Personality Disorders

- Using DSM system
  - Longstanding difficulties coded on Axis II
  - Idea is to capture developmental concerns
  - Often described as problems more “interpersonal” in nature

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.

“Disordered Personality”

- 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

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”

- 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
Problems with diagnosing PDs

- 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

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 characterized by behaviors that are
Strange
Odd
Bizarre
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 B

These behavioral patterns are characterized as
- Dramatic
- Erratic
- Emotional
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
Suicidality and Parasuicidality

- Suicidal feelings
  - in a great deal of pain
  - often dealing with overwhelming histories
  - genuinely attempt here
  - BPD patients 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 outcome data

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

<table>
<thead>
<tr>
<th>Hospitalization days</th>
<th>Self-mutilation acts</th>
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<tr>
<td>Treatment</td>
<td>8.5 days</td>
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<tr>
<td>No treatment</td>
<td>39 days</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

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
- tend to take more than they can give in relationships
- Need others to tell them that they are important
  - But will deny that they need anyone
  - Defended against feelings of attachment
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
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

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”
- Not the same as OCD
- Perfectionistic
- Overly conscientious

Obsessive Compulsive PD

- 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