What Is A Personality Disorder?

Personality traits are patterns of perceiving, thinking about, relating and interacting with people. These traits contribute to how a person is perceived by others in all types of interaction, whether it is social, at work or in personal relationships. Everybody has personality traits.

A personality disorder is when these personality traits are inflexible, maladaptive, and cause significant impairment to a person's functioning (e.g. in relationships, or at work). Personality disorders cause significant distress to the person and affect their thinking, and emotion (e.g. sadness, elation, anger). This pattern of maladaptive personality traits is stable and long lasting, they apply to a wide range of social and personal situations and cannot be explained by the differences in beliefs and behaviours found in different cultures.

Personality disorders can often be traced back to childhood or adolescence and are often diagnosed in early adulthood. They tend to become less obvious through middle age, mainly because people are able to function well by having acquired good coping mechanisms.

CAUTION!

Because the traits found in personality disorders are broadly similar to those found in people without a mental illness, it can be very easy to read this fact sheet and ‘see’ yourself or other people in it. The traits mentioned in each disorder are extreme and long-lasting and cause considerable distress to the person and those around them. For example, all humans can feel dependent, angry or suspicious at times; a personality disorder is only considered when these traits are unusually strong and cause considerable distress and difficulty for the person. Please do NOT try to diagnose yourself or anyone else – this requires the skill of a professional such as a psychiatrist or psychologist.

Based on their similarities, personality disorders are grouped into 3 clusters:

**Cluster A:** Individuals in this cluster often appear odd or eccentric. This includes the Paranoid, Schizoid and Schizotypal personality disorders.

**Cluster B:** Individuals in this cluster appear dramatic, emotional or erratic. This includes the Antisocial, Borderline, Histrionic, and Narcissistic personality disorders.

**Cluster C:** Individuals in this cluster often appear anxious or fearful. This includes the Avoidant, Dependent and Obsessive-Compulsive personality disorders.
What are the symptoms of personality disorders?

Cluster A

Paranoid

An individual with paranoid personality disorder generally tends to interpret the actions of others as threatening. This distrust and suspiciousness is indicated by four (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1. suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
2. is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
3. is reluctant to confide in others because of unwarranted fear that the information will be used against him or her
4. reads hurtful or threatening meanings into even kind remarks or events
5. is unforgiving of insults or injuries
6. perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily
7. has recurrent suspicions, without justification, regarding faithfulness of spouse or sexual partner

Schizoid

An individual with schizoid personality disorder is generally detached from social relationships, and shows a narrow range of emotional expression in various social settings. This pattern is indicated by four (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1. neither desires nor enjoys close relationships, including family relationships
2. often chooses activities that don't involve other people
3. has little interest in having sexual relations with another person
4. enjoys few activities
5. lacks close friends other than immediate family
6. appears indifferent to praise or criticism
7. shows emotional coldness, detachment, or little emotional expression

Schizotypal

A person with schizotypal personality disorder is uncomfortable in close relationships, has thought or perceptual distortions, and peculiarities of behaviour. This disorder is indicated by five (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1. ideas of reference, i.e., believes that casual and external events have a particular and unusual meaning that is specific to him or her
2. odd beliefs or magical thinking that influences behaviour and is inconsistent with cultural norms (e.g., belief in superstitions or clairvoyance, telepathy, or "sixth sense"
3. unusual perceptual experiences (e.g., hears a voice murmuring his or her name; reports bodily illusions)
4. odd thinking and speech (e.g., unusual phrasing, speech which is vague, overly elaborate, and wanders from the main point)
5. excessively suspicious thinking
6. inappropriate or constricted emotions (reduced range and intensity of emotion)
7. behaviour or appearance that is odd or peculiar (e.g., unusual mannerisms, avoids eye contact, wears stained, ill-fitting clothes)
8. lack of close friends or confidants other than immediate family
9. excessive social anxiety that remains despite familiarity with people and social situation. The anxiety relates more to suspiciousness about others’ motivations than to negative judgments about self.

