychotherapy are becoming increasingly monothetic (Govrin, 2014; Heatherington et al., 2012; Levy & Anderson, 2013; Wachtel, 2014). This movement toward monocultures is in contrast to the development of a comprehensive and integrative theory of psychotherapy that operates across different biological, psychological, and social levels (Dimaggio & Lysaker, 2014; Levy & Anderson, 2013). The Society for the Exploration of Psychotherapy Integration (SEPI) and the *Journal of Psychotherapy Integration* can potentially serve an important role in the field by providing a context in which thoughtful scholars capable of generating comprehensive and integrative theories of psychotherapy, and researchers capable of translating and operationalizing complex concepts, can work toward this shared goal. This special issue edited by Dimaggio (2015b) and including leading integrative thinkers in the field represents such an effort. The editor and contributors are to be congratulated for their thoughtful and stimulating papers.

Personality disorders (PDs) are important to psychotherapists because these difficulties derive through developmental processes (Levy, 2005) and are thus more amenable to psychological interventions rather than to psychopharmacological ones. Research shows that personality disorders are highly prevalent. Recent epidemiological studies suggest that PDs have a prevalence rate between 9 and 15% in the general population (Grant et al., 2004; Trull, Jahng, Tomko, Wood, & Sher, 2010), whereas clinical studies have found that 40% of outpatients have a diagnosable PD (Zimmerman, Rothschild, & Chelminski, 2005). With these prevalence rates PDs are more common than schizophrenia, bipolar disorder, and autism combined. Personality disorders are also commonly comorbid with a range of other disorders such as bipolar disorder, depression, anxiety disorders, eating disorders, posttraumatic stress disorder, and substance abuse disorders. This comorbidity is especially meaningful given that the presence of PDs negatively affects the course and treatment efficacy for these disorders (see Newton-Howes, Tyrer, & Johnson, 2006).

With such high prevalence rates and comorbidity almost half the patients a clinician will treat on an outpatient basis, regardless of other diagnoses or presenting problems, will have a diagnosable personality disorder that will affect the course and outcome for the patient. In addition, many more patients are subthreshold for a personality disorder, which also poses a significant challenge for clinicians. For instance, Zimmerman and colleagues found that the presence of only a single borderline personality disorder (BPD) symptom increases the likelihood of suicide attempts, suicidal ideation, worse social and occupational functioning, and greater utilization of health care services (Ellison, Rosenstein, Chelminski, Dalrymple, & Zimmerman, in press; Zimmerman, Chelminski, Young, Dalrymple, & Martinez, 2012). Thus, it is incumbent on the treating clinician to not only assess for PDs when treating patients who suffer from problems that are frequently comorbid with PDs but to also privilege the treatment of PDs.

Despite the presence of a number of empirically supported, efficacious treatments for per-

Kenneth N. Levy and J. Wesley Scala, Department of Psychology, Pennsylvania State University.

Correspondence concerning this commentary should be addressed to Kenneth N. Levy, Department of Psychology, Pennsylvania State University, 362 Bruce V. Moore Building, University Park, PA 16802. E-mail: klevy@psu.edu

sonality disorders, individuals with PDs continue to pose a significant challenge for the treating clinician. An integrative approach to the treatment of personality disorders is likely to advance our understanding of and ability to treat PDs more effectively. The papers in this special issue represent a thoughtful and creative contribution to current thinking about integrative treatments for personality disorders.

Dimaggio, Salvatore, Lysaker, Ottavi, and Popolo (2015) posit that behavioral activation (BA) can be a key principle of change in the psychotherapy for personality disorders. Consistent with their contention, most empirically supported treatments for BPD stress the importance of the patient being "active" through work, exercise, and/or other investments. The rationale is that by "doing," patients will a) experience events that stimulate experiences and material for consideration in treatment, b) experience exposure to feared situations and learn that these experiences are tolerable and can result in the development of increased efficacy, and c) experience affective-exposures that lead to affect and distress tolerance, particularly in the "real world," which are particularly generalizable. In their description of BA with PD patients, Dimaggio and colleagues focus on avoidant and dependent patients. However, they clearly see this technique as having value with more severely disturbed patients such as those with BPD.

