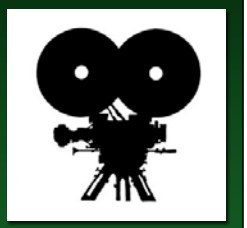
Abnormal Psychology

PSYCH 40111

Personality Disorders



Personality Disorders: An Overview

- The Nature of Personality and Personality Disorders
  - A **personality** is all the ways we have of acting, thinking, believing, and feeling that make each of us unique and different from every other person
    - Enduring and relatively stable predispositions
  - **Personality disorders** are long-standing patterns of thought, behavior, and emotions that are maladaptive for the individual or for people around him or her
    - Predispositions are inflexible and maladaptive, causing distress and/or impairment
    - Coded on Axis II of the DSM-IV and DSM-IV-TR

Table 17-1 DSM-IV Checklist

PERSONALITY DISORDER

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, with at least two of the following areas affected: • cognition • affectivity • interpersonal functioning • impulse control.
2. Pattern is inflexible and pervasive across a broad range of personal and social situations.
3. Pattern is stable and long-lasting, and its onset can be traced back at least to adolescence or early adulthood.
4. Significant distress or impairment.

Based on APA, 2000, 1994.

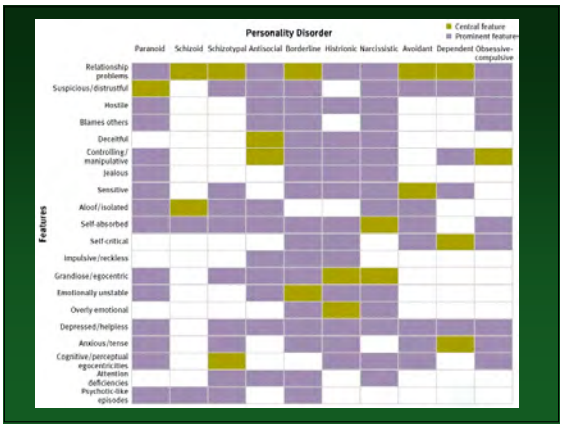
Personality Disorder Clusters

- Personality disorders fall into three general clusters:
  - Persons in Cluster A seem odd or eccentric
    - Paranoid, schizoid, schizotypal
  - Persons in Cluster B seem dramatic, emotional or erratic
    - Antisocial, borderline, histrionic, narcissistic
  - Persons in Cluster C appear as anxious or fearful
    - Avoidant, dependent, obsessive-compulsive

Table 17-2

Comparison of Personality Disorders

	DSM-IV CLUSTER	SIMILAR DISORDERS ON AXIS I	RESPONSIVENESS TO TREATMENT
Paranoid	Odd	Schizophrenia; delusional disorder	Modest
Schizoid	Odd	Schizophrenia; delusional disorder	Modest
Schizotypal	Odd	Schizophrenia; delusional disorder	Modest
Antisocial	Dramatic	Conduct disorder	Poor
Borderline	Dramatic	Mood disorders	Moderate
Histrionic	Dramatic	Somatoform disorders; mood disorders	Modest
Narcissistic	Dramatic	Cyclothymic disorder (mild bipolar disorder)	Poor
Avoidant	Anxious	Social phobia	Moderate
Dependent	Anxious	Separation anxiety disorder; dysthymic disorder (mild depressive disorder)	Moderate
Obsessive-compulsive	Anxious	Obsessive-compulsive anxiety disorder	Moderate



Categorical vs. Dimensional Views of Personality Disorders

An Alternative: The Five-Factor Model

- Neuroticism
- Extraversion
- Openness to experience
- Agreeableness
- Conscientiousness

Personality Disorders: Facts and Statistics

- Prevalence of Personality Disorders
  - About 0.5% to 2.5% of the general population
  - Rates are higher in inpatient and outpatient settings
- Origins and Course of Personality Disorders
  - Thought to begin in childhood
  - Tend to run a chronic course if untreated
- Co-Morbidity Rates are High
- Gender Distribution and Gender Bias in Diagnosis
  - Gender bias exists in the diagnosis of personality disorders
  - Such bias may be a result of criterion or assessment gender bias

