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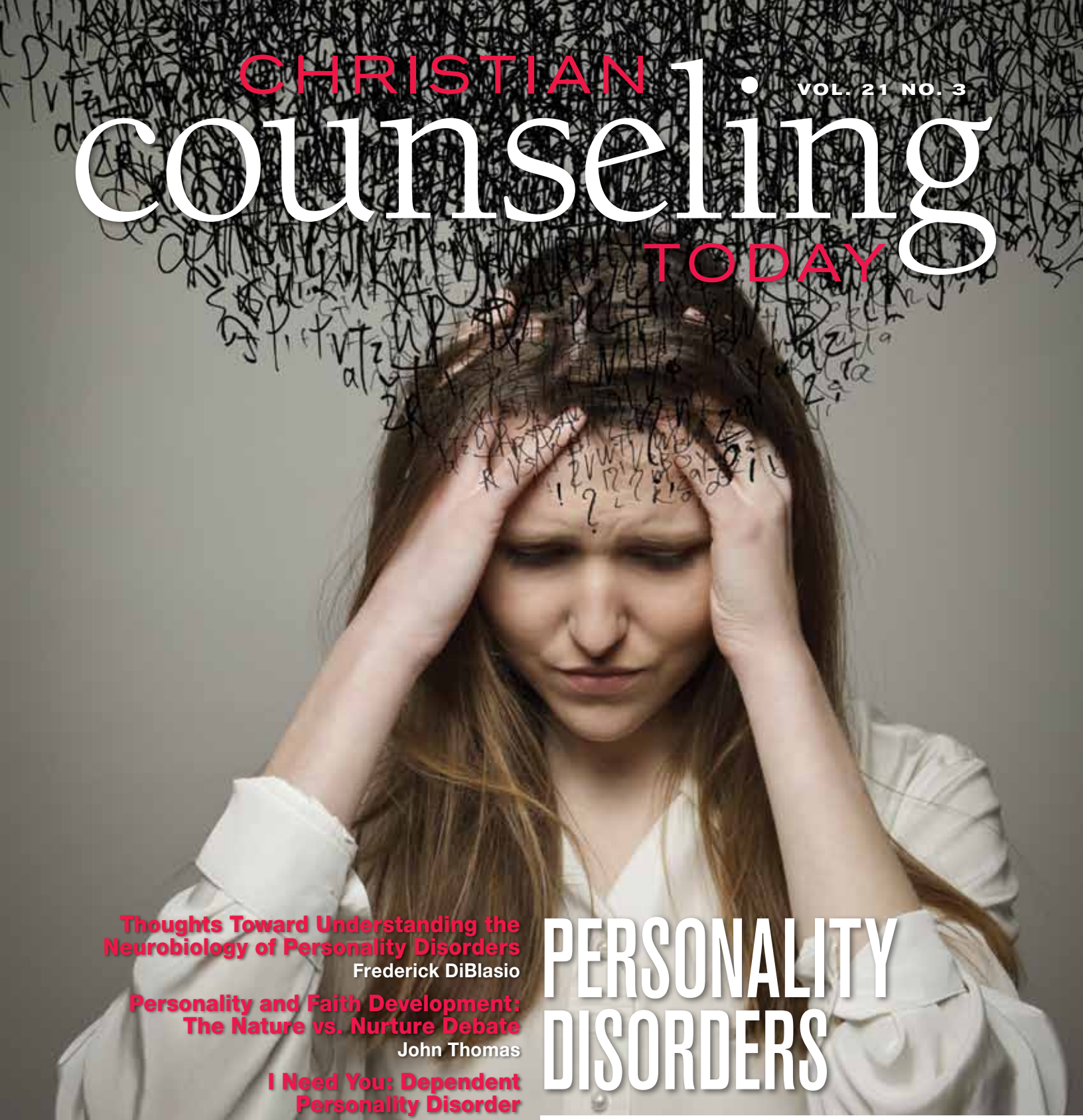

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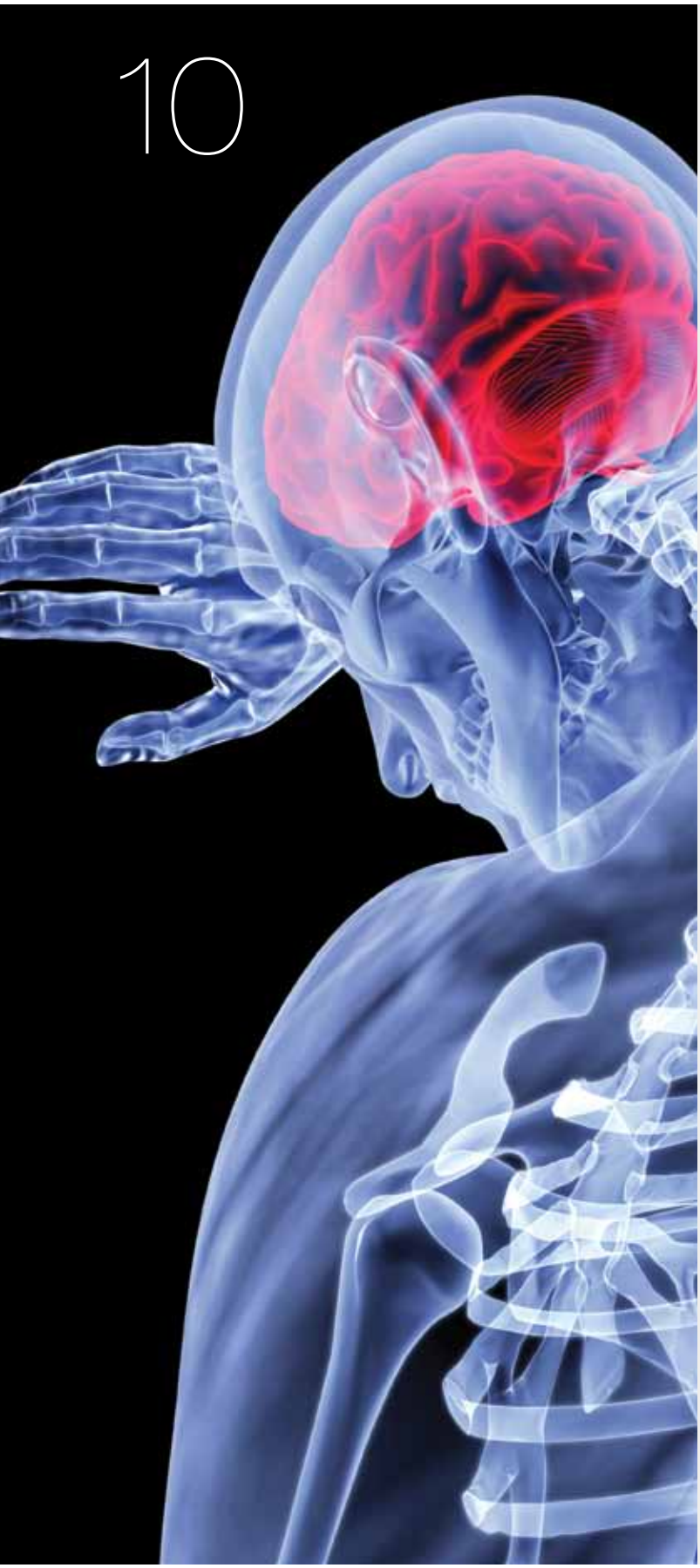
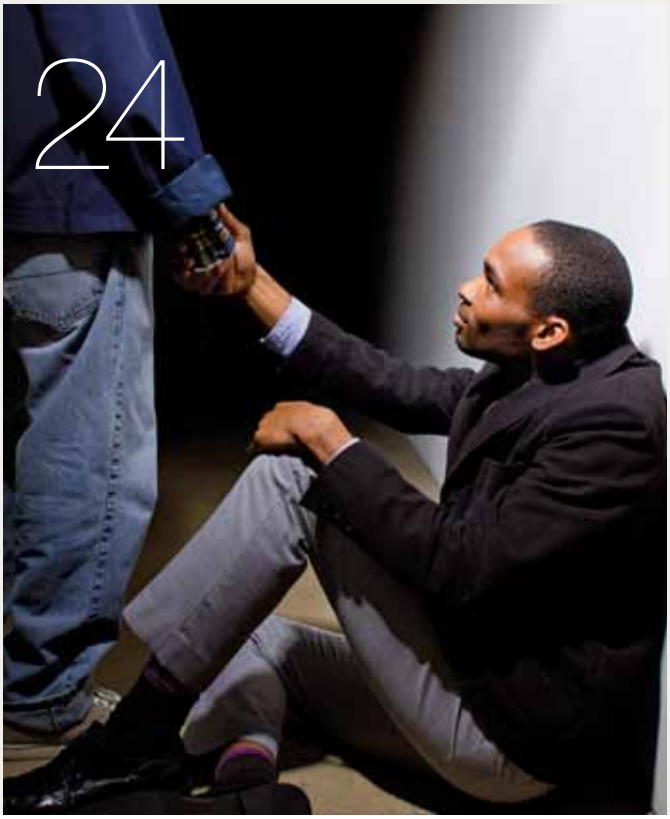


FEATURES



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departments

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Created in the Image of God

In Psalm 139, David acknowledges God's role in shaping us and said, "For You formed my inward parts; You wove me in my mother's womb. I will give thanks to You, for I am fearfully and wonderfully made; Wonderful are Your works, And my soul knows it very well. My frame was not hidden from You, When I was made in secret, And skillfully wrought in the depths of the earth…" (vs. 13-15, NASB).

Here, we see the Creator pouring Himself and His image joyfully and completely into His creation—a divine and holy design that, like so many other things He fashioned, represents unique, individual, and colorful reflections of His nature. Man was not created out of a one-of-a-kind, "cookie-cutter" mold, but as a rich tapestry of features, appearances, gifts, talents, temperaments and, yes, personalities. C.S. Lewis, in his book, *Beyond Personality: The Christian Idea of God*, posits a notion for personalities in God and God as the ultimate personality.

One's personality relates to the individual differences between people in terms of their cognition, emotions, traits, and behaviors. It is regarded as a particular and enduring pattern that is developed over time and impacted by both genetic/biological (nature) and environmental/social factors (nurture)—producing the true self. The degree to which either set of factors has the greater influence has been debated for centuries and something researchers continue to define and quantify. Twin studies have supported the notion that both heritability and the environment equally affect personality development. A helpful metaphor might be as follows: genetics and biology determine *what* kind of car you are and the environment and social interactions determine *how* you will drive it.

The study of personality may have originated with the Greek physician, Hippocrates, and his theory of "four humours." The model was based on the balance of bodily humours or substances that included yellow bile (the choleric personality), black bile (the melancholy personality), phlegm (the phlegmatic personality), and blood (the sanguine personality). Within the discipline of psychology, a construct having broad domains and often used in describing the personality is known as The Big Five. The term and its dimensions are typically viewed as being on a continuum and are briefly summarized as follows: 1.) Openness to Experience (inventive/curious vs. consistent/cautious); 2.) Conscientiousness (efficient/organized vs. easy-going/careless); 3.) Extraversion (outgoing/energetic vs. solitary/reserved); 4.) Agreeableness (friendly/compassionate vs. analytical/detached); and 5.) Neuroticism (sensitive/nervous vs. secure/confident). The acronym, OCEAN, is used when referring to this model and the concepts have been replicated in a variety of languages and cultures. While The Big Five Model enjoys a wide acceptance, it is not without its critics who argue certain descriptors are merely clustered together empirically, but no real underlying theoretical basis exists. There are numerous assessments designed to measure personality types, such as the Myers-Briggs Type Indicator (MBTI), as well as those

that measure psychopathology, like the Minnesota Multiphasic Personality Inventory (MMPI).

The reality that we live in a broken world—one that impacts both biology and the environment—also allows for the existence of personality-related disorders. These disorders, as outlined in the *DSM-5*, tend to be inflexible and pervasive across a number of different circumstances and are primarily defined as mental and behavioral traits that differ from most societal norms and expectations. Christian counselors, life coaches, and caregivers frequently work with clients who may manifest symptoms of a personality disorder… and this issue of *CCT* seeks to explore and describe these concepts in an integrative way.

There are several articles that take a more global look at the subject matter, including John Thomas' review of the nature vs. nurture debate and its relationship to faith development. In looking deeper into the nature component, Frederick DiBlasio addresses the neurobiology of personality disorders, while Gary Sibcy focuses on the social influences pertaining to intimacy-related factors. Eric Johnson brings a theological orientation to the discussion and the connection between one's personality and soul. Trauma experiences and the resulting detachment and dissociation of the personality are discussed by Eric Scalise. Even our regular columnists used their space to speak on various personality-based themes. Finally, a number of articles describe specific personality disorders, such as Dependent Personality Disorder by Gregory Jantz, the "eccentric" group of personalities with Miriam Stark Parent, Borderline Personality Disorders with Marian Eberly, and antisocial individuals by Linda Mintle.

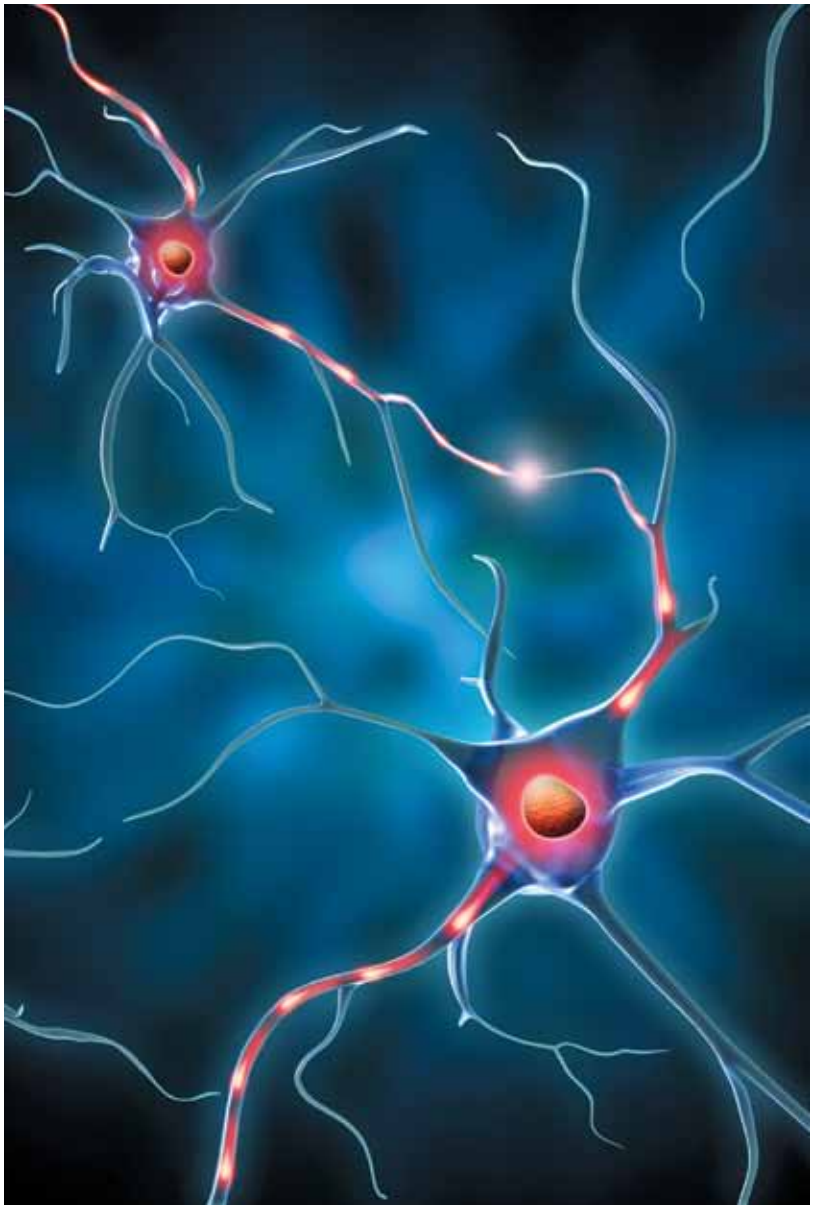
At the beginning of this introduction, David speaks of our physical formation in Psalm 139. Corrie ten Boom, a Dutch Christian, Holocaust survivor and beloved author of *The Hiding Place*, penned her thoughts on the day-to-day transformation of having a relationship with God in what she referred to as the *Tapestry Poem*:

> *"My life is but a weaving between my God and me. I cannot choose the colors, He weaveth steadily. Oft' times He weaveth sorrow; and I in foolish pride, forget He sees the upper and I the underside. Not 'til the loom is silent and the shuttles cease to fly, will God unroll the canvas and reveal the reason why. The dark threads are as needful in the weaver's skillful hand, as the threads of gold and silver in the pattern He has planned. He knows. He loves. He cares. Nothing this truth can dim. He gives the very best to those who leave the choice to Him."*

THOUGHTS TOWARD UNDERSTANDING THE Neurobiology of Personality Disorders

Christian counselors around the world vicariously and empathetically suffer with people as they witness mistreatment and abuse at the hands of acting-out family members, employers, and yes, even pastors and fellow church members. At other times, counselors work with individuals who, despite the counseling wisdom, seem to have magnetized attraction to trouble and self-sabotage. These tough cases typically involve *personality disorders* (PD) where symptoms often last a lifetime. About 10-20% of the general population has PD (Lenzenweger et al., 2008; Sadock & Sadock, 2007). When it comes to the clinical population of clients as a subset, the figure rises to nearly 50% (Sadock & Sadock, 2007; Zimmerman et al., 2005) and a significant portion of the remaining group need therapy to resolve the emotional issues created at the hands of family members with PD. My heart and prayers for decades have gone out to these troubled situations, asking God to explain, and I believe He has given a partial answer.

FREDERICK A. DIBLASIO



In one low-income family in the 1950s, both parents had severe PD that resulted in eight young children being physically and emotionally abused. It is to these two parents, who are my now deceased parents, that in love this article is dedicated. Now looking back with the eyes of a counselor and clinical professor, what stands out most for me is that my parents were very insecure and wanted to be understood and loved. Yet, because of their mostly unintentional, but nevertheless, offensive and cruel behavior, they seldom received the love and understanding from others that they craved. They were caught in a lonely vicious cycle of not learning how to negotiate in the give-and-take of love that is part of any relationship. Even as a child, I knew their brains experienced the world in abnormal ways.

To not have a "normal" brain is something I understand, since academic learning disabilities caused me to have to work very hard throughout my life to achieve what seemed so effortless for others. Arduous and repetitive work allowed me to eventually earn decent grades and achievements. Becoming more competent over time, I relied on my strengths to get an abnormal brain to repetitively practice improving my weaknesses to a point where I achieved my desired goals. This required not trusting my natural and automatic thinking in certain areas of academics and speech. Although not knowing it at the time, I was using a God-given neurological fact—a brain can make up deficiencies and adapt by forming new pathways through a process called neuroplasticity. Neuroplasticity is the ability of human brains to form pathways and grow stronger through the use and stimulation of brain neurons. When neurons are repetitively activated (fired) in a brain structure, a protein synthesis occurs (neurons getting fed so to speak) that strengthens them and they, in turn, literally "piggyback" onto one another to form permanent pathways (referred to as simply

Neuroplasticity is the ability of human brains to form pathways and grow stronger through the use and stimulation of brain neurons.

plastic changes). Like plastic, the pathways are moldable but, once established, they become rigid. As neurologists like to say, "Neurons that fire together, wire together."

The hallmark of people with PD is that they frequently do not learn from the consequences of their behaviors. One day it dawned on me that some clients were having problems learning because they had what I have come to call *emotional and interpersonal dyslexia* (EID). The solution became obvious—just as with academic dyslexia, they had to avoid trusting their natural feelings and thinking in certain emotional and interpersonal arenas and practice repetition of functional thinking and behavior as guided by a trusted counselor. As I witnessed Christian clients improving through this approach, I had a front row seat watching God transform them by the renewing of their minds (Romans 12:2). I believe the brain is neurologically/spiritually renewed as one draws closer to Him, and also practices and thinks upon self-control and love.

Miraculously, our brains are designed by God to perform functions that allow us to walk in His ways and follow the example of Jesus, while at the same time have free will to

The hallmark of people with PD is that they frequently do not learn from the consequences of their behaviors.

The initial evidence is mounting as the literature base is showing people with PD have slightly smaller brain structures, less gray matter, and more brain function problems when compared to normal controls.

choose to love and serve Him. Humans have a *limbic system* that is found in the *lower-ordered structures* of the brain. Lower-ordered not only refers to the fact that they are in the lower part of the brain, but also indicates that its function is more basic and primary. One of the main set of structures in the limbic system is the amygdala, two small almond shape groups of nuclei that work in unison as the first responder to love, fear, survival, emotions, and pleasures. The amygdala communicates with most of the brain's structures relatively directly. It does an array of functions, such as processing memories, stimulating our brainstem to move the body out of the path of danger and sending signals to the prefrontal cortex because of a pleasurable love feeling. Above the limbic system are the *higher-ordered structures* where much of our cognitive understanding of the world takes place and cognitive and automatic inhibitions emanate to control impulses in the lower-ordered structures.

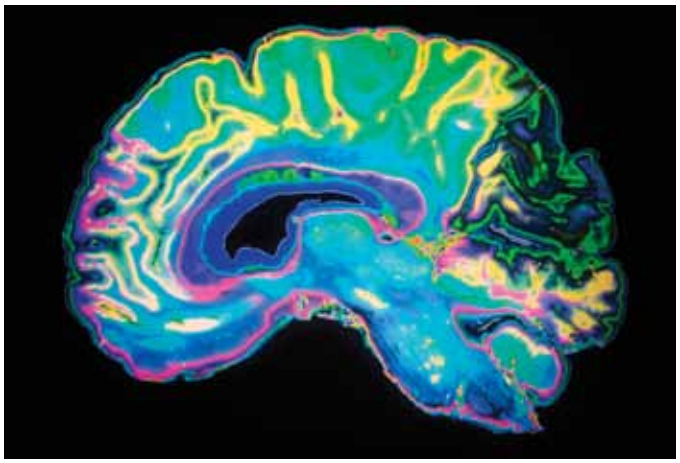
Current neurological research is indicating that the brains of people with PD are different than normal (see DiBlasio et al., 2014 for more detailed information). The initial evidence is mounting as the literature base is showing people with PD have slightly smaller brain structures, less gray matter, and more brain function problems when compared to normal controls (e.g., Carrasco et al., 2012; Díaz-Marsá et al., 2011; New et al., 2013; Goodman et al., 2011; O'Neill et al., 2013; Sato et al., 2012; Sundram et al. 2012).

