Unit 4 - Personality Disorders

I. Introduction
Reading: Oldham (1994); Westen, 1997; Maxmen Ch 19; DSM-IV

A. Description of personality disorders vs. traits
1. Rigid and inflexible

2. Maladaptive

3. Distress -- self or others

4. Need to seek treatment

5. More extreme

6. DSM-IV definition of personality disorder (overhead)
   a) deviates from expectations of the culture: deviance definition

   b) clinically significant

   c) DSM-IV: pers traits=enduring patterns of perceiving, relating to and thinking
      about the environment and oneself: only when inflexible, maladaptive and cause signif
      functional impairment or subjective distress do they constitute pers dis

B. Brief History
1. Kraepelin (1899)

2. Psychoanalytic; Reich (1930) Character Analysis

3. Schneider (1934; 1958): 11 categories

C. American Classification
1. DSM-I (1952): disturbance of pattern; trait; drive, control and relationships; sociopathic
   disturbance (drug abuse, sexual deviance, antisocial)

2. DSM-II (1968): 11 categories:
   Some same as current: paranoid, antisocial, passive-aggressive, hysterical (histrionic),
   obsessive-compulsive, schizoid (although included schizoid, schizotypal, avoidant)

   Some now consider axis I: explosive (epileptic); cyclothymic (affective)

   Some have since been deleted: asthenic (reduced energy); inadequate
“Other” group: passive-dependent, immature

3. Feighner Criteria (1972): no pers dis

4. RDC -- Research Diagnostic Criteria (1975)
   a. Antisocial: Robins’ behavioral criteria

   b. with Borderline features (actually Schizotypal):
      1) from “borderline schiz” – Spitzer, Endicott & Gibbons (1979): used describe
         two types pts - unstable (borderline) and schizotypal

   c. Depressive and cyclothymic personality disorders (became what disorders?)

5. DSM-III (1980)
   a. Description: 11 categories + mixed and atypical

   b. Criticisms:
      1) Poor reliability
         a) DSM field trials: k=.56 to .65
         b) Mellsop et al. (1982): k=.41 presence/absence; .23 for specific disorders
         c) Drake & Vaillant (1985): k=.2 (dep) to .87 (parnd)

      2) Differentiation from personality styles

      3) Co-morbidity of personality disorders and overlapping sx

      4) Gender bias: Kaplan (1980)

6. DSM-IIIR (1987)
   a. Changes
      1) Increased specificity of criteria

      2) Similar number of criteria for disorders

      3) Name changes: NOS (was mixed and atypical), obsessive compulsive

      4) Sadistic and self-defeating in Appendix

   b. Introduced the 3 Clusters:
      1) Odd/eccentric: schizoid, schizotypal, paranoid

      2) Dramatic/erratic: antisoc., histrion., narciss., borderline

      3) Anxious/fearful: avoidant, ob comp, dependent, pass agg

7. DSM-IV (1994)
   a. Changes
      1) Reduced overlap of criteria (decrease comorbidity)
2) Passive-Aggressive: moved to appendix; combined with Millon's negativistic personality

3) Self-defeating and Sadistic: eliminated entirely

4) Depressive personality disorder appendix

8. Structured interviews: developed to address issue of poor reliability of dx

   a. Personality Disorder Examination (PDE; Loranger et al., 1985)

   b. Diagnostic Interview for Borderlines (DIB; Kolb & Gunderson)

   c. Structured Int for DSM-IIIR Personality Questionnaire (SCID-II PQ- part of autoSCID-II; First et al., 1991)

   d. Reliability and validity of self-report data: PDE, SCID

       1. Are patients able to accurately report personality disorder sx? Reliability? Insight?

       2. **Westen (1997):** Q validity of using direct questions to assess personality sx:
          (have taken axis I method and applied to diagnosing axis II)

       3. Martin & Arntz (1998): found patients more reliable than informants in using structured interviews to diagnose pers dis on the SCID-II (DSM-IIIR)

   e. Differences between research and clinical dx: structured interviews (researchers) assign multiple dx; clinicians assign one
II. Alternative Classifications

