THREE PEOPLE AND ONE MANUAL DESERVE CREDIT FOR KICK-STARTING THE PERSONALITY DISORDER FIELD
THEODORE MILLON

The American Psychological Association awarded him its Gold Medal Award for Lifetime Achievement in 2008.

Major theorist – inclusive of other theories - integration

Wedding cake depth model of personality disorders

Developmental approach

Accused of being overly speculative and story telling

Developed PD measure
Arguably the most important living psychoanalytic theorist

Known for borderline concept - a broader construct than BPD

Not resistant to subjecting his therapy to empirical testing

Important bringing depth to the field.

Importance of transference
JOHN GUNDERSON

Came from analytic/dynamic tradition

Focused on borderline concept for long time

Developed the Diagnostic Interview for Borderline Patients (DIB) measure

Interested in all aspects of BPD but best known for therapy

In more recent times focused on developing simpler, more transportable therapy for BPD
DSM-III was innovative and deserves credit

- Implicit in the DSM manual was the following points which indeed led to the first wave of research.

- PDs exist concomitantly with, or alone without, Axis 1 Disorders

- PDs predispose individuals to certain Axis 1 disorders

- PDs prevent/interfere with Axis 1 treatment

- Allowed the subsequent development of the epidemiology of personality disorder
LET'S BEGIN!
OVERVIEW: HOW IS OUR FIELD PROGRESSING?

- The following series of slides shows the increase in the study of and activity around personality disorders in 5-year periods from 1970 through to and including 2014.

- The methodology I used was the Web of Science search engine for 5-year periods commencing 1970 for term “personality disorder”, and then each specific personality disorder, e.g., “paranoid personality disorder”.

- Where ICD terms were different from DSM terms, e.g., “anankastic” as opposed to “obsessive compulsive personality disorder”, results were combined for DSM and ICD categories.
NUMBER OF PD PUBLICATIONS IN 5-YEAR BLOCKS FROM 1970-2014 - WEB OF SCIENCE FIGURES
NUMBER OF CLUSTER A PD PUBLICATIONS IN 5-YEAR BLOCKS FROM 1970-2014 - WEB OF SCIENCE FIGURES
NUMBER OF CLUSTER B PD PUBLICATIONS IN 5-YEAR BLOCKS FROM 1970-2014 - WEB OF SCIENCE FIGURES
NUMBER OF CLUSTER C PD PUBLICATIONS IN 5-YEAR BLOCKS FROM 1970-2014 - WEB OF SCIENCE FIGURES
PERCENTAGE OF ARTICLES FOCUSING ON SPECIFIC PDS FOR 2010/14 PERIOD – WEB OF SCIENCE

- Schizoid: 142 (2%)
- Schizotypal: 607 (7%)
- Paranoid: 235 (3%)
- Borderline: 3487 (43%)
- Histrionic: 1341 (17%)
- Antisocial: 1341 (17%)
- Narcissistic: 703 (8%)
- Dependent: 674 (8%)
- OCPD: 142 (2%)
- Avoidant: 339 (4%)
- Dependent: 139 (2%)
- Histrionic: 235 (3%)
- Antisocial: 1341 (17%)
- Borderline: 3487 (43%)
- Schizotypal: 607 (7%)
- Schizoid: 142 (2%)

Total: 6854 articles
OVERVIEW: HOW IS OUR FIELD PROGRESSING?

• Key points from preceding figures:

• Borderline and then antisocial show most activity (combined 60% of activity) and paranoid and histrionic the least activity (combined 5%)

• 1970-1980 amount of PD articles of any kind according to Web of Science was low. Partly but only partly this might be due to definitional issues, e.g., use of the term ‘hysterical personality’ rather than ‘histrionic personality disorder’, ‘narcissism’ rather than ‘narcissistic personality disorder’, and so on.

• The general increase might also be reflective of increased interest in research in psychiatry, psychology and mental health generally. But DSM-III and subsequent editions deserve much credit.

• The search fails to take into account the type of article, e.g., research, review etc, and one is not sure whether the specific disorder is the key focus of attention or secondary to that focus.
SPECIALIST JOURNALS
DEDICATED TO PERSONALITY DISORDERS
LANDMARK ONE

- **Dramatic increase in interest and activity in personality disorders**

- As evidenced by publications

- The creation of specialist journals

- Formation of Societies, e.g., International Society for the Scientific Study of Personality Disorders (ISSPD)

- The running of international Congresses and Conferences like the Project Air Conference at Wollongong now in its 10th year

- The development of consumer advocacy groups, at least for BPD

- Less tangible but appears to be increased public interest in concepts such as borderline personality disorder, narcissism, antisocial personality disorder and psychopathy
LANDMARK TWO – FIRST WAVE OF RESEARCH 1980-1995?

