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An Integrated Approach to Treatment of Patients With Personality Disorders

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We describe a framework for the application of treatment modules to the major domains of dysfunction manifested by clients with personality disorder. This integrated approach takes the clinician beyond the existing limited treatment research by using strategies and techniques from all the major treatment schools and orientations. This effort is necessary and timely because the field of personality disorders is currently struggling to further define and understand personality pathology beyond categories by articulating major dimensions of dysfunction across the personality disorder types marked by various degrees of severity.

Keywords: personality disorders, psychotherapy, psychotherapy integration

Personality disorders (PDs) are prevalent and debilitating and have a powerful negative impact on work functioning and intimate and interpersonal relations. There are many impediments to the treatment of patients with personality pathology, including controversies in defining PD, the rampant comorbidity among PDs and with symptom disorders, the range of severity across the disorders, the difficulties in identifying the key dimensions of personality dysfunction, and the paucity of treatment research on the numerous PD types.

In this article, we articulate an integrated modular approach to the treatment of PDs. We describe a framework for the application of treatment modules to the major domains of dysfunction manifested by clients with PD. This is called an *integrated approach* (Stricker, 2010; Norcross & Wampold, 2011), because it takes the clinician beyond the existing treatment research—which is limited—and uses strategies and techniques from all the major treatment schools and orientations. An integrated modular approach emphasizes: (a) the individuality of the patient, and not the category of disorder, (b) the domains of dysfunction in the individual patient, (c) the therapeutic use of modules of intervention from existing clinical approaches, especially those that have been empirically investigated, and (d) the construction of a smooth fabric of intervention in the context of a developing alliance between therapist and patient.

Our attempt here and elsewhere (Livesley, Dimaggio, & Clarkin, in press) is to further the effort at integration by articulating a treatment framework specifically for those individuals with PDs. This effort is necessary because the field of PDs is currently struggling to further define and understand personality pathology beyond categories by articulating major dimensions of dysfunction across the PD types marked by various degrees of severity (Clarkin, 2013).

There is an emerging consensus that the essence of the PDs across the various categorical types centers on difficulties in self-functioning and interpersonal functioning (Sanislow et al., 2010). The product of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) Personality Disorder Work

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Group—located in Section III of *DSM-5* (2013)—provides a potential correction to the previously predominant focus on symptoms, because it brings the field back to focus on the essence of personality pathology that is self and interpersonal functioning.

Why Consider an Integrated Approach to Treatment?

Evidence-based practice is defined as the combination of best available research with clinical expertise in the context of patient characteristics, culture, and preferences. There is every cogent reason to use information from empirically supported treatments when available, but in reference to the PDs, the treatment research is limited to a few disorders, and even with those disorders, the results tend to be comparable across treatment packages. Evidence-based practice for PDs must contend with a number of limitations in the research literature, and use clinical expertise to match the individual client with the best treatment approaches.

The difficulties with applying the empirically supported treatment approach to the PDs are numerous. For example, PDs are marked by heterogeneity both within diagnosis and with comorbidity across the PDs. The various constellations that PD assumes make it difficult to articulate a treatment that fits all individuals even within one PD category. In addition, psychotherapy research to date is limited to a few disorders with relatively comparable effects. Only a few of the 10 *DSM* PDs have attracted psychotherapy research, with the vast majority of treatment research focused on borderline personality disorder (BPD). There is no indication that each disorder will be investigated with treatment research, but the clinician must proceed despite this situation.

There is also a growing awareness that genes and neurocognitive dysfunction are not specific to a particular diagnostic category, but rather are functions across diagnostic categories that are potential foci for therapeutic intervention. Molecular genetics will not provide a simple, gene-based classification of psychiatric illnesses, but rather genetic findings will likely delineate specific biological pathways and domains of psychopathology (Craddock, 2013). In this regard, the National Institute of Mental Health has declared an initiative to focus research not on categories of mental illness but on systems of neurocognitive functioning and dysfunction that extend across diagnostic categories (Hyman, 2011).

