Cluster B Personality Disorders and Its Treatment from Cognitive Behavioral Therapy Perspective

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ABSTRACT

Cluster B Personality Disorders are characterised by overly emotional, impulsive behaviour, reduced empathy and unstable relationships with others. Four personality disorders are included which are Narcissistic Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder and Antisocial Personality Disorder. This reviewed is aimed to discuss the procedure and effectiveness of Cognitive behavioural Therapy (CBT) as a treatment to Cluster B Personality Disorders. Besides, we provided an overarch summary of the primary risk factors of the development of these personality disorders. Family environment was expectedly found influencing the precipitation across these personality disorders. Other factors were also discussed in the current review. In addition, the working techniques during the treatment of personality disorder of Cluster B from a cognitive behavioral perspective was delineated and hopefully can educate more people in this regard.

Keywords: *Cluster B Personality Disorders, Cognitive Behavioral Therapy, Narcissistic Personality Disorder, Borderline Personality Disorder, Antisocial Personality Disorder, Histrionic Personality Disorder*

1. INTRODUCTION

The aim of this paper is to review the role and impact of CBT therapy on cluster B personality disorders. The characteristics and causes of Cluster B personality disorders are included in this article. The causes are multifaceted and there is no a dominant cause. The patients are influenced by genetic inheritance, childhood experiences and many other factors.

Cluster B personality disorders are the most 'dangerous' of all existing personality disorders, characterized by their difficulty to control, impulsivity and tendency to cause harm to others in both mental and physical dimensions. In turn, CBT is the most widely used for mental disorders, apart from the pharmacological therapies. Therefore, to review the role of CBT therapy for Group B personality disorders has a great significance. Of the literature reviewed here, the earliest use of CBT therapy occurred in 1994, with the rest of the literature dating from after the 21st century. The difficulty for therapists working with patients with personality disorders in Group B is to mediate their emotions and the way they talk about their childhood experiences and attitudes.

In terms of the results, although CBT therapy has been widely used to treat a variety of psychiatric disorders, it is still only in its early stages and its effectiveness is not significant in terms of improving Group B personality disorders.

1.1. Characteristics

The basic characteristics of narcissistic personality disorder are self-aggrandizement, need to be admired, and lack of empathy. Individuals with this disorder are always exaggerating self-importance purposely. They are always immersed in their success, beauty, and power intangibly. They always believe they are special, outstanding, and exclusive. They expect others to treat them in this way and be desperate to attract others' attention. According to the DSM, it is estimated that 0-6.2% individuals were diagnosed with narcissistic personality disorder.

1.2. Risk Factors

1.2.1. Family

Family environment is one crucial factor that contributes to the development of narcissistic personality disorder. Kemberg considered that the development of narcissistic personality disorder is that their parents are exercising their responsibility in an organized and good way. However, this process leads to the potential neglect of their children. The emerge of narcissistic personality disorder is still due to too much attention and demand from parents, especially from their mother.[1] Miller pointed out that in that kind of family, in which usually the mother has limited sense of security in herself which led to a toxic relationship with her children. In this relationship, the mother relies extremely on the children such that the children cannot even respond to their mothers' demands.[2]

Gickanf-Hughes and Well pointed out that parents with Narcissistic personalities need to strengthen their children's mistakes to satisfy their own needs.[3] According to Glickauf-Hughes' theory, most of the individuals with Narcissistic personality disorder are usually the first kids of their family.[3] Glickauf-Hughes found that it is much easier for the first boy kids to develop Narcissistic personality disorder. Individuals' parents devote more attention to the first kids, which the other children cannot compare with. If the first kid is a boy, which means their parents will probably devote more attention to this boy.[3]

Sullivan considered that individuals experience their parents' anxiety during the process of empathizing transference, which will cause distress to individuals. It is unsuccessful for parents to try to comfort their children at this time. This will motivate parents potential Narcissistic' trauma. The more worried their children are, the more likely they would develop into Narcissistic personality disorder. [4]

1.2.2. Gender

Gender may also contribute to the development of narcissistic personality disorder. Researchers including Emily Grijalva of the University at Buffalo in New York analyzed data from a study of 475,000 participate over nearly 30 years and found that men are more narcissistic than women on average [5]. First, men are more narcissistic than men are manifest in power. Men are more autocratic and power-desire than women.