   A. Problems with DSM approach

      2. Oldham (1994)

      3. Livesley et al. (1994)

   B. Dimensional approaches:
      a. Widiger and Frances

      b. Millon
         1. MCMI - Millon Clinical Multiaxial Inventory (MCMI-III)

         2. overview of Millon's model (see Table 1)

      c. Others: Costa & McCrae (1985, 1987): FFM (5 Factor model) and neo-PI test:
         1. five dimensions of personality: neuroticism, extroversion, openness to experience,
            agreeableness, and conscientiousness

         2. based on the five-factor ("Big Five") model of personality; derived from multivariate studies of
            personality

   C. Circumplex: (see appendices included with the articles)
      1. Is a dimensional model with intersecting dimensions to define the relationship between
         the dimensions

      2. Number of versions:
         a. Leary
         b. Wiggins
         c. Kiesler

         d. Benjamin

         e. Widiger & Frances

III. Personality Disorders in a Diverse Society
Reading: Functowiz & Widiger (1999); Zlotnik et al. (2002); Stevenson et al.(2003)

A. Gender differences and bias in diagnosis


2. critiques: Spitzer et al. (1983); Kass et al. (1983)

3. Warner (1975): vignette study; male diagnosed antisocial, female hysterical (histrionic)

   1. 3 basic types of sex bias
      a. social-cultural etiologic bias
      b. sampling bias
      c. diagnostic: differential false positives or negatives for one sex or the other (diagnosis rate differs from "true" rate based on sex; 2 types of diagnostic bias:
         1) criterion sex bias: bias in diagnostic criteria
         2) assessment sex bias: 2 sources:
            a) instruments
            b) clinical judgment

5. Golumb et al. (1995)
   1. Failed to find sex bias against women using structured interview and DSM-IIIR criteria to dx personality disorders in 288 pts with major depression
      2. men had higher rates of narcissistic, antisocial, obsessive-comp pers dis using one structured interview and for narcissistic and ob-comp pers dis using another
      3. Women did not have a higher rate of any personality disorder

6. Functowiz & Widiger (1999): no bias in diagnostic thresholds for male and female weighted personality disorders (if anything, threshold lower for male typed disorders)


B. Personality disorders in the elderly
   1. lower rate, especially dramatic/erratic pds; what are possible reasons??
2. Hillman et al. (1997): vignette study: depressed pt with Borderline features (presented same case with different ages – middle aged, old, very old)
   a. failed to find clinician age bias in diagnosing personality disorder in the vignette
   b. however, clinicians responded very neg to the case w/ Bord features (not to another case that included only depression)
   c. clinicians made age appropriate recs for older pts (mainly very old)

   a. DSM descriptive approach vs psychodynamic formulations
   b. Factors associated with aging in personality disorders

4. Stevenson et al. (2003). MARYANN: reduced impulsivity in BPD with older age

D. Personality Disorders and Cultural Aspects:
1. Alarcon (1996) presented a quantitative evaluation of the degree to which the recommendations of the NIH-sponsored Culture and Diagnosis Group to APA’s DSM-IV Task Force were included in the final version of the DSM-IV.
   a. Only 27.5% were included; 51% for text related to the personality disorders
   b. Paranoid and schizoid included most of their recs
   c. Recs for narcissistic, histrionic and avoidant ignored
   d. Some recs not included: a cultural dimension, consideration of self-image, acculturation, exclusionary criteria and recs for differential diagnosis
   e. Uneven attention to culture throughout pers dis section

2. Discussion: role of culture in personality disorder. Can there ever be a culture free definition?
IV. Specific Personality Disorders: Description, Etiology, Treatment

Reading: Paris (2001); Piper & Joyce (2001); Soloff (1998); (also see Oldham, 1994)