Cluster B

Antisocial

Individuals with antisocial personality disorder show a pervasive disregard for, and violation of, the rights of others since age 15 years, as indicated by three (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1. repeated acts that are grounds for arrest
2. deceitfulness, i.e., repeated lying, use of aliases, or conning others for personal profit or pleasure
3. impulsiveness or failure to plan ahead
4. irritability and aggressiveness, such as repeated physical fights or assaults
5. reckless disregard for the safety of self or others
6. consistent irresponsibility, i.e., repeated failure to sustain consistent work behaviour or honour financial obligations
7. lack of remorse, as indicated by indifference to, or rationalising having hurt, mistreated, or stolen from another

Borderline

Individuals with borderline personality disorder show a generalised pattern of instability in interpersonal relationships, self image, and observable emotions, and significant impulsiveness. This pattern begins by early adulthood, occurs in various contexts, and is indicated by five (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1. frantic efforts (excluding suicidal or self-inflicted cuts or burns) to avoid real or imagined abandonment
2. a pattern of intense and unstable interpersonal relationships that may quickly alternate between extremes of idealisation (the other person may be ‘put on a pedestal’) and devaluation (the other person’s negative qualities are now exaggerated)
3. identity disturbance, such as sudden and dramatic shifts in self-image in terms of shifting values (e.g. sexual identity, types of friends) and vocational goals
4. impulsiveness in at least two areas that are potentially harmful (e.g. spending, sex, substance abuse, reckless driving, binge eating, excluding suicidal or self-mutilating behaviour)
5. repeated suicidal behaviour or threats, or self-inflicted cuts or burns (e.g. self mutilating behaviour)
6. significant, sudden changes in mood and observable emotion (e.g. intense periodic sadness, irritability, or anxiety, usually lasting a few hours and rarely lasting more than a few days; extreme reactivity to interpersonal stresses)
7. chronic feelings of emptiness; also may be easily bored
8. inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. temporary, stress-related psychosis (symptoms such as paranoia or grossly distorted body image)

Histrionic

Beginning in early adulthood, individuals with histrionic personality disorder often display excessive emotionality and attention seeking in various contexts. They tend to overreact to other people, and are often perceived as shallow and self centred. This pattern is suggested by five (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1. discomfort in situations in which he or she is not the centre of attention
2. frequent, inappropriate, seductive or provocative behaviour in interpersonal interactions
3. rapid shifts of emotions, and shallow expression of emotions; emotions often appear to be ‘turned on and off’ too quickly to be deeply felt
4. consistent use of physical appearance to draw attention to self
5. excessively dramatic style of speech that lacks detail; opinions are strongly presented, but underlying reasons may be vague, without supporting facts and details
6. dramatic, theatrical, and exaggerated expression of emotion
7. easily influenced by others or circumstances (e.g. fads)
8. views relationships as more intimate than they actually are

Narcissistic

Individuals with narcissistic personality disorder often have a grandiose view of themselves, a need for admiration, and a lack of empathy that begins by early adulthood and is present in various situations. These individuals are very demanding in their relationships. This pattern is indicated by five (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1. has an inflated sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without corresponding achievements)
2. is overly concerned with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4. requires excessive admiration
5. has a sense of entitlement, i.e., unreasonable expectations of very positive treatment or automatic compliance with his or her expectations
6. takes advantage of others to achieve his or her own ends
7. lacks empathy, is unwilling to identify with the feelings and needs of others
8. is often jealous of others or believes that others are jealous of him or her
9. shows arrogant or domineering behaviours or attitudes
Cluster C

Avoidant

An individual with avoidant personality disorder typically is socially inhibited, feels inadequate, and is oversensitive to criticism, as indicated by four (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1. avoids work-related activities that involve much social contact, because of fears of criticism, disapproval, or rejection
2. is unwilling to get involved with people unless certain of being liked
3. fears of shame or ridicule lead to excessive shyness within intimate relationships
4. is overly concerned with criticism and rejection in social situations
5. is inhibited in new social situations because of feelings of inadequacy
6. views self as socially incompetent, personally unappealing, or inferior to others
7. unusually reluctant to take personal risks or do new activities because of fear of embarrassment

Dependent

A person with dependent personality disorder shows an extreme need to be taken care of that leads to fears of separation, and passive and clinging behaviour. This disorder is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1. difficulty making daily decisions without an excessive amount of advice and reassurance from others
2. needs others to assume responsibility for most major areas of his or her life
3. difficulty voicing disagreement with others because of fear of loss of support or approval (excluding realistic fears of punishment)
4. difficulty starting projects or doing things on his or her own (because of little self confidence in judgment or abilities, rather than a lack of motivation or energy)
5. excessively attempts to obtain support from others such that he or she volunteers to do unpleasant tasks
6. feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for him or herself
7. urgently seeks another relationship as a source of support when a close relationship ends
8. overly worried about being left to take care of him or herself

