MANAGEMENT OF PERSONALITY DISORDERS

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Learning Objectives

1. Review basics on Personality Disorders [PD]

2. Describe clinical evaluation of individuals with PD.

3. List different management options of personality disorders

4. Describe some current treatments for personality disorders.

5. Develop some strategies for dealing with the difficult patient

WHY LECTURE ON PERSONALITY DISORDERS IS IMPORTANT

- Prevalence - 0.5% to 2.5% general population/higher among patients
- Patients with personality disorders are common in Health care settings; caring for them can be difficult and frustrating. *50% comorbidity, *Comorbidity makes Mx difficult. *PDs predisposing factor for many other psychiatric diseases eg, suicide, SUD, mood disorders, impulse-control, eating disorders and anxiety disorders.
- The characteristics of these patients' personalities tend to elicit strong feelings in doctors, lead to the development of problematic doctor–patient relationships, and complicate the task of diagnosing and managing medical and psychiatric disorders.
- Knowledge of the core characteristics of these disorders allows doctors to recognize, diagnose, and treat affected patients.
- Effective interpersonal management strategies exist for PDs.

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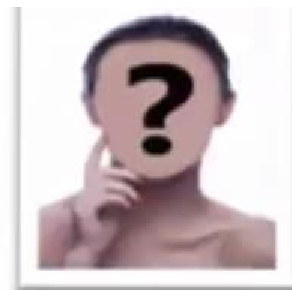
How would you describe your personality?

Review: Basics about personality disorders [PDs]:



- The word **'Personality'** derived from Latin word **'Persona'.**

Ancient Greek used 'Persona' to describe theatrical mask, actors used to wear on their face before going to stage to act. So, in the those t olden days, term 'personality' used to depict outward appearance of a person.

- Today the term personality is explained in various ways; and today there are >50 different definitions of personality!

- Personality traits - enduring patterns of perceiving, relating and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts.

WHAT IS PERSONALITY

- **Personality is defined as the sum total characteristic patterns of thinking, feeling and acting that make a person unique**
- Personality arises from within the individual; and remains fairly consistent throughout life.
- Everyone has a **personality,** but **not all** have **Personality Disorder.**
- People react differently to different situations due to their personalities, but still we expect them to behave within a range of commonly accepted ways.
- People with a **healthy personality** have ability to enjoy, to relate and to work; while people with **personality disorder** are often those whom others regard as **"difficult"** people.

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- People with PD behave in ways that do not fit with accepted social standards, and they are unable to adapt their behaviors to better suit their environments. Most defining feature of PDs is their negative effect on interpersonal relationships.
- **3 P'S-OF-PERSONALITY DISORDERS [PDS]:**

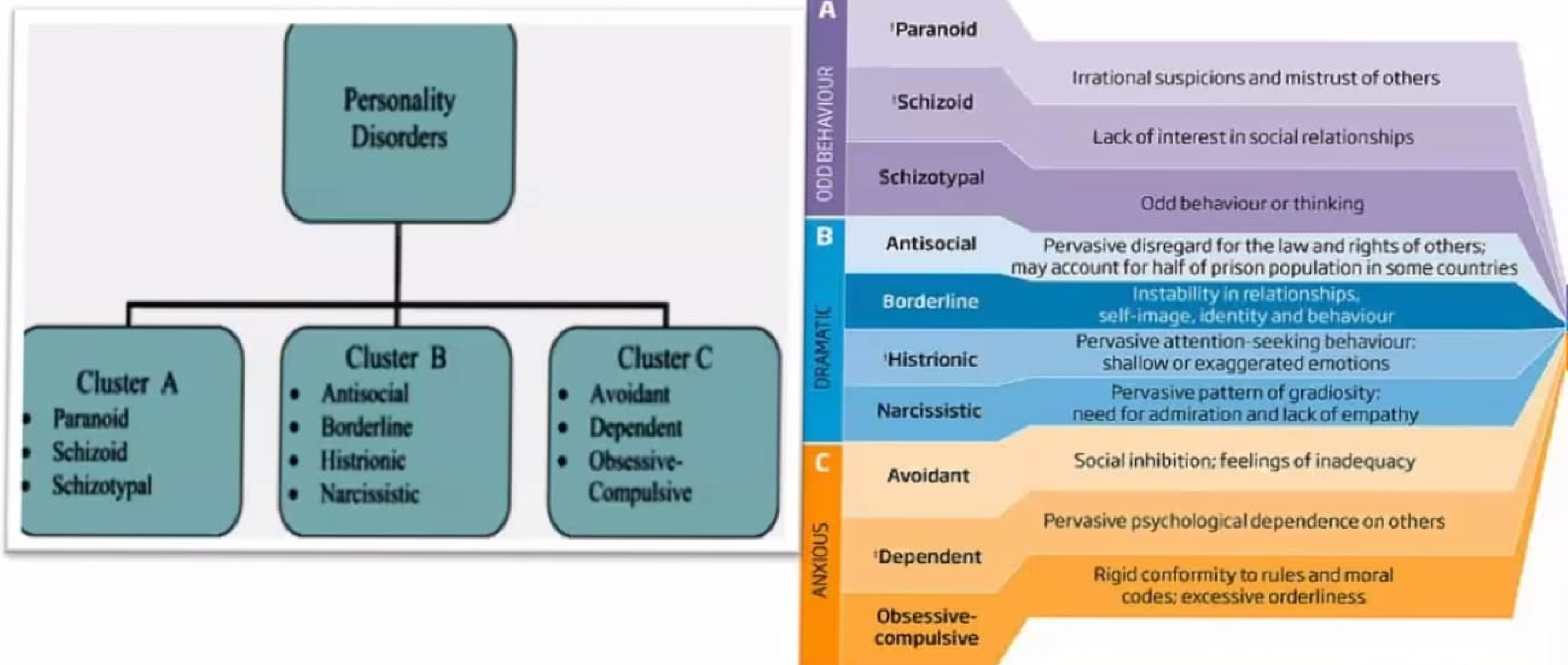
1. **P**ersistent-happens frequently
2. **P**ervasive-across many circumstances
3. **P**roblematic-for selves/others

