Personality Disorders

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Lecture Outline

- Nomothetic & idiographic approaches
- Millon's nomological principles
- Definitions –character, temperament, personality
- Personality Disorders – Clusters A, B & C
- Epidemiology
- Treatment considerations

The study of personality

Gordon Allport (1937) proposed two approaches to the study of personality

1. *Nomothetic* – focused on principles and general laws that can be applied to a large number of people
2. *Idiographic* – focused on the unique aspects of a particular individual

The study of personality

Gordon Allport (1937) pursued the *nomothetic* approach, the search for universal truths in personality and for commonalities and regularities between people - asks about the "*what?*"

The study of personality

Henry Murray (1938) pursued the *idiographic* approach, the search for particular truths about particular persons - asks about the "*how*?" and the '*why*?"

Disorders of personality

- "Ask not what disease the patient has, but rather who the patient is who has the disease." Theodore Millon, in *Disorders of personality. DSM-IV and beyond* (1996)

- Millon is one of the proponents of a multiaxial format of the DSM.

Millon's nomological principles:

1. Personality disorders are not diseases.
2. Personality disorders are internally differentiated functional and structural systems, not internally homogeneous entities.
3. Personality disorders are dynamic systems, not static, lifeless entities.

Millon's nomological principles:

4. Personality consists of multiple units at multiple data levels.
   (biophysical & phenomenological)
5. Personality exists on a continuum: no sharp division is possible between normality and pathology.
6. Personality pathogenesis is not linear, but sequentially interactive and multiply distributed throughout the entire system.

Millon's nomological principles:

7. Criteria by which to assess personality pathology should be logically coordinated with the systems model itself:
   - Tenuous stability
   - Adaptive inflexibility
   - Vicious (self-defeating) circles

Millon's nomological principles:

8. Personality disorders may be assessed, but not definitively diagnosed.
9. Personality disorders require strategically planned and combinatorial modes of tactical intervention (i.e., the interdependency and synergistic tenacity of personality argues for interventions that are not only multidomained but also coordinated across time in a logical fashion)

Temperament & Character

- **Temperament** = the *biologically based* dispositions that underlie the energy level and color the moods of the individual.

- **Character** = Personal qualities that represent the individual's *adherence to the values and customs of society*

Persona

The word
'personality'
is derived from
the Greek term
persona,
originally representing
a theatrical mask

Personality

Personality is a complex pattern of deeply embedded psychological characteristics that are largely unconscious and not easily altered, a complicated matrix of biological dispositions and experiential learnings, and comprises the individual's distinctive patterns of perceiving, feeling, thinking, coping & behaving

Millon, 1996

Personality Traits

- Enduring patterns of perceiving relating, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts
- Only when personality traits are inflexible, maladaptive and cause significant functional impairment or subjective distress they constitute Personality Disorders

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Personality Disorder

Enduring pattern of subjective experience and behavior based in personality development

- Onset in adolescence or early adulthood
- Deviant from cultural expectations of the individual's culture Manifested in 2 or more areas: cognition, affectivity, interpersonal functioning, impulse control
- Inflexible and pervasive across a broad range of personal and social situations
- Leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning

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Personality Disorder

- Characteristics
  - Onset in adolescence or early adulthood
  - Stable and of long duration
  - Not a manifestation or consequence of another mental disorder
  - Not due to the direct physiological effects of a substance or a general medical condition
- People with *personality disorders* do not have periods of remission, change in severity of symptoms or improvement over time.

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Personality Disorders Clusters

- **Cluster A** (*odd or eccentric*)
  - Paranoid – suspicious
  - Schizoid – detached
  - Schizotypal – eccentric

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Personality Disorders Clusters

- **Cluster B** (*dramatic, emotional, or erratic*)
  - Borderline – unstable
  - Histrionic – attention-seeking
  - Narcissistic – grandiose
  - Antisocial – non-conforming

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Personality Disorders Clusters

- **Cluster C** (*anxious or fearful*)
  - Avoidant – inhibited
  - Dependent – submissive
  - Obsessive-Compulsive - perfectionistic

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301.0 Paranoid PD

301.0 Paranoid PD

Key features:

- *Pervasive distrust* of other people who are perceived as threatening or hostile.
- Constantly '*on guard*', assuming and behaving as if in danger & others were exploitive & deceptive
- Great *need for self-sufficiency* & autonomy