Finally, medicine in general is advancing toward an individualized approach to both assessment and treatment. Each individual is biologically unique, and this uniqueness suggests that treatment should be tailored to the individual. Although there are commonalities across people at the psychological level of functioning, it has become evident that each individual has a unique psychological history of development and engagement in the environment (Norcross & Wampold, 2011). This uniqueness is the focus of the clinicians' assessment of clients with suspected PD, the results of which guide the tailored intervention with that client.

With these issues in mind, we are recommending an integrated treatment approach that is probably already the most popular approach to the treatment of clients with PDs. We think it remains important to describe an integrated approach to the treatment of PDs in order to further clarify the issues and refine the approach. An articulation of an integrated approach to treatment may also legitimize the wise integrative approaches of many clinicians who worry that they are violating the empirical treatment recommendations.

What Is Integration?

We regard integration as a mental process engaged in by the clinician. This process begins at the first meeting between therapist and patient. The focus of the integration is the individual patient with a PD who is seeking help. The content of integration is the unique combination of domains of dysfunction matched with modules of intervention that are applied in a particular sequence over time.

In this conception of integration, one can conceive of a number of steps in this process: (a) arriving at a working conception of the patients' dysfunctional domains, (b) generating a vision of how the client could realistically achieve a better level of adjustment, (c) imagining how this client can improve over time in a stepwise, progressive pattern, (d) using therapeutic interventions timed to the client's readiness to change and salient problems at the moment, and (e) therapist awareness throughout

treatment of the client's perception of him or her and the impact on the process of change. The process of integration as conceptualized here is quite consistent with the empirically supported treatment approach mentioned before. In the absence of empirical evidence for specific treatments for each of the PDs, and in the absence of empirical information on mechanisms of change, the clinician is forced to use his or her clinical judgment moment-to-moment and across a treatment episode.

Probably the most salient exception to the dearth of empirically supported treatments for PDs is the treatment evidence for BPD. Cognitive–behavioral (Linehan, 1993), mentalization-based (Bateman & Fonagy, 2006), and object relations treatment (Clarkin, Yeomans, & Kernberg, 2006) are all empirically supported. Although we know that these treatment packages are associated with symptom change, there is little clarity about which elements in each approach are effective. In addition, some clients do not respond to the particular approach. It is possible that a more tailored approach to the particular patient with his or her unique strengths, weaknesses, and environment may produce significant change.

Different Approaches to Psychotherapy Integration

Stricker (2010) has summarized the history and approaches to psychotherapy integration, that is, common factors and technical, theoretical, and assimilative approaches. Each of these approaches deserves description to clarify how they might be used in full or in part for clients with PD. The *common factors approach* refers to the use of techniques that are used across treatments, regardless of the theoretical orientation. *Theoretical integration* is an attempt to integrate theories, such as behavioral theory and psychoanalytic theory, to guide the treatment interventions. Our own view is that the field of PDs has profited from multiple theoretical approaches, but none of which to date are comprehensive and empirically grounded to adequately guide therapeutic interventions (Lenzenweger & Clarkin, 2005). These theories are best described as part-theories. Theoretical integration concerning the PDs will advance as the empirical research progresses; however, the clinician cannot wait for the emergence of a comprehensive theory of personality and PDs and instead needs a near-experience model of personality and personality disordered functioning as a map to assessment and intervention. *Assimilative integration* is an approach that rests on one theoretical position, and from that position incorporating techniques from other therapeutic approaches.

The framework for an integrated modular approach in this article is closest to *technical integration*, which is the systematic use of techniques from numerous orientations without regard for theoretical orientation. Although we refer to a prominent theory of normal personality functioning to guide thinking, there is still no comprehensive theory of PDs (Lenzenweger & Clarkin, 2005).

