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**PERSONALITY AND RECOVERY:  
INTEGRATING PERSONALITY  
ASSESSMENT DATA  
TO FACILITATE THE  
RECOVERY PROCESS**

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*The relatively enduring and persistent nature of personality traits means that they will likely continue to impact the course of psychiatric recovery after Axis I symptoms are stabilized. These traits can significantly impact the choices that recovering persons make and the quality of interpersonal relationships with care providers who are trying to facilitate the recovery process. Despite this, they are often inadequately assessed and considered in providing psychiatric care. This manuscript reviews the common combinations of personality traits that have emerged across a variety of clinical samples. The implications of these personality features for the provision of care in an inpatient setting to facilitate recovery are discussed.*

The third edition of *Diagnostic and Statistical Manual for Mental Disorders*. (American Psychiatric Association, 1987) introduced a multiaxial approach to psychiatric diagnosis. This enabled clinicians to separate the person's acute symptom picture, recorded on Axis I, from the relatively enduring patterns of thoughts, feelings, and behavior that characterize personality functioning, which can be recorded separately on Axis II (Millon, 1981; Williams, 1985). The DSM developers specifically sought to insure that consideration was given to the possible presence of important characteristics (personality or trait pathology) that are frequently overlooked, because attention is directed to the usually more florid Axis I symptoms (Hyler & Frances, 1985).

The Axis I – Axis II distinction was considered important because research has

demonstrated that maladaptive personality traits may coexist with, predispose to, or result from Axis I conditions and may significantly influence their presentation, course, management, and response to treatment (Williams, 1985). Even among the relatively severe and persistent psychiatric conditions, such as bipolar disorder (Akiskal, 1984; Gaviria, Flaherty & Val, 1982), schizophrenia (Gunderson & Siever, 1985; Holzman et al., 1988; Smith et al., 1995), and major depression (McGlashan, 1987; Pilkonis & Frank, 1988), differences in personality traits have been found to influence the vulnerability and resilience of individuals at risk for development of the condition. They also influence the specific expression of symptoms, time of onset, long-term course, quality of intermorbid adjustment, and the person's evaluation

of treatment received (Holzman et al., 1988).

Despite the innovation of a multiaxial approach, prominent personality traits and pathology are often ignored in contemporary psychiatric practice (Andreoli, Gressot, Aapro, Tricot & Gognalons, 1989). Because of this, potentially vital information is often ignored that may aid in treatment planning and facilitating the long-term recovery process (Andreoli et al., 1989). In the public mental health system, for example, the failure to adequately assess the influence of personality traits or the interaction between personality and Axis I conditions has been identified as the source of numerous complications and frustrations in the development and implementation of intervention strategies (Pepper & Ryglewicz, 1984).

The relatively enduring and persistent nature of personality features makes them likely to have a significant impact on the long-term recovery process. For individuals undergoing inpatient psychiatric care, for example, differences in prominent personality traits affect how individuals present their Axis I psychiatric symptoms, how they typically cope with stressful conditions that they encounter, and how they evaluate the quality of care being offered to them (Donat, Geczy, Helmrich & LeMay, 1992). They have also been found to be associated with significantly different rates of rehospitalization (Donat, 1997). Thus, they represent information that should be considered in planning for and facilitating the long-term recovery of people with a severe and persistent psychiatric disability.

While personality traits are enduring features that are more difficult to change, they do not have an immutable effect on behavior. Rather, they are best conceptualized as strong predispositions in how the person interprets and responds to environmental events (Millon, 1981;

1996). Despite the predisposition, the behavior that eventuates is partly dependent on the nature of the environmental events that the person encounters. Prominent among those environmental events is the behavior of persons providing care. If care providers can recognize the person's prominent personality features, they can more accurately predict likely responses and devise compensatory interpersonal strategies to maximize the likelihood that adaptive challenges to recovery will be successfully negotiated. However, if employed defensively, they can become imposing obstacles to the recovery process.

The failure to include personality features in psychiatric diagnosis is partly due to poor reliability of Axis II diagnoses based on interview data. A second problem is that personality is best conceptualized in dimensional, rather than categorical terms (Cuesta, Peralta & Caro, 1999; Cloninger, 1987). When viewed dimensionally, clinicians should expect to see characteristics of several disorders coexisting. This often frustrates many clinicians, who persist in trying to conceptualize and diagnose personality with singular categories, such as borderline or antisocial.