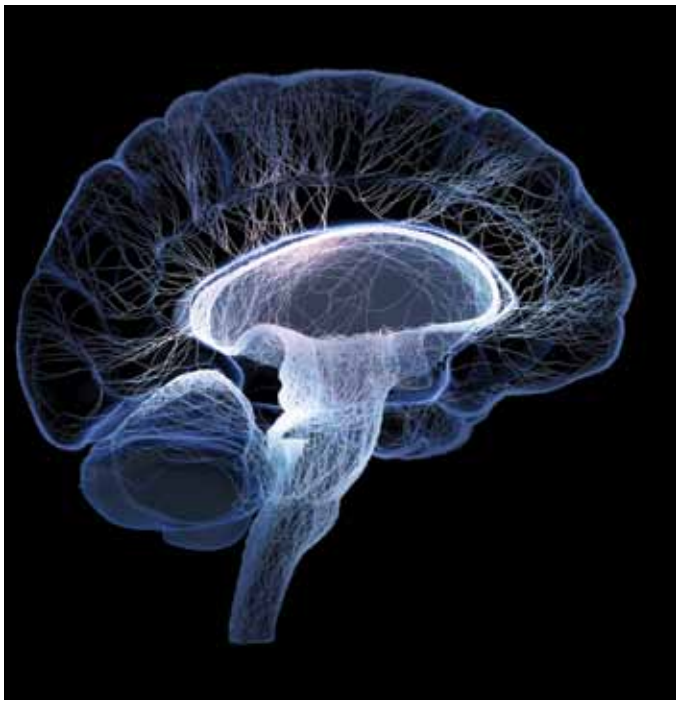
A primary area of PD neurological investigation reflects functional deficits of the connections between the limbic system and the *higher-ordered* structures that inhibit dysfunctional responses and regulate self-control. For example, Kluetsch et al. (2012) found that when compared to normal controls, subjects with borderline PD had less effective connectivity in the brain structures that instinctively shift the brain from external stimuli to self-controlling internal thoughts. Therefore, a person with PD has a deficiency in the brain's ability to control feelings and thoughts so that socially-appropriate responses and behaviors naturally result. Another study found that subjects with PD showed slower reaction times and higher activation in the amygdala than normal controls (Kraus-Utz et al., 2012).

When active from a negative or threatening stimulus, the amygdala directly signals for the release of cortisol and adrenaline (the primary stress hormones). Cortisol begins to shut down certain brain functions so the brain can focus primarily on survival, while adrenaline provides a boost of energy to keep the brain on high emotional and physical survival alert. Without sufficient higher-ordered inhibitions and regulation, the amygdala can keep someone with PD in a self-protective emotional frenzy for longer periods of time. Interestingly, the military train their elite forces how to read and cognitively reduce the release of cortisol and adrenaline to keep them cognitively sharp and provide correct responses in highly-charged, top-secret operations (the release of too much cortisol can result in faulty thinking and overreaction). On the other hand, when humans receive empathy, human touch or loving eye-contact, the amygdala signals for the release of soothing oxytocin (the love/attachment/nurture hormone). People with PD live in a world that is flooded with cortisol and adrenaline and have a low release of oxytocin due to the lack of human love they receive and the steady existence of fear and insecurity.

With the recent advancement in imaging technology, researchers are able to track signaling within the neurons of the brain. The typical brain is thought to have 100 billion neurons that are intricately wired together. When a normal brain fires, signals (like electrical charges) shoot down a neuron and are carried across a synaptic gap by a neurotransmitter that delivers them to the adjacent neuron where the charges continue their journey. Like a garden hose without leaks carries water, the normal brain likewise contains the flow of charges so they reach their destinations. Diffusion Tensor Imaging (an MRI method that allows the mapping of how molecules are diffused in biological tissues) is showing that people with PD have leaks in their garden hoses resulting in the metaphoric "puddling" of signals outside of the neuro-pathway. Signals are not reaching their intended structures with the full force needed. However, treatment is hopeful because pathways can be created that mediate the dysfunction and get the job done over time and through neuroplasticity.

Alternatively, repetitive patterns of behavior that are sinful and dysfunctional can also produce negative *plastic changes* resulting in pathways that form to sharpen the person's efficiency to engage in sinful thinking and behaviors. The lifetime longevity of PD might be partially explained by the "leaks" that go uncorrected and negative plastic changes that develop when sin is constantly repeated. Further, this may be part of the neurological explanation of how humans can get a *debased* (*retrobated*) mind leading to the spiritual death discussed in Romans 1:28.





Readers are cautioned to remember that even when there is brain disability, biblically there is no temptation to sin that can overtake a person… and with every temptation comes a *door of escape* (1 Corinthians 10:13). Using neurological principles to change brain function can be one such *door of escape*.

Treatment for PD starts by a gentle presentation of the diagnosis and an action plan. When counselors use a positive and empathic perspective by targeting client strengths and finding areas of admirable qualities, defenses are lowered providing opportunities to freely discuss the downside of symptoms. The fact that this approach views the emotional and interpersonal problems as a dyslexia, clients with PD become more approachable because their entire personal integrity has not been attacked and they have been genuinely valued by the counselor (valuing the people we meet is something we all should do for each other). Given that many famous and noteworthy people have overcome dyslexia in academic areas (e.g., Benjamin Franklin), an EID client can view the reframed treatment as embarking on a gallant mission to overcome a disability. Further, family members develop a fresh perspective and gain some empathy toward the person with PD and, thereby, become more motivated to demonstrate love, rather than fear, anger, and resentment.

After presentation and agreement on the diagnosis, the counselor attempts to use a

With the recent advancement in imaging technology, researchers are able to track signaling within the neurons of the brain.

number of methods to assist in the development of plastic changes. It is beyond the scope of this article to review all of the specific treatment strategies. However, in addition to presenting and getting acceptance on the diagnosis from the client, there are two other strategies necessary to achieve so a more neurological therapeutic approach can begin.

First, while constantly using clients' strengths, counselors need to establish a therapeutic contract where willing clients agree not to trust certain feelings and thoughts. By doing so, clients are held accountable to practicing cognitive choices during emotional and stressful times. This act has two primary benefits: 1.) clients are avoiding reflexive signaling down old and well-established, negative neural pathways; and 2.) clients are firing neurons that can build needed connectedness and plastic changes from the amygdala to *higher-ordered* cognitive structures. Consistently avoiding immediate gratification of amygdala-motivated drives and putting cognitive assessment between feeling impulse and action can lead to new pathways to defeat impulsivity and lack of self-control. For a period of time, clients need to check with their counselor and a trusted Christian mentor concerning the reality of their emotional and interpersonal experience.

Second, achieving new pathways requires clients to have a 100% commitment to *zero-based tolerance* for the reflexive and old patterns of negative feelings and behavior. To this end, I encourage clients to have zero tolerance for allowing their brains to dwell on old ways so they can build new pathways. Putting off the old and putting on the new is a strong biblical concept (Ephesians 4:22-24). Interestingly, the commitment does not mean client perfection, but instead reflects an unwavering direction of the therapy.

However, one thing is for sure, if the therapeutic helping professions are to become more effective in treating our statistically largest epidemic mental health problem, there must be an appropriate paradigm shift. Psychotherapy that is insight oriented and focuses on stimulating emotional catharsis is counterproductive for a brain that is not well-connected to higher-ordered functions and already overly amygdala-driven. Ironically, we have to learn from the consequences of decades of not effectively dealing with this population, as well as attempt new neurological therapeutic interventions. Further, we can no longer treat people with PD as having normal brains and automatically conclude their abusive and self-destructive behaviors are knowingly and entirely intentional. ✠

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Personality and Faith Development

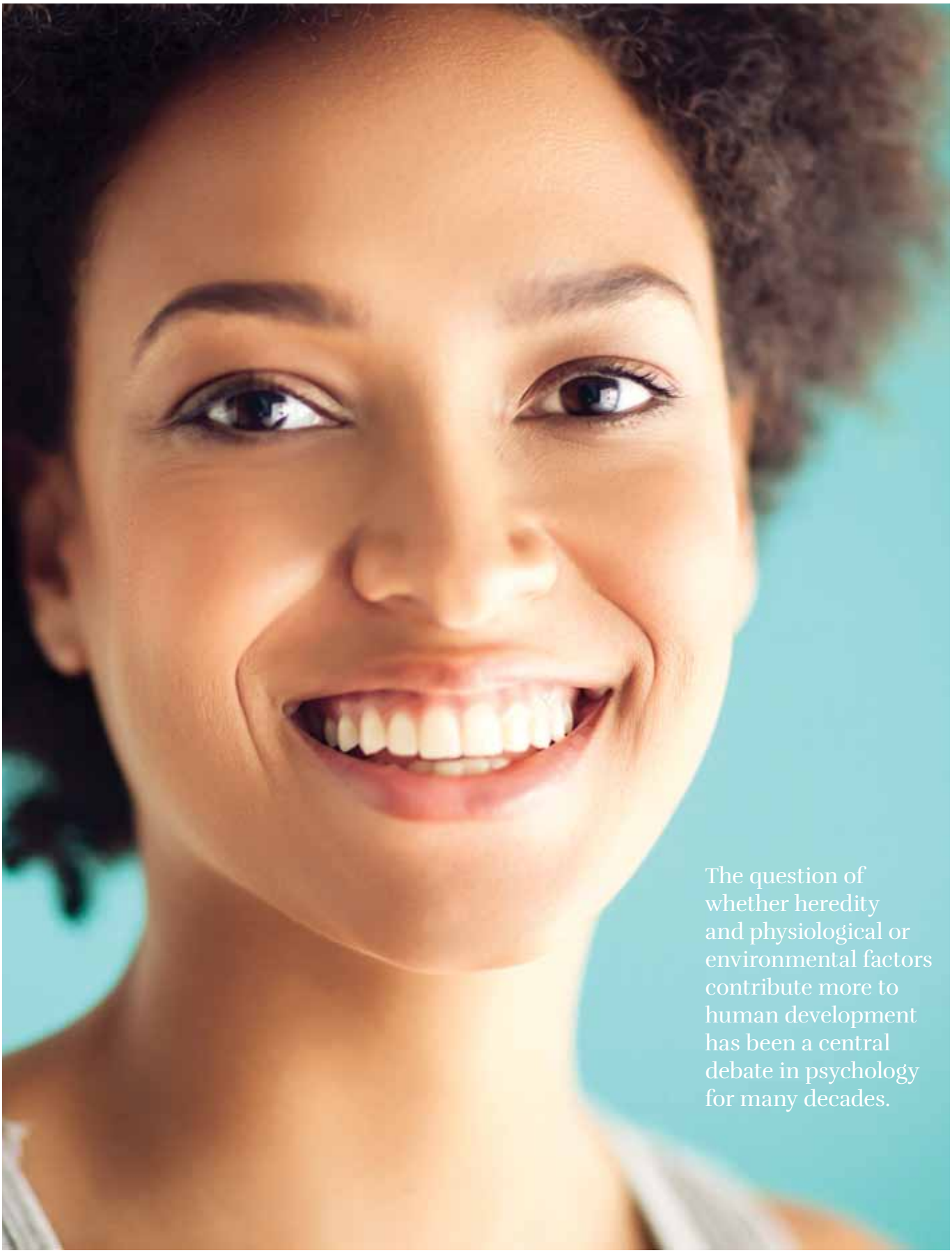
THE NATURE VS. NURTURE DEBATE

Pam grew up in a spiritually strong and supportive home. For generations, her family was actively involved in church ministry. Desiring to be a missionary to Spain, Pam attended a Christian university where she met a man who would become her husband. Against the advice of both sets of parents, they married during their sophomore year. Dreams for a "happily ever after" life shattered only months into the marriage, resulting in Pam's "breakdown" and inpatient hospitalization.

The outcome was various medications and an extensive aftercare program to treat her schizophrenia diagnosis. Demoralized and devastated, Pam's emotions spiraled downward until she was also depressed. No aspect of her marriage and life were unscathed. Tragically, a once vibrant faith metastasized to gloomy lifelessness. Bewildered and in deep shame, she could not figure out what she did to deserve this punishment. Pam's melancholic faith offered no sustenance; in fact, it became detrimental.

Tamara is the third of five children who were all raised by a single mother. Faith was nowhere to be found in their home. She described generations of her family as cold and controlling. Hardship has visited each member of her family—two brothers are incarcerated, while many of the others are addicted to drugs, unemployed or divorced… and her mother's health is rapidly failing. As with Pam, Tamara's

JOHN C. THOMAS



The question of whether heredity and physiological or environmental factors contribute more to human development has been a central debate in psychology for many decades.

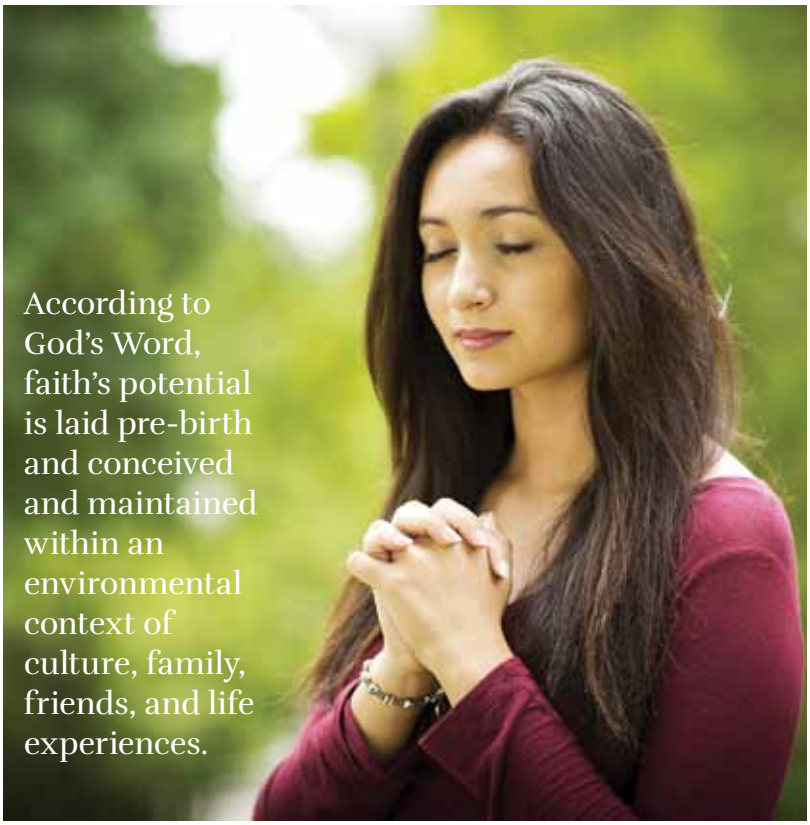
life has been a gloomy existence. During her youth, she was sexually abused by her brothers and their friends. Tamara became sexually active at the age of 11 and soon became the "pass around" girl for the football and basketball teams. While attending college, her roommate, a committed Christian, invited her to a campus Christian organization. Embraced by community for about one year, Tamara eventually opened herself to Christ. Her conversion was evident and touched every part of her life. Tamara's prior melancholia evolved into radiance and she finally seemed to be comfortable in her own skin.

Pam and Tamara's stories reflect the power of nature and nurture. Pam's family of origin, and seemingly strong faith, failed to insulate her from the genetic vulnerability of schizophrenia. In its wake, her life and faith were disconsolate. It took three years for Pam to find stable ground upon which to rebuild her life, marriage, and faith. In contrast, the trajectory of Tamara's life was redirected by circumstances. Never having stability, Tamara sought deeper meaning. As a young adult, she found it in a Christian group where she learned of Christ's love. Pam and Tamara, with their unique physiological and psychological DNA, each experienced changes in their faith throughout their lifespans. Accordingly, this article considers personality and faith development from a nature-nurture perspective.

Nature and Nurture

The question of whether heredity and physiological or environmental factors contribute more to human development has been a central debate in psychology for many decades. The controversy involves how much of people's behavior is due to biology/genetics (nature) and how much is due to social/environmental factors that occur throughout the lifespan (nurture), especially during the early childhood years. Whether nature or nurture is dominant in the shaping and developing of personality is not agreed upon. For researchers and practitioners alike, understanding the role that either plays in a particular characteristic is of greater concern.

Practically speaking, the nature side of the debate includes a synergy of genetic, physiological, and neurobiological capacities, processes and traits that are inherited from parents. Nature lays a template or foundation for the child's life trajectory. In contrast, nurture is comprised of environmental influences such as early life experiences, parents' caregiving skills, social-economic



circumstances, family and peer relationships, traumas, and stressors among numerous others. A simple illustration is how a computer functions. The hardware and programs from the manufacturer equate to nature, whereas those added by the user represent nurture. One person might purchase a Mac® and another purchase a PC (related to nature), and two people could purchase the same computer but load additional (and different) programs.

Over the course of time, the debate commuted from whether nature or nurture was at the heart of development, to what and how each contributes to it, as well as the interactions between them. In other words, multiple interlinking nature and nurture factors combine and interact to influence how each person develops. This dynamic interaction is captured by the phrase, "diathesis-stress," referring to a genetic-environmental connection. The plasticity of the brain (nature) allows nurture's influence, while it also exerts its own. The reciprocal relationship between nature and nurture is evident in the functional MRI studies associated with interpersonal neurobiology. To return to the computer analogy, programs and files added and created by the user may function well in the manufacturer's design and installations or interfere with those processes. Just like a computer may not have the capacity or speed to run some programs, the nature factors of a person might not be able to process and make the best use of what has been uploaded. Due to nature, not everyone will be able to benefit from nurturing experiences. Moreover, the role of free will in the entire process adds another layer to the discussion.

Not only does a nature-nurture interaction exist for each individual, but the development of the person within the mother's womb (nature) is impacted by how she lives her life and the choices made during pregnancy (nurture). For example, a child may be diagnosed with Fetal Alcohol Syndrome if the mother drinks excessively throughout pregnancy. Even the womb is not free from the outside world.

Lastly, nature and nurture are goal-directed—what genetic factors set in motion, environment uses as raw material to develop the person. Both genetics and environment impose their will through direct and indirect forces. Consider Pam and Tamara: how would their lives be different if Pam was born to her biological parents, but raised by Tamara's… or vice versa? How might this have impacted their life experiences and development of faith? How might life experiences have altered their neurobiology? How might Tamara's brain begin and continue to transform as she grows in her faith in Christ? How would Pam's life have been different had genetics not predisposed her to schizophrenia?

The fact that we are fearfully and wonderfully made might also indicate the dynamic relationship between nature and nurture is beyond the scope of human thought and empirical inquiry. The bottom line is that the complex interaction of genetic predispositions and environmental influences are impossible to disentangle. Thankfully, neither nature nor nurture ultimately define destiny.

Faith Development

Faith is a subject of much professional thought (cf. Fowler, 1981; Kirkpatrick & Shaver, 1990; Lonergan, 1972) and interest. Though many definitions exist, the construct simply refers to a set of beliefs and actions that operate without proof; a means of knowing that is distinct from empiricism. It involves a trust and devotion to its ideals and typically fosters dependence upon an *other* of some kind. Though linked to religious involvement, it is distinct and transcends any faith community. Faith is intrapersonal (emotions, cognitions, behavior, and will) and interpersonal (with God and others). From the complex interactions of nature-nurture, faith expands, restricts, progresses, evolves, and even falters over the lifespan.

According to God's Word, faith's potential is laid pre-birth and conceived and maintained within an environmental context of culture, family, friends, and life experiences. The starting place for faith is in the realm of nature. Since the fruit debacle in the Garden of Eden, sin has been inextricably knit into every person's DNA.

Early Warning Signs for Personality Problems in Children

Personality disorders typically become apparent in adolescence or early adulthood. Children, however, may exhibit the signs of a budding personality disorder. Personality problems are often complex reflections of nature and nurture variables. Moreover, the particular signs of an emerging personality problem are hard to detect since there are various manifestations and 10 different disorders.

The following are early warning signs that a child might be developing personality problems. These signs would need to be exhibited in a variety of settings and contexts:

- Lack of a secure attachment to parents/caregivers
- Difficulty establishing or maintaining friends in school
- Difficulty playing or relating to others
- Breaking close friendships
- Seeming distressed or alienated
- Rigid or inflexible
- Changes in behavior
- Behavioral disinhibition (e.g., aggression, bullying, impulsivity, stealing)
- Refusal to cooperate with authority
- Provocation of others
- Chronic procrastination
- Perfectionism
- Emotional dysregulation
- A family history of personality problems and disorders
- Maltreatment
- Parents/caregivers have diminished capacity to effectively parent

What Do I Do Next?

- Have the child evaluated by an appropriately trained professional
- Consider family history and other nature factors in concert with family of origin and early life experiences
- Find a counselor trained to deal with the particular issues
- Educate the parents/caregivers on effective parenting strategies
- Coordinate efforts between parents, school, church workers, etc.

From the moment of conception, the newly forming human has a sin nature that will impact every aspect of personality and faith development. Yet, human beings are also made in the image of God (cf. Genesis 1:27), who fearfully and wonderfully fashions each life (cf. Psalm 139:13-16). We are a composite of divinity and earthliness. Our Creator has set eternity in each heart (nature; cf. Ecclesiastes 3:11) that prompts a longing for other connection (nurture). Blaise Pascal, a 17th century French philosopher and mathematician, framed it in this manner:

> … there was once in man a true happiness of which there now remain to him only the mark and empty trace, which he in vain tries to fill from all his surroundings, seeking from things absent the help he does not obtain in things present? But these are all inadequate, because the infinite abyss can only be filled by an infinite and immutable object, that is to say, only by God Himself (Trotter, 1958).

