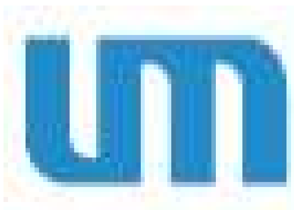
Personality disorders

Agnieszka Pawelczyk MA, PhD
Clinical Neuropsychologist
Department of Affective and Psychotic Disorders



Agenda

- Personality & Personality disorder
- Biology of personality
- DSM – clasification (plus menemonics)
- Treatment

Personality
& Personality disorder

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Personality

Personality – relatively stable and enduring set of characteristic behavioral and emotional traits

Personality Disorder

inflexible & pervasive
in personal,
social situations

not physiological effects of
a substance or
a general medical condition

clinically significant
stress or impairment

not a manifestation
or consequence of another mental disorder

stable and of long duration

Personality Disorder

pervasive

negatively affect work, family and social life

in increased stress –
symptoms seriously interfere with emotional & psychological functioning

Feature of Personality Disorder

- deeply ingrained
- maladaptive
- relatively stable
- impairs functioning
- distresses others

Feature of Personality Disorder

- ❖ disturbances in self-image
- ❖ difficulty in interpersonal relationships
- ❖ inappropriateness of range of emotion
- ❖ distinct ways of perceiving themselves, others and the world
- ❖ difficulty possessing proper impulse control

Gender differences

differences between men and women in certain basic experiences that are genetic, sociocultural, or both, or do they represent biases on the part of the clinicians who make the diagnoses?

study by Maureen Ford and Thomas Widiger (1989), who sent fictitious case histories to clinical psychologists for diagnosis. One case described a person with *antisocial personality disorder*,; the other case described a person with *histrionic personality disorder*

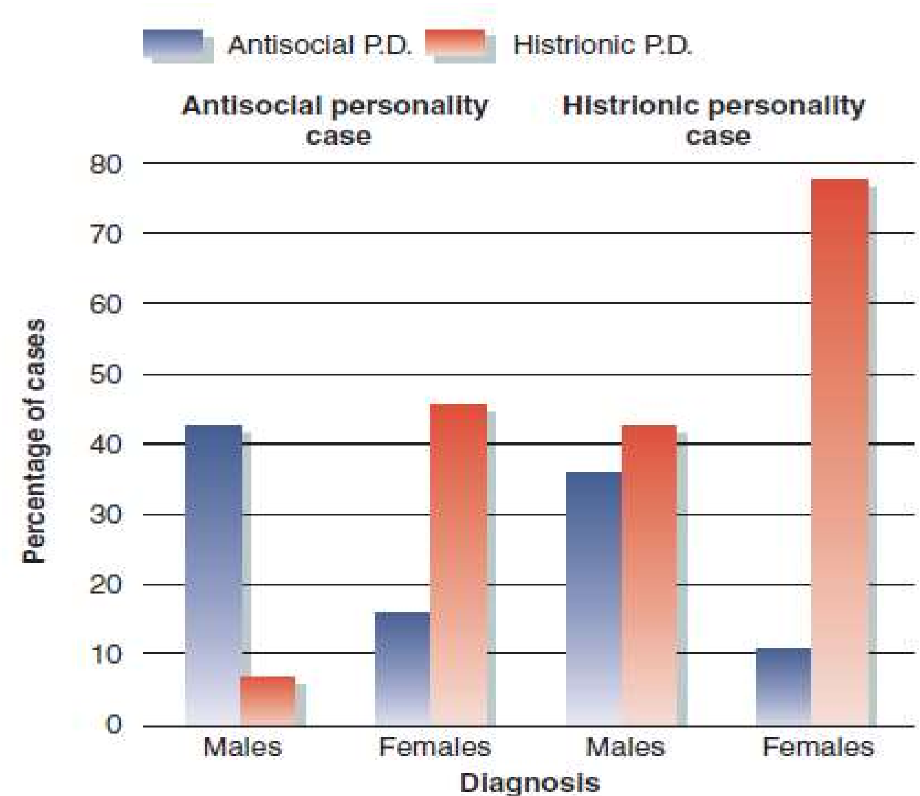

FIGURE 12.1 Gender bias in diagnosing personality disorders (P.D.). Data are shown for the percentage of cases clinicians rated as anti-social personality disorder or histrionic personality disorder, depending on whether the case was described as a male or a female. (From Ford, M. R., & Widiger, T. A., 1989. Sex bias in the diagnosis of histrionic and antisocial personality disorders. *Journal of Consulting and Clinical Psychology, 57*, 301–305.)

TABLE 12.2 Statistics and Development of Personality Disorders

Disorder	Prevalence*	Gender Differences†	Course
Paranoid personality disorder	In the clinical population: 4.2% In the general population: 2.3%–2.4%	In the clinical population: More common in males In the general population: No difference	Insufficient information
Schizoid personality disorder	In the clinical population: 1.4% In the general population: 1.7%–4.9%	In the clinical population: More common in males In the general population: No difference	Insufficient information
Schizotypal personality disorder	In the clinical population: 0.6% In the general population: 0.6%–3.3%	In the clinical population: More common in males In the general population: No difference	Chronic; some go on to develop schizophrenia
Antisocial personality disorder	In the clinical population: 3.6% In the general population: 0.7%–1%	In the clinical population: More common in males In the general population: No difference	Dissipates after age 40 (Hare, McPherson, & Forth, 1988)
Borderline personality disorder	In the clinical population: 9.3% In the general population: 0.7%–1.6%	In the clinical population: More common in females In the general population: No difference	Symptoms gradually improve if individuals survive into their 30s (Zanarini et al., 2006); approximately 6% die by suicide (Perry, 1993)
Histrionic personality disorder	In the clinical population: 1.0% In the general population: >1%–2.0%	In the clinical population: No difference In the general population: No difference	Chronic
Narcissistic personality disorder	In the clinical population: 2.3% In the general population: >1%	In the clinical population: More common in males In the general population: No difference	May improve over time (Cooper & Ronningstam, 1992; Gunderson, Ronningstam, & Smith, 1991)
Avoidant personality disorder	In the clinical population: 14.7% In the general population: 5.0%–5.2%	In the clinical population: No difference In the general population: No difference	Insufficient information
Dependent personality disorder	In the clinical population: 1.4% In the general population: .6%–1.5%	In the clinical population: No difference In the general population: No difference	Insufficient information
Obsessive-compulsive personality disorder	In the clinical population: 8.7% In the general population: 2.0%–2.4%	In the clinical population: More common in males In the general population: No difference	Insufficient information

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Prevalence

✓ adding up the prevalence rates across the personality disorders, you might conclude that up to 25% of all people are affected

✓ the percentage of people in the population with a personality disorder is likely closer to 10%

people tend to be diagnosed with more than one **COMORBIDITY**

Do people really tend to have more than one personality disorder?

Are the ways we define these disorders inaccurate, and do we need to improve our definitions so that they do not overlap?

Or did we divide the disorders in the wrong way, and do we need to rethink the categories?

TABLE 12.4 Diagnostic Overlap of Personality Disorders

	Odds Ratio† of People Qualifying for Other Personality Disorder Diagnoses									
Diagnosis	**Paranoid**	**Schizoid**	**Schizotypal**	**Antisocial**	**Borderline**	**Histrionic**	**Narcissistic**	**Avoidant**	**Dependent**	**Obsessive-Compulsive**
Paranoid		2.1	37.3*	2.6	12.3*	0.9	8.7*	4.0*	0.9	5.2*
Schizoid	2.1		19.2	1.1	2.0	3.9	1.7	12.3*	2.9	5.5*
Schizotypal	37.3*	19.2		2.7	15.2*	9.4	11.0	3.9*	7.0	7.1
Antisocial	2.6	1.1	2.7		9.5*	8.1*	14.0*	0.9	5.6	0.2
Borderline	12.3*	2.0	15.2*	9.5*		2.8	7.1*	2.5*	7.3*	2.0
Histrionic	0.9	3.9	9.4	8.1*	2.8		13.2*	0.3	9.5	1.3
Narcissistic	8.7*	1.7	11.0	14.0*	7.1*	13.2*		0.3	4.0	3.7*
Avoidant	4.0*	12.3*	3.9*	0.9	2.5*	0.3	0.3		2.0	2.7
Dependent	0.9	2.9	7.0	5.6	7.3*	9.5	4.0	2.0		0.9
Obsessive-compulsive	5.2*	5.5*	7.1	0.2	2.0	1.3	2.0	2.7	0.9	

†The "odds ratio" indicates how likely it is that a person would have both disorders. The odds ratios with an asterisk (*) indicate that, statistically, people are likely to be diagnosed with both disorders—with a higher number meaning people are more likely to have both. Some higher odds ratios are not statistically significant because the number of people with the disorder in this study was relatively small.

Biology of Personality

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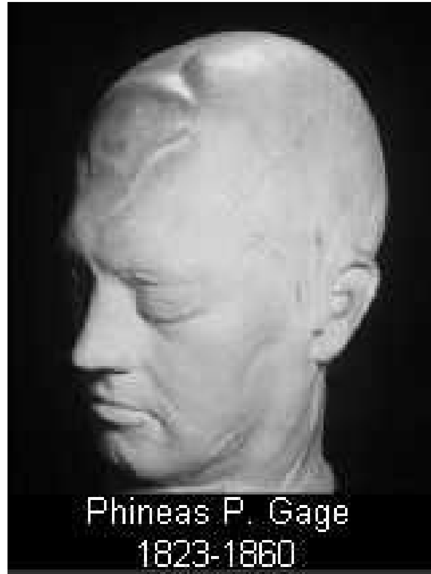
❖Questions regarding **anatomy**: What can the structure of the brain tell us about personality?