- When personality patterns/traits [such as impulsivity, dissocial behavior, agressivity, psychasthenic symptoms], are **rigid** & **self-defeating**, they may **interfere with functioning** & lead to psychiatric symptoms, cause more or less **suffering** of individual or other people or both & lead to **maladaptation** in relations, family and work.

DEFINING PERSONALITY DISORDERS [PD].

- DSM defines **PD** as "an enduring pattern of inner experience and behavior that deviates markedly from person's culture, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time and leads to distress or impairment."
- PDs not diseases in the usual medical disease sense but represent varied patterns where the personality system functions maladaptively in relation to its environment. Having a PD limits a person's ability to interact socially, function within a family, or cope in a workplace setting.
- **PDs** are different from **other mental disorders** as considered a part of a person's **personality** or character rather than a disease that exists outside the **personality**. PD forms as personality itself is developing, making these maladaptive patterns ingrained into the sense of self. Pinpointing the onset is also very difficult.

Types of Personality Disorders



PDs are "syndromes", each of the ten DSM-5 PDs is a constellation of maladaptive personality traits, rather than just one particular personality trait. People with PDs believe others should change to accommodate them/their wishes & view their features acceptable and not in need of change, i.e. "alloplastic defences" experience less distress as direct result of PDs than might be expected.

Personality Disorders Management

Personality Disorders Management Plan Outline

A. Investigations - biopsychosocial

1. physical
2. psychological
3. social

B. Treatment - biopsychosocial

1. physical
2. psychological
3. social

- ❑ Treatment of Personality Disorders, specifically tailored to individual patient's type of personality disorder, personality psychopathology domains involved, severity of their illness and the presence of comorbid psychiatric disorders.
- ❑ Manage comorbid conditions in standard manner.

Assessment of Personality Disorders

Management planning starts with assessment ; interview patient and an informant (~ 2-3 interviews) as follows:

- ***History***.
  - Subjective information taken through history may not provide accurate data with patients suffering from a PDs.
  - Responses may be falsified, either purposively or unintentionally.
  - History- taking still offers information into patient's disorder.
  - Key points include medical/psychiatric history, family history, work and school history, substance use, nutrition & established interpersonal relationships.
- ***Physical assessment***
  - Physical assessment can provide valuable information eg, evidence of self-mutilation or suicide attempts. Laboratory studies can demonstrate substance use, nutritional status, and sexually transmitted diseases that can result from patient's PD.

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- **Use of Questionnaires and Tools.**
  - Questionnaires are available for assessment of PDs such as:
  - Minnesota Multiphasic Personality Inventory-2 (MMPI-2).
  - Personality Inventory for DSM-5, available in both long and short version to assess personality traits.
- **Personality Disorders – MSE**
  - Observations during an interview or interaction with the patient can afford pertinent clues. Observe patient's general appearance, speech pattern, affect & behavior. Blunt affect or guarded behavior common with Cluster A personality disorders. Communication may be tangential or difficult to follow. Patients may exhibit behaviors indicating paranoia or hallucinatory in nature. Abrupt behavior demonstrates lability of emotions is typical with Cluster B and C personality disorders. Cognitive functions and thought process not usually impaired in PDs. Questions regarding judgment are important for insight.

- **Risk to Self and Others.**
  - Assessment for risk and harm to self or others is important with patients diagnosed with personality disorders. Ask directly about potential for harm to self or others. Current ideation and intent are vital to determine lethality or severity of risk. The objective reactions to these questions can be just as informational as the actual answers given. If patient states he/she has had thoughts of harming self or others, this needs to be further explored.
  - Risk factors to be assessed include: history of past suicidal ideation, suicide attempts, self-mutilation, poor impulse control. Mood and affect should also be incorporated – depressed, angry or labile mood can indicate higher risk.
  - Protective factors should also be reviewed such as methods of coping and spiritual beliefs.
- **Formulate** pt's psychopathology, circumstances that led to current problems [what, why, how, when], strengths; construct treatment plan and negotiate treatment contract.