Basic Information about PDs:

• Axis I and Axis II associations

• Axis II and Axis II associations (overlap/comorbidity)

• Sex differences (sex bias?)

• Associations with treatment outcome. Interference or otherwise with treatment of Axis I condition

• The structure of personality disorders and development of PD measurement tools
TREATMENT!
THE WASTELAND - THERAPEUTIC NILHILISM?
BPD - TREATMENT

NO! THERE IS HOPE AND GOOD EVIDENCE IN THE BORDERLINE PD AREA
LANDMARK THREE: EFFECTIVE TREATMENT FOR BPD

• There has been increasing activity in this space and this has been pleasing.

• Seen the initial emergence of Linehan’s DBT and she has been the person who has received the most attention.

• Her work is most cited but we have also seen the emergence of:

  • Schema-based therapy

  • Bateman and Fonagy’s work – Mentalisation

  • The work of Clarke and Kernberg – Transference-based Psychotherapy for BPD

  • Chanen - CAT therapy – Three-arm study near its end with youth

  • What I call Good No Brand Therapy from Gunderson and Livesley
TRANSFERENCE-BASED PSYCHOTHERAPY

Key ingredients: Focus on deep structure - a mind based around fundamental split determining patients way of experiencing self and others and the environment.

Early affectively-charged experiences internalized over time as ‘object-relations dyads – representations of self and other linked by specific affect.

Dyads linked with different affects not integrated with one another.

Splitting key concept – identity diffusion and use of primitive defense mechanisms.

In therapy transference all important: patient will play out these object relation dyads with therapist.

Assessment, treatment contract, structure, limit setting and setting treatment frame key pre-requisites.
DIALECTIC BEHAVIOR THERAPY (DBT)

Dialectic – tension between two opposites – e.g., stay same or get better

Emotional dysregulation and emotionally invalidating early environments - key concepts

Treatment: Behavioural and Zen (mindfulness) therapy blend

Weekly psychotherapy plus weekly skills based therapy focused on four components:

- Mindfulness
- Distress tolerance
- Interpersonal effectiveness
- Emotional regulation

Marsha Linehan
MENTALISATION-BASED THERAPY

Key Ingredients:

Understanding other people’s intentions. How people make sense of their social worlds by imagining how other peoples states of mind could influence their behaviour.

Attachment theory – insecure attachment.

 Patients with BPD show reduced capacities to mentalize, which leads to problems with emotional regulation and difficulties in managing impulsivity, especially in the context of interpersonal interactions.

Therapy:

Therapist tries to help manage the client’s levels of emotional arousal to enable mentalising capacity.

MBT places less emphasis on past relationships and the meaning of events; rather the therapist and client explore the client’s processes when mentalising capacity is compromised in present relationships.
Arnoud Arntz based on Jeffrey Young’s work

Early maladaptive schemas in which cognition and emotion mutually infused

5 major groupings of schemas

Coping styles that can reinforce schemas, e.g., avoidance or surrender

Most important modes: (transitory states of mind): 10 schema modes grouped into four categories: Child modes, e.g., angry child, impulsive, abandoned

Therapy contains three major components: cognitive, experiential and behavioural
A randomized clinical trial was conducted to evaluate the effectiveness of a cognitive-behavioral therapy, ie, dialectical behavior therapy, for the treatment of chronically parasuicidal women who met criteria for borderline personality disorder. The treatment lasted 1 year, with assessment every 4 months. The control condition was "treatment as usual" in the community. At most assessment points and during the entire year, the subjects who received dialectical behavior therapy had fewer incidences of parasuicide and less medically severe parasuicides, were more likely to stay in individual therapy, and had fewer inpatient psychiatric days. There were no between-group differences on measures of depression, hopelessness, suicide ideation, or reasons for living although scores on all four measures decreased throughout the year.
TOP SIX RCTS BORDERLINE PERSONALITY DISORDER

1. **Cognitive-behavioural treatment of chronically parasuicidal borderline patients**
   By: LINEHAN, MM; ARMSTRONG, HE; SUAREZ, A; et al.

2. **Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder**
   By: Linehan, Marsha M.; Comtois, Katherine Anne; Murray, Angela M.; et al.

