

# Personality Disorders

# 12

## Learning aims

At the end of this chapter you should:

- Comprehend the classifications used for personality disorders
- Understand the different types of personality disorders
- Be knowledgeable of the various models/theories of personality disorders
- Be familiar with the various treatments utilized for personality disorders.

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## INTRODUCTION

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### CASE STUDY

#### Andrew's story

Andrew was referred to court-ordered counselling because of a drink driving conviction. As part of his sentencing he was required to attend 15 counselling sessions. The first five sessions were uneventful; he told the therapist that he had simply misjudged his limit and should have called a friend or taken a taxi home. He only drank the occasional pint and didn't consider himself to be an

alcoholic. He did feel that his conviction was rather excessive considering all the crime that was going on, but he would pay the fine, finish the counselling sessions and would never get caught out again. He then told the therapist that having to come to the sessions was cramping his style as he was planning on moving out of the area and now he would have to wait. Andrew insisted that he did not have a drinking problem, and didn't really have any issues he needed to discuss. He avoided any discussions about family and was evasive any time the therapist brought up any conversations concerning family or intimate relationships. The sessions continued as non-eventful with Andrew mostly discussing various places where he had been on holiday. On the last session, Andrew said he had something he wanted to talk about. He then related how 'a friend' liked to pick up recently divorced women with small children who had been in difficult custody battles with their ex-husbands. His 'friend' would then be very gracious and kind, buying the woman flowers and small gifts, stuffed toys and computer games for the kids. He said his 'friend' would become the best boyfriend ever; paying bills, buying food, and very quickly his 'friend' would be invited to move in. After a few weeks his 'friend' would begin to sexually abuse the children. When his 'friend' had finished after a few months, he would cause an argument that would be a full blown fight and his 'friend' would pack up his belongings and leave, and his ex-girlfriend would find out afterwards what his 'friend' had done to her children. Andrew said his 'friend' felt safe because he knew the woman would never report what happened to the police because if her ex-husband found out she would lose her kids as he would probably take her back to court to fight for custody since she was responsible for what had happened. Andrew said his 'friend' had done this at least six times that he was aware of. The therapist sat stunned. When she asked what the friend's name was, and said that Andrew was duty bound to report him to the police as he was committing a horrendous crime, Andrew just smiled and said, 'I guess our time is up. Good bye Doc, have a nice life. It's been fun.'

### Edie's story

Edie was a pretty 32-year-old who had been admitted to hospital for a suicide attempt. Her boyfriend had called the ambulance after he had found that she had ingested all the pills in the house and drunk a bottle of vodka and was unconscious on the floor in their flat. He had told the police that they had been fighting on the phone and he had come home to find her. He also said that this wasn't the first time and that he was sick of the drama and was going home to pack and leave. He then related to the police that this was Edie's ninth attempt and that whenever things became difficult in their relationship that she would attempt suicide. He was also fairly certain that the three 'miscarriages' were probably lies as well. He had been manipulated for the last time and was leaving while he had the chance and she was in the hospital.

## WHAT IS A PERSONALITY DISORDER?

If a friend said to you before they introduced another person to you, they had a 'lousy personality' what would you be expecting? Someone with poor social skills? Someone who wasn't friendly? Someone who wasn't going to make the evening enjoyable? Your expectation of this new person

would probably not be one of anticipation; probably more than likely you would dread the experience. However, if they described the person as having a ‘great personality’ you would probably expect to spend an enjoyable evening and possibly make a new friend. Having a ‘good’ personality is desirable, while having a ‘bad’ personality isn’t something that anyone wants.

What is personality? Generally it is defined as the embodiment of the physical, mental, emotional and social characteristics of an individual and how these various characteristics interact and impact each other as well as being influenced by the environment (Eysenck, 1987). How is ‘personality’ different from the previously discussed element of temperament?

Temperament refers to innate individual differences which are characterized by particular behavioural styles and are significantly affected by the interplay of environmental forces (Thomas and Chess, 1977). Buss & Plomin (1975) felt that individual differences are governed by four temperaments which are innate: activity, emotionality, sociability and impulsivity, and that every person represents some combination of the four temperaments. Goldsmith and Rothbart (1991) proposed that behaviour manifestations of temperamental dispositions change during the course of childhood development. Thomas & Chess (1977) believed that temperament was biologically determined and modified by environmental elements. Personality is slightly different. It is also a product of the social environment; it is not innate, and it is shaped during later periods of development with the fundamental origin of personality being temperament. Personality is the result of all the influences, past and present, which shape and modify the outcome in a constantly evolving interactive process and is an integrative function of human behaviour that underlies temperament. Personality is generally referred to as the content of behaviour whereas temperament refers to intensity. Personality also refers to an individual’s pattern of thoughts, feelings and behaviours; individuals may not always think, feel and behave in exactly the same way, but each person has a set of predictable patterns that are characteristic of them and can be describe by others (Pervin & Cervone, 2010).

Now that we have defined personality, what is a personality disorder? Personality disorders are different from any of the other disorders discussed. They are not diseases, but are considered to be maladaptive patterns to the affective and conative qualities of an individual. Buss and Plomin (1975) believed that after the age of ten years a child’s temperament becomes relatively stable and consistent and that personality being a factor of temperament would also stabilize and become consistent during adolescence. After this point in development it is believed that personality doesn’t change very much and that patterns that are developed will be applied through adulthood whether they are normal or maladaptive. The next question is: why are we concerned with personality disorders? Research has indicated that personality disorders constitute one of the most important sources of long-term impairment in both treated and untreated populations (Merikangas & Weissman, 1986).

## HISTORY

Individuals with character flaws have always existed. Many books, plays and songs describe individuals who are not in control of their impulses and desires, engaged in immoral acts and

cause mayhem and destruction to other people's lives as well as their own. During the nineteenth century, as other mental illnesses were being examined and classified, the disorders of personality were also being examined and re-classified. Previously they were referred to as 'moral insanity' but in 1891 Koch, a German physician, proposed replacing the label with the term 'psychopathic inferiority' which included all mental irregularities that were not classified as madness (Kellerman, 2012). Koch believed that a physical basis existed for these individuals with character impairments and that they stemmed from a congenital or acquired inferiority of brain constitution (Kellerman, 2012). Freud had a different view and believed that these individuals resulted from a psychodynamically defective constitution where the personality had not fully developed. Kernberg (1975) broke away from the more traditional psychoanalytic characterology and constructed a different framework for organizing personality types in terms of the level of their severity. While Kernberg was redefining the categories of personality disorders, the DSM was in revision and included many of the categories that Kernberg had previously redefined (Jansz & Van Drunen, 2004). The DSM III discarded psychoanalytic concepts and sought to group patients on the basis of observable symptoms with the objective of standardizing the new edition with the European classification system. This edition abandoned much of the psychodynamic view of mental disorders and the approach was based on particular underlying pathology (Jansz & Van Drunen, 2004).

As the DSM was being revised, a decision to include the personality disorders that had been earlier reclassified by Kernberg was made and the new classification system has been controversial ever since. Instead of placing personality disorders in a category or grouping them with the impulse control disorders, they were placed under the Axis II dimension which reflected the view that personality disorders were stable patterns and recalcitrant. Personality disorders were believed to be pervasive features which characterized an individual's enduring personality pattern and therefore virtually impossible to change. During the diagnosis phase, a clinician had to decide whether an individual was demonstrating a transient state that was associated with a clinical disorder or a pervasive enduring pattern (trait) or both. The new classification system enabled them to code both 'state' and 'trait' simultaneously (Benjamin, 2003).

The personality disorders continue to remain on Axis II because it is thought they are largely non-conscious, not easily altered and express themselves automatically in almost every aspect of functioning, but the placement under Axis continues to be an area of controversy (Roysamb et al., 2010).

The diagnostic criteria for personality disorders are either near to descriptions of actual behaviours or they are descriptions of traits and dispositions which could be readily operationalized and refined by behavioural referents and standardized behavioural observations. The DSM-IV-TR identifies four core features that characterize all personality disorders: extreme and distorted thinking patterns, problematic emotional response patterns, impulse control problems and significant interpersonal problems (APA, 2000). Currently the personality disorders are categorized under three main clusters: suspicious, emotional and impulsive and anxious. Table 12.1 categorizes the different groupings and disorders. There are three recurrent issues with the classification of personality disorders: the division appears to be arbitrary and not adequately justified, there is a great deal of overlap between the criteria which compromises their validity as separate disorders as well as overlap on the Axis I disorders, and the current three groupings have not been satisfactorily validated (Shedler et al., 2010).

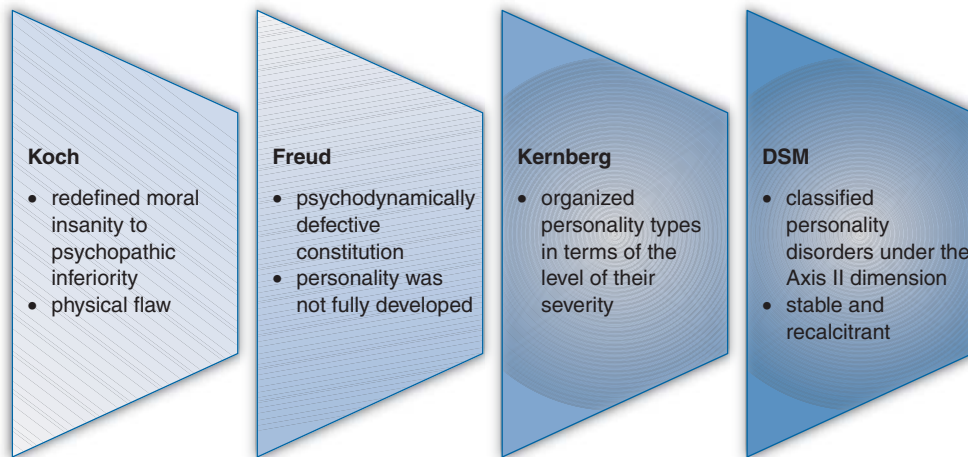


Figure 12.1

## DSM CLASSIFICATION BY THE THREE MAIN CLUSTERS

The new changes to the DSM-5 have suggested significant changes to the current classification system including revised general criteria, provisions for clinical to evaluate a limited set of disorder types according to criteria and an overall measure of the severity of personality dysfunction. There is also a hybrid dimensional-categorical model that has been proposed (APA, 2012).