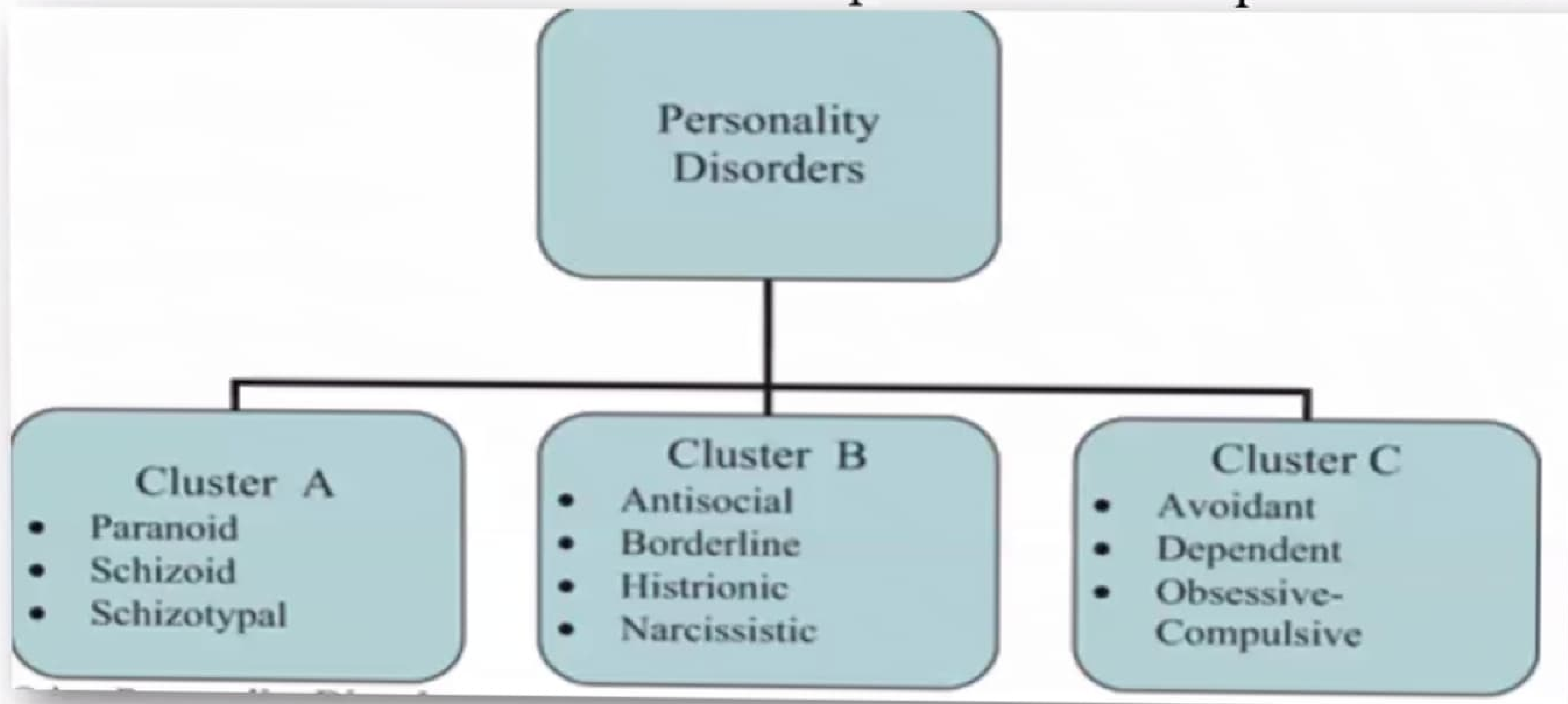
Assessment Summary:

1. Interview patient and informant (s).
2. Establish a diagnosis of personality disorder.
3. Evaluate personality patterns, describe problems across domains of psychopathology-symptoms [psychological distress, self-harming, dysphoria, cognitive disorganization, dissociative behavior, cognitive -perceptual and neuropsychological symptoms], interpersonal function, social function [work history, inner experience]
4. Delineate any comorbidity.
5. Formulate the individual patient's psychopathology, circumstances that led to current problems and construct treatment plan; feedback to patient and negotiate treatment contract.

–However, in emergency crisis evaluation/serious self-harming, suicidal behavior or serious clinical disorder symptoms; more focused assessment appropriate to get information to ensures patient's safety and manage immediate problems.

Diagnosis and assessment of PD is approached in two steps.

1. First, evaluation for presence of PD based on adaptive failure or diagnostic criteria core pathological personality features –present / pervasiveness, long-term duration & interpersonal difficulties.
2. Second, assessment of individual differences in PD, using dimensional model such as the 4 patterns and component traits.



