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Introduction

Personality disorders have been subject to much discussion and curiosity in the field of mental health over the years. Often referred to by many clinicians as difficult patients, people who present with a personality disorder are diagnosed because of a lifetime with a lack of flexibility in their personality. Behavioral change is often required because personality change may not occur and certainly will not occur easily.

Originally identified in the 18th century, it was noticed that there was a subset of people in the population who presented with “a lack of impulse control, raged when frustrated, and were prone to outbursts of violence. Such patients were not subject to delusions'' (Vaknin, 2020). Eventually, it was noted that these symptoms were not related to “gloom or sorry but the predominate feature”.

Much of the early work in personality disorders was focused on narcissism and psychopathy because of the aggressiveness of these behaviors and the tendency for those afflicted to commit violent crime (Vaknin, 2020). However, today there are 10 personality disorders identified across three clusters: Cluster A, B, and C. The disorders are clustered together based on their similarities in their presentation.

This course will review the clusters, the specific diagnoses, and treatment options for individuals who present with a personality disorder.

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Section 1: What is a personality disorder?

A personality disorder is diagnosed when a patient presents with traits that are prominent, rigid, and maladaptive (Skodol, 2019). These diagnoses impact peoples’ ability to function independently in most aspects of their lives: employment, relationships, health, environment, etc. The symptoms that the individuals present with can be very distressing for those people in their lives because of the dramatic, dangerous, or obsessive behaviors that they might experience.

What are the symptoms of a personality disorder?

Symptoms of personality disorders will often present in adolescence and early adulthood but often the signs go as far back as infancy and childhood. For example, such children might be commonly referred to by their parents as “over the top” or “needing a lot of support” when compared to other children. Some people might find that these symptoms are reduced naturally over time and others might not. Most people will

require intensive mental health supports to function independently and effectively with a diagnosis of a personality disorder.

What are the different clusters of personality disorders?

Currently, the Diagnostic and Statistical Manual 5 identifies 10 types of personality disorders among the three clusters. They are as follows:

Cluster A personality disorders:

Paranoid, Schizoid, and Schizotypal personality disorders

Cluster B personality disorders:

Antisocial, Borderline, Histrionic, and Narcissistic personality disorders

Cluster C personality disorders:

Avoidant, Dependent, and Obsessive-compulsive personality disorders

Basic statistics about personality disorders identify the following:

- 10% of the population may qualify for a diagnosis of a personality disorder
- Up to half of all patients in a psychiatric hospital may quality for a personality disorder
- Men outnumber women with Antisocial personality disorder 6:1
- Women outnumber men with Borderline personality disorder 3:1

Section 1: Summary

Personality disorders are characterized by a lifelong experience with rigid and inflexible personality traits. These traits are problematic for functioning and require treatment for patients to be as healthy and appropriate as possible. There are 10 disorders across three different clusters: A, B, and C.

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Section 2: Cluster A Personality disorders

What do patients with Cluster A personality disorders present like?

Patients who qualify for a Cluster A personality disorder diagnosis are often referred to as odd or eccentric. They might behave in a way that isn't aggressive or illegal but is not necessarily "normal" or consistent with the behavior of the general population. These people will be noticed by others because of these odd traits.

There are three disorders in Cluster A: paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder. Paranoid personality disorder is characterized by distrust or suspicion of others. Schizoid personality disorder is characterized by a complete disinterest in other people. Finally, schizotypal personality disorder is characterized by ideas and behavior that appear eccentric (Skodol, 2019). More information about these disorders and their symptoms, diagnosis, and treatment are below.

What are the three personality disorders in Cluster A and how are they treated?

Paranoid personality disorder

Patients with this diagnosis are simply put, paranoid (Vyas & Khan, 2016). Their behavior may present as being aloof, cold, or distant (Porter, 2020). They may be guarded, secretive, hostile, hyper-rational, and complain frequently. Because of this, they might have a difficult time getting along with their peers and family members. This might originally be recognized as a mood disorder or depression but because of the predominant nature should be acknowledged as a personality disorder as these symptoms will endure. Symptoms will become apparent in childhood and often these children will be subjected to bullying and rejection by their peers. This could make the child even more paranoid and learn to not trust others, reinforcing the internal experience.

A family history of delusional behavior and schizophrenia are risk-factors for paranoid personality disorder. This diagnosis is often given comorbid to other personality disorders, substance use disorders, mood disorders, and obsessive-compulsive disorders (Porter, 2020).

These patients are unlikely to seek treatment and support because of the paranoia (Vyas & Khan, 2016). Treatment becomes difficult because it is often pushed by family or

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friends and not the patient initially. There are currently no pharmacological medications for this diagnosis and few studies are researching the best treatment options.

To qualify for a diagnosis of paranoid personality disorder, a person must present with the following per the DSM-5:

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

    1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving them
    2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
    3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against them
    4. Reads hidden meaning or threatening meanings into benign remarks or events
    5. Persistently bears grudges and cannot forgive others
    6. Perceives attacks on their character or reputation that are not apparent to others and is quick to react angrily or to counterattack
    7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during schizophrenia, a bipolar disorder or a depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition

The treatment recommended for paranoid personality disorder is currently behavioral therapy. The goals of therapy will often include learning to work well with others and shift perceptions from paranoia because of external stimuli to paranoia because of internal stimuli. These patients must be able to understand that their mental health is what is causing the paranoia rather than the behavior of those around them (Vyas & Khan, 2016).

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Schizoid personality disorder

Individuals with schizoid personality disorder appear to be uninterested in close connections and relationships with others (Skodol, 2019). They might often be referred to as “loners” because they appear to not be interested in what others think about them. They might not notice social cues or prompts and are often thought of as aloof or self-absorbed. They are slow to react with emotion if they react emotionally to a situation at all. They struggle to appear angry even in situations where anger is warranted. They might appear to lack direction or drive in life.

Symptoms of schizoid personality disorder remain stable and predictable over time. This is truly more of this personality disorder than others.

Based on the DSM-5, four of the following must be present:

1. No desire or interest in close relationships, including with family members
2. Strong preference for independent activities
3. Little interest in sexual activity with others
4. Little pleasure derived from activities
5. Lack of close friends or confidants
6. Indifference to praise or criticism
7. Emotional coldness, detachment, or flat affect

These symptoms will have begun in early childhood showing a detachment and lack of interest in relationships and an absence of expression of emotions. This diagnosis must be differentiated from schizophrenia, autism spectrum disorders, schizotypal personality disorders, and avoidant personality disorder (Skodol, 2019).

Treatment for schizoid personality disorder consists of behavioral therapies (Psychology Today, 2020). Medication does not appear to be helpful or recommended for the long-term, however, if patients present with anxiety associated with the disorder they may receive medication for this. Cognitive-behavioral therapy should focus on simple goals to alleviate stress in the patient’s life and to identify more effective and clear thought patterns that allow for better functioning and reduce negative behaviors (Psychology Today, 2020).

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Schizotypal personality disorders

Individuals who have schizotypal personality disorder also are unlikely to have close friends or peers although they may be somewhat close with family members (Skoland, 2019). They may feel as though they do not belong and are different from those around them. They will be extremely anxious in situations where they are around others and even more so in situations that feel unfamiliar. Additional time to "become comfortable" does not help this person. They will not experience less anxiety with simply time or exposure like many people without a personality disorder may be able to do.

People with this disorder may struggle to interpret social cues. They may think that something is important or has meaning when it is simply ordinary. These individuals might also believe that they have special powers or may perform rituals that make others uncomfortable. Their speech may be different than others and perceived as odd in that they may be very abstract in their use of language. They may use strange phrases or words. They may also lack appropriate understanding or desire for hygiene and dressing. They may appear unkempt or dirty. They may also display paranoid thoughts and traits.