Table 12.1 DSM classification by the three main clusters

<b>Cluster A – suspicious</b>	Paranoid personality Schizoid personality Schizotypal personality	Lack of trust – assume others will harm them Socially isolated – detached
<b>Cluster B – emotional and impulsive</b>	Anti-social personality  Borderline personality Histrionic personality Narcissistic personality	Socially isolated – odd beliefs Hostile – aggressive behaviours  Intense and unstable emotions Drama often with somatic illnesses
<b>Cluster C – anxious</b>	Avoidant personality Dependent personality Obsessive-compulsive personality	Uniquely talented – brilliant/attractive Social inhibition – sense of inadequacy Need to be taken care of by others Preoccupied with rules, regulations and orderliness

## THE SOCIAL ASPECTS OF PERSONALITY DISORDERS

Disorders of personality are vastly different from other clinical disorders and many tend to see them as involving the same types of difficulties, namely social-interactive problems, manifest in action and in thought. They are general dispositions or traits which are characteristic responses to a broad range of stimuli and in this case are disordered adjustment responses. Individuals with personality disorders are often difficult to treat as often they don't consider themselves as having a problem. They see other people as having a problem with them (Sperry, 2003).

Cognitions influence a variety of human behaviours. If you consider the four core features defined by the DSM classification system that categorize personality disorders, they all tend to include disruptions of appropriate social behaviour or disorders of social dysfunction in one form or another. When examining the inappropriate social behaviour, one could say that personality disorders are an extreme lack of social skills that causes an interference with daily functioning. All personality disorders have difficulty in social behaviour; they are consistently dysfunctional or maladaptive perceptions, cognitions, or overt responses in an interpersonal context (Adshead & Jacob, 2008). There are five basic social skills: assertion, interpersonal aversion, rewardingness, social ability and affiliation (Cottrell, 2003). It is important to think of these five skills as being on a continuum of functioning. Not all personality disorders are on the extremes and not all personality disorders are flawed on all five social skills, although problematical behaviour on one tends to influence the other four. Table 12.2 describes the various social skills.

**Table 12.2** Dimensions of social dysfunction in personality disorders

Social dimension	Negative	Positive
<b>Assertion</b>	Aggressive/manipulative/bullying/timid/ineffectual	Firm/confident/self-assured
<b>Interpersonal aversion</b>	Argumentative/confrontational/awkward	Pleasant/affection/attachment/fondness
<b>Rewardingness</b>	Selfish/greedy/egocentric	Caring/kind/altruistic
<b>Social anxiety</b>	Criticism/rejection/evaluation	Praise/approval/admiration
<b>Affiliation</b>	Aloofness/detached/distant	Alliance/friendship/association

## DIMENSIONS OF SOCIAL DYSFUNCTION IN PERSONALITY DISORDERS

The first of the basic social skills is called assertion and is best described as one individual's influence over another person's behaviour (Cottrell, 2003). Assertion is dysfunctional when the

behaviour is ineffective in influencing others in the desired way, or when it produces undesirable effects in others. Assertion exists on a continuum and is best described as standing up for one's rights, having oneself 'heard' over a crowd, an act of asserting or stating something, convincing others of a cause. For example, individuals in a discussion attempt to influence each other in a mutual way. A negative assertion would be talking over the other person, yelling, or in any way becoming aggressive and the opposite would be to agree with everything and not put up any defences. Both are examples of dysfunctional assertions.

The second social skill is defined as interpersonal aversion (Hutchings, Comins & Offiler, 1997). This is defined as an individual's behaviour that is consistently unpleasant or inappropriate, or when it repeatedly harms or disadvantages others. As a result of their inappropriate and unpleasant behaviour other people learn to avoid the individual's presence. This is a result of the individual's unskilled social behaviour and is defined as interpersonal aversion.

The third type of social skill is called rewardingness and is a type of social performance (Hutchings, Comins & Offiler, 1997). An individual is rewarding in their interactions with others when they are agreeable, cooperative, helpful, supportive, kind, generous, affectionate or enthusiastic. We learn these types of social interactions by appropriate modelling by our primary caregivers. These include what is often called 'social graces', e.g. saying 'please' and 'thank you'. Children are taught 'manners' – to share, be pleasant, be polite to others, to wait patiently, not to crowd in a queue. Individuals with a personality disorder are not likely to be rewarding in their interactions with others; they tend to be unpleasant and difficult and other people see them as being rude, impolite, discourteous and bad-mannered.

The fourth type of social skill is social anxiety (Csoti, 2001). Social anxiety manifests itself in a variety of forms and approaches; this includes behaviour and cognitions which are responses to a perceived threat from others, criticism from others, negative evaluation and fear of rejection by others. For example, nearly everyone will have some element of performance anxiety and people learn to adapt and conquer their fears. Individuals with high social anxiety are unable to overcome their negative attributions and cope by either becoming extremely defensive or complete avoidance of social situations.

The last dimension is affiliation (Antonello, 1996). Affiliation is defined as an association, relationship, connection, attachment with other people. Humans are social creatures and have a need to establish and maintain close interpersonal relationships with others. Individuals with personality disorders have a defect in their capacity to establish close relationships and maintain them over a period of time. They tend not to have warm and tender feelings for others and there is an indifference to praise or criticism. Dysfunctional affiliation takes a variety of forms and occurs for diverse reasons with the various personality disorders. For example, unlike the avoidant personality disorder, individuals with a schizoid personality disorder are socially isolated with no apparent desire for affiliation or social interaction; they rebuff any attempt, whereas the narcissist craves the social interaction but acts in ways that are inappropriate so that others do not want to interact with them. Appropriate social cognitions go hand in hand with effective social behaviour and dysfunctional social cognitions contribute to ineffective social behaviour (Linehan, 1993).



## AETIOLOGY/MODELS

Personality disorders are believed to have their precursors in childhood although they are generally not diagnosed until adulthood as it is believed that during childhood and adolescence the personality is still developing and is malleable. The general consensus is that early experience plays a central role in shaping personality attributes. Research has suggested that a number of different interacting factors are involved in the aetiology of personality disorders. What is unknown is how much influence is important over the development of different personality disorders and how they interact with the temperament, social rearing practices, quality and type of attachments, culture, ethnicity, and family dynamics (Lewis-Fernandez & Kleinman, 1993).

Another factor that has been researched is early childhood traumas. It has been suggested that early and severe emotional trauma creates individuals who are vulnerable and when combined with temperament and environmental factors can cause personality difficulties (Ball & Links, 2009; Heim et al., 2008). Other evidence of causal factors in the development of personality disorders has been in family dynamics; research has indicated that family members with schizophrenia and manic depression are at higher risk for personality disorders (Erlenmeyer-Kimling et al., 1995; Maier et al., 1994).

What is difficult to determine is whether multiple combinations of these factors or one single factor may be much more important in the development of personality disorder. The fact that entire families or groups of siblings from high-risk families do not develop personality disorders leads us to believe that multiplicities of factors are responsible.

Figure 12.2 outlines the various models that have been hypothesized to be causal in the development of personality disorders.

### Psychoanalytic model

The psychoanalytic model is based on the premise that early childhood experiences are responsible for the formation of personality disorders. The psychoanalytic model has three main approaches.

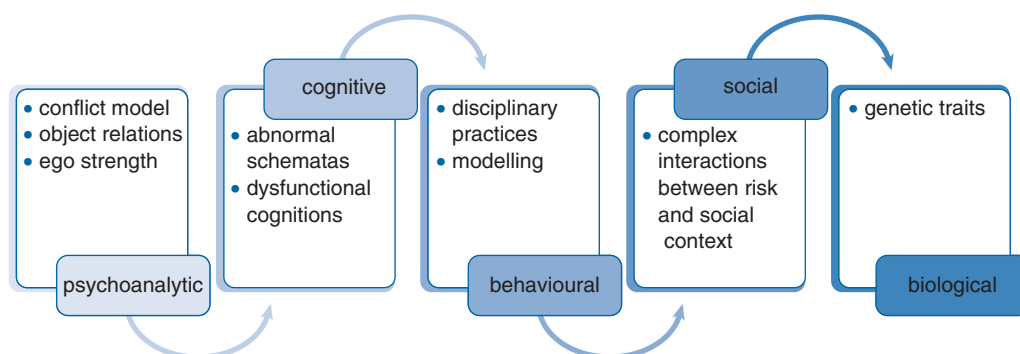


Figure 12.2



The first is based on ego strength and defence mechanisms. Individuals develop personality disorders as a direct response to defence mechanisms that are flawed and underdeveloped that interfere with the individual's ability to function. The individual develops primitive defence mechanisms that are maladaptive and cannot control the id's desires for immediate gratification without regard to reality. As a result of low ego strength the individual ignores all social norms and rules and gives into the id's desires (Clarkin, Fonagy & Gabbard, 2010).