3. **Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial**
   By: Bateman, A; Fonagy, P
TOP SIX RCTS BORDERLINE PERSONALITY DISORDER

4. Evaluating three treatments for borderline personality disorder: A multiwave study
   By: Clarkin, John F.; Levy, Kenneth N.; Lenzenweger, Mark F.; et al.

5. Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: An 18-month follow-up
   By: Bateman, A; Fonagy, P

6. Dialectical behaviour therapy for women with borderline personality disorder - 12-month, randomised clinical trial in The Netherlands
   By: Verheul, R; Van den Bosch, LMC; Koeter, MWJ; et al.
But we need to sound a warning. There is still work to be done – the bar is being raised (see Tolin et al. (2015)).

Need for more high quality RCTs from independent researchers. Must focus on functioning not just symptoms/features. Effectiveness studies needed.
DIALECTICAL BEHAVIOR THERAPY FOR BORDERLINE PERSONALITY DISORDER

• **2015 EST Status:** Treatment pending re-evaluation

• **1998 EST Status:** Strong Research Support Strong: Support from two well-designed studies conducted by independent investigators.

• Basic premise: A subset of individuals experience emotions more intensely than others. In order to regulate heightened emotions, they tend to react in a more extreme and impulsive manner (e.g., self-harm, suicide attempts). It is thought that a lack of awareness and acceptance of these emotional experiences interferes with developing more effective coping strategies for distress.

• Essence of therapy: Dialectical behavior therapy teaches clients behavioral skills in mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation.

• Length: Varies, but usually lasts 1-1.5 years including both individual therapy and skills groups.
MENTALIZATION-BASED TREATMENT FOR BORDERLINE PERSONALITY DISORDER

Status: Modest Research Support

Description
Mentalizing is the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes. Patients with BPD show reduced capacities to mentalize, which leads to problems with emotional regulation and difficulties in managing impulsivity, especially in the context of interpersonal interactions. Mentalization based treatment (MBT) is a time-limited treatment which structures interventions that promote the further development of mentalizing.

Key References (in reverse chronological order)
TRANSFERENCE-FOCUSED THERAPY FOR BORDERLINE PERSONALITY DISORDER

Status: Strong/Controversial Research Support

Description
Transference-Focused Therapy (TFP) focuses on revealing the underlying causes of a patient’s borderline condition and working to build new, healthier ways for the patient to think and behave. From the perspective of TFP, the borderline patient’s perceptions of self and of others are split into unrealistic extremes of bad and good. These conflicting dyads are thought to be expressed through the specific self-destructive symptoms of BPD. The term “transference” refers to the patient’s experience of his or her moment-to-moment relationship with the therapist. The treatment focuses on transference, because it is believed that patients will display their unhealthy dyadic perceptions not only in day-to-day life, but also in the interactions they have with their therapist. TFP focuses on using patient-therapist communications to help the patient integrate these different representations of self and, in the process, develop better methods of self-control.

TFP has the unusual designation of strong/controversial research support because of mixed findings. TFP performed favorably in two randomized controlled trials (Clarkin et al., 2007; Doering et al., 2010), but performed less well than a comparison treatment in another (Giesen-Bloo et al., 2006). More research is needed to clarify the research status of TFP.
SCHEMA-FOCUSSED THERAPY

Status: Modest Research Support

Description

Schema Focused-Therapy (SFT) is an integrative approach founded on the principles of cognitive-behavioral therapy and then expanded to include techniques and concepts from other psychotherapies. Schema therapists help patients to change their entrenched, self-defeating life patterns – or schemas – using cognitive, behavioral, and emotion-focused techniques. The treatment focuses on the relationship with the therapist, daily life outside of therapy, and the traumatic childhood experiences that are common in borderline personality disorder. Participants in the first study of SFT for borderline personality disorder received therapy for three years.

Key References (in reverse chronological order)

LANDMARK FOUR: BEGINNINGS OF A EPIDEMIOLOGY OF PERSONALITY DISORDER AND PROSPECTIVE FOLLOW-ALONG STUDIES

• Although not without limitations epidemiological studies collectively show:

• Prevalence data for individual personality disorders ranging from 6.5% to 13% (measurement as well as population differences). Strongest semi-structured instruments tend to find higher prevalence in community

• Relationship to so-called Axis I disorders - strong comorbidity

• Demands on health and mental health resources – high usage of consultations - BPD most

• Functioning levels - important! OCPD better than BPD unless OCPD has Axis I disorder(s)

• Overlap with other Axis II disorders
There are increasing number of follow-along studies – some like the CLIPS study dealing with a limited number of PDs. Others focus on BPD only.