Cluster A: Paranoid Personality Disorder

- Overview and Clinical Features
  - Pervasive and unjustified mistrust and suspicion
  - Occurs more frequently in men than in women
  - Lifetime prevalence is about 1 percent
- The Causes
  - Biological and psychological contributions are unclear
  - May result from early learning that people and the world is a dangerous place
- Treatment Options
  - Few seek professional help on their own
  - Treatment focuses on development of trust
  - Cognitive therapy to counter negativistic thinking
  - Lack good outcome studies showing that treatment is efficacious

Cluster A: Schizoid Personality Disorder

- Overview and Clinical Features
  - Pervasive pattern of detachment from social relationships
  - Very limited range of emotions in interpersonal situations
  - Prevalence of schizoid PD is less than 1 percent and occurs more commonly in men than women
- The Causes
  - Etiology is unclear
  - Preference for social isolation in schizoid personality resembles autism
- Treatment Options
  - Few seek professional help on their own
  - Focus on the value of interpersonal relationships, empathy, and social skills
  - Treatment prognosis is generally poor
  - Lack good outcome studies showing that treatment is efficacious

Cluster A: Schizotypal Personality Disorder

- Overview and Clinical Features
  - Behavior and dress is odd and unusual
  - Most are socially isolated and may be highly suspicious of others
  - Magical thinking, ideas of reference, and illusions are common
  - Risk for developing schizophrenia is high in this group
  - Many also meet criteria for major depression
  - Prevalence of schizotypal PD is about 3 percent and occurs slightly more commonly in men than women
- The Causes
  - Schizoid personality – A phenotype of a schizophrenia genotype?
  - Left hemisphere and more generalized brain deficits

Cluster A: Schizotypal Personality Disorder

- Treatment Options
  - Main focus is on developing social skills
  - Treatment also addresses comorbid depression
  - Medical treatment is similar to that used for schizophrenia
  - Treatment prognosis is generally poor

Etiology of the Odd/Eccentric Cluster

- These disorders are linked to schizophrenia and may represent a less severe form of the disorder
  - Schizophrenia has clear genetic determinants
  - Family studies reveal that relatives of schizophrenia patients are at increased risk for developing schizotypal PD as well as paranoid PD
    - No clear pattern for schizoid PD

Cluster C: Avoidant Personality Disorder

- Overview and Clinical Features
  - Extreme sensitivity to the opinions of others
  - Highly avoidant of most interpersonal relationships
  - Are interpersonally anxious and fearful of rejection
  - Prevalence of Avoidant PD is about 1 percent and this disorder is co-morbid with dependent PD and borderline PD
- The Causes
  - Numerous factors have been proposed
  - Early development – A difficult temperament produces early rejection
- Treatment Options
  - Several well-controlled treatment outcome studies exist
  - Treatment is similar to that used for social phobia
  - Treatment targets include social skills and anxiety

Cluster C: Dependent Personality Disorder

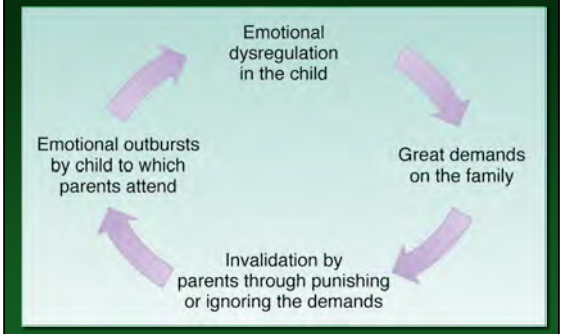
- Overview and Clinical Features
  - Excessive reliance on others to make major and minor life decisions
  - Unreasonable fear of abandonment
  - Tendency to be clingy and submissive in interpersonal relationships
  - Prevalence of Dependent PD is about 1.5 percent and occurs slightly more commonly in women than men
- The Causes
  - Still largely unclear
  - Linked to early disruptions in learning independence
- Treatment Options
  - Research on treatment efficacy is lacking
  - Therapy typically progresses gradually
  - Treatment targets include skills that foster independence