One way to improve the reliability is through the use of objective psychological inventories. One measure that is potentially useful in this area is the Millon Multiaxial Personality Inventory (MCMI; Millon, 1987). The test developer was a member of the Task Force that introduced the multiaxial system in DSM-III. The personality scales of the MCMI more closely parallel the personality categories found in the DSM than other psychological inventories. It is also grounded in a theory, based on past research in personality development, which allows for a science-based explanation of why these behavior patterns develop. This allows scientist-practitioners to propose compensatory behavioral approaches by persons providing care

that can enhance the recovery process. Beyond this, the use of continuous scales allows for the consideration of the relative strength of characteristics associated with different categories.

A series of studies has employed the MCMI to identify common combinations of personality features that emerge in psychiatric and other clinical groups. These studies have focused on the empirical identification of commonly occurring sets of personality characteristics through the application of cluster analysis (Grove & Andreasen, 1986) to large numbers of MCMI profiles. In such studies, four clusters have commonly emerged across a variety of psychiatric treatment settings, including (a) psychiatric inpatient (Donat et al., 1992), (b) psychiatric outpatient (Lorr & Strack, 1990), (c) forensic psychiatric inpatient (Blackburn, 1996), (d) alcohol treatment (Bartsch & Hoffman, 1986; Donat, 1988; Donat, Walters & Hume, 1991; Mayer & Scott, 1988), (e) substance abuse treatment (Fals-Stewart, 1992), and (f) outpatient counseling (Craig & Olson, 1995). The use of cluster analysis to define groups is superior to the traditional method of identifying code types, defined by their high scale scores on objective psychological inventories, because it employs all profile information in the classification process.

The purpose of this manuscript is to review the interpersonal and clinical characteristics of these clusters and discuss the implications of these characteristics for developing strategic behavioral or interpersonal interventions to facilitate the recovery process. We will focus our examples on the application of this knowledge to the inpatient psychiatric setting. This setting provides care for the most seriously impaired psychiatric conditions. In this setting, the emergent process of psychiatric stabilization often overshadows the fact that this is also the beginning of a recovery process. During the exacerbation that provokes psychi-

atric hospitalization, it is more likely that personality characteristics will be employed defensively. It is those prominent personality features that persons providing care will be most challenged to redirect toward beginning the recovery process.

Much of this information is summarized in Table 1. We will refrain from reviewing constitutional and developmental factors that promote the development of each of these clusters.

For such information the reader is referred to Millon (1996). The following descriptions of interpersonal/clinical features and suggestions for caregivers are gleaned from a variety of sources, including Millon (1996), Choca, Shanley & Van Denburg (1997), Craig (1993) and Donat (1995). They represent the descriptions and conclusions that would derive from MCMI results and characterize each group based on an understanding of the research and theory that

provided the foundation for MCMI development. The research findings are gleaned from the studies that have included an examination of the external validity of the MCMI clusters emerging from cluster analysis. To avoid confusion with the proposed clusters outlined in DSM-IV, which were not based on cluster analytic research, we will refer to the empirically derived clusters as groups.