An empirically supported theory of personality functioning can serve as a foundation for progressing to an understanding of personality dysfunction. For example, Mischel and Shoda (2008) have articulated a cognitive−affective processing system (CAPS) model of personality functioning that can provide an overall framework for understanding personality functioning. The CAPS model focuses on the processes by which individuals construe situations and themselves in adapting to the environment. This metatheory emphases five levels of experience: (a) an organized pattern of activation of internal cognitive−affective units (e.g., conceptions of self and others, expectancies and beliefs, affects, goals and values, self-regulatory plans), (b) behavioral expressions of this internal processing system, (c) self and other perception of these behaviors over time, (d) construction of one's typical environment, and (e) the predispositions at the biological and genetic levels of existence. This framework suggests that personality dysfunction can occur at multiple levels, and assessment of these crucial areas could guide targets for intervention. Lacking a comprehensive theory of personality pathology, we suggest that the therapist focus on the domains of dysfunction and how they manifest in the client's particular environment. With the CAPS model, the therapist would attend to both observable behavior and how the patient uses his or her particular conceptualizations of self-other interactions that guide behavior.

An Integrated Modular Approach

Given the issues we have described above with the assessment and treatment of PD, it seems logical to consider the specific client in terms of salient interpersonal difficulties and how these difficulties are manifested in that individual's unique environment. Domains of dysfunction and severity of these dysfunctions become as important in the clinical workup as the identification of the PD category itself. An integrated modular approach is an invitation to drop categorization of strategies and techniques related to therapy school (e.g., cognitive–behavioral, psychodynamic), and instead to focus on patient domains of dysfunction and a variety of ways to approach them with effective treatment modules.

Domains of Pathology in Clients With PDs

An integrated approach focuses on domains of pathology rather than on the specific diagnostic categories of PD. We do this because of the domains of dysfunction that are common across the various PD diagnoses. The central difficulty in those with PD is an observable dysfunction in interpersonal relations, with a more covert difficulty in the mental representations of self and others (Pincus, 2005; Kernberg, 1984). It is well documented that individuals scoring high on any PD dimension have considerable interpersonal difficulties characterized by a solitary lifestyle, conflicted and distressed social relations, and lack of social support (Hengartner, Müller, Rodgers, Rössler, & Ajdacic-Gross, 2014).

With a focus on the CAPS model (Mischel & Shoda, 2008), the domains of PD functioning can be identified through an inspection of *DSM-5*, self-report instruments, and theoretical descriptions of the PDs.

When the *DSM* categories are examined at the individual criterion level, one can recognize the following domains of dysfunction:

- Defective or relative absence of moral functioning (e.g., dishonesty, stealing, physical violence, disregard for the rights of others)
- Suicidal and self-destructive behavior; fearful behaviors; obsessive behaviors
- Difficulties relating to others (e.g., pervasive distrust of others, detachment from social relations, reduced capacity for close relationships, instability in interpersonal relations, excessive attention seeking, avoidance, submissive and clinging behavior, preoccupation with interpersonal control, conflict, aggression)
- Difficulties in self-definition (e.g., feelings of inadequacy, hypersensitivity to negative evaluation, grandiosity, lack of empathy, lack of goals).

Another approach to capture the salient areas of function and dysfunction in personality and PDs is to examine the factors or traits incorporated in major self-report questionnaires. For example, major dimensional models of personality and personality pathology converge on four higher order traits: (a) neuroticism/negative affectivity/emotional dysregulation, (b) extraversion/positive affectivity, (c) dissocial/antagonism, and (d) constraint/compulsivity, conscientiousness (Trull, 2006). Newer instruments (e.g., the Severity Indices of Personality Problems) focus on five factors of personality functioning: self-control (e.g., emotion regulation, effortful control), identity integration, relational capacities (e.g., intimacy, enduring relationships), responsibility, and social concordance (e.g., respect, cooperation; Verheul et al., 2008).

