Understanding Personality Disorders

THE TALKING THERAPIES UK PRACTITIONER SERIES



Understanding Personality Disorders

Science, stigma and the modern dimensional model

Foundation level · 6 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Understanding Personality Disorders course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 5. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 History, stigma and the case for change 3

1. The history of a contested concept 4
2. Stigma and the untreatability myth 9

How to use this manual

Grounded in the principles of the Definitive British Textbook of Personality Disorders, this foundational course offers trainees and practitioners a comprehensive, humane, and evidence-based overview of personality pathology. We move beyond historical misconceptions to explore the biological and psychological underpinnings of personality, examining how temperament, early attachment experiences, and adversity shape neurobiological development. You will investigate the interplay between genetic predisposition and environmental stressors, gaining insight into why some individuals develop significant difficulties in emotional regulation and interpersonal functioning. The curriculum critically addresses the stigma that has historically surrounded these conditions, replacing judgment with a nuanced understanding of human complexity. Central to this module is the transition from outdated categorical typologies to the modern ICD-11 dimensional model. Learners will master the grammar of this new system, specifically focusing on trait domains and severity ratings, including the complex borderline pattern. By dismantling the myth that personality disorders are untreatable, this course demonstrates that a compassionate, dimensional framework is the essential prerequisite for effective assessment and intervention. Designed for those with no prior experience, it provides the necessary theoretical grounding to progress confidently into clinical assessment and treatment pathways.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at foundation level and carries 6 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the

conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Describe what personality disorder is and is not, and the harm loose usage does
- Explain the shift from categorical types to the severity-and-trait model in ICD-11
- Recognise the common presentations, including emotionally unstable and avoidant patterns, without caricature
- Explain aetiology evenhandedly: temperament, attachment, adversity and their interaction
- Challenge stigma, including your own service's, with evidence and language
- Describe the evidenced treatment approaches and what they share

PART 1

History, stigma and the case for change

How the concept developed, the harm stigma has done, and why understanding must change.

CHAPTER 1

The history of a contested concept

Every diagnosis has a history, but few carry theirs as heavily as personality disorder. The idea that character itself could be disordered predates psychiatry by millennia: Theophrastus sketched difficult characters in ancient Athens, and every culture has had words for people whose way of being, rather than any episode of illness, brought suffering to themselves and others. Psychiatry inherited the territory in the nineteenth century under names that announce their own verdicts. Pinel's manie sans delire described madness without delusion, a disturbance of conduct in a clear mind, while Prichard's moral insanity extended the concept, and although moral then meant something closer to emotional than to ethical, the slippage between the two meanings was present from the first and never entirely left. By the early twentieth century, Schneider's psychopathic personalities offered a typology whose definition deserves quoting for what it reveals: those who suffer from their abnormality, or from whose abnormality society suffers. The diagnosis was, from its beginning, half clinical description and half social complaint, a doubleness that has shaped every subsequent classification.

That doubleness is the thread to follow through the century that made the modern category. The psychoanalytic tradition deepened the clinical half, treating character as structured defence and giving clinicians a language of narcissistic, obsessional and borderline organisation, the last named for a supposed border between neurosis and psychosis. Kernberg's formulation of borderline personality organisation as a level of severity defined by identity diffusion, primitive defences and intact reality testing provided a structural map that still informs contemporary dimensional thinking. When the American diagnostic manuals systematised the field, the third edition of the DSM in 1980 placed personality disorders on their own axis, which had the paradoxical double effect of taking them seriously as a domain and quarantining them from the illnesses psychiatry treated. Ten categories were specified by criterion counts, and the arrangement survived, barely amended, for forty years, long after research had documented that the categories overlapped massively, that the commonest diagnosis in practice was the

unspecified remainder, and that two people could share a label while sharing almost nothing else. The categorical model's failure to capture the empirical reality of personality pathology was demonstrated repeatedly in factor analytic and taxometric studies, yet the clinical infrastructure of training, commissioning and service design remained anchored to the axis II framework.