DIAGNOSTIC CRITERIA IN THE DSM

DIAGNOSIS OF PERSONALITY DISORDER:

DSM-5 PDs Diagnostic criteria:

- Each PD has own set of diagnostic criteria. However, generally diagnosis of a PD includes: [1]. long-term marked deviation from cultural expectations that leads to [2]. significant distress or impairment in at least two of these areas: {a}. way perceive and interpret self, other people and events and {b}. impulse control, appropriateness of emotional responses and functioning when dealing with other people and in relationships.
- Sometimes it can be difficult to determine the type of PD, as some PDs share similar symptoms and more than one type may be present.
- Other disorders such as depression, anxiety or substance abuse may further complicate diagnosis of PDs.

How to diagnosis a personality disorder:

- *PD diagnosis:* PD diagnosis and assessment approached in 2 steps-

[1]. First is evaluation for presence of PD based on adaptive failure or diagnostic criteria for PD_ longstanding, pervasive PD_defining features; presence since adolescence or early adulthood and adversely impacting individual's life and functioning.

[2]. Second is assessment of individual PD psychopathology differences, using patterns and component traits dimensional model.

TREATMENT FOR THE 'UNTREATABLE'

➡Prior 1990s, treatment for PDs often not provided or if offered, seen as a "heroic effort" based on belief PDs treatment taxed clinician with little hope for a promising outcome. PDs treatment then dominated by psychoanalytical therapies and therapeutic nihilism prevailed. People with PDs viewed as difficult patients resulting in negative thoughts and feelings about them in **care providers–counter transference**!

➡Reflexive acts rarely help. Reinforce fears of abandonment, rejection – leading to increased efforts to remain attached. More phone calls, hospital visits, noncompliance to "stay sick".

➡Even though, research in that era, led to understanding of importance of structured approach, consistency, treatment contract and treatment alliance in the formulation implementation of treatment plans.

Are PDs Untreatable? NOT TRUE Now there is evidence PDs treatable with specialized psychotherapies and various medications.

Treatment planning involves five broad decisions:

1. Treatment setting: inpatient, day hospital or outpatient
   a. **Opt for the least restrictive safe treatment setting**
   b. Focus on helping patients cope in their natural environment
   c. Hospitalization vehicle for maintaining safety; consider if risk of suicide outweighs risk of inappropriate hospitalization
2. Treatment format: individual, group, family or combotherapy
3. Major strategies/techniques to use, sequence of interventions, theoretical models: psychodynamic, cbt or psychoanalytic.
4. Treatment duration & frequency: crisis intervention, short or long-term therapy and frequency of appointments;
5. Use of medication & way it's combined with other interventions.

Together, these 5 categories provide a comprehensive way to plan treatment that is consistent with the tailored approach advocated.

Key interventions and actions when interacting with PDs patients:

1. Maintain safe environment. Take precautions to reduce risk of harm to self or others. Remove items that may be used as weapon.
2. Establish a written contract with patient discussing expected behaviors of patient and that patient will not harm self or others, and will notify a member of the team if feelings to do so develop.
3. Establish therapeutic relationship with patient. Be straightforward in communications. Empathy and non-judgmental attitude is vital.
4. Establish a therapeutic relationship with patient.
5. Maintain objectivity & consistency amongst healthcare team Consistent information & interactions with patient can be assured by developing an interdisciplinary plan of care and ensuring communications between healthcare team is consistently updated. Maintain objectivity and consistency.
6. Set behavioral limits Let patient know what behaviors acceptable, which are not and outline consequences for inappropriate behavior.

TREATMENT

Treatment depends on nature of PDs, patient willingness to engage in treatment and the available resources.

•Psychotherapy (Mainstay):

A.General Principles

- Focus on pt-therapist relationship in “here & now”
- Utilize countertransference to explore relationship
- Educate patients to recognise their affective reactions and what triggers them. Connect actions with thoughts and feelings, aiming to examine and to improve perceptions and responses.

B.Primary treatment for PDs is psychotherapy. Psychotherapy Types :

- Dialectical Behavior Therapy (DBT)
- Transference-based psychotherapy
- Mentalization-based psychotherapy
- Schema-focussed therapy
- Cognitive-Behavioral Therapy

PD PSYCHOEDUCTION: *Increases hopefulness on change possibility & encourages active participation in treatment planning.

MOTIVATIONAL INTERVIEWING:

*Ask for permission to discuss the problem – raise awareness.

*Elicit talk about change, change possibilities advantages/ disadvantages and taking the first step. *Ability check (1-10) – pt's confidence in ability to change, elicits possible barriers. End with summary of discussion points, what agreed and what uncertain.

PROBLEM SOLVING:

*Identify the problem –specify, define; brainstorm possible solutions /alternatives, their pros and cons, choose most suitable ones.

*Seek commitment with specific details; summarize, schedule follow up, acknowledge further barriers may be encountered and that solutions for these will also be found.