From a baby's first breath in the physical world, heredity is fused with sin in a dynamic existence with everything around the child. Nevertheless, the child's life is programed at some point in development to prompt an awareness that something special is needed to give life meaning. Whether the person will come to depend upon God through faith or a "god" of his making links both nature (a thirst to seek God) and nurture (an awakening of a hole to fill). Tamara was well acquainted with a gnawing in her soul that was at least blunted when she encountered the community of Christians. In contrast, Pam had numbed her longing so it would not be felt.

Fowler (1981) has been one of the leading theorists on faith development. He asserted that faith is a universal human concern that seeks meaning. Fowler's belief tied faith and life together in both the present and eternal. From this foundation, he conceptualized six stages of faith development plus

infancy. Other developmental theorists, such as Piaget, Erikson, and Kohlberg, contend spiritual growth proceeds from a pre-faith stage to a universalizing one that involves ultimate meaning. Just as personality development increases in complexity and comprehensiveness through each life stage, Fowler's model proposed that faith evolves from simplicity to complexity as well.

Although Fowler's work has been extensively studied, it lacks the substance of content. It is intended to be inclusive of all faiths, so it does not distinguish between the qualitative differences in faith perspectives. As evangelicals, we recognize that beliefs, values, morals, motivations, and practices matter in regard to spiritual direction. The real issue is not that faith develops, but to what end the faith is developing. In other words, the larger question is, "Develop into what?" The answer for us is conformity with Christ (cf. Romans 8:29, 12:2; 1 Corinthians 11:1; Ephesians 4:17; Colossians 3:7-8; 1 Peter 1:14, 4:3).

The term, "spiritual formation," is used to describe the process of the shaping and growing of faith. From our perspective, it begins at salvation and evolves to higher levels of spirituality with the destination viewed as conformity to Christ. It is the result of the work of the Holy Spirit through numerous means to form Christ in us. While the goal is Christlikeness, the formative process emerges out of the uniqueness of each person. Even though my brother and I possessed similar genetics and grew up in the same home, we were distinct in nature and personality. The formation of our faiths began at a different time, from a different place within us, took different paths, and we arrived at different places.

The 12 disciples represented diversity. Nature and nurture formed each one into who they were as individuals. From the point of Christ calling them to follow Him, they each had their own experience with Jesus. As the early church entered infancy, each one played his own role. Peter's impulsiveness, leadership, and boldness shaped his faith very differently than the Apostle John or Matthew. The power of the Gospel is about transforming lives, not just the nurture aspects of our personalities, yet extends to such nature issues as depression, anxiety disorders, and the like. The Gospel has the power to lead to changes in the brain that will be in dynamic relationship with the individual's experience of life. The Gospel transforms each person's personality from the inside out and from the outside in.

The stories of our lives are not complete. Between our natural capacities, environmental opportunities and experiences, and a God who specializes in transforming lives, we can be made new and become better personally and spiritually.

** Special thanks to Alicia Hamlin for her help with this article.*

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Dialectical Behavioral Therapy

A CHRISTIAN APPROACH TO THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Dialectical Behavioral Therapy (DBT) is a highly utilitarian and comprehensive cognitive-behavioral form of therapy introduced in the early 1990s (Linehan, 1993) as a treatment for those suffering from parasuicidal tendencies and later found effectiveness with Borderline Personality Disorder (BPD). DBT is uniquely suited to those suffering with BPD because it is based on a central dialectic of change and acceptance: concepts that can create particular cognitive and behavioral disturbance in BPD. This dialectic of change refers to opposing forces that create a synthesis, emphasizing the *and* or *both* as opposed to either.

A dialectic is defined as "a cognitive process through which potentially contradictory facts (a thesis and an anti-thesis) are harmonized by discovering a more fundamental truth (a synthesis) from which both facts arise" (Linehan, 1993). In DBT, the dialectic emphasizes working effectively with the tension between freedom and control. The goal of DBT is to seek to find the balance between two opposing viewpoints: implying balanced, synthesized responses between emotional, cognitive and behavioral extremes. DBT functions on the premise that one is continually in a process of change and instills belief in the patient's capability for change. This is an especially significant concept when treating BPD, where self-defeating beliefs reign supreme.

MARIAN EBERLY

BPD is defined and characterized by the following features most often seen in the difficult-to-treat contingent of the patient populace: emotional instability; problems with anger; unstable relationships; efforts to avoid loss; suicidal threats and parasuicidal behavior; self-damaging, impulsive behaviors such as drug and alcohol abuse; cognitive disturbances; chronic emptiness and an unstable self-image. In brief, BPD is characterized by a highly mood-dependent style of doing life and, as such, results in great heartache and suffering, often self-inflicted.

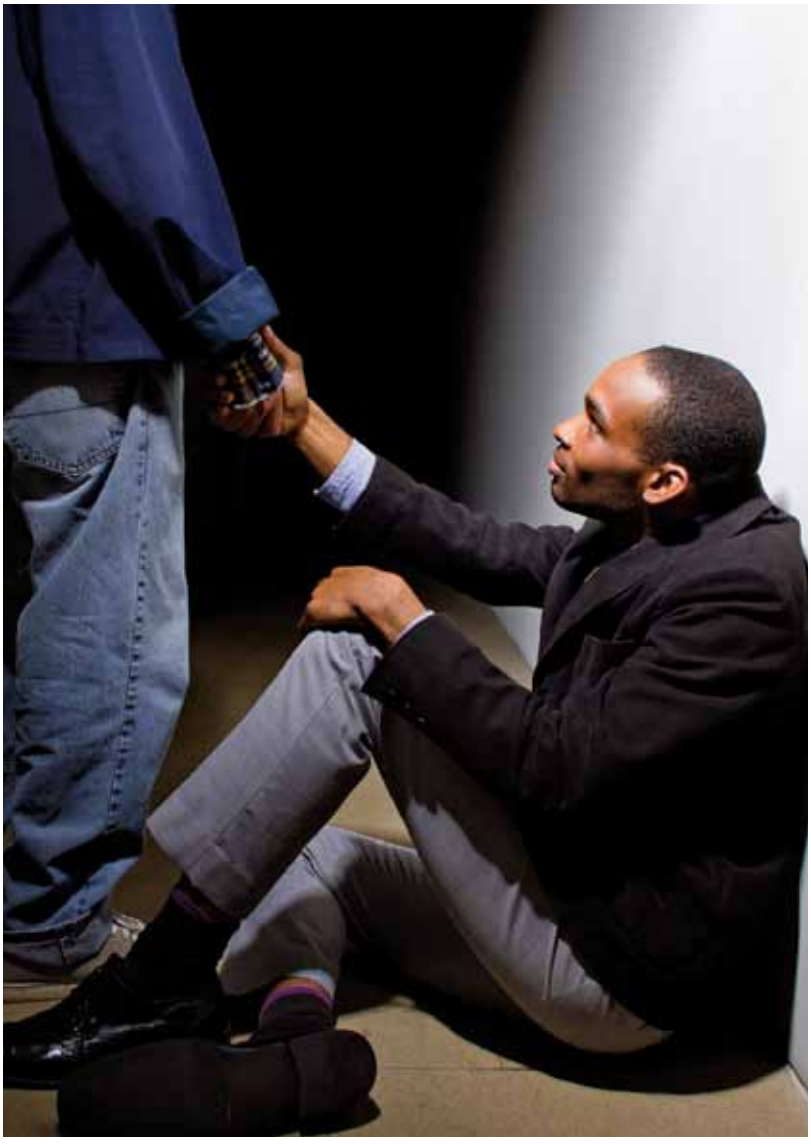
DBT is based heavily on the bio-social theory of emotion-dysregulation (as a result of genetics or trauma) giving recognition to the

In brief, BPD is characterized by a HIGHLY MOOD-DEPENDENT STYLE of doing life and, as such, results in great heartache and suffering, often self-inflicted.

physical and emotional components of chronic distress. Those who demonstrate the following patterns benefit from DBT: 1.) inability to regulate their emotions when necessary due to a very high sensitivity to emotional stimuli; and 2.) potentially distorted informational processing that can lead to disorganized thinking and impulsive decision making.

DBT includes an emphasis on the problems associated with this pattern of mood-dependent problem solving. As such, DBT gives more than just a cursory nod to the invalidating environment as a causal effect in emotional disturbance. This modality addresses contributing bio-social factors of influence through education and coping strategies, as well as introducing change and acceptance concepts.

In recent years, the use of DBT in multiple clinical trials and extensive research history has supported its effectiveness across a variety of diagnostic categories, including substance abuse disorders, post-traumatic stress disorders, and eating disorders to name a few (Linehan et al. 2006). This evidence-based treatment has received considerable attention from practitioners, specifically for the skills training component as is reflected in the research literature (Robins & Chapman, 2004).

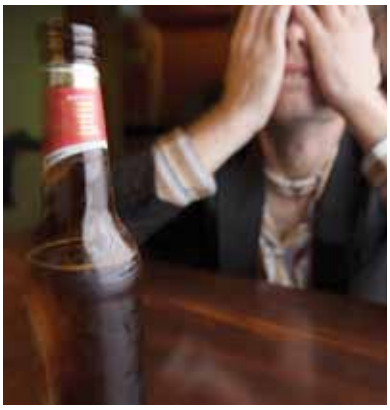


Treatment delivery options vary; however, DBT was originally designed for use in a team environment involving modalities of individual therapy, group skills training, coaching-phone sessions as needed in between sessions, and periodic consultation meetings with the treatment team. Practitioners receive specialized training and certification in DBT. Although DBT has been adapted for use in various settings and contexts, the group skills component is the foremost element to be utilized. The teaching and practice of new skills to regulate and enhance one's ability to control emotions can increase the capacity to tolerate distress without the consequential self-destructive reaction. Group Skills training includes several behavioral strategies in the context of increasing mindful awareness (meditation) and quieting the over-stimulated brain.

All too often, treatment for BPD fails. Why is this? Emotions may be so dysregulated that patients cannot tolerate the inevitable distress of counseling. Ambivalence about changing their behaviors must be acknowledged and discussed. Therapists must have an ability to be both compassionate and sophisticated in their ability to see these clients as fearful of change and lacking the skills to create a new reality for themselves. In many cases, it is the therapist who encounters countertransference problems. This scenario may lead to transitioning the client to yet another therapist, resulting in the patient facing abandonment issues once again. DBT treats *both* of these likelihoods as resources are given to the therapist and patient alike. The unique blend of principles and skills in DBT lends itself well to the successful treatment of those suffering with BPD.

DBT has five core areas of function:

1. Enhancement of individual capabilities (skills training in mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance)
2. Improving motivation (individual therapy to target the hindrance to decreased motivation)
3. Generalization of acquired skills to promote adaptability in new environments ("coaching" between sessions)
4. Environment restructuring (may involve family therapy to address system patterns)
5. Improvement of therapist capabilities (case consultations, meetings with patient and the treatment team)



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Mindfulness

One concept within DBT has created controversy in the Christian practice community since its inception in 1993. The incorporation of Mindfulness concepts, and accompanying behavioral strategies, has been a stumbling block for many practitioners in the Christian faith.

The concept and techniques of mindfulness in DBT were originally derived from Buddhist meditative practices. Mindfulness in DBT is viewed as: observing, describing, participating, giving focused attention to doing one thing well at a time, considering what is effective, and then acting on what is necessary to be effective. The focus of mindfulness in DBT is to develop the ability to accept and tolerate powerful emotions that may interfere with desired change. None of the aforementioned skills are necessarily in contrast to Christian thought, belief or practice. This expression of mindfulness is utilized in several modern models of psychotherapy, including Acceptance and Commitment Therapy (ACT) and DBT, both based on cognitive behavioral constructs and influenced by Eastern religious conceptualizations. Although it is important to recognize that no metaphysical or particular religious practices are taught in DBT, the orientation of the term creates pause.

Students of world religions recognize the term "mindfulness" as being derived from Buddhism: *Right mindfulness* is the 7th noble truth of the eight-fold path of Buddhism. This concept refers to an openness and acceptance of one's inner world. This path may be linked to being "non-judging" about what one may find there and, as such, is juxtaposed to the Christian practice of self-examination or, more importantly, *petitioning God to search the soul within* and reveal the truth (Psalm 139:23-24). Consequently, the Christian discipline of repentance and confession is often the outcome of thinking about right and wrong "mindfully"—becoming aware of one's inner thoughts, motives and choices in *relationship* to the righteousness of God (I John 1:9). It calls one to an intentional acknowledgment of his or her sin before Jesus Christ, and receiving forgiveness through His atoning blood. Clearly, these definitions of the term "mindful" are divergent one from another and have different implications altogether (Colossians 2:8).

As Christian practitioners, this is *not* the first time (and it will not be the last) therapists have encountered challenges like this one. Since its beginning, DBT has been empirically proven to be an effective form of psychotherapy with a multitude of serious disorders. This is not surprising because it is primarily based on cognitive-behavioral principles. However, one of the main tenets of the therapeutic process in DBT includes techniques that are juxtaposed to the biblical understanding of *mindfulness* (having the mind of Christ). This is an important and significant distinction.

So, what is a Christian therapist to do? Shall we toss out all of DBT because it has been influenced by Buddhist thought? Abraham Maslow was not a Christian… shall we throw out his hierarchy of needs? What shall we do with Erik Erikson's theory of identity and psychosocial development… or countless others who have made valuable contributions to the field of behavioral health? As believers, we look to Scripture for guidance when these dilemmas occur.

"… but test everything that is said. Hold on to what is good" (I Thessalonians 5:21, NLT).

"See to it that no one takes you captive through philosophy and empty deception, according to the tradition of men, according to the elementary principles of the world, rather than according to Christ" (Colossians 2:8, NASB).

"But if any of you lacks wisdom, let him ask of God, who gives to all generously and without reproach, and it will be given to him" (James 1:5, NASB).

"Where there is no guidance the people fall, but in abundance of counselors there is victory" (Proverbs 11:14, NASB).

The concept of mindfulness in the Buddhist tradition does not pass the test for Christian practitioners. Rather than declaring DBT invalid, consider possible opportunities for modification. Exploring this further, the concept can be scrubbed and a new concept may replace it, such as a reflection on having the *mind of*

Christ (instead of the Buddhist understanding of mindfulness) and being thoughtful about aligning one's heart and mind and choices with the truth of the Bible: the Word of God. If one does modify DBT from its original form, this should be stated outright in accordance with ethical practice, as is done with CBT, IPT and other models of psychotherapy when altered from the original understanding.

As Christ-centered therapists, we adhere to the belief that it is Jesus Christ who brings about healing; that we are vessels or conduits in that process (John 15:5). Christ-centered therapy will incorporate the best of therapeutic approaches and strategies for change, while adhering to scriptural principles.

Measure, Measure and Measure Again

So the question is… does DBT square with Scripture? Does *any* traditional model of psychotherapy *completely* square with Scripture? The answer is an emphatic, *"Of course not!"* It never has… and why should we ever expect it to? We may, at times, see similarities in conceptual thought and practice. However, that said, we are called to sift and weigh as Christians and therapists. Do we not take the underlying fundamentals of various models that square well and adapt them? The list of models that have been through the "squaring" process is very long. This practice is to be applauded and encouraged. It is exciting and reassuring to know therapists and researchers, who are also Christians, have taken the time to carefully put a secular psychological model through the rigors of analysis. This requires a tremendous amount of time, study, research and discernment. I have done this with DBT to the best of my ability and have shared some of my discoveries here. However, as offensive as this practice of integration may be to some (Christians and non-Christians alike), there will always be great challenges before any therapists who are also believers in Christ:

- To rightly divide the Word of God in their counseling, writing and teaching
- To measure correctly the theoretical frameworks, conceptualizations and models before them (systems theory, CBT, trauma theories, etc.)

Christian therapists must learn to "take the best (that squares with Scripture) and leave the rest." This means practicing the discipline to pray and study, search the Scriptures, and take materials and questions to other trusted Christian practitioners for counsel on the subject. As a result, therapists may find themselves using an *adapted* form of a model such as DBT.

Core principles of DBT congruent with Scripture include:

- Validation—countering invalidation and instilling hope (I Thessalonians 2:16-17; 3:5)
- Acceptance vs. Change
- Responsibility (patients may have caused all of their problems, but need to solve them anyway… we do this with God's help)
- Contingency Management (use of natural and logical consequences, sinful choices have logical outcomes—Romans 6:13-14, 23; Matthew 25:14-30)
- Change with Cognitive Restructuring (Romans 12:1-2; Philippians 4:6-9; Proverbs 3:5-6; Ezekiel 36:26)
- Dealing with Therapy Interference (calling to responsible Godly living, repentance and forgiveness—Romans 7:15; Psalm 51:10, 139:23-24)

In summary, why consider DBT as a treatment for BPD? DBT has had empirically-demonstrated outcomes for 20 years with randomized controlled trials. It focuses on helping people control their own thinking, choices and behavior (CBT emphasis), while taking into account trauma effects and invalidating environmental effects. In fact, DBT may be the first form of therapy empirically demonstrated to be effective with BPD (meta-analysis found that BPD reached moderate effects with DBT). DBT is easy to use and understand for both the client and therapist. The approach does not teach any specific form of Buddhism, though it is influenced by Buddhist thought. It seems much of DBT can be used without violating scriptural teachings and enhanced by the influence of the Christian practitioner. DBT encourages the use of thoughtfulness and meditation, which can draw many to consider a life with Christ. As Christian practitioners, we carefully measure and scratch what we must, but also do not need to walk in fear of new psychotherapies that may emerge in the future. After all, there is no real threat, Buddha has been long dead. *Jesus is RISEN!*

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DEPENDENT PERSONALITY DISORDER

From the beginning, human beings were made to exist within relationships. Each of us has a deeply felt need to experience the love, acceptance and approval of others. We satisfy this need by looking to family, friends, and even those with whom we work. These relationships add to our lives. In Dependent Personality Disorder (DPD), relationships do not add to life; relationships *become* life.

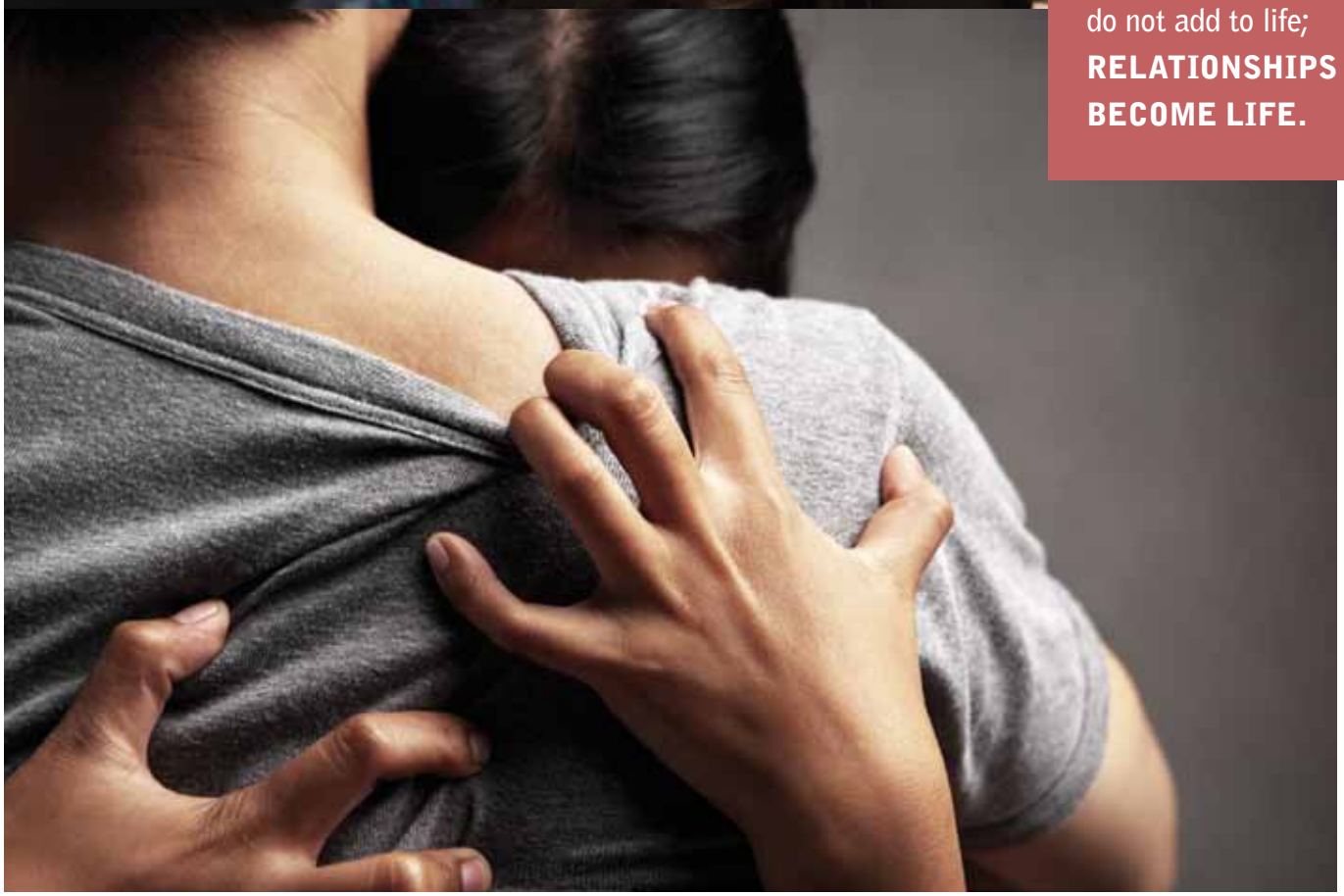
A functional person says: I need you to *help define* who I am. A dependent person says: I need you to *define* who I am. The key word difference between those two statements is *help*, and the key concept is *control*. While functional people ask others to help define who they are, they retain control over their identities. Dependent people do not; they give over control of their identities to others.