❖Questions regarding **physiology**: To what degree is personality a matter of chemistry?

Phineas P. Gage (1823 –1860)

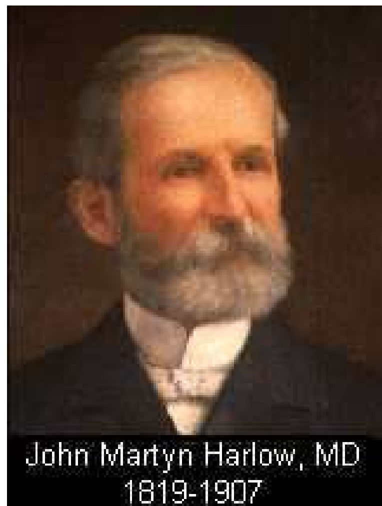


1,19 m length

6,13 kg

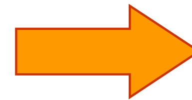
„…no longer Gage…"

J. M. Harlow (1848). Passage of an iron rod through the head. *Boston Medical and Surgical Journal*, *39*, 389-393.



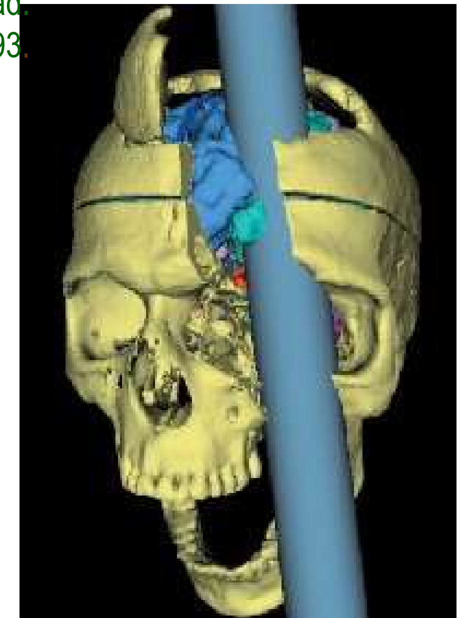
Pre-accident Gage:

- „…well-balanced in mind
- shrewd
- smart
- energetic
- hard-working,
- responsible
- persistant…"



Post-accident Gage:

- „…fitfull
- indulging,
- Impatient
- obsinate
- capricious
- vacillating.."



Prefrontal cortex

Dorsolateral prefrontal cortex (DLPFC):

- control, regulation and integration of cognitive activities
- working memory or „on-line" processing of information

Anterior cingulate cortex (ACC):

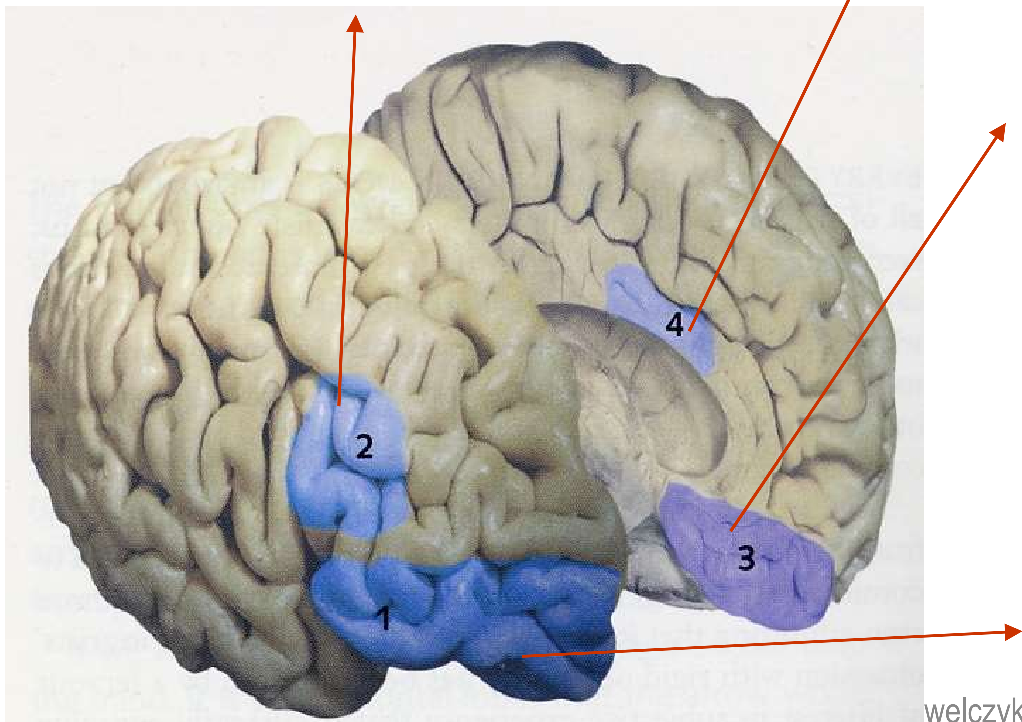
- Helps focus attention
- Needed to carry out a task such as learning and problem solving

Ventromedial cortex (VMC):

- Emotional experience
- Meaning bestowed on our percepitons

Orbito-frontal cortex (OFC):

- Impulse control
- Maintenance of set and of ongoing behavior
- Ability to be guided by future consequence



Neuroanatomy and personality

the left fusiform gyrus of the cerebral cortex is active

right frontal lobe more active

left frontal lobe more active

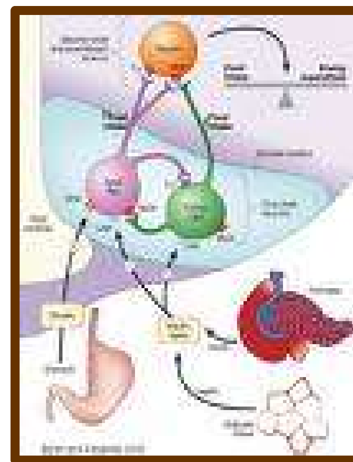
left hemisphere is more active when one is motivated to approach

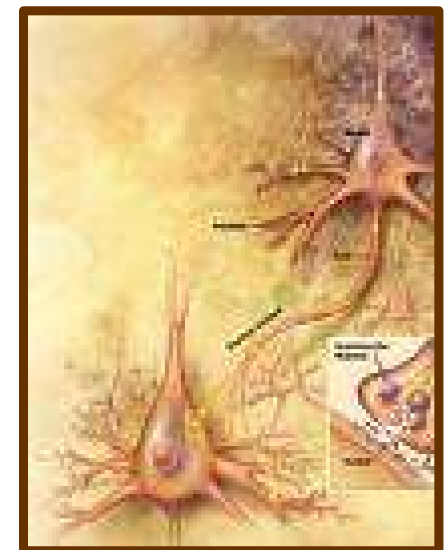
right hemisphere more active when one is motivated to avoid

Amygdala is involved in experiencing of fear and produces this emotions even without conscious awarness

Neurochemistry and Personality

- About 70 different chemicals that effect neurons have been identified, so far
- Neurochemistry transmits information throughout the body
- Neurotransmitters and hormones affect behavior.

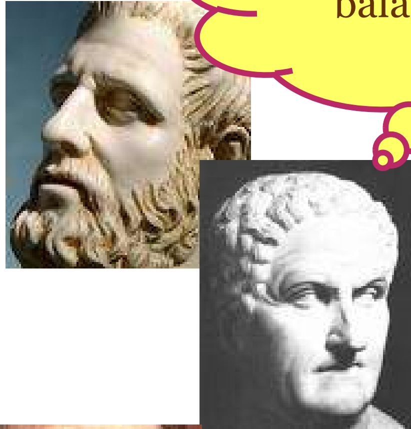




Neurochemistry and Personality

The brain is not a digital computer, it is a juicy gland. Robert Zajonc

Personality – balance of humors



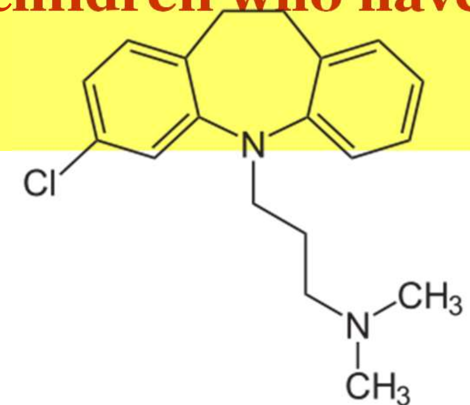
Irritable	**Choleric**	yellow bile	Agreeableness
Depressed	**Melancholic**	black bile	Neuroticism
Optimistic	**Sanguine**	blood	Openness to experience
Calm	**Phlegmatic**	phlegm	Neuroticism

Sheldon's Somatotype	**Character**	**Shape**
Endomorph [viscerotonic]	relaxed, sociable, tolerant, comfort-loving, peaceful	plump, buxom, developed visceral structure
Mesomorph [somatotonic]	active, assertive, vigorous, combative	muscular
Ectomorph [cerebrotonic]	quiet, fragile, restrained, non-assertive, sensitive	lean, delicate, poor muscles

Neurochemistry and Personality

- ✓ Enzymes break down neurotransmitters - levels of enzymes can affect the level of neurotransmitters.