Specific manualized therapies for Personality Disorders:

Second era of PDs treatment marked by development of several evidenced-based effective treatments for PDs including: *Cognitive-behavioral therapy (CBT); *Mentalization based therapy (MBT); *Dialectical behavior therapy (DBT); *Transference focused therapy (TFP); *Schema therapy. Now there is hope for people affected by PDs, including their family members and loved ones.

Cognitive Therapy

- This is a modification of standard cognitive and behaviour therapy that is goal directed and focused more on altering underlying belief structures rather than reduction of symptoms
- It is likely to take up to 30 sessions of treatment of which the initial ones help to define the areas of intervention by identifying what are the fundamental structures of past, present and future experiences
- The therapist and patient maintain a collaborative therapeutic alliance throughout treatment and include homework and testing of core beliefs and structures

Mentalisation Based Therapy (MBT)

- A mixed group and individual therapy based on psychoanalytic principles
- Treatment typically lasts 18 months
- Directed towards developing the ability to mentalise, that is to interpret the actions of oneself and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons)

Dialectic Behaviour Therapy (DBT)

- This is a special adaptation of cognitive therapy, originally used for the treatment of women with borderline personality disorder who harmed themselves repeatedly
- DBT is a manualised therapy including functional analysis of behaviour, skills training and support (empathy, validation of feelings, management of trauma)
- Directed at reducing self-harm

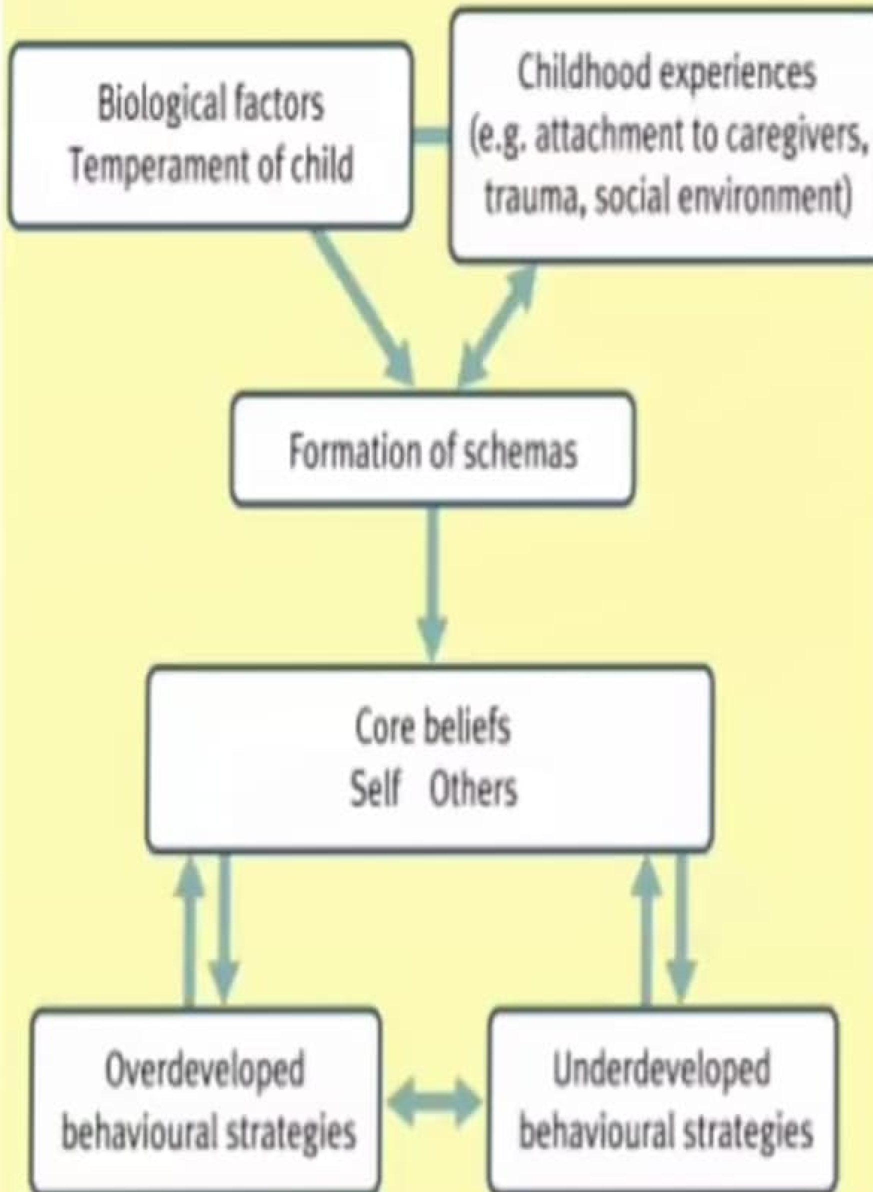
Cognitive Analytical Therapy

- Postulates that a set of partially dissociated 'self-states' account for the clinical features of
- borderline personality disorder
- Rapid switching between these self-states leads to dyscontrol of emotions including intense expression and virtual absence (depersonalisation)
- Therapy aims to formulate these processes collaboratively,examining them as they occur in treatment as well as in life experiences

