

PERSONALITY DISORDERS

Lecture 6.

A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

DSM 5, 2013, p.645.

PERSONALITY DISORDERS

Are... a heterogeneous group of disorders defined by long standing, pervasive patterns of behaviour and inner experience that deviate from a persons culture.

PREVIOUSLY...DSMIV-TR

- 10 personality disorders in 3 clusters:
- Cluster A: Odd/eccentric: Paranoid, Schizoid & Schizotypal
- Cluster B: Dramatic/Erratic: Antisocial, Borderline, Histrionic & Narcissistic
- Cluster C: Anxious/Fearful: Avoidant, Dependent & Obsessive-compulsive
- Prior to DSMIV the diagnosis was very unreliable!

WHY?

- For many personality disorders diagnosis varies by gender.
- Women more likely to be diagnosed with borderline, dependent and histrionic disorders and men with antisocial, narcissistic and obsessive-compulsive disorder.
- This happens because clinicians are focusing on different behaviours depending on whether it is a man or woman. For example 2 clinicians are given identical cases, except one is named John, the other Joan. Following diagnoses are 'antisocial personality' and histrionic personality' respectively (Garb 1997)

INTER-RATER RELIABILITY FIGURES

- Paranoid-.86
- Schizoid-.69
- Schizotypal-.91
- Antisocial-.97
- Borderline-.90
- Histrionic-.83
- Narcissistic-.88
- Avoidant-.79
- Dependent-.87
- Obsessive-compulsive-.85

DIAGNOSIS FIGURES

- What do you think are the most widely diagnosed disorders in the UK?
- What percentage?
- Obsessive-compulsive (2%) schizoid and avoidant (0.8%), closely followed by borderline, paranoid (0.7%) and antisocial (0.6%).
- Which are the least?
- Schizotypal (0.06%), narcissistic and histrionic (0%): *Coid et al., (2006)*.

COMORBIDITY

- When individuals meet the criteria for more than one disorder (e.g Justine)
- What two personality disorders do you think that Justine could be diagnosed with?
- What does this imply about diagnosis?
- Over 50% of people diagnosed with a personality disorder meet the criteria for another
- Within two years (Shea, 2002) people diagnosed with a personality disorder had been given a different diagnosis from the original one!

WHAT PERSONALITY AM I?

- Martin- Schizoid P.D.
- John- Narcissistic P.D.
- Paul- Anti Social P.D.
- Magda- Dependent P.D.
- Matthew- Avoidant P.D.
- Justine- co morbidity for Borderline and Paranoid P.D.

DIAGNOSIS-

- These disorders have exaggerated traits that are frequently disturbing or annoying to others.
- In order to qualify for DSM5 diagnosis you must fit both the **general** criteria and the **specific** criteria.
- The pattern of behaviour must be **inflexible** and **across all situations**.
- A source of **distress/impairment**.
- **Stable** and enduring from adolescence/early adulthood.
- The concept of **social impairment** is important in diagnosis, as personality disorders are the most controversial in the diagnostic system.

DIAGNOSIS-

- Why?
- They are difficult to identify reliably, they have high levels of comorbidity and the definitions themselves are not well grounded in scientific knowledge from basic personality theory (Ottman, 2015).
- But-
- They are associated with significant social and occupational impairment.
- During adolescence they may signify the onset of other mental illnesses.
- They could represent the beginning of serious psychopathology.

GENERIC SYMPTOMS

- They affect the building blocks of personality:
- A) **Social motivation**- unconsciously or consciously. The two most important are affiliation & power (Winter et al. 1998).
- B) **Cognitive perspective of self and others**- these distortions of mental processes can result in an unrealistic but stable view of the self (Baumeister 1997).
- They afford confidence in our own view and perspective.
- They can lead to the misperception of intentions/motives of others.
- They are highly important because social interaction relies on the ability to evaluate relationships with others and to make accurate judgements.