In their model, BA is not limited to the provision of environmental reinforcements and reduction of environmental punishments but also as an opportunity to rework maladaptive interpersonal schemas and thus view oneself differently—as efficacious and agentic. Dimaggio and colleagues stress the importance of supporting and validating the patient in the context of negotiating problems interfering with the patient's ability to utilize BA interventions. This is a creative idea for sure. However, it is important to note that not all patients with PDs respond positively to validation. The evidence for mutative aspects of validation is mixed. There is converging evidence that validation can have a negative, disorganizing impact on BPD patients, especially early on in treatment (Prunetti et al., 2008). Additionally, borderline patients can have strong negative emotional reactions to positive affect (Scott et al., 2014), become antagonistic in response to feelings of closeness (Bartz et al., 2011), and validation in the face of doubt can lead to greater levels of depression (Wood, Perunovic, & Lee, 2009).

Dimaggio (2015a) contends that a focus on maladaptive interpersonal schemas is a "mandatory treatment goal in any treatment for PDs." In doing so, Dimaggio highlights some of the ways this concept operates in other treatments such as Transference-Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006), Schema-Focused Psychotherapy (SFT; Young, Klosko, & Weishaar, 2003), and Dialectical Behavior Therapy (DBT; Linehan, 1993), among others. Dimaggio notes that there are many areas of consensus among these approaches but points out that there is less consensus regarding the structure of schemas and the patient's level of awareness of such schemas. In addressing the issue of structure, Dimaggio draws upon the work by Luborsky and colleagues and their Core Conflictual Relationship Theme model (CCRT; Luborsky & Crits-Christoph, 1990) which identifies a representation of the self, of the other, and wished and feared aspects of the relationship between the self and other representation. Dimaggio suggests that the central treatment approaches to PDs do not utilize the CCRT model sufficiently.

In addressing Dimaggio's paper, we would like to stress three issues. First, we could not agree more strongly with Dimaggio's contention about the centrality of a concept such as maladaptive interpersonal schema. We too agree that most treatments have described constructs similar to maladaptive interpersonal schema, particularly psychodynamic concepts of object relations (Levy, Scala, Temes, & Clouthier, in press) including concepts such as the quality of object relations (QOR; Amlo et al., 1993; Piper et al., 1999; Piper, Azim, Joyce, & McCallum, 1991), object relations dyads (ORD; Kernberg, 1984), internal working models (IWM; Bowlby, 1973), but also schemas (Young et al., 2003). Even the idea of a cognitive affective processing system (CAPS; Mischel & Shoda, 1995, 2008) is remarkably consistent with these perspectives (Clarkin, Levy, & Ellison, 2010). Second, Dimaggio models for us the importance of thinking integratively. Limiting oneself to one's own perspective and adherence to that jargon is a vice that should not be tolerated because doing so results in missing important ideas and nuance. For instance, psy-

chodynamic therapy (PDT) concepts of representation include a strong emphasis on many of the issues Dimaggio raises, such as the structure of representations or schemas. PDT conceptions also stress structural issues such as the degree of differentiation and integration of representations as well as their hierarchical organization, all of which have implications for the capacity to maintain a consistent sense of oneself and of others, for accessing soothing representations, and for the tendency to vacillate between disparate mental states. PDT conceptions also emphasize the affective link between representations and that affective experience includes object relations (Jurist, 2005; Kernberg, 1984). Finally, PDT conceptions of representation have also focused on what Dimaggio calls "levels of awareness." From their inception, PDT approaches have focused on levels of consciousness and bringing unconscious processes into consciousness. However, as pointed out by Wachtel (2005), consciousness is better conceptualized as a matter of degree of accessibility and articulation than as a discrete division between conscious and unconscious. The therapist's close attendance to and monitoring of the patient's phenomenological experience of themselves and others is essential for deepening the patient's experience and facilitating greater integration, which allows for experience to be accessible for introspection, reflection, and conscious decision making. CBT perspectives remind us of the importance of conscious experience and the valence and content of schemas. Debates over the relative weight of conscious versus unconscious thought—or even if there is unconscious thought and associated defensive processes—occupied the literature for many years. Current findings from diverse areas of psychology such as social, cognitive, developmental, and neuroscience (Custers & Aarts, 2010; McClelland, Koestner, & Weinberger, 1989; Weinberger, Siefert, & Haggerty, 2010; Weinberger, Siegel, Siefert, & Drwal, 2011; Wilson, Lindsey, & Schooler, 2000) are consistent with the conceptualizations by Kernberg and others stressed by Dimaggio and highlighted by us.