BPD associated with stable poor social functioning (and probably most for intimate relationships). Gunderson et al. found persistent poor social functioning, although high rates of BPD remission and low rates of relapse.

PD features can wax and wane. BUT Some BPD features more constant – affective instability but then impulsivity most likely to remit.

PD features not uncommon in early life but most remit. On the other hand, those with adult PDs have PD traits in early life - they persist!
The Prevalence of Personality Disorders in a Community Sample

Svenn Torgersen, PhD; Einar Kringlen, MD; Victoria Cramer, PhD

Background: To our knowledge, no previous studies of personality disorders (PDs) in a large representative sample of the common population have been conducted.

Methods: A representative sample of 2053 individuals between the ages of 18 and 65 years in Oslo, the capital of Norway, was studied from 1994 to 1997. Information about PDs was obtained by means of the Structured Interview for DSM-III-R Personality Disorders, in conjunction with an interview recording demographic data. The subjects were interviewed primarily at home, but in some instances, also at the clinic.

Results: The prevalence of PDs was 13.4% (SE, 0.7). The prevalence rates (SEs) for specific PDs, irrespective of whether a person had 1 or more PD, were: paranoid, 2.4% (0.3); schizoid, 1.7% (1.6); schizotypal, 0.6% (0.2); antisocial, 0.7% (0.2); sadistic, 0.2% (0.1); borderline, 0.7% (0.2); histrionic, 2.0% (0.3); narcissistic, 0.8; (0.2); avoidant, 5.0% (0.5); dependent, 1.5% (0.3); obsessive-compulsive: 2.0% (0.3); passive-aggressive, 1.7% (0.3); self-defeating, 0.8%, (0.2). The prevalence of PDs was highest among subjects with only a high school education or less, and living without a partner in the center of the city.

Conclusions: Personality disorders were found to be prevalent, with avoidant, schizoid, and paranoid PDs more common, and borderline PD less common than what is usually reported. Personality disorders tend to be more frequent among single individuals from the lower socioeconomic classes in the center of the city. It is impossible to determine what is cause and what is consequence from a cross-sectional study.

Arch Gen Psychiatry. 2001;58:590-596
Ten-Year Course of Borderline Personality Disorder

Psychopathology and Function From the Collaborative Longitudinal Personality Disorders Study

John G. Gunderson, MD; Robert L. Stout, PhD; Thomas H. McGlashan, MD; M. Tracie Shea, PhD; Leslie C. Morey, PhD; Carlos M. Giraldo, PhD; Mary C. Zanarini, EdD; Shirley Yen, PhD; John C. Markowitz, MD; Charles Sanislow, PhD; Emily Ansell, PhD; Anthony Pinto, PhD; Andrew E. Skodol, MD

Context: Borderline personality disorder (BPD) is traditionally considered chronic and intractable.

Objective: To compare the course of BPD's psychopathology and social function with that of other personality disorders and with major depressive disorder (MDD) over 10 years.

Design: A collaborative study of treatment-seeking, 18- to 45-year-old patients followed up with standardized, reliable, and repeated measures of diagnostic remission and relapse and of both global social functioning and subtypes of social functioning.

Setting: Nineteen clinical settings (hospital and outpatient) in 4 northeastern US cities.

Participants: Three study groups, including 175 patients with BPD, 312 with cluster C personality disorders, and 95 with MDD but no personality disorder.

Main Outcome Measures: The Diagnostic Interview for DSM-IV Personality Disorders and its follow-along version (the Diagnostic Interview for DSM-IV Personality Disorders–Follow-Up Version) were used to diagnose personality disorders and assess changes in them. The Structured Clinical Interview for DSM-IV Axis I Disorders and the Longitudinal Interval Follow-up Evaluation were used to diagnose MDD and assess changes in MDD and in social function.

Results: Eighty-five percent of patients with BPD remitted. Remission of BPD was slower than for MDD (P < .001) and minimally slower than for other personality disorders (P < .03). Twelve percent of patients with BPD relapsed, a rate less frequent and slower than for patients with MDD (P < .001) and other personality disorders (P = .008). All BPD criteria declined at similar rates. Social function scores showed severe impairment with only modest albeit statistically significant improvement; patients with BPD remained persistently more dysfunctional than the other 2 groups (P < .001). Reductions in criteria predicted subsequent improvements in DSM-IV Axis V Global Assessment of Functioning scores (P < .001).