301.0 Paranoid PD

Key features:

- Want *tight control* over their environment
- Keenly *aware of dominance hierarchies*, power and rank – difficulty with authority
- *Quick to anger*. May be pathologically jealous

301.0 Paranoid PD

Epidemiology

- 0.5 to 2.5 % of the general population
- 2% - 10% among outpatient population
- 10%-30% among psychiatric inpatients

- Rarely seek treatment
  - Usually referred by employer or spouse
  - Disorder is more common in men than women (in clinical settings)

301.0 Paranoid PD

Differential diagnosis issues:

- Assess history of trauma & possibility of PTSD

- Assess the possibility of real persecution, discrimination, abuse, humiliation in the person's social environment

301.0 Paranoid PD

Differential diagnosis issues:

- Assess cultural values & norms
  - Members of minority groups, immigrants, political and economic refugees, different ethnic groups may display guarded or defensive behaviors

301.20 Schizoid PD

301.20 Schizoid PD

Key features:

- *Restricted range of emotions*
- Feeling *awkward & uncomfortable* in social situations
- *Pervasive detachment* from social relationships
- Appear to have *no desire to have social contacts*

  Emotional disengagement may be an adaptation to a painful environment

  (Castillo, 1994)

301.20 Schizoid PD

Epidemiology

- Unknown prevalence
- Uncommon in clinical settings

301.22 Schizotypal PD

301.22 Schizotypal PD

Key features:

- *Anxiety* in social relationships
- *Eccentric behaviors* (e.g., superstitiousness, magical thinking, preoccupation with paranormal phenomena, use of rituals in everyday situations) – when inconsistent with prevailing cultural schemes

301.22 Schizotypal PD – Criterion A

A pervasive pattern of social and interpersonal deficits marked by acute *discomfort with, and reduced capacity for, close relationships* as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

301.22 Schizotypal PD – Criterion A

- *Ideas of reference* (excluding delusions of reference)
- *Odd beliefs or magical thinking* that influences behavior and is inconsistent with sub-cultural norms(e.g. telepathy, superstitiousness)
- *Unusual perceptual experiences*, including body illusions

301.22 Schizotypal PD – Criterion A

- *Odd thinking and speech* (e.g. vague, overelaborate, or stereotyped)
- Suspiciousness or paranoid ideation
- *Inappropriate or constricted affect*
- Behavior or appearance that is odd, eccentric, or peculiar

