

Introduction

Personality disorders (PDs) are commonly encountered in practice, but their management is challenging. Patients with these diagnoses can be described as the “stepchildren” of the mental health professions, the patients we have to take care of, even if we would rather not. However, one message of this book is that some forms of PD have a good prognosis and many (but not all) patients can be treated effectively. These conditions are no more mysterious or problematic than psychoses, mood disorders, or any other major group of mental illnesses. However, treating this population requires a wide range of knowledge and skill in biological, psychological, and social domains.

To provide effective therapy, you first have to recognize the problem. In many patients, PD goes undiagnosed. Clinical psychologists may prefer to diagnose anxiety and depression because they have tools designed to

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A Concise Guide to Personality Disorders, by J. Paris

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deal with those problems. One has to wonder whether psychiatrists tend to avoid making these diagnoses because they prefer to prescribe medication. Yet all mental health professionals need to understand the difference between transient symptoms and lifelong dysfunction.

This having been said, making a diagnosis of PD requires a certain level of skill. The construct is defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition; *DSM-5*; American Psychiatric Association, 2013) as an enduring, inflexible, and pervasive pattern of inner experience and behavior that begins in late adolescence or early adulthood and that continues to impede functioning in work and relationships over many years. However, clinicians have to make judgment calls, such as how enduring the personality pattern is and the extent to which it impedes functioning. As this book will show, there is no absolute boundary between variations in normal personality and PD. However, some PDs have striking symptoms that may be mistaken for other categories of mental illness.

WHY I WROTE THIS BOOK

The primary focus of my professional career has been patients with PDs. Some of my colleagues try to avoid these cases—in vain, because they are common in practice (unless, of course, you entirely ignore the role of personality in psychopathology). I also have colleagues who think these patients are just too difficult. I find the problems they present fascinating and challenging, but there is no easy fix, either through medication or psychotherapy.

When I began to treat patients with PD, I was not satisfied with what were then the most influential theories, explaining personality pathology as a result of an unhappy childhood. I saw many patients with traumatic childhoods who grew up to be normal. I also saw patients with severe PDs who had suffered little more than misunderstanding.

I was curious to find out more about PDs, so after almost 15 years of clinical practice and teaching, I started a second career as a researcher. This meant returning to my roots in psychology (my undergraduate major). I was fortunate to be able to collaborate with psychologists trained in

research. I had the added benefit of having practiced psychiatry on some of the sickest patients that mental health professionals see.

I entered the PD field just as it began to take off. The International Society for the Study of Personality Disorders was founded in 1987 and held its first meeting in 1988 (a 25th anniversary conference was held in 2013). The first issue of the *Journal of Personality Disorders* was published in 1987, and there are now two other print journals that focus on PD (*Personality Disorders: Theory, Research, and Treatment* and *Personality and Mental Health*). Attending scientific meetings over the years, I have met stimulating colleagues from all over the world, from whom I have learned much. Researchers in the same area tend to be spread around but form a kind of “invisible college”—we often see more of each other than colleagues from the same university. There are not many of us, only about 200 active PD researchers worldwide. I am proud to be of these happy few.

As a clinician, a teacher, and a researcher, I am also pleased to say that interest in PDs is definitely on the rise. Research on PDs has become much more active in the past 30 years, moving the field from clinical speculation to solid empirical investigation; since 1987, more than 20,000 articles reporting empirical research have been published. However, clinicians in practice, as well as many academics, continue to be reluctant to recognize PDs or to offer patients the specific forms of treatment they need. In this book, I try to explain why and give reasons why minds need to be changed.

Despite a rapidly developing knowledge base, PD remains mysterious in many ways. The goal of this book is to review what we know, what we don't know, and what the current state of knowledge implies for treatment. I aim to bring clinicians up-to-date with the latest research on PD and to suggest management strategies that are consistent with that evidence base. I will show that even if we cannot always provide definitive treatment for these patients, we can reduce distress and promote functioning.

This book differs in three important ways from previous guides to the management of PDs. First, it provides an evidence-based perspective. It makes no sense to depend entirely on clinical impressions when thousands of research papers have been published. Where there is strong evidence, I review the literature and suggest how it can be integrated into practice.

Where there is little or no literature, I say less and suggest where further investigation is needed. Although it is not possible to write a book on this subject without relying on clinical experience, I make clear what is science and what is opinion.

Second, this book focuses on clinical problems that have been examined in systematic research. Because borderline PD (BPD) is by far the best-studied disorder (nearly 7,000 articles published since 1987), it is the main subject of this book. Antisocial PD also has a large literature (nearly 5,000 articles over the same period), but I still have more to say about BPD because, as we now know, it is usually treatable. BPD is a problem that challenges clinicians, but there is strong and growing research supporting effective therapy of these patients. When a larger body of data emerges on other PDs, we may develop treatment packages for them as well.

Third, this book argues that clinicians need to replace systems of therapy identified by acronyms and associated with charismatic founders. Even if some of these methods are evidence based, we need to adopt integrative, eclectic methods that combine the best ideas from all schools. A single paradigm, called *psychotherapy*, is needed to heal these divisions. An integrative approach is well supported by research and also makes the most practical sense.

THE STRUCTURE OF THIS BOOK

This book consists of three parts. The first is devoted to general issues about PDs. Chapter 1 addresses thorny problems of definition and the uncertain boundary between PD and personality. Chapter 2 focuses on the relationships between traits and disorders and assesses the advantages and disadvantages of proposals to revised or replace the *DSM* system. Chapter 3 examines etiology and risk factors, and Chapter 4 reviews prevalence and outcome.

The second part of the book is devoted to specific PD categories: Chapter 5 on antisocial PD, Chapter 6 on BPD, Chapter 7 on narcissistic PD, Chapter 8 on other PDs (schizotypal, schizoid, paranoid, histrionic, avoidant, obsessive–compulsive, dependent, and PD, not otherwise specified).

The third part of the book concerns treatment. Chapter 9 examines the efficacy of pharmacotherapy, and Chapter 10 reviews evidence concerning the various psychotherapies developed for PD. Chapter 11 presents a general approach to management, with emphasis on the borderline category. Finally, Chapter 12 summarizes what we know about PD and what we need to find out.