Personality Disorders

Using DSM system
- Longstanding difficulties coded on Axis II
- Idea is to capture developmental concerns
- No real utility to this Axis I vs Axis II distinction

Definition of personality
- This is theoretically determined
- Notion of a “personality” may be rooted in psychodynamic tradition
- Do we have a “personality?”

Trait theory of Personality
- Personality can be defined as a set of traits
  - Traits are relatively enduring patterns of
    - Perceiving the environment
    - Relating to the environment and oneself
    - Thinking about the environment and oneself

Trait theory of Personality
- Problem with trait theory is that traits are not typically consistent over time or situations
- Research on temperament (as an aspect of expressed traits) shows that these are consistent about 10% of the time
  - Environmental conditions account for outcome 90% of the time
  - State vs. trait argument

Personality as Behavior Patterns
- Discriminate between behaviors specific to certain situations and behaviors which occur over a wide range of social and personal situations
  - This allows for both stability and the environment to impact behavior
- Looking for transitiuational consistency
- For enduring patterns of behavior
  - Essential to understand “enduring pattern” as subject to change with time and (especially) situation
What is a “disordered Personality?”

- Consider behaviors as being either effective or ineffective
  - A personality disorder may be a set of ineffective behaviors
- All people engage in a variety of behaviors that are effective and ineffective
  - Karen Horney: three styles
    - moving away, moving towards, moving against
    - said that everyone does these
    - get in trouble when only do one to an extreme

“Disordered Personality” (cont’d)

- Features of behaviors associated with personality disorders
  - inflexible
  - maladaptive
  - cause significant impairment in occupational or social functioning
  - and/or subjective distress

Features of PDs

- These features must
  - be associated with individual over long periods of time
  - not be associated with only discreet episodes as a result of distress or illness
    - e.g., if outbreaks of acute suspiciousness occur during psychotic episodes, but not during episodes of remission, not evidence of a personality disorder

Features of PDs

- Implicit in the definition of personality disorders is continuity over time
- Likely that these occur more in some situations than others
  - i.e. with particular individuals, in particular settings, or in particular periods of distress

Age of Onset of PDs

- for PDs this is difficult to pinpoint
- people begin to form their personalities from the day they’re born
- stable patterns of personality, however, tend to form in late childhood, early adolescence or young adulthood

Problems with diagnosing PDs

- Labeling effects
  - very pejorative, very negative
  - refer to PD diagnosis when you don't like someone
    - “you're passive aggressive.” “paranoid,”
    - call a client “borderline”
Problems with diagnosing PDs

- Implies a poor prognosis (bad outcome)
  - that the PD is unchangeable
  - How do you change a “personality”
- Implies that the problem resides within the client
  - that it’s not due to the environment
  - but that it’s the client’s fault

There is very poor diagnostic reliability with the PDs
- can’t get clinicians to agree always
- except for Antisocial PD
- Some clinicians give up on trying to help the person change
  - many referrals with these cases

Terminology used with PDs

- PDs are described as being experienced as either ego-syntonic or ego-dystonic
- ego-syntonic disorder
  - person does not perceive anything to be problematic about the way he or she is acting or feeling
  - most syntonic PDs are narcissistic and antisocial
- ego-dystonic
  - person experiences some sort of subjective distress

PDs in Treatment

- two reasons people with PDs are in treatment:
  - ego-dystonic present themselves
    - complain generally of anxiety and depression
    - due to the way they interact with the environment
  - those who are ego-syntonic are presented for therapy
    - by spouses, friends, or as the result of a court order

Contextualizing PDs

- What the heck is a personality and how do other cultures see this
  - Are there different cultures with different “classic” personalities?
  - Is one gender, ethnicity, etc. more at risk for being labeled with the PD?
- Need to consider the context in which this “disordered” personality occurs
- Is the behavior distressing to the individual or others (or both)?
  - What does this mean for choice of diagnoses?

Can we talk about a set of behaviors more effectively than a “personality?”

What is the bigger picture where we see these behaviors?
- What is going on in the person’s life?
- May be causing other family/relationship probs
- May be facilitated by family/relationship probs
Case conceptualization with PDs

- From your theoretical position
- Need to
  - Identify source of pathology (Where does this come from?)
    - Intrapersonal?
    - Interpersonal?
    - Developmental?
    - Learned?
    - Cognitive?
    - Underlying pathology that is symbolically represented?

