Personality Disorders
Personality Disorders: An Overview

• Difference between “personality”

• Where it goes on the Axis lines
  – There can be multiple axis 1 and 2 disorders, but this goes on 2!
    • This is so clinicians don’t mistakenly attribute Axis I disorders; this process requires clinicians to questions each PD symptom.

• Relatively Permanent Pattern
  – Enduring and pervasive predispositions
    • Perceiving
    • Relating
    • Thinking

• Inflexible and maladaptive
  – Distress
  – Impairment
Personality Disorders

- Begins in early childhood, last whole life.
- Distressful to self and others!
- Can’t diagnose in adolescence?
- 10 specific personality disorders
  - Several under review for DSM-V
- 3 clusters
- High comorbidity with Axis I disorders
  - Poorer prognosis
- Therapist reactions
  - Countertransference
    • Bad for clusters A and B in particular
Categorical vs. Dimensional Views

- Personality may fit better in degree because everybody has these characteristics to some extent.

- “Kind” vs. “Degree”

- DSM is categorical
  - Reifies concepts
  - Less flexible
  - Loss of individual information
  - Sometimes arbitrary

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<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Five-Factor Model</strong></td>
<td></td>
</tr>
<tr>
<td>Neuroticism</td>
<td>Proneness to psychological distress and impulsive behavior</td>
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<tr>
<td>Extroversion</td>
<td>Tendency to join in social situations and feel joy and optimism</td>
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<tr>
<td>Openness to experience</td>
<td>Curiosity, receptivity to new ideas, and emotional expressiveness</td>
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<tr>
<td>Agreeableness</td>
<td>Extent to which someone shows both compassion and hostility toward others</td>
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<tr>
<td>Conscientiousness</td>
<td>Degree of organization and commitment to personal goals</td>
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<td><strong>Westen and Shedler Model</strong></td>
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<tr>
<td>Psychological health</td>
<td>Ability to love others, find meaning in life, and gain personal insights</td>
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<tr>
<td>Psychopathy</td>
<td>Lack of remorse, presence of impulsiveness, and tendency to abuse drugs</td>
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<tr>
<td>Hostility</td>
<td>Deep-seated ill will</td>
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<tr>
<td>Narcissism</td>
<td>Self-importance, grandiose assumptions about oneself, and tendency to treat others as an audience to provide admiration</td>
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<tr>
<td>Emotional dysregulation</td>
<td>Intense and uncontrolled emotional reactions</td>
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<tr>
<td>Dysphoria</td>
<td>Depression, shame, humiliation, and lack of any pleasurable experiences</td>
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<tr>
<td>Schizoid orientation</td>
<td>Constricted emotions, inability to understand abstract concepts such as metaphors, and few or no friends</td>
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<tr>
<td>Obsessivity</td>
<td>Absorption in details, stinginess, and fear of dirt and contamination</td>
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<tr>
<td>Thought disorder</td>
<td>Such as believing one has magical powers over others or can directly read their minds</td>
</tr>
<tr>
<td>Oedipal conflict</td>
<td>Adult pursuit of romantic partners who are already involved with others, inappropriate seductiveness, and intense sexual jealousy</td>
</tr>
<tr>
<td>Dissociated consciousness</td>
<td>Fragmenting of thought and perception often related to past sexual abuse</td>
</tr>
<tr>
<td>Sexual conflict</td>
<td>Anxieties and fears regarding sexual intimacy</td>
</tr>
</tbody>
</table>

Difficult to tell if these PDs are extreme versions of otherwise normal personality variations (dimensions)
Or, ways of relating that are different form psychologically healthy behavior (categories)
Personality Disorders: An Overview

• Q-sort vs. Lexical retrieval models:
• Obvious problems for practicality (clinically but not for research)
• Five factor model of personality (“Big Five”)
  – Openness to experience
  – Conscientiousness
  – Extraversion
  – Agreeableness
  – Emotional stability
DSM Personality Disorder Clusters