Clarkin and colleagues (Clarkin, Cain, & Livesley, 2015) highlight a recent shift in thinking about PDs from a focus on symptoms and categorically based disorders to a focus on underlying domains of dysfunction, particularly in terms of self and interpersonal functioning (Cuthbert & Insel, 2013; Insel et al., 2010; Sanislow et al., 2010). These authors expand on Livesley's modular integrated treatment approach (Livesley, Dimaggio, & Clarkin, in press), which involves the articulation of a more tailored approach to treatment utilizing various aspects of existing empirically supported treatments, and focusing on the individuality of the patient in terms of their strengths, weaknesses, and unique environmental contexts. Clarkin and colleagues' integrated approach has a number of strengths that are important to note. They focus on linking treatment approaches to concepts in the *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition* (DSM-5; American Psychiatric Association, 2013) in terms of domains of dysfunctions, particularly with regard to self and interpersonal functioning. The growing emphasis on conceptualizing PDs in terms of broader domains of dysfunction is important and is not only reflected in the recently proposed DSM-5 model of PDs (Skodol, Bender et al., 2011; Skodol, Clark et al., 2011) but also in NIMH's push for research utilizing *research domain criteria* (RDoC; Cuthbert & Insel, 2013; Insel et al., 2010; Sanislow et al., 2010), a method of classifying psychopathology based on broad domains that cut across different levels of analysis. As integrated treatments for PDs are developed, further refined, and researched, it will be important for these treatments to incorporate and consider these changing views of PDs. However, it may be premature to move to such models, particularly the RDoC model, which while conceptually useful for guiding research has less value for guiding clinicians at this time. Another strength of Clarkin and colleagues' approach is their focus on tailoring treatment based on individual characteristics of the patient that are relevant for delivering interventions. Clarkin et al. also point out that patterns of interaction between the patient and therapist can be particularly informative when working with patients who are poor at recognizing their own problematic ways of interacting with others outside of therapy.

McMain, Boritz, and Leybman (2015) provide a rich and nuanced perspective on the ways in which various specified treatments for BPD operationalize how to manage the patient–therapist relationship. Much of the focus is on cultivating a positive alliance. McMain and col-

leagues' work is truly integrative in trying to help the clinician avoid ruptures that impact the alliance. However, it is important to note that the early alliance–later outcome relationship, which is quite robust in general, tends to be much weaker for BPD patients (Scala, Ellison, & Levy, 2014). This finding is consistent with clinical folklore that notes that a strong alliance with BPD patients is neither easily achieved nor predictive early on in treatment but rather it is the outcome of a successful treatment. Another important issue with regard to the alliance in BPD has to do with distinguishing between positive alliance and patient idealizations of the therapist, which ironically may suggest a weak alliance in that the patient's idealizations can be an attempt to protect the therapist from their anger at the therapist. A goal in the treatment of BPD is for the patient to develop a stable, essentially positive but ealistic alliance with the therapist.

As Paris (2015) points out, sufficient evidence has amassed suggesting that there are a number of specified treatments that show comparable efficacy when compared to TAU (Doering et al., 2010; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), in direct comparison with each other (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; McMain et al., 2009), and in terms of within- and between-group effect sizes (Levy, 2014). Thus, there are a number of specialized treatments available to clinicians working with such patients. However, Paris also points out that while patients may change in the theorized domains (e.g., Levy et al., 2006), there is little evidence that the putative mechanisms are responsible for such changes. Instead, given the findings that multiple treatments show efficacy, Paris (as well as Clarkin et al., 2015 and McMain et al., 2015) joins a growing number of clinical researchers (Bateman & Fonagy, 2000; Levy, 2008, 2013; Schiavone & Links, 2013; Swenson, 1989; Zanarini, 2009) who have suggested that shared properties or common factors in these treatments are the most likely operative mechanisms of action in the treatment of BPD.

This leads Paris (2015) to suggest that DBT, because it contains these shared properties and has been replicated in a number of trials, should be considered the gold standard. While we agree that DBT is an excellent treatment, clearly integrative (Heard & Linehan, 1994), and has widely influenced the field for the better, we do not think that the data should be interpreted as suggesting any gold standard quite yet. First, while the findings from the literature would suggest that shared or common properties are in large part responsible for the outcomes seen, this idea has not been empirically tested. Thus we are unsure of which shared properties are operative and to what extent. It is quite possible that these shared properties are responsible for some improvement but that each of the treatments has unique contributions too. It is also possible, given the heterogeneity in BPD, that some treatments might be better for particular patient presentations. Second, given the relatively modest change we do see (e.g., only 50–60% of patients are improving and average posttreatment GAF scores in the 60s range), it might be more fruitful to assess the nonshared aspects that can then be integrated across treatments and possibly improve the rate and level of change. Third, we would suggest that the fact that there have been a number of replications trials of DBT does not mean that it has more evidence than other less tested treatments. Rather, because the effect sizes are no different for DBT compared to other tested treatments, we would argue that the evidence suggests that DBT's equivalency to these other tested treatments is more firmly established.