The second approach is the conflict model and has a slightly different paradigm. It is based on personality constellations that are assumed to originate from developmental conflicts and defences that become translated into the trait structure of personality. Therefore all personality processes are the products of conflicts and compromises involving basic drives, especially sexual and aggressive impulses (Clarkin, Fonagy & Gabbard, 2010).

The last approach is the object relations premise. This approach believes that personality structures, including self and identity, are shaped by interactions with significant others. Problems arise from the failure to integrate different representations of the self or others, leading to fragmented images of self and others. Kernberg's concept of borderline personality is a classic example of how biologically determined aggressive feelings are assumed to impede integration of positive and negative object representations, resulting in splitting that leads to ego weakness. The borderline personality disorder individual displays the splitting by the intensity of emotions they often feel toward intimates (Kernberg, 1993).

### Cognitive model

The cognitive model assumes that dysfunctional cognitions are at the core of an individual with a personality dysfunction. Their maladaptive patterns of cognition influence behaviour that is a product of a dysfunctional belief system and abnormal expectations. Young children are exposed to and frequently learn different and contrasting sets of perceptions, feelings, attitudes and behaviours as well as a mixed set of assumptions about themselves and others. Interactions between temperament and confusing life experiences lead to the formation of abnormal schematas which remain dysfunctional throughout the majority of adult life. Various life experiences continue to strengthen and support the abnormal schema that was formed during childhood and adolescence with the result being abnormal cognitions and behaviours (Linehan, 1993).

### Behavioural model

The behavioural model is based on a broader perspective that emphasizes various factors such as inherited dispositions, organic dysfunctions and early childhood experiences as well as environmental and internal cues in the maintenance of dysfunctional behaviour. Behaviourists place emphasis on the reinforcement and punishment practices of the family as well as behaviours and attitudes modelled by parents and primary caregivers. According to the behavioural model, children are provided with little or no experience of consistent and supportive affectionate relationships when they are young and therefore never have the opportunity to model appropriate interpersonal behaviours

(Bandura, 1961). In addition, inconsistent and severe disciplinary practices of the parents make feedback irrelevant and do not provide the child with any reinforcement value. The child then fails to respond to appropriate feedback provided by others as a direct result of the feedback having no significant value to the child. Not only do they fail to develop by imitation, affectionate responses and an emotional concern for others, they are also provided with models for inappropriate, antisocial behaviours (Bandura, 1961). Research has shown that modelling is effective in producing a variety of behaviours both beneficial and detrimental. In particular, it has been demonstrated that children can acquire, via observational learning, responses such as self-controlling behaviour (Mischel & Liebert, 1966), empathy (Aronfreed & Paskal, 1970), and aggression (Bandura et al., 1963), to mention just a few of the more relevant behaviours to personality disorders.

### Social model

The social model is based upon the ideology that unstable social structures and high rates of social change are factors in the development of personality disorders. Certain societies emphasize image over substance with various images projecting aggressive behaviour and antisocial attitudes as well as cultural norms which emphasize interpersonal superficiality and self-interest over appropriate social norms and behaviours. Contemporary examples of antisocial behaviour displayed as a result of flawed social structures are the recent riots in various cities in the UK.

Some of the factors shaping personality also come from outside the family, emerging out of experiences with peers and with the wider community. The social model is based on the idea that there are complex interactions between risk and protective factors and that social risk factors can be balanced by increased economic opportunities. Therefore the development of personality dysfunction is relevant to issues such as social context, social change, occupation, representation of mental illness, gender roles, social disparities, self-harm or self-threats, suicide, case identification and treatment interventions (Lopez & Guarnaccia, 2000).

### Biological model

The biological model is based upon the premise that individuals are born with the genetic traits for a personality disorder which is then ‘triggered’ by the individual’s environment. Research has not yet identified specific central nervous system structures correlated with personality dysfunction, nor has it identified gene linkages and personality disorder associations. However, there is promising research in the area of serotonergic function and the trait of impulsivity. Hernana et al. (2010) found lowered values of serotonin in the CSF of those exhibiting a variety of aggressive behaviours directed towards others and towards self (suicide). Livesley & Jang (2008) found in their research on genetically determined processes of behavioural activation, behavioural inhibition and behavioural maintenance that these behaviours were governed by the catecholamine system and subject to genetic influence.

Antisocial behaviour has been associated with high levels of neuroticism and extroversion which lead to changes in reactivity of autonomic nervous system and heightened arousal mediated by reticular activating system (Corr, 2008). Individuals with personality disorders exhibit lower

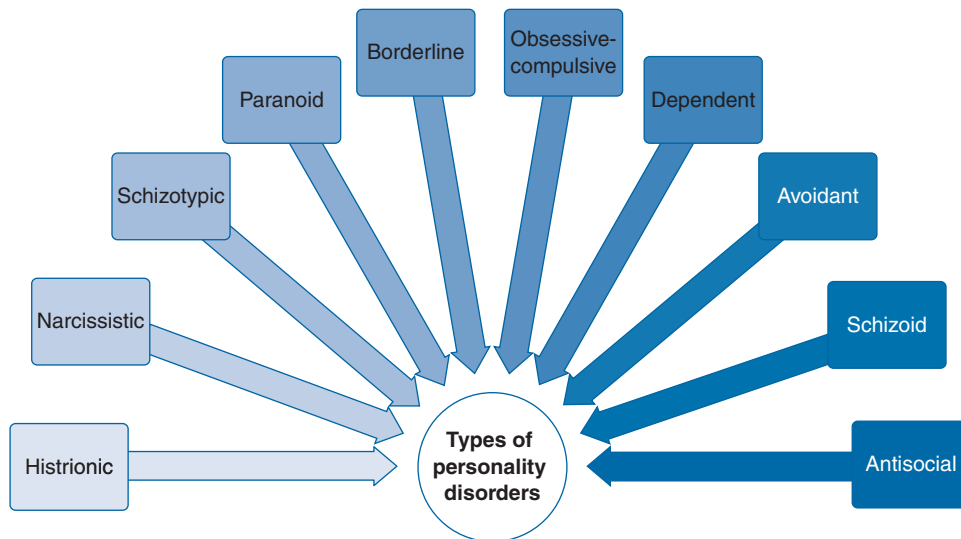


Figure 12.3

anticipatory fear as demonstrated by lower galvanic skin responses (Crider, 2008). In addition, Zuckerman (1990) found that adults with antisocial characteristics have a high level of sensation-seeking behaviour and children with conduct disorders show heightened response to reward in the form of changes in heart rate and skin conductance which is slow to fade when the stimulus is withdrawn. Other biological markers for impulsivity include defects in executive function on neuropsychological testing, as well as imaging findings pointing to dysfunction in prefrontal cortex (New et al., 2004; Soloff et al., 2003; Stein et al., 1993).

## SPECIFIC TYPES OF PERSONALITY DISORDERS

### Histrionic personality

The personality characteristics of the histrionic are extravagant, dramatic, overacted, and appear artificial or ‘over the top’, often accompanied by an air of superiority and a seductiveness designed to manipulate other people or to gain their sympathy, attention, or admiration (Alarcon & Covi, 1973). The histrionic personality tends to be very shallow and superficial in their relationships with others and is predisposed to be suggestible and easily influenced by other people in order to maintain their manipulative relationships. Individuals with histrionic personality disorder want to be the centre of attention and often will appear or become impaired and/or fragile in order to manipulate or receive attention from others. Nestadt, Romanoski, Chahal, Merchant, Folstein, Gruenberg and McHugh (1990) found that individuals with this disorder tend to use health care facilities more frequently than others.

Research has identified a positive association between somatoform disorders and histrionic personality disorders in clinical populations. Garyfallos, Adamopoulou, Karastergiou, Voikli, Ikonomidis, Donias, Giouzevas and Dimitriou (1999) found that 24 percent of patients with somatoform disorders also met the diagnostic criteria for histrionic personality disorders compared to 7 percent of the psychiatric patients with no somatoform diagnosis. Individuals with histrionic personality disorder are uncomfortable being alone and often become depressed and resentful when they are not the centre of attention. Corruble, Ginestet and Guelfi (1996) found that depression is common in this disorder with rates in the range of 15–30 percent.

When these individuals are in casual relationships, they often assume these relationships to be more intimate in nature than they actually are and behave in very egocentric ways, usually at the expense of the other person. Slavney and McHugh (1975) found that histrionic patients were more likely than controls to come from unhappy homes and marriages, and many were admitted to hospital after the breakup of romances or after arguments with partners.

Grant, Hasin, Stinson, Dawson, Chou, Ruan and Pickering (2004) found a prevalence of approximately 1 percent in the general population with males and females equally affected, suggesting that prior reports of an increased prevalence in females were an expression of gender bias found in hospital-based studies.

Torgersen, Lygren, Skre, Onstad, Edvardsen, Tambs and Kringlen (2000) found a heritability index of 0.67 in a large twin study indicating that environmental effects were minimized and that heritability played a large factor.

In terms of dysfunction in the social dimensions, the histrionic personality is a case of inappropriate assertive responding. The positive relationship between depression and lack of assertive behaviour suggests that histrionic individuals are not as skilled in assertion and become angry and depressed when they are unable to manipulate others to their intentions. Initially, they superficially appear not to have social aversion, but this is generally a tactic utilized to establish a relationship. Once this has been secured their manipulation and negative assertion generally drives the person away. They have a high need for affiliation, are not rewarding in their behaviour and seek praise and admiration from others.