- ❖ Monoamine oxidase (MAO) breaks down dopamine, norepinephrine, and serotonin.
  - ➢ **A low level of MAO** in the blood, which allows higher levels of these neurotransmitters, is associated with **sensation seeking, extraversion, and even criminal behavior.**
  - ➢ **A gene that promotes the action of MAO** in breaking down these neurotransmitters seems to **help prevent the development of delinquency among children who have been maltreated.**



Neurochemistry and Personality

Epinephrine & norepinephrine

❖Too easily triggered response *Fight-or-flight* can be problematic.
Over-reactive people; anxious and/or neurotic;
may have an **overactive norepinephrine** system

❖ The release of **epinephrine** related to the **encoding of memories about events**
that triggered fight-or-flight (how strong, how easily recalled, and how vivid the memory is).

❖over-release of **epinephrine** accompanies **remembering traumatic events**

Neurochemistry and Personality

Dopamine

- ❖associated with humans' **response to reward** (BAS – Behavioural Activation System)

- ❖the basis of **sociability**, and the instinct to **approach attractive objects and people**

- ❖seems to be related to the trait of **novelty-seeking**

Neurochemistry and Personality

Jeffrey Gray's theory

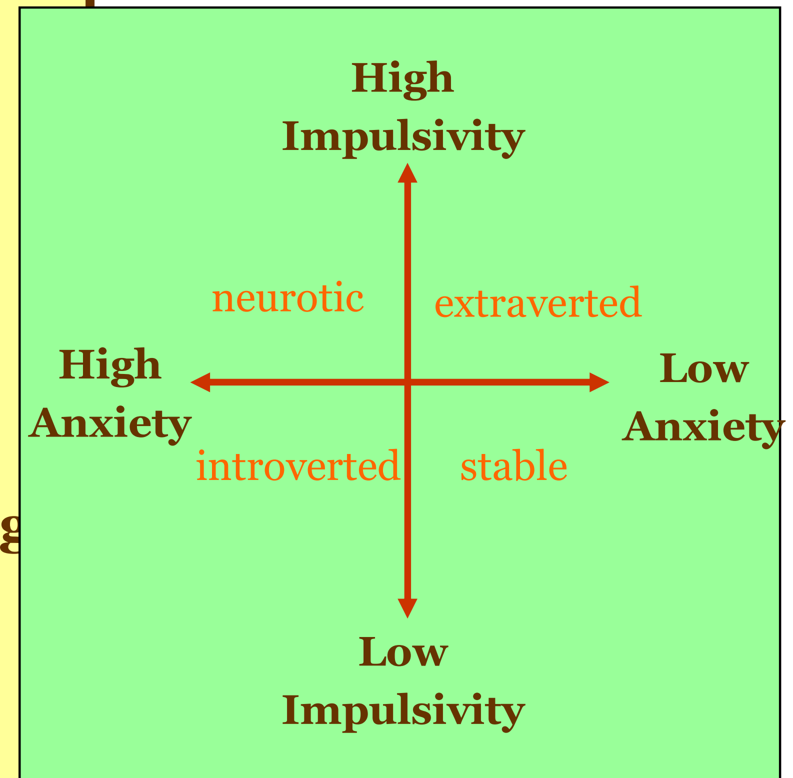
❖ Behavioral activation system (BAS)

✓**Dopamine** in the hypothalamus triggers **the behavioral activation system; Reward seeking; Approach-related behavior; Energetic; Impulsive**

❖ Behavioral inhibition system (BIS)

✓Includes the frontal lobes; Responds to risk; **Hig levels of dopamine are indicative of being inhibited and anxious.**

➢These are separate systems, not opposites, so any combination is possible.



Gray's Two-Dimensional Model of Personality

More recent theories

Focusing on the degree to which people develop nerve cells that are responsive to dopamine

Neurochemistry and Personality

Serotonin

❖Inhibition of behavioral & emotional impulses

➢Some inhibition of emotional impulses can help:

•avoid excessive worrying.

•decrease their sensitivity to the social and physical environment

❖Low serotonin levels

➢Dangerous criminals, arsonists, and violent, suicidal individuals

➢Irrational anger, hypersensitivity to rejection, chronic pessimism, obsessive worry and fear of risk taking

➢controversial topics

Hormones important for behavior are released by

❖ the hypothalamus

❖ the gonads

❖ the adrenal cortex

Neurochemistry and Personality

testosteron

- **Agression** – mixed findings
- Violent criminals are more likely to have higher levels of testosterone,

but the reverse is not true

- The potential role of social and economic status in the expression of anger, frustration and related emotional experiences

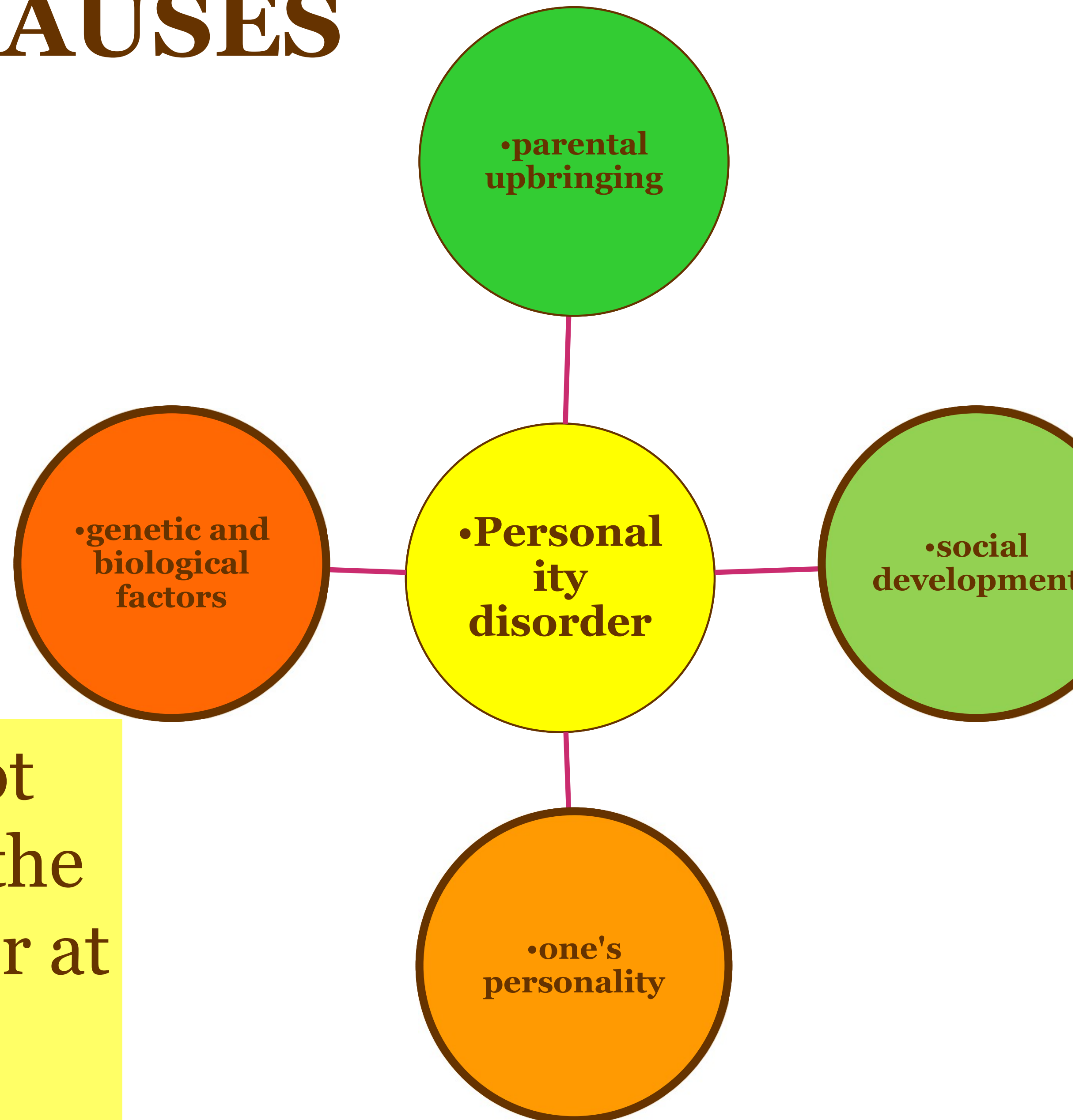
- Associated with
  - **sociability, impulsivity, lack of inhibition, and lack of conformity**
  - holding blue-collar industrial jobs, types of roles within occupations (e.g., lawyer study)

Neurochemistry and Personality

cortisol

- Response to physical or psychological stress
- Chronically **high levels** of cortisol in the bloodstream - **depression and high levels of stress**
- Infants with high levels of cortisol (developmental outcomes):
  - Timid
  - Vulnerable to developing social phobias, **but**
  - causal direction is questionable

PERSONALITY DISORDERS - CAUSES



research has not narrowed down the cause to any factor at this time

Personality

- Personality developed as an encounter of:
  - Inborn temperamental traits of a child
  - Temperamental traits of a significant person
  - Parenting style
  - Environment

Temperament

❖ Bilological foundation of personality based on child's inherited predisposition for characteristics pattern of emotionality, activity and sociability

❖ Referes to a distinctive profile of feelings and behaviuors that originate in the child's biology and appear early in development

