Personality Disorders Article

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A personality disorder is a type of mental disorder in which one has a rigid and unhealthy pattern of thinking, functioning, and behaving. Personality disorders are deeply ingrained behavior patterns, typically being apparent by the time of adolescence. A critical distinguishing feature of personality disorders is that they cause major impairment in multiple domains of one's life such as in our personal relationships. Personality disorders result in difficulty in forming lasting relationships.

Etiology: Research suggests that genetics, abuse, trauma, and other factors contribute to the development of obsessive-compulsive, narcissistic, or other personality disorders.

There are 10 specific types of personality disorders:

Paranoid, Schizotypal and Schizoid Personality Disorder (Stone, 1993)

These individuals have in common a disinclination to interact with others, often associated with a diminished capacity for empathetic understanding of other individual's feelings. In contrast, individuals with avoidant PD are more empathetic, yet have difficulty with forming close attachments to others.

Patients with these disorders tend to be guarded, secretive, and refractory to treatment. The main traits associated with these 3 disorders are:

- Suspiciousness- Paranoid PD (PPD)
- Eccentricity- Schizotypal PD (STPD)
- Aloofness (or emotional detachment)- Schizoid PD (SZPD)

Defense Mechanisms

Paranoid Persons- Blame others

Schizotypal- Dismissiveness, empathic deficiency affects their ability to read other people's minds correctly. Their capacity for the compassionate aspect of empathy is often well preserved. For example, they can react with sadness upon learning of someone else's problems.

Although the aforementioned three disorders represent categories of personality, in reality, individuals display enough traits to be diagnosed with one disorder will likely show a few traits compatible with the other two or with other categories of personality disorder. Thus, individuals with the schizotypal disorder may display paranoid traits and paranoid persons may display schizoid traits as well as narcissistic or antisocial traits. Thus, mental health providers need to view personality in multidimensional terms, viz, how much of the various categories does the individual manifest. None of the categories are homogenous. The actual mix will affect

how approachable the individual is to treatment and the best approach to treatment. Resistance to treatment will be less, eg, if a patient with mainly a schizotypal, schizoid, or paranoid configuration also has significant antisocial features.

Paranoid Personality Disorder (PPD)

PDD may be encountered in non-psychotic individuals or may be associated with a psychotic condition such as schizophrenia, or delusional disorder as well as bipolar disorder. These individuals are suspicious, mistrustful, and significantly misread the meaning and intentions of others. At the psychotic end of the paranoid spectrum, delusions are seen in patients with pathological jealousy or those with presenting convictions. These false beliefs amount to defenses against feelings of weakness or insensitivity in some important aspects of their life. Contradicting an individual about false beliefs results in the individual being angry. Individuals take this as an assault on their self-esteem. These individuals create self-fulfilling prophecies. In the workforce, an employee may be convinced that their coworkers are talking about them behind their back and end up rejecting them. Coworkers then react by shaming them yet other individuals who were let go due to substandard work may believe that they were fired due to factors other than their job such as race, religion rather than the fact that their work was consistently poor.

Are individuals with PD amenable to Treatment?

Due to their suspiciousness, these individuals seldom seek professional help.

In working with patients with PPD, a viable strategy is to enter the patient's world as best one can. For example, one does find at times that there is some truth stemming from delusions.

Cognitive-Behavioral Therapy (CBT)

In CBT, the ability of the practitioner to begin treatment by embracing the patient's world is essential. For example, the patient stating that he always expects the worst in people were told by the practitioner, "how do you know if it's safe to trust one or not?". It's hard to get help without trusting at least a little, but it's hard to tell if it's safe to trust. The patient felt that he had been heard.

Group therapy

Due to their hypersensitivity to others, poor empathy, tendency to misinterpret others' motivations and attitudes, paranoid patients are uncomfortable in group therapy.

