UNIT 1 BORDERLINE PERSONALITY DISORDER

Structure

1.0 INTRODUCTION

In our lives, we come across different types of people. Some persons might be over suspicious, distrustful to others while others might be much orderly and systematic even in trivial matters. We also see people who give too much importance to self and have little time for others. These people may suffer some sort of personality disorder. The individual's characteristic ways of responding are often referred to his or her personality. Most people's personality styles do not affect their behaviour similarly in all situations. Personality styles can be maladaptive if an individual is unable to modify his or her behaviour when the environment undergoes significant changes. If personality characteristics are not flexible enough to allow an individual to respond adaptively to at least an ordinary variety of situations, a disorder may be present. Personality disorders are longstanding and inflexible styles of relating to the environment. They cause problems in interpersonal relationships, on the job or result into personal distress. In this unit we will first try to understand major personality disorders and their characteristics, and then we will discuss border line personality in detail.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define the nature and types of personality disorder;

- Describe the diagnostic criteria of personality disorder;
- Describe the causes and treatment of personality disorder;
- Explain the clinical features of borderline personality disorder;
- Elucidate the causes of borderline personality disorder; and
- Discuss the treatment and prognosis of borderline personality disorder.

1.2 PERSONALITY DISORDERS

Personality disorders, which were formerly referred to as *character disorders*, are a class of personality types and behaviours that the American Psychiatric Association (APA) defines as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the culture of the individual who exhibits it. Personality disorders are noted on *Axis II the Diagnostic of Statistical and Manual-IV- Text Revised or DSM-IV-TR* of the American Psychological Association.

According to DSM- IV- TR (2000) Personality disorder is enduring subjective experiences and behaviour that deviates from cultural standards, are rigidly pervasive, have an onset in adolescence or early adulthood, are stable through time, and lead to unhappiness and impairment. So the onset of these patterns of behaviour can typically be traced back to late adolescence and the beginning of adulthood and, in rarer instances, childhood. It is therefore unlikely that a diagnosis of personality disorder will be appropriate before the age of 16 or 17 years.

Moreover, personality disorders typically do not stem from debilitating reactions to stress, as in post-traumatic stress disorder or in many cases of major depression. Rather, personality disorders stem largely from the gradual development inflexible and distorted personality and behavioural patterns, which result in persistently maladaptive ways of perceiving, thinking about, and relating to the world. These maladaptive approaches usually significantly impair at least some aspects of functioning and in some cases cause a good deal of subjective distress. For example, people with avoidant personality disorder are so shy and hypersensitive to rejection that they actively avoid most social interaction.

The DSM- IV lists ten personality disorders, grouped into three clusters in Axis II. The DSM - IV also contains a category for behavioural patterns that do not match these ten disorders, but nevertheless exhibit characteristics of a personality disorder. This category is labeled Personality Disorder not Otherwise Specified.

1.2.1 Cluster A (odd or eccentric disorders)

1) **Paranoid personality disorder (DSM- IV code 301.0):** Paranoid personality disorder is characterised by irrational suspicions and mistrust of others. Personality characteristics may be 'active', resulting in hostility, quarrels, litigation, and even violence or destructive behaviour on occasions, or 'passive', with the individual facing the world from a position of submission and humiliation. Person suffering from paranoid personality disorder believes that others dislike him and will do him down but is not able to do much about it.

2) **Schizoid personality disorder (DSM-IV code 301.20):** This disorder is characterised by lack of interest in social relationships, seeing no point in sharing time with others, anhedonia, introspection. Schizoid personalities are introverted, withdrawn, solitary, emotionally cold, and distant. Often absorbed with their

own thoughts and feelings, they fear closeness and intimacy with others. People suffering from schizoid personality disorder tend to be more daydreamers than practical action takers, often living "in a world of their own."

3) **Schizotypal personality disorder (DSM-IV code 301.22):** This is characterised by odd behaviour or thinking. Schizotypal personalities tend to have odd or eccentric manners of speaking or dressing. They often have strange, outlandish, or paranoid beliefs and thoughts. People with Schizotypal personality disorders have difficulties bonding with others and experience extreme anxiety in social situations. They tend to react inappropriately or not react at all during a conversation, or they may talk to themselves. They also have delusions characterised by "magical thinking," for example, by saying that they can foretell the future or read other people's minds.

1.2.2 Cluster B (dramatic, emotional or erratic disorders)

1) **Antisocial personality disorder (DSM-IV code 301.7):** Antisocial personality disorder is characterised by a pervasive disregard for the law and the rights of others. Antisocial personalities typically ignore the normal rules of social behaviour. These individuals are impulsive, irresponsible, and callous. They often have a history of violent and irresponsible behaviour behaviour, aggressive and even violent relationships. Antisocial personalities are at high risk for substance abuse, since it helps them to relieve tension, irritability and boredom.

2) **Borderline personality disorder (DSM-IV code 301.83):** Borderline personalities are characterised by unstable interpersonal relationships, behaviour, mood, and self-image. They are prone to sudden and extreme mood changes, stormy relationships, unpredictable and often self-destructive behaviour. These personalities have great difficulty with their own sense of identity and often experience the world in extremes, viewing experiences and others as either "black" or "white." They often form intense personal attachments only to quickly dissolve them over a perceived offense.

3) **Histrionic personality disorder (DSM-IV code 301.50):** Histrionic personality disorder, previously known as hysterical personality disorder, is a pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions. Theatrical behaviour, craving for attention and excitement, excessive reaction to minor events, and outbursts of mood characterises histrionic personality. There is a shallowness of feelings and relationships, seen by others as lack in genuineness, and producing difficulty in long-term partnership.

4) **Narcissistic personality disorder (DSM-IV code 301.81):** Narcissistic personality disorder is characterised by a pervasive pattern of grandiosity, need for admiration, and a lack of empathy. . Narcissistic personalities tend to have an exaggerated sense of self-importance, and are absorbed by fantasies of unlimited success. They also seek constant attention, and are oversensitive to failure, often complaining about multiple physical disorders. They also tend to be prone to extreme mood swings between self-admiration and insecurity, and tend to exploit interpersonal relationships.

1.2.3 Cluster C (anxious or fearful disorders)

1) **Avoidance personality disorder (DSM-IV code 301.82):** Social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance

of social interaction are the characteristic features of avoidance personality disorder. People suffering from Avoidant personality disorder are often fearful of rejection and unwilling to become involved with others. They are characterised by excessive social discomfort, shyness, fear of criticism, and avoidance of social activities that involve interpersonal contact.

2) **Dependent personality disorder (DSM-IV code 301.6):** It is characterised by pervasive psychological dependence on other people. People suffering from dependent personality disorders exhibit a pattern of dependent and submissive behaviour, relying on others to make decisions for them. They fear rejection, need constant reassurance and advice, and are oversensitive to criticism or disapproval. They feel uncomfortable and helpless if they are alone and can be devastated when a close relationship ends. Typically lacking in self-confidence, the dependent personality rarely initiates projects or does things independently.

3) **Obsessive-compulsive personality disorder (DSM-IV code 301.4):** Obsessive-compulsive disorder is characterised by rigid conformity to rules, moral codes and excessive orderliness. People suffering from this disorder are conscientious, reliable, dependable, orderly and methodical, but with an inflexibility that often makes them incapable of adapting to changing circumstances. They have such high standards of achievement that they constantly strive for perfection. Never satisfied with their performance or with that of others, they take on more and more responsibilities.

Self Assessment Questions

1) Discuss cluster A personality disorders.

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2) What are the characteristic features of cluster B personality disorders?

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3) Elucidate all the personality disorders under cluster C and highlight their characteristics.

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1.2.4 Appendix B: Criteria Sets and Axes Provided for Further Study

Appendix B contains the following disorders:

1) **Depressive personality disorder:** Depressive personality disorder is a pervasive pattern of depressive cognitions and behaviours beginning by early adulthood.

2) **Passive-aggressive personality disorder (negativististic personality disorder):** Passive-aggressive personality disorder is characterised by a pattern of negative attitudes and passive resistance in interpersonal situations.

1.2.5 Symptoms of Personality Disorder

Symptoms vary widely depending on the specific type of personality disorder, but according to the American Psychiatric Association, individuals with personality disorders have most of the following symptoms in common:

- Self-centeredness that manifests itself through a "me-first," self-preoccupied attitude.
- Lack of individual accountability that result in a "victim mentality" and blaming others for their problems.
- Lack of empathy and caring.
- Manipulative and exploitative behaviour.
- Unhappiness, suffering from depression, and other mood and anxiety disorders.
- Vulnerability to other mental disorders.
- Distorted or superficial understanding of self and others' perceptions that results in being unable to see how objectionable, unacceptable, and disagreeable their behaviour is.
- Self-destructive behaviour.
- Socially maladaptive changing the "rules of the game," or otherwise influencing the external world to conform to their own needs.

1.2.6 Causes of Personality Disorder

The exact cause of personality disorders is unknown. However, evidence points to genetic and environmental factors such as a history of personality disorders in the family. Some experts believe that traumatic events occurring in early childhood exert a crucial influence upon behaviour later in life. Others propose that people are genetically predisposed to personality disorders or that they have an underlying biological disturbance (anatomical, electrical, or neurochemical).

1.2.7 Treatment of Personality Disorder

For treatment of personality disorder, personality type entirely dictates the nature of treatment and differs for each type. Thus, for obsessive-compulsive personality disorder, for example, pharmacological treatment may be used for the component of anxiety associated with doubts, indecisiveness, and scruples.

Psychological treatment, especially cognitive behavioural treatment, concentrates upon

perfectionism, rigidity, scrupulousness, and intolerance of failure. Psychodynamic psychotherapy was formerly extensively used. For dissocial personality disorder, drugs have been used to control impulsivity and aggression. In-patient small self-help groups and the larger group therapeutic community have proved beneficial to a limited extent. Personality is regarded as relatively fixed during adult life and the aim of treatment is to enable patients to live more comfortably and safely with themselves.

Frequently personality disorder overlaps with other psychiatric disorder and this makes the other condition more difficult to treat and exacerbates the prognosis. Co-morbidity is especially frequent with substance misuse but also quite often occurs with schizophrenia, depressive illness, and neurotic disorders such as anxiety, dissociative, and obsessive–compulsive disorders.

Self Assessment Questions

1) Explain major personality disorders and their main characteristics.

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2) What are the main symptoms of personality disorder?

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3) Discuss the causes and treatment of personality disorder.

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1.3 BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder, one of ten personality disorders recognised by the DSM IV, is one of the most common personality disorders. In psychiatric settings, it accounts for about 15% of the population and about 50% of the patients with personality disorders (Widiger & Weissman, 1991). The name borderline was coined by Adolph Stern in 1938. It was officially recognised as a diagnosis in 1980. Since that time the borderline category has been used so widely that 20% of psychiatric patients are given this diagnosis and it is estimated to occur in 3 to 5% of the general population (Frances & Widiger, 1986). About two thirds of those with borderline personality disorder are female.

The name borderline personality disorder was used for patients who were on a 'borderline' between neurosis and psychosis. However, the symptoms of borderline personality disorder are not as simple as this description might make them sound: the

diagnosis of borderline personality disorder is based upon signs of emotional instability, feelings of depression and emptiness, and identity and behavioural issues, rather than signs of neurosis and psychosis. However, the 'borderline' label has remained, even though the definition has changed.

People with borderline personality disorder are often very intense, going from anger to deep depression in a short time. They are characterised by impulsivity. The mood disorders are also common with borderline personality disorder, with 24% to 74% having major depression, and 4% to 20% having bipolar disorder (Widiger & Rogers, 1989). Up to 67% of the people with personality disorder are also diagnosed with at least one induced disorder (Dulit et.al., 1993).

1.3.1 Clinical Features of Borderline Personality Disorder

According to the DSM IV (Diagnostic and Statistical Manual of Mental Disorders, fourth edition), "A person who suffers from borderline personality disorder has labile interpersonal relationships characterised by instability". This pattern of interacting with others will have persisted for years, and is usually closely related to the individual's self-image and early social interactions. The pattern is present in a variety of settings (i.e. not just at work or home), and is often accompanied by a similar lability (fluctuation back and forth, often in a quick manner) in a person's affect (mood) or feelings. Relationships and the person's affect may often be characterised as shallow. A person with this disorder may also exhibit impulsive behaviours and exhibit a majority of the following symptoms:

1) Frantic efforts to avoid real or imagined abandonment.
2) A pattern of unstable and intense interpersonal relationships characterised by alternation between extremes of idealisation and devaluation.
3) Identity disturbance - markedly and persistently unstable self-image or sense of self.
4) Impulsivity in at least two areas that are potentially self-damaging, e.g. spending, sex, substance abuse, reckless driving or binge-eating.
5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6) Affective instability due to a marked reactivity of mood, e.g. intense episodic dysphoria, irritability or anxiety, which usually lasts for between a few hours and several days.
7) Chronic feelings of emptiness
8) Inappropriate, intense anger, or difficulty controlling anger, e.g. frequent displays of temper, constant anger or recurrent physical fights.
9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

Anyone with six or more of the above traits and symptoms may be diagnosed with borderline personality disorder. However, the traits must be long standing (pervasive), and there must be no better explanation for them, e.g. physical illness, a different mental illness or substance misuse.