301.22 Schizotypal PD – Criterion A

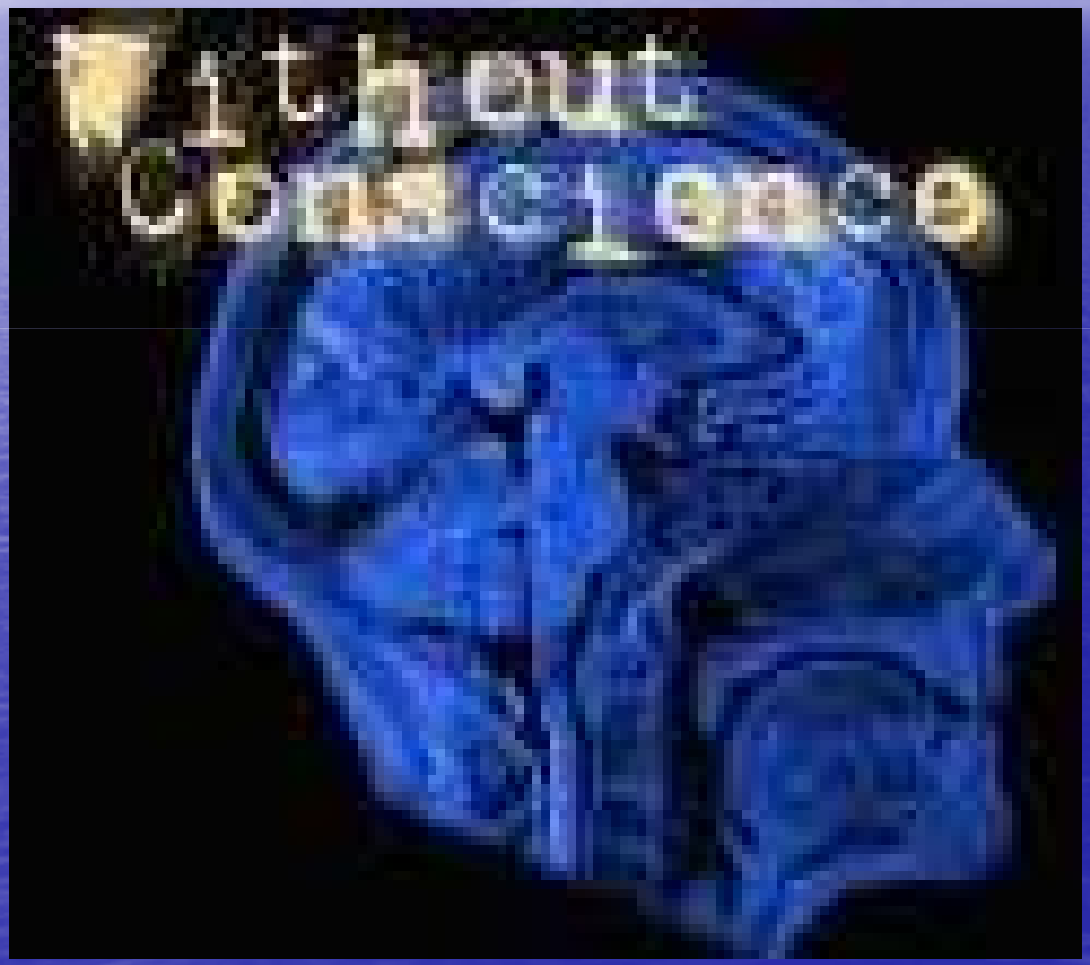
- *Lack of close friends* or confidants other than first-degree relatives
- *Excessive social anxiety* that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

301.22 Schizotypal PD

Epidemiology

- 3% of the general population
- Higher prevalence among monozygotic twins & in individuals with biological relatives diagnosed with schizophrenia
- May be prodromal to schizophrenia

301.7 Antisocial PD (APD)



301.7 Antisocial PD (APD)

Key features:

- *Deceit to gain personal profit or pleasure*, with *little or no remorse* for their actions
- Persistent pattern of *victimizing others*

- Begins in childhood or early adolescence
- Continues into adulthood

301.7 Antisocial PD (APD)

A. Pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three or more of the following:

1) failure to conform to social norms with respect to the law (multiple arrests)

2) Deceitfulness (lying, conning, use of alias)

3) Impulsivity

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301.7 Antisocial PD (APD)

A. (continued)

4) Irritability & Aggressiveness

5) Reckless disregard for safety of self and others

6) Consistent irresponsibility (work, financial obligations)

7) Lack of remorse, indifferent/rationalize/ minimize having hurt, mistreated or stolen from another.

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301.7 Antisocial PD (APD)

B. Individual is at least 18 years old.

C. Evidence of Conduct Disorder with onset before 15 years old.

C. Antisocial behavior is not exclusively during the course of Schizophrenia or Manic Episode.

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301.7 Antisocial PD (APD)

Key features:

- Persistent pattern of *victimizing others* through theft or destruction of property, physical assault
- *Deceit to gain personal profit* or pleasure
- *Little or no remorse* for their actions (may blame victim for being foolish, naïve, weak, etc.)
- Feelings of *entitlement*

301.7 Antisocial PD

Associated Features

- Frequently *lacks empathy* and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others
- May have an *inflated and arrogant self-appraisal* and may be excessively opinionated, self-assured

301.7 Antisocial PD

- May be irresponsible as parent as evidenced by malnutrition, poor hygiene, and illness
- May display a *superficial charm*
- *Impulsive behaviors & substance abuse* likely

301.7 Antisocial PD

- May be irresponsible and *exploitive* in sexual relationships. May have history of *many sexual partners* and may never have sustained a monogamous relationship.
- Complaints of tension, *inability to tolerate boredom, and depressed mood*.

301.7 Antisocial PD

- Are more likely to *die prematurely* by violent means (suicide, accidents, and homicides).