The following must be met for a formal diagnosis to be given per the DSM-5:

Five or more of the following must be true:

1. Patients will have ideas of reference (notions that everyday occurrences have special meaning or significance personally intended for or directed to themselves) but not delusions of reference (similar but have great conviction)
2. Odd beliefs or magical thinking
3. Unusual perceptional experiences
4. Odd thought and speech
5. Suspicious or paranoid thoughts
6. Incongruous or limited affect
7. Odd, eccentric, or peculiar behavior and/or appearance
8. Lack of close friends or confidants, except for relatives
9. Excessive social anxiety that does not lessen with familiarity and is related to paranoid fears

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These patterns of intense discomfort for connection and cognitive distortions will have presented by early adulthood and other thought disorders must be ruled out to give this diagnosis. Patients with schizotypal personality disorder are likely to have had at least one episode of major depressive disorder and often this is when the patient will also receive their personality disorder diagnosis. Many patients also present with substance use issues. It is likely because they would like to avoid the difficult symptoms of anxiety through alcohol or drug use.

Treatment for schizotypal personality disorder is generally a combination of medication management and psychotherapy. Patients will often receive an antipsychotic medication to reduce the psychotic-like symptoms. They might also take an antidepressant to reduce depressive and anxiety symptoms. Finally, cognitive-behavioral and other therapies are often utilized to improve social skills and awareness so that patients can interact with others more effectively and reduce the anxiety that they feel in social situations (Skoland, 2019).

Section 2: Summary

Disorders in Cluster A present as odd and eccentric in patients. They are difficult to treat because these individuals are generally uninterested in forming relationships with others, including therapists. They also struggle to trust others and might believe that they do not need to change. Cognitive-behavioral therapy is most often effective for teaching patients skills for more productive living.

Section 3: Cluster B personality disorders

What do patients with Cluster B personality disorders present like?

Individuals with personality disorders in this cluster are often referred to as dramatic, emotional, or erratic (Young, Habarth, Bonger, & Packman, 2018). Patients with cluster B personality disorders are often not the initiators of seeking treatment. Many are court mandated or required because of criminal offenses they have committed.

There are four personality disorders in this cluster: antisocial personality disorder, borderline personality disorder, narcissistic personality disorder, and histrionic personality disorder. antisocial personality disorder is characterized by a lack of empathy and a sense of responsibility. Borderline personality disorder is characterized by intense mood dysregulation and volatile relationships. Narcissistic personality disorder is

characterized by grandiosity and an entitled sense of self. Histrionic personality disorder is characterized by shallow displays of emotion and dramatic behavior.

More information about these disorders and their symptoms, diagnosis, and treatment are below.

What are the three personality disorders in Cluster A and how are they treated?

Antisocial personality disorder

Individuals with antisocial personality disorder are generally people who lack empathy and remorse. They may commit reckless and impulsive acts to please themselves or make money (Skodol, 2019). Patients with this diagnosis can rationalize their behavior, even if it does not make sense to others. For example, they might believe someone else deserves to lose or get hurt. They might blame their victims or be indifferent towards their victims.

Research shows that most patients with antisocial personality disorder also have a substance use disorder. Additionally, many experience attention-deficit/hyperactivity disorder. 0.2%-3.3% of the population may qualify for this diagnosis. It is very rare but more common in men than women by 6:1.

It appears that genetics and childhood experience impact the likelihood of developing this disorder. Childhood abuse can cause development. It is also more likely for people with parents with the disorder. Conduct disorder in childhood can also be a warning sign for the disorder as an adult.

Three of the following must be present to qualify for a diagnosis:

1. Disregarding the law, indicated by repeatedly committing arrest-qualifying acts of crime
2. Being deceitful – lying, using aliases, conning others, etc.
3. Acting impulsively
4. Being easily provoked by others and becoming aggressive – getting into physical fights and assaulting others
5. Recklessly disregarding the safety of others

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6. Being financially reckless – quitting a job with no plans or not paying bills
7. Not feeling remorseful when hurting someone or mistreating someone else

To diagnose someone with antisocial personality disorder, professionals must first rule out the following: substance use issues, conduct disorder, narcissistic personality disorder, and borderline personality disorder.

Antisocial personality disorder, and many of the cluster B personality disorders, are highly stigmatized because of the difficult nature of trying to treat these individuals. Many clinicians state they may have to work harder to support individuals with cluster B tendencies than their other patients. Supporting individuals with this disorder is especially difficult because the patients will tend to believe they are correct and the clinicians they are working with are wrong.

Treatment for antisocial personality disorder will generally be determined by the person's circumstances (Harvard Health Publishing, 2019). People who are involved in legal issues may be mandated to participate in treatment. Younger people who have family oversight might be taught skills that are reinforced in their family unit. Therapy can teach people to reframe their way of thinking to be more socially acceptable and productive. Often a reward and punishment system is helpful to promote positive and law-abiding activities. Change is unlikely to occur, as found by research if a person has severe antisocial traits (Harvard Health Publishing, 2019).

There is some evidence that suggests that democratic therapeutic community treatment is an effective treatment method (Pearce, Scott, Attwood, Saunders, Dead, Ridder, Galea, Konstantinidou, & Crawford, 2016). Democratic therapeutic communities (DTC) utilize a community-based approach to treatment. They focus on reducing institutionalization so that clinicians and staff are empowering patients to take responsibility for their behavior, share in decision making that occurs, and participate in a community. This may be a new experience for many people with this condition who prefer to spend time alone. This kind of integration into socialized norms can help promote law-abiding and integrated behavior. The core elements of this treatment program are as follows:

1. **Democratization -** making decisions as a group when required through the use of voting or other democratic processes. Staff leads patients through the group decision making process. The decisions they make generally relate to the group therapy process and how it runs. This teaches patients about responsible decision making and understanding the impact of decision making

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2. **Permissive behavior -** behavior that patients present with is generally tolerated and understood rather than being forbidden. Responsibility is a core belief of the treatment program, therefore behavior is analyzed from the perspective of impact. People are not blamed or shamed but rather asked to understand that how they behave directly impacts the health of those around them

3. **Reality confrontation -** because behavior is analyzed from an impact perspective, this allows both patients and staff to hold others accountable for the impact of their behavior. To do so, patients have to be present with reality. They have to learn to watch, notice, and name feelings. Patients can challenge staff and one another based on behavior and impact. They are encouraged to do so in a way that is kind and considerate and not shaming

4. **Communalism -** patients in DTC programs are required to share space. They attend meals together, complete basic living tasks together, and attend pleasurable activities together (based on rules of the program). During this time patients are encouraged to be their inherent selves and practice authentic behavior

5. **Enquiry culture -** It is important in DTC programs that staff and patients honor the questioning of others. Attempting to understand the process shows that patients are actively engaged in treatment. Therefore, they are encouraged to ask 'why', 'how', and 'when' questions of patients and staff members

6. **Milieu environment -** the community atmosphere in a DTC program is therapeutic and should be consistent with the process and programs put in place (Pearce, et al., 2016)

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Borderline personality disorder

Perhaps the most stigmatized mental illnesses, borderline personality disorder is characterized by intense mood swings and feelings of perceived abandonment and rejection. Patients with borderline personality disorder will go out of their way to avoid abandonment and often be manipulative towards others as an unintended consequence.