❖ Moderatelty stable through life and across situation

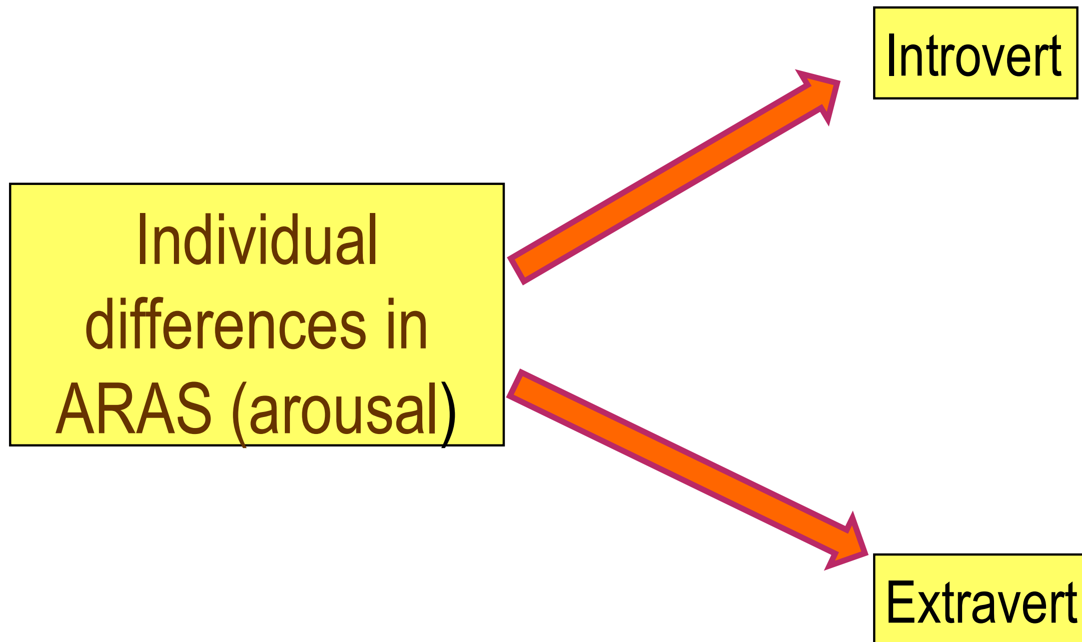
Temperament

- ❖ Highly **heritable**

- ❖ Genetics inheritance and early experience influence produce individual's temperament

- ❖ **Cloninger** - 4 basic temperament & 3 character traits from which various type of Personality and Personality disoder are constructed (*novelty seeking, harm avoidance reward dependence, persistance, determination, ambitiousness and perfectionism)*

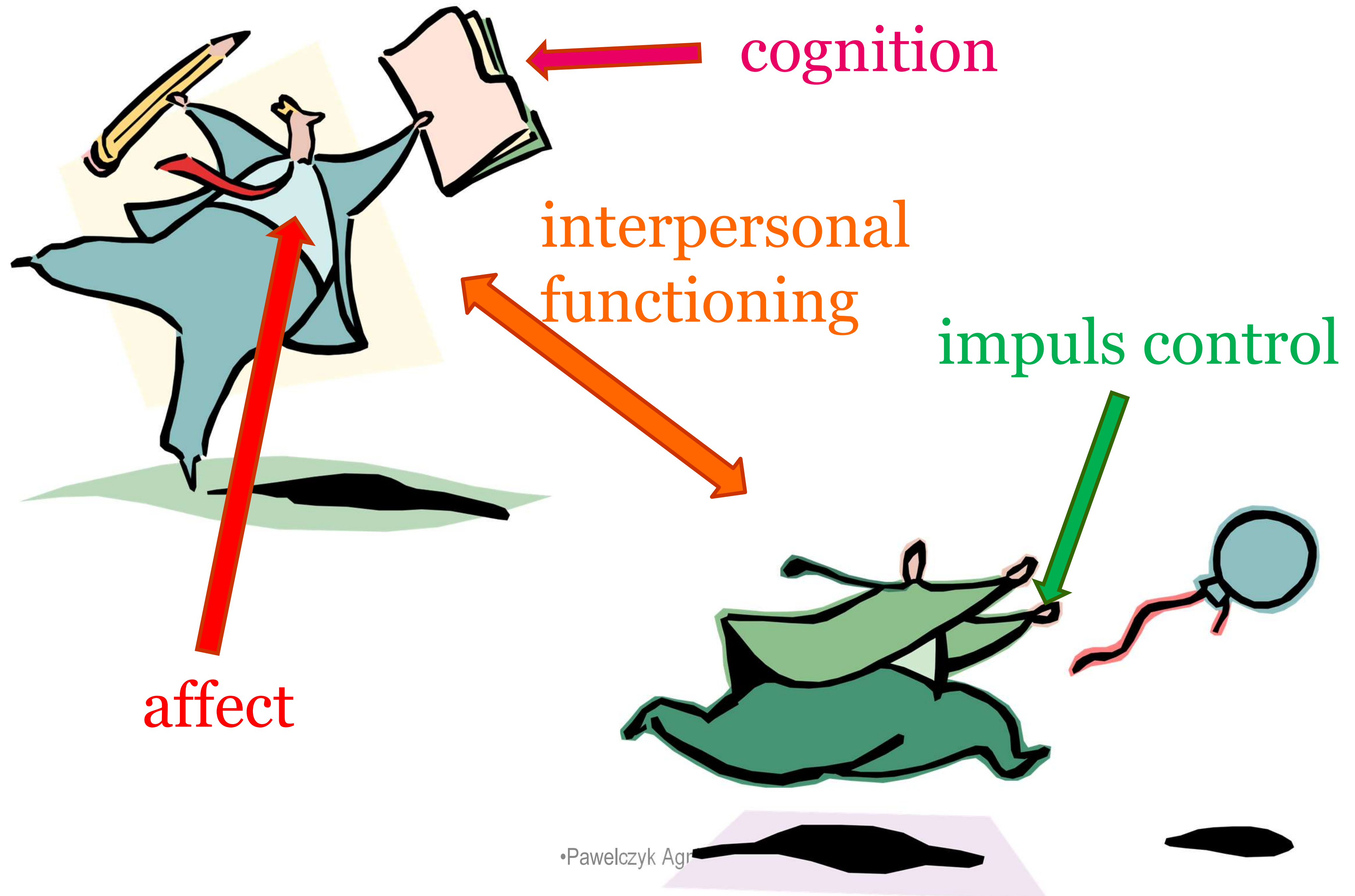
Eysenck's Theory



She's had enough of the party; She wonders why she even came!

He's just getting started, he feels like he could party all night!

PERSONALITY DISORDERS



Clasification - DSM

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The personality disorders represent long-standing and ingrained ways of thinking, feeling, and behaving that can cause significant distress. Because people may display two or more of these maladaptive ways of interacting with the world, considerable disagreement remains over how to categorize the personality disorders.

DSM-V includes 10 personality disorders that are divided into three clusters: Cluster A (odd or eccentric) includes paranoid, schizoid, and schizotypal personality disorders; Cluster B (dramatic, emotional, or erratic) includes antisocial, borderline, histrionic, and narcissistic personality disorders; and Cluster C (anxious or fearful) includes avoidant, dependent, and obsessive-compulsive personality disorders.

DSM – V Classification

Cluster A **Odd/Eccentric**	Cluster B **Dramatic/Erratic**	Cluster C **Anxious/Fearful**
Schizoid Paranoid Schizotypal	Histrionic Antisocial Borderline Narcissistic	Avoidant Dependent Obsessive-Compulsive

Claster A

Schizoid Personality

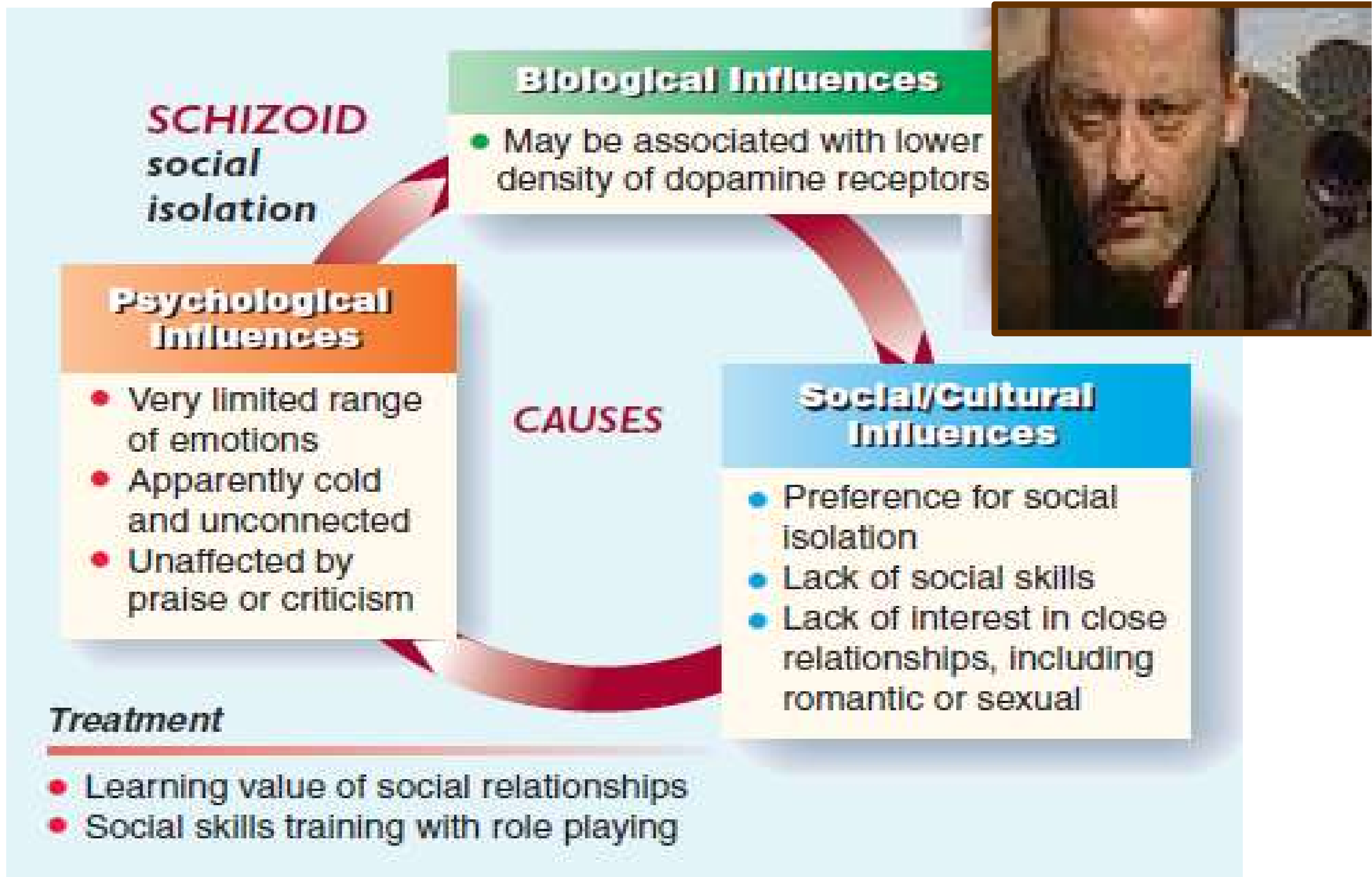
- Pervasive pattern of detachment from social relationships
- Restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts,
- Indicated by four (or more) of the following:
  - neither desires nor enjoys close relationships, including being part of a family
  - almost always chooses solitary activities
  - has little, if any, interest in having sexual experiences with another person
  - takes pleasure in few, if any, activities
  - lacks close friends or confidants other than first-degree relatives
  - appears indifferent to the praise or criticism of others
  - shows emotional coldness, detachment, or flattened affectivity