GENERIC SYMPTOMS

- C) **Temperament and personality traits**- our temperament is the most basic characteristic by which we relate to the world- it is HOW we react EMOTIONALLY, whereas personality is the behavioural manifestation.
- D) **Context and personality**- personality features should be evident in all situations, but are not always- furthermore how others perceive our behaviour as positive or negative differs from situation to situation too!
- However- DSM has always treated PD's as discrete categories with sharp boundaries, but many people do not fit the typical types. Should we be using arbitrary thresholds to distinguish between normal and abnormal personality types?

- Additionally, there is considerable overlap between categories, with some individuals meeting the categories for two or more types (Grant et al., 2005).
- So... DSM5 workgroup established-
- With the focus on thinking beyond the previous framework.
- The outcome was to remain with the existing categories, but to acknowledge the multi dimensional approach of using section 3* within the manual.
- *Remember section 3 pertains to emerging measures and models (with an alternative model for PD's).

WHY DOES DSM₅ HAVE 2 SECTIONS FOR PD'S?

- DSM usually takes an 'all or nothing' approach to diagnosis, which is problematic for PD's because they tend to represent 'extensions' of normal traits.
- Furthermore, personality scores on conventional personality measures (e.g. 'The Big Five') support the notion of 'dimensions of personality'.
- This has led to the suggestion that PD's are 'extremes' of personality dimensions (Samuel & Widiger, 2008).
- In addition, studies have shown that the stability of PD's are not as consistent as previously believed; Grilo et al. (2004) found that almost half of those diagnosed with a PD did not receive the same diagnosis two years later.
- Therefore, a dimensional approach may be more appropriate than the 'all or nothing' original approach.

THE DSM₅ ALTERNATIVE MODEL

- The alternative model has 3 discrete types of personality ratings that contribute to a diagnosis.
- This system is designed to provide ratings of an individual on a series of dimensions rather than an all or nothing diagnosis.
- This also reduces PD's from 10 to 6 categories.
- The new categories are: Antisocial PD, Avoidant PD, Borderline PD, Narcissistic PD, Obsessive-Compulsive PD and Schizotypal PD.
- In addition, it describes the level of functioning (behavioural and emotional) a person has and whether or not they demonstrate any pathological traits.
- The diagram on the next slide indicates how assessment takes place.

EVALUATING PD'S

Personality functioning:

Impaired sense of identity, failure to develop effective interpersonal functioning



Trait domains:

Negative affectivity
Detachment
Antagonism
Disinhibition
Psychoticism



Personality disorder types:
(x6).

Severity of impairment:

Client evaluated on 5 point scale from 'no impairment' to 'extreme impairment'



Ratings on personality traits:

Client assessed on 5 basic traits each on 4 point dimensional scale. These are then assessed using up to 25 sub-traits.



Diagnosis:

Each of 6 PD traits has it's own diagnostic criteria based upon ratings achieved on 'impairment' and on 'personality traits' (step 1 & 2).

TRAIT DOMAINS

Negative affectivity

Emotional lability, anxiousness, separation insecurity, submissiveness, hostility, perseveration, depressivity, suspiciousness, restricted affectivity.

Detachment

Withdrawal, intimacy avoidance, anhedonia, depressivity, restricted affectivity, suspiciousness.

Antagonism

Manipulativeness, deceitfulness, grandiosity, attention seeking, callousness, hostility.

Disinhibition

Irresponsibility, impulsivity, distractibility, risk taking, rigid perfectionism.

Psychoticism

Unusual beliefs and experiences, eccentricity, cognitive and perceptual dysregulation.

WHICH ONE?

- The diagnostic approach in the main body of DSM5 is the same as for DSMIV-TR; the inclusion of the alternative model in section 3 is for the purpose of research generation and future consideration.
- Therefore, the remainder of this lecture will concentrate on this approach.
- To help the clinician decide when personality traits have become maladaptive, DSM5 states that a persons inner experience and behaviour must differ markedly from that expected of their culture and be reflected in two of the following:
 - Cognition, affectivity, interpersonal functioning and impulse control.