**Table 1—Behavioral Predispositions and Compensatory Guidelines for Care Providers for the Personality Groups**

PERSONALITY GROUPS	PREDISPOSITIONS FOR COGNITIVE, EMOTIONAL, AND OVERT BEHAVIOR	BEHAVIOR CLASSES TO DIFFERENTIALLY REINFORCE	STYLISTIC CONSIDERATIONS FOR SOCIAL REINFORCEMENT
<b>Group I</b>	<ol style="list-style-type: none"> <li>1. Avoids identifying problems</li> <li>2. Emotionally constrained</li> <li>3. Superficially friendly to avoid scrutiny</li> </ol>	<ul style="list-style-type: none"> <li>• Requesting assistance for personal problems</li> <li>• Expression of emotions</li> <li>• Assertion of concerns or disagreements</li> </ul>	Use brief comments which emphasize personal regard; Allow the person to take the lead; Avoid probing for insight
<b>Group II</b>	<ol style="list-style-type: none"> <li>1. Low concern for standards of others</li> <li>2. Emotionally uninhibited; sensitive to frustration</li> <li>3. Forceful and persistent in pursuit of personal goals</li> </ol>	<ul style="list-style-type: none"> <li>• Expression of concern for opinions or concerns of others</li> <li>• Restraint, particularly under frustration</li> <li>• Acceding to the desires and priorities of others</li> </ul>	Focus on the personal benefit of adaptive behavior; Use confrontive assertion for problems; Avoid arguments whenever possible
<b>Group III</b>	<ol style="list-style-type: none"> <li>1. Behaviorally inconsistent; dependent yet passive-aggressive; may be explosive and dangerous toward others</li> <li>2. Highly sensitive to evaluation by others; prone to misperceiving</li> <li>3. Emotionally variable; inclined to blame others when upset</li> </ol>	<ul style="list-style-type: none"> <li>• Moderation of behavior related to emotions</li> <li>• Accurate self-reinforcement for personal strengths</li> <li>• Ability to assert and resolve interpersonal problems</li> </ul>	When possible, ignore minor passive aggressive behavior; Use empathetic assertion for countering problems; Focus on strengths of the person; Try to strengthen likelihood of self-reinforcement
<b>Group IV</b>	<ol style="list-style-type: none"> <li>1. Behaviorally inconsistent; dependent yet inclined to socially withdraw; may engage in self-harm</li> <li>2. Highly sensitive to interpersonal evaluation; prone to misperceiving</li> <li>3. Emotionally variable; inclined to self-blame when upset</li> </ol>	<ul style="list-style-type: none"> <li>• Moderation of behavior related to emotions</li> <li>• Accurate identification of personal strengths and self-reinforcement</li> <li>• Exploration of discouragement and self-doubt with resolve to assess accurately</li> </ul>	Use empathetic assertion for countering problems; Focus on strengths of the person; Try to strengthen likelihood of self-reinforcement; Watch for social withdrawal

### Group I: Compulsive and Dependent Features

*Interpersonal/clinical features.* One group that reliably emerges across cluster analytic studies involves prominent dependent and compulsive personality traits. For individuals with these traits, the responses of other people have a strong valence as a behavioral antecedent and consequence. Because of this, they purposely guide their own behavior with the goal of successfully managing those responses.

Individuals with these personality features strongly desire to avoid being viewed by other people as a source of problems or emotional distress. Rather than actively identifying and instrumentally seeking sources of personal positive reinforcement, members of this group seek to avoid arousing others to be upset with them. They believe that if others assess them as a source of problems or distress, they will be socially rejected. Thus, their interpersonal interactions are motivated more strongly by a process of negative reinforcement than of positive reinforcement.

Because they strive to avoid disturbing others, individuals with these personality features are often viewed as more agreeable and compliant than individuals from other groups. However, their cooperative demeanor is motivated by a desire to avoid close scrutiny, and what they view as associated “intrusions” into private matters that may arouse negative evaluations of them. Thus, in projecting a demeanor of cooperation, they attempt to communicate that there are no significant problems for others to be concerned about.

While members of this group may initially appear friendly to other people, they also have difficulty allowing themselves to experience the full range of human emotional experience. They judge extreme emotions as an inability to establish sufficient self-control due to

personal flaws and inadequacies. Thus, they dilute their emotional expression and, as a result, fail to develop strong emotional ties to others. They are often easy to get to know at a superficial level, but have extreme difficulty achieving even modest degrees of intimacy.

These characteristics can make it difficult to establish and maintain a focus on the challenges faced in proceeding with recovery. In inpatient treatment settings, individuals from this group will often distance themselves from confronting problems by resorting to alternative explanations that they view as more acceptable than a severe psychiatric disability. For example, the person may attribute behavior that led to hospitalization to “nerves” that “just get out of hand” every now and then. They may reject antipsychotic medication as being unnecessary, but state a desire for something for the nerves. They may also affiliate with socially accepted groups that can strengthen their ability to avoid acknowledging needed treatments. For example, they may affiliate with religious or social groups that espouse a belief that spiritual pursuits override the need for modern medicines. Others may affiliate with AA or NA groups that argue that recovering persons should not rely on any drug, including medications. In this manner, they employ respected groups to counter the message that they need to examine the possibility of mental illness more seriously.