### Narcissistic personality disorder

This disorder is defined by extreme self-centredness, self-aggrandizement, self-indulgence, manipulation and taking advantage of others without regard for their feelings or rights. It is at the extreme other end of a continuum from altruism. Where someone would give their life for a stranger, the narcissist would expect that everyone else would sacrifice themselves for their life. Narcissists have a grandiose sense of self-importance and accompanying grandiose fantasies. They believe that they are special and unique and have a strong need for admiring attention. The cognitions are characterized by extreme self-centredness and self-absorption. Individuals exaggerate their abilities and hold unrealistically high expectations for achievement, together with the expectation that others are obliged to do favours for them but with no expectation of reciprocation. They become angry and hostile if others have any type of reciprocating expectations. They tend to be very sensitive and do not cope well with criticism, often having intense emotional reactions and outbursts (Masterson, 1999).

Individuals with this type of personality disorder are considered to be highly resistant to change; the perpetuation of narcissistic patterns especially in interpersonal relations leads to poor prognosis. The denial of problems and factors in the environment that interfere with grandiosity and narcissistic pursuits, combined with a compensatory fantasy life, and the opportunities for gratifying support of grandiose self-experience, are additional contributing factors (Millon, 1981; Kernberg, 1980).

Individuals with narcissistic personality disorder also like to be the centre of attention, but want the attention to be based on their perceived superiority over others. The most important discriminator is the inflated self-concept of the narcissist and its various manifestations of grandiosity, including exaggeration of talent, attractiveness, grandiose fantasies and sense of uniqueness (Plakun, 1987; Ronningstam & Gunderson, 1991). They are unwilling to recognize or identify with the feelings or needs of others and when they are unable to get their needs met they discard the individual and find someone who is willing to provide for them (Holdwick et al., 1998). As a consequence they have multiple failed relationships and friendships. When they are not the centre of attention they become envious and hostile toward others and often engage in dangerous and destructive behaviours in an effort to neutralize the competition. Ronningstam (2001) found that many individuals with narcissistic personality disorder also have antisocial characteristics ranging from inconsistent and contradictory moral stands to specific criminal behaviour. Blais (1997) identified a sociopathic factor in individuals with narcissistic personality disorder in terms of their lack of empathy, exploitation, envy and grandiose sense of self-importance.

The prevalence rate for narcissistic personality disorder in the general population ranges from 0.4–1 percent (Mattia & Zimmerman, 2001; Torgersen, Lygren, Oien, Skre, Onstad, Edvardsen, Tambs & Kringlen, 2007). Research has shown that narcissistic personality disorder is found more frequently among people in higher education or special professional groups and is equally prevalent in both genders (Maffei, Fossati, Lingiardi, Madeddu, Borellini & Petrachi, 1995; Crosby & Hall 1992; Plakun, 1990). Higher rates of the disorder are found in clinical populations: 32 percent among cocaine abusers (Reich, Yates & Nduaguba, 1989), 47 percent among bipolar patients (Turley, Bates, Edwards & Jackson, 1992), 21 percent among depressed patients (Sato et al., 1997).

Narcissism is a good example of aversive social behaviour. There are elements of narcissism in both the histrionic and borderline personality disorders. Narcissism is also a good example of dysfunctional assertion; exerting influence over others that is consistently exploitative to the other's disadvantage and without regard for the other's rights is frowned upon by most groups in our society. Others will have a high social aversion to them – they are not rewarding in their relationships, have a high affiliation (how else could others admire them?) and high social anxiety.

## Schizotypic personality disorder

This personality disorder is characterized by individuals who are described as being odd and extremely isolated. Individuals with this disorder avoid forming close relationships and they frequently experience perceptual abnormalities and have odd beliefs, for example it is common for them to believe they are telepaths and have the ability to read other people's thoughts. Schizotypic speech involves many peculiarities, including unusual use of words or concepts, and

lack of clarity of thought. These peculiarities, however, never become so severe as loosening of associations or incoherence and do not meet the diagnostic criterion for schizophrenia (Burack & Enns, 1997).

Schizotypic perceptions include recurrent illusions, depersonalization or derealization. These abnormal cognitions are generally stable, but under stress can increase in severity resulting in temporary psychosis. Individuals with schizotypal personality disorder have extreme social anxiety that manifests itself in a variety of ways such as perceived threat from others, negative evaluation and rejection (Lenzenweger, 2010). Fossati et al. (2003) found that individuals with schizotypal personality disorder have difficulty with aspects of close relationships: confidence and have great discomfort with closeness.

Individuals with schizotypal personality disorders have a poor quality of life, deprived subjective well-being, reduced self-realization, less contact with friends and family, less social support, a lot of negative life events and generally a poorer global quality than the general population (Cramer et al., 2003). Skodol et al. (2002) found dysfunction in relation to parents, siblings, family members and friends as well as occupational dysfunction. Individuals with schizotypal personality disorders appear to be emotionally constricted and indifferent, experience little or no pleasure in things, seem indifferent to praise or criticism and come across as detached, cold and unexpressive (Goulding, 2004).

Neurological studies have identified brain abnormalities in people with schizotypal personality disorder such as peculiarities in startle response and eye movement response (Cadenhead et al., 2000). Coccaro & Siever (2005) have documented distinctive behavioural patterns in family members diagnosed with schizophrenia and those diagnosed with schizotypal personality disorder suggesting these behaviours share a common genetic origin.

Prevalence studies show that schizotypal personality disorder is relatively rare and occurs in 0.7–0.6 of the general population, with a higher number of schizotypal traits found in individuals with less education, and living apart from families and partners (Maier, Lichtemann, Klinger, Heun, & Hallmayer, 1992; Torgersen, Lygren, Oien, Skre, Onstad, Edvardsen, Tambs & Kringlen, 2001; Zimmerman & Coryell, 1989).

Genetic studies indicate a specific familial and genetic relationship between schizophrenia and schizotypal personality disorder, with no other personality disorder being consistently related to schizophrenia (Torgersen, 1992; Kendler & Gruenberg, 1984).

In terms of social dysfunction schizotypal individuals' major dysfunction is in affiliation; they are detached and distant and do not want close relationships. They don't tend to be overly assertive, and instead are ineffectual; they have virtually no interpersonal aversion because they have no affiliation and are not rewarding in their relationships, although they do not display the geocentricism that other personality disorders do.

## Paranoid personality disorder

This disorder is characterized by extreme suspiciousness or mistrust of people (although suspiciousness in normal social interaction is often adaptive, as the opposite of this characteristic would be naivety). Individuals with this disorder have a rigid belief system that others are out to harm them, take advantage of them, or humiliate them in some way. Even when contrary evidence and



information exists they will ignore anything that does not support their original hypothesis of harm. They continuously imagine hidden motives, are constantly scanning their environment for signs of betrayal or hostility; they often read threats and menace into everyday situations and are always on their guard. They find evidence of threat and menace with no appreciation for the context in which this evidence is found and their expectations of threat are always confirmed. Those with paranoid personality disorder also may be very critical of others, argumentative and rigid in beliefs, again stemming from harbouring unwarranted suspicions about people around them. They put a lot of effort into protecting themselves and keeping their distance from others. They are known to preemptively attack others whom they feel threatened by. They tend to hold grudges, are litigious, and display pathological jealousy. Distorted thinking is evident: their perception of the environment includes reading malevolent intentions into genuinely harmless, innocuous comments or behaviour, and dwelling on past slights. Their emotional life tends to be dominated by distrust and hostility. People with a paranoid personality disorder tend to think that other people are deliberately putting them down or are out to get them. They react really badly when they have setbacks in their lives and often bear grudges, or believe in conspiracies against them that are clearly not backed up in fact (Freeman, Bentall & Garety, 2008).

Transient ideas of reference are also part of paranoia and when inevitable interpersonal conflict arises, the paranoid individual exaggerates the problem and is reluctant to come to a resolution, remaining argumentative and disagreeable (Kantor, 2008). Requests for changes in their behaviour are interpreted as criticism and confirm their ideas of threat, which precludes criticism ever being constructive. It has been observed that the course of the disorder rarely worsens or goes into remission and remains stable over time (Akhtar, 1990). Fulton et al. (1993) found that paranoid personality disorders had less psychiatric intervention, were themselves less likely to seek treatment and although extremely dysfunctional were less likely to worsen on follow-up compared to other personality disorders.

Recent studies examining the possible relationship of PTSD and paranoid personality disorder found that individuals with paranoid personality disorder had a higher rate of comorbid post-traumatic stress disorder than subjects without the disorder (29 percent compared with 12 percent) and had higher rates of physical abuse and assault in childhood and adulthood (54 percent compared with 35 percent), suggesting a possible link between trauma during early events in life and subsequent paranoid behaviour and mistrust (Golier, Yehuda, Bierer, Mitropoulou, New, Schmeidler, Silverman & Siever, 2003). In a similar study, Humphreys et al. (2001) found that in a group of drug-dependent women who had suffered physical, emotional or sexual abuse, the survivors of physical abuse in particular were more likely to be paranoid than the emotionally or sexually abused women. Bierer & Elliott (2003) found that sexual and physical abuse in childhood appeared to be predictive of paranoid and antisocial personality disorders in later life.

The prevalence rate for paranoid personality disorder was 0.5 to 2.5 percent in the general population, and more common in males (Grant, Hasin, Stinson, Dawson, Chou, Ruan & Pickering, 2004). Ramklint, Von Knorring, Von Knorring & Ekselius (2003) identified higher risk factors for individuals developing a paranoid personality disorder if they had a previous childhood substance-related disorder. Kendler (1985) identified individuals at higher risk if first-degree relatives had a delusional disorder as opposed to relatives with schizophrenia (4.8 percent compared to 0.8 percent).