Conclusions: The 10-year course of BPD is characterized by high rates of remission, low rates of relapse, and severe and persistent impairment in social functioning. These results inform expectations of patients, families, and clinicians and document the severe public health burden of this disorder.

Age-related change in personality disorder trait levels between early adolescence and adulthood: a community-based longitudinal investigation


Objective: To investigate change in personality disorder (PD) traits between early adolescence and early adulthood among individuals in the community.

Method: PD traits were assessed in 1983 (mean age = 14), 1985–86 (mean age = 16) and 1992 (mean age = 22) in a representative community sample of 816 youths.

Results: Overall, PD traits declined 28% during both adolescence and early adulthood. PD traits were moderately stable during the first 2-year interval, and were as stable as they have been reported to be among adults over similar intervals. PD trait stability declined slightly as the inter-assessment interval increased. Adolescents with PDs tended to have elevated PD traits during early adulthood.

Conclusion: PD traits tend to decline steadily in prevalence during adolescence and early adulthood. However, adolescents with PDs often have elevated PD traits as young adults, and the stability of PD traits appears to be similar during adolescence and early adulthood.

Key words: personality disorder

Accepted for publication June 13, 2000
LANDMARK FIVE – NORMAL AND ABNORMAL PERSONALITY

• Beginnings of a rapprochement between personality and personality disorder researchers.

• Acceptance in general that personality disorder may represent extreme, and configurations of severe, scores on normal personality measures.

• During last 25 or more years we have seen the emergence of a variety of dimensional instruments including the TCI (Cloninger) and the SNAP of Lee Anna Clarke, the MCMI (Millon), the DAP (Livesley), Lesley Moreys (PAI) instrument.

• PLUS the importation of the NEO from so called ‘normal ‘ personality field.
LANDMARK FIVE – NORMAL AND ABNORMAL PERSONALITY

• However, issues remain about how many dimensions?

• Also and even if one looks at the facet level of a number of these instruments whether they provide sufficient coverage of some aspects of PDs, the odd metaphorical speech of those with schizotypal PD

• Thomas Widiger and John Livesley probably strongest advocates of this approach

• DSM-5 tried to introduce a no-brand model which was shouted down and the instrument is in the Appendix of DSM-5 awaiting research
The Dimensionalists!

THE FIVE-FACTOR MODEL OF PERSONALITY AND ITS RELEVANCE TO PERSONALITY DISORDERS

Paul T. Costa, Jr., and Robert R. McCrae

The five-factor model is a dimensional representation of personality structure that has recently gained widespread acceptance among personality psychologists. This article describes the five factors (Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness): summarizes evidence on their consensual validity, comprehensiveness, universality, heritability, and longitudinal stability; and reviews several approaches to the assessment of the factors and their defining traits. In research, measures of the five factors can be used to analyze personality disorder scales and to profile the traits of personality-disordered patient groups: findings may be useful in diagnosing individuals. As an alternative to the current categorical system for diagnosing personality disorders, it is proposed that Axis II be used for the description of personality in terms of the five factors and for the diagnosis of personality-related problems in affective, interpersonal, experiential, attitudinal, and motivational areas.
GETTING BELOW THE SURFACE IN PERSONALITY DISORDER RESEARCH

SCHEMAS, GENES, BRAIN MORPHOLOGY AND FUNCTIONING, EMOTION, THEORY OF MIND, SOCIAL COGNITION
LANDMARK SIX - BIOLOGICAL AND COGNITIVE RESEARCH

• Work on Schemas

• Genes (Behavioural and Endophenotypes)

• Brain Morphology and Functioning

• Emotion, Theory of Mind and Social Cognition
SCHEMAS

• Early maladaptive schemas in personality disordered individuals.
  By: Jovev and Jackson

• Addicted patients with personality disorders: Traits, schemas and presenting problems.
  By: Ball and Cecero

• The long-term stability of early maladaptive schemas.
  By Riso, Froman, Raouf et al.
  Cognitive Therapy and Research, 30, 515-529. Published: August 2006.
• Abnormal cortical activity in response to stimuli (abnormal information processing) is an example of a biological endophenotype.

• A single symptom of a mental illness associated with a mental illness is an example of a symptom endophenotype.