Although a heterogeneous group of individuals receive this diagnosis, yet they share a number of characteristics, including fears of abandonment, unstable personal relationships, impulsivity, threats of self-destructive behaviour, and chronic range of

cognitive distortions. Many people with borderline personality disorder are prone to impulsive behaviour. This impulsiveness can manifest itself in negative ways. For example, self-harm is common among individuals with borderline personality disorder and, in many instances, this is an impulsive act.

Sufferers of borderline personality disorder can also be prone to angry outbursts and even criminal offences as a result of impulsive urges (mainly male sufferers). Another common feature of borderline personality disorder is affective liability; sufferers have trouble stabilizing moods – as a result, mood changes can become erratic. Other characteristics of this condition include the distortion of reality, a tendency to see things in 'black and white' terms, excessive behaviour such as gambling or sexual promiscuity, and proneness to depression. A person with this disorder can often be bright and intelligent, and appear warm, friendly and competent.

They sometimes can maintain this appearance for a number of years until their defense structure crumbles, usually around a stressful situation like the breakup of a romantic relationship or the death of a parent. Relationships with others are intense but stormy and unstable with marked shifts of feelings and difficulties in maintaining intimate, close connections. The person may manipulate others and often has difficulty with trusting others.

There is also emotional instability with marked and frequent shifts to an empty lonely depression or to irritability and anxiety. The person may show inappropriate and intense anger or rage with temper tantrums, constant brooding and resentment, feelings of deprivation, and a loss of control or fear of loss of control over angry feelings. There are also identity disturbances with confusion and uncertainty about self-identity, sexuality, life goals and values, career choices, friendships. Under extreme stress or in severe cases there can be brief psychotic episodes with loss of contact with reality or bizarre behaviour or symptoms. Even in less severe instances, there is often significant disruption of relationships and work performance. The depression which accompanies this disorder can cause much suffering and can lead to serious suicide attempts.

1.3.2 Causes of Borderline Personality Disorder

Although there is no specific cause for borderline personality disorder, like most other mental disorders, it is understood to be the result of a combination of biological vulnerabilities, ways of thinking, and social stressors. An overview of the existing literature suggested that traits related to borderline personality disorder are influenced by genes (Torgersen, 2000). A major twin study found that if one identical twin met criteria for borderline personality disorder, the other also met criteria in 35% of cases. People that have borderline personality disorder influenced by genes usually have a close relative with the disorder (Torgersen, Lygren, Oien, 2000).

One psychosocial influence that has received great deal of attention is the possible contribution of childhood trauma, especially sexual and physical abuse. Numerous studies have shown a strong correlation between child abuse, especially child sexual abuse and development of borderline personality disorder (Kluft, 1990; Zanarini et.al., 1989; Herman, 1992; Quadrio, 2005). Many individuals with borderline personality disorder report to have had a history of abuse and neglect as young children (Zanarini & Frankenburg, 1997).

Patients with borderline personality disorder have been found to be significantly more likely to report having been verbally, emotionally, physically or sexually abused by their caregivers of either gender. There has also been a high incidence of incest and

loss of caregivers in early childhood for people with borderline personality disorder. They were also much more likely to report having caregivers (of both genders) deny the validity of their thoughts and feelings.

They were also reported to have failed to provide needed protection, and neglected their child's physical care. Parents (of both sexes) were typically reported to have withdrawn from the child emotionally, and to have treated the child inconsistently. Besides the child abuse other factors including family environment have also been found to contribute to the development of the disorder (Bradley, Jenei, & Westen, 2005).

For example Bradley et al. (2005) found that both child sexual abuse and childhood physical abuse and borderline personality disorder symptoms were significantly related, and both child sexual abuse and childhood physical abuse were significantly related to family environment. When family environment and childhood physical abuse were entered simultaneously into a regression equation, family environment was related to borderline personality disorder symptoms and childhood physical abuse was related to borderline personality disorder symptoms, although the relationship between borderline personality disorder symptoms and childhood physical abuse was reduced.

Therefore, child sexual abuse and childhood physical abuse both directly influence the development of borderline personality disorder symptoms directly and are mediated by family environment.

Borderline personality disorder has been found among people who have gone through rapid socio-cultural changes. The problem of identity, emptiness, fears of abandonment, and low anxiety threshold have been found in child and adult immigrants (Laxenaire, Ganne-Vevonec, & Streiff, 1982; Skhiri, Annabi, Bi, & Allani, 1982).

These observations further support the possibility that early trauma may, in some individuals, lead to borderline personality disorder.

1.3.3 Treatment of Borderline Personality Disorder

The American Psychiatric Association reports that recent advancements have led to treatments reaching an 86% remission rate 10 years after treatment. Treatments for borderline personality disorder have improved in recent years. Group and individual psychotherapy are at least partially effective for many patients.

Within the past 15 years, a new psychosocial treatment termed dialectical behaviour therapy (DBT) was developed specifically to treat borderline personality disorder, and this technique has looked promising in treatment studies (Koerner, & Linehan, 2000).

Dialectical behaviour therapy is an approach to psychotherapy in which the therapist specifically addresses four areas that tend to be particularly problematic for individuals with borderline personality disorder: self-image, impulsive behaviours, mood instability, and problems in relating to others.

To address those areas, treatment with dialectical behaviour therapy tries to build four major behavioural skill areas: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness.

Talk therapy that focuses on helping the person understand how their thoughts and behaviours affect each other (cognitive behavioural therapy or CBT) has also been found to be effective treatment for borderline personality disorder.

Other psychotherapy approaches that have been used to address borderline personality disorder include interpersonal psychotherapy (IPT) and psychoanalytic therapy. Interpersonal psychotherapy is an approach that focuses on how the person's symptoms are related to the problems that person has in relating to others.

Psychoanalytic therapy, which seeks to help the individual understand and better manage his or her ways of defending against negative emotions, has been found to be effective in addressing borderline personality disorder, especially when the therapist is more active or vocal than in traditional psychoanalytic treatment and when this approach is used in the context of current rather than past relationships.

Pharmacological treatments are often prescribed based on specific target symptoms shown by the individual patient. Antidepressant drugs and mood stabilizers may be helpful for depressed and/or labile mood. Antipsychotic drugs may also be used when there are distortions in thinking.

1.3.4 Prognosis

As with any illness, an appropriate question about borderline personality disorder is if it is curable. While improvement in any personality disorder is not synonymous with being cured, the symptoms of borderline personality disorder do tend to diminish with time.

How well or poorly people with borderline personality disorder progress over time seems to be influenced by how severe the disorder is at the time that treatment starts, the state of the individual's current personal relationships, whether or not the sufferer has a history of being abused as a child, as well as whether or not the person receives appropriate treatment.

Simultaneously suffering from depression, other emotional problems, or a low level of conscientiousness have been found to be associated with a greater likelihood of symptoms of borderline personality disorder returning (relapse).

Self Assessment Questions

1) Explain the characteristic features of borderline personality disorder.

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2) What are the causes of borderline personality disorder?

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3) Discuss the treatment and prognosis of borderline personality disorder.

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1.4 LET US SUM UP

Personality disorder is enduring subjective experiences and behaviour that deviates from cultural standards, are rigidly pervasive, have an onset in adolescence or early adulthood, are stable through time, and lead to unhappiness and impairment. The DSM- IV lists ten personality disorders, grouped into three clusters in Axis II. These ten personality disorders are: 1-Paranoid personality disorder, 2-Schizoid personality disorder, 3-Schizotypal personality disorder, 4- Antisocial personality disorder, 5- Borderline personality disorder, 6-Histrionic personality disorder, 7- Narcissistic personality disorder, 8- Avoidance personality disorder, 9- Dependent personality disorder, and 10- Obsessive-compulsive personality disorder.

The exact cause of personality disorders is unknown. However, evidence points to genetic and environmental factors such as a history of personality disorders in the family. Some experts believe that traumatic events occurring in early childhood exert a crucial influence upon behaviour later in life. Others propose that people are genetically predisposed to personality disorders or that they have an underlying biological disturbance (anatomical, electrical, or neurochemical).

For treatment of personality disorder, personality type entirely dictates the nature of treatment and differs for each type. Psychological treatment, especially cognitive–behavioural treatment, concentrates upon perfectionism, rigidity, scrupulousness, and intolerance of failure. Psychodynamic psychotherapy was formerly extensively used. For dissocial personality disorder, drugs have been used to control impulsivity and aggression.

Borderline Personality Disorder, one of ten personality disorders recognised by the DSM IV, is one of the most common personality disorders. In psychiatric settings, it accounts for about 15% of the population and about 50% of the patients with personality disorders. Borderline personality disorder is a personality disorder characterised by consistently problematic ways of thinking, feeling, and interacting. In order to be diagnosed with borderline personality disorder, the sufferer must experience at least five of the following symptoms: unstable self-image, relationships or emotions, severe impulsivity, repeated suicidal behaviours or threats, chronic feelings of emptiness, inappropriate anger, trouble managing anger, or transient paranoia or dissociation. Psychotherapy approaches that have been helpful in treating borderline personality disorder include dialectical behaviour therapy, cognitive behavioural therapy, interpersonal therapy, and psychoanalytic psychotherapy.

The use of psychiatric medications like antidepressants, mood stabilizers, and antipsychotics may be useful in addressing some of the symptoms of borderline personality disorder but do not manage the illness in its entirety. While the symptoms of borderline personality disorder tends to diminish over years for many people, how well or poorly people with borderline personality disorder progress over time seems to be influenced by the severity of the symptoms, the individual's current personal relationships, whether or not the sufferer has a history of being abused as a child, as well as whether or not the individual receives appropriate treatment.

1.5 UNIT END QUESTIONS

1) What do you mean by personality disorder? Discuss the major personality disorders.

2) Explain the diagnostic features of personality disorder.

3) Discuss the symptoms and treatment of personality disorder.

4) Prepare a clinical picture of borderline personality disorder.

5) What are the causes of borderline personality disorder?

6) Discuss the treatment and prognosis of borderline personality disorder.

1.6 GLOSSARY

Anhedonia : Inability to experience pleasure, associated with some mood and schizophrenic disorders.

Antisocial personality disorder: Personality disorder involving a pervasive disregard for the law and the rights of others.

Avoidant personality disorder : Personality disorder characterised by social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction.

Borderline personality disorder : Personality disorder involving extreme "black and white" thinking, instability in relationships, self-image, identity and behaviour. Borderline personality disorder occurs in 3 times as many females than males.

Cognitive-behavioural therapy : Group of treatment procedures aimed at identifying and modifying faulty thought processes, attitudes and attributions, and problem behaviours.

Dependent personality disorder : Personality disorder characterised by pervasive psychological dependence on other people.

Depressive personality disorder: Personality disorder involving is a pervasive pattern of depressive cognitions and behaviours beginning by early adulthood.

Dialectical behaviour therapy : It is an approach to psychotherapy in which the therapist specifically addresses four areas that tend to be particularly problematic for individuals with borderline personality disorder: self-image, impulsive behaviours, mood instability, and problems in relating to others.

Histrionic personality disorder: Personality disorder characterised by pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions.

Interpersonal psychotherapy : Newer brief treatment approach that emphasises resolution of interpersonal problems and stressors such as role disputes in marital conflict, or forming relationships in marriage or new job. It has demonstrated effectiveness for such problems as depression.

Interpersonal therapy : Brief, structured treatment that focuses on teaching a person skills to improve existing relationships or develop new ones.

Narcissistic personality disorder: Personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.

Obsessive-compulsive personality disorder : Personality disorder characterised by rigid conformity to rules, moral codes and excessive orderliness.

Paranoid personality disorder : Personality disorder characterised by irrational suspicions and mistrust of others.

Passive aggressive personality disorder Personality disorder characterised by a pattern of negative attitudes and passive resistance in interpersonal situations.

Personality disorders : Enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.

Schizoid personality disorder : Personality disorder involving lack of interest in social relationships, seeing no point in sharing time with others.

Schizotypal personality disorder : Personality disorder characterised by odd behaviour or thinking.

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UNIT 2 NARCISSISTIC PERSONALITY DISORDER

Structure

2.0 INTRODUCTION

In our social interactions we sometimes come across to such persons who are in love with the self and give too much importance to it. They have great expectations of social favours and constant attentions for others. They feel that they are very special in brilliance, power and, beauty and take advantage of others. They consider themselves somehow different from others and deserving special treatment. They exhibit extreme self-importance, inability to empathize with others and heightened sensitivity to criticism. Self-involvement and lack of empathy characterise this personality disorder. In narcissistic personality disorder this tendency is taken to its extreme. Narcissistic personality disorder is a pervasive disorder characterised by self-centeredness, lack of empathy, and an exaggerated sense of self-importance. In the present unit we will discuss the nature, diagnostic features, causes, and treatment of narcissistic personality disorder.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the meaning of narcissistic personality disorder;
- Understand the diagnostic features of narcissistic personality disorder;
- Describe the causes of narcissistic personality disorder; and
- Explain the treatment and prognosis of narcissistic personality disorder.