FREQUENCY OF PD'S.

- Are they the most common form of psychopathology?
- In the general population?
- In the clinical population- 10% (Trull et al., 2010) which remains largely consistent.
- However, most precise figures seem to be 3% in the community for lifetime prevalence of ASPD, 2% for all other types and 1% for Narcissistic.
- And, 75% of individuals with one PD also meet the criteria for other mental illnesses.

GENDER DIFFERENCES AND STABILITY

- Lezenweger (2007) equal numbers in both genders.
- But... ASPD slightly higher in men (5% vs 2%).
- And...BPD & DPD higher in women (Skodol & Bender, 2003).
- Limited studies regarding stability, but Robbins (1966) reported young children treated for adjustment problems forty years later showed a significant correlation between early behaviour and adult behaviour.
- Cohen et al. (2005) in a non clinical population, those who met the criteria for a PD met the same criteria several years later.

CULTURE AND PD'S

- DSM5 'behaviour that deviates markedly'
- So, two considerations when referring to culture-
- 1. In other cultures what are the personality traits that lead to interpersonal difficulties, social and emotional impairments?
- 2. Are our diagnostic criteria meaningful to other cultures?

ODD/ECCENTRIC CLUSTER A

- This cluster shares many of the characteristics of schizophrenia but without the hallucinations and detachment from reality.
- DSMIV-TR criteria for presence of 4 or more of the following:
 - Pervasive, unjustified suspiciousness of being harmed, deceived or exploited.
 - Unwanted doubts about the loyalty or trustworthiness of friends or associates.
 - Reluctance to confide in others because of suspiciousness.
 - The tendency to read hidden meanings into the innocuous actions of others.
 - Bears grudges for perceived wrongs.
 - Angry reactions to perceived attacks on character or reputation.
 - Unwanted suspiciousness of the fidelity of the partner.

PARANOID PD

- People with paranoid personality disorder are suspicious of others and it influences their relationships. They expect to be exploited or mistreated and are always on the lookout for signs of trickery and abuse.
- This disorder is different from paranoid schizophrenia because other symptoms of schizophrenia are not present such as hallucinations and social/occupational functioning impairment.
- They can co-exist with schizotypal, borderline and antisocial disorders.
- [Paranoid pd](#)

SCHIZOID PERSONALITY DISORDER

- Clinical case: Martin
- A pattern of detachment from social relationships and a restricted range of emotional expression.
- People with this disorder do not enjoy close relationships and do not usually have many friends. They tend to prefer solitary interests.
- They appear dull and aloof with no warm feelings.
- They rarely experience strong emotions, are not interested in sex and have few pleasures.
- Comorbidity is highest with schizotypal, avoidant and paranoid personality.

SCHIZOTYPAL PERSONALITY DISORDER

- A pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.
- Socially isolated as schizoid disorder, but with more eccentricities such as odd beliefs and magical thinking.
- They often think they can read peoples minds and have inaccurate sensory perception.
- Their behaviour may be eccentric as in their clothing, appearance and they may talk to themselves.
- Comorbidity is high for two other personality disorders such as avoidant and paranoid.

AETIOLOGY OF CLUSTER A

- Being socially withdrawn or exhibiting rambling speech, or disorganised thoughts has led some to argue that these are part of a wider schizophrenia spectrum disorder, therefore the causes will be similar to those of schizophrenia (Siever & Davis, 2004).
- Twin, adoption and family history studies support the idea of a genetic component (Tienari et al., 2003).
- Individuals with cluster A symptoms possess similar brain abnormalities to those with schizophrenia (Fervaha & Remington, 2013).
- They also exhibit physiological difficulties such as smooth pursuit movements (Cadenhead et al., 2002) and the demonstrate cognitive deficits also observed in schizophrenia sufferers (Dickey et al., 2002).
- Finally, there is some support for the psychodynamic explanation for these disorders, particularly as many of those diagnosed with PD's have suffered childhood abuse or neglect (Johnson et al., 1999).