Cluster C: Obsessive-Compulsive Personality Disorder

- Overview and Clinical Features
  - Excessive and rigid fixation on doing things the right way
  - Tend to be highly perfectionistic, orderly, and emotionally shallow
  - Obsessions and compulsions are rare
  - Prevalence of Obsessive-Compulsive PD is about 1 percent and this disorder is co-morbid with avoidant PD
- The Causes
  - Are largely unknown
- Treatment Options
  - Data supporting treatment are limited
  - Treatment may address fears related to the need for orderliness
  - Other targets include rumination, procrastination, and feelings of inadequacy

Cluster B: Borderline Personality Disorder

- Overview and Clinical Features
  - Patterns of unstable moods and relationships
  - Impulsivity, fear of abandonment, coupled with a very poor self-image
  - Self-mutilation and suicidal gestures are not uncommon
  - Prevalence of Borderline PD is about 1-2 percent and occurs more commonly in women than men
  - Most common personality disorder in psychiatric settings
  - Comorbidity rates are high
- The Causes
  - Borderline personality disorder runs in families
  - Early trauma and abuse seem to play some etiologic role



Cluster B: Borderline Personality Disorder

- Treatment Options
  - Few good treatment outcome studies
  - Antidepressant medications provide some short-term relief
  - Dialectical behavior therapy is the most promising psychosocial approach

Cluster B: Histrionic Personality Disorder

- Overview and Clinical Features
  - Patterns of behavior that are overly dramatic, sensational, and sexually provocative
  - Often impulsive and need to be the center of attention
  - Thinking and emotions are perceived as shallow
  - Prevalence of histrionic PD is about 2-3 percent and occurs slightly more commonly in women than men
- The Causes
  - Etiology is largely unknown
  - Is histrionic personality a sex-typed variant of antisocial personality?

Cluster B: Histrionic Personality Disorder

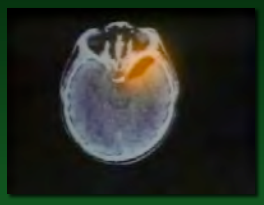
- Treatment Options
  - Few good treatment outcome studies
  - Treatment focuses on attention seeking and long-term negative consequences
  - Targets may also include problematic interpersonal behaviors
  - Little evidence that treatment is effective

Cluster B: Narcissistic Personality Disorder

- Overview and Clinical Features
  - Exaggerated and unreasonable sense of self-importance
  - Preoccupation with receiving attention
  - Lack sensitivity and compassion for other people
  - Highly sensitive to criticism
  - Tend to be envious and arrogant
  - Prevalence of narcissistic PD is less than 1 percent and this disorder co-occurs with borderline PD
- The Causes
  - Psychoanalytic Viewpoints-child as a means to parent's end
  - Sociological view – Narcissism as a product of the "me" generation

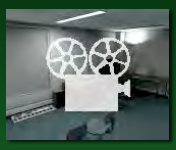
Cluster B: Narcissistic Personality Disorder

- Treatment Options
  - Extremely limited treatment research
  - Treatment focuses on grandiosity, lack of empathy, unrealistic thinking
  - Treatment may also address co-occurring depression
  - Little evidence that treatment is effective



What's Normal?: Violence in US society

- Violence is accepted aspect of U.S. culture
- U.S. has higher rate of violent crime and greater proportion of people in jail compared to other industrialized countries
- Young American men die from violent causes such as homicide, car accidents and suicides at rate of more than 70 per 100,000
- Violence is an accepted method of dealing with interpersonal conflict- 1 in 8 males and 1 in 25 females had been in fight in last 30 days
- Southerners more likely to endorse violence in situations involving protection of self, family and property and in response to insults, and child discipline technique



Cluster B: Antisocial Personality Disorder

Characteristics of the antisocial personality

- A predatory attitude toward other people
- A chronic indifference to and violation of the rights of one's fellow human beings
- A history of illegal or socially disapproved activity beginning before age 15 and continuing into adulthood
- Failure to show constancy and responsibility in work, sexual relationships, parenthood, or financial obligations
- Irritability and aggressiveness
- Reckless and impulsive behavior
- Disregard for the truth

Antisocial Behavior and Psychopathy

The Psychopath

- Deeds are not motivated by any understandable purpose
- Have only the shallowest emotions
- Poor judgement and failure to learn from experience
- Ability to maintain a pleasant and convincing exterior
- Inadequate conscience development
- Irresponsible and impulsive behavior
- Rejection of authority
- Ability to impress and exploit others
- Inability to maintain good relationships