2.2 NARCISSISTIC PERSONALITY DISORDER

Sigmund Freud (1856-1939) is credited with the promulgation and presentation of a first coherent theory of narcissism. He described transitions from subject directed libido (*The psychic and emotional energy associated with instinctual biological*

drives. According to Freud, all behaviour is motivated by the desire to feel pleasure. That motivation is organised and directed by two instincts: sexuality (Eros), and aggression (Thanatos). Freud conceptualised both these instincts as being powered by a form of internal psychic energy that he called the Libido. Libido is the pleasure principle, or basic psychic energy.) to object directed libido through the intermediation and agency of the parents. To be healthy and functional, the transitions must be smooth and unperturbed. Neuroses are the results of such perturbations.

Freud conceived of each stage of development linked to the next stage of development. Thus, if a child reaches out to his objects of desire and fails to attract their love and attention, the child will regress to the previous phase, to the narcissistic phase. The first occurrence of narcissism is adaptive.

It "trains" the child to love an object. It ensures gratification through availability, predictability and permanence. But regressing to "secondary narcissism" is maladaptive. It is an indication of failure to direct the libido to the "right" targets (to objects, such as the child's parents).

Secondary narcissism corresponds to the return of the libido to the ego , that is withdrawn from objects. Freud described this for the first time in relation to a state he called "paraphrenia," which corresponded to the schizophrenia identified by Bleuler. Withdrawal of the libidinal investment in objects, followed by a reinvestment in the ego, was considered responsible for two characteristic manifestations, that is,

i) lack of interest in the external world and

ii) delusions of grandeur.

If this pattern of regression persists and prevails, a "narcissistic neurosis" is formed. The narcissist prefers fantasyland to reality, grandiose self conception to realistic appraisal, masturbation and sexual fantasies to mature adult sex , and daydreaming to real life achievements.

Carl Gustav Jung (1875-1961) had a mental picture of the psyche as a giant warehouse of archetypes (the conscious representations of adaptive behaviours). Fantasies to him were just a way of accessing these archetypes and releasing them. Any reversion to earlier phases of mental life, to earlier coping strategies, to earlier choices is interpreted as simply the psyche's way of using yet another, hitherto untapped, adaptation strategy.

Actually, there is little difference between Freud and Jung. When libido investment in objects (esp. the Primary Object) fails to produce gratification, maladaptation results that is a default option is activated which is secondary narcissism. This default enhances adaptation, it is functional and adaptive and triggers adaptive behaviours. As a by product, it secures gratification.

We are at such peace when we exert reasonable control over our environment, i.e., when our behaviours are adaptive. The compensatory process has two results (i) enhanced adaptation and (ii) inevitable gratification. Perhaps the more serious division between them is with regard to introversion. Freud regards introversion as an instrument in the service of a pathology

As opposed to Freud, Jung regards introversion as a useful tool in the service of the endless psychic quest for adaptation strategies (narcissism being one such strategy). The Jungian adaptation repertoire does not discriminate against narcissism. To Jung

it is as legitimate a choice as any. But even Jung acknowledged that the very need to look for a new adaptation strategy means that adaptation has failed. In other words, the search itself is indicative of a pathological state of affairs. It does seem that introversion per se is not pathological (because no psychological mechanism is pathological per se). Only the use made of it can be pathological.

Jung distinguished introverts (those who habitually concentrate on their selves rather than on outside objects) from extroverts. Not only was introversion a totally normal and natural function in childhood, it remains normal and natural even if it predominates the mental life.

Pathological narcissism is exclusive and all pervasive. Other forms of narcissism are not. Hence though there is no healthy state of habitual, predominant introversion, it remains a question of form and degree of introversion. Often a healthy, adaptive mechanism goes awry. When it does, as Jung himself recognised, neuroses form.

Freud regards Narcissism as a point, while Jung regards it as a continuum (from health to sickness).

In a way, Heinz Kohut took Jung a step further. He said that pathological narcissism is not the result of excessive narcissism, libido or aggression. It is the result of defective, deformed or incomplete narcissistic (self) structures. Kohut postulated the existence of core constructs which he named: the Grandiose Exhibitionistic Self and the Idealized Parent Image.

Children entertain notions of greatness (primitive or naive grandiosity) mingled with magical thinking, feelings of omnipotence and omniscience and a belief in their immunity to the consequences of their actions. These elements and the child's feelings regarding its parents combine and form these constructs. The child's feelings towards its parents are reactions to their responses (affirmation, buffering, modulation or disapproval, punishment, even abuse). These responses help maintain the self structures. Without the appropriate responses, grandiosity, for instance, cannot be transformed into adult ambitions and ideals. To Kohut, grandiosity and idealisation were positive childhood development mechanisms. Even their reappearance in transference should not be considered a pathological narcissistic regression.

Kohut agreed with Freud that neuroses are conglomerates of defence mechanisms, formations, symptoms, and unconscious conflicts. He even accepted the unresolved Oedipal conflicts (ungratified unconscious wishes and their objects) as the root of neuroses. But he identified a whole new class of disorders: the self-disorders. These were the result of the perturbed development of narcissism.

It was not a superficial distinction. Self disorders were the results of childhood traumas quite different from Freud's Oedipal, castration and other conflicts and fears. These are the traumas of the child either not being seen (an existence, not affirmed by the Primary Objects, that is the parents) or being regarded as an object for gratification or abuse. Such children develop to become adults who are not sure that they do exist (lack a sense of self continuity) or that they are worth anything (lack of self worth, or self esteem). They suffer depressions, as neurotics do. But the source of these depressions is existential (a gnawing sensation of emptiness) as opposed to the "guilty-conscious" depressions of neurotics.

They are individuals whose disorders can be understood and treated only by taking into consideration the formative experiences in childhood of the total body mind self and its self object environment as for instance, the experiences of joy of the total self

feeling confirmed, which leads to pride, self esteem, zest, and initiative; or the experiences of shame, loss of vitality, deadness, and depression of the self who does not have the feeling of being included, welcomed, and enjoyed."

This is not to say that they do not change - rather, that they are capable only of slow change. Kohut and his Self-psychology disciples believed that the only viable constructs are comprised of self-selfobject experiences and that these structures are lifelong ones. Melanie Klein belived more in archaic drives, splitting defenses and archaic internal objects and part objects. Winnicott (and Balint and other, mainly British researchers) as well as other ego-psychologists thought that only infantile drive wishes and hallucinated oneness with archaic objects qualify as structures.

Narcissism. Karen Horney's Contributions

Horney is one of the precursors of the "Object Relations" school of psychodynamics. She said that personality was shaped mostly by environmental issues, social or cultural. She believed that relationships with other humans in one's childhood determine both the shape and functioning of one's personality. She expanded the psychoanalytic repertoire. She added needs to drives. Where Freud believed in the exclusivity of the sex drive as an agent of transformation, Horney believed that people (children) needed to feel secure, to be loved, protected, emotionally nourished and so on. She believed that the satisfaction of these needs or their frustration early in chlildhood were as important a determinant as any drive. Society was introduced through the parental door. Biology converged with social injunction to yield human values such as the nurturance of children.

Horney's great contribution was the concept of anxiety. Freudian anxiety was a rather primitive mechanism, a reaction to imaginary threats arising from early childhood sexual conflicts. Horney argued convincingly that anxiety is a primary reaction to the very dependence of the child on adults for its survival. Children are uncertain (of love, protection, nourishment, nurturance) and so they become anxious.

Defenses are developed to compensate for the intolerable and gradual realisation that dults are human. They are capricious, arbitrary, unpredictable and non dependable. Defenses provide both satisfaction and a sense of security. The problem still exists, even as the anxiety does, but they are "one stage removed". When the defenses are attacked or perceived to be attacked (such as in therapy) anxiety is reawakened.

The capacity to be alone develops out of the baby's ability to hold onto the internalisation of his mother, even during her absences. It is not just an image of mother that he retains but also her loving devotion to him. Thus, when alone, he can feel confident and secure as he continues to infuse himself with her love. The addict has had so few loving attachments in his life that when alone he is returned to his detached, alienated self.

This feeling state can be compared to a young child's fear of monsters without a powerful other to help him, the monsters continue to live somewhere within the child or his environment. It is not uncommon for patients to be found on either side of an attachment pendulum. It is invariably easier to handle patients for whom the transference erupts in the idealising attachment phase than those who view the therapist as a powerful and distrusted intruder.

So, the child learns to sacrifice a part of his autonomy, in order to feel secure. Horney identified three neurotic strategies: submission, aggression and detachment. The choice of strategy determines the type of personality, or rather of neurotic

personality. The submissive (or compliant) type is fake. He hides aggression beneath the facade of friendliness. The aggressive type is fake as well: at heart he is submissive. The detached neurotic withdraws from people. This cannot be considered an adaptive strategy.

Horney's is an optimistic outlook. Because she believes biology is only one of the forces shaping our adulthood, and culture and society being the predominant ones, she believes in reversibility and in the power of insight to heal. She believes that if an adult were to understand his problem (his anxiety) he would be able to eliminate it altogether. Other theoreticians are much more pessimistic and deterministic.

They think that childhood trauma and abuse are rather impossible to reprogramme, let alone erase. Modern brain research tends both to support this view and offer some solution. The brain seems to be plastic. It is physically impressed with abuse and trauma. But no one knows when this "window of plasticity" shuts. It is conceivable that this plasticity continues well into adulthood and that later "reprogramming" (by loving, caring, compassionate and empathic experiences) can remold the brain permanently. Yet others believe that the patient has to accept his disorder as a given and work AROUND it rather than attack it directly.

Our disorders were adaptive and helped us to function. Their removal may not always be wise or necessary to attain a full and satisfactory life. additionally, we should not all conform to a mold and experience life the same. Idiosyncracies are a good thing, both on the individual level and on the level of the species. The word "narcissism" comes from a Greek mythology in which a handsome young man named Narcissus sees his reflection in a pool of water and falls in love with it. Psychoanalysts, including Sigmund Freud, used the term narcissistic to describe people who show an exaggerated sense of self-importance and are preoccupied with receiving attention (Cooper & Ronningstam, 1992). Narcissistic personality disorder is one of a group of conditions called dramatic personality disorder. People with these disorders have intense, unstable emotions and a distorted self-image. Narcissistic personality disorder is further characterised by an abnormal love of self, an exaggerated sense of superiority and importance, and a preoccupation with success and power. However, these attitudes and behaviours do not reflect true self-confidence. Instead, the attitudes conceal a deep sense of insecurity and a fragile self-esteem. Some of the common traits of a narcissistic type person are:

- An inability to listen to others, and
- A lack of awareness of another person's deadlines, time frames, or interests.
- An inability to admit wrongdoing, even sometimes when presented with evidence of their 'wrong' behaviour.
- Coldness or overly practical responses to interpersonal relationships,
- A sense of distance or matter of factness emotionally.
- Can be prone to severe bouts of anger.
- Has the ability to write friends off forever, over one perceived or actual transgression.
- Pride in the accomplishments of children if they have them, often combined with an overly developed desire for control over their directions and activities.
- An above average interest in social class and importance may be seen.

It should be noted that narcissistic personality disorder exists as a diagnostic category only in *DSM-IV-TR*, which is an American diagnostic manual. The *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-*10,* the European equivalent of *DSM)* lists only eight personality disorders. What *DSM-IV-TR* defines as narcissistic personality disorder, *ICD-10* lumps together with "eccentric, impulsive-type, immature, passive-aggressive, and psychoneurotic personality disorders."

Narcissistic personality disorder was introduced as a new diagnostic category in *DSM-III*, which was published in 1980. Prior to *DSM-II*, narcissism was a recognised phenomenon but not an official diagnosis.

At that time, narcissistic personality disorder was considered virtually untreatable because people who suffer from it rarely enter or remain in treatment. Typically, they regard themselves as superior to their therapist, and they see their problems as caused by other people's "stupidity" or "lack of appreciation."

More recently, however, some psychiatrists have proposed dividing narcissistic patients into two subcategories based roughly on age:

i) those who suffer from the stable form of narcissistic personality disorder described by *DSM-IV-TR*, and

ii) younger adults whose narcissism is often corrected by life experiences.

This age group distinction represents an ongoing controversy about the nature of narcissistic personality disorder whether it is fundamentally a character disorder, or whether it is a matter of learned behaviour that can be unlearned. Therapists who incline toward the first viewpoint usually pessimistic about the results of treatment for patients with narcissistic personality disorder.

2.2.1 Diagnostic Features of Narcissistic Personality Disorder

DSM-IV-TR specifies nine diagnostic criteria for narcissistic personality disorder. For the clinician to make the diagnosis, an individual must fit five or more of the following descriptions:

- He or she has a grandiose sense of self-importance (exaggerates accomplishments and demands to be considered superior without real evidence of achievement).
- He or she lives in a dream world of exceptional success, power, beauty, genius, or "perfect" love.
- He or she thinks of him or herself as "special" or privileged,
- He or she can only be understood by other special or high status people.
- He or she demands excessive amounts of praise or admiration from others.
- He or she feels entitled to automatic deference, compliance, or favourable treatment from others.
- He or she is exploitative towards others and takes advantage of them.
- He or she lacks empathy and does not recognise or identify with others' feelings.
- He or she is frequently envious of others or thinks that they are envious of him or her.