• In the path from gene to mental illness, a genotype may code for a subtle molecular abnormality that is closely linked to a biological endophenotype (such as abnormal information processing in specific neuronal circuits), which in turn may be linked to a symptom or behavior (symptom endophenotype) associated with mental illness.

• The borderline diagnosis: II: Biology, genetics, and clinical course
  • By: Skodol, Siever, Livesley et al.
  • Biological Psychiatry, 51, 951-963  Published: June 2002

• The borderline diagnosis III: Identifying endophenotypes for genetic studies
  • By: Siever, Torgersen, Gunderson et al.
  • Biological Psychiatry, 51, 964-968  Published: June 2002

• Heritability of personality disorder traits: A twin study
  • By: Jang, Livesley, Vernon et al.
  • Acta Psychiatrca Scandinavica, 94, 438-444  Published: December 1996
BRAIN MORPHOLOGY

• Magnetic resonance imaging of the thalamic mediodorsal nucleus and pulvinar in schizophrenia and schizotypal personality disorder.
  By: Byne, Buchsbaum, Kemether, et al.
  Archives of General Psychiatry, 58, 133-140. Published: February 2001.

• Reduced anterior and posterior cingulate gray matter in borderline personality disorder.
  By: Hazlett, New, Newmark et al.

• Shape and size of the corpus callosum in schizophrenia and schizotypal personality disorder.
  By: Downhill, Buchsbaum, Wei, et al.
BRAIN FUNCTIONING AND EMOTION

• Failure of frontolimbic inhibitory function in the context of negative emotion in borderline personality disorder.
  Published December 2007.

• Amygdala-prefrontal disconnection in borderline personality disorder.
  By New, Hazlett, Buchsbaum et al. Neuropsychopharmacology, 32, 1629-1640.
  Published July 2007.

• Evidence of abnormal amygdala functioning in borderline personality disorder: A functional MRI study.
  Published August 2001.
EMOTION

• Emotion in criminal offenders with psychopathy and borderline personality disorder.
  By Herpertz, Werth, Lukas et al.
  *Archives of General Psychiatry, 58, 737-745, Published August 2001.*

• Affective responsiveness in borderline personality disorder: A psychophysiological approach: By Herpertz, Kunert, Schwenger, et al.
  *American Journal of Psychiatry, 156, 1550-1556. Published: October 1999.*

• Emotion recognition in borderline personality disorder – A review of the literature. By: Domes, Schulze, and Herpertz
  *Journal of Personality Disorders, 23, 6-19. Published: February 2009.*
THEORY OF MIND, COOPERATION AND TRUST IN BPD

• Facial trust appraisal negatively biased in borderline personality disorder.
  By: Fertuck, Grinband, and Stanley
  *Psychiatry Research, 207, 195-202* Published: May 2013

• Enhanced ‘Reading the Mind in the Eyes’ in borderline personality disorder compared to healthy controls.
  By: Fertuck, Jekal, Song, et al.
  *Psychological Medicine, 39, 1979-1988.* Published: December 2009

• The rupture and repair of cooperation in borderline personality disorder.
  By King-Casas, Sharp, Lomax-Bream, Lohrenz, Fonagy and Montague
KEY FIGURES IN BIOLOGICAL WORLD OF PD: SABINE HERPERTZ AND LARRY SIEVER
BIG ISSUES
ISSUE 1: CATEGORIES VERSUS DIMENSIONS
ISSUE 2: PSYCHOPATHY OR ANTISOCIAL PERSONALITY DISORDER? DID DSM GET IT WRONG?
ISSUE 2: PSYCHOPATHY

DR HERVEY CLECKLEY       DR ROBERT HARE       DR SCOTT LILIENFELD
DSM-III (APA, 1980) concept of antisocial personality disorder was rooted in studies of delinquent and juvenile offenders (see work of Lee Robins).

It is mostly based on a description of overt antisocial behaviours associated with criminal behaviours, e.g., stealing, lying, cheating, property destruction. These are observable behaviours that in a sense can be counted and listed.

A rival model has been one that was based on the clinical descriptions most famously described by Dr Hervey Cleckley in The Mask of Sanity first published in 1941.
ISSUE 2: PSYCHOPATHY: DR ROBERT HARE AND SCOTT LILLIENFELD

• Canadian psychologist who using Cleckley’s work as the primary basis, came up with a two factor structure of psychopathy which has been psychometrically road –tested.

• It consists of two factors -

• (1) which includes a list of criminal, antisocial behaviours similar to DSM-III antisocial personality disorder; and

• (2) psychopathy defined in terms of callousness, unemotional, meanness, power-mongering and has some overlap with DSM- narcissistic personality disorder. These are more personality-like, less behavioural and require more inference on the part of the observer.