What gives this history its charge is what the label did in the world. A diagnosis of personality disorder has functioned, for much of its life, as a clinical verdict of a particular kind: not you are ill, but you are like this. It has been recorded to explain treatment failure rather than to plan treatment, invoked to exclude people from services on the grounds that nothing could be done, and attached disproportionately to people whose difficulties began in abuse and neglect, so that survivors of maltreatment found their adaptations to it renamed as defects of character. Women receiving the borderline label have often heard it as an accusation of manipulativeness; people in forensic settings have received the antisocial label as a sentence within a sentence. None of this is an argument that the difficulties are unreal. It is the observation that a diagnosis can be simultaneously clinically meaningful and socially weaponised, and this one, more than most, has been both. The Power Threat Meaning Framework, developed within UK clinical psychology, articulates this tension by reframing what psychiatry calls symptoms as understandable responses to threat, and the personality disorder label has frequently operated as a threat in its own right, compounding the original adversity.

Why does the history matter to present practice? Because the past is in the room. The person in front of you may have met the label before, in a discharge summary they were never meant to read, in a service refusal, in a clinician's changed tone, and their expectations of you are calibrated to that experience. The clinician's own training carries the history too, in half-absorbed attitudes about manipulation, attention-seeking and untreatability that the next lesson will confront directly with evidence. And the field's present reforms, above all the ICD-11 dimensional model this course will teach, are only fully intelligible as answers to this history: severity in place of stereotype, description in place of verdict, a diagnosis designed to plan care rather than to close doors. The ICD-11 model replaces the ten categories with a single diagnosis of personality disorder qualified by severity — mild, moderate, severe — and optional trait domain specifiers

such as negative affectivity, detachment, dissociality, disinhibition and anankastia. This structure was built explicitly to solve the problems the categorical model created: comorbidity, heterogeneity within categories, arbitrary thresholds, and the stigma of labels that functioned as character judgements.

One more layer of the history repays attention before the exercise, because it explains a tension you will meet in your own casework: the history of the borderline concept specifically. Coined by Stern in the 1930s for patients on the border of analysability, sharpened by Kernberg into a level of personality organisation, and operationalised by Gunderson into the criterion set the DSM adopted, the term travelled from a psychoanalytic map reference to a category applied overwhelmingly to women with histories of trauma, and each stop added connotations the next inherited. By the 1980s, the label had acquired its clinical folklore: the difficult patient, the ward split into rescuers and sceptics, the warning passed between staff, and a generation of survivors encountered their own case notes with the word written like a caution. The campaigning that followed, much of it led by people with lived experience, did not dispute that the suffering was real; it disputed who owned the telling of it, and it is one reason the ICD-11 reform demoted the categories while retaining, deliberately and only as an optional pattern specifier, the borderline term whose treatment evidence base could not responsibly be orphaned. Knowing this lineage, and knowing that both readings of the word are live in every waiting room this pathway serves, changes how you use it in a room: for one person it names their tribe and their treatment evidence, for another it is the sound of every door that closed, and asking which it is, rather than assuming, is the history lesson applied.

There is also a discipline the history teaches, which the rest of this pathway will keep applying: distinguish the diagnosis from the judgement at every step. The diagnosis, properly made, is a description of how a person's patterns of self-experience and relating cause them suffering and cost, held with the same neutrality as any clinical finding. The judgement is everything the culture and the institution smuggle in alongside: the sigh at handover, the eye-roll in the notes, the quiet triage of the deserving. The first is an instrument of care. The second is the reason so many people who most needed help learned to stop asking for it. This distinction maps directly onto the Social GGRRAAACCEEESSS framework, which reminds us that gender,

geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality all shape how the label is applied and received. A clinician who has internalised the history will notice, for example, that a young Black man presenting with emotional dysregulation after repeated racialised trauma is far more likely to receive an antisocial or borderline label than a formulation that centres his adaptive survival strategies, and that the label itself then becomes a barrier to the trauma-informed care he needs.