DRAMATIC/ERRATIC CLUSTER

- Cluster B:
- These are dramatic and emotional disorders where individuals are dominated by self interest to the detriment of others.
- They are typically attention seeking and emotionally labile.
- Within this cluster are:
 - Antisocial PD (APD/ASPD)
 - Borderline PD (BPD)
 - Narcissistic PD
 - Histrionic PD

AETIOLOGY OF CLUSTER B

- Some of the disorders share characteristics in common, such as impulsivity, lack of empathy and aggression or emotional outbursts, leading some to propose that these may be manifestations of a single underlying disorder (Widiger & Corbitt, 1997).
- Most explanations however, focus on explaining each disorder as an individual disorder.
- When we look at antisocial personality disorder, there comes a word of caution; much of the research on APD has been conducted using a variety of methods of defining the disorder, including the term psychopathy. This is problematic because only 20% of people diagnosed with APD under DSM5 will score high on measures of psychopathy (Rutherford, Cacciola & Alterman, 1999).

BORDERLINE PERSONALITY DISORDER

- Very common in clinical populations and very hard to treat. It is also associated with suicide.
- Core features are impulsivity instability in relationships and mood.
- Attitudes and feelings towards other people can change rapidly from idealisation to anger.
- They are overly sensitive to small signs of emotions in others and often do not have a clear sense of self.
- Their potentially self damaging behaviour can include gambling reckless spending indiscriminate sexual activity and substance abuse.
- They do not like to be alone, fear abandonment, demand attention, and experience chronic depression.
- They may also engage in self mutilation.
- However, over 10-15 years they usually no longer meet the criteria and certainly by the age of 40.

AETIOLOGY OF BORDERLINE PERSONALITY DISORDER

A pattern of instability in interpersonal relationships, self-image, affect and marked impulsivity.

- There are several views:
 - Neurobiological factors such as twin and family studies suggest a strong genetic component.
 - Deficits in sensitivity to serotonin also has much research support. This is also consistent with dysregulation of emotion witness in BPD.
 - Parents of BPD sufferers often have elevated rates of mood disorders.
 - Increased activation of the Amygdala is another factor along with poor frontal lobe functioning.
 - Social factors such as childhood abuse, emotional and verbal, and parental separation are more frequent in BPD sufferers and also DID and BPD are often comorbid.
 - Other explanations are Object Relations Theory and Diathesis Stress Theory.

AETIOLOGY OF BORDERLINE PD

- Causes tend to be genetic, particularly for personality factors such as neuroticism and impulsivity.
- It is also proposed that patients suffer from negative consequences of parental loss, neglect and/or mistreatment.
- These findings are mirrored in results from studies with monkeys of varying species.
- Evidence also points to general widespread problems with parents (Pally 2002).
- Longitudinal research from Johnson et al. (1999) taken from the NY Registry for child abuse found those individuals four times more likely to suffer with this type of PD. Strongest connections were between APD and physical abuse, BPD and sexual abuse and finally neglect with APD, BPD, NPD and APD.
- However, of those diagnosed with BPD, 20% have never experienced abuse or neglect (Graybar & Boutilier, 2002).

HISTRIONIC PERSONALITY DISORDER

A pattern of excessive emotionality and attention seeking.

- Overly dramatic and attention seeking behaviour by actions and their dress. Whilst being seen as intense in their emotions they are usually emotionally shallow.
- They are self centred and overly concerned with their physical attractiveness and have to be the centre of attention.
- They can be overly seductive and inappropriately provocative and are easily influenced by others.
- The aetiology suggests a psychodynamic influence, a family that encourages seductiveness, or alternatively a family that talks as if sex is dirty but acts as if it is exciting, leading to a pre occupation with sex.