Identify mechanism of change by theory
- examine relevance of theory to this client
  - look for problem with client
- identify steps of behavioral change
  - apply to client and identify behaviors
  - relate these behaviors to each other given theory
  - attempt to alter behavior
  - ASSESS for changes in behaviors

The Paul question and PDs

- "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (Paul, 1969, p. 44)
- What are these "personality" behaviors, for this person, in these circumstances (culture, family, gender, etc.)?
- How do I bring about change with these behaviors for this person?

DSM’s classification of PDs

- Cluster System
- Cluster A: odd or eccentric behavior
  - paranoid PD, schizoid PD, schizotypal PD
- Cluster B: dramatic, emotional, or erratic behaviors
  - borderline PD, histrionic PD, narcissistic PD, antisocial PD
- Cluster C: anxious or fearful characteristics
  - avoidant PD, dependent PD, obsessive compulsive PD

Cluster A

- These are behavioral patterns that are characterized by behaviors that are
  - strange
  - odd
  - bizarre
  - see very odd relationships with others
    - tend to keep a distance from others

Paranoid PD

- these people have a very suspicious style
  - they are guarded, hold grudges against people, look out for someone to be tricking them
- cold and aloof
- distinguishing characteristic from schizophrenia is that there are no delusions or hallucinations like you see in schizophrenia
Schizoid PD

- very socially isolated, no close relationships of any sort -- loners
- tend to be indifferent to praise or criticism (kind of unreachable)
- show very little emotion
- the biggest feature is that they don’t like being around other people
- distinguished from schizophrenia in that they are NOT of touch with reality
  - looks like the prodromal phase of schizophrenia sometimes

Schizotypal PD

- very odd thoughts or appearance (or both)
- these people are extremely eccentric
- tend to be excessively superstitious
- have “magical thinking”
  - can hear other people’s thoughts and can send thoughts

Schizotypal PD

- often they are isolated from other people
- have odd speech patterns, but not the kind you see in schizophrenia
- have been described as hanging on the edge of reality

Does cluster A predict Schizophrenia?

- Researchers predicted that if these individuals were subjected to a sufficient amount of stressors, they would become schizophrenic (e.g. Meehl, 1948)
- Research does not support this completely
  - Premorbid PD predicts poor outcome

Cluster A Treatment Considerations

- May not see much change
- These clients do not typically present themselves for treatment
- May aim for prevention of deterioration
  - Patient education
  - “Symptom Management”

Cluster B

- These behavioral patterns are characterized as
  - Dramatic
  - Erratic
  - Emotional
  - See very dependent or hostile interactions with others
Borderline PD
- characterized by instability in relationships, mood, and self-image
- person has a disturbed sense of self and how she or he relates to others
- cannot stand to be alone
  - major fears of abandonment
- because the mood fluctuations are so wild, must R/O a mood disorder
- often see drug and alcohol abuse

Borderline PD
- see extreme fluctuations in relationships, either love or hate the other person
- these people are often very angry at and/or hostile toward the world
- you see a lot of drug and alcohol problems here
- these people tend to be very impulsive - especially in sexual relationships

Borderline PD
- often see eating disorders in this group
- they feel very empty inside, have no sense of self
  - Sometimes will fill this void with food
- when there are bad environmental stressors they tend to fall apart, begin to look psychotic
  - Probably where the term came from

Borderline PD
- Much comorbidity
  - Substance abuse
  - Eating disorders
  - MDD
  - PTSD
  - Relational problems

Suicidality and Parasuicidality
- suicidal feelings
  - in a great deal of pain
  - often dealing with overwhelming histories
- they often get labeled as being manipulatively suicidal
  - this may be a move to avoid abandonment

Suicidality and Parasuicidality
- parasuicidal behaviors
  - not a suicide attempt
  - may engage in self-mutilation
    - surface cutting, burning
    - risk is that it will produce an actual response
    - may be a distracter from emotional pain
    - this may ground the person if they can feel pain at times when they feel disconnected from the world
What is it that they are on the border of?