*Guidelines for care providers.* The behavioral inclinations of individuals with these personality features can cause problems in beginning of and persisting at recovery. After an acute episode of psychiatric distress, they often stabilize more rapidly than other inpatients, because they are more inclined to employ their personal resources to minimize problems that will attract the attention and concern of others. In an inpatient setting, staff may initially be encouraged with the rapidity of their stabilization.

After seeing the florid symptoms improve, however, staff will often become frustrated at the person’s reluctance to exert more effort in exploring and developing plans to deal with problems that they face. Eventually, treatment staff members often label them as “superficial” because they act friendly and cooperative but avoid intensive therapeutic effort.

Direct care providers must remain supportive while maintaining a comfortable interpersonal distance. While doing this, however, they should watch and socially reinforce any inclination to express and share emotional experiences and emphasize that, for the staff member, it was a positive experience to be able to listen. The staff should also look for any evidence of a willingness to seek interpersonal guidance for difficulties that they face. The basic techniques of assertion, focusing on the identification and expression of emotions to other people are especially relevant for members of group I. A study of inpatient management and treatment of a person with group I features is outlined in Donat (1995).

The treatment staff should remember that it is not that members of this group don’t exhibit these behaviors. Rather, they are less inclined to show them and they require more frequent and powerful reinforcement to alter their past pattern of behavior. Their reluctance to engage in these behaviors also means that their level of competence is likely to be low. They may also require skill training to maximize the potential for reinforcement from the environment when they attempt them.

*Research findings.* Research data support the clinical characteristics described above. As expected, individuals from this group are more likely to report less severe symptoms and fewer ancillary problems associated with their disorder. In an inpatient substance

abuse treatment program, for example, people with these personality features self-report a relatively minor impact of alcohol and other substance abuse on their life circumstances (Donat et al., 1991). In a psychiatric inpatient setting, individuals with these personality features self-report fewer psychiatric symptoms and relatively low levels of severity for those symptoms that they are willing to acknowledge (Donat et al., 1992).

Individuals from this group have been found to be less likely to complain of problems regarding the quality of care they receive. In a psychiatric inpatient setting, they are less likely to complain of problems with caregivers (Donat et al., 1992) and have a lower rate of rehospitalization than members of other personality clusters (Donat, 1997). They also are less likely to require rehospitalization for substance abuse during the year following discharge (Fals-Stewart, 1992) from treatment. In addition, they have been found to employ personal resources to avoid attracting the attention of persons providing care. They are more likely to cope with difficult circumstances by trying to quietly endure the stressful conditions rather than making active attempts to alter those conditions (Donat et al., 1992).

In comparison with the other groups, individuals from this group are also more likely to engage in practices that are conventional or socially approved. They report a stronger religious affiliation than members of other groups (Mayer & Scott, 1988). When treated for substance abuse, the substance is more likely to be alcohol only. They are less likely than members of other clusters to have a history of illegal substance use (Mayer & Scott, 1988; Fals-Stewart, 1992).

## **Group II: Narcissistic, Antisocial, and Histrionic Features**

*Clinical/interpersonal features.* A second set of personality features that reliably emerges in cluster analytic studies involves prominent narcissistic, antisocial, and histrionic features. Individuals with these personality traits are more facile at identifying and pursuing personal reinforcers than members of other groups. However, the reactions of other people have less importance as an antecedent or consequence. Thus, they are less likely than members of other groups to inhibit their own behavior to accommodate the reactions and opinions of other people.

The relative lack of social anxiety and behavioral inhibition that members of this group experience will often make them appear more spontaneous and gregarious than members of the other groups. However, their relative disinclination to inhibit their behavior according to the reactions of others means that they are also more likely to be impulsive and to violate social standards. They will also be more prone to experiencing frustration when access to reinforcers is impeded. When frustrated, they are inclined to try harder to achieve their desired goal. If the frustration builds, they are less likely to withdraw and more likely to engage in behavior that is dangerous toward others.