Overlap and lack of overlap among antisocial personality disorder, psychopathy, and criminality

Antisocial Personality Disorder: Facts and Statistics

- Predominantly affects young, low income, poorly educated males
- One of most frequent personality disorders (3.5%)
- Appears far more frequently in men (5-6x) and starts earlier
- Rates differ by type of sociocultural variations
- Course of childhood deviance- the longer the pattern exists, the less likely they will outgrow these behaviors
- Of children with CD, 40% of males and 24% of females will be diagnosed with adult APD; 50-75% of adolescent delinquents go on to be adult offenders

Antisocial Personality Disorder: Biological Causes

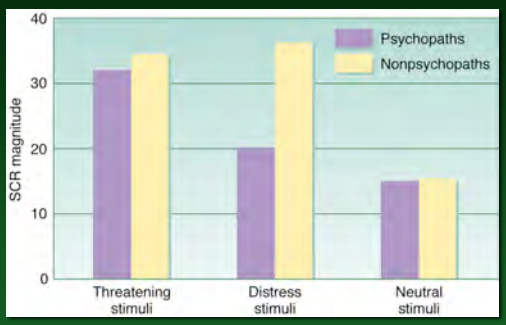
- Genetics: A bad seed?
  - Higher similarity of antisocial traits and criminal behaviors between male MZ twins (51.5%) than DZ twins (23.1%)
  - Studies demonstrate a portion of criminality is consistent with genetic vulnerability
  - Danish and Swedish studies- rates of criminality among adoptees more similar to that of biological parents than between adoptive parents
  - Environmental factors are more important predictors of antisocial conduct than genetics, but there is some genetic vulnerability

Antisocial Personality Disorder: Biological Causes

- Testosterone may play a role in violent behavior, but research is inconsistent
- Impulsive aggresiveness might be associated with low serotonin, but not with planned violence
- Children in treatment for disruptive behavior disorders found to have low serotonin levels
- Aggressiveness ratings and loss of impulse control in rhesus monkeys correlated significantly with low serotonin metabolite levels
- Some forms of violence may be linked to genetic abnormalities: absence of monoamine oxidase A (metabolism of serotonin) in family with violent males
- Serotonin deficit may be linked to frontal cortex- affect self-control and judgment

Antisocial Personality Disorder: Biological Causes

- Deficiencies in emotional arousal- low levels or absence of physical reactions to fearful or aversive conditions
- Sensation seeking may be one explanation of antisocial behavior
- Show deficient avoidant learning- psychopaths do not respond to fear-arousing learning situations
- May lack the ability to inhibit responses even in the face of punishment, difficulty inhibiting certain responses



Antisocial Personality Disorder: Psychological Causes

- Freud says result of malformed superego
- Social learning theorists say environment provides aggressive role models, reinforces aggressive conduct, instigates aggression through frustration and provocation
- Hostile attribution bias (the tendency to believe that negative events are caused by other people intending harm) increases the chances of aggressive responses
- Exposure to violent models in culture
- Dysfunctional family experiences (such as conflict, negativity, criticism, inconsistent anger) in childhood are a powerful predictor of later APD and aggressive conduct

Treatment of Antisocial Personality Disorder

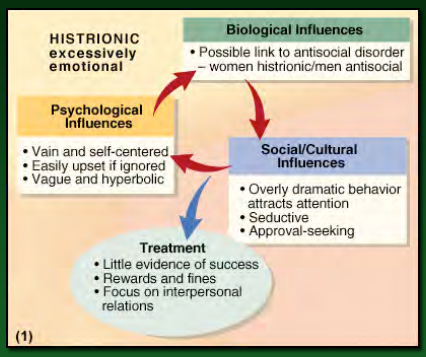
- Treatment
  - Few seek treatment on their own
  - Antisocial behavior is predictive of poor prognosis, even in children
  - Emphasis is placed on prevention and rehabilitation
  - Often incarceration is the only viable alternative