A. Cluster A: Odd/Eccentric Cluster
   1. Paranoid
      a. long hx: Kraepelin, Schneider, DSM-II
      b. features: suspiciousness, mistrust core features; argumentative, critical, hostile, stubborn
         language of paranoid: spite, plans, plots
         Rarely seek tx on own (unless acute)
      c. epidemiology: variable (2.5% general, 2-10% outpt, 10-30% inpt):
      d. Etiology
         1) Biological - genetic link to delusional disorder rather than schiz
         2) Psychological: harsh, critical parents -> underlying feelings inadequacy; expect criticism; withdrawal, grandiosity, attack are defenses
      e. Treatment:
         1) therapeutic relationship, collaboration, open, don’t argue, attack back; also maintain
            appropriate distance, empathy, patience, slow; therapeutic relationship key, honest
            avoid reflecting back projections
         2) few comparison studies meds+therapy; low dose antipsychotics; pimozide:
            antidopaminergic (effective w/ del dis); may also benefit from Prozac

   2. Schizoid and Schizotypal
      a. Origins:
         1) DSM-II Schizoid -> Avoidant, Schizoid, Schizotypal
         2) Millon: passive (schizoid) and active (avoidant) detached; are related disorders
         3) Spitzer, Endicott & Gibbons (1979) lit review study of borderline schiz: 2 groups:
            1. unstable (bord)
            2. schizotypal
         4) RDC (1975): "with borderline features" = schizotypal
      b. Schizoid and schizotypal: genetic link to schiz
         1) Stone (1985) continuum: schizoid-schizotypal-schiz
         2) "Schizophrenic spectrum" disorders
3) Stress diathesis models, Meehl's schizotype and schizotaxia

C. Cluster C: Anxious-Fearful Cluster

1. Avoidant
   a. Co-morbidity/Differentiation from social phobia
      1) Barlow (1988)
      2) More overlap w/ DSM-IIIIR (generalized social phobia subtype)
      3) May be less with DSM-IV (not much research yet)

   b. Psychological: Beh theories: poor role models->poor social skills->negative
      conseq->avoidance, expect negative reaction from others

   c. schizoid, schizotypal may be avoidant too - Rado, Kretschmer: may vascillate in the
      same person

   d. Treatment
      1) low dose antipsychotics (schizoid, schizotypal)
      2) Cog-beh: social skills training, activity assignments (exposure, practice),
         relaxation, group (avoidant)

2. Obsessive-Compulsive
   a. History/ description
      1) Name changes/confusion

   2) Psychoanalytic concept

   3) DSM concept: ego-syntonic

   4) Millon's "conforming": ego-dystonic

   b. Etiology
      1) Family:genetic vs environ/role models/patterns reinforcement

      2) Psychoanalytic: fixation anal retentive stage, harsh parenting

   c. Treatment:
      1) Behavioral: relax tr; stress management
2) Cognitive: should statements; unrealistic expectations

3) Other recommendations

3. Passive-Aggressive and Dependent
   a. Passive-aggressive - Description/History
      1) from similar concept: passive-aggressive, aggressive vs passive-aggressive, dependent
         2) in all previous DSMs but little research for its validity
         3) DSM-IV appendix - Millon's negativistic (broader)- "active ambivalent"

   b. Dependent - Description/History
      1) from passive-aggressive, dependent
      2) gender issues

c. Etiology
   1) Psychoanalytic: oral aggressive, dependent; overprotective parents
      2) Behavioral: Social learning/modeling, reinforcement
      3) Gender roles

d. Treatment
   1) Assertiveness training
   2) Feminist therapy
   3) Expression/exploration of feelings

B. Cluster B: Dramatic/Erratic Cluster
   1. Antisocial:
      a. Description: Eli Robbins and DSM criteria (+ and -) vs Cleckley (1938) The Mask of Sanity

      b. Etiology
         1) Biological
            a) Genetic
            b) 50-60% abnormal EEG - limbic abnormalities
c) "soft" neurological

d) Lower anticipatory anxiety-> failure learn

e) Underaroused

f) Hare (1984): defect L hem

2) Psychological
   a) Psycho analytic - failure devel superego
   b) Social learning - modeling
   c) Pattern of reinforcement
   d) Sociocultural

c. Treatment

2. Borderline
   a. History/Description
      1) borderline schizophrenia

      2) Spitzer, Endicott & Gibbon (1979): unstable group

      3) Kernberg- borderline personality organization

      4) Gunderson & Elliot (1985) review: 60% major depression


   b. Etiology
      1) Genetic: relationship to mood disorders

      2) Role of neurotransmitters in affective instability, other sx (Soloff, 1998)