- He or she "has an attitude" or frequently acts in haughty or arrogant ways.

In addition to these criteria, *DSM-IV-TR* groups narcissistic personality disorder together with three other personality disorders in Cluster B. These four disorders are grouped together on the basis of symptom similarities, insofar as patients with these disorders appear to others as overly emotional, unstable, or self dramatising.

The other three disorders in Cluster B are antisocial, borderline, and histrionic personality disorders.

The *DSM-IV-TR* clustering system does not mean that all patients can be fitted neatly into one of the three clusters. It is possible for patients to have symptoms of more than one personality disorder or to have symptoms from different clusters. In addition, patients diagnosed with any personality disorder may also meet the criteria for mood, substance abuse, or other disorders.

People with narcissistic personality disorder have an unreasonable sense of self-importance and are so preoccupied with themselves that they lack sensitivity and compassion for other people (Gunderson, Ronningstam, & Smith, 1995). They are not comfortable unless someone is admiring them. Their exaggerated feelings and their fantasies of greatness, called "grandiosity" create a number of negative attributes. They require and expect a great deal of special attention. They also tend to use or exploit others for their own interests and show little empathy. When confronted with other successful people, they can be extremely envious and arrogant. Thus narcissistic personality disorder involves a pattern of self-centered or egotistical behaviour that shows up in thinking and behaviour in a lot of different situations and activities. People with narcissistic personality disorder would not (or can not) change their behaviour even when it causes problems at work or when other people complain about the way they act, or when their behaviour causes a lot of emotional distress to others (or themselves). This pattern of self-centered or egotistical behaviour is not caused by current drug or alcohol use, head injury, acute psychotic episodes, or any other illness, but has been going on steadily at least since adolescence or early adulthood.

2.2.2 Subtypes of Narcissistic Personality Disorder

Millon (1996) identified five subtypes of narcissist. Any individual narcissist may exhibit none or one of the following:

i) **Unprincipled narcissist including antisocial features:** Such an Unprincipled narcissist will be fraudulent, exploitative, deceptive and unscrupulous individual.

ii) **Amorous narcissist including histrionic features:** Such an Amorous narcissist will be an erotic, exhibitionist.

iii) **Compensatory narcissist:** This includes negativistic (passive-aggressive), avoidant features.

iv) **Elitist narcissist:** This is a variant of pure pattern. Corresponds to "phallic narcissistic" personality type.

v) **Fanatic type including paranoid features:** A severely narcissistic individual, usually with major paranoid tendencies and who holds onto an illusion of omnipotence.

Some have suggested the following subcategories of narcissistic personalities:

i) **Craving narcissists:** These are people who feel emotionally needy and undernourished, and may well appear clingy or demanding to those around them.

ii) **Paranoid narcissists:** This type of narcissist feels intense contempt for him- or herself, but projects it outward onto others. Paranoid narcissists frequently drive other people away from them by hypercritical and jealous comments and behaviours.

iii) **Manipulative narcissists:** These people enjoy "putting something over" on others, obtaining their feelings of superiority by lying to and manipulating them.

iv) **Phallic narcissists:** Almost all narcissists in this subgroup are male. They tend to be aggressive, athletic, and exhibitionistic; they enjoy showing off their bodies, clothes, and overall "manliness."

DSM-IV-TR states that 2% to 16% of the clinical population and slightly less than 1% of the general population of the United States suffers from narcissistic personality disorder. Between 50% and 75% of those diagnosed with narcissistic personality disorder are males. Little is known about the prevalence of narcissistic personality disorder across racial and ethnic groups. Like most personality disorders, narcissistic personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

Narcissistic personality disorder is more prevalent in males than females. The high preponderance of male patients in studies of narcissism has prompted researchers to explore the effects of gender roles on this particular personality disorder. Some have speculated that the gender imbalance in narcissistic personality disorder results from society's disapproval of self centered and exploitative behaviour in women, who are typically socialised to nurture, please, and generally focus their attention on others.

Some are of the view that the imbalance is more apparent than real, and that it reflects a basically sexist definition of narcissism. Like most personality disorders, narcissistic personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

2.2.3 Causes of Narcissistic Personality Disorder

While the exact cause of narcissistic personality disorder is unknown, researchers have identified some factors that may contribute to the disorder. Childhood experiences such as parental overindulgence, excessive praise, unreliable parenting, and a lack of realistic responses are thought to contribute to narcissistic personality disorder.

Although researchers today do not know what exactly causes narcissistic personality disorder, there are many theories, however, about the possible causes of narcissistic personality disorder.

For example, Kohut (1977) and Kernberg (1984) attempted to trace the roots of narcissistic personality disorder to disturbances in the patient's family of origin specifically, to problems in the parent child relationship before the child turned three.

Where they disagree is in their accounts of the nature of these problems. According to Kohut (1977), the child grows out of primary narcissism through opportunities to be mirrored by (i.e., gain approval from) his or her parents and to idealise them,

acquiring a more realistic sense of self and a set of personal ideals and values through these two processes.

On the other hand, if the parents fail to provide appropriate opportunities for idealisation and mirroring, the child remains "stuck" at a developmental stage in which his or her sense of self remains grandiose and unrealistic while at the same time he or she remains dependent on approval from others for self-esteem.

In contrast, Kernberg (1985) views narcissistic personality disorder as rooted in the child's defense against a cold and unempathetic parent, usually the mother.

Emotionally hungry and angry at the depriving parents, the child withdraws into a part of the self that the parents value, whether looks, intellectual ability, or some other skill or talent. This part of the self becomes hyper-inflated and grandiose.

Any perceived weaknesses are "split off" into a hidden part of the self. Splitting gives rise to a lifelong tendency to swing between extremes of grandiosity and feelings of emptiness and worthlessness. In both accounts, the child emerges into adult life with a history of unsatisfactory relationships with others.

The adult narcissist possesses a grandiose view of the self but has a conflict-ridden psychological dependence on others. At present, however, psychiatrists do not agree in their description of the central defect in narcissistic personality disorder; some think that the problem is primarily emotional while others regard it as the result of distorted cognition, or knowing.

Other theorists maintain that the person with narcissistic personality disorder has an "empty" or hungry sense of self while others argue that the narcissist has a "disorganised" self. Still others regard the core problem as the narcissist's inability to test reality and construct an accurate view of him- or herself.

According to sociologist Lasch (1978) narcissistic personality disorder is increasing in prevalence, primarily as a consequence of large scale social changes, including greater emphasis on short-term hedonism, individualism, competitiveness, and success. He further stated that the "me-generation" has produced more than its share of individuals with narcissistic personality disorder. Indeed reports confirm that narcissistic personality disorder is increasing in prevalence (Cooper & Ronningstam, 1992).

Some other theorists believe that narcissistic personality disorder results from extremes in child rearing. For example, the disorder might develop as the result of excessive pampering, or when a child's parents have a need for their children to be talented or special in order to maintain their own self-esteem. On the other end of the spectrum, narcissistic personality disorder might develop as the result of neglect or abuse and trauma inflicted by parents or other authority figures during childhood. The disorder usually is evident by early adulthood.

Some other theorists subscribe a bio psychosocial model of causation that is, the causes which are biological and genetic in nature, the social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress).

This suggests that no single factor is responsible rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children.

2.2.4 Treatment of Narcissistic Personality Disorder

It is important to note that people with this disorder rarely seek out treatment. Individuals often begin therapy at the urging of family members or to treat symptoms that result from the disorder. So the therapy for the persons suffering from narcissistic personality disorder can be especially difficult because they are often unwilling to acknowledge the disorder. In addition, the tendency of these patients to criticize and devalue their therapists (as well as other authority figures) makes it difficult for therapists to work with them.

Narcissistic personality disorder treatment is centered around psychotherapy. There are no medications specifically used to treat narcissistic personality disorder. However, if the person has symptoms of depression, anxiety or other conditions, medications such as antidepressants or anti-anxiety medications may be helpful.

Psychotherapy helps the person learn to relate to others in a more positive and rewarding way. Psychotherapy tries to provide the person with greater insight into his or her problems and attitudes in the hope that this will change behaviour.

The goal of therapy is to help the person develop a better self-esteem and more realistic expectations of others. Medication might be used to treat the distressing symptoms, such as behavioural problems, that might occur with this disorder.

Several different approaches to individual therapy have been tried with narcissistic personality disorder patients, ranging from classical psychoanalysis and Adlerian therapy to rational emotive approaches and Gestalt therapy. The consensus that has emerged is that therapists should set modest goals for treatment with narcissistic personality disorder patients. Most of them cannot form a sufficiently deep bond with a therapist to allow healing of early childhood injuries. Other forms of psychotherapy that may be helpful for narcissistic personality disorder include:

i) **Cognitive behavioural therapy:** Cognitive behavioural techniques are often effective to help individuals change destructive thinking and behaviour patterns. The goal of treatment is to alter distorted thoughts and create a more realistic self-image. In general, cognitive behavioural therapy helps to identify unhealthy, negative beliefs and behaviours and replace them with healthy, positive ones.

ii) **Family therapy:** It is a type of group therapy in which the members of the family of the patient all participate in group treatment sessions. The basic idea is that the family, not just the individual patient has to alter behaviour to solve the problem. By bringing the whole family together in therapy sessions, joint efforts by all family members are made to explore conflicts. Communication among family members and problem solving help cope with relationship problems.

iii) **Group therapy:** Group therapy, in which client meets with a group of people with similar conditions, may be helpful by teaching him to relate better with others. This may be good for the client to learn about truly listening to others, learning about their feelings and offering support.

The goals are to help the patient develop a healthy individuality (rather than a resilient narcissism) so that he or she can acknowledge others as separate persons, and to decrease the need for self defeating coping mechanisms.

The first step toward developing a working alliance is empathy with the surprise and hurt that the patient experiences as a result of confrontations within the group. The external structuring that the group therapy provides can control destructive behaviour in spite of ego weakness.

In groups,

a) the therapist is less authoritative (and less threatening to the patient's grandiosity);

b) intensity of emotional experience is lessened and

c) regression is more controlled,

d) create a better setting for confrontation and clarification.

Because personality traits can be difficult to change, therapy may take several years. The short-term goal of psychotherapy for narcissistic personality disorder is to address such issues as substance abuse, depression, low self-esteem or shame. The long-term goal is to reshape the personality, at least to some degree, so that the person can change patterns of thinking that distort his self-image and create a realistic self-image.

Psychotherapy can also help the person to learn to relate better with others so that his relationships are more intimate, enjoyable and rewarding. It can help the person to understand the causes of his emotions and what drives him to compete, to distrust others and perhaps to despise himself and others.

Narcissistic patients generally enjoy the attention they receive through involvement in the treatment. Long-term outpatient involvement is critical to maintain a narcissistic patient's pro-social behaviour and sobriety. Therapists who strive to build narcissistic patients' strengths and who pay close attention to them in therapy will find them active participants in the recovery process.

2.2.5 Prognosis

The prognosis for younger persons with narcissistic disorders is hopeful to the extent that the disturbances reflect a simple lack of life experience. The outlook for long standing narcissistic personality disorder, however, is largely negative.

Some narcissists are able, particularly as they approach their midlife years, to accept their own limitations and those of others, to resolve their problems with envy, and to accept their own mortality.

Most patients with narcissistic personality disorder, on the other hand, become increasingly depressed as they grow older within a youth-oriented culture and lose their looks and overall vitality.

The retirement years are especially painful for patients with narcissistic personality disorder because they must yield their positions in the working world to the next generation.

In addition, they do not have the network of intimate family ties and friendships that sustain older people

2.3 LET US SUM UP

The word "narcissism" comes from a Greek mythology in which a handsome young man named Narcissus sees his reflection in a pool of water and falls in love with it. The term narcissistic is used to describe people who show an exaggerated sense of self-importance and are preoccupied with receiving attention.

Narcissistic personality disorder is characterised by an abnormal love of self, an exaggerated sense of superiority and importance, and a preoccupation with success and power.

Narcissistic personality disorder exists as a diagnostic category only in DSM-IV-TR. DSM-IV-TR specifies nine diagnostic criteria for narcissistic personality disorder. For the clinician to make the diagnosis, an individual must fit five or more of the following descriptions:

A grandiose sense of self-importance (exaggerates accomplishments and demands to be considered superior without real evidence of achievement).

He or she lives in a dream world of exceptional success, power, beauty, genius, or "perfect" love.

He or she thinks of him- or herself as "special" or privileged.

He or she demands excessive amounts of praise or admiration from others.

He or she feels entitled to automatic deference, compliance, or favourable treatment from others.

He or she is exploitative towards others and takes advantage of them.

He or she lacks empathy and does not recognise or identify with others' feelings.

He or she is frequently envious of others or thinks that they are envious of him or her.

He or she "has an attitude" or frequently acts in haughty or arrogant ways.

The exact cause of narcissistic personality disorder is unknown.

Researchers have identified some factors that may contribute to this disorder.

Childhood experiences such as parental overindulgence, excessive praise, unreliable parenting, and a lack of realistic responses are thought to contribute to narcissistic personality disorder.