Patients with Borderline must meet at least five of the following symptoms to qualify for a diagnosis:

1. Desperate efforts to avoid abandonment (actual or imagined)

2. Unstable, intense relationships that alternate between idealizing and devaluing the other person
3. An unstable self-image or sense of self
4. Impulsivity in two or more of the following areas: unsafe sex, binge eating, reckless driving or spending
5. Repeated suicidal behavior, gestures, threats, or self-mutilation
6. Rapid changes in mood, lasting usually only a few hours and rarely more than a few days
7. Persistent feelings of emptiness
8. Inappropriate and intense anger and problems controlling anger
9. Temporary, paranoid thoughts or severe dissociative symptoms triggered by stress

These symptoms must have begun by early adulthood but generally appear during adolescence. Borderline personality disorder is most commonly misdiagnosed as bipolar disorder as a result of the similarities with mood dysregulation. People with borderline personality disorder may commonly also be diagnosed with depression, anxiety, substance use issues, or posttraumatic stress disorder.

Research has found that early childhood stress contributes to the development of symptoms. This is especially true for people with a history of physical and sexual abuse, neglect, and separation from primary caregivers in early childhood. People with a family member with borderline personality disorder are five times more likely to have the disorder than the general population.

Borderline personality disorder is treated with a combination of psychotherapy and medication management. There is no medication to reduce or diminish the symptoms of borderline personality disorder, however many patients take SSRIs (Selective Serotonin Reuptake Inhibitors) to reduce anxiety, depression and help regulate mood. Most people find that these medications simply reduce the severity of symptoms so that patients can learn skills and tools to implement for managing behavior.

The main goal of therapy for these patients is to reduce suicidal ideation, manage mood dysregulation, improve interpersonal effectiveness, and enhance the quality of life. Most patients who are successful with treatment and find effective tools to manage their symptoms do so utilizing Dialectical Behavioral Therapy (DBT), Schema-focused therapy,

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Mentalization-based therapy (MBT), and Systems training for emotional predictability and problem-solving therapy (STEPPS) (Skodol, 2019).

Dialectical Behavioral Therapy

A standard DBT program is quite intensive. Most programs include one weekly individual therapy session, one weekly group therapy session that focuses on skills training and can last up to two hours in length, and a consultation with the therapist team as well as medication management and 24/7 crisis phone support (Reddy & Vijay, 2017). The model takes patients through four stages of treatment:

1. Reducing suicidal ideation; reducing therapy-interfering and quality-of-life interfering behaviors; and improving behavioral skills
2. Treating issues that are related to historical trauma
3. Supporting the development of self-esteem to improve daily skills and reduce depression
4. Development of purpose and higher purpose in life

DBT has been heavily researched over the past few decades and found to be very successful for patients with this condition, however, it is an intensive program and requires a great time commitment. It is often difficult for patients with high impulsivity to stay engaged for long periods (Reddy & Vijay, 2017).

Schema-focused therapy

A schema is a thought or belief that impacts behavior (Salters-Pedneault, 2020). Schema-focused therapy is a type of therapy that works towards identifying and adjusting inappropriate and unhealthy ways of thinking. It especially focuses on the childhood schemas that patients believe around their needs being met inadequately. These thought patterns impact the self-worth and sense of self that patients have toward the world. It impacts their ability to relate to others and their immediate environments. The goal of therapy then is to process and reframe the schemas that patients identified throughout their lives. The following are common schemas that patients with borderline personality disorder experience:

1. **Defensiveness or shame** – patients might think that they are unworthy of love and therefore sabotage relationships because they do not believe they deserve love. They believe that everyone will leave them because they are not loveable

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2. **Emotional deprivation** – patients believe that their needs cannot be met by others and therefore they choose partners who are unable to meet those needs at their baseline. They might be abusive or neglectful or people with their mental health struggles who are unable to show up the way that the patient might require

3. **Isolation** – patients believe that because nobody loves them and they cannot be accepted that they are not supposed to be around the general population. They often isolate themselves as a way of avoiding others and potential abandonment

4. **Enmeshment** – patients often become highly dependent upon other people such as family, friends, and intimate partners. This is often because they believe they cannot be healthy, worthy, successful, or happy without these individuals around them

Schema-therapy believes that there are multiple ways that most people cope with the difficult symptoms of borderline personality disorder:

1. Surrendering to the beliefs to reinforce behavior

2. Avoiding situations that trigger difficult symptoms such as fearful situations or vulnerable situations – this is especially true where interpersonal relationships are concerned

3. Overcompensation – behaving in a way that is extremely opposite to the core belief

Schema-focused therapy has a goal of identifying the negative schemas that individuals hold and linking them as the root cause of maladaptive symptoms. The therapist and patient identify, name, and notice these schemas and correlating symptoms. Then they break down the schemas, identify the purpose or prompting event, and process through them to identify more adaptive schemas and adaptive behaviors. For example, a patient may have to work to believe they are inherently worthy of good things in life instead of abusive or negative situations but they can learn this (Salters-Pedneault, 2020).

Mentalization-based therapy

Mentalization-based therapy focuses on the difference between thoughts and the feelings of those around the individual (Grohol, 2019). Therefore, the goal of the therapy is to enhance the ability to mentalize or understand that behavior is associated with a mental state in others as well. Many people with borderline personality disorder tend to have a decreased ability to do this because they are so focused on their thoughts and

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behaviors and rightfully so. A person with this disorder experiences heightened emotional states that make it difficult to feel, notice, or think about the thoughts that are outside of their own experience.

Mentalization is a skill. It is often thought of in clinical realms as similar to socializing with others or learning to speak publicly. It can be learned and unlearned. The therapeutic experience will focus on learning how to notice the feelings of others and consider them when analyzing their behavior. This skill helps patients to regulate their behavior because it allows them to identify what is real versus what is not realistic and therefore they can assimilate their behavior accordingly. Mentalization is a skill that requires patients to balance their internal thoughts with their external behavior and it is a very important skill to learn (Grohol, 2019).

1.6% of the population has this personality disorder and women are far more likely than men to be diagnosed with it (Salters-Pedneault, 2020). 75% of people diagnosed with borderline personality disorder are women. It is unclear if this is because women experience it more or if women are more likely to see treatment than men are generally. Men may also often be misdiagnosed with another condition such as depression or post-traumatic stress. Additionally, 70% of people with borderline personality disorder will attempt suicide at least once in their lifetime.

Borderline personality disorder can be controlled well with treatment. Ten years after diagnosis, 88% of people will have their symptoms controlled so well they no longer meet the criteria for a diagnosis (Salters-Pedneault, 2020).

Histrionic personality disorder

A histrionic personality disorder is characterized by attention-seeking behavior and a lack of direction or sense of self (Skohol, 2019). These patients struggle to effectively build relationships and may inappropriately act as the center of attention to connect with others. They may feel depressed when not given attention or praise. They are referred to often as dramatic, flirtatious, and lively. They are initially thought of as charming. These individuals might dress inappropriately to impress others, speak dramatically, have strong opinions, and be influenced easily by others.

To be diagnosed, patients must show five or more of the following symptoms:

1. Discomfort when they are not the center of attention
2. Interaction with others that is inappropriately sexual or provocative

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3. Rapidly shifting between shallow expressions of emotions
4. Consistent use of physical appearance to receive attention
5. Dramatic, impressionistic, and vague speech
6. Self-dramatization, theatricality, and extravagant expression of emotion
7. Easily influenced by others
8. Perceive relationships to be more intimate than they are

This disorder is diagnosed in less than 2% of the population and more often in women than in men.

Treatment consists of cognitive-behavioral strategies and medication management to reduce the severity of depression, anxiety, or mood dysregulation that comes with the diagnosis. Therapy generally focuses on teaching skills to reduce interpersonal conflicts. Therapists might work with patients on reducing inappropriate behavior and implementing more effective communication strategies.

Narcissistic personality disorder

Individuals with narcissistic personality disorder struggle with the ability to regulate. This is a common symptom of most personality disorders. They need praise and need to feel higher in value than other people around them. They need to feel superior and be connected to esteemed people and organizations.