Schizoid Personality

"DISTANT"

- **D**etached (or flattened affect)
- **I**ndifferent to criticism and praise
- **S**exual experiences of little interest
- **T**asks (activities) done solitarily
- **A**bsence of close friends
- **N**either desires nor enjoys close relations
- **T**akes pleasure in few activities

Schizoid Personality



A 39-year-old scientist was referred after his return from a tour of duty in Antarctica where he had stopped cooperating with others, had withdrawn to his room, and begun drinking on his own. Mr. Z. was orphaned at 4 years, raised by an aunt until 9, and subsequently looked after by an aloof housekeeper. At university he excelled at physics, but chess was his only contact with others. Throughout his subsequent life he made no close friends and engaged primarily in solitary activities. Until the tour of duty in Antarctica, he had been quite successful in his research work in physics. He was now, some months after his return, drinking at least a bottle of Schnapps each day, and his work had continued to deteriorate. He presented as self-contained and unobtrusive and was difficult to engage effectively. He was at a loss to explain his colleagues' anger at his aloofness in Antarctica and appeared indifferent to their opinion of him. He did not appear to require any interpersonal relations, although he did complain of some tedium in his life and at one point during the interview became sad, expressing longing to see his uncle in Germany, his only living relation.

Paranoid Personality

A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

❖suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her

❖is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates

❖is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her

❖reads hidden demeaning or threatening meanings into benign remarks or events

❖suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her

Paranoid Personality

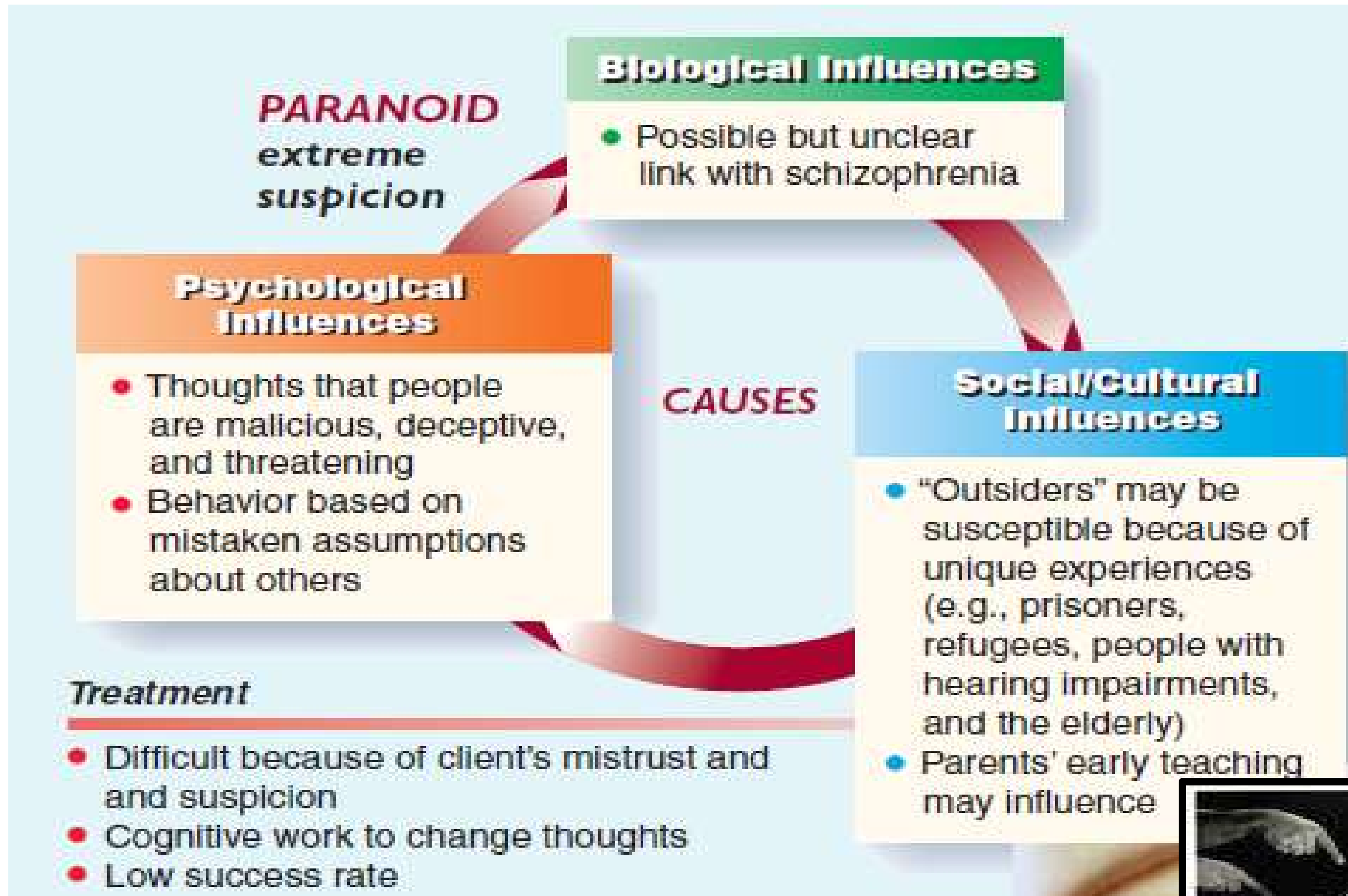
- persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
- perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
- has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

Paranoid Personality

“SUSPECT”

- **S**pouse fidelity suspected
- **U**nforgiving (bears grudges)
- **S**uspicious of others
- **P**erceives attacks (and reacts quickly)
- “**E**nemy or friend” (suspects associated and friends)
- **C**onfiding in others feared
- **T**hreats perceived in benign events

Paranoid Personality



Jake grew up in a middle-class neighborhood, and although he never got in serious trouble, he had a reputation in high school for arguing with teachers and classmates. After high school he enrolled in the local community college, but he flunked out after the first year. Jake's lack of success in school was partly attributable to his failure to take responsibility for his poor grades. He began to develop conspiracy theories about fellow students and professors, believing they worked together to see him fail. Jake bounced from job to job, each time complaining that his employer was spying on him while at work and at home.

At age 25—and against his parents' wishes—he moved out of his parents' home to a small town out of state. Unfortunately, the letters Jake wrote home daily confirmed his parents' worst fears. He was becoming increasingly preoccupied with theories about people who were out to harm him. Jake spent enormous amounts of time on his computer exploring websites, and he developed an elaborate theory about how research had been performed on him in childhood. His letters home described his belief that researchers working with the CIA drugged him as a child and implanted something in his ear that emitted microwaves. These microwaves, he believed, were being used to cause him to develop cancer. Over 2 years, he became increasingly preoccupied with this theory, writing letters to various authorities trying to convince them he was being slowly killed. After he threatened harm to some local college administrators, his parents were contacted and they brought him to a psychologist, who diagnosed him with paranoid personality disorder and major depression.