Dependent Personality Disorder is a persistent need to be taken care of by others, out of fear of abandonment, with recognizable traits and behaviors such as:[1]

- Difficulty making routine decisions without input, reassurance, and advice from others.
- Requiring others to assume responsibilities which they should be attending to.
- Fear of disagreeing with others and risking disapproval.
- Difficulty starting projects without support from others.
- Excessive need to obtain nurturance and support from others, even allowing others to impose themselves rather than risk rejection or disapproval.
- Feeling vulnerable and helpless when alone.
- Desperately seeking another relationship when one ends.
- Unrealistic preoccupation with being left alone and unable to care for themselves (American Psychiatric Association, 2013).

(In the *DSM-5*, the *DSM-IV* criteria for personality disorders were retained,[2] after revisions to this section were debated and, ultimately, rejected. Under *DSM-IV*, a precipitating event or condition might propel a person into treatment. For example, a major depressive episode would appear under Axis I, with DPD listed under Axis II. With *DSM-5*, Axes I-III combine, removing the barriers between precipitating events or symptoms and their underlying causes. Section III of *DSM-5* outlines an alternative approach for personality disorders, evaluating typical impairments with pathological traits. This alternative approach is presented in *DSM-5* for review and study, but was not formally adopted.)[3]

GREGORY L. JANTZ



In Dependent Personality Disorder (DPD), relationships do not add to life; **RELATIONSHIPS BECOME LIFE.**

In DPD, normal psychological changes that should manifest independence in adolescence or early adulthood do not. This natural transition to independence is met with clinically significant distress.

There does not appear to be consensus over what causes DPD. One therapeutic view holds a biopsychosocial connection. In this orientation, a genetic predisposition toward heightened anxiety may be coupled with learned dependent coping strategies, stemming from a maladaptive attachment style.[4] In other words, people who are highly anxious may learn dependency growing up within a chaotic family structure. Another therapeutic view holds a stronger social component, with DPD linked to an overbearing or controlling parent/caregiver.

What does seem to have consensus is tracing DPD back to adolescence or early adulthood. In DPD, normal psychological changes that should manifest independence in adolescence or early adulthood do not. This natural transition to independence is met with clinically significant distress. If the primary relationship providing safety is disrupted, such as to a parent, the person will seek out a surrogate relationship to provide direction, authority and safety, even if that relationship comes with physical, psychological or emotional risk.

Regardless of the precise etiology, DPD can be diagnosed through behaviors that are repetitive, rigid, non-productive, and debilitating. There are a few important qualifiers to consider when diagnosing DPD. The effects of substance abuse or a physical cause, such as a chronic illness or an incapacitating injury, should be factored. A cultural and/or gender filter should be used for symptoms and behaviors. For example, different cultures may view living at home with a parent long into adulthood differently. Deferring to a parent or other authority figure as a mature individual may be considered acceptable, and even expected, in one culture, while looked upon as abnormal in another. Various cultures have different gender expectations that may need to be evaluated in light of dependent behavior.

As counselors looking at a mental health disorder, we sometimes long to point to a single cause, with a single "cure." We know, though, that psychological disorders can have a variety of root causes. I tend toward the biopsychosocial view of DPD. For years, I have promoted a whole-person approach to treating mental health disorders. From this perspective, people and the disorders they bring are an amalgamation of emotional, physical, relational, and spiritual components.

Emotional Factors: DPD creates deep emotional distress and anxiety. When another person is interpreted as safety, then separation provokes the trauma of unsafety. Even the thought of being apart creates panic and pain. People with DPD traits spend much of their time and energy devoted to caring for, and remaining with, others. Because their focus so often is on others, they may subconsciously justify focusing on themselves through a perceived crisis, escalating their emotions even further.

Physical Factors: Whenever a person undergoes long-term distress, panic and pain, there are physical effects. As sometimes happens

with mental disorders, the person may go first to a physician. Hearing vague, but significant, symptoms, the doctor may order diagnostic test after diagnostic test. The doctor may prescribe multiple medications to alleviate symptoms, but be unable to address the underlying cause. Whole-person care means the therapist and doctor work together, each within their scope of practice. This close coordination is vital to avoid abuse of anti-anxiety, sedative or anti-depressant medications. While these medications may be effective to address the precipitating event, such as depression or panic attacks, they should not be seen as a long-term answer for DPD, which can more effectively be addressed through therapeutic, not pharmaceutical, strategies. Professional collaboration not only combines expertise, but it can also reduce recovery time by combining efforts simultaneously and ensuring professionals are not working at cross-purposes.

Relational: People with DPD traits are adept at finding others who need them. They may enter into relationships with narcissistic or controlling personalities who are all too willing to take control over their lives. They may also enter into a relationship with someone who has a substance abuse or behavior disorder and needs the dependent person as an enabler. This joining of dysfunctional purposes is the essence of codependency. The joint pressure upon the codependent relationship makes for bonds not easily separated. People with DPD may also have alienated loved ones with their needy, clinging, suffocating personalities and behaviors. A person with DPD comes with relational ties that must be untangled in order to achieve recovery.

Spiritual: DPD complicates all relationships, including relationship with God. People with DPD abdicate authority over their lives to others because of a deep distrust in their own ability to live life successfully. Somewhere in their past, they have learned that alone is unsafe; that they are unsafe. Somewhere in their past they have learned

People with DPD traits are adept at finding others who need them. They may enter into a relationship with a narcissistic or controlling personality, someone all too willing to take control over their lives.

they are not enough. This sense of being flawed, incomplete, and unworthy has spiritual ramifications. God may be seen as the ultimate, condemning judge, with salvation attained only through a perfectionistic attempt by works. Condemnation becomes assured without a concept of grace and forgiveness. Those with DPD already have a self-critical, pessimistic worldview. For Christians with DPD, spiritual counseling is vital for recovery and healing.

DPD can be an entrenched, long-term condition resistant to treatment. Nonetheless, intentional and patient therapeutic strategies can lead to healing and a positive prognosis. When entering into counseling with a person diagnosed with DPD, be aware of the following:

- The person may initially enter into counseling for a precipitating event, such as major depression or the loss of a significant relationship. Those with DPD may start counseling by reciting a long list of complaints about life, family, friends or work. A dependent person will not always be aware of the dysfunctionality of his or her dependency. Instead of identifying themselves as the source of their difficulties, they may consistently point to, and complain about, others.
- The person may subconsciously look to create or perpetuate a crisis in order to promote conditions for "rescue." You should avoid the temptation to rescue the person. Avoid becoming emotionally attached yourself.
- The person may show outward compliance to treatment while in your presence, but passivity when away from you.
- The person may demonstrate a constant need for reassurance and support.
- The person may sabotage treatment outcomes in order to remain in treatment. Be alert to the person becoming attached to you, or to therapy in general. Ask about other counselors the person has seen, duration and frequency. Transference of dependency needs to be monitored.
- Avoid the temptation to provide "answers," but instead ask questions and work with the person to identify his or her own answers. The person needs to learn and practice skills to take ownership of life and choices.
- Realize people with DPD can cause therapist burn-out because of their excessive demands on your time. They may call, e-mail or text you needing constant reassurance and direction—all rationalized as valid and often crisis-based.
- Treatment agreements should be put in place as soon as possible, outlining duration and frequency of sessions, as well as boundaries for contact between sessions. You should expect these boundaries to be frequently tested.
- Cognitive Behavioral Therapy (CBT) should be used as a way to help the person learn how to learn from his or her own experiences. People with DPD have rigid rules for relationships and rely on those rules instead of learning to adapt to life and its circumstances. CBT also places the focus on the person's thoughts and corresponding actions. By examining those thoughts, the person can come to understand the source. Ultimately, the person can learn to reject those thoughts for others that are more positive, changing how he or she thinks and acts.
- Dialectical Behavior Therapy (DBT) should also be used, especially given its non-judgmental strategies for dealing with life-in-the-moment mindfulness. In addition, DBT contains valuable distress tolerance, emotional regulation, and interpersonal effectiveness skills.
- Group therapy can be helpful, but group rules and boundaries will need to be explicitly and rigorously maintained in order to avoid dependent relationships forming within the groups.
- The onset of therapy should include and continually work toward the "end goal." Specific markers should be established for what that end goal looks like because the dependent person may have difficulty "feeling" the therapeutic relationship should end.
- Distress tolerance and stress-relieving skills should be introduced immediately and specific situations used as training ground for these techniques. The more these skills are practiced and integrated, the more they can be used to counter the stress of therapeutic separation.

As I have worked over the years with DPD, my goal has been to help people discover or rediscover two important relationships in their lives: their relationship with themselves and their relationship with God. When those two, core relationships are healed and healthy, relationships with others have a way of healing as well. ✠

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Endnotes

1 http://www.theravive.com/therapedia/Dependent-Personality-Disorder-DSM-5-301.6-(F60.7).

2 http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf, p. 17.

3 http://www.dsm5.org/Documents/Personality%20Disorders%20Fact%20Sheet.pdf.

4 For more information on attachment styles, please see *Why You Do the Things You Do: The Secret to Healthy Relationships* by Drs. Tim Clinton and Gary Sibcy (Thomas Nelson, 2006).

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High Conflict Relationships

WORKING WITH **ANTISOCIAL** PEOPLE

Jeremy has been in and out of trouble most of his life. Diagnosed with conduct disorder as a child, Jeremy's parents divorced when he was three-years-old after years of violent and turbulent fighting. His father was a raging alcoholic and his mother severely depressed, in and out of psychiatric hospitals.

Often left to fend for himself, Jeremy joined a gang at the age of 11. What followed was years of arrests, substance abuse and chaotic relationships. A consummate rule breaker, Jeremy was reckless, deceitful and impulsive. His girlfriend described him as a psychopath who would exploit anything and anyone to get his way. She had had enough of his constant blaming and irresponsibility. Unless he got help, she was done with their turbulent relationship.

Jeremy, now 22, was someone who failed to conform to the rules of society. His reckless behavior, lack of empathy, arrogance, unstable interpersonal relationships, total disregard for the consequences of his behavior and superficial charm led the therapist to diagnose him with Antisocial Personality Disorder (ASPD). Years of deviating from the norm, being deceitful, impulsive, aggressive, irritable, reckless regarding the safety of others, and showing no remorse for any of his actions made relationships difficult and unstable. His longstanding and enduring patterns of behavior were characteristic of antisocial personality disorder. It took more than a girlfriend to threaten him with abandonment before he would ever walk into a therapist's office. Jeremy, like others who share his diagnosis, does not perceive his behavior as abnormal and had to be court ordered into therapy after being picked up on theft charges.

Most likely, Jeremy is a combination of biological, genetic, social and psychological factors that were then shaped by his environment. Specific unhealthy coping skills were reinforced. Viding, Blair, Moffitt, and Plomin (2005) found evidence that aggressive antisocial behavior could be hardwired in the brain and then exacerbated by life circumstances and negative interactions.[1] However, there is hope that this gene-environment interaction can be moderated through early life parenting interactions and improved social conditions.

When it comes to disputes in his interpersonal relationships, Jeremy represents high conflict people whose patterns of behavior make matters worse rather than better. Conflict is usually viewed as a personal assault by these individuals. Typically, their thinking is rigid and emotions are not managed. They blame, which is not exactly the necessary trait for working things out. It is rare for them to care if they harm others and act in lawless

LINDA MINTLE

ACTIONS AND CONSEQUENCES OF HIGH CONFLICT PEOPLE ARE NOT CONNECTED BECAUSE THERE IS LITTLE INSIGHT INTO BEHAVIOR. MUCH ENERGY GOES INTO ATTACKING OTHERS RATHER THAN REFLECTING ON THEIR OWN ACTIONS.

ways. In fact, more than 70% of people with antisocial personality disorder can be found in prisons and substance abuse clinics.[2]

With ASPD, conflict is escalated, making it more difficult to ever resolve issues. It is not based so much on an issue, but on who the person is and the patterns of behavior that have developed. When this is the case, problems can erupt anytime, anywhere.

Actions and consequences of high conflict people are not connected because there is little insight into behavior. Much energy goes into attacking others rather than reflecting on their own actions. Extreme action follows intense emotions—yelling, controlling, saying disrespectful things, the silent treatment, spreading rumors, hitting, stalking, threatening if you do not agree, and lying. The core social skills of honesty, respect and responsibility are missing. People with ASPD do not cooperate well and are often hostile and callous to the feelings of others.

High-conflict people push others away, sabotaging their desire for satisfying relationships. Most of this is driven by trying to control and dominate. Blaming leads to feeling stronger and creates a false sense of safety. This enduring pattern makes conflict resolution difficult because they are not looking to solve problems, but rather blame or hurt the other person.

Treatment

Intervention is difficult because of the externalizing of problems and tendency for these patients to drop out of treatment. When the going gets tough, they get going—out of therapy and relationships.

One important goal is to help ASPD people see that they are creating their own problems in relationships and hold distorted views about themselves. Others do not see them the way they see themselves. Since people with ASPD have a low tolerance for frustration and distrust of people, interpersonal effectiveness work is often slow and difficult. If the person with ASPD becomes hostile or verbally abusive, the therapist must confront calmly and be specific about the behavior. Tell the person to stop bullying or belittling and talk about the issue without the abuse. Be specific about the behavior. Safety is a concern, and the high-conflict person needs to know that there will be consequences for abusive behavior.

Antisocial personality disorders may benefit from anger management and contingency management therapy when dealing with interpersonal issues. Both of these approaches help connect action to consequences, a necessary component of treatment. Another goal is to decrease verbal and physical aggression and reward progress toward prosocial behavior.

In terms of conflict, identify the person involved (who); ask what he or she did or did not do; ask how the antisocial person responded; ask if that response helped the outcome; and finally, ask what part might the ASPD have played to trigger the problem. Once you have this information, focus on developing life skills that could better help conflict.

Treatment of ASPD appears grim in terms of prognosis, but the application of Cognitive Behavioral Therapy (CBT) is showing some reduction in symptoms (e.g., delinquency, criminal behavior, etc.).[3] The goal is to target the dysfunctional underlying beliefs associated with aggression, criminal behavior and self-damaging behavior.

From a Christian perspective, the ASPD person is no different than anyone else. He or she is in need of the recognition that *all* have sinned and come short of the glory of God and are in need of salvation and repentance. The transformation by Christ in a person's life gives hope to changing, enduring patterns of behavior.

However, that need for change and fear of the Lord must be recognized and ongoing.

In coaching those who must interact with high conflict people with ASPD, here are 10 guidelines adapted from my book, *We Need to Talk*:[4]

1. **Do not label the person with ASPD.** Labeling backfires. Instead, concentrate on ways to better manage the relationship. Since the high-conflict person struggles with connection, you will need to be the one who listens and shows empathy and respect. Doing this will lower the ASPD person's defenses, making room for the beginning of trust. Labeling or pointing out the person's faults escalates rage and irrationality.
2. **Try to stay calm.** When emotions intensify, say something like, "We can revisit this when we are both calmer." The person in the conflict can own his or her part of the problem, rather than singling out the high-conflict person for being so unreasonable. Don't engage in blame or it will become a contest. Begin a conflict by saying something like, "I understand your frustrations. I am paying attention to what you say. Let's see if we can come up with a solution." Or respond by saying, "You may be right" or "Tell me more about that." This eliminates pushback and keeps the emotion level down.
3. **Assess your safety.** If there are dangerous behaviors like domestic violence or criminal acts, you need to make sure you are safe and appropriate controls are in place.
4. **Relate to the person around tasks that need to be done or possible solutions rather than reacting to his or her symptoms.** Symptoms distract from the issue at hand, so keep the issue front and center. Focus only on behavior. Think like a detective, "Just the facts."
5. **Choose your battles.** Since most high-conflict people love the battle, minimize your contact with that person when you can. When you do engage, resist the urge to defend yourself, which only ends in more conflict.
6. **Set a structure for conflict discussion and talk about expectations.** Establish fair fighting rules, such as no yelling, name-calling, interrupting, etc. It may help to meet in a public place and/or take a mediator.
7. **Set boundaries.** If a boundary is violated, be firm. Tell the person what the expectation is and what is needed to continue the conversation. Although you may want to, do not ignore the person. Ignoring usually sets the person up for even more anger because it triggers feelings of emotional neglect and abandonment. It is better to revisit the rules of engagement.
8. **Disengage from the drama and manage your own thoughts and feelings.** When someone starts accusing you, disengage and realize this will go nowhere. Take a time-out or concentrate on your reaction only.
9. **Forgive readily.** Chances are you will be treated unfairly. No matter what, you need to forgive and then be cautious with your trust. Holding on to unforgiveness hurts you, even when reconciliation is not possible.
10. **Do reality testing.** You cannot challenge a person's perception directly because the conflict will escalate, emotion will take over, and nothing will get solved. However, you can ask questions in a more *indirect* way. Say something like, "Sometimes people get really angry at others when they are hurt and want to make them pay. Do you know what I mean?" This is indirect, but will keep the conversation going and help you discern whether the person is intentionally trying to deceive you to get what he or she wants, or whether there really is a distortion in his or her thinking. Chances are that everything the person says is not a lie or exaggeration. Parts may be true.

Finally, research does not support the use of medications for this disorder. However, some medications, like lithium carbonate, have been shown to reduce aggression, bullying, and fighting… common problems in ASPD relationships. ✠

HIGH-CONFLICT PEOPLE PUSH OTHERS AWAY, SABOTAGING THEIR DESIRE FOR SATISFYING RELATIONSHIPS. MOST OF THIS IS DRIVEN BY TRYING TO CONTROL AND DOMINATE. BLAMING LEADS TO FEELING STRONGER AND CREATES A FALSE SENSE OF SAFETY.

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Detached

The Traumatized Personality

Personality development can be a multifaceted construct involving both biological/genetic and social/environmental factors—the age old nature vs. nurture debate. Many researchers believe that due to the biogenetic component, aspects of the personality remain somewhat static and unchangeable once an individual's basic structure is fully formed. However, new discoveries in the study of trauma, particularly during early childhood, expand the conversation when it comes to this domain. Severe trauma has been shown to have a wide impact on the development of various psychological problems and personality variables, especially as it pertains to one's awareness of reality.

The concept of a "nervous breakdown" is not new and can represent a range of mental illnesses or give the impression that someone "snapped" as a result of extreme pressure, stress or trauma. Research suggests that as many as one third of all Americans have felt on the verge of a nervous breakdown at some point in their lives. However, the term is more popular than clinical, in that people often seek to avoid the negative stigmatization and stereotypes that are frequently associated with certain diagnoses.

ERIC SCALISE

This particular clinical area is often confusing, even to trained professionals, because distinguishing between diagnoses on the schizophrenia spectrum, Dissociative Identity Disorder (DID) and other personality disorders, is challenging. With the release of the *DSM-5* two years ago, diagnostic categories were moved from a multiaxial to a single axis system, thereby removing the previous boundaries that existed between personality and other mental disorders. The presence of some personality disorders (Paranoid, Histrionic, Narcissistic, Schizotypal and Borderline) can increase the risk for manifesting related symptoms. Since there are a number of syndromes (personality or trauma-based) that may encompass psychotic or detachment features—including the ability for certain drugs (e.g., hallucinogens, such as LSD) and physiological problems (e.g., brain injury or tumors) to produce the same effects—an accurate diagnosis is essential for effective intervention strategies to be implemented. This helps avoid unnecessary delays in appropriate treatment for what could be a serious, underlying problem.

Schizophrenia, a severe mental illness involving chronic or recurrent psychotic episodes, is predominantly characterized by hallucinations and delusions. Contrary to a frequent misconception, people with schizophrenia do not have multiple personalities (an earlier description for DID). Delusions are the most common symptom in schizophrenic adults, while hallucinations (particularly those that are auditory) present in about half the people with the illness.

Delusions are marked by a set of false beliefs in which individuals misinterpret their experiences or what they perceive to be going on in the environment. The focus of the delusion can revolve around different themes such as: 1.) the notion one is being purposely tormented and persecuted, 2) when there are unfounded somatic complaints, or 3) having an abnormal sense of grandiosity. A delusion of reference describes a person who avidly believes certain statements, gestures, news

Severe trauma has been shown to have a wide impact on the development of various psychological problems and personality variables, especially as it pertains to one's awareness of reality.

stories or other environmental cues are expressly being directed at him or her in order to produce a loss of control over the mind and/or body. The two most common themes in this category are "thought withdrawal" (the belief that thoughts have been unwillingly removed by some outside force) and "thought insertion" (the belief that one's thoughts and actions are being directed or manipulated externally).

Hallucinations, like delusions, represent completely unfounded or mistaken impressions that have no basis in reality, but occur in a person's sensory modalities. This includes hallucinations that are auditory, visual, olfactory (referring to the sense of smell), gustatory (referring to the sense of taste), and tactile (referring to the sense of touch). However, auditory hallucinations, often described as "hearing voices," are significantly more frequent than any of the other sensory distortions. It is possible for someone experiencing a psychotic episode to hear more than one voice conversing simultaneously. However, a distinguishing feature for auditory hallucinations is that the voices are perceived as being "external" to the person hearing them. This is in contrast to individuals diagnosed with DID, where the voices are described as "internal."

Complex trauma, first described by Dr. Judith Herman, professor of clinical psychiatry

at Harvard Medical School, generally refers to multiple traumatic stressors that involve direct harm and are interpersonal; that is, they tend to be premeditated, planned, and caused by other humans. We now know the brain is not as rigid as once believed, but pliable (defined by the term, plasticity) and can change its structure and function in response to lived experiences. When someone is repeatedly exposed to traumatic stress, disruptions can occur in brain functions and structures, endocrinological and immunological function, and central and autonomic nervous system arousal. Recent research suggests that for younger children, neuro-psychological development is actually altered which, in turn, can shift learning patterns, behavior, belief systems, cognition, self-identity, and social skills.

Dissociation can be viewed as a defense against pain, and the process of integration relates to addressing painful memories, as well as restoration of the core personality. Additional personalities, or "alters," are formed when an experience is traumatic enough, as a preferred method of coping and internalization, and sometimes as part of intentional cultic and occultic practice in conjunction with ritualistic abuse. Some level of amnesia is usually present for significant periods of time. Systemically, these alters want to maintain stability, equilibrium, and safety. People have the memory of the mind, the memory of emotions, the memory of the body, and the human will. When all four are broken, the result can be dissociation.