Second, the researcher also analyzed the reasons why men are more narcissistic than women. That is the gender stereotype of individuals, family background, and social background. After women enter society, they will face some customs of gender difference and the reality of gender discrimination. This will often impose more pressure on women than that on men, thereby greatly inhibit women's self-expression and narcissistic behavior.

1.3. Cognitive behavioral therapy for narcissistic personality disorder

Cognitive behavioral therapy has shown great effectiveness in treating HPD. CBT therapy for NPD can help patients stabilize their family relationships, confirm their innermost and long-standing emotional needs, and weight the way of realistic needs. Research found that CBT delivered twice a week is more effective than once a weak. The length of treatment is not fixed and needed to depend on the patients' situation.

Cognitive behavioral therapy aims to recognize maladaptive thinking patterns and mitigate their impact on individuals' emotions. It can cultivate individuals' emotion regulation capability, emphasize endure temporary frustrate, imperfect, and normal durable emotion. For the narcissistic personality disorder patients, CBT wants to Improve their respect and empathy for other people's feelings and boundaries, and improve their ability to delay gratification socially. In the meanwhile, it aims to keep a balance between talent, advantages, and unconditional sense of self-worth, facilitate Improvement on proper social ability. All goals serve a one purpose is to establish an adult mode of functional and healthy.

In the initial conceptualization phase, the following approach is helpful. (1) Deal with any immediate crisis or sabotage. (2) Focus on the symptomatic disorder. (3) Cooperates to define more and broader goals to revise maladjustment patterns. (4) Specific clinic interventions include psychology education, cognitive intervention, experiential method, and relational feedback method.

Psychological education. Brief psychological education on the interaction between temperament and experience was provided to weaken patients' skeptical attitude towards psychotherapy. In this therapy, therapists need to make immediate strategies to respond when the patients have impulsion-based responses to similar situations. This helps normalize the defensive response of patients with NPD and reducing their skepticism about treatment.

Cognitive intervention. Therapists can utilize diverse strategies to cope with different patterns, which use for therapy objects.

Activity Schedule: The researcher can use activity schedule to record self-exaggerate and detachment mode in an active situation. Recording the significant reaction and cognitive at the same time. In this way, we can clearly recognize some distorted belief in a given

situation. This will help patients to form self-value demands from a deep mind.

Schema dialogue. The other cognitive intervention is schema dialogue, which build a conversation between patients' different patterns. This practice offers a practical experience against highly distorted beliefs and assumptions. During the conversation, the therapist acts as a gentle facilitator to frame a conversation that reduces the possibility of power struggles or staged arguments. A helpful strategy for schema dialogue is to ask where the source of information comes from in experiences. However, the most efficient strategy is that when patients role-play "health mode", they ask about their "arrogant" side. This helps patients relate their life experiences to their current maladaptive behavior.

Apart from the traditional cognitive reconstruction strategies, some other skills are also adopted in the CBT to help NPD patients.

Experiential method. The experiential method is used to emotion-focused strategies, such as Guided imagery [6], will be particularly helpful in reducing the maladaptive patterns that the patient preoccupies with. Guiding imagery is especially used to describe the development of schema patterns, to identify unfulfilled needs from earlier experiences to form the patient's narrative, and to reshape bad, deprived memories. In the process of image guidance, the unmet needs of lonely children and stressed adolescents will be taken care of by the patients' won "healthy adult model". First in the imagination, then by helping the "healthy Adult model" crate more satisfying and emotionally authentic relationships in their present reality.

Relational feedback method. The most important clinical intervention is to address maladaptive interpersonal behavior and to provide empathic relational feedback on the spot once the behavior is activated in the interview or in the corresponding mode. This feedback is designed to make people with NPD realize that they can actually change the vicious cycle of maladjustment.

2. BOARDERLINE PERSONALITY DISORDER

2.1. Characteristics

Borderline personality disorder is one of the most common and challenge disorders to the treatment of the personality disorder. It is characterized by instability of interpersonal relationship and self-characteristic. Interpersonal and self-emotion instability and remarkable impulsivity is most common and significant pattern of borderline personality disorder. Onset of borderline personality disorder is in early adulthood and does not vary by background or region. BPD often accompanies with Suicidal behavior that can complicate medical care in Borderline personality disorder.