In addition, measures such as the Inventory of Interpersonal Problems have been used to examine the specific interpersonal difficulties associated with PDs. For example, paranoid, narcissistic, and antisocial PDs are often associated with domineering, vindictive interpersonal behavior, while histrionic PD is related to intrusive interpersonal behavior. Avoidant PD has been linked to avoidant and nonassertive interpersonal behaviors and dependent PD is characterized by exploitable interpersonal behavior (Wiggins & Pincus, 1989).

In summary, converging lines of evidence have suggested four major areas of dysfunction in individuals with PD: symptoms, emotion regulation difficulties, interpersonal functioning, and self-functioning.

Treatment Modules

One way to tailor the treatment to the individual is to assess for domains of dysfunction and to match treatment modules to these domains. We describe modules of treatment as an

interconnected series of therapist interventions (i.e., techniques) that have a specific dysfunctional target. We have selected treatment modules from larger intervention packages that have been empirically investigated (e.g., Bateman & Fonagy, 2006; Clarkin et al., 2006; Linehan, 1993), or treatment modules devised by clinical researchers with experience intervening with specific target areas (e.g., Safran & Muran, 2000).

We describe two overarching modules of treatment for those suffering from PD: (a) general treatment modules that are used to structure treatment, to enhance motivation for change, and to manage the relationship between patient and therapist (see Table 1), and (b) specific treatment modules for specific domains of dysfunction.

General Treatment Module

Structuring treatment can be accomplished by a careful and collaborative assessment (Hilsenroth & Cromer, 2007), followed by negotiating a verbal contract and framework for the therapeutic work (Clarkin et al., 2006). The framework provides the client with the responsibilities of both therapist and client necessary to achieve a successful treatment. However, the structure of the treatment continues beyond the early assessment and throughout the entire treatment episode.

Clients with PDs often encounter difficulties with interpersonal functioning. Inevitably, one of the first challenges of working with PD clients is navigating the interpersonal component of the therapy—the therapeutic relationship. Safran and Muran (2000) have emphasized that clients and therapists are embedded in a relational matrix (Mitchell, 1988)—the therapeutic alliance—which is shaped moment-to-moment by the implicit needs and desires of client and therapist. Ruptures occur when there is tension between the client's and the therapist's respective needs and desires (Safran & Muran, 2000), and, thus, ruptures are inevitable events in therapy and should not be viewed as obstacles to overcome but rather as opportunities for therapeutic change. It is important for therapists to be aware that clients often have negative or ambivalent feelings about the therapeutic relationship, which may be difficult for them to acknowledge or to even understand. This is especially true for PD clients. Therefore, therapists should be attuned to subtle indications of changes or ruptures in the therapeutic alliance and should take the initiative to explore these changes or ruptures moment-to-moment in the therapy. Client change following the exploration of an alliance rupture can be understood as involving two processes: an increasing immediate awareness of self and other, and a new interpersonal experience with the therapist ideally resulting in social learning that can be generalized outside of the therapeutic relationship (Safran & Muran, 2000).

Treatment Modules for Specific Domains and Their Sequencing

Most central to the process of treatment integration is a vision or road map concerning the sequence of change for clients with PD. Because one of the client's difficulties is an inability to see a way out of current difficulties, it is the therapist who must have an eye on the

Table 1
General Treatment Module

Treatment modules	Specific procedures
Assessing personality pathology	Assessment interview
	Focus on domains of dysfunction
Structuring the treatment	Establishing a treatment framework
Monitoring the relationship	Resolving alliance ruptures
	Validating the patient
	Therapist alert to indications of patient positive and negative views of therapist/therapy
	Reciprocal communication strategies
	Mentalizing interventions

changes needed and a flexible plan of sequential changes.