Their relative lack of concern about the reactions of other people means that they are also less likely to seek out and integrate the opinions and guidance that those people have to offer. Thus, they are less likely to voluntarily involve themselves in mental health treatment. To become involved, they usually require external factors that coerce such involvement.

*Guidelines for persons providing care.* The high energy level and apparent self-confidence of individuals with these personality features can often be mistaken

as an early positive sign by direct care providers. As familiarity increases, staff members realize that such individuals are disinclined to seek help or accept any that is offered unless there is clear and immediate personal benefit.

The staff must understand and accept that it is extremely difficult to realize an acceptance of the need for assistance from others. Inclinations of staff members to act more forcefully to “make them understand” or “show more respect for other people” are likely to provoke frustration and possible aggression. On the other hand, caregivers must also be aware that these individuals are strongly self-directed and motivated by positive reinforcement. If care providers accede to their desires, they will be more likely to expect such acquiescence in the future.

Staff members must nurture their own ability to discriminate those behaviors that are relatively more important to foster, and they must be able to selectively assert themselves to target increases in those behaviors. They must also nurture their ability to decline requests in a firm and matter-of-fact manner. Strong assertion skills are especially important for care providers working with members of this group.

Staff members should remain watchful for certain behaviors that are relatively important to nurture for individuals with these personality features. For example, they should acknowledge any instance where the person accedes to the desires of others. People providing care should also be looking for expressions of genuine remorse or regret over problems that their behavior has caused for themselves or others.

Members of group II may benefit from a variety of behavioral interventions if sufficient cooperation can be achieved. Most prominent among these are listening skills, both assertion and empathetic

assertion, and anger management training that focuses on the inhibition of impulsive behavior.

As we noted for group I, it is not that members of this group fail to exhibit these needed behaviors. Rather, it is that they are less inclined to engage in them than most other people. They require more frequent and intensive reinforcement to strengthen the probability of these behaviors in the future.

When attempting to socially reinforce, staff members must remember that a usual compliment from them does not have as much influence as it does for members of other groups. They must amplify their message, perhaps by stating that they are impressed with how “psychologically mature” the person is by being able to engage in such behavior. Staff members can also strengthen the reinforcement valence of the compliment by pointing out in what way that this behavior benefits the person in the long run. The process of recovery can often be presented as a challenge in life that only the most capable individuals can successfully negotiate. Such “competitive” messages often serve as a stimulus for a person with these personality features to try harder.

**Research findings.** Research results support many of the points made in the clinical characteristics outlined above. Individuals with these personality features are less likely to express a desire to improve their circumstances through treatment. In an inpatient substance abuse treatment setting, individuals from this group report relatively little concern (as opposed to fewer problems) about the impact that substance abuse has had on their social or vocational circumstances (Donat et al., 1991). They do not deny that the problems exist, but rather assert that this is not a major cause for concern or that it's nobody else's business.

Members of this group are also more likely to have engaged in behavior that clearly violates social standards or laws. They are more likely to be younger and to have abused a variety of illegal drugs, especially cocaine (Donat et al., 1992). Members of this group are more likely to require legally mandated treatment for their substance abuse (Mayer & Scott, 1988).

They are also more likely to be self-directed, even when circumstances would indicate to most other people that assistance from other people is needed. In a psychiatric inpatient setting, Donat et al. (1992) found that members of this group are more inclined to attempt to control sources of stress than endure them. In addition, individuals with these personality features are more likely to perceive persons providing care as unnecessarily intrusive and emotional in their attempts to provide assistance (Donat et al., 1992).

### **Group III: Passive Aggressive, Avoidant, and Antisocial Features**

*Interpersonal/clinical features.* A third set of personality features that reliably emerges in cluster analytic research involves prominent passive-aggressive, avoidant, and antisocial features. Members of this group are most notable by the inconsistency of their interpersonal behavior. This inconsistency results largely from their perception of the quality of their relationships with other people. In contrast to members of group II, the behavior and perceived positive regard of other people has strong valence as an interpersonal stimulus and consequence. They often actively direct their behavior to realize what they perceive to be positive responses and indications of interpersonal approval from most other people.