Pharmacological Therapy

Psychoactive medicines have minimal impact on paranoid patients due to their deep characterological faults. (Stone) reports some alteration of anxiety with small doses of (risperidone, 1-2 mg/day; haloperidol 5mg/day) which may alleviate anxiety in some paranoid

patients. However, paranoid pathology may interfere with medicine compliance, eg, these patients are always alert, hypersensitive, and suspicious. In forensic settings, the court may order medicines to address cumulative or delusional symptoms. For example, a paranoid patient was admitted to a hospital after having assaulted someone. He refused medicine in the hospital thinking of it as poison. Faced with a court order to take medicine, he accepted Risperadone tablets. Three days later, his condition had partially resolved. He had no insight as to why he had assaulted the individual.

(Stone) notes that in treating patients with nonpsychotic forms of paranoid personality disorder (entrenched racial and religious bigotry, pathological jealousy, litigious individuals) there are poor outcomes with psychiatric medicines. (Steve) notes that a few studies find positive results in uncontrolled trials of paranoid patients taking pimozide (Callard, 1979, Ungravi and Hukokoi, 1993).

Schizotypal Personality Disorder

(Kendeler and Walsh, 1995) notes that STPD had been considered a form of schizophrenia as though some of the same genes that contributed to the risk for the "parent" (and psychotic-level illness were present also in the milder, non-psychotic form of schizotypy (the umbrella term for related condition). (Kendler and Walker, 1995; and Rick and Schilsenger, 1968). One cannot accept eccentricity as the defining feature of STPD as there is overlap with treating suspicious and paranoid ideas. Many schizotypal patients also show narcissistic traits not to make the comparison establishment of narcissistic PD projects, but self-centeredness and lack of regard for others feelings.

Drug Abuse as an Aggravating Factor

(Gabbard, 2005) relates that among the mind-altering drugs that can provoke a schizotypal reaction or aggravate a pre-existing STPD, cannabis is implicated. A certain segment of the population is vulnerable to decompensation with cannabis use. Gabbard notes the substance abuse problems appear worse than in prior generations as cannabis has become a rite of passage into adolescence. The THC content in marijuana is often stronger than it was in the past (Kleber and DuPont, 2012). As (Anglin et al, 2012) notes, cannabis use prior to age 14 is a strong predictor of schizotypal symptoms in adulthood. Recent studies have also shown a decline in the learning trajectory of adolescence.

Individual Psychotherapy

Types of individual psychotherapy currently used in the treatment of schizotypal patients 1) Dynamic 2) Cognitive- Behavioral and supportive. (Gabbard, 2005) notes that, compared to BPD patients, fewer schizotypal patients will derive significant benefits from typical therapies.

Dynamic Psychotherapy

(Gunderson, 1984) notes that dynamic therapies include psychoanalytically oriented therapies such as intensive exploratory and transference-focused psychotherapies (Clarkin, et al 1990). (Gabbard, 2005) states that dynamic treatments of STPD are contingent upon a patient being highly motivated, and capable of insight into their problems, ability to work with symbolism dreams, and sufficient reflective capacity involves being able to have empathy for others and ability to have insight into one's own inner conflicts. (Baterman and Fonagy 2004). For schizotypal patients who are amenable to dynamic therapies, twice-weekly sessions are indicated. Openness to new ideas and new ways of thinking about oneself and others is conducive to amenability to dynamic therapy. Schizotypal patients are related by (Gabbard, 2005) to demonstrate openness, whereas others manifest paranoid characteristics. (Gabbard, 2005) notes that psychoanalysis is contraindicated for schizotypal patients. These patients are fragile with poor personality organization.

Cognitive-Behavioral Therapy (CBT)

A common characteristic of schizotypal patients is social skills deficits and oddities in social behavior. CBT addresses these deficits by increasing awareness of automatic thoughts and assumptions which interfere with activities of daily living. Examples of automatic thoughts are, "I know they will not like me," and "I have a feeling something bad is going to happen." Combating negative thoughts always begins with awareness of these thoughts in our minds when we are out and about as well as entering in a diary the intensity of these symptoms, the situation, and triggers to regulate thoughts.

Supportive Psychotherapy

Supportive measures are much more prevalent than psychodynamic techniques. There are measures such as encouragement, teaching adaptive skills, etc. (Winston, et al., 2001). (Applebaum, 2005) recommends responding directly to questions (evaluated in dynamic therapies) and avoiding confrontation and interpretation.