- Cluster A: **Odd or eccentric**  
  - Paranoid, schizoid, schizotypal

- Cluster B: **Dramatic, emotional, erratic**  
  - Antisocial, borderline, histrionic, narcissistic

- Cluster C: **Fearful or anxious**  
  - Avoidant, dependent, obsessive-compulsive
Personality Disorders: Facts and Statistics

• Prevalence = 0.5 - 2.5%,

• Origins and Course
  – Begin in childhood
  – Chronic course
  – High comorbidity
Gender Differences

- Differences in diagnostic rates
  - Borderline (75% female)

- Clinician bias
  - Study of antisocial symptoms where male and female label was switched
  - When male (APD), female (histrionic)

- Assessment bias
  - Measures

- Criterion bias
  - Histrionic = extreme “stereotypical female”
  - No “macho” disorder
Personality Disorders Under Study

• Individual disorders
  – Sadistic
  – Self-defeating

• Categories of disorders
  – Depressive
  – Negativistic
    • Passive aggressive

TABLE 12.3 Diagnostic Criteria for “Independent” Personality Disorders

A. Puts work (career) above relationships with loved ones (for example, travels a lot on business, works late at night and on weekends).
B. Is reluctant to take into account others’ needs when making decisions, especially concerning the individual's career or use of leisure time, for example, expects spouse and children to relocate to another city because of individual’s career plans.
C. Passively allows others to assume responsibility for major areas of social life because of inability to express necessary emotion (for example, lets spouse assume most child-care responsibilities).
Cluster A: Paranoid Personality Disorder

- **Clinical Description**
  - Mistrust and suspicion
    - Pervasive
    - Unjustified
  - Few meaningful relationships
  - Volatile
  - Tense
  - Sensitive to criticism
Cluster A: Paranoid Personality Disorder

• Causes
  – Mistaken attributions
  – Placing own “bad” thoughts on everyone
  – Possible role of early experience
    • Trauma
    • Abuse
    • Learning
      – “World is dangerous”
Cluster A: Paranoid Personality Disorder

- Treatment
  - Unlikely to seek on own
    - Crisis
  - Focus on developing trust
  - Cognitive therapy
    - Assumptions
    - Negative beliefs
  - No empirically-supported treatments
Cluster A: Schizoid Personality Disorder

• Clinical Description
  – Appear to neither enjoy nor desire relationships

  – Limited range of emotions
    • Appear cold, detached

  – Appear unaffected by praise, criticism
    • Unable or unwilling to express emotion

  – No thought disorder
• The Diagnosis of Schizoid Personality Disorder

Daryl is a 28-year-old male who lives in an apartment above his parents’ garage. Because he tends to avoid interacting with his family, his parents felt that he would feel happy about the move to his own space. He appeared indifferent to the change. Daryl works as a computer programmer in a small firm and is in danger of losing his job. His supervisor is becoming frustrated because Daryl seems indifferent to feedback or criticism. His co-workers describe him as a “loner” and report being disconcerted by his apparent lack of emotion. Daryl’s mother complains that he never smiles or frowns at anything. When she tries to include him in family activities, he appears cold and detached. Daryl has little interest in making friends and has never been in a romantic relationship. He has never been excited by the prospect of sexual intercourse. Although he spends most of his free time building models of airplanes, he does not overtly enjoy this activity. When complimented about his airplanes, Daryl appears not to notice or to care.
Cluster A: Schizoid Personality Disorder

• Causes
  – Limited research
  – Precursor: childhood shyness

  – Possibly related to:
    • Abuse/neglect
    • Autism
    • Dopamine
Cluster A: Schizoid Personality Disorder

• Treatment
  – Unlikely to seek on own
    • Crisis
  – Focus on relationships
  – Social skills therapy
    • Empathy training
    • Role playing
    • Social network building

  – No empirically-supported treatments
Cluster A: Schizotypal Personality Disorder