The sequence of targets of change depends on the specific PD, but more directly, it depends on the relative severity. Of necessity, the therapist places a priority in the sequence of addressing domains of dysfunction. We have described the five phases of the treatment of patients with PDs, including: (a) ensuring the *safety* of the patient and others in the patient's environment; (b) c*ontainment* of symptoms, emotions, and impulses; (c) co*ntrol and modulation* of emotions and impulses that contribute to symptoms, including deliberate self-harm; (d) e*xploration and change* of the more stable cognitive−emotional structures underlying maladaptive behavior and interpersonal patterns; and (e) i*ntegration and synthesis* of a more adaptive self-structure (see Table 2). The sequence of intervention is dictated by concern for patient safety before moving onto other issues, and a conception of what domains must change in order for other domains to be approached.

The safety issue is clear when physical integrity of either the patient or a significant others is relevant. For example, behaviors such as wrist cutting or more serious suicidal behaviors must be addressed immediately. This would also include potentially dangerous physical fights between patients and their intimate others. Crisis intervention, medication, structure, and support are all important elements in ensuring safety for the patient. As patient safety increases, the treatment can progress to a containment phase in which structure and support are essential for the modulation of intense emotions and impaired cognitive functioning.

Emotion regulation, either deficient regulation or constriction and inhibition, becomes the next focus of intervention. Emotion regulation refers to a range of cognitive−affective abilities the individual uses to monitor, evaluate, and modify their emotional response to interpersonal and other environmental demands in order to achieve their goals (Nolen-Hoeksema, 2012). In contrast to individuals with emotion regulation skills and strategies, individuals with psychopathology often exhibit emotion dysregulation. Emotion dysregulation is a disrupted domain of functioning that is central to many disorders, including depression and anxiety dis-

Table 2
Treatment Phase and Priorities Matched to Treatment Modules

Treatment phase	Treatment modules
Phase 1: Patient safety	Crisis intervention
	Brief hospitalization
	Medication
	Structure and support
Phase 2: Containment	Structure and support
	Establishing the treatment frame (Clarkin et al., 2006; Linehan, 1993)
	Medication
Phase 3: Control and modulation	Functional analysis of behavior (Linehan, 1993), with a growing awareness of links between cognition, emotion, and behavior
	Awareness and mentalization of interpersonal triggers (Bateman & Fonagy, 2006)
	Mindfulness (Linehan, 1993)
	Ability to identify and label emotions (Linehan, 1993)
	Distress tolerance skills, such as distraction and self-soothing (Linehan, 1993)
	Interpersonal effectiveness skills, such as the ability to seek out appropriate social support and effective help-seeking behavior (Linehan, 1993)
Phase 4: Exploration and change	Examination of interpersonal schemas and alliance ruptures (Safran & Muran, 2000), interpersonal signatures (Pincus, 2005; Cain & Pincus, in press), and dominant object relations (Clarkin et al., 2006)
Phase 5: Integration and synthesis	Examine sense of self and expand self-narrative (Dimaggio et al, in press) by constructing a personal niche through engaging in hobbies, work, and improved romantic relationships (Clarkin et al., 2006)
	Expand curiosity and perception of others through mentalization (Bateman & Fonagy, 2006) and exploration of transference (Clarkin et al., 2006)

orders, eating disorders, alcohol abuse, and PDs (Nolen-Hoeksema, 2012).

The treatment of those with emotion dysregulation can take many forms with the overlapping goals of decreasing maladaptive emotion strategies, such as rumination, and increasing emotion regulating strategies, such as attentional redeployment, reappraisal, and problem solving. The treatment of emotion dysregulation can be approached by role playing of various relevant scenarios (Linehan, 1993), and by increasing awareness of and mentalization about disruptive interpersonal relations in which affect regulation is problematic (Bateman & Fonagy, 2006). By focusing on the emotion arousing events in the interaction between client and therapist, an object relations approach fosters reappraisal of perceptions of self and other (Clarkin et al., 2006) in the sometimes emotionally charged interaction between therapist and client.