Dynamic psychotherapy

- This is based on a developmental model of personality
- Treatment is generally long term
- The aim of therapy is to understand the way in which the past influences the present with the use of interpretation
- Treatment focuses on the therapeutic alliance between patient and therapist, the individual's emotional life, and defences
- Therapy uses the relationship between patient and therapist (transference) as a way to understand how the internal world of the individual affects relationships

Cognitive-Behavioral Therapy for PDs (CBT)



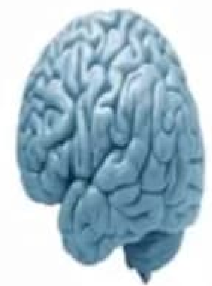
- CBT for PDs derives from traditional CBT, a highly effective, evidence-based therapy.
- People with PDs have characteristic patterns of thinking that tends to be somewhat extreme, inflexible, and distorted gets them into trouble.
- CBT is helpful for people with PDs due to its emphasis on identifying and changing dysfunctional thinking patterns.
- CBT conceptualises all 10 PDs as dysfunctional core beliefs about the self, others and the world. The cognitive therapist helps those with PDs learn identify and change these core beliefs.
- A challenge for CBT therapist is that pts with PDs do not come into therapy ready to trust.

Dialectical Behavior Therapy for PDs (DBT)

DBT, based on biosocial theory of mental illness, is a modified form of CBT, that was developed by Marsha Linehan. DBT is a comprehensive, multimodal treatment that combines CBT techniques for emotion regulation, social skills, exposure, empathy & reality-testing with concepts of distress tolerance, problem solving with acceptance & mindful awareness meditative practice and emphasises the patient-therapist connection. DBT aims is to reduce ineffective action patterns.

DBT Skill Sets at a Glance

Core Mindfulness	Interpersonal Effectiveness	Emotion Regulation	Distress Tolerance
What Skills	Describe	Accumulate positive experiences	Activities
Observe	Express	Build mastery	Contributing
Describe	Assert	Cope ahead of time	Comparisons
Participate	Reinforce		Emotion opposites
		treat Physical Illness	Pushing away
How Skills	Mindful	Eat balanced meals	Thoughts
One-mindfully	Appear Confident	Avoid mood-altering drugs	Sensations
Non-judgmentally	Negotiate	Sleep balanced	
Effectively		Exercise	Imagery
	Gentle		Meaning
Reality Acceptance	Interested	Validate	Prayer
Radical Acceptance	Validate	Imagine	Relaxation
Turn the Mind	Easy Manner	Take small steps	One thing at a time
Willingness		Applaud yourself	Vacation
Notice Willfulness	Fair	Lighten your load	Encouragement
	no Apologies	Sweeten the pot	
	Stick 2 Values	★ Mindful to emotion	Temperature
	Truthfulness	★ Behavior chain analysis	Intense physical exertion
		★ Opposite Action	Paced breathing
		★ Pros and Cons	



Dialectical Behavior Therapy

CBT	VERSUS	DBT
Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty,thinking patterns cause maladaptive behavior and negative emotions		Dialectical Behavioral Therapy is a specific type of cognitive-behavioral psychotherapy which was originally developed to help better treat borderline personality disorder and chronically suicidal individuals
Anxiety, depression, and substance abuse can be treated with CBT		Suicidal or self-harm motives and multiple, complex difficulties in life can be treated with DBT
A short term, goal-oriented therapy		A long term process
Helps to identify, analyze and re-organize unhealthy and negative thoughts in people		Positive interpersonal relationships, stress management, accepting the reality and proper control of emotions are targeted

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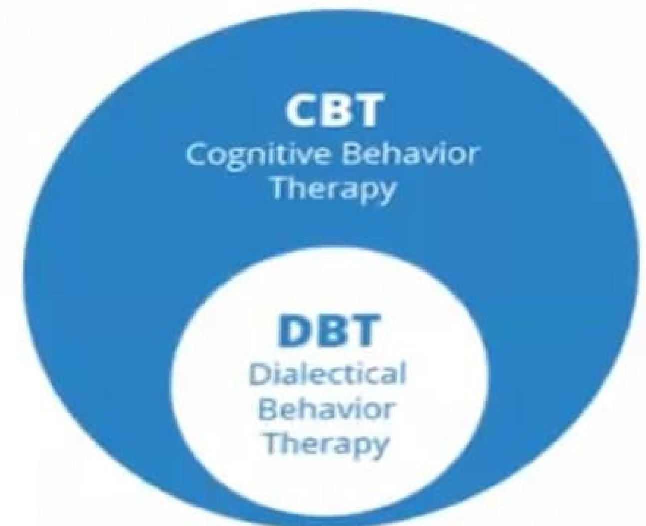
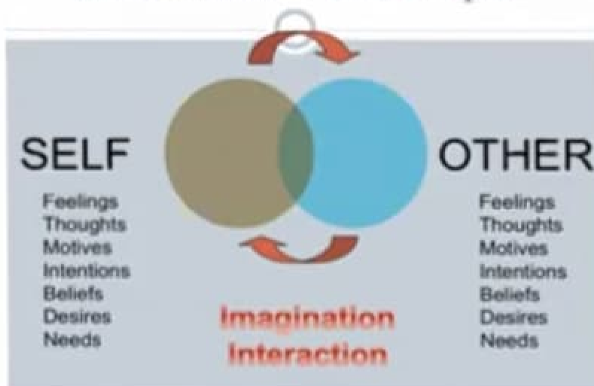