AETIOLOGY OF HISTRIONIC PD

- Relatively little research into histrionic personality disorder and the poor construct validity may well mean that it becomes excluded from future editions of DSM (Bakkevig & Karterud, 2010).
- Theories have tended to be psychodynamic based understandings of hysteria in general, which view the dramatic displays of attention seeking as manifestations of underlying conflicts related to acceptance by members of the opposite sex.
- Psychodynamic explanations focus on parental acceptance and approval, inconsistent parental attitudes to sex and an inappropriate flirtatious relationship between father and daughter resulting from a cold or uncaring mother (Phillips & Gunderson, 1994).
- Psychodynamic accounts focus mainly on female sufferers, despite the evidence suggesting equal diagnosis in both men and women (Mattia & Zimmerman, 2001).

NARCISSISTIC PERSONALITY DISORDER

A pattern of grandiosity, need for admiration and lack of empathy.

- A grandiose view of themselves and fantasise of their great success. (John).
- They are totally self centred and require constant excessive admiration.
- They are arrogant, lack empathy and extremely envious.
- They are also extremely sensitive to criticism and become enraged if others do not admire them.
- They usually seek high status who they idealize, but when the partners fall short they become increasingly angry.
- The aetiology suggests two successful explanatory theories:
 - The Self Psychology Model (Kohut, 1977) NPD masks a fragile self esteem arising from cold parenting and a sense of shame for their shortcomings.
 - The Social Cognitive Model (Morf & Rhodewalt, 2001) again a fragile self esteem; this one is worth a look!

AETIOLOGY OF NARCISSISTIC PD

- Pervasive patterns of grandiosity.
- Need for adoration.
- Preoccupation for success, beauty etc.
- South et al. (2012) demonstrates support for twin studies and a genetic element, but what precisely is inherited is yet unknown.
- Therefore most explanatory models have been based upon psychodynamic or social learning theory.
- Horton (2011) proposes it develops due to an excessive idealisation by parents, which is incorporated into the child's self image.

ANTISOCIAL PERSONALITY DISORDER

- There is debate regarding whether this is Psychopathy or whether they are two separate disorders, in DSMIV-TR, APD is included but Psychopathy is not!
- <http://www.youtube.com/watch?v=WaAPIGnAXsQ>

A pattern of disregard for, and violation of, the rights of others.

ANTISOCIAL PERSONALITY DISORDER & PSYCHOPATHY

- The two terms are often used interchangeably, however whilst law breaking is present in both, only ASPD is present in DSMIV-TR, Psychopathy is not. Continued debate over whether they can be considered the same or different.
- This is reflected in section 3 of DSM5, and the additional PD diagnostic section, which considers specific traits (more on this on the forensic lectures).
- The clinical characteristics of APD: a pervasive pattern of disregard for others since the age of 15, and a conduct disorder must be present before the age of 15.
- More common in low SES and culture is definitely a factor. Seems to mature out as is more prevalent in the younger population.

CLINICAL CHARACTERISTICS OF PSYCHOPATHY

- Cleckley (1976) refers to thoughts and feelings as opposed to behaviours in the sense that they appear to have 'a poverty of emotion'.
- They do not feel shame their feelings are an act, they are charming to manipulate, lack remorse and are irresponsible and cruel.
- They are assessed by a PC-R or similar measures. Some items on these overlap with APD, but there are still differences.
- Some criteria differ greatly and the criteria for Psychopathy is broader than for APD.

AETIOLOGY OF BOTH:

- **Genetic:**

- Adoption studies show that higher rates of APD in adopted individuals from biological parents with APD and substance abuse.
- There appears to be a genetic risk for APD, Psychopathology, conduct disorder and substance abuse: is this a vulnerability? (Larson et al., 2007).
- However, genetics, biology, behaviour and family factors are hard to separate.
- In Forensic Psychology, we will look at the aetiology for psychopathy in more detail; for today we will just take a snapshot view.

SOCIAL FACTORS:

- E.g. Family, poverty and environment are the three primary agents of socialisation:

Family:

- High negativity, low warmth, parental inconsistency can predict APD.
- Especially important if child has genetic predisposition.
- Poverty and violence also predict APD even if no genetic predisposition.
- For example, children with conduct disorder and poverty are twice as likely to develop APD compared to those of a higher SES.