With more modulated emotional responses, the treatment can focus on dysfunctional interpersonal patterns. Patients with PD are disturbed in relating to others in a cooperative, satisfying, and productive way. These difficulties are central in reducing patients' satisfaction in attaching to others in friendly and intimate ways, and in interfering with work and professional success and productivity. The individual with PD has an interpersonal style that is counterproductive, that is, that gets one into conflict with others and/or isolation. Why does this seemingly counterproductive behavior continue, and what interaction processes are maintaining it? In everyday interaction, the patient is not usually given the opportunity to examine relationship interaction. Others react to the behavior of the client with PD, and the perceptions of both parties are usually not articulated or shared. Without self-examination and self-reflection, the patient go into a habitual, overlearned pattern of interacting that defends his or her self-esteem despite the interaction disruptions. One possibility is that the individual is unaware of his impact on others. He may lack awareness when others are offended. Or he may misinterpret the reactions of others, that is, seeing them as problems that the other has. This inability of typical, daily interactions to lead to self-correction in interpersonal conflicts and distortions is precisely why the unique qualities of a therapeutic interaction are needed.

Given patients' selective attention to details and need to present self in a positive light, the information provided by the patient to the therapist about interpersonal problems is of variable accuracy. The patient's narrative about current interpersonal relations can be supplemented by careful evaluation of how he or she relates to the therapist, not in one moment, but in identifiable patterns of interaction. Patients are sometimes unaware of how they appear to others, how they impact on others, and how their interaction styles lead to their own difficulties. The extent to which PD patients recognize their own contributions to their interpersonal difficulties varies from patient to patient, and from time to time in the same patient. It is with those patients who are poor at recognizing their troubling interactions with others that dialogue with the therapist are most informative.

The term *interpersonal functioning* covers a wide range of activity, from intimate sexual relations, to intimate friendships, to social relations, to work and task-oriented relations, to instrumental relations, such as negotiating at the counter in a food market. Relevant here are the types of relationship deficits that patients bring to therapy, and the ones that most interfere with patients' quality of life. For patients with severe PDs, their relationships may be so isolated or conflicted that they have not functioned in a career or work setting. This kind of disability seriously interferes with patients' ability to be independent and self-sustaining, and seriously reduces quality of life. At the other end of the spectrum, there are patients with less severe PDs who are functional and quite successful in work and profession, and who have friendships, but who do not achieve a satisfying intimate relationship in which love and sexuality are combined. It is along this continuum of interpersonal relations and the competencies required that one could think of modules of treatment for these conditions.

Setting the treatment frame (Clarkin et al., 2006) and explaining the responsibilities of both participants is a crucial first step in constructing a context and atmosphere in which the patient can examine without fear or embarrassment or rejection his or her interpersonal behavior, attitudes, and feelings. Patients' interpersonal behavior can be examined as it unfolds with others in their current life context, and/or in their immediate behavior with the therapist. Most probably, thera-

pists of various persuasions use material from both situations to deepen patients' self-understanding. It seems to be a common approach to focus on current relationships rather than on temporally distant ones. Patients, of course, may comment on what they see as the origins or history of their patterns in relating, but it is the focus on current relationships that provides the opportunity for a wider behavioral repertoire with new ways of relating.

Maladaptive interpersonal patterns are enacted both inside and outside therapy, thus giving the therapist the opportunity to understand and explore the etiology and maintenance of these disturbed interpersonal patterns with the client in the present moment. Pincus and colleagues (Cain & Pincus, in press; Pincus, 2005; Pincus & Hopwood, 2012) have articulated a treatment approach that integrates contemporary interpersonal theory with an object relations-based understanding of personality structure (Clarkin et al., 2006). The underlying premise is that interpersonal situations occur not only between self and other but also in the mind via mental representations. Following Kernberg's (1975, 1984) object relations theory, these internalizations often consist of a self-representation, an other-representation, and a linking affect. Thus, treatment can proceed via an articulation of the internalizations of self and other using a sequence of clarifications, confrontations, and well-timed interpretations of current interactions (Clarkin et al., 2006) to identify, challenge, and ultimately understand the etiology and maintenance of maladaptive interpersonal patterns, thereby, leading to increased interpersonal awareness and social learning.

