PERSONALITY DISORDERS - 1

I. Statistics and Development
   A. 0.5% to 2.5% of the general population,
      higher rates in inpatient and outpatient settings.
   B. originate in childhood and continue into the adult years;
      relatively little is known about the developmental course.
   C. Significant comorbidity
      about half of those diagnosed with a personality disorder also meet criteria
      for another personality disorder.
   D. **Gender biases**
      borderline personality disorder is diagnosed much more frequently in
      females, who make up 75% of the identified cases.

      Knowledge of whether the client is male or female can influence whether a
      client receives one personality disorder diagnosis over another. For example,
      antisocial personality disorder is assigned more often when the patient is
      male, whereas a similar description of antisocial personality features with a
      fictitious female client is more likely to be labeled histrionic personality
      disorder. Many features of histrionic personality disorder are characteristic of
      the stereotypical Western female.

      1. **criterion gender bias**
      2. **assessment gender bias**
PERSONALITY DISORDERS - 2

II. Cluster A (odd, eccentric) Personality Disorders

A. Paranoid personality disorder (PPD)

1. Evidence for a biological contribution to PPD is limited, and evidence for a psychological contribution is unclear. The most salient psychological feature is a pervasive negative view of the world and the motives of others; a view that may originate in early childhood.

2. Treatment for PPD is difficult

   few persons with this disorder seek professional help on their own,
   difficulty in developing trusting relationships
   a. Treatment focuses on development of trust and may include cognitive therapy to counter the person’s mistaken assumptions about others.
   b. There are no good studies showing that treatment is effective for PPD.

B. Schizoid personality disorder (SZPD)

Unlike the DSM-IV, the DSM-IV-TR recognizes that at least some people with SZPD are sensitive to the opinions of others but are unwilling or unable to express this emotion. For this group, social isolation may be painful.

Homelessness is quite prevalent in persons with SZPD.

1. The etiology of SZPD is unclear.
2. Treatment for SZPD focuses on the value of social relationships, including

   learning empathy skills,
   social skills training.
   Role playing is also used to help the person learn to establish and maintain social relationships.
   Treatment prognosis is poor for people with SZPD,
   persons with this diagnosis rarely seek treatment, except in response to a crisis.
C. **Schizotypal personality disorder (STPD)**

Some increased risk that many may go on to develop more severe characteristics of schizophrenia.

1. Some consider STPD a phenotype of a schizophrenia genotype and genetic research seems to support such a relationship.

   Family, twin, and adoption studies have shown an increased prevalence of STPD among relatives of people with schizophrenia who do not have schizophrenia themselves.

   Exposure to influenza during pregnancy may increase risk of STPD in the unborn fetus.

2. Cognitive factors include mild-to-moderate deficits in memory and learning, suggesting damage to the left hemisphere of the brain, whereas MRI studies suggest more generalized brain abnormalities in STPD individuals.

3. Few controlled treatment studies exist for STPD.

   The main treatment focus tends to be on developing social skills.

   Given that as many as 30% to 50% of persons with STPD who seek treatment meet criteria for major depressive disorder, therapy also tends to focus on alleviating depressed mood.

   Medical treatment tends to follow that for people with schizophrenia.

   Prognosis is poor for persons with STPD.
III. Cluster B (dramatic) Personality Disorders

A. **Antisocial personality disorder (ASPD)**

Substance abuse occurs in about 83% of persons with antisocial personality disorder.

Long-term outcome of persons with ASPD is poor, regardless of gender.

1. **Dyssocial psychopathy** (i.e., antisocial behavior that is thought to originate in a person’s allegiance to a culturally deviant group, such as a gang) may be included with ASPD, but not psychopathy. Dyssocial psychopaths are presumed to have the capacity for guilt and loyalty.

2. Psychopathy and ASPD are not synonymous with legal problems. Those that get into legal problems seem to have lower IQs.

3. The diagnosis of **conduct disorder** is reserved for children who engage in behaviors that violate cultural norms.

   Many with this disorder become juvenile offenders and tend to become involved with drugs.

   Lack of remorse is not part of the DSM-IV-TR criteria for conduct disorder, but is present for ASPD.

4. **Family, twin, and adoption studies** all suggest a genetic influence on ASPD and criminality.

   A gene-environment interaction appears involved, suggesting that genetic vulnerability interacts with environmental factors

   a. The average concordance rate for criminality among monozygotic twins is 55%, whereas with dizygotic twins the rate drops to about 13%.

5. **Neurobiological research** suggests that general brain damage does not explain why people become psychopaths or criminals.

   Two theories have attracted a great deal of attention.

   a. According to the **underarousal hypothesis**, psychopaths have abnormally low levels or cortical arousal. Low cortical arousal is used to explain antisocial risk taking behavior.

   Future criminal behavior is predicted by low skin conductance activity, lower heart rate during rest, and slow brain wave activity.
b. The **cortical immaturity hypothesis** suggests that the cerebral cortex of psychopaths is at a primitive stage of development and may explain why the behavior of psychopaths is often childlike and impulsive.

c. According to the **fearlessness hypothesis**, psychopaths show higher thresholds for experiencing fear than most persons. Research suggests that psychopaths have difficulty associating cues with impending punishment or danger.

6. **Psychological and social dimensions** of psychopathy and ASPD include the following:

   a. Family and social factors may also contribute to psychopathy and ASPD, particularly inconsistent parental discipline, trust and solidarity in the family and community neighborhood.

7. An **integrative model of ASPD** includes:

   genetic vulnerability, perhaps resulting from underarousal or fearlessness,

   Family stress and family interaction styles may activate the biological vulnerability, and

   the resulting antisocial behavior, including problems at school, may further alienate the individual from other children that may serve as good role models.