To make this concrete, consider a worked example. Maria, thirty-two, is referred to a community mental health team after a suicide attempt. Her GP's letter notes "emotionally unstable personality traits" and adds "difficult to engage, frequent crisis presentations". The triage clinician reads the phrase and, without meeting Maria, allocates her to a generic waiting list rather than the dialectical behaviour therapy pathway, noting "PD — likely BPD — not suitable for structured therapy at this time". When Maria is eventually assessed, she describes a childhood of sexual abuse by a relative, chronic emotional neglect, and a pattern of intense relationships that end in abandonment panic and self-harm. She meets ICD-11 criteria for personality disorder, severe severity, with the borderline pattern specifier. A purely descriptive account would read: "Maria shows pervasive difficulties in self-regulation and interpersonal functioning of severe intensity, characterised by frantic efforts to avoid real or imagined abandonment, identity disturbance, recurrent self-harm and chronic feelings of emptiness, in the context of complex developmental trauma. These patterns cause her significant distress and functional impairment. She is motivated for therapy and has capacity for mentalising." The judgement-laden version reads: "Borderline personality disorder, manipulative, treatment-resistant, high risk." The first opens a pathway to evidence-based treatment such as mentalisation-based therapy or dialectical behaviour therapy; the second closes it. The history of the label is not abstract: it is the difference between a care plan and a closed door.

Write a short reflection before the next lesson: one moment in your own training or practice where you watched the label function as judgement rather than description, what it cost the person, and what a purely descriptive account would have said instead. That reflection is the standard this course will hold itself to.

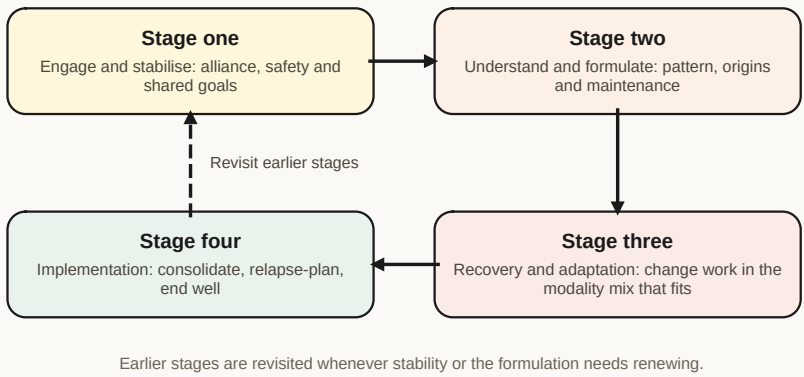


FIGURE 1.1 The IPTF pathway at a glance

The integrative pathway taught across the IPTF courses moves through four broad stages: engaging and stabilising, understanding and formulating, working for recovery and adaptation, and implementing gains so they hold in everyday life. Progress is cyclical rather than strictly sequential; earlier stages are revisited whenever the work requires it.

Points worth keeping

- The concept's origins and evolution
- Diagnosis versus judgement
- The consequences of a contested label
- Why history matters to present practice

PRACTICE TASK

Note two ways the term has been used as a judgement rather than a diagnosis.

CHAPTER 2

Stigma and the untreatability myth

The diagnosis of personality disorder has long been accompanied by a heavy burden of stigma, a phenomenon that the sociologist Erving Goffman famously described as Social GGRRAAACCEEESSS. In everyday conversation the label often functions as a social scar, signalling to others that the bearer is not merely ill but fundamentally flawed, dangerous, or morally deficient. This stigma is not confined to the public sphere; it permeates clinical environments, shaping the attitudes of doctors, nurses, psychologists and other professionals. When a clinician enters a consultation room with the implicit belief that a client labelled with a personality disorder is “difficult” or “untreatable”, a subtle form of medical nihilism takes hold. The therapeutic alliance, which is the cornerstone of any effective psychological intervention, is eroded before it can be built, and the client is denied the hope and partnership that are essential for change.

The untreatability myth rests on the assumption that personality traits are immutable, forged in early childhood and therefore beyond the reach of therapeutic influence. This view, while intuitively appealing to some, neglects a substantial body of evidence from neuroscience, developmental psychology and clinical outcome research that demonstrates the brain’s capacity for change throughout the lifespan. Neuroplasticity studies, for example, have shown that repeated patterns of emotional regulation and interpersonal interaction can remodel synaptic connections in regions such as the prefrontal cortex and the amygdala, areas implicated in the dysregulation that characterises many personality disorders (Schulz et al., 2015). Moreover, longitudinal studies of adolescents with emerging borderline features reveal that targeted interventions can alter the trajectory of personality development, reducing the likelihood of entrenched disorder in adulthood (Chanen et al., 2017).