• More recent work from Scott Lilienfeld found in nonclinical populations a third factor he calls fearless dominance (boldness)
ISSUE 2: PSYCHOPATHY – AN IMPORTANT OMISSION?
ISSUE 3: PSYCHOTHERAPY FOR BPD: BRAND NAME DISTINCTIONS - DO THE SIMILARITIES BETWEEN THE PRODUCTS OUTWEIGH THE DIFFERENCES?
ISSUE 3: THE CULT OF PERSONALITY OR CELEBRITY IN PERSONALITY DISORDER RESEARCH

• We need to be respectful towards our leaders but skeptical of elevating them to cult-like status.

• Need to be clear that understandably they are invested in their particular approach
ISSUE 4: NARCISSISM

• Controversy over whether it should be included in DSM-5

• Three major positions theoretically:
  • Kernberg/Clarkin/Masterson/Ronningstam/Kohut
  • Million – social/ bio-behavioural
  • Twenge – social-cultural

• Two competing views - Love too much or not loved enough

• Most of the recent action has come from social psychology which has treated it as a dimensional construct. And states two forms - one grandiose narcissism and the other vulnerable or fragile narcissism (Pincus)

• Jean Twenge’s work on rise of narcissism as a dimension in USA. Important figure

• Ronningstam important figure in keeping NPD alive and well!
NARCISSISM - ONE FACE OR TWO
ISSUE 5: DON’T NEGLECT THE THERAPEUTIC ALLIANCE - TECHNIQUE IS NOT ALL -1

• Key figure: Lester Luborsky

• Different positions on this: At one end – the relationship is the therapy. At the other end - the relationship is of no to little importance.

• Both positions are extreme and the actual evidence is somewhat in between - See the work of Michael Lambert, John Norcross and Allen Bergin, although the relationships may account for more or less of the outcome variance depending on condition.

• Important work here in Wollongong by Brin Grenyer and colleagues specifically with BPD.

• Psychotherapists’ response to borderline personality disorder: A core conflictual relationship theme analysis.
• By: Bourke and Grenyer
• Psychotherapy Research, 20, 680-691. Published: 2010
DON’T NEGLECT THE THERAPEUTIC ALLIANCE -2

• Statement
  • “The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment. Moreover efforts to promulgate best practices or evidence-based practices without including the relationship are seriously incomplete and potentially misleading” (Norcross & Lambert, 2014, p.399).

• Ingredients: What does research tell us?
  - Alliance, cohesion in group therapy, goal consensus and collaboration, empathy, positive regard/affirmation/support, congruence/genuineness, collecting client feedback, **repairing alliance ruptures**
  - Avoid therapist rigidity, pervasive confrontations, and comments that are hostile, pejorative, critical, accusatory or blaming

Generally, average effect size between psychotherapy and no psychotherapy is about .80-85 and so any single relationship behaviour in table in next slide is about .55.
Don’t neglect the therapeutic alliance -3

<table>
<thead>
<tr>
<th>Meta-analysis authors</th>
<th>Relationship element</th>
<th>r</th>
<th>d</th>
<th>% of variance in outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horvath et al.</td>
<td>Alliance in individual adult therapy</td>
<td>.28</td>
<td>.58</td>
<td>8%</td>
</tr>
<tr>
<td>Shirk &amp; Karver</td>
<td>Alliance in youth therapy</td>
<td>.19</td>
<td>.39</td>
<td>4%</td>
</tr>
<tr>
<td>Friedlander et al.</td>
<td>Alliance in couple/family therapy</td>
<td>.26</td>
<td>.53</td>
<td>7%</td>
</tr>
<tr>
<td>Burlingame et al.</td>
<td>Cohesion in group therapy</td>
<td>.25</td>
<td>.51</td>
<td>6%</td>
</tr>
<tr>
<td>Elliot et al.</td>
<td>Empathy</td>
<td>.30</td>
<td>.62</td>
<td>9%</td>
</tr>
<tr>
<td>Tryon et al.</td>
<td>Goal consensus and collaboration</td>
<td>.34</td>
<td>.72</td>
<td>12%</td>
</tr>
<tr>
<td>Farber et al.</td>
<td>Positive regard/affirmation/support</td>
<td>.27</td>
<td>.56</td>
<td>7%</td>
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<tr>
<td>Kolden et al.</td>
<td>Congruence/genuineness</td>
<td>.24</td>
<td>.49</td>
<td>6%</td>
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<tr>
<td>Lambert et al.</td>
<td>Collecting client feedback</td>
<td>.25</td>
<td>.51</td>
<td>6%</td>
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<tr>
<td>Safran et al.</td>
<td>Repairing alliance ruptures</td>
<td>.24</td>
<td>.49</td>
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</tbody>
</table>