Paris contends that DBT principles may have been integrated into the larger community, thereby reducing the effect sizes of DBT and TAU. However, again the data are inconsistent with that view. DBT has shown moderate ES in comparison with TAU (Kliem, Kröger, & Kosfelder, 2010), but when compared to alternative treatments (Clarkin et al., 2007; Linehan et al., 2002; McMain et al., 2009; Sachdeva, Goldman, Mustata, Deranja, & Gregory, 2013), there is no difference in outcome or ES (Kliem et al., 2010; Levy, 2014). What the data does tell us is that there is no gold standard treatment but, rather, there are a number of treatments that have been well articulated (e.g., manualized), that can be taught to others, and that have shown moderate efficacy in comparison to TAUs but no reliable differences with each other. Again, given the heterogeneity in BPD, some treatments may be better for certain patients while other treatments may be better for certain other patients. But we have little evidence that would guide such prescriptions. Ad-

ditionally, although the various treatments have many shared or common properties, there may be unique aspects to these treatments that could be integrated in order to improve outcomes. However, these studies have not been carried out.

Our concern is that by declaring one treatment as the gold standard and containing all the necessary shared properties (when it's outcome is no different than other specified treatments and without yet testing which are the effective shared properties) we foreclose on and inhibit the kind of innovation necessary to improve treatments for BPD and instead propagate the status quo when exactly the opposite is needed.

We would also challenge the idea that BPD can be thought of as a good outcome disorder and that short-term treatments are sufficient. While it is true that the participants in the McLean Study of Adult Development (MSAD; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005) and Collaborative Longitudinal Study of Personality Disorders (CLPS; Lenzenweger, 2006) showed unexpected levels of symptom reduction including high rates of remission of a BPD diagnosis over a 10-year period, functional impairment remained impaired when compared to major depressive disorder and OCPD (Skodol, 2008). It is also important to stress that the CLPS and MSAD samples do not represent a naturalistic follow-along sample. The participants in these studies were in treatment (many in the kind of treatments that have shown efficacy). However, in these studies, treatments were not well specified and therefore difficult to examine for effects.

With regard to short- versus long-term treatments, there is little doubt that we can see symptom reduction within 4–6 months and certainly within a year's time in those patients that respond. The symptom change we see is not just statistically significant but clinically significant too. That is, for many patients the symptom reduction leads to a qualitatively better life—a life out of the emergency room and hospital and with less turbulent and closer relationships. However, these changes, while important, often fall far short of what our patients aspire toward. These changes are often short of the "life worth living" goal that Linehan articulated or the "love and work" ideal that Freud and other psychoanalytic writers espoused. Along these lines, Howard, Lueger, Martinovich, and Lutz (1999) suggested a three-phase dose-response model of psychotherapy in which patients initially experience remoralization (the initial boost experienced from the feeling that help is there), followed by remediation (symptom reduction), and finally by rehabilitation (establishing adaptive ways of living, also conceived of as personality change). Remoralization is usually accomplished quickly, whereas remediation is more gradual and typically occurs between 3 and 8 months. Rehabilitation is quite gradual and can take years. Each phase may have different treatment goals, measurable by different outcome variables, and require different interventions.

Paris is on point regarding his suggestion to develop integrated principles rather than "acronym-based treatments." However, there is no reason to believe that people who treat borderline patients' wouldn't need extensive, specialized training/supervision. One of the advances Linehan brought forward was to formulize and operationalize training. Since Linehan articulated a training model, which other treatments have emulated, psychotherapy training for treating personality disorders has moved from a highly inefficient one-on-one supervision with an identified "Guru," to more transparent, structured, and exported training experiences that include articulated principles in manuals, workshops, and intensive trainings. Nonetheless, this training model does require some combination of individual and group supervision or intervision. Moving to principle-based understanding of treatment should not license clinicians to feel as if they don't need proper and extensive training and supervision.