Although researchers today do not know what exactly causes narcissistic personality disorder, there are many theories, however, about the possible causes of narcissistic personality disorder.

For example, Kohut (1977) and Kernberg (1984) attempted to trace the roots of narcissistic personality disorder to disturbances in the patient's family of origin. Specifically, to problems in the parent-child relationship before the child turned three.

At present, however, psychiatrists do not agree in their description of the central defect in narcissistic personality disorder.

Some think that the problem is primarily emotional while others regard it as the result of distorted cognition, or knowing.

Some maintain that the person with narcissistic personality disorder has an "empty" or hungry sense of self while others argue that the narcissist has a "disorganised" self. Still others regard the core problem as the narcissist's inability to test reality and construct an accurate view of him- or herself.

Some other theorists believe that narcissistic personality disorder results from extremes in child rearing.

Some other theorists subscribe a bio-psychosocial model of causation - that is, the causes of are likely due to biological and genetic factors, social factors (such as how

a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress.

People with this disorder rarely seek out treatment. Individuals often begin therapy at the urging of family members or to treat symptoms that result from the disorder. So the therapy for the persons suffering from narcissistic personality disorder can be especially difficult because they are often unwilling to acknowledge the disorder. In addition, the tendency of these patients to criticize and devalue their therapists (as well as other authority figures) makes it difficult for therapists to work with them. Narcissistic personality disorder treatment is centered around psychotherapy. There are no medications specifically used to treat narcissistic personality disorder. Several different approaches to individual therapy have been tried with narcissistic personality disorder patients, ranging from classical psychoanalysis and Adlerian therapy to Rational-Emotive approaches and Gestalt therapy. Other forms of psychotherapy that may be helpful for narcissistic personality disorder include cognitive behavioural therapy, family therapy, and group therapy.

Goal of Therapy in Narcissistic Personality Disorder

Because personality traits can be difficult to change, therapy may take several years. The short-term goal of psychotherapy for narcissistic personality disorder is to address such issues as substance abuse, depression, low self-esteem or shame.

The long-term goal is to reshape your personality, at least to some degree, so that you can change patterns of thinking that distort your self-image and create a realistic self-image.

The prognosis for younger persons with narcissistic disorders is hopeful to the extent that the disturbances reflect a simple lack of life experience.

The outlook for long standing narcissistic personality disorder, however, is largely negative.

Some narcissists are able, particularly as they approach their midlife years, to accept their own limitations and those of others, to resolve their problems with envy, and to accept their own mortality.

2.4 UNIT END QUESTIONS

1) Prepare a clinical picture of narcissistic personality disorder.

2) How does narcissistic personality disorder differ from borderline personality disorder?

3) Discuss the diagnostic features of narcissistic personality disorder.

4) Discuss the causes of narcissistic personality disorder.

5) Explain the treatment and prognosis of narcissistic personality disorder.

2.5 GLOSSARY

Cognitive-behavioural therapy : Group of treatment procedures aimed at identifying and modifying faulty thought processes, attitudes and attributions, and problem behaviours.

Craving narcissists : These are people who feel emotionally needy and undernourished, and may well appear clingy or demanding to those around them.

Empathy : Ability to understand and to some extent share the feelings and emotions of another person.

Gestalt therapy : Type of therapy emphasising wholeness of the person and integration of thought, feeling, and action.

Manipulative narcissists : These people enjoy "putting something over" on others, obtaining their feelings of superiority by lying to and manipulating them.

Narcissistic personality disorder : Personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.

Paranoid narcissists : This type of narcissist feels intense contempt for him or herself, but projects it outward onto others. Paranoid narcissists frequently drive other people away from them by hypercritical and jealous comments and behaviours.

Passive aggressive personality disorder : Personality disorder characterised by a pattern of negative attitudes and passive resistance in interpersonal situations.

Personality disorders : Characterised by enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.

Psychoanalysis : Method used by Freud to study and treat patients.

Psychotherapy : Treatment of mental disorders by psychological methods.

Phallic narcissists : Phallic narcissists tend to be aggressive, athletic, and exhibitionistic; they enjoy showing off their bodies, clothes, and overall "manliness."

Rational-Emotive therapy : A cognitive-behavioural approach that seeks to identify and eliminate irrational beliefs that may cause maladaptive behaviours.

2.6 SUGGESTED READINGS

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UNIT 3 DEPENDENT AND HISTRIONIC PERSONALITY DISORDER

Structure

3.0 INTRODUCTION

In your social interactions you might come across such persons who are extremely dependent on other persons. They behave in extremely submissive way. They show acute discomfort at the possibility of separation or sometimes of simply having to be alone. They build their lives around other people and subordinate their own needs or views for the sake of other persons, even when their needs are justified and their views are right. The persons having these characteristics are labeled as suffering from dependent personality disorder. On the other hand, you might come across to such persons are typically concerned about their looks. They are inclined to express their emotions in an exaggerated fashion; for example hugging someone they have just met or crying uncontrollably during a sad movie. Their self-esteem depends on the approval of others and does not arise from a true feeling of self-worth. These are the characteristic features of histrionic personality disorder. In the present unit we will discuss the nature and symptoms of dependent and histrionic personality disorders. We will also attempt to understand the causes and treatment of dependent and histrionic personality disorders.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the meaning of dependent personality disorder;

- Describe the diagnostic features of dependent personality disorder;
- Distinguish dependent personality disorder from other forms of personality disorders;
- Elucidate the causes of dependent personality disorder;
- Explain the treatment of dependent personality disorder;
- Define histrionic personality disorder and explain its symptoms;
- Delineate the diagnostic features of histrionic personality disorder;
- Distinguish histrionic personality disorder from borderline and dependent personality disorders;
- Analyse the causes of histrionic personality disorder; and
- Describe the psychotherapies used for the treatment of histrionic personality disorder.

3.2 DEPENDENT PERSONALITY DISORDER

Dependent personality disorder, formerly known as asthenic personality disorder is a personality disorder that is characterised by a pervasive psychological dependence on other people. Persons affected by dependent personality disorder have a disproportionately low level of confidence in their own intelligence and abilities and have difficulty in making decisions and undertaking projects on their own. They rely on others to make ordinary decisions as well as important ones. Their pervasive reliance on others, even for minor tasks or decisions, makes them exaggeratedly cooperative out of fear of alienating those who help their needs. Individuals with dependent personality disorder sometimes agree to other people when their own opinion differs, so as not to be rejected (Hirschfeld, Shea, & Weise, 1995). They are reluctant to express disagreement with others and are often willing to go to abnormal lengths to win the approval of those on whom they rely. Their desire to obtain and maintain supportive and nurturant relationships may lead to lead to their other behavioural characteristics (Bornstein, 1997), including submissiveness, timidity, and passivity. Another common feature of the disorder is an exaggerated fear of being left to fend for oneself. Adolescents with dependent personality disorder rely on their parents to make even minor decisions for them, such as what they should wear or how they should spend their free time, as well as major ones, such as what college they should attend or which career they should choose.

In the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revision (DSM-IV-TR)*, the American Psychiatric Association states that five of the following criteria should be present for a diagnosis of dependent personality disorder.

Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others;

Require others to take responsibility for major decisions and responsibilities beyond what would be age-appropriate (e.g., letting a parent choose a college without offering any input on the decision);

Has difficulty expressing disagreement with others because of fear of loss of support or approval;

Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy);

Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant;

Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself;

Urgently seeks another relationship as a source of care and support when a close relationship ends;

Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Dependent personality disorder is more common in those who have suffered from chronic illness in childhood.

A child may also exhibit dependent behaviour in response to a specific stressful life event (such as the death of a caregiver or divorce). However, it should not be considered a potential symptom of dependent personality disorder unless the behaviour becomes chronic and significantly interferes with day-to-day functioning and/or causes the child significant distress.

The ICD- 10 of World Health Organisation lists dependent personality disorder as F 60.7.

Dependent personality disorder is characterised by at least 3 of the following:

- encouraging or allowing others to make most of one's important life decisions;
- subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes;
- unwillingness to make even reasonable demands on the people one depends on;
- feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself;
- preoccupation with fears of being abandoned by a person with whom one has a close relationship, and of being left to care for oneself;
- limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others.

3.2.1 Diagnostic Features

The essential feature of Dependent Personality Disorder is a pervasive and excessive need to be taken care of. Individuals with Dependent Personality Disorder have great difficulty making everyday decisions (e.g., what color shirt to wear to work or whether to carry an umbrella) without an excessive amount of advice and reassurance from others (Criterion 1).

These individuals tend to be passive and to allow other people to take the initiative and assume responsibility for most major areas of their lives (Criterion 2).

Adults with this disorder typically depend on a parent or spouse to decide where they should live, what kind of job they should have, and which neighbours to befriend.

Adolescents with this disorder may allow their parent(s) to decide what they should

wear, with whom they should associate, how they should spend their free time, and what school or college they should attend.

This need for others to assume responsibility goes beyond age appropriate and situation appropriate. Because they fear losing support or approval, individuals with dependent personality disorder often have difficulty expressing disagreement with other people, especially those on whom they are dependent (Criterion 3).

These individuals feel so unable to function alone that they will agree with things that they feel are wrong rather than risk losing the help of those to whom they look for guidance.

They do not get appropriately angry at others whose support and nurturance they need for fear of alienating them. Individuals with this disorder have difficulty initiating projects or doing things independently (Criterion 4).

They lack self-confidence and believe that they need help to begin and carry through tasks. They will wait for others to start things because they believe that as a rule others can do them better.

These individuals are convinced that they are incapable of functioning independently and present themselves as inept and requiring constant assistance.

They are, however, likely to function adequately if given the assurance that someone else is supervising and approving.

There may be a fear of becoming or appearing to be more competent, because they may believe that this will lead to abandonment.

Because they rely on others to handle their problems, they often do not learn the skills of independent living, thus perpetuating dependency.

Individuals with Dependent Personality Disorder may go to excessive lengths to obtain nurturance and support from others, even to the point of volunteering for unpleasant tasks if such behaviour will bring the care they need (Criterion 5).

They are willing to submit to what others want, even if the demands are unreasonable.

Their need to maintain an important bond will often result in imbalanced or distorted relationships.

They may make extraordinary self-sacrifices or tolerate verbal, physical, or sexual abuse.

Individuals with this disorder feel uncomfortable or helpless when alone, because of their exaggerated fears of being unable to care for themselves (Criterion 6).

They will "tag along" with important others just to avoid being alone, even if they are not interested or involved in what is happening.

When a close relationship ends (e.g., a breakup with a lover; the death of a caregiver), individuals with dependent personality disorder may urgently seek another relationship to provide the care and support they need (Criterion 7).

Their belief that they are unable to function in the absence of a close relationship motivates these individuals to become quickly and indiscriminately attached to another person. Individuals with this disorder are often preoccupied with fears of being left to care for themselves (Criterion 8).

They see themselves as so totally dependent on the advice and help of an important other person that they worry about being abandoned by that person when there are no grounds to justify such fears. To be considered as evidence of this criterion, the fears must be excessive and unrealistic.

Dependent Personality Disorder must be distinguished from other personality disorders, especially from borderline personality disorder, histrionic personality disorder, and avoidant personality disorder, because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features.

Similarities and differences

Both dependent personality disorder and borderline personality disorder are characterised by fear of abandonment.

However, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands.

The individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support.

Borderline personality disorder patients show a typical pattern of unstable and intense relationships.

Individuals with histrionic personality disorder, like those with dependent personality disorder, have a strong need for reassurance and approval and may appear childlike and clinging.

However, unlike dependent personality disorder, which is characterised by self-effacing and docile behaviour, histrionic personality disorder is characterised by gregarious flamboyance with active demands for attention.

Both dependent personality disorder and avoidant personality disorder are characterised by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance.

However, individuals with avoidant personality disorder have such a strong fear of humiliation and rejection that they withdraw until they are certain they will be accepted.

In contrast, individuals with dependent personality disorder have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships.

3.2.2 Causes

Although the exact cause of dependent personality disorder is not known, it most likely involves both biological and developmental factors.

Some researchers believe an authoritarian or over-protective parenting style can lead to the development of dependent personality traits in people who are susceptible to the disorder.

It is commonly thought that the development of dependence in these individuals is a result of over-involvement and intrusive behaviour by their primary caretakers.

Caretakers may foster dependence in the child to meet their own dependency needs, and may reward extreme loyalty but reject attempts the child makes towards independence.

Families of those with dependent personality disorder often do not express their emotions and are controlling.

They demonstrate poorly defined relational roles within the family unit.

Some other researchers suggest that dependent children are insecurely attached to their mothers or other caregivers and may not have had close and trusting relationships with others during childhood.

Individuals with dependent personality disorder often have been socially humiliated by others in their developmental years. Hence they may carry significant doubts about their abilities to perform tasks, take on new responsibilities, and generally fear to function independently of others. This reinforces their suspicions that they are incapable of living autonomously.

In response to these feelings, they portray a helplessness that elicits care giving behaviour from some people in their lives.

3.2.3 Treatment

The primary treatment for dependent personality disorder is psychotherapy with an emphasis on learning to cope with anxiety, developing assertiveness, and improving decision-making skills. The most effective psychotherapeutic approach is one which focuses on solutions to specific life problems the patient is presently experiencing.