Pros and Cons of Group Therapy

Schizotypal patients tend to be shy and uncomfortable speaking up in a group. In a positive, qualitative fashion, the group can serve to diminish a patient's negative assumptions such as, "People wouldn't like me." Optimal leaders in group therapy for schizotypal patients are directive, engaging, and sympathetic.

Family Therapy

One finds that young, schizotypal patients are often immersed in intense family situations. These patients are more likely than individuals in the general population to have a sibling or parent with a schizophrenic spectrum disorder. As is often observed with patients who

are exceptionally bright, it can become difficult for parents to comprehend that high intelligence may not outweigh the social and occupational disadvantages that this disorder may impose on the child. Evaluations of family therapy are to assist parents in becoming more realistic about a patient as opposed to what they "hope" he may be. This in turn results in a family embracing a more patient approach to a schizotypal child (Anderson, 1989). In some families with a schizotypal young person, the family atmosphere is volatile and even hostile. A worthwhile intervention in family therapy is to decrease tension in the family by having the parents refrain from humiliating the schizotypal child by calling them "weird" or "disrespectful."

Pharmologicaltherapy

Schizotypal symptoms exist on a spectrum less pathological → More pathological

Eccentric views → Odd Thoughts → Delusions

Schizotypal patients

Patients with BPD
Increase suicidal acts and threats
Increase self-mutilation
Increase in rage and outbursts

STPD Spectrum

Less Psychotic Symptoms — More Psychotic Symptoms

(Stone, 1993) Patients recover from the schizophrenic role and tend to benefit more from low dose antipsychotic medicines for brief time periods. Accordingly, STPD patients with significant anxiety tend to benefit from antipsychotics such as Buspirone. (Serban and Siegal, 1984) A meta-analytical study of patients with severe PDS (STPD and BPD), antipsychotic medicines were found to be effective with cognitive-perceptual symptoms. Psychotropic medicines do not tend to be effective with permanent paranoid symptoms.

Schizoid Personality Disorder (SPD)

Aloofness is a prime characteristic of this PD. These individuals are islands of themselves having few close friends and have little eye contact with others. (Gabbard, 2005) notes that group therapy may be helpful as group members can provide acceptance and sympathy. These individuals function well in their occupations. They are frequently found in science or academics.

Supportive therapy is the most promising modality. Group and family therapy do not have good outcomes nor do psychotropic medicines.

Conclusions and Findings

Schizotypal, paranoid, and schizoid PD's schizotypal patients are noted to be resistant to therapy as they are more likely to form relationships and paranoid patients are prone to blame others. Thus, direct therapy needs to be avoided. Supportive therapy is the main treatment approach for each of the aforementioned PDs and will need a varied selection from the overall menu of supportive therapies.

Borderline Personality Disorder (BPD)

BPD patients can not tolerate being alone, having a concerned fear of abandonment. Their interpersonal relationships are volatile and unstable marked by impulsivity in the areas of spending, sex, substance abuse, binge eating, and reckless driving. These patients often suffer from inappropriate, intense anger, paranoid ideas, and recurrent suicidal ideas.

(Gunderson et al, 2011) noted three widely prevalent clinical failures in this field are 1) misdiagnosis 2) excessive reliance on medicine and 3) inadequate psychoeducation. Patients and families need to understand the origins, course, and treatment

Treatment Guidelines

Structure

- Primary treating provider for continuity of care
- Clear, well-defined treatment goals eg:
  - Specific goals- ↓ self-injury ↓anger
  - General goals- improving communication with others, improving the quality of life

Support

- Validate patient's distress
- Encouragement regarding the ability to change

Involvement

- A therapeutic relationship is dyadic
- The provider should limit self-disclosure
- Providers need to be active but non-reactive
- Facilitating the nexus of actions and feelings to events---assisting patients with correcting their feelings to lost supports and other several network factors

Countertransference

- BPD individuals characteristically idealize or devalue others. (Gunderson et al, 2011) points out the frequently seen problem with countertransference reactions from therapists, eg, tendency to rescue. Consultation with one's colleagues is highly recommended.