Five or more of the following symptoms must be present to give a diagnosis:

1. An exaggerated, unfounded sense of importance and talents
2. A preoccupation with influence, power, and achievement
3. Belief that they are special and unique and should only affiliate with high power individuals
4. A need to be admired
5. A sense of entitlement
6. Exploitation of others to achieve goals
7. A lack of empathy

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8. Envy of others and a belief that others envy them
9. Arrogance

It is important to note that this disorder is often commonly misdiagnosed as bipolar disorder, antisocial personality disorder, and histrionic personality disorder. However, mood changes in this condition are triggered by insults to their self-esteem and not general mood changes. Patients also exploit others for enhancing their self-esteem and not for personal gain. Finally, people with this condition do not want to be cute or silly to get attention. They find this disgusting in most cases and beneath them.

It appears that 6.2% of the population will be diagnosed with narcissistic personality disorder. It is diagnosed more in men than in women. Patients often have comorbidities including depressive disorder, eating disorders, substance use disorders, or another personality disorder such as borderline personality disorder.

Signs that a person may benefit from support for mental health include aggressive outbursts when receiving criticism or during failure. These patients might counterattack if they feel attacked. They may withdraw from others to protect their sense of self. They will easily feel humiliated and defeated. This can lead to depression.

Treatment for narcissistic personality disorder also includes psychotherapy to identify and treat underlying conflicts or issues (Skodol, 2019). However, treatment is often not productive for these patients because unfortunately there are few training programs that focus on supporting patients with narcissistic personality disorder (Greenberg, 2019). Training that would specialize in this is often expensive and time-consuming. Finally, many narcissists avoid therapy or quit when they become uncomfortable.

A psychologist who treated patients with narcissistic personality disorder for 40 years identified these general steps for treatment:

1. **Symptom relief** – most patients enter therapy to experience relief from uncomfortable feelings such as depression or anxiety. They may also attend to please those close to them
2. **Avoid future pain** – many patients might find therapy interesting. They will want to avoid future pain and therefore may often develop a plan to do so.
3. **Coping mechanisms** – patients learn their primary defense patterns in this stage. They often look at their childhood and learn to cope with the difficult parts of it. They generally find this easy

4. **Development of new coping mechanisms** – after identifying past maladaptive strategies, patients and therapists begin to identify more adaptive strategies for coping and meeting needs.
5. **Forming new habits** – Implementing new and more appropriate routines becomes a focus. This reduces the historically inappropriate behavior patterns and implements the more appropriate coping strategies
6. **Impact on other people** – patients are generally able to begin to see the impact of their behavior only after new strategies are in place securely. Forming new habits may give them a sense of pride and therefore reduce the likelihood of feeling shame about the impact of their behavior. Once this has occurred, patients can see the benefit of considering the needs of others.
7. **Focus on childhood pain** – generally by this step, patients are calmer than they have historically been. They have become aware of their triggers and experience some sense of empathy, however small. In this step, they can develop empathy for their childhood self that grew into this adult version of who they are. They begin to see shades of grey.
8. **Inner voice** – patients have to develop empathy for themselves before they can do so for others. Implementing positive self-talk helps them to see the positives in others.
9. **Empathy for others** – patients who can see their pain and their harsh inner voice can then start to see others similarly. They can begin to see that others are not a threat to them and that they can relate to others.
10. **Authentic behavior** – patients begin to be able to be authentic with their therapist and others.

It should be noted that this work is time-consuming and lengthy. This process could take months to years with many bumps on the way but patients can learn more appropriate behavior and have a less elevated sense of self (Greenberg, 2019).

Section 3: Summary

Cluster B personality disorders are the most difficult to treat in many cases. Individuals with these disorders are high-risk for self-harm, suicidal behavior, aggressive behavior, and criminal behavior. Patients with Cluster B personality disorders will require treatment in order to effectively function in their interpersonal relationships. DBT,

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Schema-focused therapy, and Mentalization therapy are common services being provided to patients with Cluster B personality disorders. It is important for therapists supporting these patients to use strong boundary setting skills, and be clear in their communication.

Section 4: Cluster C personality disorders

What do patients with Cluster B personality disorders present like?

Cluster C personality disorders are most often thought of as anxious and afraid disorders (Skodol, 2019). There are three personality disorders in this cluster: avoidant, dependent, and obsessive-compulsive personality disorders. An avoidant personality disorder is characterized by sensitivity. Dependent personality disorder is characterized by dependence on others. Obsessive-compulsive personality disorder is characterized by rigidity and perfectionism.

What are the three personality disorders in Cluster A and how are they treated?

Avoidant personality disorder

Individuals with avoidant personality disorder present with feelings of inadequacy. They feel negative about themselves and therefore struggle to interact with others. People will consistently avoid contact with others because of the fear of rejection or criticism from others. They believe it is coming and so avoid it at all costs.

Four or more of the following symptoms must be met for a diagnosis of avoidant personality disorder to be given:

1. Avoidance of job-related activities that involve interpersonal contact because they fear that they will be criticized or rejected or that people will disapprove of them
2. Unwillingness to get involved with people unless they are sure they will be accepted and liked
3. Reserve in close relationships because they fear ridicule or humiliation
4. Preoccupation with being criticized or rejected in social situations
5. Inhibition in new social situations because they feel inadequate
6. A view of the self as socially incompetent or inferior to others

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7. Refusal to take risks or participate in a new activity or setting for fear of embarrassment

These symptoms must be present by at least early adulthood and persistently experienced. 2.4% of the population appears to experience this disorder and it is equally experienced in men and women.

Avoidant personality disorder needs to be distinguished from social phobia. The difference is that this diagnosis experiences more pervasive anxiety than a social phobia, which is generally specific to only situations that can cause public embarrassment. For example, new places or public speaking, whereas the person with avoidant personality disorder will be anxious even in very familiar settings. The two can exist together.

Avoidant personality disorder also needs to be distinguished from schizoid personality disorder. Both cause social isolation, however people with schizoid personality disorder are isolated because they are not interested in others. People with avoidant personality disorder are isolated because of fear of criticism and rejection.

Some research supports suggestions that childhood rejection can increase the likelihood of developing this disorder. Some patients with the disorder present symptoms as far back as two years old.

Treatment for the disorder includes cognitive-behavioral therapies to improve skills and reduce anxiety as well as medication to reduce anxiety. Patients generally are uninterested in therapy and maybe pushed by family or peers to attend. They benefit from individual therapy rather than group therapy because of the fear of embarrassment or criticism.

Dependent personality disorder

People with dependent personality disorder generally feel as though they need to be taken care of by others. They prefer to lead submissive lives and may present with tendencies to be “clingy” or hyper-focused on others. This often leads to patients being unable to autonomously support themselves and their family, friends, and loved ones feeling burdened by providing care.

To receive a diagnosis of dependent personality disorder, five or more of the following must be present:

1. Difficulty making decisions in daily life without advice and reassurance from others

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2. A need to be taken care of or have someone be responsible for them
3. Difficulty expressing opinions or judgment that is in disagreement with others is directly related to fearing the loss of support
4. Difficulty beginning new projects alone as directly related to a lack of confidence in abilities
5. Willing to go far to please others and support others – often willing to complete unpleasant tasks
6. Uncomfortable feelings or feeling helpless when alone because of the inability to support self
7. Need to establish a relationship immediately after the loss of previous to receive care and validation
8. Preoccupation with being left alone or having to care for self – this causes great fear and worry

When giving this diagnosis, clinicians must distinguish the symptoms from the presentation of the following: borderline personality disorder, avoidant personality disorder, and histrionic personality disorder. Patients who are borderline may be willing to give some control to others but will be too afraid to be completely dependent on another person. People with avoidant personality disorder are also afraid to relinquish such levels of control unless certain they will be accepted. Finally, people with histrionic personality disorder will seek reassurance but not complete service from others. Symptoms should also be distinguished from depression, panic disorder, and agoraphobia.