      3) Modeling/social learning: Millon (1986)

      4) Association w/ (sexual) abuse (Paris, 2001)
c. Treatment
   1) medications: +/- (Soloff, 1998): sx focused

   2) Intensive, long term, insight oriented, fam of origin

   3) Briefer, focused, here and now, coping
      e.g., Linehan’s (1983) Dialectical Behavior Therapy (DBT)

3. Histrionic
   a. History/Description
      1) Hysteria & hysterical pers dis

      2) Millon

   b. Etiology
      1) Genetics and relationship to antisocial pd

      2) Social learning/modeling; reinforcement

      3) Gender roles and gender bias

   c. Treatment
      1) medications: +/-

      2) Therapy

4. Narcissistic
   a. History/Description

   b. Etiology
      1) Psychoanalytic/object relations

      2) Social learning
e. Treatment
   1) medications: +/-

   2) Therapy
V. Treatment of Personality Disorders

Reading: Piper & Joyce (2001); Perry et al. (1999); Soloff (1998); (also see Oldham, 1994)

A. Biological treatment
   1. originally thought not useful; recent work suggesting biological basis to major dimensions of temperament (e.g., Siever & Davis, 1991; Cloninger’s work): affective instability, cognitive-perceptual, impulsive

   2. Soloff (1998): algorithms for medication tx of pers dis; organized according to above dimensions; gives med to start with, what to add or try if not respond or partial response:
      a. affective instability/dysregulation: anxious, depressed, angry: start with SSRI; then can add another SSRI or antidep; then low dose antipsychotic for anger or anxiolytic for anxiety; then MAOIs; then lithium or seizure meds
      b. cognitive-perceptual: low dose antipsychotics; then try atypical antipsychotics or if depressed-> antidepressants
      c. impulsive (and self-injurious, acting out): SSRI; then can add low dose antipsychotics; can then try lithium or seizure meds; then atypical neuroleptics
      d. Also discussed use of opiate agonists and stimulants (more experimental; less support)

3. Usefulness of meds for specific disorders:
   a. antipsychotics:
      1) low dose for schizotypal
      2) for borderline - haldol, mellaril-sedation, acting out
   b. antidepressants: for depression, esp. borderline
      1) MAOI for histrionic, borderline, ob. compulsive
      2) problem of overdose
   c. lithium (other mood stabilizers - tegretol): borderline, reduce acting out cluster B
   d. anti-anxiety: benzodiazepines - problem of abuse; buspar and slower acting better; possibly useful for cluster A or C

B. Psychological treatment: Piper & Joyce (2001) review chapter of psychosocial treatments
   1. psychoanalytic/psychodynamic:
      a. therapeutic relationship, insight, corrective emotional experiences
      b. psychoanalytic: transference and countertransference issues

d. Perry et al. (1999): effectiveness of psychotherapy for pers dis (dynamic included)  
review of tx studies: CBT, psychodynamic/interpersonal
  1) support for the effectiveness of therapy for pers dis  2) only a few  
controlled studies, and relatively few studies overall  
  3) 25.8% per year recovered (no longer met criteria) with therapy: significantly higher  
  than rate of natural recovery  
  4) need more research; research on specific therapies, specific disorders

