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Invited Essay

Behavioral assessment of personality disorders

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Abstract

This article examines the definition of personality disorders (PDs) from a functional analytical framework and discusses the potential utility of such a framework to account for behavioral tendencies associated with PD pathology. Also reviewed are specific behavioral assessment methods that can be employed in the assessment of PDs, and how information derived from these assessments may be linked to specific intervention strategies. © 1999 Elsevier Science Ltd. All rights reserved.

To some, the very title of this article might seem oxymoronic as some behaviorists eschew the concepts of personality and personality disorder (PD) because of their trait and mental illness connotations and because of the inferential nature of such constructs. Indeed, the DSM-IV defines the concept of PD as: "...an *enduring* pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is *pervasive and inflexible*, has an onset in adolescence or early adulthood, is *stable over time*, and leads to distress or impairment" (American Psychiatric Association, 1994, p. 629, emphasis ours). This definition contains some apparent incompatibilities with the behavioral view (e.g., that behavior is situation specific, as elaborated below). Despite these apparent contradictions, this article seeks to describe how concepts within a behavioral model can provide a useful framework for the assessment of PDs and PD features. This is then followed by a discussion of behavioral techniques suitable for the assessment of PDs and associated features, and the application of assessment information to specific intervention strategies. We begin by providing an overview of the utility of PD diagnosis from a behavioral perspective, while highlighting some of the relevant controversies currently debated within this area.

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1. Utility of personality disorder diagnoses from a behavioral perspective

Historically, behavioral assessors were satisfied with identifying target behaviors for each individual; that is, idiographic problematic responses that were selected for intervention. More contemporary behavioral assessors find diagnoses, including the DSM diagnoses, to be useful (Kazdin, 1983; Nelson & Barlow, 1981). Most importantly, a clinical science rests on the recognition of commonalities among groups of individuals. Diagnosis recognizes and labels these commonalities so that researchers can make contributions to the research literature and access the contributions of others. Diagnosis, especially when based on an internationally-recognized diagnostic schema, allows communication among professionals (e.g., in the making referrals, in record-keeping, and in accountability). Diagnosis also provides suggestions of responses that nomothetically covary. A wise clinician will assess for other responses within a diagnostic set when some responses from that set are evident. Some diagnostic manuals such as the DSM provide suggestions of nomothetic controlling variables. The DSM does so in the narrative sections in the chapters on various diagnostic groups. Finally, diagnosis can provide nomothetic suggestions for treatment; for example, dialectical behavior therapy for those with borderline PD described by Linehan (1993a) or Beck's suggestions for modifications of cognitive therapy for specific PDs (Beck, Freeman, & Associates, 1990). As suggestions provided by diagnosis are nomothetic, the behavioral assessor must determine if idiographic modifications are needed for the particular client.

Although it is beyond the scope of the present article to evaluate thoroughly the utility of DSM PD diagnostic concepts or, for that matter, the utility of diagnosis from a behavioral assessment perspective, we well recognize that controversies exist in these areas (Farmer, 1997). For example, in the area of PDs, there is debate as to how PDs should be best classified or modeled (e.g., Cantor & Genero, 1986; Livesley, 1986; Widiger & Frances, 1985), particularly in light of data which suggest that PD features tend to be continuously distributed (Frances, Clarkin, Gilmore, Hurt, & Brown, 1984; Kass, Skodol, Charles, Spitzer, & Williams, 1985; Zimmerman & Coryell, 1990a). These latter findings are problematic for the utility of psychiatric diagnosis which presumes an underlying dichotomous distribution (i.e., present versus absent). Additional research (reviewed in Widiger, 1992) further suggests that dimensional modeling of PDs is associated with higher reliability and validity indices than the present categorical modeling scheme. The difficulty of imposing a discontinuous categorical classification scheme on continuously distributed dimensional phenomena is not unique to PDs, however. Indeed, the same concerns apply to the so-called "syndromal disorders" codes on Axis I of DSM (e.g., mood and anxiety disorders) (Kendler, Neale, Kessler, Heath, & Eaves, 1992; Rutter, 1989).

One of the more reliable findings in the PD assessment literature is empirical support for the DSM's clustering of PDs into three symptomatological groupings: odd–eccentric (paranoid, schizoid, schizotypal), dramatic–emotional (histrionic, borderline, narcissistic, antisocial), and anxious–fearful (dependent, obsessive-compulsive, avoidant, and in previous editions of DSM, passive–aggressive). Multivariate studies provide support for this clustering scheme (Bagby, Joffe, Parker, & Schuller, 1993; Farmer & Nelson-Gray, 1995; Hyler & Lyons, 1988; Kass, et al., 1985; Morey, 1988; Zimmerman & Coryell, 1990b). This research, coupled with that of other multivariate studies which indicate that individual PD features generally do not factor