Evidence-Based Treatments (EBT)

- (Gunderson, et al., 2011) points out EBTs form randomized controlled trials (RCTs). Some types of EBTs are noted:

Dialectical Behavior Therapy (DPT) - DPT is characterized by individual and group components. Group therapy focuses on teaching patients skills enabling them to cope better. Individual therapy sets treatment plans addressing suicidal behaviors, behaviors interfering unto quality of life, acquiring behavioral skills, post-traumatic stress behavior, and self-enhancing, self-respect behaviors. DPT utilizes what is called consultation groups where co-therapists and the individual therapist meet weekly. These groups help to manage provider burnout related to the stress of working with BPD patients. (Linehan 1993) DBT emphasizes the role of validating a patient's feelings and empathy.

Mentalization-Based Treatment- MBT (Baterman and Fonagy, 1993, 2003, 2009) developed from Fonagy's observation about children at risk for BPD confront in their early attachment experiences (Fonagy et al, 2000). Fonagy finds that borderline children fail to develop a coherent sense of self absent sensitive, timely responses from caretakers. Such caretaker responses provide a child with a language to identify feelings and an awareness of their effect on others. These comprise mentalization. Findings were on labeling feeling states and connecting them to feel.

Transference Based Psychotherapy (TFB)- TFB has a greater focus on maladaptive targets for change, viz, abandonment, loss, unlovability, dependence, mistrust, poor self-discipline, fear of losing control, guilt, and punishment and emotional deprivation.

BPT is described as a disorder of external and behavioral dysregulation. Individuals utilize self-destructive behaviors (self-mutilation) as providing temporary relief of emotional distress. They may also be viewed as the consequences of trauma, viz, tension-relief behaviors such as self-mutilation so that individuals can learn to "feel" their emotions.

Multimodal Treatments

(Gunderson et al, 2011) relates that the continuation of individual and group therapies reduces non-compliance and self-harm.

Pharmacotherapy

(Gunderson et al, 2011) relates that the FDA has yet to approve anti-psychotic medicines for BPD. (Stoffers et al, 2010) relates that impulsive behaviors are apt to respond to antipsychotics and mood stabilizers, but that feeling of abandonment and dissociation does not seem to respond to medicines. With co-occurring disorders such as major depression, antidepressants are related to having only moderate effects.

Conclusions

Personality disorders (PDs) stems from the disruption of an individual's developmental trajectory. They predispose individuals to maladaptive behaviors. PDs indicate the need for warm, consistent, empathic parenting with demonstrative and clearly defined consequences and rewards for behaviors. Today, many parents are "helicopter" parents who tend to provide controlling outcomes of behavior.

Antisocial Personality Disorder (APD)

APD is not frequently seen in association with individuals who come in contact with the criminal justice system. There is a pervasive disregard for the rights of others. This pattern of behavior is also referred to as psychopathy. These individuals fail to conform to social norms. They repeatedly engage in antisocial behaviors such as harassing others, theft, etc. These individuals can present as a "Jekyll and Hyde" as Eminem states, "Will the real Slim Shady please stand up?" They are frequently deceitful and manipulative for personal gain, eg, to obtain money, sex, or power. These individuals do not plan ahead and are impulsive. They also tend to be unstable and aggressive and get into altercations, reckless driving, risky sex, child neglect/ abuse, and engage in substance abuse. These individuals can be irresponsible. They have a tendency to blame others. These individuals frequently lack empathy and have a disregard for the rights of others. They may have an emergent self differential tendency to exploit others and may have a history of many sexual partners. The likelihood of developing this disorder increases if there is a conduct disorder in childhood. This disorder tends to have a chronic course.

Histrionic Personality Disorder (HPD)

These patients present with attention-seeking behavior. They are uncomfortable in situations where they are not the center of attention. Social interactions are characterized by inappropriate sexually seductive/ provocative behavior. Emotional expression is shallow, superficial, and hostile. These patients are characterized by much drama and theatrics. Relationships are characterized by being more intimate than they are. (Gutierrez et al 2012) found that patients do not show deviance in symptomatology over time. HPD had the highest rate of comorbidity with lifetime drug dependence (29.72%) of all personality disorders.