Obsessive-Compulsive

An individual with obsessive-compulsive personality disorder is preoccupied with orderliness, perfectionism, and control at the expense of flexibility, openness, and efficiency. This pattern is indicated by four (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1. is overly concerned with details, rules, lists, order, organisation, or schedules such that the major point of the activity is lost
2. is unable to complete a project because his or her own overly strict standards are not met
3. excessive emphasis on work and productivity such that leisure activities and friendships are devalued (not accounted for by obvious economic need)
4. is overly conscientious and inflexible about issues involving morality, ethics, or values (not accounted for by cultural or religious identification)
5. is unable to throw out worn-out or worthless objects despite lack of emotional value
6. is reluctant to delegate tasks or work with others unless they agree to exactly his or her way of doing things
7. adopts a stingy spending style toward both self and others; money is seen as something to be gathered for future catastrophes
8. rigidity and stubbornness

**Personality Disorders Not Otherwise Specified**

There also is a diagnosis known as ‘Personality Disorders Not Otherwise Specified’, which is separate from the disorders described above. This diagnosis may be given for disturbed personality functioning that does not meet criteria for any specific personality disorder, but which leads to distress or harm in one or more important areas of functioning (e.g., social or work-related).

**What is the impact of personality disorders?**

**Impact on person with the disorder**

- The person is typically distressed and mystified by their thoughts, behaviours and interpersonal problems but have no explanation for them. Some individuals spend a lot of time and money searching for help in inappropriate places or seek help only for individual symptoms, such as depression, not understanding that these are part of a broader problem. Sometimes the person joins all kinds of inappropriate organisations in a desperate attempt to find out what is wrong and get help.
- Stigma of the label of ‘personality disorder’ among mental health professionals. In the past, this has sometimes been used as a ‘catch all’ diagnosis for people whose illness is difficult to diagnose or manage.
- The extensive psychotherapy usually recommended for personality disorders is usually long and expensive.
- Disorders such as depression and anxiety often co-exist with personality disorders
- People with personality disorders are more likely to abuse drugs and alcohol
- Individuals with personality disorders are more likely to be stigmatized and blamed for their illness, relative to other psychiatric and medical disorders. Personality disorders have been less understood and recognised than other psychiatric disorders; and treatment options and appropriate support has been less available.

**Impact on other people**

- Behaviour causes distress to the person’s family, colleagues, friends, partners, children
- Families often feel ambivalence towards the person with the disorder, as they can also be charming, creative, kind, intelligent etc. These positive traits can make it difficult to understand the disordered behaviour
The person may have great difficulty controlling their impulses and emotions, and often have distorted perceptions of themselves and others.

Families commonly endure episodes of explosive anger and rage, extreme depression (e.g. person rarely gets out of bed), self mutilation (self-inflicted cuts and burns), and suicide attempts by family members with personality disorders. Families and friends may struggle to understand the person and cope with their behaviours and their consequences.

What are the causes?

Genetic

Some research indicates that personality disorders are inherited to a significant degree. The most dramatic research in this area are the studies of identical twins who were adopted separately at birth, raised in different households and then found to have similar personality traits when studied as adults.

Environmental

Personality traits develop in response to our environment. The problem behaviour displayed by the person with a personality disorder once had a function (often during childhood) and served the person well in the circumstances they were in.

For example, a child living in a household where violence was frequent, learned to be constantly vigilant and on the lookout for the first sign of trouble. This vigilance protected them in that situation, and the protective behaviour became part of the child’s personality. However, when they reached adulthood and were no longer in that dangerous situation, they no longer needed to be constantly vigilant. However, the way they learned to cope then stuck firmly, even though, in adulthood, it caused difficulty and distress – perhaps in the form of suspicion or paranoia. When the child reaches adulthood, these traits and ways of being are entrenched and very hard to change, even though they are now dysfunctional and detrimental to the person’s relationships.

An ‘invalidating’ environment as a child is thought to often contribute to a diagnosis of borderline personality disorder. This type of environment is one where the child’s feelings, experiences and wishes are dismissed as trivial or silly and their real needs are not met. The child’s personal communications are not accepted as an accurate indication of her true feelings and it is implied that, if they were accurate, then such feelings would not be a valid response to circumstances. An ‘invalidating’ environment is characterised by a tendency to place a high value on self-control and self-reliance.