  More likely to develop in hierarchical & egocentric societies (Castillo, 1994)

301.7 Antisocial PD

Epidemiology

- 3% of men and less than 1% of women in the general population

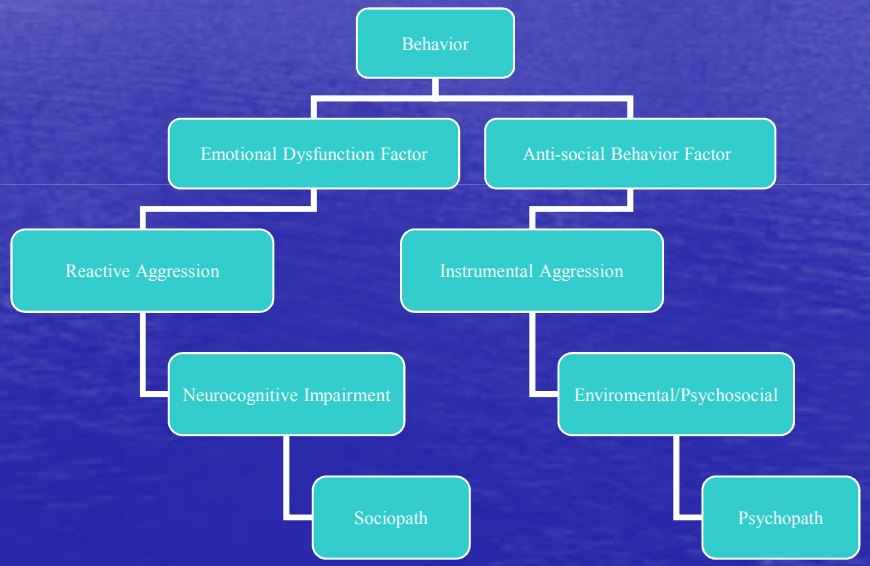
- 3% to 30% in clinical settings, depending on the type of setting and characteristics of the clinical population sampled

Alternate terms

- Psychopathy, sociopathy, dyssocial personality disorder
- Prior to the DSM-III, *psychopathy* was a term used to denote a personality disorder characterized by an abnormal lack of empathy and a strongly amoral conduct in individuals who appeared outwardly normal

Robert Hare's Psychopathy Checklist (PCL)

- PCL was developed based on Cleckley's model to asses ASPD not diagnosable due to lack of CD history. PCL is divided into two factors illustrated in this chart →



301.83 Borderline PD

301.83 Borderline PD

Key features:

- Persistent *instability in social relationships, self-image, & emotions* - impulsive
- *Fear of abandonment or rejection*
- Extreme sensitivity to social environment

301.83 Borderline PD

Key features:

- Intense *unmet needs for affection* & closeness – frantic efforts to gain attention & affection
- *Intolerance of being alone* – emptiness, boredom
- Brief episodes of hallucination, depersonalization, derealization may occur

301.83 Borderline PD – DX criteria

5 or more of the following 9 sxs:

1. Frantic efforts to *avoid abandonment*
2. Pattern of *unstable & intense interpersonal relationships*
3. Identity disturbance – *unstable self* image
4. *Impulsivity* in at least two areas

301.83 Borderline PD – DX criteria

5 or more of the following 9 sxs (continued)

5. Recurrent *suicidal/parasuicidal behaviors* or threats, or self-mutilating behaviors
6. *Affective instability*
7. Chronic feelings of *emptiness*
8. Inappropriate *anger*
9. Dissociative symptoms or paranoid ideation

301.83 Borderline PD

Epidemiology - Prevalence

- 2% in the general population
- 10% of the outpatient population
- 20% of the psychiatric inpatient population
- 30% - 60% of individuals diagnosed with a personality disorder

DSM-IV

301.83 Borderline PD

Who meets BPD criteria?

- 11% of all psychiatric patients
- 19% of all psychiatric inpatients
- 33% of outpatients with a personality disorder
- 63% of inpatients with a personality disorder

Linehan, 1993

301.83 Borderline PD

- 74% of BPD patients are female
- 70-75% of BPD patients have a history of at least one self-injurious act
- 9-10% eventually commit suicide

Linehan, 1993

301.83 Borderline PD

Course- Most common pattern

- Chronic instability in early adulthood
- Recurrent episodes of affective and impulse dyscontrol/dysregulation
- High levels of use of health and mental health services

301.83 Borderline PD

Psychoanalytic etiological models for BPD

- Kohut, 1971 (Self Psychology): Failure of parents/caregivers to empathize with the child, to provide mirroring and idealizing responses results in frustration and activation of instinctual aggression, intense anger & destructive impulses, rigid defense structure & deficiency in the formation of the self.