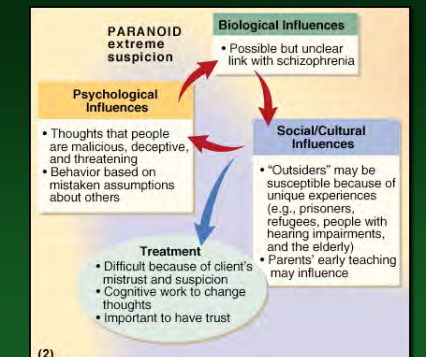
DSM-IV Personality Disorders Under Study

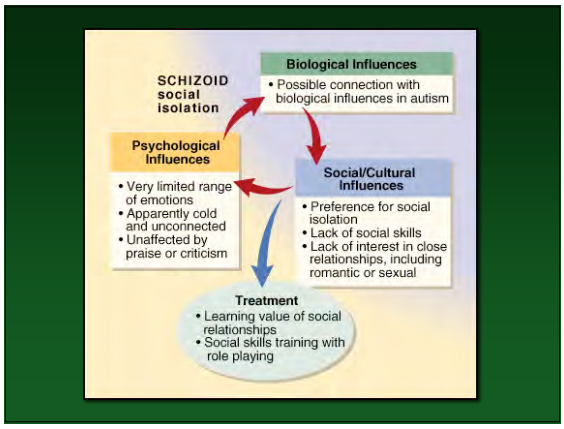
- Proposed DSM Personality Disorders
  - Sadistic personality disorder
  - Self-defeating personality disorder
- New Categories of DSM Personality Disorders Under Study
  - Depressive personality disorder
  - Negativistic personality disorder

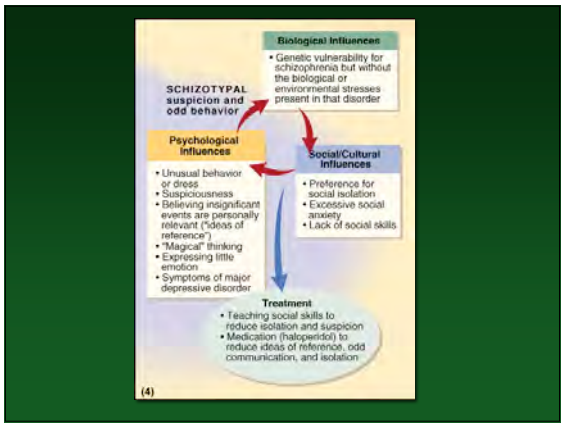
Summary of Personality Disorders

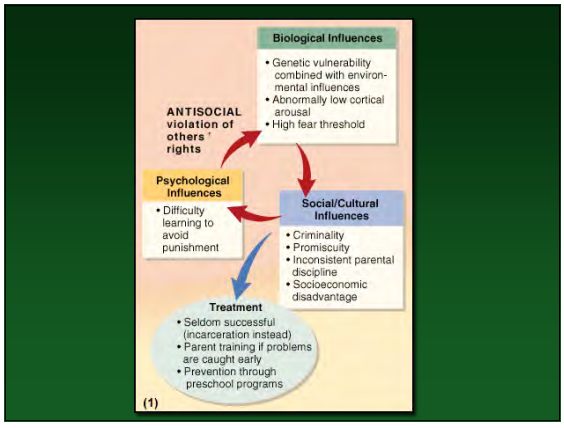
- Personality Disorders
  - Long-standing, ingrained ways of thinking, feeling, and behaving
- DSM-IV Includes 10 Personality Disorders
  - Personality disorders fall in one of three clusters – Cluster A, B, or C
- The Causes of Personality Disorders Are Difficult to Pinpoint
  - May be interaction between a child's biological temperament and from the reactions of self and others to that temperament may emerge a lifelong pattern of dysfunction
- Treatment of Personality Disorders Is Often Difficult