Schizotypal Personality

A pervasive pattern of social and interpersonal deficits marked by

- ➢ acute discomfort with, and reduced capacity for, close relationships
- ➢ 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:

- ❖ ideas of reference (excluding delusions of reference)
- ❖ unusual perceptual experiences, including bodily illusions
- ❖ odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
- ❖ suspiciousness or paranoid ideation
- ❖ inappropriate or constricted affect
- ❖ behavior or appearance that is odd, eccentric, or peculiar
- ❖ 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

Schizotypal Personality

"ME PECULIAR"

- **M**agical thinking or odd beliefs
- **E**xperiences unusual perceptions
- **P**aranoid ideation
- **E**ccentric behavior or appearance
- **C**onstricted (or inappropriate) affect
- **U**nusual (odd) thinking and speech
- **L**acks close friends
- **I**deas of reference
- **A**nxiety in social situations
- **R**ule out psychotic disorders

Schizotypal Personality

SCHIZOTYPAL
suspicion and odd behavior

Biological Influences
- Genetic vulnerability for schizophrenia but without the biological or environmental stresses present in that disorder

CAUSES

Social/Cultural Influences
- Preference for social isolation
- Excessive social anxiety
- Lack of social skills

Psychological Influences
- Unusual beliefs, behavior, or dress
- Suspiciousness
- Believing insignificant events are personally relevant ("ideas of reference")
- Expressing little emotion
- Symptoms of major depressive disorder

Treatment
- Teaching social skills to reduce isolation and suspicion
- Medication (haloperidol) to reduce ideas of reference, odd communication, and isolation
- Low success rate

Mr. S. was a 35-year-old chronically unemployed man who had been referred by a physician because of a vitamin deficiency. This was thought to have developed because Mr. S. avoided any foods that “could have been contaminated by machine.” He had begun to develop alternative ideas about diet in his 20s and soon left his family and began to study an eastern religion. “It opened my third eye, corruption is all about,” he said.

He now lived by himself on a small farm, attempting to grow his own food, bartering for items he could not grow himself. He spent his days and evenings researching the origins and mechanisms of food contamination and, because of this knowledge, had developed a small band who followed his ideas. He had never married and maintained little contact with his family: “I've never been close to my father. I'm a vegetarian.”

He said he intended to do a herbalism course to improve his diet before returning to his life on the farm. He had refused medication from the physician and became uneasy when the facts of his deficiency were discussed with him.

Claster B

Histrionic Personality

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

❖ is uncomfortable in situations in which he or she is not the center of attention

❖ interaction with others is often characterized by inappropriate sexually seductive or provocative behavior displays rapidly shifting and shallow

❖expression of emotions consistently uses physical appearance to draw attention to self

❖has a style of speech that is excessively impressionistic and lacking in detail shows self-dramatization, theatricality, and exaggerated expression of emotion

❖is suggestible, i.e., easily influenced by others or circumstances

❖considers relationships to be more intimate than they actually are

Histrionic Personality

"PRAISE ME"

- **P**rovocative (or sexually seductive) behavior
- **R**elationships (considered more intimate than they are)
- **A**ttention (uncomfortable when not the center of attention)
- **I**nfluenced easily
- **S**tyle of speech (impressionistic, lacks detail)
- **E**motions (rapidly shifting and shallow)
- **M**ade up (physical appearance used to draw attention to self)
- **E**motions exaggerated (theatrical)

Histrionic Personality

HISTRIONIC
excessively emotional

Biological Influences
- Possible link to antisocial disorder – women histrionic/men antisocial

Psychological Influences
- Vain and self-centered
- Easily upset if ignored
- Vague and hyperbolic
- Impulsive; difficulty delaying gratification

CAUSES

Social/Cultural Influences
- Overly dramatic behavior attracts attention
- Seductive
- Approval-seeking

Treatment
- Little evidence of success
- Rewards and fines
- Focus on interpersonal relations

When we first met, Pat seemed to radiate enjoyment of life. She was single, in her mid-30s, and was going to night school for her master's degree. She often dressed flamboyantly. During the day she taught children with disabilities, and when she didn't have class she was often out late on a date. When I first spoke with her, she enthusiastically told me how impressed she was with my work in the field of developmental disabilities and that she had been extremely successful in using some of my techniques with her students. She was clearly overdoing the praise, but who wouldn't appreciate such flattering comments?

Because some of our research included children in her classroom, I saw Pat often. Over a period of weeks, however, our interactions grew strained. She often complained of various illnesses and injuries (falling in the parking lot, twisting her neck looking out a window) that interfered with her work. She was disorganized, often leaving to the last minute tasks that required considerable planning. Pat made promises to other people that were impossible to keep but seemed to be aimed at winning their approval; when she broke the promise, she usually made up a story designed to elicit sympathy and compassion. For example, she promised the mother of one of her students that she would put on a “massive and unique” birthday party for her daughter but forgot about it until the mother showed up with cake and juice. Upon seeing her, Pat flew into a rage and blamed the principal for keeping her late after school, although there was no truth to this accusation.

Pat often interrupted meetings about research to talk about her latest boyfriend. The boyfriends changed almost weekly, but her enthusiasm (“Like no other man I have ever met!”) and optimism about the future (“He's the guy I want to spend the rest of my life with!”) remained high for each of them. Wedding plans were seriously discussed with almost every one, despite their brief acquaintance. Pat was ingratiating, especially to the male teachers, who often helped her out of trouble she got into because of her disorganization.

When it became clear that she would probably lose her teaching job because of her poor performance, Pat managed to manipulate several of the male teachers and the assistant principal into recommending her for a new job in a nearby school district. A year later, she was still at the new school but had been moved twice to different classrooms. According to teachers she worked with, Pat still lacked close interpersonal relationships, although she described her current relationship as “deeply involved.” After a rather long period of depression, Pat sought help from a psychologist, who diagnosed her as also having histrionic personality disorder

Antisocial Personality

This disorder is characterized by a long-standing pattern of a disregard for other people's rights, often crossing the line and violating those rights.

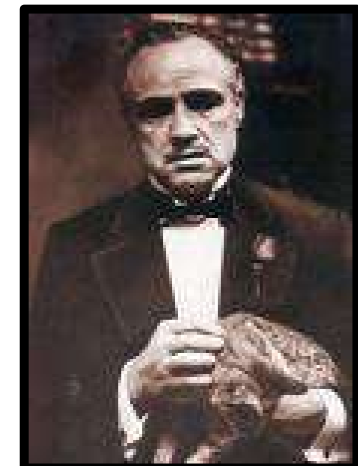
This pattern of behavior has occurred since age 15 (although only adults 18 years or older can be diagnosed with this disorder) and consists of the majority of these symptoms:

- ❖ failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- ❖deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- ❖impulsivity or failure to plan ahead
- ❖irritability and aggressiveness, as indicated by repeated physical fights or assaults
- ❖reckless disregard for safety of self or others
- ❖consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligation
- ❖lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Antisocial Personality

"CORRUPT"

- **C**onformity to law lacking
- **O**bligations ignored
- **R**eckless disregard for safety of self or others
- **R**emorse lacking
- **U**nderhanded (deceitful, lies, cons others)
- **P**lanning insufficient (impulsive)
- **T**emper (irritable and aggressive)



Antisocial Personality

ANTISOCIAL
violation of others' rights

CAUSES

Biological Influences
- Genetic vulnerability combined with environmental influences
- Abnormally low cortical arousal
- High fear threshold

Psychological Influences
- Difficulty learning to avoid punishment
- Indifferent to concerns of others

Social/Cultural Influences
- Criminality
- Stress/exposure to trauma
- Inconsistent parental discipline
- Socioeconomic disadvantage

Treatment
- Seldom successful (incarceration instead)
- Parent training if problems are caught early
- Prevention through preschool programs

I first met Ryan on his 17th birthday. Unfortunately, he was celebrating the event in a psychiatric hospital. He had been truant from school for several months and had gotten into some trouble; the local judge who heard his case had recommended psychiatric evaluation one more time, even though Ryan had been hospitalized six previous times, all for problems related to drug use and truancy. He was a veteran of the system and already knew most of the staff. I interviewed him to assess why he was admitted this time and to recommend treatment.

My first impression was that Ryan was cooperative and pleasant. He pointed out a tattoo on his arm that he had made himself, saying that it was a “stupid” thing to have done and that he now regretted it. He regretted many things and was looking forward to moving on with his life. I later found out that he was never truly remorseful for anything.

Our second interview was quite different. During those 48 hours, Ryan had done a number of things that showed why he needed a great deal of help. The most serious incident involved a 15-year-old girl named Ann who attended class with Ryan in the hospital school. Ryan had told her that he was going to get himself discharged, get in trouble, and be sent to the same prison Ann's father was in, where he would rape her father. Ryan's threat so upset Ann that she hit her teacher and several of the staff. When I spoke to Ryan about this, he smiled slightly and said he was bored and that it was fun to upset Ann. When I asked whether it bothered him that his behavior might extend her stay in the hospital, he looked puzzled and said, “Why should it bother me? She's the one who'll have to stay in this hell hole!”

Just before Ryan's admittance, a teenager in his town was murdered. A group of teens went to the local cemetery at night to perform satanic rituals, and a young man was stabbed to death, apparently over a drug purchase. Ryan was in the group, although he did not stab the boy. He told me that they occasionally dug up graves to get skulls for their parties—not because they really believed in the devil but because it was fun and it scared the younger kids. I asked, “What if this was the grave of someone you knew, a relative or a friend? Would it bother you that strangers were digging up the remains?” He shook his head. “They're dead, man; they don't care. Why should I?”

Ryan told me he loved PCP, or “angel dust,” and that he would rather be dusted than anything else. He routinely made the 2-hour trip to New York City to buy drugs in a particularly dangerous neighborhood. He denied that he was ever nervous.This wasn't machismo; he really seemed unconcerned.