Long term therapy, while ideal for many personality disorders, is contra indicated in this instance since it reinforces a dependent relationship upon the therapist. While some form of dependency will exist, no matter of the length of therapy, the shorter the better in this case. Examining the client's faulty cognitions and related emotions (of lack of self-confidence, autonomy versus dependency, etc.) can be an important component of therapy.

Assertiveness training and other behavioural approaches have been shown to be most effective in helping treat individuals with this disorder.

Group therapy can also be helpful, although care should be utilised to ensure that the patient doesn't use groups to enhance existing or new dependent relationships. Challenging dependent relationships the client has with others that may be unhealthy for the client should generally be avoided at the onset of therapy.

As therapy progresses, these challenges can occur but must be done carefully; restraint must be used if the individual is not ready to give up these unhealthy relationships.

Termination issues will likely be of extreme importance and will virtually be a litmus test of how effective the therapy has been.

If the individual cannot end therapy successfully and move on to become more self-reliant, it should not be seen as a therapeutic failure. Rather, the individual was not likely seeking life-changing therapy in the first instance but instead solution-focused therapy.

Self Assessment Questions

1) What do you mean by dependent personality disorder?

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2) Discuss the diagnostic features of dependent personality disorder.

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3) How does dependent personality disorder differ from other personality disorder?

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4) Explain the causes of dependent personality disorder.

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5) How can dependent personality disorder be treated? Discuss the methods of treatment.

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3.3 HISTRIONIC PERSONALITY DISORDER

Histrionic personality disorder is a type of personality disorder in which the affected individual displays an enduring pattern of attention-seeking and excessively dramatic behaviours beginning in early adulthood and present across a broad range of situations. Individuals with histrionic personality disorder are highly emotional, charming, energetic, manipulative, seductive, impulsive, erratic, and demanding. Individuals with histrionic personality disorder tend to be so overly dramatic that they often seem almost to be acting which is why, the term *histrionic*, which means theatrical in manner, is used.

The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition- Text Revised (the *DSM-IV- TR)* classifies histrionic personality disorder as a personality disorder. More specifically, histrionic personality disorder is classified by DSM-IV-TR as a Cluster B (dramatic, emotional, or erratic) personality disorder. The personality disorders which comprise Cluster B include histrionic, antisocial, borderline, and narcissistic. Histrionic personality disorder is defined as a personality disorder characterised by a pattern of excessive emotionality and attention seeking including an excessive need for approval and inappropriate seductiveness usually beginning in early adulthood. These individuals are lively, dramatic, enthusiastic, and flirtatious.

DSM-IV-TR lists eight symptoms that form the diagnostic criteria for histrionic personality disorder. An individual having at least five of the below characteristics might be considered to have a histrionic personality disorder:

- Center of attention: Patients with histrionic personality disorder experience discomfort when they are not the center of attention.
- Sexually seductive: Patients with histrionic personality disorder displays inappropriate sexually seductive or provocative behaviours towards others.
- Shifting emotions: The expression of emotions of patients with histrionic personality disorder tends to be shallow and to shift rapidly.
- Physical appearance: Individuals with histrionic personality disorder consistently employ physical appearance to gain attention for themselves.
- Speech style: The speech style of patients with histrionic personality disorder lacks detail. Individuals with histrionic personality disorder tend to generalise, and when these individuals speak, they aim to please and impress.
- Dramatic behaviours: Patients with histrionic personality disorder display self-dramatisation and exaggerate their emotions.
- Suggestibility: Other individuals or circumstances can easily influence patients with histrionic personality disorder.
- Overestimation of intimacy: Patients with histrionic personality disorder overestimate the level of intimacy in a relationship.

The ICD-10 of World Health Organisation lists histrionic personality disorder as *(F60.4)* Histrionic personality disorder is characterised by at least 3 of the following:

- self-dramatisation, theatricality, exaggerated expression of emotions;
- suggestibility, easily influenced by others or by circumstances;
- shallow and labile affectivity;
- continual seeking for excitement and activities in which the patient is the center of attention;
- inappropriate seductiveness in appearance or behaviour; and
- over-concern with physical attractiveness.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

3.3.1 Diagnostic Features of Histrionic Personality Disorder

Excessive attention-seeking behaviour and emotionality is the essential feature of histrionic personality disorder. Individuals with histrionic personality disorder tend to feel unappreciated if not the center of attention, and their lively, dramatic, and excessively extraverted styles often ensure that they can charm others into attending to them.

In seeking attention, their appearance and behaviour are often quite theatrical and emotional, as well as sexually provocative and seductive. They are inclined to express their emotions in exaggerated fashion; for example hugging someone they have just met are crying uncontrollably during a sad movie (Pfohl, 1995).

They are often seductive in appearance and behaviour, and typically concerned about their looks; for example they may spend a great deal of money on unusual jewelry. Their style of speech may also be dramatic but is quite impressionistic but often vague, lacking in detail, and characterised by hyperbole.

The cognitive style associated with histrionic personality disorder is impressionistic (Shapiro, 1965) characterised by a tendency to view situations in very global, black-and-white terms. Individuals with this disorder are usually able to function at a high level and can be successful socially and professionally.

People with histrionic personality disorder usually have good social skills but they tend to use these skills to manipulate other people and become the center of attention.

Furthermore, histrionic personality disorder may affect a person's social or romantic relationships or their ability to cope with losses or failures.

Their sexual adjustment is usually poor (Apt and Hurlbert, 1994) and their interpersonal relationships are stormy because they may attempt to control their partner through seductive behaviour and emotional manipulation, but they also show a good deal of dependence.

Usually they are considered to be self-centered, vain, and over-concerned about the approval of others. People with these disorders have also distorted self-images.

For people with histrionic personality disorder, their self-esteem depends on the approval of others and does not arise from a true feeling of self-worth.

They have an overwhelming desire to be noticed, and often behave dramatically or inappropriately to get attention.

Prevalence rate

The prevalence of histrionic personality disorder in the general population is estimated to be approximately 2%-3% (and 10%-15% of psychiatric outpatients). Individuals who have experienced pervasive trauma during childhood have been shown to be at a greater risk for developing histrionic personality disorder as well as for developing other personality disorders.

Clinicians tend to diagnose histrionic personality disorder more frequently in females; however, when structured assessments are used to diagnose histrionic personality disorder, clinicians report approximately equal prevalence rates for males and females. In considering the prevalence of histrionic personality disorder it is important to recognise that gender role stereotypes may influence the behavioural display of histrionic

personality disorder and that woman and men may display histrionic personality disorder symptoms differently.

Similarities and differences

Histrionic Personality Disorder must be distinguished from other personality disorders, especially from dependent and borderline personality disorders because they have certain features in common.

It is, therefore, important to distinguish among these disorders based on differences in their characteristic features.

Both histrionic personality disorder and borderline personality disorder are characterised by manipulative, projection sensitive, and attention seeking behaviours.

However histrionic personality disorder and borderline personality disorder have different emphasis.

Borderline personality disorder is characterised by intense clinging dependency, whereas for the persons with histrionic personality disorder getting the attention of others is a high priority.

Histrionic personality disorder can further be distinguished from dependent personality disorder.

Patients with histrionic personality disorder and dependent personality disorder share high dependency needs, but only dependent personality disorder is linked to high levels of self-attributed dependency needs.

Moreover, persons with histrionic personality disorder tend to be more active and seductive as compared to those persons with dependent personality disorder.

3.3.2 Causes of Histrionic Personality Disorder

The exact cause of histrionic personality disorder is not known, but many mental health professionals believe that both learned and inherited factors play a role in its development. For example, the tendency for histrionic personality disorder to run in families suggests that a genetic susceptibility for the disorder might be inherited.

However, the child of a parent with this disorder might simply be repeating learned behaviour.

Other environmental factors that might be involved include a lack of criticism or punishment as a child, positive reinforcement that is given only when a child completes certain approved behaviours, and unpredictable attention given to a child by his or her parent(s), all leading to confusion about what types of behaviour earn parental approval.

Psychosexual stages of development through which each individual passes determine an individual's later psychological development as an adult.

Early psychoanalysts proposed that the genital phase is a determinant of histrionic personality disorder. Later psychoanalysts considered the oral phase, Freud's first stage of psychosexual development, to be a more important determinant of histrionic personality disorder.

Most psychoanalysts agree that a traumatic childhood contributes towards the development of histrionic personality disorder.

Some theorists suggest that the more severe forms of histrionic personality disorder derive from disapproval in the early mother-child relationship.

Anthony Storr, a psychoanalyst, (1980) has interpreted histrionic behaviour as a pattern that is often adopted by individuals who do not feel able to compete with others on equal terms and believe that no one is paying attention to them.

According to Storr such people may have been disregarded by their parents as children. Although the child repeatedly tried to get the parents to think of him or her as an individual, those attempts failed.

The child then becomes demanding and resorted to all kinds of dramatic behaviour in order to be noticed. The less attention the parents paid to the child, the more the child has to shout or dramatise to get their attention.

Another component of Freud's theory is the defense mechanism. Defense mechanisms are sets of systematic, unconscious methods that people develop to cope with conflict and to reduce anxiety. According to Freud's theory, all people use defense mechanisms, but different people use different types of defense mechanisms. Individuals with histrionic personality disorder differ in the severity of the maladaptive defense mechanisms they use. Patients with more severe cases of histrionic personality disorder may utilise the defense mechanisms of repression, denial, and dissociation.

3.3.3 Treatment of Histrionic Personality Disorder

Histrionic personality disorder, like other personality disorders, may require several years of therapy and may affect individuals throughout their lives. Some professionals believe that psychoanalytic therapy is a treatment of choice for histrionic personality disorder because it assists patients to become aware of their own feelings. Long term psychodynamic therapy needs to target the underlying conflicts of individuals with histrionic personality disorder and to assist patients in decreasing their emotional reactivity. Cognitive behaviour therapy, group therapy, and family therapy have been used for treating histrionic personality disorder.

3.3.3.1 Cognitive Behavioural Therapy

Cognitive therapy is a treatment directed at reducing the dysfunctional thoughts of individuals with histrionic personality disorder. Such thoughts include themes about not being able to take care of oneself. Cognitive therapy for histrionic personality disorder focuses on a shift from global, suggestible thinking to a more methodical, systematic, and structured focus on problems. Cognitive behavioural training in relaxation for an individual with histrionic personality disorder emphasises challenging automatic thoughts about inferiority and not being able to handle one's life. Cognitive behavioural therapy teaches individuals with histrionic personality disorder to identify automatic thoughts, to work on impulsive behaviour, and to develop better problem-solving skills.

3.3.3.2 Group Therapy

Group therapy is suggested to assist individuals with histrionic personality disorder to work on interpersonal relationships. Psychodrama techniques or group role play can assist individuals with histrionic personality disorder to practice problems at work and to learn to decrease the display of excessively dramatic behaviours. Using role-playing, individuals with histrionic personality disorder can explore interpersonal relationships and outcomes to understand better the process associated with different

scenarios. Group therapists need to monitor the group because individuals with histrionic personality disorder tend to take over and dominate others.

3.3.3.3 Family Therapy

To teach assertion rather than avoidance of conflict, family therapists need to direct individuals with histrionic personality disorder to speak directly to other family members. Family therapy can support family members to meet their own needs without supporting the histrionic behaviour of the individual with histrionic personality disorder who uses dramatic crises to keep the family closely connected. Family therapists employ behavioural contracts to support assertive behaviours rather than temper tantrums.

3.3.4 Prognosis

The personality characteristics of individuals with histrionic personality disorder are long-lasting. Individuals with histrionic personality disorder utilise medical services frequently, but they usually do not stay in psychotherapeutic treatment long enough to make changes. They tend to set vague goals and to move toward something more exciting. Treatment for histrionic personality disorder can take a minimum of one to three years and tends to take longer than treatment for disorders that are not personality disorders, such as anxiety disorders or mood disorders.

Research indicates that a relationship exists between poor treatment outcomes and premature termination from treatment for individuals with Cluster B personality disorders.

Self Assessment Questions

1) Define histrionic personality disorder and describe its symptoms.

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2) Discuss the diagnostic features of histrionic personality disorder.

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3) Distinguish histrionic personality disorder from dependent personality disorder.

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4) Explain the causes of histrionic personality disorder.

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5) Discuss the psychotherapies used for the treatment of histrionic personality disorder.

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3.4 LET US SUM UP

Dependent personality disorder is characterised by a pervasive psychological dependence on other people. Persons affected by dependent personality disorder have a disproportionately low level of confidence in their own intelligence and abilities and have difficulty in making decisions and undertaking projects on their own. They rely on other to make ordinary decisions as well as important ones. The essential feature of Dependent Personality Disorder is a pervasive and excessive need to be taken care of.

The cause of dependent personality disorder is not known, it most likely involves both biological and developmental factors. It is believed that an authoritarian or over-protective parenting style can lead to the development of dependent personality traits in people who are susceptible to the disorder. It is commonly thought that the development of dependence in these individuals is a result of over-involvement and intrusive behaviour by their primary caretakers other caregivers or did not have close and trusting relationships with others during childhood.