EMOTION AND PSYCHOPATHY

- According to Cleckley, Psychopaths do not learn from experience and are often chronic law breakers despite jail. They cannot seem to curb their impulses and appear to have no conscience.
- Lykken (1957) argues that they have few inhibitions due to low levels of anxiety. Studies of the ANS support this, along with low levels of skin conductivity reaction studies.
- Lorber (2004) proposes that skin conductivity to aversive stimuli at age 3 can predict psychopathy at age 28. they fail to classically condition.
- Is it because perhaps, that empathy is missing, they cannot respond or recognise the feeling of others?

RESPONSE MODULATION, IMPULSIVITY AND PSYCHOPATHY

- Psychopaths are impulsive, pursuing rewards without considering the threats. The prefrontal cortex is implicated in these tasks and typically psychopaths have shown to have less grey matter in this region.
- They demonstrate impulsivity when performing tasks that test their modifying responses; they do not learn.
- However when a 5 second delay is presented before asking for a response, they seem to use the opportunity to reflect on feedback and can modify their behaviour.

ANXIOUS/FEARFUL CLUSTER C

- Anxious and fearful behaviour, which is a stable feature of their behaviour from childhood.
- There does not appear to have been a specific trigger for this anxiety.
- These PD's are often co-morbid with anxiety disorders, where triggers can be identified, but the ways of dealing with anxiety is ingrained in their coping strategies to many life's threats.
- The disorders are:
 - Avoidant PD
 - Dependent PD
 - Obsessive Compulsive PD

AVOIDANT PD

A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

- Intense fear of criticism rejection and disapproval resulting in avoidance of jobs relationships to avoid negative feedback.
- In social situations avoid talking for fear of being foolish or anxious etc.
- They feel inferior to others, do not take risks or try new activities.
- 80% have comorbid depression (Matthew) and sometimes alcohol abuse.
- There is a high comorbidity rate with social phobias.

DEPENDENT PD:

A pattern of submissive and clinging behaviour related to an excessive need to be taken care of.

- An over reliance on others, a lack of self confidence and a need to be taken care of.
- They do not like to be alone and subordinate their own needs to ensure that their relationships do not break up. If they do, they urgently seek another, turning to others for support and decision making.
- The prevalence of DPD is higher in Japan and India as opposed to the US, possibly due to societal and cultural factors.
- DPD is often comorbid with anxiety disorders and bulimia. E.g. Magda.

DEPENDENT PD

- Insecure attachment is central to this via either a clingy parent or a parent continually infantilising of the child where separation should be natural.
- This leads to the belief that self worth is dependent on their importance to another person.
- Usually results in problems throughout life such as depression, anxiety and self esteem issues.
- Whilst there are no validated treatments as yet, CBT and group therapy are promising (Leahy & McGinn 2012).

OBSESSIVE COMPULSIVE PD

A pattern of preoccupation with orderliness, perfectionism, and control.

- A perfectionist, preoccupied with details rules and schedules.
- They often pay so much attention to detail that they fail to finish projects.
- Work oriented rather than pleasure oriented, personal relationships are difficult as everything has to be done their way a 'control freak.'
- They are serious, formal, inflexible, frugal and unlikely to discard even the most useless objects.
- It is not the same as OCD, which has the sufferer COMPELLED to act on their OBSESSION. The comorbidity is very low between them.
- The comorbidity for avoidant personality disorder is most common.
- Aetiology is mixed from Freud, early childhood experiences, authoritarian parenting or problems in the attachment process.

OTHER TYPES:

Personality change due to another medical condition:

is a persistent personality disturbance that is judged to be due to the direct physiological effects of a medical condition (e.g., frontal lobe lesion).