2.2. Risk Factors

The cause of the Borderline personality disorder is still uncertain. Investigation has been in several domains. The environmental causes of BPD are significantly related to childhood experiences of sexual abuses, while other common causes include childhood separation from family and poor parental relationships. BPD has a genetic potential. Studies of the brains of people with BPD have shown that the area most associated with BPD is the hippocampus, which has a smaller volume than that of healthy people.

2.3. Cognitive Behavioral Therapy for Borderline Personality Disorder

CBT is the most studied therapy for Borderline disorder and can cure to great extent.

Beginning Phase: The first phase of cognitive behavioral therapy usually starts with building relationship between the psychiatrist and the patient. Because of the specialness of borderline disorder, this step is very essential, and the therapist should not enforce too much on the patient. Additionally, enough control should be offered to the patients, so that they are in the lead of the therapeutic process. As a result, patient can stop the discussion of subjects that are too frustrating by giving a signal before head, e.g. raising a finger. It helps to maintain emotional stability. The therapists should identify the problem with patients, but not to directly affecting the background; they should also increase different possibilities for emotional expression of patients.

Work on the distorted cognition: Most people with borderline disorder usually have thinking deviation and need to be correct. For example, Dichotomous (black-and-white) thinking is the most characteristic thinking error which borderlines make [7]. It will result in varying moods. They will also overthink and possess double standards towards others and themselves. It is important for therapist to amend the patients' way of thinking and establish self-confidence. In the patients with borderline disorder, correcting thinking mistakes is difficult since basic schemas are firmly ingrained. Furthermore, the patients are concerned about the repercussions of abandoning these ideas.

Work on the childhood trauma: Clinical studies suggest that in order to change the patient's representation of the traumatic childhood experiences that contributed to the establishment of these assumptions, the patient's depiction of those experiences must be modified. The childish perceptions that lead to the formation of the underlying schema are changed in a psychodrama. Role-play is commonly used in the treatment to challenge those dysfunctional representation of parents in the patients. In a role-play, the therapist or a stand-in can assume the part

of the parent, reenacting a normal interaction between the patient as a kid and (for example) the parent. By allowing patients to play themselves as children, the childlike interpretations are traced; by changing roles, a different perspective is offered, which breaks open the childlike (egocentric) interpretations and leads to the formulation of alternative interpretations (the patient can now use adult insights and cognitive powers that he or she did not have as a child); finally, the role-playing model is revoked.

3. ANTISOCIAL PERSONALITY DISORDER

3.1. Characteristics

The DSM-5 gives the diagnostic criteria for ASPD. Patients need to be 18 years of age or older to be diagnosed, or under 15 years of age to be diagnosed with conduct disorder. People with ASPD are described as a "pervasive pattern of disregard for and violation of the rights of others". They have difficulty conforming to social norms and legal standards. They lie, or often do not tell the truth. They do not have the ability to plan their future rationally because they are too impulsive. Patients are irrational and aggressive. There is a constant irresponsibility. They lack emotional compassion for others and are indifferent even when others are hurt or treated unfairly. The diagnosis of ASPD is made when three or four of the above criteria are met and, in the case of schizophrenia or bipolar disorder, the above antisocial behaviour is not exclusively present during the illness.

The most important characteristic of ASPD is that it is extremely cold and unemotional towards others. Their interpersonal relationships are short and fickle.

3.2. Risk Factors

3.2.1. Prevalence of ASPD

According to DSM-5, the prevalence rates of ASPD in total population, using the above criteria, are between 0.2% and 3.3%.

3.2.2. Genetic Factors

The contributive relationship of synaptosomal-associated protein 25 (SNAP25) and ASPD was examined. Those two polymorphisms are more frequently present in male patients of ASPD than in male healthy controls [8].

3.2.3. Environmental Factors

One of the acquired causes of ASPD is physical abuse in childhood, and organic brain lesions caused by physical violence (e.g. reduced volume of the anterior cingulate) make these children much more likely to become ASPD sufferers. Another major cause is parental withdrawal during the infant and early childhood period, when children who do not receive adequate parental support are deprived of the opportunity to connect emotionally with their parents. Parents who show emotional and physical detachment from their children are also likely to develop more dysfunctional attachments, further contributing to the development of ASPD [9, 10].