The primary treatment for dependent personality disorder is psychotherapy with an emphasis on learning to cope with anxiety, developing assertiveness, and improving decision-making skills. The most effective psychotherapeutic approach is one which focuses on solutions to specific life problems the patient is presently experiencing. Long-term therapy, while ideal for many personality disorders, is contra-indicated in this instance since it reinforces a dependent relationship upon the therapist.

Histrionic personality disorder is classified by DSM-IV-TR as a Cluster B (dramatic, emotional, or erratic) personality disorder. Histrionic personality disorder is a type of personality disorder in which the affected individual displays an enduring pattern of attention-seeking and excessively dramatic behaviours beginning in early adulthood and present across a broad range of situations.

Excessive attention seeking behaviour and emotionality is the essential feature of Histrionic Personality Disorder. Individuals with histrionic personality disorder tend to feel unappreciated if not the center of attention, and their lively, dramatic, and excessively extraverted styles often ensure that they can charm others into attending to them. In seeking attention, their appearance and behaviour are often quite theatrical and emotional, as well as sexually provocative and seductive. The prevalence of

histrionic personality disorder in the general population is estimated to be approximately 2%-3% (and 10%-15% of psychiatric outpatients

The exact cause of histrionic personality disorder is not known, but many mental health professionals believe that both learned and inherited factors play a role in its development. Early psychoanalysts viewed the genital stage of psychosexual development is a determinant of histrionic personality disorder. Later psychoanalysts considered the oral phase to be a more important determinant of histrionic personality disorder. Most psychoanalysts agree that a traumatic childhood contributes towards the development of histrionic personality disorder.

Some theorists suggest that the more severe forms of histrionic personality disorder derive from disapproval in the early mother-child relationship.

Psychoanalytic therapy is a treatment of choice for histrionic personality disorder because it assists patients to become aware of their own feelings. Long-term psychodynamic therapy needs to target the underlying conflicts of individuals with histrionic personality disorder and to assist patients in decreasing their emotional reactivity. Cognitive behaviour therapy, group therapy, and family therapy have been used for treating histrionic personality disorder.

3.5 UNIT END QUESTIONS

1) Define dependent personality disorder and explain its symptoms.
2) Discuss the diagnostic features of dependent personality disorder.
3) In what respect does dependent personality disorder differ from other forms of personality disorder?
4) Explain the causes of dependent personality disorder.
5) How can dependent personality disorder be treated? Discuss the methods of treatment.
6) Explain the nature and symptoms of histrionic personality disorder.
7) Explain the diagnostic features of histrionic personality disorder.
8) In what respect histrionic personality disorder is different from dependent personality disorder?
9) Discuss the causes of histrionic personality disorder.
10) Discuss psychotherapies used for treating the individuals with histrionic personality disorder.

3.6 GLOSSARY

Borderline personality disorder : Personality disorder involving extreme "black and white" thinking, instability in relationships, self-image, identity and behaviour. Borderline personality disorder occurs in 3 times as many females than males.

Cognitive-behavioural therapy : Group of treatment procedures aimed at identifying and modifying faulty thought

processes, attitudes and attributions, and problem behaviours.

Dependent personality disorder : Personality disorder characterised by pervasive psychological dependence on other people.

Histrionic personality disorder : Personality disorder characterised by pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions.

Family therapy : Specialised type of group therapy in which the members of the family of the client all participate in group-treatment session.

Group therapy : Psychotherapy of several persons at the same time in small groups.

Narcissistic personality disorder : personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.

Oral stage : First stage of psychosexual development, during which pleasure is derived from lip and mouth contact from need-fulfilling objects.

Personality disorders : Characterised by enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.

Phallic stage : Stage of psychosexual development during which a childbegins to perceive his or her own body as a source of gratification. Feelings of narcissism are heightened during this period.

Psychoanalysis : Method used by Freud to study and treat patients.

Psychotherapy : Treatment of mental disorders by psychological methods.

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UNIT 4 SCHIZOID AND PARANOID PERSONALITY DISORDER

Structure

4.0 INTRODUCTION

In our social interaction we sometimes come across to such persons who are alone, reserved, socially withdrawn, and seclusive. They choose a solitary walk over an invitation to a party. Such people rarely express their feelings directly. Since they show an inability to form social relationship, they typically do not have good friends. The persons having these characteristics are labeled as suffering from schizoid personality disorder. On the other hand we sometimes come across to such persons who are very mistrustful and suspicious of others. Being too distrustful they can interfere with making friends, working with other. The persons having these characteristics are labeled as suffering from paranoid personality disorder. In the present unit we will discuss the meaning, diagnostic criteria of schizoid and paranoid personality disorders. We will also try to understand the causes and treatment of schizoid personality disorder and paranoid personality disorder.

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the meaning of schizoid personality disorder;
- Discuss the diagnostic criteria of schizoid personality disorder;
- Distinguish schizoid personality disorder from other mental disorders;
- Understand the causes of schizoid personality disorder;
- Explain the treatment of schizoid personality disorder;

- Define paranoid personality disorder and explain its symptoms;
- Understand the diagnostic criteria of paranoid personality disorder;
- Explain the differential diagnosis of paranoid personality disorder;
- Explain the causes of paranoid personality disorder; and
- Understand the treatment of paranoid personality disorder.

4.2 SCHIZOID PERSONALITY DISORDER

The term schizoid is relatively old, having been used by Bleular (1924) to designate a natural human tendency to direct attention toward one's inner life and away from the external world, a concept akin to introversion in that it was not viewed in terms of psychopathology. Bleuler also labeled the exaggeration of this tendency the "schizoid personality". Schizoid Personality Disorder is characterised by a long-standing pattern of detachment from social relationships. A person with schizoid personality disorder often has difficulty in expressing emotions and does so typically in very restricted range, especially when communicating with others. A person with this disorder may appear to lack a desire for intimacy, and will avoid close relationships with others. They may often prefer to spend time with themselves rather than socialise or be in a group of people. In lay people terms, a person with schizoid personality disorder might be thought of as the typical "loner." Individuals with Schizoid Personality Disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion. Their lives sometimes seem directionless, and they may appear to "drift" in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Employment or work functioning may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation.

4.2.1 Diagnostic Criteria

The *DSM- IV-TR* defines schizoid personality disorder (in Axis II, Cluster A) as:

A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood (age eighteen or older) and present in a variety of contexts, as indicated by four (or more) of the following:

- neither desires nor enjoys close relationships, including being part of a family;
- almost always chooses solitary activities;
- has little, if any, interest in having sexual experiences with another person;
- takes pleasure in few, if any, activities;
- lacks close friends or confidants other than first-degree relatives;
- appears indifferent to the praise or criticism of others;
- shows emotional coldness, detachment, or flattened affectivity.
- it is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

The ICD-10 of World Health Organisation lists schizoid personality disorder as *(F 60.1)*. It is characterised by at least four of the following criteria:

- Emotional coldness, detachment or reduced affection.
- Limited capacity to express either positive or negative emotions towards others.
- Consistent preference for solitary activities.
- Very few, if any, close friends or relationships and a lack of desire for such.
- Indifference to either praise or criticism.
- Taking pleasure in few, if any, activities.
- Indifference to social norms and conventions.
- Preoccupation with fantasy and introspection.
- Lack of desire for sexual experiences with another person.

People with schizoid personality disorder show no interest or enjoyment in developing interpersonal relationships; this may also include family members. They perceive themselves as social misfits and believe they can function best when not dependent on anyone except themselves. They rarely date, often do not marry, and have few, if any, friends (criterion-1). They prefer and choose activities that they can do by themselves without dependence upon or involvement by others. Examples of activities they might choose include mechanical or abstract tasks such as computer or mathematical games (criterion-2). There is typically little or no interest in having a sexual experience with another person. This would include a spouse if the affected person is married (criterion-3). Lacks pleasure: There is an absence of pleasure in most activities. A person with schizoid personality disorder seems unable to experience the full range of emotion accessible to most people (criterion-4). People affected with this disorder typically do not have the social skills necessary to develop meaningful interpersonal relationships. This results in few ongoing social relationships outside of immediate family members (criterion-5). Indifferent to praise or criticism: Neither positive nor negative comments made by others elicit an emotionally expressive reaction. They don't appear concerned about what others might think of them (criterion-6). Their emotional style is aloof and perceived by others as distant or "cold." They seem unable or uninterested in expressing empathy and concern for others. Emotions are significantly restricted and most social contacts would describe their personality as very bland, dull or humorless. The person with schizoid personality disorder rarely picks up on or reciprocates normal communicational cues such as facial expressions, head nods, or smiles (criterion-7).

It is difficult to accurately assess the prevalence of this disorder because people with schizoid personality disorder rarely seek treatment. Schizoid personality disorder affects men more often than women and is more common in people who have close relatives with schizophrenia. Schizoid personality disorder usually beings in early adulthood. Schizoid personality disorder is uncommon in clinical settings. Schizoid personality disorder is rare compared with other personality disorders. Its prevalence is estimated at less than 1% of the general population (Weismann, 1993).

Although schizoid personality disorder shares several aspects with other psychological disorders, there are some important differentiating features. While people who have schizoid personality disorder can also suffer from clinical depression, this is certainly

not always the case. Unlike depressed people, persons with schizoid personality disorder generally do not consider themselves inferior to others, although they will probably recognise that they are different. The social deficiencies of people with schizoid personality disorder are also similar to those of people with paranoid personality disorder, although they are more extreme. As Beck and Freeman (1990) put it, they "consider themselves to be observers rather than participants in the world around them". They do not seem to have the very unusual thought processes that characterise the other disorders in Cluster A (Kalus et.al., 1993). Unlike avoidant personality disorder, those affected with schizoid personality disorder do not avoid social interactions due to anxiety or feelings of incompetence, but because they are genuinely indifferent to social relationships.

4.2.2 Cause

The exact causes of schizoid personality disorder are unknown, although a combination of genetic and environmental factors, particularly in early childhood, are thought to contribute to development of all personality disorders. The schizoid personality disorder has its roots in the family of the affected person. These families are typically emotionally reserved, have a high degree of formality, and have a communication style that is aloof and impersonal. Parents usually express inadequate amounts of affection to the child and provide insufficient amounts of emotional stimulus. This lack of stimulus during the first year of life is thought to be largely responsible for the person's disinterest in forming close, meaningful relationships later in life. People with schizoid personality disorder have learned to imitate the style of interpersonal relationships modeled in their families. In this environment, affected people fail to learn basic communication skills that would enable them to develop relationships and interact effectively with others. Their communication is often vague and fragmented, which others find confusing. Many individuals with schizoid personality disorder feel misunderstood by others.

A person with schizoid personality disorder may have had a parent who was cold or unresponsive to emotional needs, or might have grown up in a foster home where there was no love. Or, because people with schizoid personality disorder are often described as being hypersensitive or thin-skinned in early adolescence, a person with schizoid personality disorder may have had needs that others treated with exasperation or scorn. A family history such as having a parent who has any of the disorders on the schizophrenic spectrum also increases the chances of developing the disorder.

Some other theorists subscribe to a bio-psychosocial model of causation- that is, the causes of are likely due to biological and genetic factors, social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress). This suggests that no single factor is responsible — rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children

4.2.3 Treatment

As with all personality disorders, the treatment of choice for schizoid personality disorder is psychotherapy. However, people with this disorder are unlikely to seek treatment unless they are under increased stress or pressure in their life. Treatment will usually be short-term in nature to help the individual solve the immediate crisis

or problem. The patient will then likely terminate therapy. Goals of treatment most often are solution-focused using brief therapy approaches. Long-term psychotherapy should be avoided because of its poor treatment outcomes and the financial hardships inherent in length therapy. Instead, psychotherapy should focus on simple treatment goals to alleviate current pressing concerns or stressors within the individual's life. Cognitive behavioural therapy, group therapy, family therapy and marital therapy have been widely used for treating people with schizoid personality disorder.

Attempting to cognitively restructure the patient's thoughts can enhance self-insight. Constructive ways of accomplishing this would include concrete assignments such as keeping daily records of problematic behaviours or thoughts. Another helpful method can be teaching social skills through role-playing. This might enable individuals to become more conscious of communication cues given by others and sensitise them to others' needs. Group therapy may provide the patient with a socialising experience that exposes them to feedback from others in a safe, controlled environment. It can also provide a means of learning and practicing social skills in which they are deficient. Since the patient usually avoids social contact, timing of group therapy is of particular importance. It is best to develop first a therapeutic relationship between therapist and patient before starting a group therapy treatment. It is unlikely that a person with schizoid personality disorder will seek family therapy or marital therapy. If pursued, it is usually on the initiative of the spouse or other family member. Many people with this disorder do not marry and end up living with and are dependent upon first-degree family members. In this case, therapy may be recommended for family members to educate them on aspects of change or ways to facilitate communication. Marital therapy may focus on helping the couple to become more involved in each other's lives or improve communication patterns.

4.2.4 Prognosis

Since a person with schizoid personality disorder seeks to be isolated from others, which includes those who might provide treatment, there is only a slight chance that most patients will seek help on their own initiative. Those who do may stop treatment prematurely because of their difficulty maintaining a relationship with the professional or their lack of motivation for change. If the degree of social impairment is mild, treatment might succeed if its focus is on maintenance of relationships related to the patient's employment. The patient's need to support him- or herself financially can act as a higher incentive for pursuit of treatment outcomes.

