# Chapter 11
# Personality disorders

## LEARNING OBJECTIVES

After reading and studying this chapter and participating in lectures and discussions, students should have an understanding of:

1. The diagnostic criteria for a range of disorders within the DSM type A, B, and C clusters.
2. More detailed consideration of the nature, aetiology, and treatment of:
    a. Borderline personality.
    b. Antisocial personality disorder and psychopathy.

## CHAPTER OUTLINE

11.1 Introduction
- A dimensional approach
- A cognitive model of personality disorders

11.2 Cluster A diagnoses: paranoid, schizoid, and schizotypal

11.3 Cluster B diagnoses
- Borderline personality disorder
    - Biological factors
    - Psychological processes
- Treatment of borderline personality disorder
    - Psychological approaches
    - Pharmacological treatment
- Antisocial personality disorder and psychopathy
- Aetiology of antisocial personality and psychopathy
    - The neurobiology of APD
    - Neurological mechanisms in psychopathy
    - Socio-cultural factors
    - Cognitive models

Treatment of antisocial behaviour

Psychological interventions

Pharmacological interventions

Treatment of psychopathy

Psychoanalysis

Therapeutic communities

Cognitive interventions

11.4 Cluster C diagnoses: avoidant, dependent, and obsessive personalities

**QUESTIONS FOR DISCUSSION**

These may helpful to include at the beginning of the teaching session to get a sense of where people lie on these issues, to spark some interest in them, and as a link to refer to as the lecture progresses.

1. Which of the following does not form a component of the dimensional model of antisocial personality disorder?

a. High neuroticism
b. Low extraversion
c. Low openness
d. Low agreeableness
e. Low conscientiousness

2. Which of the following has proven the most effective treatment for borderline personality disorder?

a. Dialectical Behaviour Therapy
b. Enhanced psychoanalysis
c. Harm-reduction focused cognitive behaviour therapy
d. Schema-focused therapy

3 The key neurological characteristics of psychopathy are:

a. Low activation of the limbic system and high activation of the frontal lobes
b. High levels of activation within the amygdala and pre-frontal lob
c. High activation of the temporo-parietal system
d. High limbic and hippocampal activity

4. The overall effectiveness of psychological interventions to reduce psychopathy are:

a. More effective than no treatment
b. More effective than a number of placebo treatments

c. Less effective than no treatment
d. More effective than pharmacological interventions

## LECTURE SUGGESTIONS

This chapter covers a range of personality disorders, but two are most likely to come to the attention of either the legal or the mental health systems, and these are the main focus of the chapter and lecture: borderline personality disorder and antisocial personality disorder/psychopathy.

### *Borderline Personality Disorder*

BPD is characterized by a number of processes, the most important of which are significant difficulties in managing strong emotions and attachment issues within relationships. As a consequence, the individual with these characteristics typically enters into relationships in which they rapidly become excessively demanding of the other person's time and attention. This quickly becomes claustrophobic to them, and eventually results in the ending of the relationship, often in a rather dramatic way. The resultant emotional turmoil is extreme and difficult to cope with and can trigger extreme coping strategies. This may include self-harm that can trigger a dissociative state to remove the person from their distress.

Within 'clinical memory' (e.g., my memory while working as a clinical psychologist), BPD was seen as a chronic, untreatable, and untreated condition. Now, there are a number of effective treatments, of which the most successful is dialectical behaviour therapy, a 3rd wave intervention focusing on learning to manage relationships, extreme mood states, and reduce self-harm. It has a high success rate but is intensive and lengthy, so is limited in the UK to specialist units.

### *Psychopathy and Antisocial Behaviour Disorder*

It is interesting that virtually all clinical studies use either the DSM or the World Health Organisation equivalent (ICD) classification system to describe the people involved. The one exception to this convention appears to be the use of the DSM diagnosis of antisocial behaviour disorder (ASD). There is a widely accepted delineation between the ASD and psychopathy (based on presentation and neurological underpinning), which is not yet reflected in DSM, although this was considered and rejected when developing the latest version. So, studies of psychopathy tend to use the Hare definition and not the ASD definition of DSM. Reflecting this distinction, most interventions for ASD tend to be with younger people, and these achieve good success rates. By contrast, interventions in psychopathy tend to be in adults and are often unsuccessful. In respect to the latter issue, it is perhaps noteworthy that Wong and Hare, who really do have expertise in this condition, developed an intervention they believed would be successful in treating psychopathy, but my annual search for the outcome of any randomized controlled trial testing this approach consistently fails to find a successful outcome of their therapeutic passage.

## CLASSROOM ACTIVITIES

**Small group discussion**: it is often said that the key to a positive therapeutic outcome in borderline personality disorder is the 'fit' between the individual receiving therapy and the therapist. Indeed, more broadly, it is possible to argue that they key to being a successful therapist is not 'what you do' but 'who you are'. So, what therapist characteristics are likely to be most effective in treating people diagnosed with BPD, and in more general settings?

**Small group discussion**: not all psychopaths are 'evil'. Indeed, if one takes a one-dimensional view of psychopaths, a degree of psychopathy may be positively beneficial and lead to highly successful lives. But what about the criminal psychopath? They may be 'untreatable' and unresponsive to therapeutic interventions because they do not have the neurological architecture to allow such responsiveness. So, like people with the rather sexily (and inappropriately) described 'warrior gene' that increases risk for high levels of anger that is difficult to control, it is possible to construct an argument that they are not 'responsible' for any crimes they commit, because the do not have the ability to fully understand or change their behaviour. Or is this a load of bunkum? Are they clearly responsible, meaning the judiciary system should treat them as such?