This sometimes happens in families where there is one child with a chronic illness or disability; this child tends to absorb most of the parent’s time and emotional resources to the detriment of the other children in the family.

Childhood Abuse

Research shows that many people with personality disorders were abused as children. About seventy-five percent of people diagnosed with borderline personality disorder have experienced physical or sexual abuse. Abuse can be physical, sexual or emotional in nature, or just not being parented appropriately. Childhood is the time to learn to cope and manage intense emotional changes and this is one of the most important goals of
parenthood. Children who are abused often do not learn these lessons, thus they are more likely to have difficulty regulating their emotions as adults.

**It is extremely important to note that childhood abuse is not always the cause of personality disorders.** As with many other mental illnesses, in the past, the trend has been to blame parents and families for their children’s mental illness. Such blame is not productive or helpful to the person with a personality disorder. Also, mental illness rarely arises from just one cause – usually a combination of factors contribute to an individual's disorder.

**Assessment**

It is important to be assessed by an appropriately qualified and experienced professional, i.e. a psychiatrist or psychologist. Physical causes for symptoms must be eliminated before a diagnosis of any mental illness can occur.

Assessment may consist of:

- Suicide risk assessment
- Self-harm assessment
- Drug and alcohol assessment
- Discussion of problem thoughts, urges and behaviours
- Family history

**Treatment**

**Medication**

There is no medication that specifically treats personality disorders; however, medication is sometimes used to relieve symptoms such as depression or anxiety. These medications may be used on an ongoing basis or only during times of particular stress in the person’s life. Antidepressant medications such as Selective Serotonin Reuptake Inhibitors (SSRIs) may be helpful in reducing other symptoms, such as impulsivity (the tendency to act suddenly without thinking through the consequences). Lithium, carbamazepine and sodium valproate have all been used to treat symptoms of mood disorder in those with a personality disorder.

It is possible for the person to experience brief ‘psychotic episodes’; periods when thinking becomes disorganised and they appear to lose touch with reality and become extremely paranoid, develop bizarre beliefs or hear voices. In this situation, low doses of antipsychotic drugs may be useful.

**Psychotherapy**

While medications can often help some symptoms of the disorder, they cannot help the patient learn new coping skills, emotion regulation, or any of the other important changes in a person's life.

The most successful and effective psychotherapeutic approach to date has been Marsha Linehan's ‘Dialectical Behaviour Therapy’ (DBT). Research conducted on this treatment have shown it to be more effective than most other psychotherapeutic and medical approaches to helping a person to better cope with this disorder. It seeks to
teach the client how to learn to better take control of their lives, their emotions, and themselves through self knowledge, emotion regulation, and cognitive restructuring (learning more effective ways of thinking). It is a comprehensive approach that is most often conducted within a group setting.

Psychotherapy for personality disorders may include contracting with the person to reduce the risk that they will commit suicide. Suicidal thoughts should be carefully assessed and monitored throughout the entire course of treatment. If suicidal feelings are severe, medication and hospitalisation should be seriously considered.

Personality disorders, by definition, are long-standing ways of coping with the world, social and personal relationships and handling stress and emotions; that often do not work, especially when a person is under increased stress. Treatment, therefore, is also likely to be lengthy in duration, typically lasting at least a year for most.

Cognitive-behavioural therapy (CBT) is also sometimes used to treat personality disorders. CBT combines two kinds of psychotherapy - cognitive therapy and behaviour therapy. Behaviour therapy helps the person to weaken the connections between troublesome situations and their habitual reactions to them; reactions such as fear, depression or rage and self defeating or self damaging behaviour. It also teaches how to calm the mind and body to enable the person to think more clearly and make better decisions. Cognitive therapy teaches the person how certain thinking patterns cause their symptoms - by giving them a distorted picture of what's going on in their life and making them feel anxious, depressed or angry.

Other therapeutic approaches have included personal psychotherapy and psychoanalysis.

**Self Help**

**Support groups**

Support and self-help groups may be a helpful adjunct to psychotherapy. Patients can be encouraged to try out new coping skills and emotion regulation with people they meet within support groups. They can be an important part of expanding the individual's skill set and develop new, healthier social relationships. Unfortunately, there are no specific personality disorder support groups in NSW. Joining a general mental health support group, such as GROW (see below) may be useful. There are many web-based support forums for people with personality disorders and their families and friends. A few are mentioned below but there are many more to be found on search engines such as Google.