* All published in Norcross (2011).
ISSUE 6: DISAGREEMENT OVER VERY NATURE OF PERSONALITY DISORDER

• 1. Both DSM-5 and proposed ICD-11 won't have multiaxial system

• 2. DSM-5 workgroup led by Andy Skodol proposed 5 PDs and a dimensional model but this was repudiated. The no-brand 6-dimensions model now in DSM-5 appendix and main text reverted back to DSM-IV categories.

• 3. ICD-11 work group lead by the iconoclastic Peter Tyrer proposes an even more radical model. - A simplified version with four levels and Severity dimensions. Currently has five domains currently labelled Detached, Anankastic, Negative Emotional, Antisocial and Borderline (histrionic, narcissistic, and borderline)
FUTURE DIRECTIONS - BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder

1. Overall, our treatments for BPD although very promising, need more development. The bulk of the evidence is not as convincing as say in the field of depression or phobic anxiety or OCD. The number of well controlled studies simply haven’t been done.

2. Although it is also important to continue to develop brand named therapies in the range of BPDs, it is equally if not important to move towards identifying common ingredients – this might be best done in a top-down and bottom up way.

3. One method - the top down method - could be achieved by organisations and third parties sitting down and going through the various components and in a rational way determining the most likely components that are effective.

4. Ultimately though, the slower and more reasoned empirical approach would be to use dismantling strategies to determine the most effective components within each therapy.
FUTURE DIRECTIONS - BORDERLINE PERSONALITY DISORDER

1. There needs to be a commitment to the common good. That is treatments are that can more easily grasped and taught to various mental health professionals. This means giving up private ambitions for the common good to attempt to get effective treatments out there to the most in need.

2. **Could good clinical care be just as good at least for youth?** See Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy; randomised controlled trial. By: Chanen, Jackson, McCutcheon, et al. *British Journal of Psychiatry*, 193, 477-484 Published: December 2008

3. There needs to be serious work done in training of professionals to counteract stigma against those with BPD. This is a problem and we have all seen this at work in various contexts, most glaringly and acutely in ER settings.

4. Speaking to my own profession of clinical psychology, there should be a focus on the hard end – the most difficult and complex cases.

5. **Need to examine process with regard to outcomes.**
FUTURE DIRECTIONS - PERSONALITY DISORDER

• Personality disorders in older age – What happens? We have some understanding of PD in younger ages thanks to the work of Cohen, Patrick Johnson, and Andrew Chanen but what happens in older age. Do some traits remit, become less obvious, and others remain?

• Needs to be more focused work on biological and cognitive biases and deficits in PDs and linkage to theorizing and hypothesis testing rather than spraypaint approach advocated by Insel’s initial RoDC approach - there needs to a plausible mode of action – how do treatments work?

• Concern that interest in other PDS will fade away and may be exacerbated by having PDs and mental state conditions on the same axis (see Newton–Howes et al., 2015)

• More cross-linkages with other branches of psychology, e.g., social and cognitive psychology
Personality disorder across the life course

Giles Newton-Howes, Lee Anna Clark, Andrew Chanen

The pervasive effect of personality disorder is often overlooked in clinical practice, both as an important moderator of mental state and physical disorders, and as a disorder that should be recognised and managed in its own right. Contemporary research has shown that maladaptive personality (when personality traits are extreme and associated with clinical distress or psychosocial impairment) is common, can be recognised early in life, evolves continuously across the lifespan, and is more plastic than previously believed. These new insights offer opportunities to intervene to support more adaptive development than before, and research shows that such intervention can be effective. Further research is needed to improve classification, assessment, and diagnosis of personality disorder across the lifespan; to understand the complex interplay between changes in personality traits and clinical presentation over time; and to promote more effective intervention at the earliest possible stage of the disorder than is done at present. Recognition of how personality disorder relates to age and developmental stage can improve care of all patients.
A DEEP ISSUE TO LEAVE YOU TO PONDER: ARE PERSONALITY DISORDERS MENTAL DISORDERS?

• Thank you for your attention!