2. Cognitive:
   a. See Appendix 1. Content of schemas in personality disorders (Beck 1990)

   b. look at consequences of behavior, alternative explanations, distorted  
interpretations - interpersonal events

   c. Linehan’s Dialectical Behavior Therapy: DBT
      1) 2 primary tasks: teach modulate emotions and learn trust emotions:
      2) 4 types of skills:
         a. increasing interpersonal effectiveness in conflict situations
         
         b. increase self-regulation of negative affect
         
         c. increase tolerance for emotional distress
         
         d. increase ability to experience emotions and avoid emotional inhibition

      3) don't blame the pt for her behaviors; need provide validating environment

      4) steps in tx:
         a. pt must agree on goals and priorities:
            1) (para)suicidal behs 1st priority
            
            2) behs that interfere with tx 2nd priority
            
            3) problems affecting quality of life
            
            4) PTSD-type sx
            
            5) increase self-validation/respect

         b. importance of strong therapeutic relationship
         c. dialectical: acceptance (of sx, probs) and promoting change

      5) core strategies: validation of pt as she is balanced by problem solving skills
a. **validation**: validation of pt strengths

b. **problem solving strategies**: behavioral analysis, analysis of solutions, orienting pt to solution, eliciting pt's commitment, applying the tx plan

c. **behavioral analysis**:
   1) does pt have the ability, if not -> teach skills: 4 types skills:
      a) core mindfulness skills
      b) distress tolerance
      c) emotional regulation
      d) interpersonal effectiveness
      e) self-management

   2) if has skills, are fears/guilt, environmental contingencies, or faulty beliefs interfering? If so -> exposure tx, contingency management, cognitive therapy

   3) most cases, skills deficits; other elements also possible

6. **irreverent** (puts pt off balance) and **reciprocal** (warm, empathic) **communication style**

7. **consultation-to-the-pt**: coaches pt how to resolve problems herself

8. **Individual outpt component**: 1/wk (but flexible: length, frequency depends on tasks)

9. **Concurrent skills group** - psychoeducational

10. **telephone contact**: learn ask for help, help with skill generalization, coaching

11. importance of **case consultation** meetings, support for therapists, supervision

12. Skills modules are fairly structured, have numerous handouts for in session and homework

13. Application of DBT to individual situation: 2 sessions per week - one individual, the other skills approach; but has limitations

14. Individual therapy: use of the skills in individual pt's life; acts as a coach; help with individual coping strategies


4. Interpersonal (Kiesler, 1982, 1987; Benjamin, 1987); (NOT same as IPT for depression)

   (See Figures 1 and 2 in appendices: Interpersonal circumplex and Benjamin’s Structural Analysis of Social Behavior)

   a) Overall strategies of all interpersonal therapies:

      1) identify maladaptive interpersonal patterns, personality style
2) identify origins of the pattern (e.g., understandable in environment grew up in)

3) look at pros and cons for the behavior (e.g., may have been adaptive in family of origin, not in adult world)

4) pt decides if wants to give up patterns, change based on #3

b) Behavior change theory and strategies

1) Interpersonal behaviors pull for other interpersonal behaviors called complementary response (e.g., person dependent, seeking help, pulls for advice giving)

    a) complementary - response pulled for (same on hostile/friendly, opposite on dominance-submission)

    b) anticomplementary - complementary of the opposite response - pulls for the opposite behavior, move towards center of circle

    c) example: pt response is H2 (helpless): want to move patient towards opposite (confident) P; give response that is complement of P → J (deferent), will pull for P

    d) Kiesler: give asocial/disengaged (neutral) response; then anti-complementary responses

    e) Benjamin: give complementary response (hook them in, establish rapport) then slowly shift to anticomplementary responses

    f) generally, therapist avoids giving the complementary response because it is the usual response the person gets from others and it reinforces the original maladaptive interpersonal behavior

6. Millon: systematic/post eclecticism:
   a. select according to target sx, not necessarily dx

   b. use prototypes to guide you

   c. See Appendix 2. Millon’s prototypes for personality disorders: personality disorders by clinical domains
7. group (Yalom; Linehan)

8. General recommendations for individual tx (See Table 2)
Table 1
Millon's theory of personality and personality disorders

I. 3 basic dimensions:

Pleasure vs. Pain (bipolar)
Self vs. Other (bipolar)
Active vs. Passive (unipolar)