Exploration of interpersonal relations very quickly and seamlessly leads into the patient's perception of self. Guiding the patient to a review of self-narrative and the gaps in it is an important approach to the improvement of the patient's self-concept and self-functioning (Dimaggio et al., 2012; Dimaggio, Popolo, Carcione, & Salvatore, in press). Self-functioning can be parsed into at least five different conceptualizations: self as the total person, self as personality, self as experiencing subject, self as beliefs about oneself, and, finally, self as an executive agent. In the realm of personality pathology, negative beliefs and feelings about self, including low self-esteem, lack of self-efficacy, and a grandiose, exaggerated sense of self-importance, are major areas of concern and therapeutic intervention.

These common principles to approach interpersonal difficulties can be specified as follows:

1. Setting a frame for treatment so that the patient can anticipate examination of interpersonal behavior without seeing it as criticism or an attack.
2. Building a therapeutic alliance with the observing part of the patient. In this way, the therapist becomes an ally to the patient in correcting his or her interpersonal behavior.
3. Ruptures in the relationship alliance between the client and the therapist should be expected, and should be seen as an opportunity for examining the client's understanding of how the therapist is viewing and relating to him or her.
4. The therapist attitude of therapeutic neutrality. The patient will, at times, see the therapist as entering into and contributing to a conflicted relationship with the patient. To examine these situations, the therapist is aided by being neutral, that is, taking the position of an outside observer not involved in the conflict and taking an observing stance.
5. Timing. It is a common assumption among experienced clinicians that the timing of the attempt by the therapist to reflect back to the client a view of his or her interpersonal behavior is crucial to the client's receptivity to the message, which could be experienced as emotional arousing, critical, and destabilizing.
6. There are many therapeutic approaches to using the relationship that emerges between client and therapist to explore the client's difficulties in relating to others. These approaches can be conceived along a continuum from attention to overt interpersonal behavior, both defective and new prosocial behaviors, to internal cognitive−affective units that represent self and other.

Research Relevant to an Integrated Modular Approach

The modular approach assumes that different domains of functioning will change at different rates of time during the treatment. We (Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy, 2008) have found that three different domains of functioning change at different rates across three

treatment approaches (i.e., transference-focused psychotherapy, dialectical behavior therapy, and a supportive treatment) for clients with BPD. Embedded in this finding is not only an identification of domains relevant to borderline patients, but also the utility of measuring domains multiple times in a treatment in order to understand the rate of change of a particular domain. It would be a tremendous advance if clinical treatment researchers could agree on crucial domains of dysfunction in PD patients, and use the same instruments to measure rates of change in these domains in various treatments.

A second type of study that would further integration is the design used by Weisz et al. (2012) in which modules from differently empirically supported treatments were combined in different ways tailored to the individual in the treatment of preadolescents for symptoms and conduct problems. This tailored approach was found superior to an empirically supported treatment alone.

Conclusion

It is paramount with PD patients, who by definition have difficulties in interpersonal relations, that the therapist be constantly attentive to the ongoing nature of the relationship with the client. Treatment modules will not work without the context of a productive relationship. The careful attention to the relationship will prevent premature dropout. The client's belief that change is possible is central to treatment success. Often, clients with PD are motivated for relief from symptoms and discomfort, but only with some relief and a sense that treatment might work does one begin to actually believe that change was possible. It seems clear that the therapist must have a vision of possible change, and only gradually can patients begin to adopt that vision and related motivation. In addition, clients' ability to go beyond their usual reactive mode of relating to their environment must be transformed slowly into a curiosity about and interest in reflecting on their own experiences and how the experiences guide their behavior.

An attempt at delivering an integrated treatment to clients with PD does not come without difficulties. Although articles like this one can suggest a framework for considering and applying an integrated approach, its value lies in the perceptiveness and talent of the individual clinician. Integration is a somewhat unique process in each therapist−client pair.

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