OTHER TYPES:

- **Other specified personality disorder and unspecified personality disorder is a category provided for two situations:**
- 1) the individual's personality pattern meets the general criteria for a personality disorder, and traits of several different personality disorders are present, but the criteria for any specific personality disorder are not met; or
- 2) the individual's personality pattern meets the general criteria for a personality disorder, but the individual is considered to have a personality disorder that is not included in the DSM-5 classification (e.g., passive-aggressive personality disorder).

PERSONALITY DISORDERS: TREATMENT

- People with PD's usually come for treatment due to another disorder, for example substance abuse.
- Why? Because they are more seriously disturbed and require intensive treatment.
- Medication is used, usually determined by the main disorder.
- Treatment for serious conditions, often psychotherapy on a group or individual basis for several hours per day and can be interspaced with social and occupational therapy.

AETIOLOGIES AND TREATMENTS: SUMMARY

- There is no overarching aetiology or treatment pathway, simply because each cluster varies so much from one another.
- One characteristic common to all PD's is that they are enduring and emerge in early childhood, which suggests a developmental or heritable component.
- However, the fact that 75% of individuals diagnosed with one form of PD do not meet the criteria some 15 years later suggests that they can remit or at least respond to some form of treatment (Zanarini et al., 2006).

CBT

- Beck evaluated PD's in terms of negative cognitions, beliefs to explain patterns of symptoms, whilst also looking for dysfunctional schema which underlie thoughts. These should then be challenged.
- Often, the traits are so ingrained that the therapist must find a way to create an ADAPTIVE way of dealing with life.

TREATING PARANOID PD

- From a CBT perspective, establishing trust is paramount. The clients feelings of self efficacy should be increased so they feel able to handle situations without having to become defensive.
- Due to the distrustful nature of the PD, therapists must ensure that the client feels that therapy is collaborative and direct confrontation will not work.
- Other beneficial interventions involve increasing the clients assertiveness to deal with conflict.

TREATING SCHIZOID PD

- Treatment is extremely difficult because they do not have normal patterns of responsiveness for human communication.
- Unrealistic high goals should not be set as progress will be excruciatingly slow and limited.
- The most encouraging approach to date is centred on focusing on their styles of communication via role-play for example.

SCHIZOTYPAL PERSONALITY DISORDER

- Treatment is much the same as for Schizophrenia, the use of neuroleptic antipsychotic medications to stabilise the distortions of reality before trying to actually confront them.
- This is because most of the research is focused on the genes responsible for schizophrenia and the associated increased risk of this personality disorder in relatives of sufferers.
- A big problem is the lack of insight into their own behaviour. If referred for treatment often terminate it prematurely as a result.
- In fact referral often comes via an alternative diagnosis e.g. depression.
- These individuals do not respond to insight orientated therapy (Gabbard, 2000).

TREATMENT OF BORDERLINE PD

- Therapists face a number of problems when treating BPD. Clients often appear more healthy than they are.
- Consequently they focus on an apparently simple problem only to find that the problem is in fact very complex.
- Due to their volatility, inconsistency and intensity they have difficulty staying in therapy long enough to make progress.
- They also become pathologically dependent on their therapist.

TREATMENT: BPD

- They may feel enraged when the therapist fails to live up to expectations and therapists have to be watchful of their own emotional reactions and keep the client grounded.
- It is crucial that a clear treatment framework is established clarifying goals and the roles of therapist and client.
- Explicit goals such as relationship improvements are set and the client is expected to discuss inner thoughts, problems in functioning and anticipated behaviour, whilst the therapist provides understanding consistency and empathetic feedback.

TREATMENT: BPD

- One main challenge is to determine the extent of support and confrontation they need.
- In therapy, they may often make derogatory remarks regarding the therapist, where the therapist should use these as opportunities to show inappropriateness and destructiveness of misdirected anger.
- This approach is based on the assumption of poor parenting and that the therapist can provide a positive parental role.
- The most successful approach seems to come from Linehan: DBT, Dialectical Behavioural Therapy, involving CBT and support to reduce self destructive acts and improve the handling of emotions.