CBT	DBT
Focus on change	Dialectic of acceptance and change
Exposure to distress	Exposure to distress with acceptance of distress
Problem focus: specific	Problem focus: broad, inclusive and use of hierarchy

Mentalization-Based Treatment (MBT)

MBT founded by Bateman & Fonagy, originates from attachment theory. Mentalization is insightful understanding of what one is feeling and why. The ability to mentalize vital for self organization and affect regulation. Mentalizing is like "hitting a pause button"- giving ability to briefly tolerate the feeling, to stop and reflect upon it, slowing down & deterring from acting on destructive impulses/urges. Difficulties with emotional regulation is a hallmark features of PDs. Insecure attachments limit the development of this important skill. MBT proposes this highly necessary skill must be learned in order to correct interpersonal difficulties and so, seeks to assist pts to develop it. MBT begins with developing a warm, empathic therapeutic alliance, which provides a context to learn mentalization.

Mentalization: Two People



- To see ourselves from the outside and others from the inside
- Understanding misunderstanding
- Having mind in mind
- Introspection for subjective self-construction – know yourself as others know you but also know your subjective self (your experience)

Benefits of Mentalizing

- Connection through shared understanding.
- A "meeting of minds".
- Leads to better interpersonal functioning, and therefore, better chance at getting objectives met in life & relationships.
- Being misunderstood is aversive, it can lead to painful emotions.
- Many BPD difficulties can result from the temporary loss of mentalizing.

Schema Therapy [Young, 1990], developed to treat PDs who failed to respond to CBT. Schema Therapy is a broad, integrative model that shares commonalities with object relations therapy, experiential therapy, DBT, interpersonal therapy as well as CBT. Schema Therapy differs from these approaches regarding nature of therapy relationship, therapist's general style, stance, degree of activity and directiveness.

SCHEMA THERAPY STAGES

- Emotional bonding
- Get around Detached Protector
- Heal Abandoned Vulnerable Child
- Banish Punitive Parent
- Channel Angry Child effectively
- Develop Healthy Adult

Schema Therapy vs Cognitive Therapy

- Greater emphasis on the therapeutic relationship
- More emphasis on affect and mood states
- More discussion of childhood origins and developmental processes
- More emphasis on lifelong coping styles
- More emphasis on core themes

Schema Therapy-concepts: [1]. early maladaptive schemas [EMS], [2]. schema domains, [3]. coping styles and [4]. schema modes. EMS-dysfunctional pervasive patterns about oneself and one's relationships with others, are triggered by encounters of environments reminiscent of childhood environments that produced them. When this happens, individual is flooded with intense negative affect. 18 EMS, due to childhood abuse, neglect, and trauma in early life-related unmet core emotional needs, plus temperament and cultural factors, delineated.

Medications: Medications may be prescribed with psychotherapy, based on the symptoms demonstrated in relation to PDs diagnosed.

•*Antidepressant medications* eg, sertraline, fluoxetine for depressed mood, anger, irritability or impulse control.

•*Mood-stabilizing medications* for emotional lability, irritability, aggression & impulse control - eg, valproic acid, lithium.

•*Anti-anxiety medications* to reduce anxiety, agitation or insomnia.

•*Antipsychotic medications eg,* risperidone, quetiapine, olanzapine, to treat psychotic symptoms, anger and anxiety.

PHARMACOTHERAPY/MEDICATIONS FOR PDs SYMPTOMS

Dysphoria-SSRI, low dose atypical AP; **Depression**-SSRI, atypical antipsychotic AP; **Anxiety**-SSRI, low dose AP, buspiron; **A cute anxiety/agitation**-benzodiazepines, **Emotional instability**-low dose AP, lithium, anticonvulsants; **Aggression**-lithium, AP; **Impulsivity**-SSRI, lithium,low dose AP, anticonvulsants; **Emotional flateness** - atypical AP, SSRI and **Psychotic** - AP

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COMORBIDITY

- Many times, personality-disordered patients seek psychotherapy or medication treatment, not because of PDs symptoms themselves, but due to comorbid condition such as Depression, Panic Disorder, Generalized Anxiety Disorder, other disorders.