Ryan made little progress. I discussed his future in family therapy sessions and we talked about his pattern of showing supposed regret and remorse and then stealing money from his parents and going back onto the street. Most of our discussions centered on trying to give his parents the courage to say no to him and not to believe his lies.

One evening, after many sessions, Ryan said he had seen the “error of his ways” and that he felt bad he had hurt his parents. If they would only take him home this one last time, he would be the son he should have been all these years. His speech moved his parents to tears, and they looked at me gratefully as if to thank me for curing their son. When Ryan finished talking, I smiled, applauded, told him it was the best performance I had ever seen. His parents turned on me in anger. Ryan paused for a second, then he, too, smiled and said, “It was worth a shot!” Ryan's parents were astounded that he had again tricked them into believing him; he hadn't meant a word of what he had just said. Ryan was eventually discharged to a drug rehabilitation program. Within 4 weeks, he had convinced his parents to take him home, and within 2 days he had stolen all their cash and disappeared; he apparently went back to his friends and to drugs.

When he was in his 20s, after one of his many arrests for theft, he was diagnosed as having antisocial personality disorder. His parents never summoned the courage to turn him out or refuse him money, and he continues to con them into providing him with a means of buying more drugs

Borderline Personality

Labile interpersonal relationships characterized by instability.

The pattern is present in a variety of settings (e.g., not just at work or home) and often is accompanied by a similar lability (fluctuating back and forth, sometimes in a quick manner) in a person's affect, or feelings.

- relationships and the person's affect may often be characterized as being shallow.
- a person with this disorder may also exhibit impulsive behaviors and exhibit a majority of the following symptoms:
- frantic efforts to avoid real or imagined abandonment
- a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- identity disturbance: markedly and persistently unstable self-image or sense of self
- impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) chronic feelings of emptiness
- inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- transient, stress-related paranoid ideation or severe dissociative symptoms

Borderline Personality
"A.M. SUICIDE"

–**A**bandonment

–**M**ood instability (marked reactivity of mood)

–**S**uicidal (or self-mutilating) behavior

–**U**nstable and intense relationships

–**I**mpulsivity

(in two potentially self-damaging areas)

–**C**ontrol of anger

–**I**dentity disturbance

–**D**issociative (or paranoid) symptoms that are transient and stress related

–**E**mptiness (chronic feelings of)

Borderline Personality

BORDERLINE
tumultuous instability

Biological Influences

- Familial link to mood disorders
- Possibly inherited tendencies (impulsivity or volatility)

Psychological Influences

- Suicidal
- Erratic moods
- Impulsivity

CAUSES

Social/Cultural Influences

- Early trauma, especially sexual/physical abuse
- Rapid cultural changes (immigration) may trigger symptoms

Treatment

- Dialectical behavior therapy (DBT)
- Medication:
  – tricyclic antidepressants
  – minor tranquilizers
  – lithium

Note: Cluster B also includes Narcissistic Personality Disorder.z

I have known Claire for more than 30 years and have watched her through the good but mostly bad times of her often shaky and erratic life as a person with borderline personality disorder. Claire and I went to school together from the eighth grade through high school, and we've kept in touch periodically. My earliest memory of her is of her hair, which was cut short rather unevenly. She told me that when things were not going well she cut her own hair severely, which helped to “fill the void.” I later found out that the long sleeves she usually wore hid scars and cuts that she had made herself.

Claire was the first of our friends to smoke. What was unusual about this and her later drug use was not that they occurred (this was in the 1960s when “If it feels good, do it” hadn't been replaced by “Just say no”) or that they began early; it was that she didn't seem to use them to get attention, like everyone else. Claire was also one of the first whose parents divorced, and both of them seemed to abandon her emotionally. She later told me that her father was an alcoholic who had regularly beaten her and her mother. She did poorly in school and had a low opinion of herself. She often said she was stupid and ugly, yet she was neither.

Throughout our school years, Claire left town periodically, without any explanation. I learned many years later that she was in psychiatric facilities to get help with her suicidal depression. She often threatened to kill herself, although we didn't guess that she was serious.

In our later teens, we all drifted away from Claire. She had become increasingly unpredictable, sometimes berating us for a perceived slight (“You're walking too fast. You don't want to be seen with me!”), and at other times desperate to be around us. We were confused by her behavior. With some people, emotional outbursts can bring you closer together. Unfortunately for Claire, these incidents and her overall demeanor made us feel that we didn't know her. As we all grew older, the “void” she described in herself became overwhelming and eventually shut us all out.

Claire married twice, and both times had passionate but stormy relationships interrupted by hospitalizations. She tried to stab her first husband during a particularly violent rage. She tried a number of drugs but mainly used alcohol to “deaden the pain.”

Now, in her mid-50s, things have calmed down some, although she says she is rarely happy. Claire does feel a little better about herself and is doing well as a travel agent. Although she is seeing someone, she is reluctant to become involved because of her personal history. Claire was ultimately diagnosed with major depression and borderline personality disorder

Narcissistic Personality

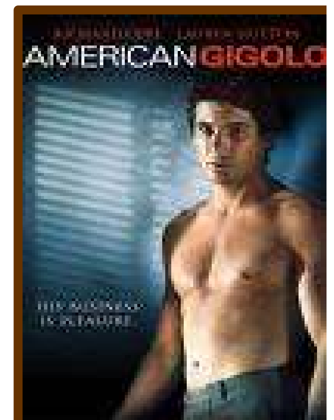
A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration lack of empathy

- Beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
- has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
- requires excessive admiration
- has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
- is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
- lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
- is often envious of others or believes that others are envious of him or her
- shows arrogant, naughty behaviors or attitudes

Narcissistic Personality

“SPECIAL”

- **S**pecial (believes he or she is special and unique)
- **P**reoccupied with fantasies (of unlimited success, power, brilliance, beauty, or ideal love)
- **E**nvious (of others, or believes others are envious of him or her)
- **E**ntitlement
- **E**xcess admiration required
- **C**onceited (grandiose sense of self importance)
- **I**nterpersonal exploitation
- **A**rrogant
- **L**acks empathy



Willie was an office assistant in a small attorney's office. Now in his early 30s, Willie had an extremely poor job history. He never stayed employed at the same place for more than 2 years, and he spent considerable time working through temporary employment agencies. Your first encounter, however, would make you believe that he was extremely competent and that he ran the office. If you entered the waiting room you were greeted by Willie, even though he wasn't the receptionist. He would be extremely solicitous, asking how he could be of assistance, offer you coffee, and ask you to make yourself comfortable in “his” reception area. Willie liked to talk, and any conversation was quickly redirected in a way that kept him the center of attention.

This type of ingratiating manner was welcomed at first but soon annoyed other staff. This was especially true when he referred to the other workers in the office as his staff, eventhough he was not responsible for supervising any of them. The conversations with visitors and staff often consumed a great deal of his time and the time of other staff, and this was becoming a problem.

He quickly became controlling in his job—a pattern revealed in his other positions as well—eagerly taking charge of duties assigned to others. Unfortunately, he did not complete these tasks well, and this created a great deal of friction.

When confronted with any of these difficulties, Willie would first blame others. Ultimately, however, it would become clear that Willie's self-centeredness and controlling nature were at the root of many of the office inefficiencies. During a disciplinary meeting with all of the law firm's partners, an unusual step, Willie became explosively abusive and blamed them for being out to get him. He insisted that his performance was exceptional at all of his previous positions—something contradicted by his previous employers—and that they were at fault. After calming down, he revealed a previous drinking problem, a history of depression, and multiple family problems, all of which he believed contributed to any difficulties he experienced.

The firm recommended he be seen at a university clinic as a condition of his continued employment, where he was diagnosed with major depression, as well as narcissistic personality disorder. Ultimately, his behavior—including lateness and incomplete work—resulted in his termination. In a revealing turn of events, Willie reapplied for another position at the same firm 2 years later. A mix-up in records failed to reveal his previous termination, but he lasted only 3 days— showing up late to work on his second and third days. He was convinced he could be successful, yet he could not change his behavior to conform to even the minimal standards needed to be successful at work.

Claster C

Avoidant Personality

- ❖ Long-standing and complex pattern of feelings of inadequacy,
- ❖ Extreme sensitivity to what other people think about them
- ❖ Social inhibition.
- ❖ It typically manifests itself by early adulthood and includes a majority of the following symptoms:

➢ Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection

➢Is unwilling to get involved with people unless certain of being liked shows restraint within intimate relationships because of the fear of being shamed or ridiculed

- ❖ is preoccupied with being criticized or rejected in social situations
- ❖ is inhibited in new interpersonal situations because of feelings of inadequacy
- ❖ views self as socially inept, personally unappealing, or inferior to others
- ❖ is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Avoidant Personality

"CRINGES"

– **C**ertainty (of being liked required before willing to get involved with others)
– **R**ejection (or criticism) preoccupies ones' thought in social situations
– **I**ntimate relationships (restraint in intimate relationships due to fear of being shamed)
– **N**ew interpersonal relationships (is inhibited in)
– **G**ets around occupational activity (involving significant interpersonal contact)
– **E**mbarrassment (potential) prevents new activity or taking personal risks
– **S**elf viewed (as unappealing, inept, or inferior)

Avoidant Personality

AVOIDANT
inhibition

Biological Influences
- Innate characteristics may cause rejection

Psychological Influences
- Low self-esteem
- Fear of rejection, criticism leads to fear of attention
- Extreme sensitivity
- Resembles social phobia

CAUSES

Social/Cultural Influences
- Insufficient parental affection

Treatment
- Behavioral intervention techniques sometimes successful
  –systematic desensitization
  –behavioral rehearsal
- Improvements usually modest