- see overlap with:
  - antisocial PD - impulsive and manipulative
  - narcissistic PD - overly sensitive to criticism, see hostility
  - histrionic PD - manipulative, projective, attention seeking

BPD Treatment Considerations

- Consider Dialectical Behavior Therapy (DBT) by Linehan
  - DBT research show it to be an effective approach to BPD
    - Focus on basic coping skills
    - Focus on cognitive behavioral skills
    - Focus on social skills

DBT

- Research seems to be revealing 3 outcomes with DBT
  - 1/3 not affected
  - 1/3 stabilized
  - 1/3 improved (hospitalizations)
- Appears to be more effective for individuals who self-injure and have low level of functioning

DBT outcome data

- Cost savings: $10,000 per patient/per year
  - Heard (1994)
- Linehan, Armstrong, Suarez (1991)
  - Treatment vs. No treatment (control)

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<th>Self-mutilation acts</th>
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<td>1.5 acts</td>
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<tr>
<td>No treatment</td>
<td>39 days</td>
<td>9 acts</td>
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Histrionic PD

- see this more often in females
- overly dramatic, very seductive style
- use seduction to get what they want
- don't usually have happy, successful, intimate relationships
- have difficulty relating to people intimately in a normal way

Histrionic PD

- don't feel like they have the ability to get people to do things in a normal way
- seen as charming, but tend to be shallow and vain
- get easily overwhelmed by emotions
- often seen as the female equivalent of antisocial PD
- get very angry or demanding when needs are not met
Histrionic PD Treatment

- Historically very psychoanalytic and psychodynamic
  - Treatments were long-term
  - No research evidence to support their effectiveness
- Cognitive Therapy of Personality Disorders

Narcissistic PD

- Grandiose view of him or herself and his or her abilities; often arrogant, pompous
- These people are preoccupied with fantasies of enormous fame and success
- These people lack empathy for others

Narcissistic PD Treatment Implications

- Consider not pushing against the narcissistic style
- Use “judo” moves here
  - Step out of the way of the attack
- Consider an interpersonal therapy approach
  - May not be able to argue them out of their style

Antisocial PD

- A.K.A. psychopath, sociopath -- sociopath is probably closer to the mark
- Person must be at least 18 years old
- Before the age of 15, had record of truancy from school, delinquent behavior, ran away from home, persistently lied, set fires, tortured animals, etc.

Antisocial PD

- Manipulative, exploitative
- Dishonest, disloyal
  - Have problems honoring financial agreements
  - No problem lying to save self when needed
- Lacking in guilt
- Habitually break social rules
- Often in trouble with the law
- Aggressive
Antisocial PD

- complaint with this disorder is that the definition is related too much to illegal behavior
- not so much a PD, but is dependent on the law
- this behavior cannot be due to severe mental retardation, schizophrenia, or manic episodes

ASPD Treatment Implications

- Unclear what the real treatment approach is here
- Try to keep them from getting into trouble with law
- Prevent violations against others
- Difficulty with 2-4 MMPI profile with outcome

Cluster C

- anxious or fearful behaviors
- people have a difficult relationships with others due to anxieties related to attachment

Avoidant PD

- “Pathological shyness”
- very sensitive to shame or social rejection
- cluster A people don’t care about shame or social rejection
- easily hurt and embarrassed
- stick to routines to avoid new and possibly stressful situations

Avoidant PD

- have few close friends
- low self-esteem
- they want to be close to people but are afraid to
- minimize the good, overestimate the bad
- as expected, these people tend to be sad

Avoidant PD

- Must differentiate from social phobia
  - Social phobia is fear of performance evaluation
    - It is very specific
    - Tend to have good relationships and are not fearful of evaluation except in (e.g.) public speaking
- Avoidant PD would be fearful of evaluation and afraid of relationships
Avoidant PD Treatment Considerations
- May consider exposure based treatment here
- Need to have a great deal of compassion
- Consider using in-session opportunities for practicing skills

Dependent PD
- want others to make decisions for them
- feel incompetent and helpless
- need constant advice and reassurance
- fear being abandoned

Dependent PD
- tend to be submissive and clinging to others
- manipulates others into making decisions for her or him
  - but if the decision produces unsatisfactory results, she or he is resentful
- very little to no self-confidence

Obsessive Compulsive PD
- "anal-retentive PD"
- This not the same as OCD
- Perfectionistic
- overly conscientious
- indecisive
- preoccupied with details
- rigid
- unable to express affection
  - usually distant, not very warm

Obsessive Compulsive PD
- real difficulty in relationships comes from him or her wanting everything her or his way
- must maintain control of situations
- these people are good at research and accounting