DBT: LINEHAN, 1990 ONWARDS

- It combines behavioural strategies and supportive psychotherapy.
- The 'dialectic' places opposite ideas side by side to help individual balance the conflicting needs of 'acceptance' and 'change' to regulate emotions.
- The emphasis is being comfortable with strong emotions, accepting good and bad in self and others. Thus the therapist has also to be accepting.
- Much supporting research-

SUPPORTING RESEARCH

- From a multitude of studies by Linehan...
- Pp's randomly assigned to either DBT or usual treatment available. Dropout rates were 17% compared to 60% respectively.
- Less suicide attempts, fewer hospitalisations and higher ratings on social adjustment.
- However, no difference on depression and hopelessness.
- More recently, Bohus et al. (2004) found improvements on both depression and hopelessness.
- Drugs (non specific) are also given due to the hypersensitivity and self critical perspective. (Also same for NPD).

TREATING APD & PSYCHOPATHY

- People with APD do not change easily and are unlikely to seek help as they do not see a problem with their behaviour.
- Treatment is often sought because of unwanted intervention.
- Therapists often have problems knowing if the client is honest or not and optimism is discouraged!
- These individuals change their behaviour only when they realise their behaviour is wrong, therefore the aim of treatment is to make them feel worse about themselves.

TREATMENT FOR NPD

- The psychodynamic approach is based on the idea that they lack early experiences of admiration for their positive qualities.
- Therapy should provide a corrective developmental experience with empathy to support search for recognition whilst acknowledging that no one is perfect.
- The more support they have, the less grandiose they become.
- CBT is also used, to reduce grandiose ideas and increasing the ability to relate to others working WITH the clients grandiose tendencies.

TREATING HPD

- Drugs are usually used although there are few RCT's which have fully explored the efficacy of these in enough depth.
- The little evidence that is available suggests that results are equivocal and often arise from poorly controlled studies and on small numbers of participants.
- Typically antipsychotic medications are prescribed for cluster A, antidepressants for cluster C and for cluster B the use of lithium, beta blockers, antipsychotics and SSRI's have been given (Olabi & Hall, 2010).
- As with other disorders, CBT and psychotherapy have also been used, with mixed results.

TREATING AVOIDANT PD

- CBT is used to break the negative cycle of avoidance, whereby the client learns to voice the automatic thoughts and dysfunctional attitudes which are responsible for their irrational beliefs.
- This must be done in a supportive environment once a trusting relationship is established.
- Therapists must be very patient to build a relationship as without trust prognosis is extremely poor.

TREATING DEPENDENT PD

- A cognitive view assumes that under assertiveness and anxiety regarding decision making are the cause of this disorder.
- They believe they are inadequate and helpless and need someone to make them for them or take care of them.
- This PD can be treated more optimistically than the others as these individuals are motivated to change, therefore whether CBT or Psychotherapy practising levels of independence are encouraged, identifying skill deficits and acquiring the ability to deal with them.
- On a cautionary note, Therapists should never assume an authority role: this would be counter productive.

TREATING OBSESSIVE COMPULSIVE PD

- CBT can be difficult due to the key features of this disorder. They tend to intellectualise, go over things constantly in case they make the same mistakes.
- CBT's use of thought examination may make this process worse.
- Therefore, therapists tend to use more traditional behavioural techniques such as thought stopping where the client is encouraged to reduce the amount of time spent in rumination.

TREATMENTS IN GENERAL: SUMMARY

- Length of treatment programmes vary but usually last several months.
- They can vary in their treatments but usually are either psychodynamic, supportive or cognitive approaches.
- Early findings suggest that both day treatments and outpatient treatments are successful, leading to improvements in symptoms and social functioning.
- A review of 15 studies suggest that 52% of clients recovered within 15 months.
- Psychodynamic approaches aim to alter the view of childhood and that this does not have to be carried into adulthood and that it is okay for people to make mistakes. Many PD's are treated via the psychodynamic approach.
- CBT breaks down the PD into a separate set of problems which can be dealt with individually.
- Social skills training has also been found to be successful.