The cost of maintaining the untreatability myth is profound and multifaceted. At the individual level, clients often internalise the stigma, interpreting their distress as a personal defect rather than a treatable condition. This internalisation can exacerbate self-harm, suicidality and chronic functional impairment. A meta-analysis of 27 studies found that individuals with a

personality disorder diagnosis who perceived higher levels of stigma were significantly more likely to report repeated self-injurious behaviour and to score higher on the PHQ-9 and GAD-7 scales (Stoffers et al., 2012). At the systems level, the myth contributes to premature discharge, reduced referral rates for specialised services, and a reluctance among clinicians to engage in the intensive, often long-term work that evidence-based treatments require. The economic impact is equally stark: untreated or inadequately treated personality disorder is associated with higher rates of emergency department attendance, inpatient admissions and utilisation of crisis services, generating costs that far exceed those of evidence-based early intervention (Moran et al., 2015).

Contrary to the myth, a robust evidence base now demonstrates that a range of structured psychotherapies can produce meaningful and lasting change for people with personality disorders. Good Psychiatric Management (GPM), developed by Gunderson and colleagues, offers a pragmatic, case-management oriented approach that emphasises psychoeducation, symptom monitoring and the development of a collaborative treatment plan. Randomised controlled trials have shown that GPM can achieve remission rates of up to 40 % for borderline personality disorder (BPD) within a year, comparable to more intensive specialist therapies but with lower therapist burden (Gunderson et al., 2011). Mentalization-Based Treatment (MBT), pioneered by Bateman and Fonagy, focuses on enhancing the client's capacity to understand mental states in self and others, thereby improving emotional regulation and interpersonal functioning. In a landmark RCT, patients receiving MBT displayed a 50 % reduction in self-harm episodes and significant improvements on the Global Assessment of Functioning (GAF) scale after 18 months of treatment (Bateman & Fonagy, 2004).

Dialectical Behaviour Therapy (DBT), originally formulated by Marsha Linehan, remains one of the most extensively studied interventions for BPD. Meta-analytic work encompassing over 30 trials has consistently reported large effect sizes for reductions in suicidal behaviour, depressive symptoms and impulsivity, with gains maintained at 12-month follow-up (Kliem et al., 2010). Schema-Focused Therapy (SFT), advanced by Jeffrey Young, integrates cognitive-behavioural techniques with experiential work to modify maladaptive schemas that underlie chronic relational patterns. Controlled studies have demonstrated that SFT can achieve remission in up to 60 % of participants with avoidant or dependent personality disorders (Giesen-Bloo

et al., 2006). More recently, transdiagnostic approaches such as the Unified Protocol for Emotional Disorders have shown promise in addressing the affective dysregulation common to many personality disorders, further expanding the therapeutic repertoire (Barlow et al., 2017).

The evidence for change is not limited to symptom reduction; it extends to improvements in quality of life, occupational functioning and relational stability. A longitudinal cohort study of 1,200 patients with BPD who completed a course of DBT reported that 72 % were employed or in education at three-year follow-up, compared with 31 % at baseline (McMain et al., 2012). These outcomes underscore that treatment can shift the narrative from one of chronic dysfunction to one of recovery and growth.

A compassionate, hopeful stance is itself a therapeutic intervention. When clinicians consciously reject the untreatability myth and convey belief in the client's capacity for change, they lay the groundwork for a secure therapeutic alliance. This stance involves validating the client's lived experience, normalising the difficulty of change, and framing the disorder as a set of maladaptive strategies that can be replaced by healthier alternatives. Such an approach aligns with the recovery model advocated by the World Health Organization, which emphasises hope, empowerment and person-centred care as central to healing.