These dissociated states are not necessarily mature personalities that have fully developed as much as they represent a broader and more disjointed sense of identity. Even though the rate of DID in the general population is small (.01-1%), the vast majority of individuals who develop the disorder (over 90%) have documented personal histories that include recurring, overwhelming, and often life-threatening traumatic experiences at a vulnerable stage of childhood (typically before age nine). Making the diagnosis usually takes time because the complexity of symptoms and overlap (comorbidity) with other psychiatric diagnoses may slow discovery.

Whenever someone is experiencing a break from reality, the first priority is to ensure that he or she, as well as any others who may be present, is safe. Self-injury, suicide attempts, and assaultiveness are common behavioral responses and care should be exercised so no one is harmed. This may necessitate a call to emergency services, the police department or other mental health professionals who are capable of advising and/or assisting in the process. Hospitalization may be required for both safety and further evaluation.

While there are no established psychotropic treatments for DID, medication for co-occurring disorders, such as depression, may be utilized. This makes psychologically-based approaches, especially talk therapy, an effective protocol. The benefits of psychotherapy include the ability to explore, monitor, and manage stress levels; process traumatic events and major losses in one's life; make needed lifestyle adjustments; develop effective coping strategies; address any cognitive and/or spiritual distortions; and assist family members in their own awareness and concerns.

Christian counselors must use discernment and wisdom in working with these clients. Man's fallen human condition, natural and complex traumatic experiences, sinful abuse and other atrocities perpetrated upon the innocent, demonic activity and spiritual warfare are all present-day realities that can twist and distort the true perception of reality, especially the reality of who God is, the power of the resurrection, and the comfort and peace that are available through Him. "Therefore, since we have a great high priest who has passed through the heavens, Jesus the Son of God, let us hold fast our confession…. Therefore let us draw near with confidence to the throne of grace, so that we may receive mercy and find grace to help in time of need" (Hebrews 4:14, 16, NASB). ✠

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Even though the rate of DID in the general population is small (.01-1%), the vast majority of individuals who develop the disorder (over 90%) have documented personal histories that include recurring, overwhelming, and often life-threatening traumatic experiences at a vulnerable stage of childhood (typically before age nine).

THE ECCENTRICS

PARANOID, SCHIZOID AND SCHIZOTYPAL PERSONALITIES




Billy is introducing his new 5th grade friend to the neighborhood. "Watch out for that house. Mr. Smith lives alone there and you don't want to cross him. Just last week he yelled at the meter reader and accused him of stealing his power. He's always angry and thinks people are out to get him. Everyone avoids him as much as possible. My dad said he once sued the police department for harassment just because they drive down our street a lot! He's not like my Uncle Joe, although Uncle Joe is a bit strange as well. He lives by himself down the block from us, but we rarely ever see him. He's my mom's brother and she says he was always a 'loner,' even as a kid. He comes for dinner once in a while and it's usually a real downer. He doesn't say much or seem to care about anything. He fixes computers for some company, but he works at home and just mails things back and forth. Mom says he doesn't really engage with people, but at least he isn't angry all the time like Mr. Smith."

MIRIAM STARK PARENT

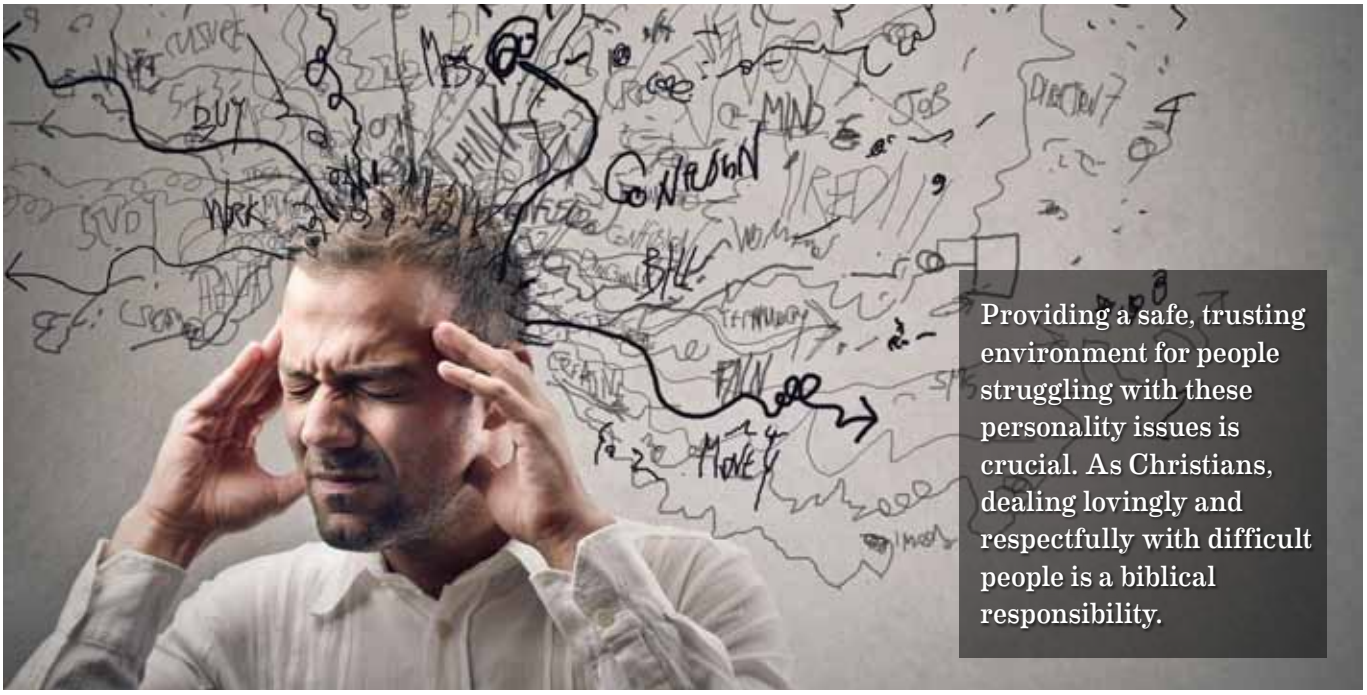
Overview and Features

What Billy is describing to his friend are two individuals who struggle with personality issues related to the Cluster A set of disorders in the *Diagnostic and Statistical Manual for Mental Disorders*, 5th edition (*DSM-5*). Such individuals are often described as odd and eccentric. Many neighborhoods and families have a "Mr. Smith'" or an "Uncle Joe" marginally functioning in their midst.

Individuals diagnosed with personality disorders display an enduring, rigid pattern of dysfunctional behaviors and inner experiences that persist across time and circumstances. Personality Disorders (PD) are determined based on categorical groupings of problematic personality symptoms and traits. The *DSM-5* includes three personality disorders in Cluster A: Paranoid, Schizoid and Schizotypal. For these disorders, traits focus on extreme suspiciousness, social isolation and peculiar ways of thinking and behaving.

Paranoid Personality Disorder is categorized by a pattern of distrust and suspiciousness of others without regard

Individuals diagnosed with personality disorders display an enduring, rigid pattern of dysfunctional behaviors and inner experiences that persist across time and circumstances.



Providing a safe, trusting environment for people struggling with these personality issues is crucial. As Christians, dealing lovingly and respectfully with difficult people is a biblical responsibility.

for evidence or justification. Such individuals frequently appear tense and angry, anticipating harm from others. They react quickly to perceived threats and often appear threatening and hostile. Highly sensitive to criticism, they are unable to recognize their own mistakes, take offense easily and persistently hold grudges. Relationships become fragile and are often broken due to pathological jealousy, distrust and inappropriate suspicion. Like "Mr. Smith," people with paranoid personality disorder can be litigious, seeking legal recourse against all kinds of imagined slights or misinterpreted events.

Schizoid Personality Disorder describes a pattern of social isolation and detachment, along with restricted emotional expression. Billy's "Uncle Joe" fits the pattern—living and working alone, having occasional interactions only with a first-degree relative, and demonstrating emotional detachment. Weak social skills combined with a genuine desire for social isolation usually lead to a lack of relationships; however, they can form work relationships to a degree if necessary. Cold, humorless and boring are words typically associated with those having Schizoid PD, as they rarely express or feel strong emotion.

The third PD in Cluster A is the **Schizotypal Personality**. Much like Paranoid and Schizoid Personalities, there is a deficit in social functioning and reduced capacity for intimate relationships. However, with the Schizotypal PD, there is also a variety of odd behaviors and perceptual distortions. Such individuals are often anxious in any kind of social interaction and may exhibit odd thinking and speech, perhaps believing they have some kind of extra-sensory perception or ability. Despite being considered by many to be a premorbid form of schizophrenia, most do not develop a psychotic disorder with delusions or hallucinations. Instead, ideas of reference (believing unrelated events pertain to them directly) and magical thinking (belief in special abilities) lead to somewhat bizarre interactions and behaviors. Like those with Paranoid PD, people with Schizotypal PD tend to be suspicious of others, but generally express little emotion rather than reacting with anger or resentment.

Etiology and Development

There is little systematic research available on causation regarding PD. For the Christian therapist who believes in a loving Creator balanced with a fallen human environment, understanding how these disorders develop can be especially challenging. The interaction of nature, as evidenced in our genetic inheritance and biological development, and nurture, early role modeling and trauma, is explained using various developmental models. Psychodynamic theories focus on unmet early needs, while cognitive theorists look more to deficiencies in thinking and maladaptive cognitive schemas. Genetic and biological influences are emerging in more recent studies, particularly with regard to Schizotypal PD, which shows the strongest link to schizophrenia research. Overall, it appears all of these factors serve as unique influences in the development of a specific PD. The uniqueness of human beings is explicit in our pathology, even as in our creation.

Treatment and Prognosis

While prevalence rates run 1-3% for Paranoid, < 1% for Schizoid, and 2-4% for Schizotypal, these numbers are influenced by cultural and diagnostic factors. Individuals struggling with Paranoid and Schizoid PD rarely present

in counseling unless in the context of some crisis, often legal or relational. Even then, they rarely stay the course long enough to significantly profit, as mistrust, lack of motivation, and deep suspiciousness make an uneasy fit in counseling. Early intervention with children exhibiting "loner" behaviors merits special attention to teaching social skills and relational training.

The link between Schizotypal PD and major depression is often the factor which brings such individuals into therapy. While medications are not seen as useful with Paranoid or Schizoid PD, there may be a role for them in combined treatment for Schizotypal PD. Reducing some of the odd thinking associated with Schizotypal PD allows for greater use of cognitive-behavioral interventions focusing on teaching social skills, interpreting interpersonal cues and community support.

For those dealing with Paranoid PD, the difficulty of staying focused on long-term goals to reduce the suspiciousness and distrust is challenging. Developing increased flexibility and the ability to step back and more accurately assess circumstances goes against their every inclination. Forgiveness and grace are particularly difficult concepts for them to engage. Likewise, people with Schizoid PD rarely feel the need for increased social skills or even the energy for social interaction. When the symptoms of the disorder are ego-syntonic, it is difficult to motivate clients toward change. Rarely do these individuals engage in the longer term counseling necessary for significant change to occur.

Providing a safe, trusting environment for people struggling with these personality issues is crucial. As Christians, dealing lovingly and respectfully with difficult people is a biblical responsibility. Modeling grace is essential, even as we set appropriate boundaries and expectations. While God can, and does, heal at every level, it is important to understand the depth of change necessary for such personality issues. Deeply ingrained internal habits that go to our sense of self and identity make it hard to sustain motivation for long-term change. Where there is commitment to Christ, sanctification, and the progressive work of the Holy Spirit in the Christian's life, we are better able to see real progress even in these most challenging cases.

Future Trends

While the current diagnostic model for personality disorders is categorical, a dimensional model has been proposed in the *DSM-5*, which will significantly affect these diagnoses. Both Paranoid PD and Schizoid PD will be eliminated as specific mental disorders under the proposed model. Only the Schizotypal PD would remain out of Cluster A. The dimensional model focuses on assessing the severity of pathological personal traits and self and interpersonal functioning along a continuum. Individuals, such as "Mr. Smith" or "Uncle Joe," may well end up with a diagnosis of Personality Disorder–Trait Specified (PD-TS) with descriptions of the specific traits they exhibit and level of severity.

Whatever the diagnoses, individuals with these odd and eccentric personality patterns deserve our very best… both clinically and interpersonally. They may be challenging individuals with whom to engage in relationship, but compassion and grace can enable us, as counselors and caregivers, to have a significant impact in these often desolate lives.

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PERSONALITY AND THE DISCONNECTIONS OF *intimacy*

GARY SIBCY

Although there are substantial changes from the *DSM-IV* to the *DSM-5*, the Personality Disorder criteria were left intact, with only the elimination of the Axis II designation (note that personality disorders were formerly designated as an Axis II phenomenon).[1] However, in Section III of the *DSM-5* (Emerging Measures and Models), an alternative template for personality disorders was introduced with the hope of addressing many of the difficulties and problems associated with the current system. This new model, which may someday replace the current structure, greatly reduces the number of personality disorders from 10 to six (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal), and more boldly embraces the move away from a categorical view of clinical disorders to a more dimensional perspective that takes into account the fact that many disorders overlap and share key symptoms and underlying risk-factors (from social and environmental factors, as well as genetics and biology).

Within this new, alternative *DSM-5* model, personality disorders are determined by problems in two main dimensions: 1.) personality functioning, and 2.) personality traits. For the purpose of this article, I would like to focus solely on the role of intimacy when making a diagnosis. The beauty in this new system is that it appreciates how core aspects of personality functioning (i.e., the ability to experience intimacy) can manifest differently across the spectrum of personality disorders. When this factor is understood within the context of other components related to personality functioning and traits, it becomes a powerful tool in guiding

the treatment goals and the range in which we use counseling strategies, techniques and tactics to bring help and healing.

The *DSM-5's* Level of Personality Functioning Scale identifies three core capacities regarding interpersonal intimacy:

1. The motivation and willingness to engage in a number of relationships that involve emotional closeness, caring, and reciprocity (mutual giving back and forth).
2. The ability to develop and maintain durable relationships, both personal (e.g., romantic partner, close friends, offspring, family, etc.) and within the community (e.g., work, church, neighbors, etc.).
3. A willingness and commitment to cooperate and collaborate with others to achieve mutually beneficial goals. This includes the ability to be flexible and responsive to the thoughts, feelings, and behaviors of others and essentially tolerate the negative feelings that can arise when one gets close to another person.

Helping clients develop closer and more rewarding relationships often begins in the therapy office, where abandonment issues can be therapeutically addressed.

How Intimacy Problems Manifest in Different Personality Disorders

As previously mentioned, the Alternative Model for Personality Disorder suggested in the *DSM-5* for future consideration reduces the number of personality disorders from 10 to six, so let's take a look at the different ways intimacy problems manifest themselves in each of the six.

1. Antisocial Personality Disorder. Characterized by a basic failure to follow and respect laws, societal norms and ethical standards of behavior, those with this disorder are egocentric and display a callous disregard for the feelings or concerns of others. They have a long history of lying, cheating, stealing and manipulation. People are seen as mere objects or simply as a means to an end. Their basic stance toward life is that they deserve to have what they want… no matter what. It is a "dog-eat-dog" world and "you must get others before they get you."[2] The intimacy impairment is obvious here: the antisocial person cannot relate to others in a mutually respectful way and simply uses people to accomplish his or her own ends through deceit, coercion and manipulation.

2. Narcissistic Personality Disorder. This is a close cousin to the antisocial personality, although narcissists are notorious for their grandiosity and attention and approval-seeking behaviors. At their core is an extremely unstable and fragile sense of self-esteem and identity. Like the antisocial, narcissists lack the capacity to relate to others in a mutually beneficial way. Their ability to deeply and genuinely form intimate bonds is sorely lacking, primarily because they seek to use people as objects for personal self-esteem enhancement. An important difference is that the narcissist is not as likely as the antisocial to violate major laws in order to achieve his or her ends.

3. Obsessive-Compulsive Personality Disorder. At the other end of the spectrum is the Obsessive-Compulsive Personality Disorder, where there is an excessive preoccupation with control, order and perfectionism. Where antisocials and narcissists lack conscientiousness and are prone to break and/or bend rules, those with obsessive-compulsive personalities are inordinately conscientious to the extent that they cannot value the thoughts, feelings and opinions of others. For those in this category, relationships and intimacy take a backseat to work and productivity. Additionally, their negativity, lack of flexibility and contrary style hamper their ability to establish warm, mutually satisfying relationships.

4. Avoidant Personality Disorder. Characterized by predominant feelings of inadequacy and incompetence, those suffering from Avoidant Personality Disorder desire to have close relationships, but are terrified by a perceived inevitability of rejection, ridicule and embarrassment, even in the absence of actual evidence or experience. Consequently, they are disinclined to pursue mutually satisfying friendships or close, romantic relationships for fear of shame or scorn.

5. Schizotypal Personality Disorder. Like those with avoidant personalities, schizotypal individuals experience a great deal of interpersonal anxiety, often driven by their basic mistrust of people's motives and

intentions. Their inability to engage in warm, intimate and engaging relationships is further hampered by their rather awkward interpersonal style and eccentric, bizarre patterns of thinking and behaving. Due to marked difficulties in accurately reading and understanding others' verbal and non-verbal behavior, they are prone to paranoia, often doubting people's loyalty and truthfulness. Also, they tend to use magical thinking and hold unusual beliefs about the world; for example, believing their private thoughts can make others perform certain actions.

6. Borderline Personality Disorder. This disorder is characterized by an unstable sense of identity, volatile relationship instability, intense emotional dysregulation and impulsive tension reduction behaviors (e.g., cutting, binging, purging, sexual acting out, speeding, etc.). In terms of intimacy, these individuals struggle on many levels. For example, they tend to start with idealization, where new connections are placed on a pedestal and viewed as "soul mates" and "rescuers." However, reality soon breaks this fantasy bond as the intense fear of abandonment and their clingy behavior drives others away, while idealization quickly turns to extreme devaluation. Borderline personality types tend to be attracted to other kinds of personalities. A classic example is the borderline-narcissistic pattern, where the narcissist's insatiable need for adoration is surrounded by the borderline's idealization. The emotional trade-off to this unconscious agreement is: "I'll stay with you as long as you feed my need for praise and admiration" and "I'll feed and build up your self-esteem as long as you don't abandon me." The difficulty is this pattern inevitably fails, leading the borderline personality to engage in a spectrum of tension reduction behaviors.

In conclusion, difficulties with intimacy are manifested across the entire spectrum of personality disorders. These struggles also intrude into one's relationship with God and the church community. It is crucial that clinicians carefully assess and consider these issues as part of their overall treatment planning process, as it is possible for individuals to have difficulties with intimacy and, yet, not meet full criteria for a personality disorder. Nonetheless, counselors should consider how intimacy concerns may influence other clinical problems like anxiety, depression, anger and addictions. Helping clients develop closer and more rewarding relationships often begins in the therapy office, where abandonment issues can be therapeutically addressed. Finally, assisting clients in developing a more stable, realistic and biblically-based view of God is a central goal for Christian counselors and one that takes skill, time and patience.

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Endnotes

1 American Psychiatric Association (2014). *DSM-5*. Washington DC: APA.

2 Millon, T. (2011-04-08). *Disorders of personality: Introducing a DSM/ICD spectrum from normal to abnormal* (Wiley Series on Personality Processes) (Kindle Locations 1616-1619). Wiley. Kindle Edition.

Disorders of the Soul

A Theological Discourse on Personality

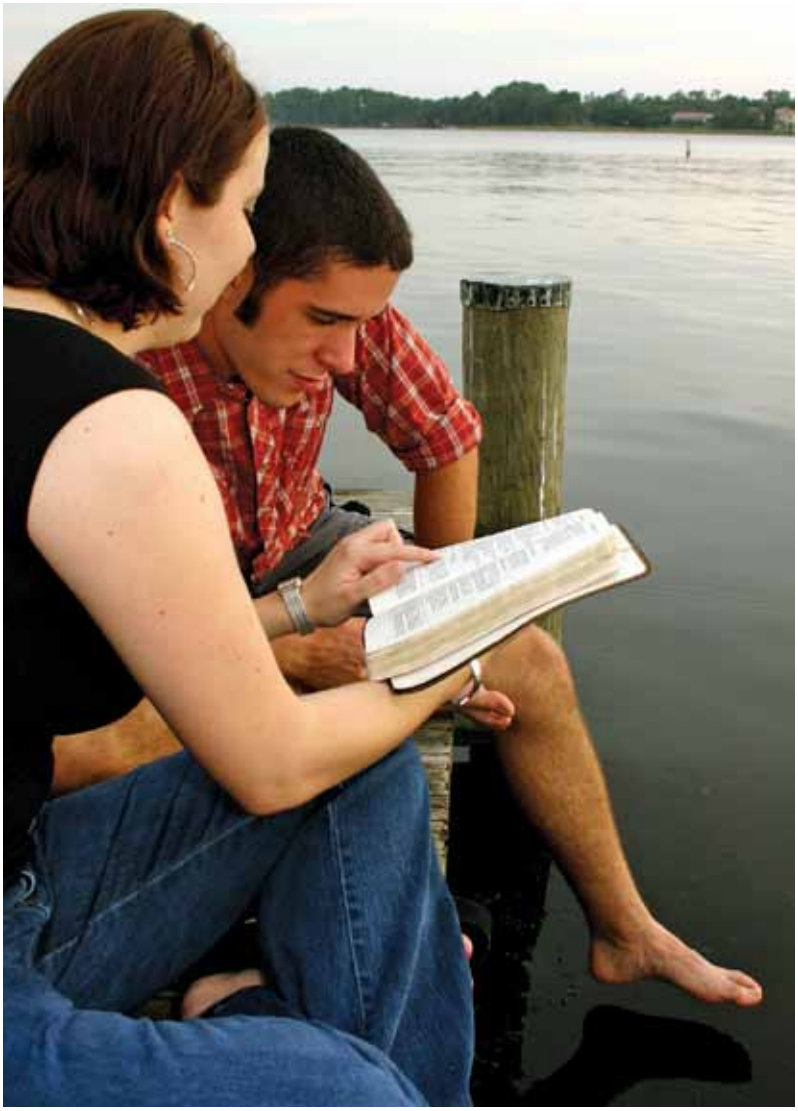
ERIC L. JOHNSON

Personality is a human's relatively enduring, overall pattern of thinking, feeling, acting, and interacting that enables the ability to adapt flexibly to changes within his or her environment, engage effectively in activities that attain fulfilling goals and accomplish life tasks, and cultivate meaningful relationships with others, including God. A personality disorder (PD), therefore, gets identified when that pattern is compromised enough to have "recurrent relationship problems, an incapacity for emotional intimacy, problems with work, periods of marked depression and anxiety, and vulnerability to substance abuse or self-harm" (PDM Task Force, 2006, p. 24). About 10% of the American population has a PD (Lenzenweger, 2008). That means there are many people with a PD in the Church.