Neurotic and Primitive Variants of HPD

Neurotic (hysterical) variant	Primitive variant
Restrained emotionality	Fluid emotionality
Sexualized exhibitionism and need to be loved	Exhibitionism; less engaging
Good impulse control subtle seductive need inhibition	Impulsive stress disorder
Maladaptive interpersonal relationships.	Inappropriate seductiveness
Can tolerate separation from love objects	Aimless, helpless
	Primitive relationships

	Binging, masochism, paranoia Separation anxiety when abandoned by love objects

Source: (Gabriel et al, 2008) Psychodynamic Psychology in Clinical Practice, 40th ed. Pearson Psychiatric Publishing

Psychodynamic Theories

(Bollas, 2000) notes that the goal of these patients is to be the object of desire to others. Many histrionic women approach men by trying to become what they think men would most want them to be. The males, on the other hand, end up disappointed because they feel they have been deceived by these women's inauthentic presentations of themselves. (Bollas 2000) notes that hysterical individuals tend to create a life narrative in which they are the erotic objects of someone else. They spend a great deal of time attempting to find someone who will recharacterize them as an individual's object of desire.

A psychodynamic perspective reveals insight into why these women will never find "Mr. Right." In this way, women are saving themselves for the father. As little girls, they idealize their father. The idealized attachment leads to competitive feelings with the mother and daughter to replace her. Patients with HPD in analysis recall these fantasies. In the circumstance wherein their brothers are favored by their fathers (Gabbard, 2014) reports that women may develop significant resentment and may become highly competitive with their mother.

Sexuality in HPD

HPD patients present with symptomatic sexual functioning but are erotically distant from any authentic inner experience of love or intimacy during sexual relations. Intimate body parts may be exhibited via provocative ways of behavior. There is minimal arousal associated with provocative behavior. (Gabbard, 2014) reports that a common occurrence in histrionic patients is surprised when others respond to them as though they are sexually provocative. He notes that in the dynamic of women with HPD, sexuality may be characterized by incestuous meanings due to Oedipal attachment to father. In turn, these patients may desire inappropriate relationships with males in defense against giving up Oedipal longings. Some HPD patients' conscious feelings about their father may be charged with anger as a defense against their underlying longings. (Gabbard 2014) notes that HPS patients are involved in triangular relationships, eg., attraction to married men.

Dissociative Identity Disorder (DID)

This disorder is defined by (Brand et al, 2012) as a disruption of identity characterized by 2 or more distinct personality states. These individuals also experience a disruption in autobiographical memory. There patients experience what is referred to as dissociative amnesia, eg, gaps in difficulties in the recall of everyday events personal and identity information.

Individuals also experience feelings of detachment from themselves and/ or their surroundings during traumatic events (motor vehicle accidents, assaults). Individuals can experience transient global amnesia, a phenomenon that can be caused by seizure disorder, transient loss of consciousness, or trauma.

(Spiegel et al. 2011) notes that population studies in North America, Europe, and Turkey have found that DID is a psychiatric disorder with an incidence of 1-3% of the general population and up to 20% of patients in inpatient and outpatient treatment programs. A causal relationship between antecedent trauma and dissociation has been validated across cultures in clinical and non-clinical samples. (Dalenberg et al. 2012). This is competing evidence against those who argue that trauma produces vivid memories and recall. To the contrary, DSMV notes the presence of dissociation - a detachment from a present state of consciousness- during traumatic events. This is the mind's way of protecting us from terror and pain.

Subjects with DID report multiple forms of maltreatment, viz, emotional, physical, and/or sexual abuse as well as neglect with the onset prior to the age of 5. Child maltreatment, eg, multiple painful early life medical procedures have also been reported (Putnam, 1997). Moreover, patients with DID report a significant incidence of sexual assault, intimate partner violence, and sexual trafficking (Simeon and Loewenstein, 2009). These patients suffer from a lack of a core sense of identity. This is often accompanied by disruptive caretaker- child attachment and parenting. These children lack a secure attachment with their caretakers. The consequences of this are that there is a lack of sense of "you are important to me", consistency of affection, and setting of firm limits. This insecure attachment is frequently seen in caretakers suffering from BPD who send ambivalent signals to a child as opposed to acceptance, security, and encouraging a child in later years to separate from the caretaker. Over time, these self-states may develop along different developmental trajectories and further elaboration of self-states may occur leading to adult forms of DID (Loewenstein and Putnam, 2004).