II. Personality Disorders and Types:

A. Pathology in the Nature of the Reinforcement (pleasure/pain)

1. Detached Patterns/Types
   Passive Detached: Schizoid: pain-/pleasure-
   Active Detached: Avoidant: pain+/pleasure-
   Passive Detached: Depressive: pain+/pleasure- (MCMI-III)

2. Discordant Patterns/Types (MCMI-II and III)
   Passive Discordant: Self-defeating: pain<->pleasure
   Active Discordant: Sadistic: pain<->pleasure

B. Pathology in the Source of the Reinforcement (self/other)

1. Dependent Patterns/Types
   Passive Dependent: Dependent: self-/other+
   Active Dependent: Histrionic: self-/other+

2. Independent Patterns/Types
   Passive Independent: Narcissistic: self+/other-
   Active Independent: Antisocial: self+/other-

3. Ambivalent Patterns/Types
   Passive Ambivalent: Compulsive: self<->other
   Active Ambivalent: Passive-Aggressive self<->other
Table 2
General recommendations for treating personality disorders
(from Vaillant and Perry (1987) - elaborated upon by Sprock)

In addition to specific recommendations (i.e., medications, specific types of therapy: cognitive; behavioral - Turkat; interpersonal - Benjamin, Kiesler; systematic eclecticism - Millon) for specific disorders, some general treatment recommendations have been made for working with individuals with personality disorders regardless of your orientation or approach.

1. Interrupt repetitive complaints (wasting time - won't lead to change - confront about willingness to change, or stop complaining)

2. Do not get overly involved (e.g., frequent phonecalls, letters) or be underinvolved (i.e., too distant). You are too involved if you frequently find yourself thinking about the case outside of the session or supervision or if you seem more invested in making changes, working in sessions than the client.

3. Do not terminate because of irresponsible behavior (e.g., missed appointments, substance abuse). This is part of the patient's pathology (you wouldn't terminate with someone who is depressed because of low energy levels and motivation).

4. Do not set ultimatums - they will push the limit and you will probably lose clients.

5. Avoid interpretation and insight early in therapy - confrontation is more effective. First, too much insight early in therapy might lead to premature termination. Second, your interpretations are likely to be rejected or denied (or too easily accepted without insight in the case of Dependent personality disorder). Confrontation does not imply hostility or being critical. Confrontation is pointing out discrepancies, contradictions, behavior patterns (in or outside the session) and doing so in the context of a supportive relationship.

6. Set limits and provide structure. No ultimatums but set limits on coming to sessions intoxicated, anger outbursts or verbally abusive behavior towards the therapist, running over the session time, confront "doorknob confessions" (e.g., don't let them establish that pattern - we'll start with that next time, discuss importance of bringing up issues early in session). Consistent times/days for appointments. Structure the session (does not mean you should be active and the patient passive).

7. Allow the patient to help others. Encouraging involvement in volunteer activities, jobs/activities that focus on others can help take the focus off the self.

8. Socratic dialogue about the consequences of behavior - here, Vaillant and Perry (who are psychodynamic) sound a lot like cognitive therapists. This is one way I have been effective in motivating behavior change in some clients who have antisocial, narcissistic features - behavior change not because of the effects of their behaviors on other people but to stop doing things that might result in negative consequences for them (e.g., arrest). Other cognitive techniques such as looking at alternative explanations, distortions, are also helpful.

9. I would also add that your relationship with the client is important in understanding how the client interacts with others and how their behavior effects others. At the very least, it helps you understand their interpersonal patterns and with many clients, giving feedback about their verbal and nonverbal behaviors is an effective way to begin to address problematic behaviors. Often, feedback about behaviors in the context of the therapeutic relationship is more effective than for other relationships or situations...
that you are hearing about second hand. This is one reason that group can be very effective with many of these clients (along with getting feedback from more than one person). However, a caution about group is that there is the potential for the patient to monopolize or disrupt the group (e.g., some patients with Borderline personality disorder).