Members of this group place such a strong emphasis on achieving the regard of others, however, that it is difficult for them to feel comfortable with the quali-

ty and results of their efforts. They often put excessive pressure on themselves to successfully elicit indications of interpersonal approval. The anxiety that this provokes will, on the one hand, impair their social performance, making it less likely that they can perform according to their own standard. On the other hand, it also makes them prone to misinterpreting the behavior of others as being overly indifferent or critical.

Consequently, they are often dissatisfied with their interpersonal relations and are prone to feeling a combination of frustration and discouragement. As these emotions build, their efforts at interpersonal competence typically suffer even more. Thus, their interpersonal relations are extremely important to them, but they are also a source of approach-avoidance conflict and emotional distress. The ambivalence resulting from this conflict becomes the source of their variable interpersonal behavior.

The continued exposure to conflictual interpersonal circumstances provokes a form of passive-aggressive behavior. They act dissatisfied with the interpersonal relationship, but are unable to verbally assert their perception of the problem. When other people detect something wrong and inquire, they will typically act surprised and deny that there is any problem. The other people will understandably become frustrated at such behavior. This provokes the other people to react in a critical manner or try to avoid future interactions. Even when others try to avoid contact, they often find themselves drawn into a conflict or crisis caused by the person's behavior. These responses by people providing care further erode the quality of the social interactions and usually leads to an intensification of the passive-aggressive behavior.

As this interpersonal cycle exacerbates, it becomes more likely that an altercation will result. Because of the prolonged emotional build up, with

associated minimization of the problem, such an altercation may be sudden and severe. Thus, the histories of members of this group often include sudden, violent outbursts, as do many histories of group II members. However, the altercations occur for very different reasons. For individuals represented by group III, such events are especially tragic in light of their strong desire to achieve positive regard. After such events, the person will often rapidly calm down and feel very guilty and apologetic. If the interpersonal ties can be salvaged, however, the cycle often begins again. The usual long-term consequence of this interpersonal behavior pattern is to repel people who they hope to strengthen ties to.

*Guidelines for persons providing care.* Treatment staff that work with such individuals must expect that, at some point, they will encounter the inconsistent and frustrating behavior described above. It is important for the staff members to actively moderate their personal frustration with the inconsistent behavior pattern. Staff members must remember that, despite their variable interpersonal behavior, members of group III are strongly motivated to attain positive regard. The staff members must continue to recognize what members of group III objectively do well and provide social reinforcement for such behavior. Staff must nurture their ability to manage frustration and employ extinction procedures to ignore minor passive-aggressive behavior, while continuing to acknowledge prosocial behaviors. The staff must also, when necessary, set limits and enforce rules with a noncritical demeanor. Empathetic assertion skills are very important when working with members of this group. Further, the staff must accept the possibility that they may be judged by the person as uncaring or unnecessarily harsh, even if they successfully meet the interpersonal challenges described above.

Members of group III may benefit from a variety of behavioral interventions if sufficient cooperation can be achieved. Most prominent among these are rational self-analysis, anger management, assertion, and self-reinforcement.

If staff members can successfully negotiate these interpersonal challenges, and the person does not provoke criticism or rejection, they may see a drastic reversal in the vigor that the person puts into complying with treatment. When members of group III feel reassured that the staff members respect them and regard them positively, they may suddenly pursue therapeutic goals with a zeal that is often startling and encouraging to staff. Their zeal usually is an overcorrection, however, that is motivated by the sudden belief that the interpersonal difficulties that have plagued their relations have been overcome. Typically, after several days or weeks of effort, they become discouraged to find that many of the interpersonal anxieties and problems persist. At this point, they often begin to believe that the staff has oversold the benefits of treatment and the passive-aggressive behavior is renewed. Staff members must anticipate such inconsistent progress and continue to employ the guidelines outlined above to help the person respond more realistically to the challenges he or she faces.

*Research findings.* In both psychiatric and substance abusing samples, individuals with these personality features are more likely to complain of a wide variety of problems. In an inpatient psychiatric setting, members of this group self-report a greater number of psychiatric symptoms with a relatively high level of severity (Donat et al., 1992). Similar to members of group II, they are more likely to report psychiatric caregivers as being overly intrusive, intolerant, and unnecessarily controlling (Donat et al., 1992). Group III members in inpatient alcohol treatment programs are more likely to report coexisting psy-

chiatric symptoms (Mayer & Scott, 1988; Donat et al., 1991). In addition, they report experiencing relatively severe psychophysical withdrawal symptoms and relatively more severe interpersonal and vocational problems resulting from their alcohol use (Donat et al., 1991).