Dissociation Can be Adaptive

Early dissociative states are related to unfortunate circumstances with children wherein they are in the path of inescapable threat and/ or danger and where comforting and restorative experiences are not available. Unfortunately, some children react to tension-reducing behaviors characteristically seen with trauma such as self mutilations as a consequence of all this, traumatized children retreat inwardly. On a positive note, early childhood dissociation can be a resilience factor in DID. Comparisons on psychological testing with patients with BPD and psychotic disorders, patients with DID are noted to be more insightful, better reliability testing, and logical thinking as well as a perceived sense of humor, creativity, and hopefulness. Traumatic material tends to recur (Freud called our need to return to the trauma as repetition compulsion). This return to trauma can in turn result in regression. These psychological complexities underline the need of patients with DID to specialized treatment.

Complex Post Traumatic Stress Disorder (C-PTSD)

C-PTSD refers to repeated severe traumatic events resulting in difficulties with regulating effect, difficulties with regulating of consciousness, difficulties with a sense of self and body image (eg, identity problems, eating disorders, lack of attention to medical needs and sanitation) relationships with intense problems with trust with co-occurring problems of vulnerability to victimization and exploitation. The world is seen as dangerous and the self as damaged from traumatization as well as self-destructiveness (viz suicide attempts, self-injury, substance abuse, and risky behaviors)

Dissociative Subtype of PTSD (DPTSD)

Approximately 15-30% of PTSD patients will fit the DPTSD subtype of PTSD. These patients report multiple episodes of childhood maltreatment and trauma. These patients also report derealization or depersonalization and display neural networks characterized by activation of frontal subcortical circuits that have a reducing effect on emotional limbic structures, e.g., the amygdala and insula. These are accompanied by reduced blood pressure and heart rate.

Comorbidities with DID

One sample from large population studies shows a correlation between early life trauma and maltreatment with high rates of depression, substance abuse, suicidality, self-destructiveness, problems with relationships, impairment in occupational duties, revictimization, amnesia in early life, and auditory hallucinations (Felitti & Anda, 2010). Early childhood adversity is also associated with high-risk behaviors and high medical problems e.g., morbid obesity, high-risk sexual behavior, increased risk of STDs, early pregnancy, autoimmune disease, and significant cardiac, hepatic, and pulmonary problems (Felitti & Anda, 2010).

Treatment Outcome Studies

C-PTSD and DPTSD convergent data from outcome studies of C-PTSD, DPTSD, and DID reveal non-responsiveness to treatment and even clinical diagnosis trauma-focused exposure and CBT treatment-based approaches for PTSD are used with these patient treatment guidelines (Forbes et. al., 2010).

Meta-analysis studies on patients with DID (Rvand, et al 2009). Patients with depression, suicide attempts, substance abuse, chronic pain, and hospitalization showed improved functioning and higher GAF scores. More patients were attending school, volunteering, and reported feeling good. Younger patients resolved self-injurious behaviors and suicidality pointing to the importance of early diagnosis and treatment. Rates of revictimization declined (Myrick et al 2013). Worsening of symptoms occurred in only (1.1%) of patients.

Norwegian Inpatient Treatment Study

(Brandt, et al 2015) cited a Norwegian study of consecutive admission to an inpatient Trauma program which demonstrates that dissociation does not substantially improve if amnesia and dissociative self-states are not addressed (Jepse et al 2013). Of trauma patients, provided dissociation-specific treatment is often associated with more positive outcomes (Clortive et al 2012). Patients with dissociative states present as fragile with regard to self-states and must have treatment directed at these states.

Phasic Treatment

(Bradt et al 2013) reported a comprehensive survey of 36 international DID Experts to identify evidence-based treatment for DID. These new ordinations were contained in ISSTD Treatment Guideline /International Study of and Dissociation 2011). Stage 1: Safety and Stabilization Stage 3: processing trauma and grieving Stage: 5 reintegration, fusion, and rumination.