To illustrate how these principles translate into practice, consider the case of Maya, a 28-year-old woman who presented to a community mental health team with a diagnosis of Borderline Personality Disorder. Maya reported a history of intense mood swings, recurrent self-harm, and a pattern of unstable relationships that had led to multiple emergency department visits. On intake, her PHQ-9 score was 19, indicating severe depressive symptomatology, and her GAD-7 score was 15, reflecting moderate anxiety. Maya's previous clinicians had described her as "highly volatile" and had discontinued therapy after three sessions, citing a perceived lack of progress.

When Maya entered the new service, the therapist adopted a stance of compassionate optimism, explicitly acknowledging the challenges she faced while affirming a belief that change was possible. The treatment plan incorporated DBT skills training, with a focus on distress tolerance, emotion regulation and interpersonal effectiveness. In parallel, the therapist employed elements of GPM, providing clear psychoeducation about the

nature of BPD, setting collaborative goals and coordinating care with Maya's primary physician to ensure medication stability.

Over the course of twelve weeks, Maya attended weekly individual DBT sessions and a weekly skills group. She learned to identify early warning signs of emotional escalation, practised paced breathing and opposite-action techniques, and gradually reduced the frequency of self-harm episodes from an average of three per week to none by week ten. Her PHQ-9 score fell to 9, moving her into the mild depression range, and her GAD-7 score decreased to 7, indicating mild anxiety. Importantly, Maya reported a renewed sense of agency; she began volunteering at a local community centre, re-established contact with her sister, and expressed confidence that she could maintain these improvements beyond the therapy setting. This concrete example demonstrates how the combination of evidence-based techniques, a hopeful therapeutic stance, and coordinated care can dismantle the untreatability narrative and foster genuine recovery.

The shift from a deficit-oriented perspective to a recovery-oriented one requires deliberate effort at both the individual clinician level and the organisational level. Training programmes must embed modules that challenge stigma, present up-to-date outcome data, and model compassionate communication. Supervision should encourage reflective practice, allowing clinicians to recognise and counteract their own biases. Service policies should promote continuity of care, ensuring that clients are not discharged prematurely on the basis of an erroneous belief in chronicity. By embedding these principles into the fabric of practice, the professional community can begin to erode the twin pillars of stigma and the untreatability myth.

In sum, the belief that personality disorders are untreatable is a myth that inflicts real harm on individuals, clinicians and health systems alike. The evidence, however, is unequivocal: structured, evidence-based psychotherapies such as GPM, MBT, DBT, SFT and emerging transdiagnostic approaches can produce substantial and lasting improvements in symptom severity, functional outcomes and quality of life. A compassionate, hopeful stance, grounded in the recovery model, not only enhances the therapeutic alliance but also serves as a catalyst for change. By rejecting the untreatability myth and embracing the wealth of empirical data, clinicians can offer a narrative of possibility, restoring dignity and hope to those whose

lives have been shadowed by stigma.

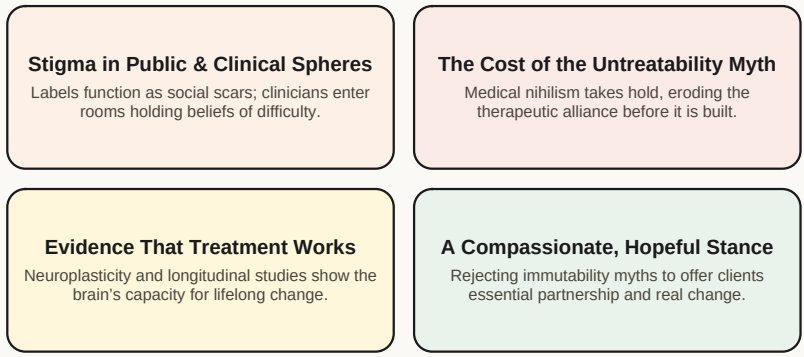


FIGURE 2.1 Challenging the Untreatability Myth
This framework contrasts stigmatising assumptions with clinical evidence, promoting a shift towards hope. It maps the transition from pervasive medical nihilism to evidence-based therapeutic change.

Points worth keeping

- Stigma among the public and clinicians
- The untreatability myth and its cost
- The evidence that treatment works
- A compassionate, hopeful stance

PRACTICE TASK

Write a sentence you could say to a colleague who calls a patient untreatable.