301.83 Borderline PD

Psychoanalytic etiological models for BPD

- Kernberg, 1975 (Object Relations): Fixation during the *separation-individuation phase of development, the rapprochement subphase* - due to disturbance in mother's emotional availability. BPD patients can be viewed as repeatedly reliving an early infantile crisis, fearing abandonment & unable to tolerate being alone (lack of object constancy).

301.83 Borderline PD

Trauma etiology of BPD

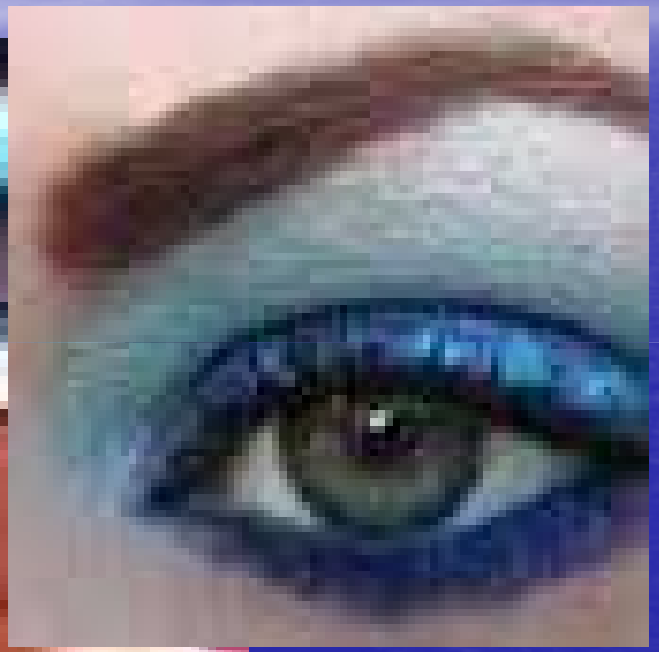
- Van der Kolk (1994) - only approximately 10% of the BPD patients did not have a history of trauma.
  - Population studies show that although 30-60% of women experience childhood sexual abuse, only about 2% are diagnosed with BPD.
  - A ***history of abuse is not a necessary, nor a sufficient cause of BPD***.

301.83 Borderline PD

Trauma etiology of BPD

- Herman & Van der Kolk hypothesized that other factors related to a history of trauma contribute to the development of BPD: experience of shame; (biparental) neglect; separations; a sense of disempowerment and disconnection from others/social isolation; lack of secure attachments; constitutional factors

301.50 Histrionic PD



301.50 Histrionic PD

Key features:

- Excessive *emotionality* & *attention-seeking* behavior
- Overly dramatic, enthusiastic, flirtatious
- Excessive attention to personal appearance, overly *sexual & seductive*

301.50 Histrionic PD

Prevalence:

- 2% - 3% in the general population (limited information is available)
- Inconsistent data regarding gender ratio (some studies suggest higher prevalence in women)

301.81 Narcissistic PD (NPD)

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Key features:

- Intense *need for admiration*
- Obsession with *grandiosity* – devaluing others; association only with the elite
- *Lack of empathy*

301.81 Narcissistic PD

5 or more of the following:

- *Grandiose sense of self-importance* (e.g., exaggerates achievements and talents, expects to be recognized as superior)
- Preoccupied with *fantasies of unlimited success, power, brilliance, beauty*, or ideal love
- Believes he/she is "*special*" and can only be understood or should associate with other special or high status people (or institutions)

301.81 Narcissistic PD

5 or more of the following:

- Requires *excessive admiration*
- Has a sense of *entitlement* (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his/her expectations)
- *Interpersonally exploitative* (i.e., takes advantage of others to achieve his/her needs)

301.81 Narcissistic PD

5 or more of the following:

- *Lacks empathy*; is unwilling to recognize or identify with the feelings or needs of another
- Often envious of others or believes that others are envious of him/her
- Shows *arrogant, haughty behaviors* or attitudes

301.81 Narcissistic PD

Prevalence:

- Less than 1% in the general population
- 2% to 16% in the clinical population

Narcissism

- *Healthy narcissism* = need for positive self regard
- *Unhealthy narcissism* = when the individual has undue concern for:
  - Age
  - Perfectionism
  - Being admired

Narcissistic features & NPD

- Many successful individuals display personality traits that might be considered narcissistic.
- Only when these traits are inflexible, maladaptive, persisting, and cause significant functional impairment or distress do they constitute NPD

301.82 Avoidant PD

301.82 Avoidant PD

Key features:

- Sense of *inadequacy*, *low self-esteem*
- *Hypersensitivity to criticism*
- *Social anxiety* – avoidance of social interactions for fear of rejection, criticism, humiliation

301.82 Avoidant PD

Prevalence:

- Less than 1% in the general population
- Approx. 10% in outpatient clinical population

- Variability among ethnic groups regarding avoidance; may be the result of problems of acculturation among immigrant population

301.6 Dependent PD

301.6 Dependent PD

Key features:

- *Submissive*, clinging behaviors
- *Fear of separation* & independence
- *Excessive need to be taken care of*
- *Self-effacing* & *self-sacrificing*

301.6 Dependent PD

Prevalence:

- One of the most frequently reported PD in mental health clinics

301.4 Obsessive-Compulsive PD

301.4 Obsessive-Compulsive PD

Key features:

- Persistent ***preoccupation with order, perfection***
- ***Attention to details, rules & control***
- Rigid, inflexible, dogmatic

301.4 Obsessive-Compulsive PD

Prevalence:

- 1% in the general population
- 3% to 10% in outpatient clinical population

OCPD – Differential diagnosis

- If the patient meets criteria for both OCD and OCPD, *both can be diagnosed*

Treatment considerations

- *Establish the frame, clear boundaries about the psychotherapeutic work*:
  - create a 'holding environment'
  - clear yet 'permeable' & flexible structure
  - explicit rules
  - open to restructuring

Treatment considerations for PD

- *Reconstructive psychotherapy*:
  If you take something away, you need to replace it with something else that is more constructive

- Instill hope and provide alternatives & structure

Gabbard, 2005

Treatment considerations

Antisocial PD

- Fear of intimacy, poor rapport
- Clients do not accept criticism or direction
- Medication is often abused
- Firm limits
- Alcoholics Anonymous

Treatment considerations

Psychotherapy with borderline patients is difficult, stress great & outcome uncertain.

Gabbard, 2005

Treatment considerations

Psychoanalytic-based tx for BPD

- *Nonintensive/supportive therapy* (advice, education, reassurance, self-disclosure) - to help patient adapt & feel better

Treatment considerations

Psychoanalytic-based tx for BPD

- *Intensive/exploratory - Expressive interventions (long-term of intensive, hard work); requires experienced therapist & availability of a social support network*

Treatment considerations

Gabbard (2005) proposed, as a general rule:

Higher level BPD, with greater ego strength and psychological-mindedness, will be more able to utilize expressively oriented psychotherapy than those closer to the psychotic border who will need a supportive emphasis.

Treatment considerations

Technical principles in therapy with BPD:

- *Stable treatment framework* (i.e., consistent appointment times, ending sessions on time, clear expectations regarding fee payment, explicit policy about missed appointments)
- Avoidance of a passive therapeutic stance (i.e., be *present and real*)

Treatment considerations

Technical principles in therapy with BPD:

- *Contain patient's anger* - supportive inquiries and empathic understanding can be helpful
- *Confront self-destructive behaviors*.
- *Establish a connection between feelings and actions* (often action is the language of the borderline patient)

Treatment considerations

Technical principles in therapy with BPD:

- *Limit setting* - ground rules about maintaining professional boundaries
- Maintain the focus of interventions in the here-and-now
- *Monitor countertransference* feelings.

Treatment considerations

Cognitive-behavioral based

- *Schema-focused therapy* - Jeffrey Young (1992) - *EMS*
- Marsha Linehan (1993): *Dialectical Behavior Therapy* - Skill-building to *enhance emotional regulation*

Treatment considerations

- Clinical management of self-destructive behaviors*:*
- *Hospitalization* (to provide sustained preventive restrictions)
- *Outpatient*: discuss P's responsibility to maintain one's safety; T's 'saving response' needs to be clarified and interpreted

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