Overview

In the third stage, the focus is on the detailed narrative and emotionally intense recollection and processing of trauma memories. This is similar to limited scripts regarding exposure therapy for Veterans for the treatment of PTSD. In the final stage, therapeutic treatment is directed towards “reintegration” living well in the present (similar to mindfulness) with traumatic memories regulated more to the status of “Bad memories" rather than flashbacks.

Core Therapeutic Interventions

The 36 experts established a core set of protocols for the treatment of DID. Developing and replacing the therapeutic alliance was primary. Safety is also primarily due to decompensating behaviors such as self-destructive (tension-reducing) behaviors found in trauma populations. Additional care interventions involved treatment of comorbid disorders, patient psychoeducation, the effectiveness of medicines, and helping patients become more in touch with emotions, improving impulse control, managing relationships, and stabilizing patients following stressful life situations/and or intuitions from abusive individuals.

Containment therapies for trauma include total self-hypnosis (provides patients with more of a sense of self-control and reduces anxiety) as well as guided imagery. These techniques assist patients in “dissociating” to a hypoactive or relaxing imagery state. Relational training such as Jaslson’s progressive relaxation is helpful. Safety agreements to stabilize the alliance and have petitions be more accurate are indicated as well as crisis management plans. (Bradit et al 2015) notes that with the treatment guidelines a standard of care for DID patients is emerging.

Stage 1: Safety and stabilization

The DID population presents problems of danger to self and patients becoming overwhelmed with symptoms. Safety problems involve self-destructive behaviors, suicidality, eating disorders, danger to the patient's minor children, substance abuse, involvement in an abusive romantic relationship including the family of origin, homelessness, and lack of access to medical care. Interactions may include identifying self-states, "taking over" the presenting self-states to other states that may be "listening", facilitating patterns of inner communication among self-states, and assisting with empathy, collaboration, and cooperation among self-states.

The self or personality of the DID patient consists of all the self-states (Putian 1997). (Feutsteam and Patnam 2004) discuss the importance of making the DID patients responsible for their behavior. On the other hand, there are no "good" or "bad" self-states. Self-states are seen as adaptive responses to trauma and the patient's development. If one attempts to escalate control self-states, it results in decompensation.

Stage 2: Safety and Stabilization

Evidence-based studies and expert consequences reported by (Brondit et al.,) indicate positive outcomes via direct work with self- states. Interventions include "taking over" presenting self-states to other states that may be listening. This author has treated patients with DID who report their verbalization being connected to other self-states, viz, other voices, about bringing understanding to this situation, and facilitate communication between self-states (Brondit et al) reports that the personality of the patients consists of all of the self-states. Which should all be addressed by the mental health provider. (Kluft, 2001). Patients with DID are noted by (Bronit et al) to be held responsible for their behavior in all the states (Laurenstem and Putnam, 2004). One must not judge self-states as "good" or "bad". Indeed they are adapted to trauma. Dissipation goes hand in hand with the effects of trauma.

Stage 3: Processing Trauma and the Grief Process

This writer offers a proposal with regard to trauma-based work with DID patients which is similar to a protocol for treating PTSD using written scripts that utilizes gradual exposure to traumatic material. (Brondit et al) notes that in stage 3 treatment there needs to be a collaboration on which traumatic material is addressed, with regard to the intensity of affect and in self-states. (Laurenstein and Wiegandt 2010). Exploratory work is done on areas of trauma that have been avoided, eg, terror, helplessness, rage, betrayal. The benefit of this treatment approach is to provide the DID patient with increasing mastery over traumatic memories and events. It empowers them. (Brondit et al) notes that this treatment approach changes "flashbacks" into bad memories and patients are able to distance themselves from traumatic beliefs.

This is a stage of collaboration between therapist and patient. Decisions need to be made as to which material will be worked on, with what intensity of the affect, and with which

self-states. This is a stage of exposure to feelings involving grief, terrors, helpfulness, betrayal, shame, and rage. Reenactment of narratives leads to the empowerment of patients.

Stage 5: Integration, Fuson and Reconnection

Integration involves improving memory continuity as traumatic memories are fragmented and discontinuous. In this stage, the goal is subjective unification of all self-states with a shift from a multiple subjective self-goal to a single subject self. In the past unification phase, patients learn to live and cope without self-states (Kloft, 2001).