Does the Bible have anything relevant to say about such disorders? Because Scripture is not a scientific text, we would not expect to find a systematic discussion of PDs there. However, God has revealed "first principles" for all of life, including His theocentric purposes for human beings, how they best flourish, their most significant problems and hindrances to flourishing, and His redemptive agenda to promote their flourishing in Christ. Consequently, we should expect that the Bible's teachings will help us understand psychopathology and its remediation differently, in some key respects, from the way modern psychology does, which is based on the worldview of secular humanism. Interested Christians, however, have to read the Bible *appropriately*, working hard to determine, to the best of their ability, God's communicative intentions relevant to their scientific and therapeutic concerns or we will likely misinterpret and misuse the Bible (as happened when Christians centuries ago defended a geocentric view of the universe).

When the Christian counselor approaches the Word of God with this mindset, three

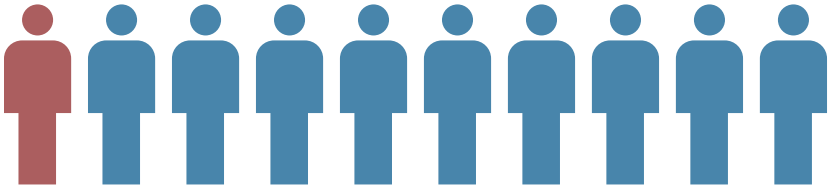

"Blessed are the poor in spirit,
for theirs is the kingdom of heaven."
MATTHEW 5:3



According to God's design plan, humans were created for Him, to reflect His character by depending upon His Word and Spirit. However, humans are all characterized by a fundamental disorder at their existential core—an opposition to God that contaminates everything they do.

perspectives on psychopathology can be identified or inferred: sin, suffering, and weakness (Johnson, manuscript in preparation). The aspect addressed the most, by far, is sin. According to God's design plan, humans were created for Him, to reflect His character by depending upon His Word and Spirit. However, humans are all characterized by a fundamental disorder at their existential core—an opposition to God that contaminates everything they do. Christian theologians going back to Augustine have termed this oppositional bent, "original sin," with which all humans are now born (Psalm 51:5; Romans 3:11-18, 7:11-25). Flowing from this tendency, humans commit various kinds of "personal sins," actions of thought, speech, and behavior that also violate God's design plan for human life, and indicate a greater love of the creation than their Creator. In addition, personal sins cause harm to self (Proverbs 1:32) and others (Romans 1:29-31). Both original sin and personal sins constitute what we might call *ethicospiritual* psychopathology.

Suffering can come from many sources, including physical pain, deprivation, maltreatment, rejection or neglect, and personal failure. It can be acute or chronic, and it is characterized by some degree of negative emotion. Suffering provides another perspective on psychopathology because it often



About 10% of the American population has a PD. That means there are many people with a PD in the Church.

(though not necessarily) contributes to its development (as discussed below). Biblical teaching on suffering, therefore, can help us better understand psychopathology. An entire book of the Bible (Job) is devoted to the topic—teaching that suffering is allowed by God, so it raises questions about God's goodness, challenges our devotion to Him, and is not necessarily tied to personal sin. Indeed, children may suffer long before they commit a personal sin (Deuteronomy 1:39). Moreover, the Bible contains many expressions of suffering to God. For example, in the Psalms (see 13, 22, 88) and in the prophets (see Jeremiah 8:18-22, 12:1-4), which theologians have termed "lament," there are instances that encourage believers to take their suffering to God and "pour out their hearts like water before the Lord" (Lamentations 2:19).

Finally, the term *weakness* is used in the New Testament (Greek, *astheneia*) to refer to a variety of deficient human conditions, including biological limitations like illness (John 5:7), poverty (Acts 20:35), and exhaustion (Matthew 26:41), as well as psychosocial limitations such as having an unimpressive personal presence (2 Corinthians 10:10) and a lack of speaking ability (2 Corinthians 11:6, 21), and spiritual limitations like religious scrupulosity (Romans 14) and even sin (Hebrews 5:1-3). On the basis of such Scripture, we are warranted in extending the biblical concept of weakness to encompass any kind of biological or psychosocial damage—from genetic abnormalities to the kinds of conditions identified in the *DSM-5* that, today, we commonly call psychopathology.

God is especially concerned for those with weaknesses (Deuteronomy 24:19; Psalm 82:2-4), and the Apostle Paul remarkably reframed weakness as a place where God's glory can shine the brightest (1 Corinthians 1:27-31; 2 Corinthians 11:16-12:10) since it shows "that the surpassing power

belongs to God and not to us" (2 Corinthians 4:7). He learned to boast in his weaknesses "so that the power of Christ may rest upon me." A Christian therapeutic approach to one's biopsychosocial damage, therefore, entails receiving God's values regarding weakness, accepting it in Christ, and seeing it as a special site of glory-manifestation.

How might this brief summary of the Bible's teaching help Christians understand and treat PDs? Well, we realize today that what we now call a PD is very likely the result of a genetic vulnerability that makes some people susceptible to the emergence of certain psychological liabilities, which are then triggered by exposure to various levels of suffering (or stress), particularly when encountered in childhood (Clarkin & Lenzenweger, 1996; Livesley, 2001; Paris, 2001). As a result, we can be confident that those with a PD have likely suffered a great deal from an early age, resulting in their specific biopsychosocial disabilities. This should predispose Christians to view those with a PD with compassion and care. Part of their Christian healing will likely entail lamenting and coming to terms with their suffering, past and present, as well as their biopsychosocial damage, and gradually learning to reinterpret it all as a story and site where God's glory can be uniquely manifested.

The specific configuration of weakness seen in a PD, however, may include lesser self-awareness and self-regulation abilities, a more elaborate defensive structure, a more rigid relational style, and a less integrated self (PDM Task Force, 2006). The fact is these liabilities can facilitate the commission of personal sins. Such actions, especially when others are hurt, will tend to bring out frustration and anger from those most impacted and can potentially make therapy with such individuals challenging, and even irritating. At the same time, their elaborate defenses; harsh, punitive moral sense; and high degree of shame (PDM Task Force, 2006; Tangney & Dearing, 2002) may make it very difficult to help those with a PD identify, own, and address their personal sins, as well as their weaknesses and suffering. Consequently, the exploration of these matters can only occur after a strong therapeutic bond has been formed between therapist and counselee… and even then, only when guided by the capacities and willingness of the counselee.

Yet, Christians should resist the common tendency to look down on those with a PD. We all have original sin, so everyone falls short of God's perfect standards in their hearts (Romans 3:10-23). Moreover, Christ taught us, "Blessed are the poor in spirit, for theirs is the kingdom of heaven" (Matthew 5:3); He came as a physician to those who were "sick" (Luke 5:31-32); and He associated with the most broken and sinful in His culture. Furthermore, we must never forget that it was the Pharisees who sought His crucifixion, not the more obvious sinners.

Thanks be to God that the Gospel of Jesus Christ tells us that all of our sin—original and personal—was absolved on the cross. Christ was also "crucified in weakness" (2 Corinthians 13:4), and His suffering shows us that God willingly entered into solidarity with us in our suffering. All believers—including those with a PD—can therefore appropriate therapeutically their forgiveness and perfection in Christ (Romans 5:1, 8:1; 2 Corinthians 5:21), knowing they are co-sufferers with Christ (Romans 8:17) and accepted and beloved by God (Romans 8:1, 31-39; Ephesians 1:5-6, 3:17-21). Along with all other believers—as they learn how to commune with their loving God in prayer, Bible reading, and meditation… and commune with others through therapy and in other healing relationships—they will gain some measure of healing, become more like their God, and glorify Him increasingly in spite of their remaining sin, suffering, and weakness. I, for one, am still in recovery.

Admittedly, the implications of the biblical teachings we have considered need to be subjected to careful empirical research (Worthington, Johnson, Hook, & Aten, 2013). As they are, we can be confident that sophisticated Christian models of psychotherapy with PDs will emerge, which utilize the rich therapeutic resources of God's redemption in Christ for use with Christian counselees. ✠

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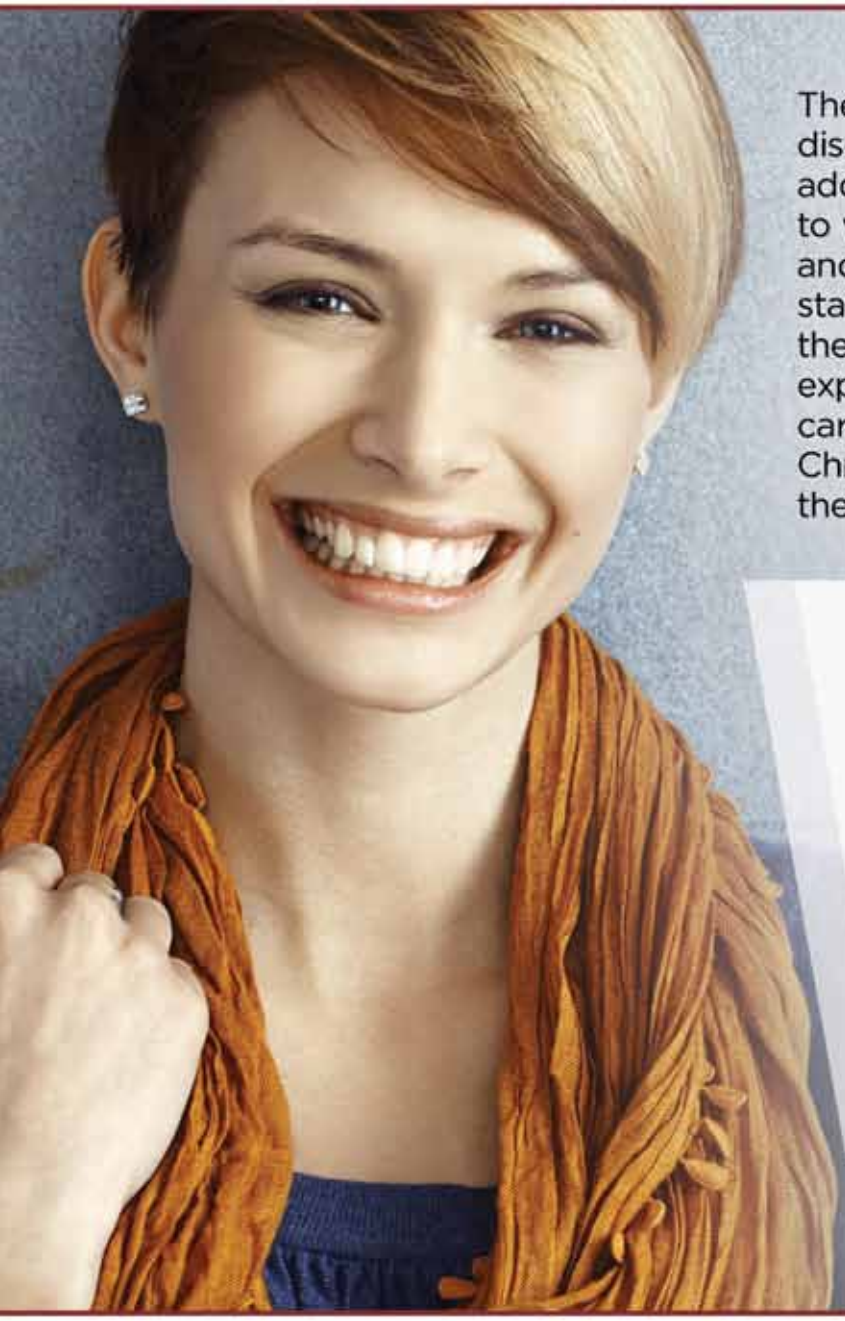

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Dealing with Difficult People: The Church is Full of Them

Okay, I have been a part of the Church all of my life. As a young kid, I noticed people in our congregation who seemed a bit odd. Now, after more than 50 years as a pastor and parachurch leader, things have not changed that much. There are still some very—may I say—odd folks filling the pews. Before you jump all over me, just think about it… you know you can identify many in your church experience who are easily classified as "different."

I am aware that the editors of this publication have chosen "personality disorders" as a theme for this issue, so I will attempt to use Scripture to both identify and moderate some of the disorders we find among church folk. However, first let's define what we are talking about when we say someone is "personality challenged." A person who is personality challenged has a deeply ingrained and maladaptive pattern of behavior of a specified kind, typically manifested by the time he or she reaches adolescence, causing long-term difficulties in personal relationships or functioning in society.

By definition, that means these individuals have issues that cause them to stand out when together with a bunch of folks. Their behavior differs from most people and, as a result, they usually create stress for the group, an individual, and, unfortunately, themselves. I am not a physician or a licensed psychologist, so I will not attempt to deal medically or clinically with this subject but, believe me, I can deal with it from the position of one who has had my share of encounters with those who called me pastor... and some other things, as well.

Some Characteristics of Challenged Church Attenders

When you read the letter the Apostle Paul wrote to the Church of Galatia, it is obvious he had experienced a myriad of challenges coming out of the congregations he had helped plant. And this was in the middle of the first century. Oh, that it was different today.

In the fifth chapter, he identified several issues that "fleshly" people possessed. Things like impure thoughts, lust, hatred, fighting, jealousy, anger, trying to be first, complaining, criticizing, thinking they were always right, envy, murder (with words), idolatry, factions, and the list from his challenge to the Church from Galatians 5:19-21 just keeps going.

As a pastor, I have faced those who carried one, or all, of those symptoms of sin. Yet, all the while, they claim a faith that is current and a lifestyle that is holy. Go figure. In the Church, unlike most other societal organizations, we are asked to tolerate these people. Many other communities would most likely expel or cast aside these individuals... but not the Church. We are people of grace. Are we? Should we be?

Well, for one thing, because we are people of grace and a body of healing, we are obligated to do what we can to assist these attendees to wholeness. So, as a pastor, I always tried the following: 1.) Talk to them and attempt to understand their journey. Have they been abused, abandoned, bullied, etc.?; 2.) Find a caregiver for them. Most churches have people who want to get involved in the healing process; 3.) If they possess gifts, find a place for them to serve that occupies their time and gives them purpose; 4.) Pray for them; 5.) Use Scripture; and 6.) Warn them

that their dysfunctional behavior will not be tolerated if it puts into jeopardy the work of the Church.

Along this line, I have said to several people under my care that the Church is the body of Christ, and our God will not tolerate anyone soiling His bride. I have been very forthcoming about the discipline they could possibly receive if they divide His Church and scatter His people. Yet, so many times their culture of self-centeredness and internal pain cannot be quieted. As long as those behaviors persist, they will continue to create division wherever they go.

Can a Damaged Individual Ever Really Change?

As we look at well-known stories of the Bible, we can see the possibility of change. We will always be the people God has created us to be, but with His help through confession, repentance, and forgiveness, we can become "changed people." Just look at the examples we have: The Apostle Paul… changed. An angry Apostle Peter… changed. A "bipolar" Prophet Elijah… changed. King David repented and was… changed. The lady at the well caught in prostitution… changed. Mary, the follower of Jesus… changed. The thief on the cross… changed. The centurion… changed. The disciples, with one exception… changed. King Felix… wrestled with change. Barnabas… changed, but in the very same church, Ananias and Sapphira did not. Why? Because they were filled with selfishness and greed. You can identify many others.

So what is the answer to a potential personality change in a dysfunctional church attendee? Here it is: In the same chapter that the Apostle Paul alerted us to the sins of those at Galatia, we are confronted with the possibility of change and healing that can take place when one surrenders to the power of a loving and forgiving God. By contrast, "… the fruit of the Spirit is love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, self-control…. And those who belong to Christ Jesus have crucified the flesh with its passions and desires" (Galatians 5:22-24).

Bottom line: It may never be perfect for any of us as we walk and interact through life, for we have our own dysfunctions… but to be guided by God's Spirit carries with it the possibility of healing and change. Let each of us examine his or her actions and motivations. Be blessed!

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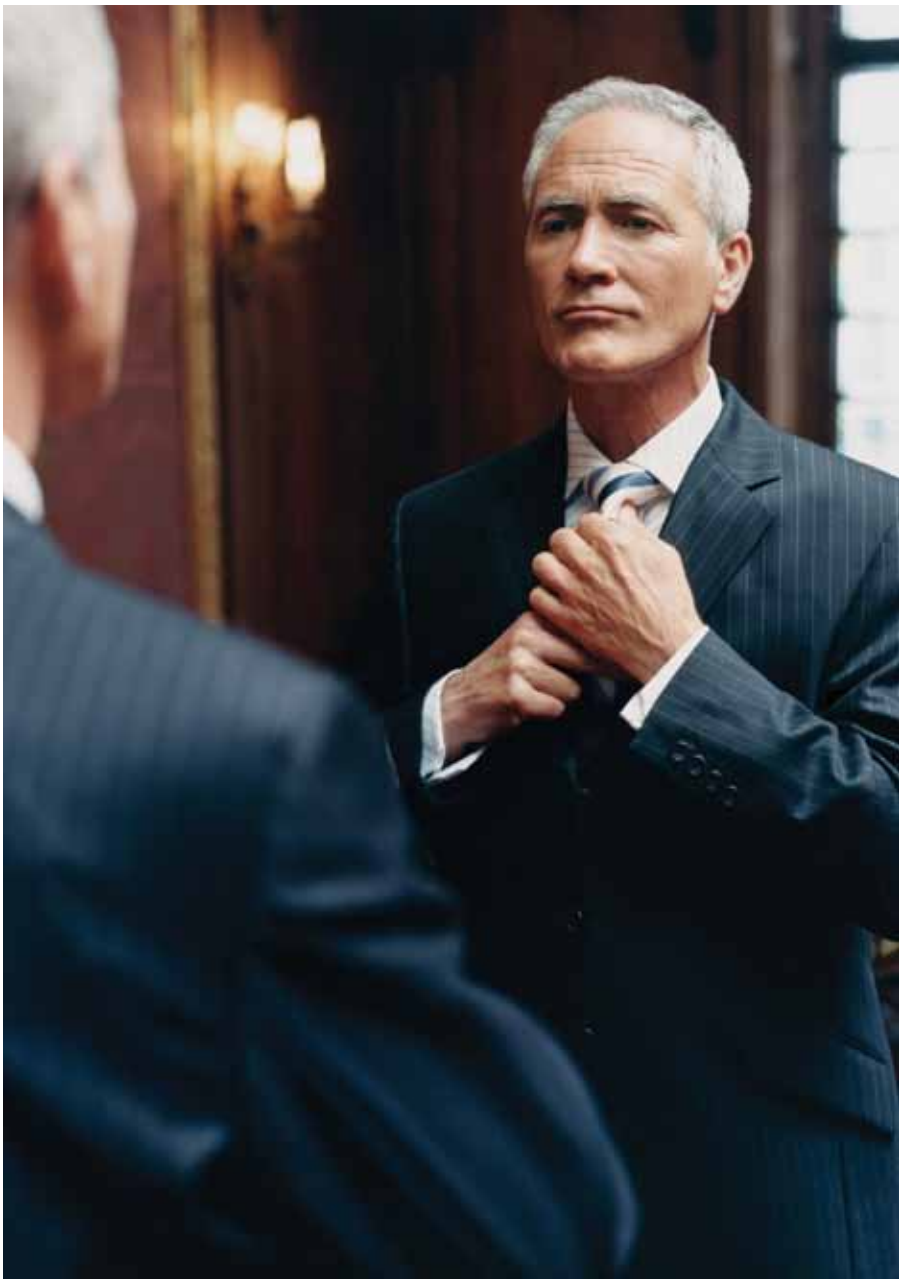
« DIANE LANGBERG, PH.D.

It's All about Me

It is sad that an understanding of narcissism is necessary in the Christian world and the discussion often revolves around those in leadership. Narcissism, at its heart, is self-absorption and a preoccupation with image, which are diametrically opposed to the essence of Christ. The core characteristics regarding the diagnosis of Narcissistic Personality Disorder (NPD) include grandiosity, a need for constant affirmation, and the lack of empathy.

Note that someone with this disorder often takes his or her bearings from externals such as achievements, success, power over others, and affirmation. The narcissist presents his or her grandiose self, not real self, to gain these externals… primarily because they are his or her food and drink. Indeed, narcissists believe these things are necessary to their very existence, that they are owed to them… and if denied, rage follows. Narcissism, at its core, is the preservation of the self as *both good and grand*. Narcissists use all they have—their abilities, brains, charisma, power, success… whatever is within their grasp—toward such preservation. They will exploit others in the service of their ends—gifts, love, beauty, connections, and faith—in order to preserve self as good and grand. However, narcissists lack one essential quality, and that is the gift of humility before God that harnesses all other abilities and allows them to be governed by His love. How easy it is for all of us to deify the gifts God has given rather than the God who gave them! How easy to use those gifts for our own good rather than pouring them out in selfless love for others. When the Church deifies gifts, she becomes extremely vulnerable to the Narcissistic Personality Disordered leader.