Dependent Personality

- Long-standing need for the person to be taken care of
- Fear of being abandoned or separated from important individuals in his or her life
- This pervasive fear leads to "clinging behavior" and usually manifests itself by early adulthood
- It includes a majority of the following symptoms:
  - has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
  - has difficulty expressing disagreement with others because of fear of loss of support or approval
  - has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
  - goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
  - feels uncomfortable or helpless when alone because of exaggerated fears of being unable
  - to care for himself or herself
  - urgently seeks another relationship as a source of care and support when a close relationship ends
  - is unrealistically preoccupied with fears of being left to take care of himself or herself
  - needs others to assume responsibility for most major areas of his or her life

Dependent Personality

"RELIANCE"

- **R**eassurance (required for decisions)
- **E**xpressing disagreement difficult (due to fear of loss of support or approval)
- **L**ife responsibilities (needs to have these assumed by others)
- **I**nitiating projects difficult (due to lack of self-confidence)
- **A**lone (feels helplessness and discomfort when alone)
- **N**urturance (goes to excessive lengths to obtain nurturance and support)
- **C**ompanionship (another relationship) sought urgently when close relationship ends
- **E**xaggerated fears of being left to care for self

Dependent Personality

DEPENDENT
pervasive need to be taken care of

CAUSES

Biological Influences

- Each of us born dependent for protection, food, and nurturance

Psychological Influences

- Early "loss" of care-taker (death, rejection, or neglect) leads to fear of abandonment
- Timidity and passivity

Social/Cultural Influences

- Agreement for the sake of avoiding conflict
- Similar to Avoidant in
  – inadequacy
  – sensitivity to criticism
  – need for reassurance

  BUT

  for those same shared reasons
- Avoidants withdraw
- Dependents cling

Treatment

- Very little research
- Appear as ideal clients
- Submissiveness negates independence

Karen was a 45-year-old married woman who was referred for treatment by her physician for problems with panic attacks. During the evaluation, she appeared to be worried, sensitive, and naive. She was easily overcome with emotion and cried on and off throughout the session. She was selfcritical at every opportunity throughout the evaluation. For example, when asked how she got along with other people, she reported that “others think I'm dumb and inadequate,” although she could give no evidence as to what made her think that. She reported that she didn't like school because “I was dumb” and that she always felt that she was not good enough.

Karen described staying in her first marriage for 10 years, even though “it was hell.” Her husband had affairs with many other women and was verbally abusive. She tried to leave him many times but gave in to his repeated requests to return. She was finally able to divorce him, and shortly afterward she met and married her current husband, whom she described as kind, sensitive, and supportive. Karen stated that she preferred to have others make important decisions and agreed with other people to avoid conflict. She worried about being left alone without anyone to take care of her and reported feeling lost without other people's reassurance. She also reported that her feelings were easily hurt, so she worked hard not to do anything that might lead to criticism.

Obsessive-Compulsive Personality

- ❖ A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency,
- ❖ Beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
- ➢ is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- ➢ shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
- ➢ is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
- ➢ is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
- ➢ is unable to discard worn-out or worthless objects even when they have no sentimental value
- ➢ is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
- ➢ adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
- ➢ shows rigidity and stubbornness

Obsessive-Compulsive Personality

"LAW FIRMS"

- **L**oses point of activity (due to preoccupation with detail)
- **A**bility to complete tasks (compromised by perfectionism)
- **W**orthless objects (unable to discard)
- **F**riendships (and leisure activities) excluded (due to preoccupation with work)
- **I**nflexible, scrupulous, over conscientious (on ethics values, or morality; not accounted for by religion or culture)
- **R**eluctant to delegate (unless others submit to exact guidelines)
- **M**iserly (toward self and others
- **S**tubbornness (and rigidity)

Obsessive-Compulsive Personality

OBSESSIVE-COMPULSIVE
fixation on details

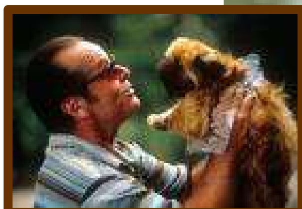
Biological Influences
- Distant relation to OCD
- Probable weak genetic role
  –predisposition to structure combined with parental reinforcement

CAUSES

Psychological Influences
- Generally rigid
- Dependent on routines
- Procrastinating

Social/Cultural Influences
- Very work-oriented
- Poor interpersonal relationships

Treatment
- Little information
- Therapy
  – attack fears behind need
  – relaxation or distraction techniques redirect compulsion to order

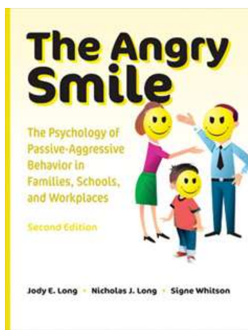


Each day at exactly 8 A.M., Daniej arrived at his office at the university where he was a graduate student in psychology. On his way, he always stopped at the 7-Eleven for coffee and the New York Times. From 8 to 9:15 AM., he drank his coffee and read the paper. At 9:15 AM., he reorganized the files that held the hundreds of papers related to his doctoral Dissertation, now several years overdue. From 10 AM. until noon, he read one of these papers, highlighting relevant passangers. Then he took the paper bag that held his lunch (always a peanut butter and jelly sandwich and an apple) and went to the cafeteria to purchase a soda and eat by himself. From 1 PM., until 5 PM>, he held meetings, organized his desk, made lists of things to do, and entered his references into a new database program on his computer. At home, Daniel had dinner with his wife, then worked on his dissertation until after 11 PM., although much of the time was spent Trying out new features of his home computer.

Daniel was no closer to completing his dissertation than he had been 4 years ago. His wife was threatening to leave him because he was equally rigid about everything at home and she didn't want to remain in this limbo of graduate school Forever. When Daniel eventually sought hepl from therapist for his anxiety over his deteriorating marriage, he was diagnosed as having obsessive-compulsive personality disorder.

Passive-Aggressive Personality

- ❖ Is currently debated whether it is a true personality disorder
- ❖ Pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance
- ❖ Beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
- ➢ passively resists fulfilling routine social and occupational tasks;
- ➢ complains of being misunderstood and unappreciated by others;
- ➢ is sullen and argumentative;
- ➢ unreasonably criticizes and scorns authority;
- ➢ expresses envy and resentment toward those apparently more fortunate;
- ➢ voices exaggerated and persistent complaints of personal misfortune;
- ➢ alternates between hostile defiance and contrition



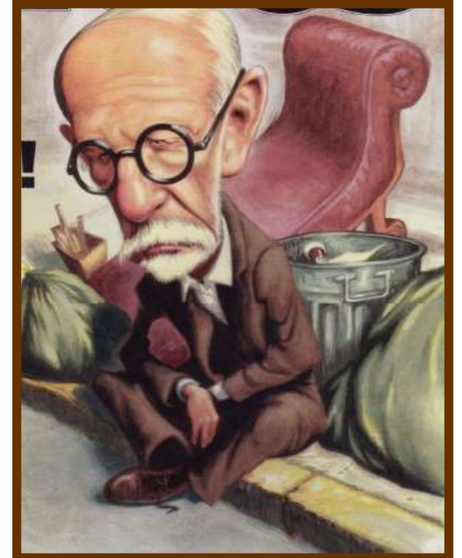
Treatment

Treatment

❖Personality disorders tend to be chronic and can sometimes last much of adult life

❖Need long-term treatment

❖Team approach



Treatment teams

The team involved in treatment may include:

➢Family or primary care doctor
➢Psychiatrist
➢Psychotherapist
➢Pharmacist
➢Family members
➢Social workers

Treatment

❖Treatment options
Several treatments are available for personality disorders. They include:

➢Psychotherapy

➢Medications

➢Hospitalization

Psychotherapy

Proven techniques for treatment are:

- Behavior Therapy/Behavior Modification
- Cognitive Therapy
- Cognitive-Behavioral Therapy (CBT)
- Dialectical-Behavior Therapy (DBT)
- Schema Therapy (ST)

Medications

❖**Antidepressants:** SSRI antidepressants or SNRI antidepressant help relieve depression and anxiety in people with personality disorders. Less often, MAOI drugs, may be used.

❖**Anticonvulsants:** These medications may help suppress impulsive and aggressive behavior. An anticonvulsant, is being researched as an aid in managing impulse-control problems.

❖**Antipsychotics:** People with borderline and schizotypal personality disorders are at risk of losing touch with reality. Antipsychotic medications such may help for severe behavior problems.

❖**Other medications:** Anti-anxiety medications and mood stabilizers such are used to relieve symptoms associated with personality disorders.

Hospitalization

Inpatient treatment is **rarely required** for patients with personality disorders.

Exceptions:

❖ **borderline patients** who are threatening suicide or suffering from drug or alcohol withdrawal

❖ patients with **paranoid personality** disorder who are having psychotic symptoms

Prevention & Prognosis

- ❖life-long disturbances
- ❖periods of worsening & improvement

❖**schizoid** patients, have better prognoses if they are given appropriate treatment

❖**paranoid** personality disorder are at some risk for developing delusional disorders or schizophrenia

Prevention & Prognosis

❖Dr. Aaron Beck estimates - **effective** cognitive therapy with patients with personality disorders takes **two to three** years on average

preventive strategy

•early identification and treatment of children at risk

➢abused children, children from troubled families, children with close relatives diagnosed with personality disorders, children of substance abusers, and children who grow up in cults or extremist political groups

Thank you!