3.3. CBT as a Therapy for ASPD

Comparative studies have shown that CBT has similar efficacy in treating patients with ASPD compared to other treatment modalities. [11]

The most important goal of CBT for people with ASPD is to remove as much violence from them as possible. In working with patients with ASPD, therapists need to be particularly aware of the legacy of the patient's history of violence. Therapists need to mention the issue of a history of violence openly and honestly with the patient, but not in an overly condemning or condoning manner, as the patient is sensitive to this issue. Therapists' risk assessment of the patient is necessary [12].

4. HISTRIONIC PERSONALITY DISORDER

4.1. Characteristics

Histrionic personality disorder is a personality disorder in Cluster B of the Diagnostic. and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), in which impulsivity, high emotionality and drama predominate, along with Borderline, Antisocial and Narcissistic Disorder. It is essentially characterized by intense emotionality, expressed in a theatrical manner, and by constant attempts to obtain attention, approval and support from others through covert or overtly seductive behavior; in addition to the dramatic and inappropriately seductive interpersonal style, impressionability, a tendency to somatization and novelty seeking characterize this disorder. The prevalence of persons with histrionic personality disorder is thought to be 2-3% of the general population and 10-15% in clinical settings [14].

4.2. Risk Factors

First of all, family environmental characteristic is a factor that will affect the possibility of getting histrionic personality disorder. Research is conducted by Millon [15]. FES, which is a 90-item, true-false inventory that assesses ten characteristics of family environment, is used to come into conclusion about the environmental factor that triggers histrionic personality disorder. The

ten subscales of the FES are: cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization, and control. After comparing the statistics of these ten judgement standards between experimental group and control group, the researchers draw a conclusion that "individuals with histrionic personality disorder will have a history that emphasizes performance that may be reflected in the high achievement orientation and stimulation scores. The trend toward higher achievement orientation scores likely reflects the families' tendency to reinforce behaviors that cause the child to stand out in a crowd. The tendency of the family to only reinforce performance may also be reflected in the higher control score." [15]. To conclude, A family background that is high in control and high in intellectual-cultural orientation was found for persons with histrionic personality disorder when compared with control subjects.

In addition, inheritance is another cause for higher possibility for individual to have HPD and it is evidenced by biology findings. Excitement, strong emotion and autonomic excitability all indicate that the hypothalamus has a lower excitability threshold in the front and back. The low threshold of the reticular ascending activation system and the low excitement threshold of the hypothalamus may interact with each other. As a result, some of the HPD patients may possess genes that will activate the nervous system.

4.3. Cognitive behavioural therapy for Histrionic Personality Disorder

Cognitive behavioral therapy is the most used psychotherapy for HPD patients, Cognitive behavioral therapy emphasizes a self-directed learning process by encouraging participants to determine their core beliefs, evaluate and improve their behavior. The ultimate goal of this treatment method is to enable patients to learn how to get along with others in life and teach them how to express their needs normally.

To treat this type of personality disorder, the goal is to moderate the patients' emotional expression, and to talk to the patient more. In the process of talking with patients, doctors should show due respect and care to patients, take the initiative to contact patients, understand their voices, understand their feelings, and try their best to meet their reasonable needs to gain trust; in establishing a good doctor-patient relationship on this basis, explain the characteristics of HPD to patients, strive to improve patients' awareness of this personality defect, and inform patients that they cannot accept their existing behaviors in society. After that, they can tell patients that they should respect the personality and human rights of others first, so that they can gain respect from others.

5. CONCLUSIONS

Cognitive behavioral therapy is widely used in the treatment of Group B Personality Disorders. It is relatively more significantly effective in treating both Narcissistic Personality Disorder and Borderline Personality Disorder.

The cognitive-behavioral treatment of Narcissistic Personality Disorder still needs to depend on different cases. The therapy of NPD in this article is a general idea and does not apply to any narcissists. It is still a significant direction for the future to choose a proper therapy to cope with narcissists' problems through the diagnose result.

A specification of cognitive behavioral therapy to Antisocial Personality Disorder can be investigated in future. The effect of CBT on ASPD is not clear compared to other therapies.

Cognitive behavioral treatment is one of the most studied method for many mental illness. However, for histrionic personality disorder, the significance is less experimented or in a small scale; the paper only provides a broad process for curing HPD, and more studies should be conducted.

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