Treatment for dependent personality disorder focuses on addressing the lack of independent-living skills that individuals have. This is generally done through therapy and medication management to navigate anxiety and depression that often comes with the diagnosis. Patients have a likelihood to develop a dependence on medication, however, so it is suggested that they not take benzodiazepines or other addicting medications/substances. Patients will likely become dependent on clinicians while establishing a therapeutic relationship. This is something clinicians need to be prepared for and work to prevent.

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Obsessive-compulsive personality disorder

Obsessive-compulsive personality disorder should not be confused with obsessive compulsive disorder (OCD). This personality disorder is identified by a preoccupation with perfection, control, and orderliness. This will impact the individuals' functional abilities because they will be unable to complete tasks if the process is not exactly how they want it to be.

Individuals with this disorder are generally thought of as rigid and stubborn. They are unable to be flexible to meet changes or ongoing needs and everything needs to be done the way they need it done. They focus on rules, details, procedures, lists, and schedules. This impacts their relationships, employment, and other aspects of their lives.

Four or more of the following must be true for an individual to receive this diagnosis:

1. A preoccupation with details, rules, schedules, organizations, and lists
2. Constantly striving for perfection – this will interfere with the completion of the work
3. Excessive devotion to work and productivity that financial need does not require – this results in neglecting other important areas of life
4. Excessive conscientiousness and inflexibility regarding moral issues, ethics, and core values
5. Reluctance to delegate work to others unless those people can follow exact prescribed steps
6. Unwillingness to throw out old objects, even those with sentimental value
7. Rigidity and stubbornness
8. Miserly approach to spending because of the belief that money should be saved (Skodol, 2019)

Section 4: Summary

Cluster C personality disorders are thought of as anxious and insecure. Patients with these disorders are likely to isolate because of their fear in relationships. These patients often present with low self-worth and self-esteem. They are often rigid in their thinking. Treatment for these disorders should focus on adjusting black and white thinking and behavioral change. Cognitive-behavioral therapies are effective for treating patients with

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Cluster C personality disorders. This is a group of patients that are likely to recover given the right supports.

Section 5: Treatment difficulty for clinicians

What disorders are difficult to treat for clinicians?

For clinicians, treating patients with personality disorders can be difficult. Women with borderline personality disorder, for example, are often considered the most difficult patients to treat. Historically, the diagnosis was thought of as being on the border of psychotic disorders and neurotic disorders. This is because patients present with both a much-distorted view of reality and high anxiety and emotional distress. People with borderline personality disorder are often thought of as difficult patients because of many factors. The first is that it is a diagnosis that is widely misunderstood (Hancock, 2017). Often clinicians do not understand why patients present as so 'difficult.' There is little training for clinicians on how to best support patients with borderline personality disorder. Because of this, many clinicians have "dropped" patients with the diagnosis. The second is the stigma that comes with many patients being terminated from therapy often perpetuates the belief that they are difficult to treat and the individuals might develop a stronger fear of rejection or abandonment. Additionally, supporting patients with this disorder takes a significant time commitment and can be very energy draining. Often people will experience a heightened symptomatic presentation before treatment becomes effective. This is because long standing beliefs are tested and patients often want to hold onto what they know, which is distorted thoughts and maladaptive behaviors.

More clinicians and mental health professionals must develop a deeper understanding of borderline personality disorder to best support patients. This should be done through education, teaching Dialectical Behavioral Therapy skills to clinicians, and encouraging interactions with patients with borderline personality disorder. Being willing to work with patients with the disorder should normalize the experience for clinicians (Hancock 2017).

What kind of stigma is related to personality disorders?

The stigma associated with personality disorders is not simply limited to borderline personality disorder. People who present with stubborn personality traits that are not easily adjusted or changed are often thought of as misbehaving. Their behavior is often so inappropriate that it is overlooked as a mental illness. There is a belief that they

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should be able to just stop doing the things they are doing. For example, parents of a young person with avoidant personality disorder might think something like 'just go out and make some friends.' In this thought, they fail to see that their child is actually struggling with a persistent mental illness and instead reduce the behavior to choice, which can make the situation even more problematic.

Section 5: Summary

The majority of research on treatment for personality disorders has focused on patients with borderline personality disorder because of its difficulty to treat. This makes it challenging for clinicians to effectively treat other personality disorders. More research in the field is required to best support patients with other conditions.

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Section 6: Comorbidity of personality disorders and substance use

What is the relationship between substance use and personality disorders?

Patients who present with a personality disorder or multiple personality disorders also commonly present with substance use tendencies. Clinicians must be prepared for how to best support individuals with maladaptive personality traits and behaviors as well as substance use issues. Research has found that 34.8%-73% of patients being treated for substance use also have a personality disorder (Parmar & Kaloiya, 2018). The most common comorbid conditions for patients with substance use disorders are antisocial, borderline, avoidant, and paranoid personality disorders. The following statistics show the severity of comorbid substance use issues:

- Patients with a personality disorder are at risk for developing alcohol use issues 5X higher than the general population
- Patients with a personality disorder are at risk for developing drug use issues 12X higher than the general population
- Almost half of the patients with borderline personality disorder have substance use issues – 47% of those patients use alcohol and 22% of those patients use drugs

There are many different beliefs about why substance use is so high for patients with personality disorders. One of the thoughts is that personality disorder symptoms are what primarily lead to substance use, as patients self-medicate. Clinicians need to understand this: the severity of symptoms can be so overwhelming for patients that the

only thing that makes sense for them is to drown the experience by using substances that alter their reality. The next thought is that the trauma that is often experienced by patients who present with these disorders puts them at risk for substance use. Finally, it is thought that patients who have “pre-addictive” personalities are inherently more likely to seek alcohol or drugs.

Research has found through neuroimaging and neuropsychological evaluations that patients with personality disorders have a low level of functioning where constraint and impulsivity are concerned in the pre-frontal cortex of the brain. They also are more likely to have less gray matter in the inferior frontal gyrus, which impacts dopamine production. Differences in dopamine production, that prompts the experience of joy, can lead patients to use substances. The dopamine system is triggered by substance use. Therefore, it makes sense that patients use substances because it promotes the dopamine response.

Patients with personality disorders often have high levels of sensitivity. They are highly sensitive to the world and the people around them. They worry and experience neuroticism. Their emotional states are often inherently negative. This high neuroticism is easily drowned out by drugs and alcohol initially. This leads to dependence over time.

The following tendencies are true for patients with personality disorders:

- Earlier onset of substance use behaviors
- Higher frequency of substance use
- Poorer social functioning, which leads to substance use
- Higher experience of suicidality, which leads to substance use
- More frequent dropouts from treatment programs and facilities
- Higher nonadherence to treatment programs
- Higher likelihood of issues between patient and therapist
- Poor motivation to change
- Higher likelihood of relapse

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How is substance use treated for patients with personality disorders?

Treatment of substance use issues for patients with personality disorders may look different than for the general population. Patients should treat primary personality disorder symptoms instead of substance use. This is because it is often these symptoms that prompt and lead to substance use. If the patients can regulate and manage these symptoms then they are more likely to manage and reduce substance use behavior. Three primary treatment programs are identified for substance use treatment and personality disorders: Dialectical Behavioral Therapy (DBT), Dual Focused Schema Therapy (DFST), and Dynamic Deconstructive Therapy (DDP) (Parmar & Kaloiya, 2018).

DBT for substance use

DBT for substance use involves the same standard DBT skills, however, it focuses on substance-use related behaviors and not just emotional dysregulation (Behavioral Tech, 2015). DBT is found to effectively treat substance use issues and other difficult experiences related to personality disorders such as impulsivity, risk-taking behaviors, depression, anxiety, and eating disorders.