In terms of social dysfunction individuals with paranoid personality disorders display extreme interpersonal aversion, negative assertions, extreme social anxiety and negative assertions.

### Borderline personality disorder

The borderline personality disorder is characterized by an enduring instability of behaviour, cognition and affect. These individuals are argumentative and devalue others. They are manipulative without finesse, demanding, dependent, irritable, and sarcastic. They tend to report chronic feelings of loneliness and emptiness, and complain that their life lacks pleasure or enjoyment. Their personal history often includes depressive episodes, impulsivity, manipulative suicide attempts, alcohol and drug abuse, self-mutilation, unusual sexual behaviour including promiscuity, inappropriate intense anger, and transient stress-related paranoid ideation or severe dissociative symptoms and brief transient psychotic episodes. This disorder is characterized by repeated, intense, one-to-one relationships which are usually unstable, transient and brief (Skodol, Gunderson, McGlashan, Dyck, Stout, Bender, Grilo, Shea, Zanarini, Morey, Sanislow & Oldham, 2002; Gunderson & Links, 2008; Skodol, Gunderson, Pfohl, Widiger, Livesley & Siever, 2002). They are extremely impulsive and often act without thinking about consequences to themselves or others. Perry and Klerman (1980) describe individuals with borderline personality disorder as individuals who report feeling angry and then behave in an angry ways often directing their anger at a variety of targets. The borderline type shows several of the characteristics of emotional instability but includes problems with self-image, lack of personal clarity about preferences (including sexual) and chronic feelings of emptiness (Gunderson, 2007).

The prevalence rate for borderline personality disorders in the general population is between 0.2–1.8 percent (Swartz, Blazer, George & Winfield, 1990). Prevalence rates increase if patients within the mental health system are sampled, with 75 percent of patients diagnosed with borderline personality disorder being female and at younger ages at diagnosis than other personality disorders and with approximately 9 percent committing suicide (Frances, 1986). Individuals with borderline personality disorder tend to be single, separated or divorced (Zimmerman & Coryell, 1989). There is a high rate of reported sexual and physical abuse and borderlines have a high rate of contact with mental health services (Zanarini, Young, Frankenburg, Hennen, Reich, Marino & Vujanovic, 2002).

Genetic studies indicate a specific familial and genetic relationship of 0.69 giving a clear indication that genetic factors are crucial in the development of borderline personality disorder (Torgersen, Kringlen & Cramer, 2001). A number of psychosocial factors have been related to the aetiology which include: prolonged early separations and losses, disturbed parental involvement, childhood histories of physical or sexual abuse, and high prevalence of affective disorder in first-degree relatives (Zanarini & Frankenburg, 1997).

The effect of these environmental factors may be mediated through their influence on neurobiological development, particularly of the arousal system. In genetically predisposed individuals, developmental abnormalities in the frontal lobes may be stimulated by environmental insults, which lead to difficulty in inhibiting impulsive action (Rinne, de Kloet, Wouters, Goekoop, DeRijk & Van Den Brink, 2002).

Comorbidity with Axis I disorders is often a common feature. Skodol, Gunderson, McGlashan, Dyck, Stout, Bender, Grilo, Shea, Zanarini, Morey Sanislow & Oldham (2002) found that around 60 percent of patients are diagnosed with major depressive disorder; 30 percent have panic disorder with agoraphobia; 12 percent substance misuse; 10 percent bipolar-I; and 4 percent bipolar-II disorder.

### Obsessive-compulsive personality disorder

This disorder is characterized by individuals who are governed by an extreme sense of rules and behaviours, excessive perfectionism, preoccupation with orderliness, and mental and interpersonal control at the expense of flexibility and openness (Pfohl & Blum, 1991). They display ritualistic behaviours that are generally taken to an extreme and exhibit maladaptive behaviours which become ineffective and inefficient and significantly disturb the individuals' functioning in daily life. Individuals with this type of personality disorder are preoccupied with lists and small details, to the extent that purposeful activity becomes lost in the preoccupation of perfectionism at every step. They are reluctant to delegate tasks, have inflexible belief systems and morality, are often over-committed to work at the exclusion of leisure activities and interpersonal relationships, and are prone to violent rages when they are unable to completely control their environments or there is interference (Sanislow, Little, Ansell, Grilo, Daversa, Markowitz, Pinto, Shea, Yen, Skodol, Morey Gunderson, Zanarini & McGlashan, 2009).

The behavioural features of obsessive-compulsive personality disorder are that they are generally polite and formal but keep social relationships at a distance. They often lack warmth and involvement, are loyal in relationships and organizations that they do subscribe to but remain emotionally detached. They are highly respectful to authority figures, seek approval from supervisors and individuals they deem to be at a higher social and/or occupational level and are highly critical of others they consider below them and seldom giving positive feedback (Calvo et al., 2009).

In terms of cognitive characteristics, individuals are dogmatic, overly sensitive to criticism, often lack empathy toward others, have difficulty expressing affection, love and tenderness, and have high social and performance anxiety. They fear failure and of making mistakes and are frequently dissatisfied with their performance in any arena (Nestadt, Riddle, Grados, Greenberg, Fyer, McCracken, Rauch, Murphy, Rasmussen, Cullen, Pinto, Knowles, Piacentini, Pauls, Bienvenu, Wang, Liang, Samuels & Roche, 2009).

Prevalence rate for obsessive compulsive personality disorder showed a range from 1.6–6.4 percent in the general population, and range from 3–10 percent among people referred to mental health clinics, with a mean of 5 percent (Widiger & Sanderson, 1997).

Millon (1996) hypothesized that environmental factors were important in the development of this disorder and proposed that parental over-control was responsible. Millon's premise is based on the child's fear of parental rejection and retaliation. As long as the child operates within the parental approved boundaries, the child is safe from parental punishment. The child is continuously taught to comply with rules and parental expectations and must be orderly, educated, organized, punctual and scrupulous. As a result of being continuously exposed to situations where they need to show their sense of responsibility they behave in order to avoid guilty feelings and parental disapproval.

The course of obsessive-compulsive personality disorder is relatively stable through time, tends to appear during adolescence or the beginning of adult life, and is more prevalent among individuals with methodical and detailed jobs (Robinson, 1999).

In terms of social dysfunction, these individuals are extremely high in social anxiety, moderate levels of affiliation and assertion and have slight elevations of interpersonal aversion.

### Dependent personality disorder

This personality disorder is characterized by allowing others to assume responsibility for all major areas of their life. They subordinate their needs to those upon whom they depend, avoiding the necessity to be self-reliant. These individuals tend to be indecisive, lack self-confidence, are timid and ineffectual to an extreme. They have difficulty completing tasks without help, feel uncomfortable and helpless when they are alone and often go to excessive lengths to obtain support, protection and nurturance. They are often preoccupied with fears of being left alone and will immediately become involved in another relationship if the current one ends (Bornstein, 2009).

This personality is often difficult to diagnose as there are many confounding variables. For example there is support for the premise that certain individuals express dependent strivings in a flexible, modulated manner which enables them to obtain needed help and support, whereas others express dependency in ways that undermine their help- and support-seeking efforts (Bornstein, 1993). Baltes (1996) found a population-wide increase in dependent behaviour through later adulthood that is a consequence of increase in functional dependency that occurs in old age. Longitudinal research indicates stability in dependency levels. Individuals who show high rates during early adulthood continue to show high levels later in life (Abrams & Horowitz, 1996).

In marked contrast, situational variability changes dramatically in response to perceived opportunities and risks. When the dependent person believes that passive behaviour will strengthen the attachment to potential care providers, passivity develops; when the dependent individual believes that active behaviour is necessary, assertive behaviour is displayed (Bornstein, 1993).

Another important element that must be considered is the factor of culture and gender. Many cultures emphasize interpersonal attachments and gender roles more strongly than individual achievement and persons raised in these cultures and environments will show higher levels of dependency than those raised in individualist cultures that are not related to dependent personality disorder and not dysfunctional within that context (Cross, Bacon & Morris, 2000).

Research indicates that dependent personality disorder is related to genetic factors with a concordance rate in monozygotic twins of approximately 30 percent (Torgersen, Kringlen & Cramer, 2001). Currently no studies have determined what inherited factors increase dependent personality disorder but temperament has been hypothesized to be a contributing factor (Richter & Brandstrom, 2009).

The prevalence rate is estimated to be between 0 percent and 10 percent in the general population (Klein, 2003) somewhat higher in women than men (Bornstein, 1997) and between 15 and 25 percent in hospital and rehabilitation settings (Oldham, Skodol, Kellman, Hyler & Steven, 1995).

Comorbidity with Axis 1 disorders indicates substantial correlations with mood disorders, anxiety disorders, adjustment disorders, eating disorders and somatization disorders (Grodniczuk & Piper, 2001). Barber and Morse (1994) found that dependent personality disorders showed significant comorbidity with paranoid, schizotypal, antisocial, borderline, histrionic, narcissistic and obsessive-compulsive personality disorders in a mixed-sex sample of psychiatric outpatients.

In terms of social dysfunction these individuals display high negative assertions in terms of timid and ineffectual behaviour, moderate interpersonal aversion, moderate rewardingness and high affiliation needs.

### Avoidant personality disorder

Another form of social anxiety is avoidance of social interaction as in the avoidant personality. These individuals withdraw from and actively avoid social interaction and any opportunities for close personal relationships despite a strong afflictive desire. This withdrawal is the result of an extremely fearful expectation of criticism, humiliation or rejection. These individuals may have one or two close friends, but only when the other person provides constant unconditional approval and acceptance: at the first sign of criticism, they will withdraw. Social phobias, or exaggerated fears of specific social situations, may complicate pervasive and general social avoidance in this personality disorder (Tillfors & Ekselius, 2009).