The interpersonal and emotional turmoil that their behavior generates results in poorer treatment outcomes. Members of this group are more likely to leave an inpatient substance abuse program against medical advice, they have a relatively poor abstinence rate after leaving, and have a higher rate of rehospitalization (Fals-Stewart, 1992). For individuals discharged after inpatient psychiatric care, members of this group also show a relatively high rate of rehospitalization during the two years after discharge (Donat, 1997).

#### **Group IV: Dependent, Avoidant, and Self-Defeating Features**

*Interpersonal/clinical features.* The last group that reliably emerges from cluster analytic studies involves prominent dependent, avoidant, and self-defeating traits. In many ways, members of this group are similar to the members of group III described above. They also strongly value the responses of other people. They are inclined to gauge their self-worth according to their perceptions of other people's responses to them. They place undue pressure on themselves to favorably impress others; this arouses additional anxiety and makes it more difficult for them to effectively interact.

In contrast to members of group III, however, members of group IV experience relatively intense discouragement when they believe that their efforts have been inadequate. Rather than blame the other people, they assess themselves as incapable of eliciting the responses from others that they so strongly desire, they become discouraged, and socially withdrawn. This results in diminished access

to their strongest source of possible positive reinforcement (other people) and intensifies the discouragement. As this pattern progresses, clinical depression may ensue. The emotional turmoil and low evaluations of self-efficacy intensify to provoke thoughts and acts of self-injury.

With time, their emotional reserves will usually strengthen and they will resume their interactions with others. However, it is unlikely that significant behavior change can result from their pattern of interpersonal behavior. Thus, when interpersonal contacts are reestablished, the pattern is eventually renewed.

*Guidelines for persons providing care.* Staff members must remain aware that their own behavior is an important consequence that strongly influences the behavior of members of this group. They should remember that their attention and compliments might be accorded undue significance. They must also understand that their behavior may be misinterpreted as indicating disinterest or even criticism when none was intended. Staff must manage their personal frustration and avoid becoming defensive or critical about what they perceive to be unfair and unjust judgements of them.

Staff members face the challenge of patiently helping such individuals to accurately identify personal strengths, continue to emit those strengths, and to begin self-reinforcing for those strengths. Staff members are challenged to accurately identify the objective strengths that group IV members have, and to socially reinforce those strengths when they are evident. By doing so, they are encouraging a process toward increasing self-reliance and self-confidence. This inevitably is a long, slow process that will be punctuated by repeated episodes of self-doubt and discouragement. Despite their best efforts, staff members must also anticipate that,

at times, the person will criticize them and other caregivers as insufficiently caring and supportive.

The process of social reinforcement can be especially challenging for staff members when working with members of group IV. Staff members who attempt to be supportive often reinforce indiscriminately, a fact that is often recognized by the person. They then discount the compliments. Some staff members try to enhance their support by being effusive in their social reinforcement. This often provokes members of group IV to feel more pressure to improve, and impairs their ability to interact effectively. Either result often leaves the staff frustrated that they tried their best and the person only got worse.

A common reaction of care providers is to want to give up and ignore the person's behavior. The lack of interpersonal attention then provokes the person to engage in any behavior that he or she considers will provoke the staff members to show more concern for their welfare. Ironically, this can involve self-defeating behavior. In frustration, inpatient staff often labels group IV members as intractable "borderlines" even if the person does not objectively merit such a diagnosis.

If sufficient cooperation can be achieved, members of this group can benefit from a variety of behavioral interventions. Most prominent among these are rational self-analysis, assertion training, anxiety management, personal strength identification, and self-reinforcement.

If the care providers can continue to manage their frustration and maintain a focus on identifying and socially reinforcing objective strengths, group IV members can develop over time a clearer image of their personal strengths and be better able to self-reinforce for those strengths. By doing so, they become less dependent on indications of approval from other people. Several studies of

the inpatient management and treatment of group IV members are outlined in McKeegan, Geczy, and Donat (1993).