Think what a weary task it must be for someone with NPD to wear the Shepherd's dress and have to borrow the Shepherd's voice and ways without truly having His heart. What a burdensome charade! Leaders can call themselves Christian; they can say they are shepherds and learn to speak in ecclesiastical words and moving tones and, yet, be imposters. As strangers to God's pastures, how can they direct or feed His sheep? Instead, they feed on their sheep. Such a leader is self-installed, not God-ordained, and we are easily seduced by his or her deified gifts, fed by our own hunger and longings for great things. Yet, in fact, this person is a hireling, more concerned for his or her

A central characteristic of narcissism is that there is a lack of insight; narcissists cannot see or assess their own weaknesses. That means when they are hurting others, being self-serving, or even flagrantly disobedient to God, they do not have eyes to see.

ego and own starving self… skillful at shearing, but not at feeding.

A central characteristic of narcissism is that there is a lack of insight; narcissists cannot see or assess their own weaknesses. That means when they are hurting others, being self-serving, or even flagrantly disobedient to God, they do not have eyes to see. The prophet Hosea says one of the things the Israelites did when they lost God and were unaware of their own failures was to build big buildings! The further they got from God, the bigger they built. The other thing they built was fortified cities. The greater the distance, the stronger their defenses became. So, you have a people who name God's name, but are unaware of their own weaknesses and failings and do not deal with themselves honestly before the Lord and others. The outcome is bigger buildings and a tighter lockdown. Does that not sound like a narcissist?

Consider with me the stunning contrast between narcissism and the Good Shepherd. Leadership that bears a likeness to Christ descends; it goes from up to down, from expansive to limited, from broad to narrow, from glory to dirt. It descends in love and humility so as to feed the sheep.

Second, God measures leadership not by its sphere, size, or approval ratings… but by its heart. The kingdom to be conquered is that of the heart, and God's rule of your heart is His foremost concern. If He governs your heart, what you do will manifest the character of Christ. God's rule in the kingdom of the heart *always* results in love and obedience to Him.

Third, leadership in the name of Jesus is regressive (i.e., a leadership that goes back). That sounds very strange, doesn't it? When we think of leadership, we think of being out in front, leading the way, heading the charge. Going back seems opposite to leading. Yet, he who is rich goes back for the poor. He who is whole goes back for the broken. He who is free returns for the captive. He who is the light goes back for the blind. And he who is strength returns for the bruised. How stunningly different from the grand and great leader!

Finally, leadership that bears the fragrance of Christ feeds on Him so that His truth and grace can be poured into hungry souls. Such leaders insure that they feed on God and His Word—not on their sheep. That Word transforms their hearts and characters so the food they give to the sheep bears His stamp.

Christ has shown us the way; He has exemplified good leadership in the flesh so we do not have to be seduced. We are complicit with ungodliness when we turn a blind eye and protect the perversions that are out there. "… Woe to the shepherds… who feed themselves! Should not the shepherds feed the flocks?" (Ezekiel 34:2). ✠

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« GARY W. MOON, PH.D.

Personality as Unity and Diversity, Fullness and Depletion

What do you think God had in mind when designing the concept of personality—the palette of individual differences in patterns of thinking, emoting, behaving, choosing and relating that are woven into the fabric of humanity? Of course, many personality theorists would say that God—if they were to concede such a possibility—had nothing in mind. Personality, it might be argued, is produced by a combination of variables that include genetics, environment, culture, and the navigation of junior high school.

Yet, what do we do with the fact that there seems to be such a small number of personality patterns? As of March 21st at 8:56 AM (PST), there were 7,302,772,231 people on the planet and only four (according to the higher order factors of the *16PF*) or five (Big Five personality model) dominant personality dimensions. Without the elements of intentionality and design, would it not make more sense that there be at least 7,000,000 personalities—one pattern for every 1,000 people on the planet—instead of such an amazingly small number?

After all, when things other than people are brought before our senses, there are predictable patterns that seem to suggest elements of design, while allowing for both unity (a few base patterns) and diversity (an almost infinite number of ways of experiencing combinations of that limited set).

Take color for instance. Isaac Newton studied color—perhaps while recovering from being hit on the head by an apple. He began to pass beams of light through a prism and observed that the light that entered would spread out into seven different colors: red, orange, yellow, blue, green, indigo, and violet. The spectrum reflected what is now known as the primary and secondary colors—if you are willing to allow for indigo and violet to represent the purple family. But these seven colors can be combined with each other and their derivatives to produce an all but infinite number of colors. Crayola® came up with 120 crayon colors (23 reds, 20 greens, 19 blues, 16 purples, 14 oranges, 11 browns, eight yellows, two grays, two coppers, two blacks, one gold, one silver, one white, and then stopped creating), but a trip to Sherwin-Williams® can take a whole day just to sort out the whites. Unity at the core… and great diversity at the outer limits. Is this a principle of design?

Think music. If we move from pulsating waves of light to vibrating patterns of sound, we see that across time and culture there are seven basic tones—from "do" to "ti." As with color, there seems to be a unity at the core of music—seven basic levels of pitch. However, this basic auditory "rainbow" can be arranged and divided, subdivided, varied in volume and speed, and combined with other sources to produce a seemingly infinite number of auditory creations… and what seems to be the very mathematics of emotion.

Some go so far as to posit a mysterious correlation between light and sound—reflecting on the fact that the first, third and fifth colors of the rainbow are primary colors (red, yellow and blue), whereas the first, third and fifth notes of a major scale form the major chord.

We could go on and talk about the unity and diversity found in our other senses—such as how the basic five elements of taste (sweetness, sourness, saltiness, bitterness, and umami—apparently a term for how your mamma used to cook) can be combined with other factors such as smell, texture, coolness, and hotness to produce enough diversity to fill all of the menus on the planet. Or we could discuss how sad it is that taste diminishes with ages to a point where people have to start eating more and more hot peppers to stay connected to their taste buds. But we will not. Our focus is on personality.

Is there a parallel between the patterns for sensing people and our other senses? Do we find similar unity and diversity in the palette of people?

Is there a parallel between the patterns for sensing people and our other senses? Do we find similar unity and diversity in the palette of people? It can be argued that the study of personality began with the Greek physician, Hippocrates, and his musings about the four bile-based humors—yellow bile, black bile, phlegm, and blood. Too much of any one of these can make a

person choleric (grumpy), depressed (gloomy), calm (maybe even sluggish), or sanguine (cheerful)—which could really tick off the choleric folks. Hippocrates' humeral theory caught on, and was adopted by Greek, Roman, Persian, and European physicians up until the advent of modern medicine in the 1800s.

However, the relative simplicity of understanding personality continued even after modern times. In 1921, Carl Jung, the founder of analytical psychology, ended a dry period of his life for publications and gave the world his now famous, *Psychological Types*. He called it "the fruit of nearly twenty years of inquiry in the domain of practical psychology," and in his autobiography he wrote: "This work sprang originally."[1] Jung's contribution to personality and type is my personal favorite, but this is likely because my own profile across his four domains is written in 24-font capital letters.

Psychologist, Ray Cattell, is another face on the Mount Rushmore of Personality investigation. Cattell, I've been told, is my academic grandfather. We have never met, but my primary mentor in graduate school, Richard Gorsuch, was Cattell's advisee and bestowed that lineage on all of his academic children. Cattell has arguably made the most scientific study of "normal" personality. After examining thousands of possible variables, he posited the existence of 16 personality factors, or "primary source traits." And if you raise the microscope to examine what has been determined through factor analytic investigation, an even smaller number of "second-stratum source traits" or "higher order" factors can be seen. Cattell's work has been judged to be in harmony with the more recent and popular understanding of the "Big Five" personality factors.

While the overlap is not 100%, Jung, Cattell, and the Big Five theorists describe an unmistakable underlying unity of the primary colors of personality: 1.) Extraversion versus Introversion; 2.) Being conscientious, methodical and organized versus those who view deadlines as a good time to get started; 3.) Being more creative and intuitive versus those who are more practical and down to earth; 4.) Making decisions with one's heart versus one's head; and 5.) The tendency to be pushed down by anxiety and worry versus the propensity to soar above such fretful concerns on the wings of ego strength.

Even if you consider the pathological side of the bell curve, across each of the editions of the *DSM* series and through the pages of Theodore Millon's investigations, the number of personality disorders has never been assessed as being fewer than 10 or more than 14. Hmmm… 7,302,836.610 on the planet (a lot of people have been born since I started writing this column) and there are fewer than 15 patterns for personality disorder. This demonstrates amazing unity at the core—for what can go right or wrong.

Musings

However, let's get back to our original questions. What do you think God had in mind with personality? And, why were so few base or core variables provided?

Well, as with color, music, and taste, it could be argued that at the center of the universe there is both a great appreciation for "string" simplicity and the "kite" of complexity, for both unity and diversity. Perhaps, when it comes to personality, individual differences are God's way of bringing a sense of community to us. Wise CEOs, it seems, eventually realize there is great advantage in drawing from the contributions of those who are different. Maybe putting all of these people on the same planet and forcing them to live together is simply meant to be a spiritual exercise for the soul. Want to become a saint? Then marry your opposite… or at least serve on a church or faculty committee with such a person.

And speaking of soul exercise, I sometimes wonder if God did have in mind a couple of educational paradigms that were insured to be all but inescapable—and designed to bring the ego (the part of a person that continues to think life separate and apart from God is a good idea) to its knees. The first has nothing to do with our topic of personality. It is the natural decay of aging, which is certainly enough to get the attention of any strong-willed ego. Yet, the other has everything to do with personality.

Ego depletion is a relatively new term in the psychological literature and refers to the fact that when a person acts in ways that are inconsistent or at odds with the fabric of his or her being (the core personality), it will become exhausting and eventually detrimental. Introverts who try too long and hard to be extraverts will become spent. Feelers who are forced to function as thinkers will eventually falter and fail. "Neat freaks" who try to live as messy folks will eventually freak out.

It seems that we each display a relatively small and God-given palette of individual differences that become shaped by life. I have come to believe that the best I can do with my patterns is to celebrate them, challenge them (a bit) on occasion, but never, ever try to sustain life in a way that is death and depletion to the core of my personality. ✠

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Endnote

1 http://www.goodreads.com/book/show/565806.Psychological_Types.

« MICHAEL R. LYLES, M.D.

Treatment Options in Obsessive Compulsive Disorder

Obsessive Compulsive Disorder (OCD) affects approximately 1.6% of the U.S. population. It can start as early as adolescence and cause significant impairment in multiple areas of a person's life. Ninety percent of patients are at risk for having another psychiatric problem, such as depression, that can incur an increased risk for suicide. Thus, good treatment begins with the early identification of OCD and any comorbid psychiatric problems. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is a commonly used rating instrument for identifying this disorder. The total scores can range from 0-40, with significant symptoms over 16 and scores in the 25-30 range not uncommon. Most studies aim for a reduction of 25-35% in score, which can make a significant difference in the quality of life. Complete remissions are rare.

The first lines of treatment usually consist of pharmacological options and/or cognitive behavioral therapy (CBT). The milder "cases" of OCD may only need cognitive behavioral interventions that focus on exposure and response prevention (ERP). Moderate to severe OCD will benefit from both medication and CBT. It should be emphasized that CBT is still underutilized in most clinical environments where medications are in use.

The National Institute for Clinical Excellence Guidelines for OCD suggests several first line treatment options (NICE, 2013). One option involves a "full trial" of at least one selective serotonin reuptake inhibitor (SSRI), such as Prozac, Paxil, Luvox, Celexa, Zoloft or Lexapro. A full trial often involves dosages that are higher than the normal range for mood disorders. The duration of treatment needed to see a clinical benefit is usually longer, lasting up to

8-12 weeks total. Within that time period, at least four to six weeks need to be at the maximum dosage that the patient can tolerate. Because of the higher dosages that are often used, one should watch for the development of serotonin toxicity syndrome with symptoms such as sweating, confusion, diarrhea, anxiety, tremor/twitches, elevated pulse, and fever (in severe cases).

A second medication option is the use of the tricyclic antidepressant, clomipramine (Anafranil), which was initially developed in the 1960s. Side effects include dry mouth, constipation, blurred vision, lowered blood pressure, weight gain, sedation, impaired urination, and EKG changes. Due to these side effects, it is usually used after a failure of an SSRI medication. CBT

is the other option that is considered first-line treatment. CBT with ERP can be used alone or with one of the above medication options. If the patient responds to one of these options, treatment should continue for one to two years and followed by several months of tapering if treatment cessation is to occur. However, some patients may need lifetime treatment.

Approximately 60-70% of OCD patients will show some reasonable level of response to one of these three interventions. For those who do not respond, there is a variety of options. Atypical neuroleptics, such as Risperdal and Abilify, have shown efficacy as adjuncts to antidepressant therapies. Usually, the benefit will be seen by four weeks of augmentation and sometimes at lower dosages—with Risperdal, doses of 0.5 mg/day outperformed higher dosages. For those who respond to this, there is no long-term guidance regarding the time frame to leave someone on atypical augmentation (Veale, D., Miles, S. et al., 2014). However, elevations in blood glucose, weight and cholesterol are known to occur with long-term exposure to atypicals.

For patients who are still non-responsive, other medication options include Effexor, Remeron or Haldol (as augmentation of SSRIs). Clomipramine can be combined with SSRIs, but this drug interaction is very risky due to changes in the liver metabolism of clomipramine that can result in high blood levels. Genetic biomarkers are needed to provide more guidance on the types of patients who may respond predictably to one of the above treatments. Until then, the treatment of OCD will be dependent on well-considered clinical trials. ✠

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« JOHN SANDY, J.D.

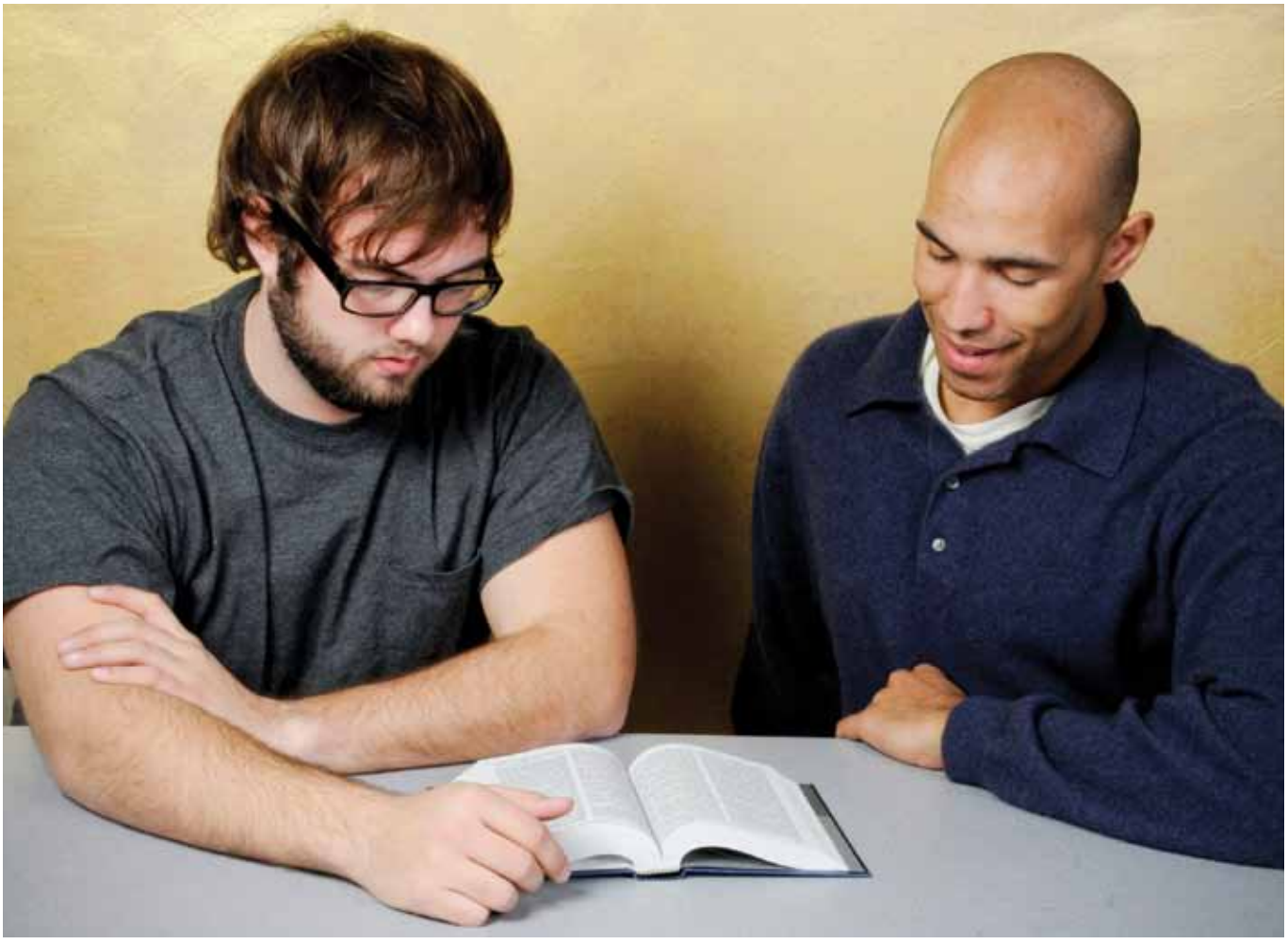
Church-based Spiritual Care Ministries and Mental Illness

It is common for people who suffer from mental illness and their families to turn to pastors and the local church for help. LifeWay Research, a Southern Baptist Convention entity, recently reported the results of a study about how churches approach mental illness. The organization surveyed the following: 1.) 1,000 senior Protestant pastors, 2.) 355 Protestant Americans with an acute mental illness that included 200 churchgoers, and 3.) 207 family members of people with acute mental illness.[1] Among the key findings:

- Only 27% of churches have a plan to assist families affected by mental illness according to pastors, and only 21% of family members are aware of any such plan in their churches.
- Two-thirds of pastors (68%) say their churches maintain a list of local mental health resources for members, but few families polled (28%) are aware of such resources.
- Family members (65%) and those with mental illness (59%) want their churches to talk more openly about mental illness. However, 66% of pastors polled speak to their churches once a year, or less, on the subject.[2]

One additional outcome of the study was a general agreement among pastors surveyed that the local church has a responsibility to provide resources and support to families struggling with mental illness.[3]

More than 3,300 people attended the "Gathering on Mental Health and the Church" at Saddleback Church in Lake Forest, California last year.[4] The event was designed to encourage individuals



living with mental illness, equip and educate church leaders in caring for those affected by mental illness, and make churches and families aware of resources. The conference followed the tragic death of Rick and Kay Warren's son, Matthew, by suicide on April 5, 2013, after his lifelong battle with a mental illness. Dr. Warren, senior pastor of Saddleback, told conference attendees that churches must "take the lead on mental illness."

Making the Church a "Safe Place" for Care

The apostle Paul writes in 2 Corinthians 1:3-4 (NIV), "Praise be to the God of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God." Church-based spiritual care ministries can encourage and strengthen individuals suffering from mental illness and their families by teaching the Word of God and providing spiritual care and fellowship opportunities. Church leaders can actively work to develop church programming that addresses the specific needs of individuals suffering from mental illness and their families. In doing so, they should plan and administer such programs in accordance with legal and ethical risk management guidelines.

Support or Recovery Groups

The recent LifeWay Research study found that respondents desired open forums whereby education and support can help address the stigma of mental illness.[5] Churches are encouraged to consider developing support or recovery groups for people who suffer from mental illness and their families. Such groups can provide opportunities for fellowship, prayer and biblical guidance. Programming should not include any curriculum or activity that is prohibited by relevant state mental health licensing laws. Also, it is recommended that all group facilitators be screened, trained and supervised.

Church-based Counseling and Referral Guidelines

Church leaders should determine the appropriate scope of issues, both legally and ethically, for which pastoral and lay counseling will be made available at the church. They are encouraged to incorporate relevant portions of the 2014 AACC Code of Ethics into their counseling ministries. The Code, in part, states in Ethical Standard 1-210-b, "Christian counselors do not offer services or work beyond the limits of their competence or scope of practice (i.e., education, knowledge, training and professional/ministerial experience), and do not aid or abet the work of Christian counseling by untrained, unqualified, or unethical practitioners or helpers."

Another recommendation church leaders should consider is fostering relationships with Christian professional mental health practitioners and other community resources to develop a network of appropriate referral sources for congregational needs relevant to mental illness issues. It is suggested that such resources be clearly communicated to the congregation. Churches may, in accordance with relevant state law, determine to have a licensed mental health practitioner on staff for certain counseling issues for which pastoral and lay counselors are not able to address due to legal and ethical considerations.

In addition, church leaders are encouraged to develop forms for pastoral counseling and lay counseling designed for the scope of their counseling ministry services (e.g., informed consent forms that clearly articulate the scope of counseling ministry services and intake forms that solicit important counselee background information). Finally, it is recommended that churches develop lay counselor screening, training and supervision policies to assure safe and competent lay counseling ministry services.

Attorney Input

It is also recommended that an attorney be consulted to help ensure church leaders that all church-based counseling and support or recovery group ministries are administered in compliance with relevant state law. An attorney can also assist church leaders in developing forms for counseling ministry, worker screening, training and supervision procedures, and guidelines for appropriate referral. ✠

The information is current as of the date that it is written. This article is provided solely for general educational purposes and does not constitute legal advice between an attorney and a client. The law varies in different jurisdictions. Consultation with an attorney is recommended if you desire legal advice.

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Leadership and Personality Disorders

I have a few pet peeves… one of them is the overuse of certain diagnostic "labels" by the popular culture to the point of the terms becoming meaningless. I hear people say, "Well… my psychologist told me my spouse has Borderline Personality Disorder (BPD) or Narcissistic Personality Disorder (NPD) or some other type of disorder… and there is no hope for him." This orientation upsets me for a few reasons, but two in particular. First, the above statement is patently not true. There is certainly hope for personality disorders. We see them change all the time. Second, the terms are so non-specific that, when used, there is no way to tell what the person is really describing.