The major disruptive effect of social anxiety in the avoidant personality disorder is social isolation. Avoidant personality disorder is a pervasive pattern of social inhibition, feelings of inadequacy or inferiority, and hypersensitivity to negative evaluation. People with this disorder are timid, extremely self-conscious and fearful of criticism, humiliation, and rejection, which are thought to be an extreme variant of the fundamental personality traits of neuroticism. They usually feel inadequate and uncertain when meeting someone new or doing something that is unfamiliar. Despite their great desire for the warmth of companionship, they try to avoid social situations at any cost due to their alleged fear of rejection. Because of their extreme vigilance about rejection, they are afraid to speak up in public or make requests of others. Individuals with this disorder experience extreme anxiety in social situations that dominate their emotional life and interfere with their ability to function. Their high levels of anxiety cause them to avoid social situations such as parties and other social gatherings (Turkat, 1990). Individuals with avoidant personality disorders often have a very limited social world with a small circle of confidants and tend to be very restricted (Herbert, 2007).

Skodol, Gunderson, McGlashan, Dyck, Stout, Bender, Grilo, Shea, Zanarini, Morey, Sanislow and Oldham (2002) found that certain personality traits in avoidant personality disorder, such as feeling socially inept and socially inadequate, tend to remain stable over time, while other dysfunctional behaviours that serve to adapt to defend against or compensate for ineffectual traits such as social isolation appear to change over time.

The prevalent rate for avoidant personality disorder is 0.5–2 percent of the general population, and appears equally in both genders (Grant, Hasin, Stinson, Dawson, Chou, Ruan & Pickering, 2004; Jackson et al., 2004). It is more prevalent within clinical settings and reported to present 5–35 percent in psychiatric populations (Zimmerman & Mattia, 2001). Grant, Hasin, Stinson, Dawson,

Chou, Ruan and Pickering (2004) found that individuals from lower income groups, basic educational levels, widowed/divorced/separated and never married were at higher risk for the disorder.

Comorbidity with Axis I disorders indicates high correlations with major depression, dysthymia, agoraphobia and social phobias (Alnaes & Torgersen, 1988; Johnson & Lydiard, 1995; Mauri, Sarno, Rossi, Armani, Zambotto, Cassano & Akiskal, 1992; Schneier, Spitzer, Gibbon, Fyer & Liebowitz, 1991). Depressed individuals with both avoidant personality disorder and social phobia but not social phobia alone appear to have greater social dysfunction (Alpert, Uebelacker, McLean, Nierenberg, Pava, Worthington, Tedlow, Rosenbaum & Fava, 1997). Avoidant personality disorder is often comorbid with social anxiety disorder; however it is not clear whether these two disorders are independent or if one is the extreme form of the other (Millon & Davis, 1996; Reich 2000).

In terms of social dysfunction, avoidant personality disorder displays extreme social anxiety and although they have a high affiliation, they are unable to overcome their fears.

### Schizoid personality disorder

The schizoid personality disorder is characterized by an all-encompassing pattern of detachment from social relationships and a restricted range of emotional expression. Individuals with this personality disorder avoid all social contact with others, are isolated, introverted, reclusive, unemotional, disinterested, impersonal and aloof. They are uncomfortable with all types of social contact, which includes physical and emotional and reject any type of connection with others including family and childhood friends. They prefer to engage in solitary activities and often do not derive any pleasure from participating in these activities. Individuals with this disorder are described as being emotionally cold, uncaring, unfeeling and basically uninterested in others. They rebuff any physical contact and do not engage in any type of sexual experiences with others. They are often described as being emotionally flat and show no range of affect including anger (Mittal, Kalus, Bernstein & Siever, 2007).

Beck (1990) found that individuals with schizoid personality disorder tend to view themselves as loners who value independence, solitude and mobility above interpersonal relationships with others. Frances, First and Pincus (1995) described individuals with this personality disorder as being unable to form personal relationships or to respond to others in an emotionally meaningful way.

The few social contacts they do maintain are generally first-degree relatives who demand little intimacy and make few emotional demands (Thylstrup & Hesse, 2009). Millon and Davis (1996) found that these individuals engage in social communication only when it is perfunctory and formal and often react passively to adverse circumstances and appear unable to respond appropriately to important life event.

Schizoid personality disorders desire to be are attached to their social contacts but often have conflicted feelings about how intimate the contact will be. They appear to long for the security relationships can provide while at the same time require freedom and independence (Kalus & Bernstein, 1995). Millon & Davis (1996) describe the schizoid personality disorder as an 'asocial' pattern in which people are preoccupied with tangential matters, are apathetic, and while not intentionally unkind, have a paucity of social skills and an inability to sense the needs of the people around them. They are under-responsive to most forms of stimulation or reinforcement, often

using intellectualization as a defence mechanism. Akhtar (1987) found that individuals with more normal variants were often described as being dull and uninteresting; they are able to function adequately in their occupations but avoid all types of social contact with colleagues. Individuals with this disorder will experience a low level of sadness if separated from social contacts and a low level of anxiety if they are forced into interaction with others; generally they have a lack of reactivity which results in little need for complex defence mechanisms as they engage in few complicated unconscious processes (Shedler & Westen, 2004; Millon & Davis, 1996).

Prevalence rates are estimated to be approximately 1.7 percent in the general population and appear more frequently in males who seem to be more impaired than females (Torgersen, Kringlen & Cramer, 2001; Gooding, Tallent & Matts, 2007).

Comorbidity with Axis I disorders indicates high correlations with drug and alcohol abuse, Asperger, social phobia and agoraphobia (Raine, 1989; Lenzenweger & Willett, 2009). On Axis II there are high correlations with avoidant personality disorders and schizotypal (Kalus, Bernstein & Siever, 1995).

Aetiological factors have not been established, however dopaminergic abnormalities have been proposed as a possible factor (Depue & Morrone-Stupinsky, 1999). Other factors hypothesize sociocultural factors, interaction of temperament and the environment (Henning, Herpertz & Houben, 2008).

In terms of social dysfunction, individuals with schizoid personality disorders have high social anxiety, moderate interpersonal aversion, low rewardingness (although not unpleasant they are not caring and altruistic) and have low affiliation.

### Antisocial personality disorder

Antisocial personality disorder is characterized by a broad range of symptoms in six different domains (Arrigo & Shipley, 2001; Berrios, 1996). Table 12.3 categorizes these behaviours under the six domains.

The single most revealing trait within the description of antisocial personality disorders is their lack of guilt or remorse. When they manipulate and/or take advantage of someone they have a total

**Table 12.3** Six domains of antisocial personality disorder

<b>Behavioural organization</b>	Lack of perseverance, unreliable, reckless, restless, disruptive, aggressive
<b>Emotionality</b>	Lack of anxiety, lack of remorse, lack of emotional depth, lack of emotional stability
<b>Interpersonal attachment</b>	Detached, lack of commitment, lack of empathy or concern for others
<b>Interpersonal dominance</b>	Arrogant, deceitful, manipulative, insincere, disingenuous
<b>Cognitive</b>	Suspicious, inflexible, intolerant, lack of concentration
<b>Self</b>	Self-centred, self-aggrandizement, self-justification, a sense of entitlement, uniqueness, invulnerability

Adapted from Berrios, 1996



lack of regard for their victim's feelings and assume no responsibility over their actions. They are able to consume their human victims as easily as drinking a beverage and then throwing away the empty container. Their lack of culpability is generally what others find so abhorrent. Other crucial features that distinguish these individuals are inability to profit from experience, inability to delay gratification, inability to form lasting emotional ties, stimulus seeking and superficiality (Farrington, 1991).

Earlier in our history they were called 'psychopathic' or 'sociopathic', terms that more closely defined their criminal actions. Both terms are still utilized by the general public, especially when another murderous crime spree is brought to our attention by the press, but the appropriate psychiatric/psychological term is antisocial personality disorder. Whereas schizophrenia is the disorder most closely associated with madness, antisocial personality disorder is most closely associated with inhumane crimes and criminal activity.

Individuals with antisocial personality disorders have both fascinated and horrified those who have attempted to explain the rationale behind their actions and crimes. In 1888, Koch was the first to use the term psychopath and attributed the disorder to a hereditarily determined weakness (Willis, Herve & Yuille, 2007). Freud considered these individuals to be defective rather than constitutionally inferior, believing that all antisocial individuals had failed to interject the requisite moral prerogative through the inappropriate or inadequate behaviours of their parents (Elliott, 2002). Behaviourists have focused on reinforcement and punishment practices of the family as well as behaviours and attitudes modelled by the primary caregivers. Others believe that there is a defect in the autonomic or central nervous system and use the evidence of the antisocial personality disorder's lack of emotionality.

Individuals with antisocial personality disorder have a characteristic 'emotional flatness', that is, they are less emotionally responsive than others, which many believe is why they have an inability to form affectionate relationships and lack guilt and empathy (Morizot & LeBlanc, 2005). In addition to being less emotionally responsive to others, they are also less responsive to stimuli or events that are emotionally provocative to others and as a result experience boredom more frequently (Romero, Luengo & Sobral, 2001). Boredom naturally leads to sensation seeking and various researchers have documented the antisocial's need for stimulation (Perez & Torrubia, 1985; Haapasalo, 1990; Sher, 1994).