DBT for substance use focuses on controlling the cravings for using drugs or alcohol. Standard DBT skills such as mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness are used to do so as well as coaching with the therapist. The ability to reach out to the therapist when a patient feels a desire to use substances is highly effective. DBT programs for substance use often also include pharmacological interventions for treatment such as Suboxone or other opioid replacing prescriptions (Behavioral Tech, 2015).

Dual Focused Schema Therapy for substance use

A schema is a “self-defeating emotional and cognitive pattern that begins in early development and repeats throughout life” (Hest, Drescher, Verschuur, & Franken, 2018). Individuals with such schemas often have a difficult time controlling how they switch from schema to schema and subsequently from maladaptive behavior to maladaptive behavior. With this comes changes in substance use behavior. The goal of this therapy from a substance use perspective is to target the schemas that prompt the most substance use and treat them. This therapy believes that substance use is a maladaptive coping tool for inappropriate schemas and therefore treats the schemas accordingly.

Example schemas that are identified in substance use treatment include the following:

1. Vulnerable child

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2. Angry child
3. Enraged child
4. Impulsive child
5. Undisciplined child
6. Happy child
7. Compliant surrender
8. Detached protector
9. Detached self-soother
10. Self-aggrandizer
11. Bully and attack
12. Punitive parent
13. Demanding parent
14. Healthy adult (Hest, Drescher, Verschuur, & Franken, 2018).

Dynamic Deconstructive Psychotherapy for substance use

DDP is generally a long treatment program (Upstate Medical University, 2020). It can last as long as 12 months to address personality disorders and substance use. The program will consist of one weekly therapy session where clients will identify their experiences and the impact they have on substance use, name their emotions, and focus on accepting and integrating those emotions, and learning more effective coping strategies. A goal of the program is to promote more effective interpersonal skills because often patients with personality disorders have the most difficulty in their relationships and social lives. Research has found that approximately 90% of patients who utilize a DDP program for one full year improve clinically (Upstate Medical University, 2020).

Section 6: Summary

Substance use is positively correlated with patients with personality disorders. This is especially true for patients with Cluster B personality disorders. Substance use increases negative behaviors such as aggressive behavior, self-harm/suicidal ideation, and law-

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breaking activities. Clinicians must be prepared to screen their patients for substance use and develop prevention plans for substance use.

Section 7: Other comorbid conditions

What other comorbid conditions are common for patients with personality disorders?

Personality disorders are often comorbid with other conditions. This is not limited to substance use. According to Eynan, Shah, & Links (2016) 42.2% of individuals with Cluster A personality disorders have a comorbid condition. 83% of individuals with a Cluster B personality disorder have a comorbid condition. And finally, 50.3% of individuals with a Cluster C personality disorder have a comorbid condition.

Patients with comorbid conditions are often difficult to provide services for clinicians. The risk for suicide is increased in patients with co-occurring conditions. Individuals with personality disorders most commonly have the following comorbid conditions: psychotic disorders, affective disorders, and anxiety disorders. Individuals with comorbid conditions are also more likely to have significant functional impairments than those without. These impairments often result in the poor prognosis of mood disorders, higher likelihood of relapse and chronic symptoms, poorer treatment response and ability to recover, poor adherence to their treatment plan, and more suicidal and self-harm behavior (Eynan, et al., 2016).

Treating the personality disorder should be primary, however, it is essential to assess the severity of the other symptoms and treat them appropriately. If the patients present with symptoms that are high-risk for self-harm, suicidal behavior, or homicidal behavior they should be treated immediately.

Section 7: Summary

It is possible that people with personality disorders also experience their comorbid conditions consistently across their life, similar to the stubborn tendency of their personality traits. If this is the case, it is necessary to develop healthy and effective coping strategies related to the presentation of such symptoms. Learning adaptive coping strategies is a core component of treatment for personality disorders.

Section 8: Personality disorders and suicidal ideation

What is the relationship between substance use and suicidal ideation, planning, and attempting?

Much research on personality disorders and suicide has focused on borderline personality disorder specifically because it is uniquely associated with high attempts and death by suicide, however suicidal ideation is consistent with many personality disorders (Ansell, Wright, Markowitz, Sanislow, Hopwood, Zanarini, Yen, Pinto, McGlashan, & Grilo, 2015).

The presence of a personality disorder increases a person's likelihood of suicidal ideation, self-harm, and attempting suicide. Different disorders will increase or decrease such risks. Borderline personality disorder and Cluster B personality disorders generally increase risk. These personality pathologies are often consistent with self-hate, dependence on others, and emotional dysregulation. These beliefs about self in addition to impulsive behavioral tendencies are risk factors. Narcissistic personality disorder is associated with less impulsive but more lethal attempts of suicide. Therefore, more patients with this condition will die by suicide than patients with other personality disorders.

Additionally, aggressiveness in female patients with antisocial personality disorder and criminal behavior appears to be a risk factor for suicide. Many of these individuals will have one or multiple attempts in their lifetime.

Ansell, et al.'s study found that paranoid, antisocial, borderline, histrionic, and dependent personality disorders have the highest risk for suicide. Borderline personality disorder was most strongly associated with attempting. Further research is needed to identify the factors that most often cause attempts or death by suicide between personality disorders. For example, shame is often associated with suicidal ideation and self-harm.

How can clinicians be prepared for how to support patients with suicidal ideation?

It is important that clinicians who are working with individuals with personality disorders develop a safety plan to prevent or address suicidal ideation. Additionally, it is critical that clinicians who are supporting patients who have attempted or have suicidal ideation assess for a personality disorder because the correlation is so high (Ansell, et al., 2015).

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The following tools are helpful for clinicians to utilize to assess for suicidal ideation:

1. **Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)** – this tools identifies risk factors, protective factors, conducts an interview with the patient based on suicide inquiry (thoughts, plans, behaviors, and intent), determines the level of risk, and documents that information (The Ontario Psychiatric Outreach Program, 2020).

   Risk is classified across three levels: high, moderate, and low. This information is presented below:

Risk level	Risk/protective factors	Suicidality	Possible interventions
High	Psychiatric disorders with severe symptoms, or acute precipitating event	Potentially lethal suicide attempt or persistent ideation with strong intent or rehearsal	Admission is generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with a plan but no intent or behavior	Admission may be necessary depending on risk factors. Develop a crisis plan. Give emergency crisis/numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis information (The Ontario Psychiatric Outreach Program, 2020)

2. **Ask Suicide-Screening Questions (ASQ) tool -** this tool asks the patients questions related to their past and current suicidal ideation. (National Institute of Mental Health, 2020). They are as follows:

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- In the past few weeks have you wished you were dead?
- In the past few weeks, have you felt that you or your family would be better off if you were dead?
- In the past week have you had thoughts about killing yourself?
- Have you tried to kill yourself? If yes, how? When?
- Are you having thoughts of killing yourself right now? (National Institute of Mental Health, 2020)

Regardless of the tool clinicians use to assess for risk, they must be prepared for the development of a safety plan with their patients. There are six steps to developing an effective safety plan with a patient (The Ontario Psychiatric Outreach Program, 2020). They are as follows:

1. **Recognize the warning signs** – these include thoughts, images, thinking patterns, mood, and behavior that the patient will present with. They will indicate if the safety plan needs to be utilized or not
2. **Using internal coping strategies** – this part of the safety plan should identify the tools, interventions, and strategies that patients can utilize to cope with suicidal thoughts. They help the patient to not act on the desire to attempt suicide
3. **Social contacts** – patients should identify the people in their lives who are loving and supportive who can distract from the crisis or difficult emotional state the patient is experiencing. Patients should identify a list of contacts and phone numbers for how to connect
4. **Contacting the family members or friends who can resolve the crisis** – in this step patients identify who can actively help them in the event of a crisis. This is different from the previous step that focuses on distraction rather than direct involvement by social support. The list should be prioritized based on who can provide the most support
5. **Contacting professional agencies** – patients need to know what professionals are available to them when they are actively in need of intervention for suicidal planning and intent. They should name the clinics and professionals and list the contact information for how to reach them. Emergency crisis lines should be listed

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Safety plans are most effective when immediately available to the patient. Patients can put them in a note on their phone or write them down and place them in their wallet or purse. They should be immediately accessible for the patient to utilize when their thoughts are overwhelming and their health is at risk (The Ontario Psychiatric Outreach Program, 2020).