Take the case of a woman I was talking to in a leadership workshop recently. She told me she had a direct report who had NPD and knew he would never change and there was nothing she could do. I asked, "What kind of NPD is he? Is he dominated by envy in his grandiosity or is his narcissism covering overwhelming shame?" She said, "What's the difference?" And that is my point here. Our popular usage of these terms lump everyone together and do not indicate needed differentials.

Personality disorders, while frequently behaviorally and symptom defined, can differ greatly in their drivers, dynamics, etiologies, and the like, which leads to the bigger issue: *What do we do with them?* And that always depends. The answer, in part, is determined by figuring out what kind of NPD, BPD or other disorder it is with which you are facing. What are their various capacities, motivators, needs, etc.?

Figuring this out in a clinical setting is one thing, and it can be very hard at times. However, in an organization, workplace or team, it can become even more difficult. The main reason treatment is not initiated (although significant personal growth can occur in individuals under great leadership), is performance in both results and relationships.

In coaching leaders, one of the most important things they can learn is that a healthy organization not only fosters great performance in mature people, but must also serve as an immune system against immaturity, which is an excellent and simple term to describe personality disorders. One of the hallmarks of many personality disorders is the inability for individuals to contain their immaturity, emotionally and otherwise, including the resulting lack of ownership and responsibility. This inevitably ends up with collateral damage among teams and cultures, and the sickness spreads, often infecting an entire department or even the whole organization.

One of the hallmarks of many personality disorders is the inability for individuals to contain their immaturity, emotionally and otherwise, including the resulting lack of ownership and responsibility.

So, how does this work? Just like our body's immune system, it begins by addressing a problem at the lowest level of intervention. When bacteria enter the body, the saliva meets it and takes appropriate action. If the invader overrides that response, it moves up the chain until it is named by a marker cell and contained, possibly even expelled. If that sounds a lot like Matthew 18, you are right. We are encouraged in this passage to first address a problem in private, one on one, and if the person takes responsibility, then the problem may be solved. If not, we are to try by bringing another person or two with us. Finally, if there is no resolution, greater immune functioning is called for, eventually resulting in separation. "Whatever you bind, will be bound" (Matthew 18:18). Behavior is to be contained and not allowed to infect a group.

Great leaders develop the culture of their organizations to function in the same way. They spend time and money training people on accountability systems that are not punitive, and this is *exactly what a personality disorder needs: a combination of love, limits, and respect.* When people are trained and developed to deal with those on their teams in this way, something powerful happens. Bad behavior, defensiveness, and the like are not only contained, but often differentially diagnosed and helped. Said another way, the personality issues that are open to change can often be helped in a context of positive relationships, loving limits and consequences. This is what effective managers do, as well as healthy cultures in companies. They do not allow regressive behavior to spread, but contain it and invite it to more mature functioning. Done well, people can mature over time, become less defensive, take more ownership, and grow personally. In a similar manner, the ones who cannot or refuse to do so will self-select out and go away, or the system will remove them. However, this

takes a strong will on the part of leadership to train people in how to address those who will not take responsibility for themselves, often a trademark of personality disorders.

The truth is, though, many have never been in a family or culture that would support and help them, while simultaneously holding them accountable. This dynamic causes people to remain stuck in patterns of functioning that are maladaptive. Nevertheless, leaders who build a culture that practices those redemptive ingredients have multifold benefits—they contain immature behavior; retain essentially good, but immature, people with great talent (because they know how to call them to higher functioning rather than further regression and ultimate loss); and protect their organizations from the collateral effects caused by many of these disorders.

In my book, *Necessary Endings*, I describe many personality disorders as part of three groups of people or behaviors outlined from the book of Proverbs: the wise, the foolish, and the evil. Many personality disordered behaviors would fall into the category we call, "foolish." It is the refusal and/or inability to take personal responsibility. Unlike the "evil" behavior, which desires to cause pain in others, foolish behavior causes pain in others unintentionally, but as a result of deflecting ownership and the inability for emotional regulation and mature relationships. In contrast, strong leadership creates a culture that is both supportive and accountable. It is relational and practices and enforces standards. It has "love and limits," or as the Bible says, "grace and truth."

For a variety of reasons, such as stewardship, success, and caring for people, leaders do well to build cultures that do exactly what personality disorders need the most—respect, empathy, understanding, and support… with strong accountability at the same time. That is the stance that will provide an integrative experience for personality disorders—to invite them to give up their old ways of surviving, give them a chance for growth and, at the same time, immunize the organization against their immaturity. It seems like when God suggests "grace and truth" as being important, He meant for leadership as well. ✠

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Personality Disorders

Distancing from God and Borderline Personality Symptoms

Sansone, R.A., & Wiederman, M.W. (2013). Distancing oneself from God: Relationships with borderline personality symptomatology. *Mental Health, Religion & Culture, 16* (2), 210-214. Doi: 10.1080/13674676.2002.666518.

Randy Sansone and Michael Wiederman at Wright State University conducted a study of the relationship between symptoms of borderline personality disorder and the decision to distance oneself from God as a form of self-punishment.

The researchers combined data collected from four previous samples over a two-year period of time for a total sample of 1,511. They had both male (N = 496) and female (N = 1,014) participants (one did not provide this information). The age range was between 18 and 97 years with a mean age of 50.83. Most participants (86.6%) identified as Caucasian. The researchers assessed personality with the borderline personality scale from the Personality Diagnostic Questionnaire-4 and the Self-Harm Inventory.

The findings were interesting. About 10% of participants reported intentionally creating distance from God as a way of punishing themselves. There were no differences between males and females. Those who reported distancing themselves from God as a form of punishment scored higher on both measures of borderline symptomatology. Also, when compared to those who denied ever doing this kind of distancing from God as self-punishment, those who admitted to doing so were more likely to score at about the clinical cutoff on the Personality Diagnostic Questionnaire-4.

The authors conclude that "intentionally or purposefully distancing oneself from God" was related to borderline personality symptomatology, which is often characterized by "ongoing self-harm behavior" (p. 212). As the authors note, this is important information for mental health professionals and pastoral care providers who work with people who suffer from borderline personality symptoms and may also identify as religious or spiritual or otherwise report a religious conflict of some kind.

Religiosity and Schizotypy

Tiliopoulos, N., & Bikker, A. (2013). A thematic comparison of religiosity profiles between Christians with low and high schizotypy. *Mental Health, Religion & Culture, 16* (2), 173-178. Doi: 10.1080/13674676.2011.652605.

This is a study in the United Kingdom of themes associated with schizotypy (a theory there is a continuum of personality characteristics) and religiosity. The researchers conducted a small qualitative study that used purposeful sampling and drew from a larger study of Christian adults who had completed the Schizotypal Personality Questionnaire and measures of intrinsic religiosity and religious life. Data was based on semi-structured interviews with eight participants who were classified as having either low or high levels of schizotypy. Five of the participants identified as female and were between 23 and 76 years of age. All participants identified as Protestant Christian.

The interviews lasted between 25-45 minutes and were transcribed. All transcripts were analyzed using indicative thematic analysis and various themes emerged. The researchers identified four themes that distinguished the two groups (low and high schizotypy): 1.) nature of faith; 2.) centrality of religion; 3.) religious choice; and 4.) religious doubt. In terms of the nature of faith, while both groups experienced their faith as personal and identified a higher power, the "low-schizotypy described religiosity as an explicit, direct, personal

relationship with God that was the essence of this group's faith" (p. 174). For example, one participant said, "[it means] having a living relationship with Jesus Christ" (p. 174). The kinds of personal qualities of a relationship with God were not present in the high schizotypy group.

Similarly, on the theme of the centrality of religion, the low schizotypy group indicated religion provided them support and guidance. In other words, "religion was highly embedded in life, giving purpose and meaning to all its aspects" (p. 175). Religion was more "defused" and "belittled" in the high schizotypy group.

With the third theme of religious choice, the low schizotypy group identified becoming religious as either a "rational choice" and/or the "result of a sudden conversion" (p. 175). For those in the high schizotypy group, religion was seen as a "natural part of life," but not connected to rational choice.

The last theme of religious doubt reflected an awareness for how religious beliefs "had been changing through their lives" for those in the low schizotypy group. For those in the high schizotypy group, doubt was more associated with various contradictions and life tragedies, including some of the distinctive thought distortions that can be evident with these individuals. For example, in attempting to form an explanation, one person shared the following: "Questions began to loom larger and larger really so that they the shape of my believing that the sort if you like both the doctrinal content and the way I regarded a whole range of other things began to open up" (p. 176).

The researchers discussed how the religiosity of the healthier people (low schizotypy) "had an outwards and upwards direction towards a personified all-loving God" (p. 176). This seemed to contrast with those whose faith "had an inwards directed, abstract, and spiritual character" and was "not explicitly bound by specific religious practices or doctrine" (p. 176). They wondered whether the best explanation is found in the attachment to God literature. This is certainly an interesting consideration, and further research with a larger sample would be a next step in exploring these reflections.

Religious/Spiritual Well-being and the Dark Triad

Kammerle, M., Unterrainer, H-F., Dahmen-Wassenberg, P., Fink, A., & Kapfhammer, H-P (2014). Dimensions of religious/spiritual well-being and the dark triad of personality. *Psychopathology, 47*, 297-302. Doi: 10.1159/000358563.

This is an interesting study out of Vienna, Austria, on the Dark Triad of personality and religious/spiritual well-being. The "Dark Triad" refers to Machiavellianism, narcissism, and psychopathy. The researchers reported on data collected from 312 college students (70% female; 30% male) ranging in age from 18 to 34 (mean = 23.76 years). The students completed measures of personality and of religious and spiritual well-being.

The researchers indicated that they "assumed that at least some facets of religiosity and spirituality could be positively linked to a lacking development of personality" (p. 300). However, the researchers reported that religious and spiritual well-being was negatively correlated with the Dark Triad. Psychopathy, in particular, was the most negatively correlated with religious and spiritual well-being. The researchers interpreted this finding on psychopathy as reflecting "the aversive and self-defeating character of psychopathy already known from previous research" (p. 300).

Religion/Spirituality and Borderline Personality

Sansone, R.A., Kelley, A.R., & Forbis, J.S. (2012). Religion/spirituality status and borderline personality symptomatology among outpatients in an internal medicine clinic. *International Journal of Psychiatry in Clinical Practice, 16*, 48-52. Doi: 10.3109/13651501.2011.605956.

This was a study of the relationship between religious/spiritual well-being and borderline personality symptomatology. The researchers reported on data from 308 participants (74% female;

26% male) ranging in age from 18 to 92 years old. Participants were contacted because they had received services at an outpatient internal medicine clinic for non-emergency medical care. Most of the participants were Caucasian (86.9%), while 6.8% identified as African-American, 2.6% as Asian, 2.3% as Hispanic, and 0.6% as Native American.

Individuals reporting borderline personality symptoms also showed lower levels of religious spiritual well-being compared to those who did not report borderline personality symptoms. That is, "… as the level of borderline personality symptomatology increases, the overall level of [religious/spiritual] well-being decreases" (p. 51).

The researchers acknowledge several possible explanations for these findings, including that people who suffer from borderline personality symptoms tend to come from families that are less religious/spiritual; that there are many other factors including early traumatic experiences that lead people away from religion ("If there were a higher force, how could this continue to happen to me?" p. 51); or that there are various biological/genetic variables that have been unexamined. In any case, there is certainly more research that could be done in this area.

Moral Judgments and Personality Traits

Arvan, M. (2013). A lot more bad news for conservatives, and a little bit of bad news for liberals? Moral judgments and the dark triad personality traits: A follow-up study. *Neuroethics, 6*, 51-64. Doi: 10.1007/s12152-012-9155-7.

Marcus Arvan reported on more than 1,000 participants (N = 1,154; 680 male, 472 female; two not indicating) who were recruited online to participate in a survey study addressing conservative and liberal moral judgments. The purpose of the study was to follow-up an original study of reported personality differences in social judgment between

those who are more conservative and more liberal and to extend the assessment to moral issues.

The median age of participants was 29. In addition to providing demographic information, participants completed two surveys. One survey addressed personality (Short Dark Triad personality survey), while the other addressed moral judgments (Moral Intuition Survey). Again, the "Dark Triad" of personality refers to Machiavellianism, Narcissism, and Psychopathy.

The results were that several (22) correlations were statistically significant between the Dark Triad and what were considered "conservative" judgments. Seven judgments were statistically significant between the Dark Triad and "liberal" judgments (and only one of these at the more stringent level of statistical significance). For example, all three Dark Triad traits correlated with conservative judgments on the item, "The government ought to use 'enhanced interrogation techniques.'" The Dark Triad was also significant (at a lower threshold) for a smaller number of liberal judgments, including "The government ought to work within the rules of the United Nations." The Dark Triad can be associated with both conservative and liberal moral judgments. However, according to Arvan, the relationship between liberal judgments and the Dark Triad "are statistically weaker, and far fewer in number, than the relationships between the Dark Triad and conservative judgments" (p. 60).

The author draws an interesting conclusion: "… suppose I were to tell you that although many people who hold your moral views do not have an antisocial trait, it is nevertheless the case that *people who share your moral views are mildly to moderately more likely to possess an antisocial trait"* (p. 61). The author raises some good points for reflection and discussion, but future research is necessary to draw any strong conclusions; in part, based on how these different variables are operationalized and, as the author acknowledges, what counts as "moral goodness" and "moral badness." ✠

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Dialectical Behavioral Therapy: A Christian Approach… – Marian Eberly

1. A concept of DBT that has created controversy with Christians is
   - ○ a. mindfulness
   - ○ b. validation
   - ○ c. contingency management
   - ○ d. cognitive restructuring

I Need You: Dependent Personality Disorder – Gregory Jantz

2. People with DPD are
   - ○ a. adept at finding others who will control them
   - ○ b. prone to alienate others with clinging behaviors
   - ○ c. at risk for codependency
   - ○ d. all of the above

Detached: The Traumatized Personality – Eric Scalise

3. Regarding DID, which of the following is not true
   - ○ a. it alters form when the experience is traumatic enough
   - ○ b. the alters want to maintain stability and safety
   - ○ c. the alters are fully developed, mature personalities
   - ○ d. people with DID generally have histories of early life-threatening abuse

Disorders of the Soul: A Theological Discourse… – Eric L. Johnson

4. The author contends that exploration and work with PD
   - ○ a. can only occur after a strong therapeutic bond is formed
   - ○ b. is not dealt with in Scripture
   - ○ c. can be challenging and even irritating
   - ○ d. a and c

High Conflict Relationships: Working with Antisocial People – Linda Mintle

5. Which of the following is not true of people with ASPD?
   - ○ a. they do not perceive their behavior as abnormal
   - ○ b. they have low tolerance of frustration and distrust people
   - ○ c. prognosis for recovery is good with treatment
   - ○ d. connecting action to consequences is a necessary component of treatment

Leadership and Personality Disorders – Henry Cloud

6. Dr. Cloud contends that personality disorders
   - ○ a. can differ widely in their drivers, dynamics, and etiology
   - ○ b. need respect, empathy, understanding, and support
   - ○ c. can be described as "the foolish" in Proverbs
   - ○ d. all of the above

It's All about Me – Diane Langberg

7. In the book of Hosea when Israel forgot God they
   - ○ a. began fighting each other
   - ○ b. counted the soldiers in their army
   - ○ c. built larger buildings and fortified cities
   - ○ d. stored up food and material supplies

Personality and Faith Development: The Nature vs. Nurture… – John C. Thomas

8. In the Nature-Nurture debate, the greater concern for practitioners is
   - ○ a. understanding the role that either plays
   - ○ b. which one is dominant in shaping personality
   - ○ c. what might happen if they were reversed
   - ○ d. to avoid blaming the past for the present

Personality as Unity and Diversity, Fullness and Depletion – Gary W. Moon

9. When you consider the personality disorders
   - ○ a. there have never been fewer than 10 or more than 14
   - ○ b. the number of disorders differs greatly from author to author
   - ○ c. there seems to be an infinite variety of disorders
   - ○ d. none of the above

The Eccentrics: Paranoid, Schizoid and Schizotypal… – Miriam Stark Parent

10. When the symptoms of the disorder are ego-syntonic
    - ○ a. the possibility of an abreaction is indicated
    - ○ b. it is difficult to motivate clients toward change
    - ○ c. a favorable prognosis can be expected
    - ○ d. genetic corruption is often the cause

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3. Be able to integrate spirituality and faith-based constructs into the delivery of care.

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« TIM CLINTON, ED.D., LPC, LMFT

Breaking the Silence: A Global Day of Hope

Susan tried to pretend she couldn't hear the conversation in the pew behind her… *"If only he would pray more…" "He should try reading Scripture…" "If he would just change his thinking and conform to the will of God, he wouldn't have these mental problems…."*

Susan was a busy mother of three who served in her church's food pantry, as a 3rd grade Sunday school teacher, and occasionally provided special music during church services. She loved her husband, children, friends and church, but often felt hopelessly isolated and alone. Susan had battled depression since her early teens, but was afraid to ask for help. She worried she would no longer be welcomed to serve if her battle with depression was discovered.

The conversation continued, *"I don't know what to say. He should just choose to be happy and thankful for the Lord's blessings. He needs to stop that 'crazy thinking.'"* Susan started to imagine similar conversations about her. Sometimes her dark thoughts scared her or added guilt to the sadness. She resolved to stay busier, work harder, smile more, and cry only when she was sure no one would see her.

Historically, the subject of mental health and its related disorders has been taboo in the Church. While the Christian counseling movement has never been stronger, criticism and sarcastic jabs are still perpetuated: *"How did they get along without therapists in Christ's day?"*

It is a tragedy that countless individuals who struggle with mental health issues are afraid to turn to their pastors and church communities for support. Some have allowed hurts from the past to hold them hostage, when there would truly be many in their church families who are ready to offer understanding and compassion. Others have a church family that would care deeply, but may not have the resources or knowledge to know how to help. Sadly, in some cases churches are more hurtful than helpful. I am also finding that many churches are completely unaware of the staggering number of individuals who are sitting in their pews each Sunday plagued by a serious mental health problem.

Near to the Brokenhearted

Witnessing another's brokenness can be uncomfortable. Even loving and well-meaning friends may find themselves starting to pull away from those who are experiencing such deep pain. That is not the heart of Christ. In Luke 4, we read of Jesus' public ministry: "The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free…" (vs. 18). Psalm 34:18, likewise, tells us, "The Lord is close to the brokenhearted and saves those who are crushed in spirit." Let us be near to the brokenhearted as well. God has no greater plan than to use His people as conduits to channel the message of hope and grace.

Recent Findings

Lifeway Research, an organization that assists and equips church leaders, conducted a study that found some revealing statistics about mental illness in the Church.[1, 2]

- 76% of pastors know someone with bipolar disorder and 74% with clinical depression.
- 22% of pastors described themselves as reluctant to counsel people having a mental illness because of their previous experiences and the thought that it would take up time and resources; yet, 59% of pastors report having counseled a person with some form of mental illness.
- A large number of pastors avoid speaking about acute mental illness to their congregations (49%).
- 68% of pastors indicated that their churches provide referral lists to connect mentally ill individuals or their families to local experts—yet only 28% of attendees believed that such a list existed.

I have to admit, even as a seasoned counselor, I was a bit surprised when reading over some of the following statistics. Though anxiety is the most common mental health disorder in the U.S., according to the National Institutes of Health, it remains highly treatable, but only about a third of the 40 million Americans suffering from anxiety issues seek help. Every day in our nation, more than 5,400 young

people in grades 12 and under attempt suicide. Each year, over three million child abuse reports are filed—and this includes some of the children in our Sunday schools and those who have grown up attending church—sometimes they carry depression as a companion or engage in escape behaviors, like alcohol or drug abuse, to numb the pain.

The Church must play an instrumental role in aiding people with mental illnesses. There is great danger in furthering the divide between the Church and its members who suffer from depression or other mental health issues. When people respond negatively to those with mental illnesses, these members often leave the congregation. In the Lifeway Research study cited above, 18% chose to leave their churches and 5% did not find a new church home.[3] If there are people in your faith community who are dealing with mental health issues, it is important to reach out and embrace them rather than stigmatizing their struggles.

Commission on the Church and Mental Health

The time is now; in fact, it is long overdue to call together denominational leaders, faith-based organizations, Christian experts, researchers, clinicians, and other frontrunners to fully address today's mental health challenges. It is time to dialogue and develop a position that clearly engages the Body of Christ on mental health.

We are calling for pastors around the world to declare a "Global Day of Hope" in May 2016. With knowledge and information at our disposal, the men, women, and young people in our pews no longer need to suffer alone. As the worldwide Church, we must take a stand for spiritual and emotional wholeness. Local congregations everywhere need to break the silence and collaborate with mental health professionals in a God-centered, biblically-based approach that offers healing, freedom, and hope. The Global Day of Hope is an opportunity to stand with our brothers and sisters in the midst of their pain and proactively work to develop an action plan that ensures quality care. Potential initiatives include acknowledging the legitimacy and prevalence of mental health issues within the congregation by inviting a Christian counselor to speak… asking a pastor to deliver a Sunday message related to mental health and the Church's role as a healing community... or developing a lay counseling ministry within the Church under the supervision of a licensed or other qualified Christian mental health professional.

May it never be said that the 21st century Church turned a deaf ear and a cold heart to the cries for help of those who are hurting and broken. As church leaders and Christian caregivers, our call is to *help people get help* through the Church and in partnership with competent mental health professionals. Let's break the silence and celebrate hope!

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Endnotes

1 Lifeway Research (2014). *Study of acute mental illness and Christian faith*. http://www.lifewayresearch.com/files/2014/09/Acute-Mental-Illness-and-Christian-Faith-Research-Report-1.pdf.

2 Stetzer, E. (2014). *The church and mental illness part 3*. http://www.christianitytoday.com/edstetzer/2014/december/church-and-mental-illness-part-3-.html.

3 Lifeway Research (2014). *Study of acute mental illness and Christian faith*. http://www.lifewayresearch.com/files/2014/09/Acute-Mental-Illness-and-Christian-Faith-Research-Report-1.pdf.

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