Eysenck's (1967) personality analysis saw antisocial as being at the lower end of the cortical arousal dimension. Studies examining this dimension have consistently observed that the electroencephalographic (EEG) patterns contained a greater incidence of slow-wave activity (Deckel, Hesselbrock & Bauer, 1996; Mednick, Vka, Gabrielli & Itil, 1981; Ishikawa & Raine, 2002). Lijffijt, Cox, Acas, Lane, Moeller and Swann (2012) found that antisocials demonstrated abnormal pre-attentive filtering in pathological impulsivity. Gao and Raine (2009) found that reduced P3 amplitudes (measure of brain activity and engagement of attention) and prolonged P3 latencies reflected inefficient deployment of neural resources in processing cognitive task-relevant information. Various studies have identified lower resting levels of galvanic skin responsivity indicating a significant difference within normals and individuals identified as antisocial personality disorders and the autonomic nervous system (Lobbestael & Arntz, 2010; Schug, Raine & Wilcoz, 2007; Macintyre & Schug, 2007).



Additional support of antisocials being stimulus seekers came in vigilance tasks, in which subjects are required to watch over long periods of time, under reduced stimulus conditions, the occasional presence of a signal. The research in this area indicated that antisocials are typically under-aroused and when they are placed in a situation where they are unable to seek stimulation, they become rapidly bored and their attention to the task weakens (Orris, 1967; Lykken, 1955). Individuals with antisocial personality disorder also show a greater preference for frightening and dangerous experiences and engage in impulsive sensation seeking more often than normal subjects (Emmons & Webb, 1974; Zuckerman, 2001).

The general conclusion of these various studies is to document that antisocials are stimulus seekers because they are emotionally under-aroused. They are less responsive to stimuli that are emotionally arousing to others, and therefore slower to acquire responses that are under the control of emotional consequences. Various techniques of punishment are less effective in modifying the behaviour of the antisocial because the emotional overtones that accompany punishment as well as the emotional anticipation are lower. Antisocials do not appear to have a constitutionally defective response system to punishment; rather they have learned to be non-responsive under certain conditions and oppositional in other situations. When there is a degree of uncertainty they are responsive to punishment but only when it is relevant to them. Neurobiological evidence does point to a defect in the autonomic nervous system of antisocials, what specific elements are still unknown.

Another significant area in the aetiology of antisocial disorders is the research in the psychosocial factors of child development and parental discipline. Previous environmental and social factors, e.g. poverty, poor stimulation, overcrowding, large families, have been proved not to be causal in the development of antisocial behaviour (Raine, 2008). McCord and McCord (1963) early on demonstrated a relationship between antisocial acts and a history of inconsistent or erratic discipline. Other researchers have confirmed their findings and found that not only do the parents of children who later become antisocial use inconsistent discipline, they almost exclusively employ harsh punishment (Straus, 1999; Patterson, 1984; Patterson & Dishion, 1988; Flynn, 1999). Inconsistent punishment rapidly becomes ineffective leading to an increase in the intensity of punishment. Several studies have described the use of excessive verbal abuse and physical punishment by parents of children who later display aggressive behaviours; in addition when physical punishment is employed it is particularly harsh and generally constitutes child abuse (Feigelman, Dudowitz, Lane, Prescott, Meyer, Tracy & Kim, 2009; Winstok, 2011).

Another factor found in inconsistent parental practices was substance abuse (Fite, Colder, Lochman & Wells, 2008; Parker & Benson, 2004; Boden, Fergusson & Horwood, 2008). The parents of antisocial individuals either inconsistently vacillate between permissiveness and harshness or are persistently severe in their responses to their children (Button, Scourfield, Martin, Purcell & McGuffin, 2005). So for example, if a child is beaten and verbally abused when they are 'good' as well as when they are "bad", punishment becomes irrelevant and will not serve to discriminate amongst behaviours, thus losing its power to control unwanted behaviours in the child. In addition, if in the context of this inconsistency, both verbal and physical punishment are excessive, then the child will gradually become desensitized to the effects of punishment, again rendering these events irrelevant in the control of behaviour. As a result of genetics, family dysfunction and inconsistent parental practices we would expect that children with a predisposition

to antisocial personality disorder would have an insensitivity to both verbal and physical punishment, social and physical feedback of any form will be less provocative and these individuals will have difficulty in responding appropriately to any type of positive reinforcement and have an inability to reciprocate. Button, Scourfield, Martin, Purcell and McGuffin (2005) found that gene–environment interaction effects were highly significant in their twin study and that a risk genotype conferring susceptibility to family dysfunction was responsible for most of the variance found in their study.

Rates of prevalence for antisocial personality disorders report approximately 2–3 percent in the general population, the rate among psychiatric patients is approximately 1–2 percent and the rate among correctional offenders and substance abusers is relatively high, with approximations of 50 percent, with males outnumbering females by about 3:1 (Robins, Locke & Regier, 1991).

Individuals with antisocial personality disorder have high rates of comorbidity with substance use disorders (Hemphill, Hart & Hare, 1990; Robins, Locke & Regier, 1991). This causes more difficulty in terms of treatment issues as the combination of substance use and antisocial personality disorder is daunting. Research indicates that individuals with antisocial personality disorder engage in more disruptive behaviour during treatment, are less likely to remain in treatment and engage in more criminal activity after treatment than controls (Hemphill & Hart, 2002).

In terms of social dysfunction individuals with personality disorders have a high assertion that is combined with low interpersonal aversion. They are pleasant in their contacts with others but in a manipulative and self-serving manner. They are high in rewardingness, high in social anxiety as they do not like negative evaluations and their affiliation is moderate. Their social dysfunctions in many ways are a paradox. They are emotionally indifferent to others and insensitive to feelings, but they are able to discern their feelings well enough to charm and manipulate others to their advantage. The former is often seen as a lack of empathy and the latter as a Machiavellian skill. It is not unusual for antisocials to live with partners and to take advantage. However once the superficial interaction is over and the antisocial has used the partner for what he/she wants, they are unable to carry the relationship further. They are able to use empathy to a dysfunctional advantage and use other's emotion to sustain their own needs. Furthermore it has been shown that empathy has little to do with accurate person perception required of successful manipulators (Guterman, 1970).

## ASSESSMENT

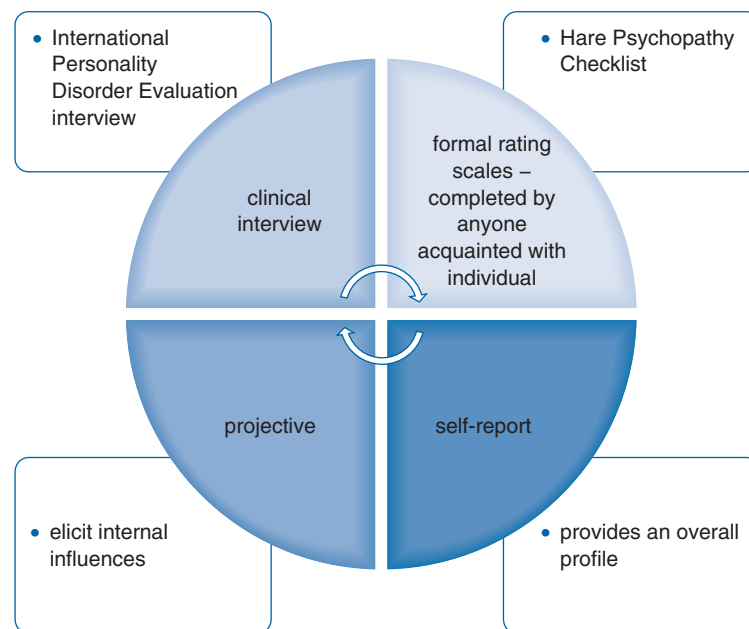
The assessment of personality disorders does not differ significantly from those disorders that are coded on Axis I and comprise the clinical disorders. There are four sources of information that are utilized in the diagnosis and assessment: observations/clinical interviews, formal rating scales and checklists, self-report inventories and projective techniques.

The clinical interview consists of the therapist asking the individual a variety of questions. A standardized type of interview has been found to be helpful as it greatly increases the reliability

and validity of the interview. One specific instrument found useful for personality disorders is the International Personality Disorder Evaluation interview. This clinical interview was developed by the World Health Organization to specifically investigate personality disorders and was designed with both the ICD-10 and the DSM-IV diagnostic criteria for personality disorders. Studies employing this instrument have demonstrated good inter-rater reliability and temporal stability (Loranger et al., 1994).

Rating scales and checklists are designed so that they can be completed by anyone who is acquainted with the individual being assessed. Rating scales are easy to use and generally require that the individual filling out the scale makes a series of judgements based on behaviour and impressions. An example of a rating scale that has been used with various personality disorders with good results is the Hare Psychopathy Checklist (PLC-R) (Hare, 1999).

Self-report inventories assess individuals by their own responses. A self-report inventory typically provides an overall profile that can be used to establish baselines to evaluate treatment progress, as well as important information on current levels of functioning and dangerous behaviour such as suicidal ideation. Two assessments that have been widely used in personality disorders are the Minnesota Multiphasic Personality Inventory (MMPI) and the Millon Clinical Multiaxial Inventory (MCMI) (Millon, Millon, Davis & Grossman, 1997; Butcher, Dahlstrom, Graham, & Tellegen, 2001).



**Figure 12.4** Assessment of personality disorders

The projective techniques are designed to elicit internal influences on behaviour with unstructured, vague or ambiguous situations. Two widely utilized instruments are the thematic apperception test which uses pictures of various interpersonal situations and the subject is asked to tell the story, and the Rorschach inkblot test where the individual is asked to describe what they see (Murray, 1943; Rorschach, 1942).