Self Assessment Questions

1) Discuss the meaning of schizoid personality disorder.

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2) Explain the diagnostic criteria of dependent personality disorder.

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3) How does dependent personality disorder differ from other mental disorders?

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4) Explain the causes of schizoid personality disorder.

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5) How can schizoid personality disorder be treated? Discuss the methods of treatment.

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4.3 PARANOID PERSONALITY DISORDER

Paranoid personality disorder is one of a group of conditions called eccentric personality disorders in which people with these disorders often appear odd or peculiar. People with paranoid personality disorder also suffer from paranoia, an unrelenting mistrust and suspicion of others, even when there is no reason to be suspicious. Paranoid personality disorder is characterised by an extreme level of distrust and suspicion of others. Paranoid personalities are generally difficult to get along with, and their combative and distrustful nature often elicits hostility in others. The negative social interactions that result from their behaviour then serve to confirm and reinforce their original pessimistic expectations. People with paranoid personality disorder are unlikely to form many close relationships and are typically perceived as cold and distant. They are quick to challenge the loyalty of friends and loved ones and tend to carry long grudges (Dobbert 2007, Kantor 2004). They are often preoccupied with doubts about the loyalty of the friends, leading to a reluctance to confide in others. They also may be hypersensitive, as indicated by a tendency to read threatening meanings into benign remarks. They also commonly bear grudges, are unwilling to forgive perceived insults and slights, and are quick to react with anger (Bernstein, Useda, & Siever, 1995; Widiger & Frances, 1994). This disorder usually begins by early adulthood and appears to be more common in men than in women. The prevalence of Paranoid Personality Disorder has been estimated to be as high as 4.5% of the general population.

4.3.1 Diagnostic Criteria

Paranoid personality disorder is a condition characterised by excessive distrust and suspiciousness of others. This disorder is only diagnosed when these behaviours

become persistent and very disabling or distressing. This disorder should not be diagnosed if the distrust and suspiciousness occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association, 1994) describes paranoid personality disorder as 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. Paranoid personality disorder is considered a Cluster A personality disorder along with schizoid and Schizotypal and characterised by odd or eccentric behaviour. A diagnosis of paranoid personality disorder should be considered when these paranoid behaviours become persistent and disabling.

According to the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders), a patient must fit at least four of the following criteria in order to be diagnosed with paranoid personality disorder:

The unfounded suspicion that people want to deceive, exploit or harm the patient.

The pervasive belief that others are not worthy of trust or that they are not inclined to or capable of offering loyalty.

A fear that others will use information against the patient with the intention of harming him or her. This fear is demonstrated by a reluctance to share even harmless personal information with others.

The interpretation of others' innocent remarks as insulting or demeaning; or the interpretation of neutral events as presenting or conveying a threat.

A strong tendency not to forgive real or imagined slights and insults. People with paranoid personality disorder nurture grudges for a long time.

An angry and aggressive response in reply to imagined attacks by others. The counterattack for a perceived insult is often rapid.

Suspicions, in the absence of any real evidence, that a spouse or sexual partner is not sexually faithful, resulting in such repeated questions as "Where have you been?" "Whom did you see?" etc., and other types of jealous behaviour.

The ICD – 10 of World Health Organisation lists paranoid personality disorder as *(F 60.0)*

It is characterised by at least 3 of the following:

- excessive sensitivity to setbacks and rebuffs;
- tendency to bear grudges persistently, i.e. refusal to forgive insults and injuries or slights;
- suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous;
- a combative and tenacious sense of personal rights out of keeping with the actual situation;
- recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner;

- tendency to experience excessive self-importance, manifest in a persistent self-referential attitude;
- preoccupation with unsubstantiated "conspiratorial" explanations of events both immediate to the patient and in the world at large.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Paranoid personality disorder is confused with other mental disorders or behaviours that have some symptoms in common with the paranoid personality. For example, it is important to make sure that the patient is not a long-term user of amphetamine or cocaine. Chronic abuse of these stimulants can produce paranoid behaviour. Also, some prescription medications might produce paranoia as a side effect; so it is important to find out what drugs, if any, the patient is taking. There are other conditions that, if present, would mean a patient with paranoid traits does not have paranoid personality disorder. For example, if the patient has symptoms of schizophrenia, hallucinations or a formal thought disorder, a diagnosis of paranoid personality disorder can't be made. The same is true of delusions, which are not a feature of paranoid personality disorder.

There are a number of disorders or other mental health conditions listed in the *DSM-IV-TR* that could be confused with paranoid personality disorder because they share similar or identical symptoms with paranoid personality disorder. It is important, therefore, to eliminate the following entities before settling on a diagnosis of paranoid personality disorder: paranoid schizophrenia; Schizotypal personality disorder; schizoid personality disorder; persecutory delusional disorder; mood disorder with psychotic features; symptoms and/or personality changes produced by disease, medical conditions, medication or drugs of abuse; paranoia linked to the development of physical handicaps; and borderline, histrionic, avoidant, antisocial or narcissistic personality disorders.

4.3.2 Causes

The specific cause of paranoid personality disorder is unknown, but the incidence appears increased in families with a schizophrenic member. There seem to be more cases of in families that have one or more members who suffer from such psychotic disorders as schizophrenia or delusional disorder (Bernstein et. al., 1993). Although evidence for biological contribution to paranoid personality disorder is limited, some studies of identical and fraternal twins suggest that genetic factors may also play an important role in causing the disorder. Twin studies indicate that genes contribute to the development of childhood personality disorders, including paranoid personality disorder (Bernstein et. al., 1995; Kendler et.al 2006).

Psychological and social factors have also been considered for the development in paranoid personality disorder. Some psychologists point directly to the thoughts of people with paranoid personality disorder as a way of explaining their behaviour. One view is that people with this disorder make the following basic mistaken assumptions about others: "People are malevolent and deceptive," "They will attack you if they get the chance" and "You can OK only if you stay on your toes" (.Freeman, Pretzer, Fleming, & Simon, 1990). This maladaptive way to view the world results in the development paranoid personality disorder. Paranoid personality disorder can also result from negative childhood experiences fostered by a threatening domestic atmosphere. It is prompted by extreme and unfounded parental rage and/ or condescending parental influence that cultivate profound child insecurities.

4.3.3 Treatment

As it has been stated that people with paranoid disorder are mistrustful of everyone, they are unlikely to seek professional help when they need it and also have difficulty developing the trusting relationships necessary for successful therapy. Therapists try to provide an atmosphere that is conducive to developing a sense of trust (Freeman et. al., 1990). Cognitive therapy is widely used to counter the person's mistaken assumptions about others (Tukat & Maisto, 1985), focusing on changing the person's belief that everyone is malevolent and that most people cannot be trusted. Group and family therapy, not surprisingly, is not of much use in the treatment of paranoid personality disorder due to the mistrust people with paranoid personality disorder feel towards others.

As personality is a relatively stable, deeply rooted aspect of self, the long-term projection for those with paranoid personality disorder is often bleak. Most patients experience the symptoms of their disorder for their entire life and, in order to manage their symptoms of paranoia, require consistent therapy (Dobbert 2007, Kantor 2004).

Medication generally is not used to treat paranoid personality disorder. However, medications, such as anti-anxiety, antidepressant or anti-psychotic drugs, might be prescribed if the person's symptoms are extreme, or if he or she also suffers from an associated psychological problem, such as anxiety or depression.

4.3.4 Prognosis

Personality disorder is a chronic disorder, which means it tends to last throughout a person's life. Although some people can function fairly well with paranoid personality disorder and are able to marry and hold jobs, others are complete disabled by the disorder. Because people with paranoid personality disorder tend to resist treatment, the outcome often is poor. Since paranoid personality disorder is often a chronic, lifelong condition; the long-term prognosis is usually not encouraging. Feelings of paranoia, however, can be controlled to a degree with successful therapy.

Self Assessment Questions

1) Discuss the nature of paranoid personality disorder.

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2) Explain the diagnostic criteria of paranoid personality disorder.

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3) How does paranoid personality disorder differ from other mental disorders?

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4) Explain the causes of paranoid personality disorder.

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5) Can paranoid personality disorder be treated? Discuss the methods of treatment.

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4.4 LET US SUM UP

Schizoid Personality Disorder is characterised by a long-standing pattern of detachment from social relationships. A person with schizoid personality disorder often has difficulty in expressing emotions and does so typically in very restricted range, especially when communicating with others. A person with this disorder may appear to lack a desire for intimacy, and will avoid close relationships with others. The *DSM- IV-TR* defines schizoid personality disorder as a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood (age eighteen or older) and present in a variety of contexts.

The exact causes of schizoid personality disorder are unknown, although a combination of genetic and environmental factors, particularly in early childhood, are thought to contribute to development of all personality disorders. The schizoid personality disorder has its roots in the family of the affected person.

Psychotherapy is the treatment of choice for schizoid personality disorder. Goals of treatment most often are solution-focused using brief therapy approaches. Long-term psychotherapy should be avoided because of its poor treatment outcomes and the financial hardships. Instead, psychotherapy should focus on simple treatment goals to alleviate current pressing concerns or stressors within the individual's life. Cognitive behavioural therapy, group therapy, family therapy and marital therapy have been widely used for treating people with schizoid personality disorder.

Paranoid Personality Disorder is characterised by an extreme level of distrust and suspicion of others. Paranoid personalities are generally difficult to get along with, and their combative and distrustful nature often elicits hostility in others. People with paranoid personality disorder are unlikely to form many close relationships and are typically perceived as cold and distant. They are quick to challenge the loyalty of friends and loved ones and tend to carry long grudge.

The exact cause of paranoid personality disorder is not known, but it likely involves a combination of biological and psychological factors. The fact that paranoid personality

disorder is more common in people who have close relatives with schizophrenia suggests a genetic link between the two disorders. Early childhood experiences, including physical or emotional trauma, are also suspected to play a role in the development of paranoid personality disorder.

Since people with paranoid disorder are mistrustful of everyone, they are unlikely to seek professional help when they need it and also have difficulty developing the trusting relationships necessary for successful therapy. Cognitive therapy is widely used to counter the person's mistaken assumptions about others focusing on changing the person's belief that everyone is malevolent and that most people cannot be trusted

4.5 UNIT END QUESTIONS

1) Define schizoid personality disorder and explain its symptoms.
2) Discuss the diagnostic features of schizoid personality disorder.
3) In what respect does schizoid personality disorder differ from other forms of personality disorder?
4) Explain the causes of schizoid personality disorder.
5) How can schizoid personality disorder be treated? Discuss the methods of treatment.
6) Explain the nature and symptoms of paranoid personality disorder.
7) Explain the diagnostic features of paranoid personality disorder.
8) In what respect histrionic personality disorder is different from paranoid personality disorder?
9) Discuss the causes of paranoid personality disorder.
10) Discuss psychotherapies used for treating the individuals with paranoid personality disorder.

4.6 GLOSSARY

Antisocial personality disorder: A personality disorder featuring a pervasive pattern of disregard for and violation of rights of others.

Avoidant personality disorder : A personality disorder featuring a pervasive pattern of social inhibition, feeling of inadequacy, and hypersensitivity to criticism.

Borderline personality disorder: Personality disorder involving extreme "black and white" thinking, instability in relationships, self-image, identity and behaviour. Borderline personality disorder occurs in 3 times as many females than males.

Cognitive-behavioural therapy : Group of treatment procedures aimed at identifying and modifying faulty thought processes, attitudes and attributions, and problem behaviours.

Delusion : False belief about reality but maintained in spite of strong evidence to the contrary.

Dependent personality disorder: Personality disorder characterised by pervasive psychological dependence on other people.

Depression : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.

Empathy : Ability to understand and to some extent share the feelings and emotions of another person.

Family therapy : Specialised type of group therapy in which the members of the family of the client all participate in group-treatment session.

Group therapy : Psychotherapy of several persons at the same time in small groups.

Hallucination : False perception; things seen or heard that are not real or present.

Histrionic personality disorder: Personality disorder characterised by pervasive attention-seeking behaviour including inappropriate sexual seductiveness and shallow or exaggerated emotions.

Introversion : Tendency to be shy and withdrawn.

Narcissistic personality disorder: personality disorder involving a pervasive pattern of grandiosity need for admiration, and a lack of empathy.

Paranoia : Person's irrational beliefs he or she is especially important or that other people are seeking to do him or her harm.

Paranoid personality disorder : Cluster A (odd or eccentric) personality disorder involving pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent.

Personality disorders : Characterised by enduring maladaptive patterns for relating to the environment and oneself, exhibited in a wide range of contexts that cause significant functional impairment or subjective distress.

Psychotherapy : Treatment of mental disorders by psychological methods.

Schizoid personality disorder : Cluster A (odd or eccentric) personality disorder featuring a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions.

Schizophrenia : Psychoses characterised by the breakdown of integrated personality functioning, withdrawal from reality, emotional blunting and distortion, and disturbances in thought and behaviour.

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