We conclude with an analogy from the well-known Hindu fable, where six blind individuals touching different parts of an elephant imagine six very different creatures. Each person extrapolates from his or her own distinct perspective and each has a tangible piece of the elephant—yet none envisions the elephant as a whole. A parallel can be drawn between this fable and psychotherapy treatment of personality disorders. While each treatment approach provides evocative and important descriptions of how to treat the personality disordered patient, the juxtaposition of these approaches can lead to meaningful theoretical integration and most importantly treatment advances. As with the proverbial elephant in which the parts obscure the whole, the divergent

views among psychotherapeutic perspectives collectively serve to fragment the field. The thoughtful contributions to this special issue have grappled with difficult issues and brought us closer to a coherent vision of the "elephant." Importantly, they not only provide us with some significant guidance but also raise crucial questions for future research.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Amlo, S., Engelstad, V., Fossum, A., Sørlie, T., Høglend, P., Heyerdahl, O., & Sørbye, O. (1993). Interpretations of the patient–therapist relationship in brief dynamic psychotherapy: Effects on long-term mode-specific changes. *The Journal of Psychotherapy Practice and Research, 2,* 296–306.

Bartz, J., Simeon, D., Hamilton, H., Kim, S., Crystal, S., Braun, A., . . . Hollander, E. (2011). Oxytocin can hinder trust and cooperation in borderline personality disorder. *Social Cognitive and Affective Neuroscience, 6,* 556–563. http://dx.doi.org/10.1093/scan/nsq085

Bateman, A. W., & Fonagy, P. (2000). Effectiveness of psychotherapeutic treatment of personality disorder. *The British Journal of Psychiatry, 177,* 138–143. http://dx.doi.org/10.1192/bjp.177.2.138

Bowlby, J. (1973). *Attachment and loss: Vol. II. Separation: Anxiety and anger*. New York, NY: Basic Books.

Castonguay, L. G. (2000). A common factors approach to psychotherapy training. *Journal of Psychotherapy Integration, 10,* 263–282. http://dx.doi.org/10.1023/A:1009496929012

Clarkin, J. F., Cain, N. M., & Livesley, W. J. (2015). An integrated approach to treatment of patients with personality disorders. *Journal of Psychotherapy Integration, 25,* 3–12.

Clarkin, J. F., Levy, K. N., & Ellison, W. D. (2010). Personality disorders. In L. M. Horowitz & S. Strack (Eds.), *Handbook of interpersonal psychology: Theory, research, assessment, and therapeutic interventions* (pp. 377–401). New York, NY: Wiley.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *The American Journal of Psychiatry, 164,* 922–928. http://dx.doi.org/10.1176/ajp.2007.164.6.922

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality disorder: Focusing on object relations*. Arlington, VA: American Psychiatric Publishing.

Custers, R., & Aarts, H. (2010). The unconscious will: How the pursuit of goals operates outside of conscious awareness. *Science, 329,* 47–50. http://dx.doi.org/10.1126/science.1188595

Cuthbert, B. N., & Insel, T. R. (2013). Toward the future of psychiatric diagnosis: The seven pillars of RDoC. *BMC Medicine, 11,* 126. http://dx.doi.org/10.1186/1741-7015-11-126

Dimaggio, G. (2015a). Awareness of maladaptive interpersonal schemas as a core element of change in psychotherapy for personality disorders. *Journal of Psychotherapy Integration, 25,* 39–44.

Dimaggio, G. (2015b). Integrated treatment for personality disorders: An introduction. *Journal of Psychotherapy Integration, 25,* 45–53.

Dimaggio, G., & Lysaker, P. H. (2014). Supporters of a single orientation may do less for science and the health of patients than integrationists: A reply to Govrin (2014). *Journal of Psychotherapy Integration, 24,* 91–94. http://dx.doi.org/10.1037/a0036996

Dimaggio, G., Salvatore, G., Lysaker, P. H., Ottavi, P., & Popolo, R. (2015). Behavioral activation revisited as a key principle of change in personality disorders psychotherapy. *Journal of Psychotherapy Integration, 25,* 30–38.

Doering, S., Hörz, S., Rentrop, M., Fischer-Kern, M., Schuster, P., Benecke, C., . . . Buchheim, P. (2010). Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: Randomised controlled trial. *The British Journal of Psychiatry, 196,* 389–395. http://dx.doi.org/10.1192/bjp.bp.109.070177

Ellison, W. D., Rosenstein, L., Chelminski, I., Dalrymple, K., & Zimmerman, M. (in press). The clinical significance of single features of borderline personality disorder: Anger, affective instability, impulsivity, and chronic emptiness in psychiatric outpatients. *Journal of Personality Disorders*.