• Clinical Description
  – Psychotic-like symptoms
    • Magical thinking
    • Ideas of reference
    • Illusions
  – Odd and/or unusual
    • Behavior
    • Appearance
  – Socially isolated
  – Highly suspicious
Cluster A: Schizotypal Personality Disorder

• Causes
  – Schizophrenia phenotype?
    • Lack full biological or environmental contributions
    • Preserved frontal lobes

Cognitive impairments
  • Left hemisphere?
  • More generalized?
• Culture Mistakes may lead to misdiagnosis here:

• Precursor to schizophrenia may be accidentally labeled as SPD.
  – We know that this is the case as 1/3\textsuperscript{rd} of adolescents meeting criteria for SPD convert to schizophrenia.
Positive Symptoms

- Perceptual Aberrations
- Confusion about what is real and what is imaginary; feeling like your mind is playing tricks on you
- Feeling that people are taking special notice of you or singling you out; paranoid thinking
- Feeling that your ideas or behaviors are being controlled by outside forces
- Unrealistic ideas of special identity or abilities
- Preoccupation with the supernatural (telepathy, ghosts, UFOs)
Cluster A: Schizotypal Personality Disorder

• Treatment Options
  – Treatment of comorbid depression
  – Antipsychotic medications (lowest dose)
    • May prevent onset or improve the outcome.
  – Multidimensional approach
    • Social skill training
    • Antipsychotic medications
    • Community treatment
Cluster B: **Antisocial Personality Disorder**

- **Clinical Description**
  - Noncompliance with social norms
  - “Social Predators”
    - Violate rights of others
    - Irresponsible
    - Impulsive
    - Deceitful
  - Lack a conscience, empathy, and remorse
Cluster B: Antisocial Personality Disorder

• **Nature of psychopathy**
  – Glibness/superficial charm
  – Grandiose sense of self-worth
  – Proneness to boredom/need for stimulation
  – Pathological lying
  – Conning/manipulative
  – Lack of remorse

• Overlap with ASPD, criminality
  – Intelligence
Cluster B: Antisocial Personality Disorder

- Psychopathy
- Antisocial personality disorder
- Criminality
Cluster B: Antisocial Personality Disorder

The graph shows the percentage of Psychopaths and Nonpsychopaths in prison across different age periods. The x-axis represents the age periods (16-20, 21-25, 26-30, 31-35, 36-40, 41-45), and the y-axis represents the percent in prison.
Cluster B: Antisocial Personality Disorder

- Developmental considerations
  - Early histories of behavioral problems
    - Conduct disorder
  - Families history of:
    - Inconsistent parental discipline
    - Variable support
    - Criminality
    - Violence
Causes of Antisocial Personality

• Gene-environment interaction
  – Genetic predisposition
  – Environmental triggers

• Arousal hypotheses
  – Underarousal
  – Fearlessness
    • Under-react to threat of punishment
Causes of Antisocial Personality

• Gray’s model of brain functioning
  — Behavioral inhibition system (BIS)
    • Low
  — Reward system (REW)
    • High
Causes of Antisocial Personality

• Interactive, integrative model
  – Genetic vulnerability
    • Neurotransmitters
  – Environmental factors
    • Family stress
    • Reinforcement of antisocial behaviors
    • Alienation from good role models
    • Poor occupational/social function
Antisocial Personality Disorder

• Treatment
  – *Unlikely to seek on own*
  – *High recidivism*
  – *Incarceration*

  – Early intervention
    • Parent training

• Prevention
  • Rewards for pro-social behaviors
  • Skills training
  • Improve social competence
Links

- http://www.youtube.com/watch?v=HPPj6vilBmU
- http://www.youtube.com/watch?v=bqLyTdcMLhc
- http://www.youtube.com/watch?v=ErNrZ6ttPul
- http://www.youtube.com/watch?v=JT7ltsxgcMw
- http://www.youtube.com/watch?v=0qyCR9tPDgM