**Bibliotherapy**

Reading as much as you can on personality disorders and about how other people have coped can be helpful in educating you about the disorder and its treatment options, and helping you to feel less alone. It can be reassuring and inspiring to read other people’s accounts of survival and coping.
Relaxation

Learning a form of relaxation, such as yoga or progressive muscle relaxation can help by reducing general stress levels and teaching coping methods for dealing with mood swings.

Families and friends

The following are some things to remember that should help you as you learn to live with someone with a personality disorder in your family:

- You cannot cure someone else’s personality disorder. Whether or not to accept treatment is their choice. However, you do have choices around how you respond to the problem behaviour and the boundaries you establish regarding behaviours you will and will not tolerate.

- Despite your best efforts, symptoms may get worse, or they may improve. There are definite limits to the influence you may have over another persons’ behaviour. Symptoms may change over time while the underlying disorder remains. Strange behaviours are symptoms of the disorder. Don't take it personally.

- The illness of a family member is nothing to be ashamed of – it is not a moral or personal weakness. However, the reality is that you may encounter prejudice from other people and the media.

- You have a right to ensure your personal safety. Verbal, psychological, financial, sexual, physical, verbal or spiritual abuse is NEVER acceptable.

- Don't be afraid to ask your relative if he or she is thinking about suicide. Suicidal thoughts are common in personality disorders and open and frank communication is important.

Self care

Don't shoulder the whole responsibility for your relative yourself. Seek help from family, friends and professional support services such as Carers NSW and the Association of Relatives and Friends of the Mentally Ill (ARAFMI). Sharing your thoughts and feelings in a support group has been helpful and enlightening for many. If you don't care for yourself, you can't care for another. You are not a paid professional; your role is to be a sibling, partner or child, not a parent or caseworker. If you feel extreme resentment or distress, you may be focusing too much on the other persons needs to the detriment of your own. It is not OK for you to be neglected; you have emotional needs and wants, too. You may have to revise your expectations and renegotiate your emotional relationship with the person. It is natural to experience many and confusing emotions such as grief, guilt, fear, anger, sadness, hurt and more. You, not the ill person, are responsible for managing your feelings.

Further reading and resources

This book has excellent tips on coping with a loved one with borderline personality disorder but has useful advice for any personality disorder


Where to get help

- See your local GP and ask to be referred to a psychiatrist
- Local mental health service – call Mental Health Information Service for details on 1300 794 991
- GROW 12-step program is a mutual help groups for people with any mental health concern
- The Shack (Australian web based forum and support) [www.mjtacc.com](http://www.mjtacc.com)
- For family members: Association of Relatives and Friends of the Mentally Ill (ARAFMI), tel (02) 9332 0700 or 1800 655 198 (rural NSW)

Telephone Interpreter Service 131 450

If English is not your first language please call the Mental Health Information Service through the Telephone Interpreter Service (TIS). This service is free to non-English speaking Australian citizens or permanent residents. TIS have access to interpreters speaking more than 120 languages and dialects.

References

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http://www.enotalone.com/article/3070.html
http://www.nami.org/Content/ContentGroups/Helpline1/Coping_Tips_for_Siblings_and_Adult_Children_of_Persons_with_Mental_Illness.htm

DSM IV-R, American Psychiatric Association, 1995

‘Interpersonal Effectiveness: Breaking the Negative Cycle’
Seminar by Judy Campbell and Michelle Meyer, DBT therapists from Wesley Private Hospital, Sydney, 8th April 2005

Mental Health Resource Centre
The Resource Centre contains material that promotes a better understanding of mental health issues. New books and DVDs are purchased on a regular basis and visitors are welcome to come in and browse.

Members of MHA, CAG and ARAFMI may check-out resources on loan. The length of the loan is 3 weeks. Membership costs between $10 - $30 per individual per annum. Please note that most of the reference books are not available for loan.

You will find the Resource Centre Booklist on our website: [www.mentalhealth.asn.au](http://www.mentalhealth.asn.au) for further information contact 1300 794 991.

Disclaimer
This information is for educational purposes. As neither brochures nor websites can diagnose people it is always important to obtain professional advice and/or help when needed. The listed websites provide additional information, but should not be taken as an endorsement or recommendation.

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This fact sheet was last updated in July 2010.

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