Pathological Possession Trace and DID

DSM-V Diagnostic Criteria for DID include "experience of possession" as a cultural component of DID that occurs in Van-Western and Western cultures as well as fundamentalist Christian Groups. Pathological possession is related to trauma and stressful events. Patients in the western culture report feeling or believing that they are "possessed" especially in self-states that are attributed to outside forces such as spirits and mythical figures. This author has seen individuals detached from their surroundings in trance-like states. They have acted against others devoid of awareness of their actions. They are in a subconscious state, yet unaware. Individuals in self-states can respond to commands yet be unaware of their surroundings. Treatment involves recognition with the possessing states: permitting them to give voice to their concerns and assist them with addressing their problems. As treatment programs, the possessing personality states may shift to a more adaptive configuration or unify into a subjectively singular self. This examiner has taken patients through the difficult self-states, had them communicate with the different self-states, and assisted them with the grounding of themselves and reliability on each other.

Psychopharmacology and electroconvulsive Therapy as Treatment Options for DID

Treatment Guidelines for DID (Pole, 2012; International Society for the Study of Dissociation, 2011) treatment protocols that do not use exposure after a period of stabilization of dissociation and other PTSD symptom have process effective for patients with PTSD (Clartie et al, 2012; Resick et al, 2012) can be found in the International Society for the Study of the Trauma and Dissociation (2011) and in work by (Laurenstein, 2005).

(Raskind et al. 2003) notes that symptoms in DID and related PTSD disorders rarely respond definitely to medicine with the exception of prazosin for PTSD nightmares to which there may be a robust response (Raskind et al 2003).

This author has treated DID patients who commonly report inner voices or conversations with other self-states and may report visual, tactile olfactory, gustatory and somatosensory hallucinations, in part, a manifestation of partial flashbacks. Clinicians should be vigilant that there is a differential diagnosis of psychosis. (Raskind et al. 2003) notes that DID hallucinations

related phenomena which stem from dissociative and post-traumatic factors rather than a psychotic illness.

In DID a highly depressed self-state is the cause of protracted mood symptoms that are unresponsive to pharmacological intervention ECT. These symptoms do respond to psychotherapy for depressed states as this author has seen in the past the use of ECT to treat DID has poor treatment outcomes and results in memory deficits.

Cluster C Personality Disorder
Avoidant, Dependent, and Obsessive-Compulsive

These personality disorders as a group produce less impairment than cluster A and B personality disorders.

Avoidant Personality Disorder (APD)

Frequently, the genetics of this disorder is related to an insecure attachment with a caregiver. There is a pattern of social inhibition, surrounding others, and restraint in intimate relationships due to fear of being shamed or ridiculed. This disorder interferes with quality of life as it interferes with resistance to taking risks due to fear of embarrassment.

Dependent Personality Disorder (DPD)

This disorder frequently begins in an enmeshed attachment with a caregiver who fosters dependency and growth in the individual. The caregiver fears being alone with the consequences of stifling their child by entangling them in dependency. Subjects with DPD have immense difficulty making decisions, have difficulty initiating things on their own, feel uncomfortable or helpless when alone due to exaggerated fears of being unable to care for themselves. These individuals are able to be exploited by others. They also are vulnerable to a checkered history of broken relationships as they urgently seek another relationship as a source of care and support when a close relationship ends. These individuals frequently have great gifts and capacities but are preoccupied with fears of being left to take care of themselves.

Obsessive-Compulsive Personality Disorder (OCD)

Being organized is a good thing. However, these individuals go over the top being preoccupied with rules, lists, details, perfectionism. These individuals have no balance in their life, i.e. over-involved with work to the exclusion of leisure activities and friendship. They are poor at delegation and tend to be hoarders. They tend to be rigid and stubborn and are misers with money.

Treatment Potential

There is a consensus that dynamic and cognitive-behavioral therapy produces good outcomes with patients with PD's (Leichsenrign and Leibing, 2003) (Perry and Bond, 2000) (Perry et al 1999) (Simm, 2009).