Govrin, A. (2014). The vices and virtues of monolithic thought in the evolution of psychotherapy. *Journal of Psychotherapy Integration, 24,* 79–90. http://dx.doi.org/10.1037/a0035972

Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Chou, S. P., Ruan, W. J., & Pickering, R. P. (2004). Prevalence, correlates, and disability of personality disorders in the United States: Results from the national epidemiologic survey on alcohol and related conditions. *The Journal of Clinical Psychiatry, 65,* 948–958. http://dx.doi.org/10.4088/JCP.v65n0711

Heard, H. L., & Linehan, M. M. (1994). Dialectical behavior therapy: An integrative approach to the treatment of borderline personality disorder. *Journal of Psychotherapy Integration, 4,* 55–82.

Heatherington, L., Messer, S. B., Angus, L., Strauman, T. J., Friedlander, M. L., & Kolden, G. G.

(2012). The narrowing of theoretical orientations in clinical psychology doctoral training. *Clinical Psychology: Science and Practice, 19,* 364–374. http://dx.doi.org/10.1111/cpsp.12012

Howard, K. I., Lueger, R. J., Martinovich, Z., & Lutz, W. (1999). The cost-effectiveness of psychotherapy: Dose-response and phase models. In N. E. Miller & K. M. Magruder (Eds.), *Cost effectiveness of psychotherapy: A guide for practitioners, researchers, and policymakers* (pp. 143–152). New York, NY: Oxford University Press.

Insel, T., Cuthbert, B., Garvey, M., Heinssen, R., Pine, D. S., Quinn, K., . . . Wang, P. (2010). Research domain criteria (RDoC): Toward a new classification framework for research on mental disorders. *The American Journal of Psychiatry, 167,* 748–751. http://dx.doi.org/10.1176/appi.ajp.2010.09091379

Jurist, E. L. (2005). Mentalized affectivity. *Psychoanalytic Psychology, 22,* 426–444. http://dx.doi.org/10.1037/0736-9735.22.3.426

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press.

Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting and Clinical Psychology, 78,* 936–951. http://dx.doi.org/10.1037/a0021015

Krueger, S. J., & Glass, C. R. (2013). Integrative psychotherapy for children and adolescents: A practice-oriented literature review. *Journal of Psychotherapy Integration, 23,* 331–344. http://dx.doi.org/10.1037/a0034949

Lenzenweger, M. F. (2006). The longitudinal study of personality disorders: History, design considerations, and initial findings. *Journal of Personality Disorders, 20,* 645–670. http://dx.doi.org/10.1521/pedi.2006.20.6.645

Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Development and Psychopathology, 17,* 959–986. http://dx.doi.org/10.1017/S0954579405050455

Levy, K. N. (2008). Psychotherapies and lasting change. *The American Journal of Psychiatry, 165,* 556–559. http://dx.doi.org/10.1176/appi.ajp.2008.08020299

Levy, K. N. (2013). Treating borderline personality disorder. In G. P. Koocher, J. C. Norcross, & B. A. Greene (Eds.), *Psychologist's desk reference* (3rd ed., pp. 193–196). New York, NY: Oxford University Press.

Levy, K. N. (2014). Recent empirical findings on borderline personality disorder and their implications for integrated treatment. In S. B. Messer (Chair), *Psychotherapy integration and different modes of treating borderline personality*. Paper presented at the annual meeting of the Society for the Exploration of Psychotherapy Integration, Montreal, Quebec, Canada.

Levy, K. N., & Anderson, T. (2013). Is clinical psychology doctoral training becoming less intellectually diverse? And if so, what can be done? *Clinical Psychology: Science and Practice, 20,* 211–220. http://dx.doi.org/10.1111/cpsp.12035

Levy, K. N., Clarkin, J. F., Yeomans, F. E., Scott, L. N., Wasserman, R. H., & Kernberg, O. F. (2006). The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. *Journal of Clinical Psychology, 62,* 481–501. http://dx.doi.org/10.1002/jclp.20239

Levy, K. N., Scala, J. W., Temes, C. M., & Clouthier, T. (in press). An integrative attachment framework of personality pathology. In S. Huprich (Ed.), *Personality disorders in the 21st century*. Washington, DC: American Psychological Association.