Section 8: Summary

Patients with personality disorders are at an increased risk for suicidal ideation, planning, and attempts. Because of this, clinicians must be prepared for risk assessing and safety planning around suicidal behavior. It is essential that patients have a plan for how to address these difficult and dangerous feelings. Additionally, supporting patients to be less impulsive is necessary as this will decrease the risk for attempting suicide.

Section 9: Personality disorders and criminal behavior

What is the relationship between personality disorders and criminal behavior?

Individuals who have personality disorders are often thought of as more likely to commit crimes. There is evidence showing that individuals with personality disorders present with more aggressive behavior than individuals who do not have personality disorders (Howard, 2015). The link between the disorders and violence continues to be a particularly important research area in the field of treating personality disorders.

Generally speaking, the more significantly impacted by mental illness an individual is, the more likely he or she will be to aggress or act violently. Beyond this, there is evidence showing that the more impulsive behavior a person presents with and the stronger their psychopathy and delusional ideation, the more violent and aggressive they will become. There are four different types of violence identified by Howard (2015):

1. **Excitement** – this violence is both impulsive and based on exhilaration or positive feelings
2. **Self-defense** – this violence is both impulsive and based on fear or negative feelings
3. **Greed** – this violence is generally controlled and based on exhilaration or positive feelings

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4. **Revenge** – this violence is generally controlled and based on fear or negative feelings

Why are patients with personality disorders more likely to be violent?

There are a few different potential causes for the increase in violent behaviors for people with personality disorders:

1. **Substance use** – substance use is higher for this population and subsequently, individuals who use substances are more likely to act violently

2. **Impulsiveness** – lack of planning during action often results in unintended behaviors and especially behaviors with consequences, such as violence

3. **Emotional dysregulation** – feelings that are so severe often prompt individuals to act aggressively when their subsequent units of distress are high

4. **Psychopathy** – captured often under antisocial personality disorder, this group of individuals performs premeditative acts of violence often compared to other mental illnesses

5. **Delusional ideation** – delusional thinking is often thought of as a cause of violence and research finds this to be true. This is common for patients with borderline personality disorder, for example, who may become violent because they have delusional thought patterns around people they love leaving them. They may act violently to try to make the person stay when the individual might not have been planning to leave in the first place. It appears that the more delusional the patients are, the more likely they are to be violent and the more severe their violent behavior becomes (Howard, 2015)

There is little evidence on the current statistics for personality disorders and law-breaking activities, however, a study by Fakhrzadegan, Gholami-Doon, Shamloo, and Shokouhi-Moqhaddam (2017) was completed on a group of prisoners and found that 87.3% of women and 83.3% of men presented with symptoms consistent for diagnosing a personality disorder at the time they committed the crime. Additionally, 46.5% of the population had a substance use issue at the time of the crime. The most common mental illnesses found in this group of prisoners were major depressive disorder, borderline personality disorder, dependent personality disorder, and antisocial personality disorder (Fakhrzadegan, et al., 2017).

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Section 9: Summary

This study suggests two important areas of work for the field of behavioral health. First, law enforcement and justice system staff must be properly trained on how to support patients with mental illnesses and specifically personality disorders. They should have a basic understanding of behavioral tools and interventions and work closely with jail and community-based mental health professionals to most appropriately meet the needs of criminals and provide person-centered rehabilitation. Secondly, more research must be done on the differences in criminal behavior between those who have been diagnosed with the ten personality disorders. This could inform specific programs and rehabilitation processes for criminals.

Section 10: Training for clinicians

What treatment modalities should clinicians be prepared to be trained in for treating personality disorders?

DBT

Mental health professionals working with patients with personality disorders should be prepared for additional training outside of their licensure. Because DBT is often a helpful service for these patients, clinicians can be prepared to utilize the skills. To offer DBT supports, clinicians must be certified to do so. Becoming DBT certified has advantages for clinicians:

1. It acknowledges the hard work that clinicians invested (DBT-Linehan Board of Certification, 2020)
2. It provides patients with confidence that clinicians are adequately trained to address their mental health needs
3. It allows for insurance reimbursement of services
4. It opens opportunities for clinicians to work in wraparound, intensive DBT programs

Clinicians looking to be able to provide DBT should have a graduate degree in a mental health field, a current unrestricted license to independently practice, take a minimum of 40 hours of didactic training specific to DBT, have participated in a DBT team experience for 12 months, and have read, completed, and taught from the DBT manual. After this,

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clinicians will take an exam, submit a letter of recommendation, and provide three videos showing their ability to teach and use the skills. Finally, they will be required to take formal training in mindfulness (DBT-Linehan Board of Certification, 2020).

Schema-focused therapy

Schema-focused therapy has been identified as another helpful treatment modality for patients with personality disorders. Clinicians should be prepared to become certified in the modality should they choose to provide it. The following benefits are identified for clinicians who are certified to provide this service:

1. It allows clinicians to present as a Certified Schema Therapist (International Society of Schema Therapy, 2019)
2. Clinicians who complete the Advanced Level certification can provide supervision and teach workshops on the modality
3. Clinicians who complete the certification are included in the referral network for the International Society of Schema Therapy

Clinicians must have a graduate degree in a mental health field, and a current, unrestricted license to practice. They will be required to attend lecture workshops, receive supervision, submit audio recordings for sessions showing the ability to use the skills, observe patient sessions by master therapists, and treat 2-4 patients for a minimum of 25 hours each (International Society of Schema Therapy, 2019).

Section 10: Summary

Clinicians who are interested in the treatment of personality disorders must be prepared for additional training and certification programs. While these can be expensive and time-consuming they are helpful in ensuring that treatment is effective, person-centered, and appropriate for patients. DBT and Schema-Focused Therapy are common treatment modalities for which clinicians can receive certification.

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Case studies

Jennifer

Jennifer is a 19-year-old female who recently received a diagnosis of borderline personality disorder. Her childhood was tumultuous. She was removed from the family home at six years old because of sexual trauma by her parents. She was in foster care

and eventually adopted after her parents gave up their parental rights. Jennifer was adopted at 9 years old by a loving and secure family. She struggled with anxiety and depression while in school. She used self-harming as a maladaptive coping strategy as a young person and recently began using alcohol and marijuana. She reports that substances help her to manage her mood swings.

Jennifer is currently a freshman in college. She lives in the dorms on campus but has requested to change roommates several times already. She is having a difficult time establishing relationships with her peers. She gets incredibly close to them quickly and then prompts fights and arguments with them. This is especially true when her friends pass up on the opportunity to spend time with her to spend time with people they are dating. Jennifer becomes incredibly jealous and is not sure why. She recognizes this as abnormal behavior compared to her peers.

Jennifer recently began drinking and using drugs when at parties and has been having sex with older men who will buy her alcohol. She has been skipping classes and has been refusing to call her parents back. They are incredibly worried about her. Jennifer has been experiencing consistent suicidal ideation and she recently attempted by stealing her roommate's pills and taking the entire bottle. Jennifer was admitted to the hospital and had her stomach pumped. She was transferred to the psychiatric unit and diagnosed with borderline personality disorder. Her main symptoms are as follows: impulsive behavior, self-hate, suicidal ideation, fear of abandonment and rejection, and turmoil in her interpersonal relationships.