8. **Treatment for ASPD** is complicated by the fact the few persons with such problems see any need for treatment.

   Antisocial behavior is generally predictive of poor prognosis, even in childhood.

   Therapists agree that incarceration is often the best alternative.

   a. Most common intervention for children is parent training, where parents are taught to recognize behavior problems early and how to use praise and privileges to reduce problem behavior and to encourage prosocial behaviors.

   b. Juvenile offenders are often treated with a combination of behavioral and family interventions.

   c. Prevention programs may be the best alternative in the long run.
B. Persons with **borderline personality disorder (BPD)**

BPD is one of the most common personality disorders in psychiatric settings, and accounts for 50% of patients with personality disorders.

BPD often co-occurs with mood disorders, including eating disorders (i.e., particularly bulimia), many improve without treatment over time.

1. **BPD runs in families** and is associated with mood disorders.
2. **Early trauma**

BPD is associated with greater reports of early abuse than other psychiatric conditions.

This connection may help explain why women are more likely to develop BPD than men, particularly as girls are 2 to 3 times more likely to be sexually abused than boys.

However, 20% to 40% of persons with BPD do not have a clear history of early abuse.

Some argue that BPD is really a case of PTSD in women.

3. Few studies exist evaluating **treatment for BPD**.
   a. **Medications**, such as tricyclic antidepressants and lithium, seem to confer some benefit as a treatment for BPD.
   b. **Psychosocial treatment** research is limited.

   The most promising approach is **dialectical behavior therapy (DBT)**, which involves helping persons with BPD cope with stressors that seem to trigger suicidal behaviors, including teaching the patient how to identify and regulate their emotions.

   Problem solving is also emphasized in DBT, and other treatment components resemble those used for PTSD, particularly trauma reexperiencing.

   DBT seems efficacious in reducing suicide attempts, dropouts from treatment, and hospitalizations.
C. **Histrionic personality disorder (HPD)**

HPD is more commonly diagnosed in females.

1. The etiology of HPD is largely unknown; though some have speculated a relation between HPD and antisocial personality disorder.

   Roughly 66% of persons with HPD also meet criteria for ASPD, leading some to suggest that HPD and ASPD may represent sex-typed alternative expressions of the same unidentified underlying condition.

2. Treatment for persons with HPD has not been extensively studied.

   Therapists usually target

   attention-getting behavior,

   problematic interpersonal relationships (e.g., manipulation of others through emotional crises, using charm, sex, or seductiveness to attain desired ends).

   Efforts are made to show persons with HPD that the short-terms gains they derive from their behavior have long-term costs, and to teach such individuals more appropriate ways of meeting their needs.
D. Narcissistic personality disorder (NPD)

Many are also depressed.

1. The etiology of NPD has been linked to an early failure in childhood to learn how to show empathy. The result is a child who remains fixated in a self-centered, grandiose stage of development.
   a. The sociological view argues that NPD results from large-scale social changes in Westernized society, particularly an emphasis on hedonism, individualism, competitiveness, and success (i.e., the "me" generation).

2. Treatment research for NPD is extremely limited.

   Therapy often focuses on
   grandiosity,
   hypersensitivity to evaluation,
   lack of empathy for others,
   unrealistic thinking,
   coping strategies to reduce sensitivity to criticism.

   Treatment also addresses depression.

IV. Cluster C (anxiety, fearful behavior) Personality Disorders

A. Avoidant personality disorder (APD)

1. Etiological factors involved in APD are numerous and include the following:
   a. Millon suggested that APD individuals are born with a difficult temperament or personality characteristics, and that these features lead their parents to reject them.

      The result is low self-esteem and social alienation.

      Many persons with APD report childhood experiences of isolation, rejection, and conflict with others.

2. There are several well-controlled treatment studies for APD.

   Behavioral interventions for anxiety and social problems are successful and resemble those used for social phobia and may include systematic desensitization and behavioral rehearsal.
PERSONALITY DISORDERS - 9

B. **Dependent personality disorder (DPD)**
   1. The etiology of DPD has been linked to disruptions in the normal early process of moving from dependence to independence.

      This view originates in the work on child attachment (i.e., how children learn to bond with their parents and other important people in their lives).

      If such bonding is interrupted, persons may end up being constantly anxious that they will lose people close to them.

   2. The treatment literature for DPD is mostly descriptive.

      Therapy typically progresses gradually and attempts to help the patient foster a sense of independence in making important life decisions.

C. **Obsessive-compulsive personality disorder (OCPD)**

   Persons with OCPD do not tend to have the obsessive thoughts and compulsive behaviors characteristic of obsessive-compulsive disorder.

   OCPD is common among gifted children.

   1. The etiology of OCPD is weakly related to genetics, and little is known about other etiologic contributing factors that may be involved.

   2. Treatment data for OCPD is limited.

      Therapy often targets

      fears that underlie the need for orderliness,

      fears of inadequacy,

      procrastination and rumination about important issues and minor details,

      may include relaxation procedures and distraction techniques.
V. Personality Disorders Under Study
   A. The following personality disorders have been proposed for inclusion in the DSM:
      1. **Sadistic personality disorder** has been suggested for persons who receive pleasure by inflicting pain on others.
      2. **Self-defeating personality** disorder has been suggested for persons who are overly passive and accept the pain and suffering imposed by others.

   B. The following two new categories of personality disorder are under study:
      1. **Depressive personality disorder** includes persons that experience self-criticism, dejection, a judgmental stance toward others, and a tendency to feel guilt.
      2. **Negativistic personality disorder** is characterized by a passive-aggressive interpersonal style in which the individual adopts a negativistic attitude to resist routine demands and expectations. This disorder represents an expansion of a previous DSM-III-R category, namely passive-aggressive personality disorder.