Linehan, M. M. (1993). *Cognitive behavioral therapy for borderline personality disorder*. New York, NY: Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060–1064. http://dx.doi.org/10.1001/archpsyc.1991.01810360024003

Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Welch, S. S., Heagerty, P., & Kivlahan, D. R. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67,* 13–26. http://dx.doi.org/10.1016/S0376-8716(02)00011-X

Livesley, J., Dimaggio, G., & Clarkin, J. F. (in press). An integrated modular approach to the treatment of personality disorders. New York, NY: Guilford Press.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The core conflictual relationship theme*. New York, NY: Basic Books.

McClelland, D. C., Koestner, R., & Weinberger, J. (1989). How do self-attributed and implicit motives differ? *Psychological Review, 96,* 690–702. http://dx.doi.org/10.1037/0033-295X.96.4.690

McMain, S. F., Boritz, T., & Leybman, M. J. (2015). Common strategies for cultivating a positive therapeutic relationship in the treatment of borderline personality disorders. *Journal of Psychotherapy Integration, 25,* 20–29.

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized trial of dialectical behavior

therapy versus general psychiatric management for borderline personality disorder. *The American Journal of Psychiatry, 166,* 1365–1374. http://dx.doi.org/10.1176/appi.ajp.2009.09010039

Mischel, W., & Shoda, Y. (1995). A cognitive-affective system theory of personality: Reconceptualizing situations, dispositions, dynamics, and invariance in personality structure. *Psychological Review, 102,* 246–268. http://dx.doi.org/10.1037/0033-295X.102.2.246

Mischel, W., & Shoda, Y. (2008). Toward a unified theory of personality: Integrating dispositions and processing dynamics within the cognitive-affective processing system. In O. P. John, R. W. Robins, & L. A. Pervin (Eds.), *Handbook of personality: Theory and research* (3rd ed., pp. 208–241). New York, NY: Guilford Press.

Newton-Howes, G., Tyrer, P., & Johnson, T. (2006). Personality disorder and the outcome of depression: Meta-analysis of published studies. *The British Journal of Psychiatry, 188,* 13–20. http://dx.doi.org/10.1192/bjp.188.1.13

Paris, J. (2015). Applying the principles of psychotherapy integration to the treatment of borderline personality disorder. *Journal of Psychotherapy Integration, 25,* 13–19.

Piper, W. E., Azim, H. F. A., Joyce, A. S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48,* 946–953. http://dx.doi.org/10.1001/archpsyc.1991.01810340078010

Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., McCallum, M., Rosie, J. S., O'Kelly, J. G., & Steinberg, P. I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 36,* 114–122. http://dx.doi.org/10.1037/h0087787

Prunetti, E., Framba, R., Barone, L., Fiore, D., Sera, F., & Liotti, G. (2008). Attachment disorganization and borderline patients' metacognitive responses to therapists' expressed understanding of their states of mind: A pilot study. *Psychotherapy Research, 18,* 28–36. http://dx.doi.org/10.1080/10503300701320645

Sachdeva, S., Goldman, G., Mustata, G., Deranja, E., & Gregory, R. J. (2013). Naturalistic outcomes of evidence-based therapies for borderline personality disorder at a university clinic: A quasi-randomized trial. *Journal of the American Psychoanalytic Association, 61,* 578–584. http://dx.doi.org/10.1177/0003065113490637

Sanislow, C. A., Pine, D. S., Quinn, K. J., Kozak, M. J., Garvey, M. A., Heinssen, R. K., . . . Cuthbert, B. N. (2010). Developing constructs for psychopathology research: Research domain criteria. *Journal of Abnormal Psychology, 119,* 631–639. http://dx.doi.org/10.1037/a0020909

Scala, J. W., Ellison, W. D., & Levy, K. N. (2014). *The working alliance in the treatment of borderline personality disorder: A meta-analysis.* In K. N. Levy (Chair), *Alliance at the border: Establishing, maintaining, and researching alliance in patients with borderline personality disorder.* Paper presented at the annual meeting of the Society for Psychotherapy Research, Copenhagen, Denmark.

Schiavone, F. L., & Links, P. S. (2013). Common elements for the psychotherapeutic management of patients with self-injurious behavior. *Child Abuse & Neglect, 37,* 133–138. http://dx.doi.org/10.1016/j.chiabu.2012.09.012

Scott, L. (2014). *Pupil reactivity to interpersonal stress predicts greater BPD symptoms for girls who experienced early adversity.* In R. Auerbach and C. Conway (Chair), Can environment trigger BPD? New evidence and clinical lessons from stress research. Paper presented at the annual conference of the Association for Behavioral and Cognitive Therapies, Philadelphia, PA.