After a short stay in the psychiatric unit to diagnose Jennifer and stabilize her condition, she was admitted to an intensive outpatient DBT program. Jennifer plans to complete the full year of DBT and has chosen to move back with her parents and take time away from school to focus on her health. Jennifer has prescribed medication for depressive symptoms and finds success with learning and using DBT skills. The skill she finds most helpful is fact-checking.

Carlos

Carlos is a 49-year-old man with antisocial personality disorder. He was young when he began presenting with symptoms consistent with the disorder. He was not interested in making friends or connecting with others. He always opted to play alone during recess in grade school. He struggled in school. He was disciplined often for inappropriate behavior towards his peers and breaking rules. He was eventually expelled from multiple schools in high school and completed his GED instead of finishing. His parents were very angry

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with him for his behavior and he left the family home at 18. He has not had a relationship with them since.

Carlos had been doing relatively well until recently. While he has always had a lack of empathy for others and no interest in interpersonal relationships (intimate or platonic) he recently has had an increase in frustration towards his peers at work. Carlos believes that he is a very good worker but his coworkers appear to think differently and have been giving him negative feedback during his workdays. While on a break recently, Carlos decided to cut the brake wire on his coworker's motorcycle. This resulted in an accident where the man was badly injured.

Carlos was being recorded, unbeknownst to him, when he did so. He was arrested and is now in prison for this crime. In prison he received the diagnosis of antisocial personality disorder and is being seen by a mental health therapist for treatment. Carlos is not invested in treatment but is happy to engage in dialogue where he can attempt to initiate arguments with others. His therapist is becoming frustrated with this behavior and despite multiple attempts to hold Carlos accountable for his inappropriate behavior in sessions, Carlos is unwilling to change his behavior at this time. Carlos's therapist is focusing on trying to teach him the impact of his behavior in an attempt to adjust his behavior.

Jackson

Jackson is a 30-year-old man who is having difficulties in his primary relationship. He has been with his partner for several years and his partner recently asked him to move out of the home that they share. They are unsure if they will continue their relationship or not at this time.

Before the start of the relationship, Jackson was doing well and functioning independently compared to how he presents now. As his relationship became more serious he became more and more dependent on his partner. He does not want to be away from his partner and this led to him not attending work and therefore losing his employment. He also began having severe worries about his partner leaving him for someone else and having an affair. Jackson would talk daily about his fear of his partner. He decided to get a dog to be with when his partner is away at work.

Jackson's partner asked him to find more employment and Jackson wanted his partner to help him to do so. This was frustrating to his partner who believes that Jackson should be able to do such simple tasks independently. Jackson was asked to move out and he decided to see a therapist to navigate the worries that he is experiencing.

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Jackson was diagnosed with dependent personality disorder. He is working with his therapist to learn independent living skills. In therapy, Jackson realized that his mother presented with symptoms consistent with dependent personality disorder as well. Jackson observed her be abnormally reliant upon his father and step-fathers. He realized that he hasn't ever witnessed a relationship with healthy boundaries and is excited to learn these skills.

After almost one year in therapy, Jackson is employed, living independently, and successfully dating. He and his partner decided to end their relationship because they wanted different lifestyles. Jackson still wants a close connection with someone but wants to be able to independently support himself and work through his fears of abandonment.

Ashley

Ashley is a 29-year-old woman who has obsessive compulsive personality disorder. She has struggled to effectively communicate for herself and her needs for many years. She has never had a close relationship and is self-employed. She is quite isolated and feels lonely often but she is afraid to establish meaningful relationships with others.

Ashley has a graduate degree in marketing and owns her marketing firm. Her focus on perfection is what has made her so successful in her work but it is also difficult for her to be constantly focused on doing more and being better. She never feels as though her work is good enough. This often makes her angry and she is sometimes a difficult person to partner with for the businesses that utilize her services. She was recently dropped from a high paying contract because her need for perfection prevented her from completing a job on time. This has prompted anxiety and depressive symptoms.

Ashley reports feeling worthless and hopeless. This brought her to see a therapist where she received the diagnosis of the personality disorder. In therapy, she is working to identify her cognitive distortions and work through black and white thinking. Her therapist is providing psychoeducation to her. She is learning about her condition and ways to be more successful in her life. Ashley recently began exercising in the mornings as a way of taking care of her health and working through some adrenaline that often prompts her to be angry easily.

After six months in therapy, Ashley's symptoms are greatly reduced. She is coping effectively in her work and is no longer missing deadlines. She is beginning to feel more confident and proud of herself and her work. Ashley's therapist expects her to regain even further control of her life and reduce her symptoms more with time.

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Harold

Harold is a 75-year-old man with paranoid personality disorder. He was diagnosed approximately 15 years ago and his symptoms have remained consistent throughout his life. Harold struggles to trust others. He has never felt that anyone was loyal or honest to him. Because of this, he has not maintained any close relationships with anyone over the years. He has not seen or talked with his siblings for months.

Harold tends to have a difficult time forgiving others. This has prompted the recent disconnection from his family. There was an argument about his care as he ages and he feels that his siblings crossed a line when planning with him. He believes he can manage his care, despite being unable to adequately meet his basic needs. Harold would benefit from assisted living services but he is afraid to move into a care setting because he believes all of his items and money will be stolen by other residents. Harold's siblings are frustrated with his stubbornness but were prepared for this situation because he has presented this way his entire life.

Harold has been offered therapy over the years and always declines. He was interested in starting therapy at 60 but was frustrated with the diagnosis he was given and declined to return for services. To best meet his health needs, Harold requires personal care services because of his lack of mobility. He has allowed his siblings to help him historically but no longer is.

Harold would benefit from mental health services and supportive living services but continues to decline all offers.

Catherine

Catherine is a college student who recently began seeing the mental health therapist on campus because of difficulties in dating relationships. She has been dating several different people because she finds it unfulfilling to date just one person. She doesn't feel the attention of one single person is enough. She wants adoration from multiple people and feels happiest when she has that.

Catherine appears to be fixated on her body. She works out every day without fail, counts calories, and wears tight and revealing clothing. She is thought of as dramatic among her friends but they enjoy spending time with her because she is the "life of the party" and her energy is exciting to them.

Catherine's relationships have started to become difficult to manage. She is dating three people consistently and has been asking for a lot of validation from each person. She wants them to constantly tell her how loved she is, how pretty she is, and that they want to be with her forever. This is overwhelming to her partners who are in their early twenties and not looking to settle down in any way.

Catherine also has not been honest about dating multiple people at once and recently got in an argument with someone she is dating who thought they were monogamously seeing one another. This fight led her to self-harm for the first time. She sought out therapy after this.

Catherine was diagnosed with histrionic personality disorder and it was revealed in therapy that she has a trauma history. Catherine was physically and mentally abused as a child and has always acted out. As a child, she had a low tolerance for frustration and anger and this caused her to be more abused than her other siblings were. She was always thought of as the "bad" child by her parents and her lack of secure attachment is difficult for her.

Catherine and her therapist choose to initially address her personality disorder symptoms. They also have a long-term goal of completing work around trauma. She is unsure if she will participate in EMDR or narrative reprocessing therapy. Catherine is focused on reducing the need to seek inappropriate attention for others because she has found in therapy this gives her a great deal of shame and she no longer wants to feel shameful. Catherine also wants to be able to effectively build relationships when she leaves college and enters the workforce.

After one year in therapy, Catherine is more rational in her behaviors. She is no longer acting so impulsively or using her body as a way to gain attention as often. She is still struggling in her relationships with wanting validation and attention but this is greatly reduced compared to when she started treatment.

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