- The comorbid condition may be not only causing more dysphoria, but also exacerbating PDs symptomatology. As such, pharmacological treatment can be more parsimonious if an agent treats the comorbid condition and core features of that patient's PD pathology.

➡**Hospitalisation** has little value for patients with PD in crisis and may negatively influence suicidal behaviour in some. Pts admitted may become dependent on the locked hospital environment and be viewed as low risk by staff who sanction discharge when the patient is in fact still at high risk. For many patients, admission to in-patient care is likely to be ineffective and counterproductive.

➡**Therapeutic community** (TC) treatment used for many years in an effort to help people with PDs. TC is a psychosocial intervention in which participants come together to a communal, ordinarily residential set ting. Staff provide safe containment and a psychotherapeutic framework. Personal accountability and democratic decision-making are highly valued: the treatment is conceptually 'delivered' by other community members, whose analysis of individual functioning has the legitimacy of peer insight. Oct 9, 2013 – Gasket al; state that there is no evidence for the effectiveness of TC in the treatment of PDs.

Personality Disorders
Integrated Modular Treatment [IMT]

Integrated Modular Treatment [IMT]

•Patients with personality disorders present with unique array of problems spanning multiple domains of functioning and treatment should utilize an integrated array of strategies and techniques to address the diverse impairments - symptoms, emotion and impulse regulation problems, interpersonal patterns and self-identity problems and overall severity of dysfunction, rather than focusing on a more globally conceptualized categorical disorder.

•Currently, PDs Rx characterized by greater concern with integrating Rx principles and methods across therapies, use of eclectic & pragmatic treatment strategies and emergence of more modular|transdiagnostic approaches focusing on specific domains of personality pathology rather than global diagnoses-integrated modular treatment [IMT] approach combines an eclectic array of treatment principles, strategies & methods drawn from all effective treatments, targeted in a way to treat specific impairments.

- The goal of management is to develop a working relationship with patients to help them receive the best possible care despite their chronic difficulties in interacting with doctors and health care system.
- Effective interpersonal management strategies exist for PDs.
- These strategies vary depending on the specific diagnosis, include:
  - Use of specific communication styles,
  - the establishment of clear boundaries,
  - limit setting on the patients' behavior and
  - use of medical resources, and provision of reassurance when appropriate.
  - Additionally, medications may be useful in treating specific symptoms in some patients.

MANAGEMENT OF SPECIFIC PDs

Cluster A Personality Disorders: Manifestations and Management Strategies

PERSONALITY DISORDER	PROMINENT FEATURES	EXPERIENCE OF ILLNESS	PROBLEMATIC BEHAVIORS IN MEDICAL SETTING	MANAGEMENT STRATEGIES
Paranoid	Distrust, suspicion	Heightened sense of fear and vulnerability	Fear physician may harm, arguments, conflict	Adopt a professional stance, provide clear explanations, be empathetic to fears, avoid direct challenge to paranoid ideation.
Schizoid	Social detachment, emotional restriction	Anxiety because of forced contact with others	Delay seeking care, appear unappreciative	Adopt a professional stance, provide clear explanations, avoid overinvolvement in personal and social issues.
Schizotypal	Odd beliefs, socially isolative	Odd interpretations of illness, anxiety because of forced contact with others	Delay seeking care, odd beliefs, odd behavior	Adopt a professional stance, provide clear explanations, tolerate odd beliefs and behaviors, avoid overinvolvement in personal and social issues.

PARANOID PERSONALITY

SCHIZOID PERSONALITY

SCHIZOTYPAL PERSONALITY

TREATMENT

- Psychotherapy – Interpersonal psychotherapy
  Psychoanalytical psychotherapy
- Group therapy
- Behavioral therapy
- Psychopharmacology
- Antipsychotics for psychotic symptoms

OTHER TREATMENT

- Occupational therapy
- Art therapy
- Music therapy
- Recreational therapy
- Individual therapy

KEY POINTS

1. Personality disorders categorized in **3** symptom clusters.
2. Personality disorders consist of an enduring pattern of experience and behavior.
3. They can produce transient psychotic symptoms during stress.
4. They treated with psychotherapy and medications targetted at symptom relief.
5. Personality disorders are resistant to treatment.
6. They have genetic asssociations with clinical pyschotic, mood and anxiety disorders

Personality disorders management

- As personality may have temperamental component and is developed over a life time of interaction with the environment, personality disorders are generally resistant to treatment.
- In general psychotherapy is recommended for most personality disorders.
- Psychodynamically based therapies commonly used, although they have to be modified to each individual and each disorder.
- Cognitive behavioral and family therapies are also used to treat these personality disorders.
- Dialectical behavioral therapy[DBT] developed specifically for treatment of personality disorders, has been valudated in empirical studies.
- Group therapy incorporating various psychotherapeutic modalities also used.
- Pharmacotherapy, with medications targetted at various symptoms assiciated with personality disorders, widely used.