Skodol, A. E. (2008). Longitudinal course and outcome of personality disorders. *Psychiatric Clinics of North America, 31,* 495–503. http://dx.doi.org/10.1016/j.psc.2008.03.010

Skodol, A. E., Bender, D. S., Oldham, J. M., Clark, L. A., Morey, L. C., Verheul, R., . . . Siever, L. J. (2011). Proposed changes in personality and personality disorder assessment and diagnosis for DSM-5 Part II: Clinical application. *Personality Disorders: Theory, Research, and Treatment, 2,* 23–40. http://dx.doi.org/10.1037/a0021892

Skodol, A. E., Clark, L. A., Bender, D. S., Krueger, R. F., Morey, L. C., Verheul, R., . . . Oldham, J. M. (2011). Proposed changes in personality and personality disorder assessment and diagnosis for *DSM-5* Part I: Description and rationale. *Personality Disorders: Theory, Research, and Treatment, 2,* 4–22. http://dx.doi.org/10.1037/a0021891

Swenson, C. (1989). Kernberg and Linehan: Two approaches to the borderline patient. *Journal of Personality Disorders, 3,* 26–35. http://dx.doi.org/10.1521/pedi.1989.3.1.26

Trull, T. J., Jahng, S., Tomko, R. L., Wood, P. K., & Sher, K. J. (2010). Revised NESARC personality disorder diagnoses: Gender, prevalence, and comorbidity with substance dependence disorders. *Journal of Personality Disorders, 24,* 412–426. http://dx.doi.org/10.1521/pedi.2010.24.4.412

Wachtel, P. L. (2005). Anxiety, consciousness, and self-acceptance: Placing the idea of making the unconscious conscious in an integrative framework. *Journal of Psychotherapy Integration, 15,* 243–253. http://dx.doi.org/10.1037/1053-0479.15.3.243

Wachtel, P. L. (2014). On the limits of theoretical fundamentalism. *Journal of Psychotherapy Integration, 24,* 95–98. http://dx.doi.org/10.1037/a0036973

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

Weinberger, J., Siefert, C. J., & Haggerty, G. (2010). Implicit processes in social and clinical psychology. In J. E. Maddux & J. P. Tangney (Eds.), *Social psychological foundations of clinical psychology* (pp. 461–475). New York, NY: Guilford Press.

Weinberger, J., Siegel, P., Siefert, C., & Drwal, J. (2011). What you cannot see can help you: The effect of exposure to unreportable stimuli on approach behavior. *Consciousness and Cognition, 20,* 173–180. http://dx.doi.org/10.1016/j.concog.2011.01.003

Wilson, T. D., Lindsey, S., & Schooler, T. Y. (2000). A model of dual attitudes. *Psychological Review, 107,* 101–126. http://dx.doi.org/10.1037/0033-295X.107.1.101

Wood, J. V., Perunovic, W. Q. E., & Lee, J. W. (2009). Positive self-statements: Power for some, peril for others. *Psychological Science, 20,* 860–866. http://dx.doi.org/10.1111/j.1467-9280.2009.02370.x

Young, J. E., Klosko, J., & Weishaar, M. E. (2003). *Schema therapy: A practitioners guide*. New York, NY: Guilford Press.

Zanarini, M. C. (2009). Psychotherapy of borderline personality disorder. *Acta Psychiatrica Scandinavica, 120,* 373–377. http://dx.doi.org/10.1111/j.1600-0447.2009.01448.x

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2005). The McLean Study of Adult Development (MSAD): Overview and implications of the first six years of prospective follow-up. *Journal of Personality Disorders, 19,* 505–523. http://dx.doi.org/10.1521/pedi.2005.19.5.505

Zimmerman, M., Chelminski, I., Young, D., Dalrymple, K., & Martinez, J. (2012). Does the presence of one feature of borderline personality disorder have clinical significance? Implications for dimensional ratings of personality disorders. *The Journal of Clinical Psychiatry, 73,* 8–12. http://dx.doi.org/10.4088/JCP.10m06784

Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of *DSM–IV* personality disorders in psychiatric outpatients. *The American Journal of Psychiatry, 162,* 1911–1918. http://dx.doi.org/10.1176/appi.ajp.162.10.1911

Received December 16, 2014
Accepted December 17, 2014 ■