*Research findings.* People with these personality features are more likely than others to self-report emotional psychiatric symptoms and distress. In an inpatient psychiatric setting, group IV members, like group III members, report a higher number of symptoms with relatively high levels of severity (Donat et al., 1992). Among persons in an inpatient alcohol treatment program, group IV members are more likely to report coexisting psychiatric symptoms, particularly depression, have psychiatric medications currently prescribed, and have a previous history of psychiatric hospitalization (Mayer & Scott, 1988). They are also more likely to have a history of overdosing that includes psychiatric medication (Mayer & Scott, 1988). Among individuals in a forensic psychiatric inpatient setting, members of this group are more likely to be described as having an Axis I psychiatric disorder, as opposed to a severe personality disorder (Blackburn, 1996).

Individuals with these personality features also report a lack of personal resources that they can draw upon to cope with challenging circumstances. They are more likely to sign themselves out of inpatient substance abuse treatment programs against medical advice than members of other groups (Fals-Stewart, 1992). They self-report a general lack of coping skills to deal with the external demands that they face (Donat et al., 1992). In contrast to members of group III, group IV members are not inclined to criticize the quality of care given to them (Donat et al., 1992). Rather, they are inclined to blame themselves for difficulties that they encounter.

## SUMMARY

As outlined above, cluster analytic studies have identified several groups of common personality traits that reliably emerge across different consumer samples in different treatment settings. These groups represent differing and enduring predispositions toward perceiving and reacting to environmental events that they encounter. These predispositions can be strategically employed as strengths to facilitate and maintain recovery. They can also be imposing obstacles to recovery if employed by the person to avoid the anxiety and frustration associated with adapting to the challenges that recovery poses. The devastating impact that severe and persistent psychiatric disability often has, which often becomes evident during a critical period of personality development, makes it more likely that personality traits will be employed defensively.

These groups of personality traits can have significant implications for the long-term recovery of consumers who have a severe and persistent psychiatric disability. While symptoms of an Axis I disorder may be florid at admission, they frequently show rapid and significant improvement with appropriate medication and supportive care. For individuals with a severe and persistent psychiatric disability, however, the stabilization of these symptoms is often just the beginning of a long recovery process. Such individuals will continue to encounter significant adaptive challenges in daily living, and this will require the assistance of other people to fully realize their capacity for independence. These challenges will arouse stress that, in turn, makes it more likely that traits will be employed defensively. One important impact is on the willingness of the person under care to seek and accept the help that is available.

A critical factor in whether these traits are employed adaptively or defensively is the behavior of care providers. The characteristics that exemplify each of these groups can result in behavior that interferes with the process of a long-term recovery. This behavior can sometimes provoke care providers to respond in a manner that does not facilitate recovery. Often, these characteristics provoke responses from care providers that simply serve to perpetuate the dysfunctional interpersonal pattern.

It is challenging for care providers to intervene when character traits strongly influence behavior. These traits represent long-standing patterns of thinking, feeling, and behaving for which rapid, enduring change is not likely. To patiently foster and maintain changes, care providers must be able to anticipate problems and have a logical strategy to adjust to them. Fortunately, research has demonstrated that these traits can be assessed and their implications for sustaining a recovery can be hypothesized and tested. Through an understanding of these common clusters of personality traits, care providers in inpatient and community environments can develop consistent interactional strategies, with a basis in scientific research, to maximize the consumer's receptiveness to available assistance, and thereby facilitate the recovery process.

It is overly simplistic to consider these groups as neat, distinct types into which all individuals can be categorically classified. There remains considerable diversity among the members of each of these groups. Even the cardinal characteristics of each group will wax and wane according to the nature of interactions with the environment. However, the consistencies among members of these cluster analytically derived groups can serve as a foundation from which to predict and understand the common behavioral inclinations of many individuals who are negotiating the challenges of

recovery. This can help care providers to strategically plan for therapeutic interventions. This can also help system administrators develop more effective training experiences to enhance the skills of both recovering individuals and the care providers who seek to facilitate the recovery process. In doing so, they can enable caregivers to be more effective in assisting consumers to be maximally self-reliant and to increase the probability of a smooth and effective transition from hospital to community care environments.

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