## TREATMENT

Generally individuals with personality disorders seek treatment for three reasons: an acute crisis caused by vocational or personal failures or losses; in response to requests or ultimatums from family, employer, or court; or due to an increasing sense of dissatisfaction or meaninglessness in their own life (Benjamin, 2003). The following is a brief discussion of the various treatments utilized in personality disorders.

### Psychodynamic therapy

Psychodynamic therapy is based on the premise that personality is shaped by childhood experiences, and unconscious mental functioning is responsible for behaviour, symptomatology and emotional distress. The displacement of past relationships (transference) onto present interactions with others is important to treatment and finally the therapist's emotional response back to the individual (countertransference) is a significant source of information within the treatment setting. Psychodynamic therapy focuses on symptomatic neuroses such as the behaviours that are displayed by individuals with personality disorders. The psychodynamic understanding of an individual is heavily influenced by transference and countertransference developments in the evaluation and treatment process. Personality is conceptualized as involving an ongoing attempt to actualize certain patterns of relatedness that largely reflect unconscious wishes. Psychoanalysis also studies the unique set of defence mechanisms found in each individual as a key to diagnostic understanding and treatment. Defences ward off awareness of unpleasant affect states, troubling sexual or aggressive wishes and attempts to stabilize a person's self-esteem, therefore are important in the therapeutic process (Sperry, 2003).

### Cognitive therapy

This type of therapy focuses on correcting the abnormal schemas with more appropriate schemas. Individuals with personality disorders are encouraged to evaluate and modify their global, rigid, negative beliefs about themselves, others and their worlds and to develop more realistic, adaptive ideas. Each personality disorder is characterized by a specific set of dysfunctional belief and compensatory strategies. Once individuals are able to identify their abnormal belief systems, cognitive

behavioural therapies then focus on a variety of emotional, interpersonal, supportive, problem-solving techniques to help them modify their maladaptive ideas and cognitions. Therapists help individuals with personality disorders to change their belief systems both at a cognitive level as well as an emotional level, exploring and modifying the meaning of significant childhood experiences. Cognitive restructuring is emphasized in order for individuals to identify their automatic thoughts and adapt their distorted cognitions into new functional behaviours. Therapists often use 'homework' assignments to elicit and help individuals to respond to maladaptive cognitions that interfere with more adaptive responses. Treatment is also used to solve problems and achieve specific goals. Often individuals with personality disorders have difficulty identifying goals or working towards problem solving behaviour, especially those who believe they are helpless or vulnerable (Beck, Freeman & Davis, 2007).

## Medication

Medication is used in managing specific features of personality disorders and can help facilitate the individual's ability to use psychotherapeutic techniques and interventions. Psychopharmacological intervention appears to be used only for the treatment of specific symptoms rather than the entire spectrum of personality disorder. Research in the use of medications has indicated that it is useful in treating individual differences such as perceptual-cognitive symptoms, quasi-psychotic features, impulsivity and aggression as well as affective symptoms (Soloff, Meltzer, Greer, Constantine & Kelly, 2000; Cornelius, Soloff, Perel & Ulrich, 1990; Nose, Cipriani, Biancosino, Grassi & Barbui, 2006; Fournier, DeRubeis, Shelton, Gallop, Amsterdam & Hollon, 2008). Psychopharmacological interventions have not proved effective in dealing with distress and modification of symptoms of self and interpersonal functioning (Binks, Fenton, McCarthy, Lee, Adams & Duggan, 2006). Pharmacotherapy trials have shown efficacy for neuroleptic drugs in low dose strategy against these symptoms in borderline and schizotypal patients (Bartak, Spreeuwenberg, Andrea, Holleman, Rijnerse, Rossum, Hamers, Meerman, Aerts, Busschbach, Verheul, Stijnen & Emmelkamp, 2010). The affective and impulsive components of personality disorders appear responsive to MAOs, tricyclic antidepressants and SSRIs (Soloff, Meltzer, Greer, Constantine & Kelly, 2000; Cornelius, Soloff, Perel & Ulrich, 1990; Nose, Cipriani, Biancosino, Grassi & Barbui, 2006; Fournier, DeRubeis, Shelton, Gallop, Amsterdam & Hollon, 2008).

## Combination treatment

Research indicates that the combination of psychotherapy and medication is probably the most effective in treating personality disorders (Bateman, 2009). The necessity of using psychotherapy and medication forces an examination of the principles and problems involved and the development of a rational framework for combined treatment. The combination of the two approaches ensures a more integrated, consistent and cohesive approach (Leichsenring & Leibling, 2003; Clarkin, Levy, Lenzenweger & Kernberg, 2007).

Psychodynamic	<ul style="list-style-type: none"> <li>• focuses on symptomatic neuroses</li> <li>• defence mechanisms</li> </ul>
Cognitive therapy	<ul style="list-style-type: none"> <li>• Individuals are helped to change their belief systems</li> <li>• cognitive restructuring</li> </ul>
Medication	<ul style="list-style-type: none"> <li>• treatment of specific symptoms</li> <li>• not useful for dealing with distress and modification of symptoms</li> </ul>
Combination treatment	<ul style="list-style-type: none"> <li>• combination of medication and therapy</li> </ul>

Figure 12.5

## CONCLUSION

Returning to our case studies: Andrew is a disturbing dilemma; he reveals information when he knows that his court-ordered counselling sessions are over and he will no longer be required to attend. Did he really have a friend who was participating in these horrendous acts? Was it Andrew? Or did he make up the story to deliberately upset his therapist? Clearly whatever his motivations were, and whether or not he was involved in the sexual abuse of young children, he deliberately manipulated his therapist in a way to cause the most harm. His actions and behaviours are characteristic of antisocial personality disorder – he does not feel guilt or remorse – he was ordered by the court to have counselling otherwise he would not have come in of his own free will – and then he used the sessions in order to manipulate and control as well as provide himself with amusement. Could Andrew’s therapist report him to the police? She could, but it is likely that they will be unable to do anything – no victim has come forward. Andrew could always say he was ‘messing’ with his therapist. There is no crime in making up stories during a counselling session. We can’t violate Andrew’s rights to privacy, so doing an investigation would be wrong. He never said HE was involved, only that he had knowledge of a friend. As troubling as this case is, unfortunately it is characteristic of individuals with antisocial personality disorder.

The second case concerning Edie is another difficult situation; clearly Edie will need some immediate intervention before she is released from the hospital. She exhibits many of the classic symptoms of a histrionic personality disorder; she uses illness to control her interpersonal relationships and is controlling and self-centred. Her boyfriend is angry and feels manipulated and it is highly likely that she did lie about being pregnant and miscarrying in order to manipulate her boyfriend. Her multiple suicide attempts appear to be designed to solicit the constant care and

approval she needs. Again, Edie's personality difficulties are documented in the literature; histrionics tend to use health issues and suicidal attempts to manipulate and control. They are without finesse so eventually their intimate relationships end. The major concern is that at some point Edie will misjudge one of her suicide attempts and will not be rescued in time. In her case psychotherapy combined with medication may help her understand that her actions are causing her to lose the things she most desires, and it may be possible with cognitive behavioural therapy to help Edie learn and utilize better strategies for achieving her goals and maintaining her relationships.

## Summary

This chapter began with a discussion of the classification and definition of personality disorders. It discussed the different social dimensions that are abnormal in individuals with personality disorder and then discussed the aetiology and various theories and models that have been used to clarify the development of personality disorders. The chapter then went on to discuss the specific personality disorders and provide a general overview of assessment and treatment strategies.

## LEARNING TOOLS

### Key terms

**Affiliation** – an association, connection

**Altruism** – concern for the welfare of others, unselfishness

**Assertion** – affirmation, a statement of assurance, confidence, insist on one's rights

**Countertransference** – the psychotherapist's reactions to the patient's feelings, complex feelings that the psychotherapist has towards the patient

**Empathy** – intellectual identification with another person's feelings, thoughts and attitudes

**Extroversion** – being concerned with things outside of the self; being concerned with the external environment rather than one's own thoughts and feelings

**Interpersonal aversion** – a strong feeling of dislike between persons

**Prevalence** – how widespread or common something is

**Rewardingness** – something that is given or provided – gratitude, positive return

**Schemata** – an underlying pattern or structure – provides the basis by which someone relates to the events he/she experiences

**Self-aggrandizement** – making it appear that someone is better/appear greater than they actually were/are

**Social anxiety** – distress concerning social events, occasions, contacts

**Sociopath** – a person who lacks a sense of moral responsibility or social conscience

**Transference** – the shift of emotions from one person or object to another – the transfer of feelings about a parent to an analyst



### Study guide

- 1 Why is the concept of disease not suitable when discussing personality disorders?
- 2 What are some of the issues of the classification of personality disorders?
- 3 Compare and contrast two models of personality disorder.
- 4 Detail two out of the ten personality disorders.

### Case study in focus

Discuss the various models that could be applied to Edie's behaviour. How would the psychodynamic model be different in explanation to the behaviourist's model? What models could we apply to Andrew?

### Personal development

Investigate the history and legal aspects of antisocial personality disorder. How does criminally insane differ from the psychological aspects?

### Suggested reading

- Dobbert, D. (2010) *Understanding personality disorders: An introduction*. New York: Rowman & Littlefield.
- Adshead, G. & Jacob, C. (2008) *Personality disorder: The definitive reader*. New York: Jessica Kingsley.
- Rotgers, F. & Maniaci, M.P. (2005) *Antisocial personality disorder: A practitioner's guide to comparative treatments (Comparative treatments for psychological disorders)*. New York: Springer.
- Moskovitz, R.A. (2001) *Lost in the mirror: An inside look at borderline personality disorder*. New York: Taylor Trade.