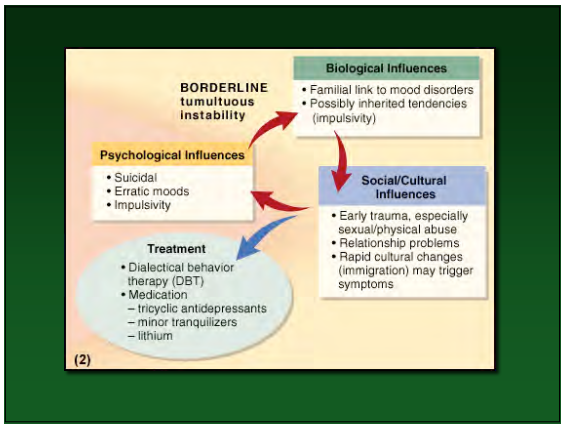


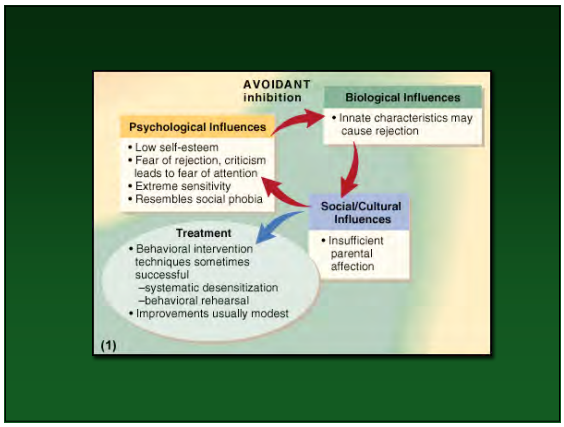


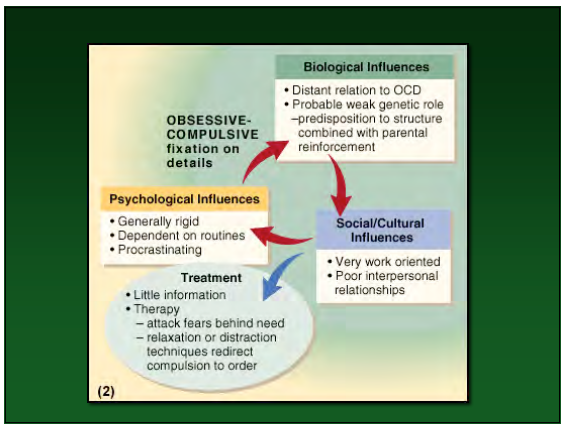

SCHIZOID social isolation
Biological Influences
• Possible connection with biological influences in autism
Psychological Influences
• Very limited range of emotions
• Apparently cold and unconnected
• Unaffected by praise or criticism
Social/Cultural Influences
• Preference for social isolation
• Lack of social skills
• Lack of interest in close relationships, including romantic or sexual
Treatment
• Learning value of social relationships
• Social skills training with role playing

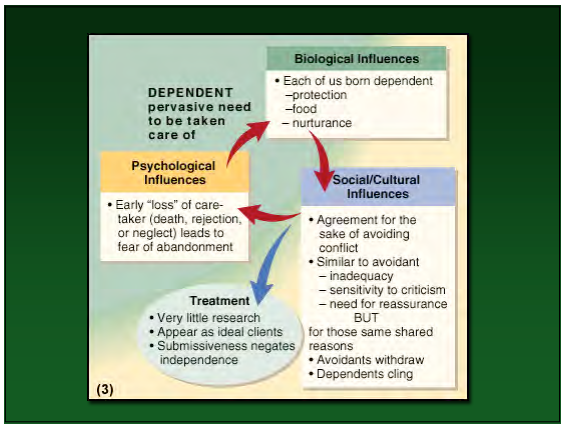

SCHIZOTYPAL suspicion and odd behavior
Biological Influences
• Genetic vulnerability for schizophrenia but without the biological or environmental stresses present in that disorder
Psychological Influences
• Unusual behavior or dress
• Suspiciousness
• Believing insignificant events are personally relevant ("ideas of reference")
• "Magical" thinking
• Expressing little emotion
• Symptoms of major depressive disorder
Social/Cultural Influences
• Preference for social isolation
• Excessive social anxiety
• Lack of social skills
Treatment
• Teaching social skills to reduce isolation and suspicion
• Medication (haloperidol) to reduce ideas of reference, odd communication, and isolation
(4)


ANTISOCIAL violation of others' rights
Biological Influences
• Genetic vulnerability combined with environmental influences
• Abnormally low cortical arousal
• High fear threshold
Psychological Influences
• Difficulty learning to avoid punishment
Social/Cultural Influences
• Criminality
• Promiscuity
• Inconsistent parental discipline
• Socioeconomic disadvantage
Treatment
• Seldom successful (incarceration instead)
• Parent training if problems are caught early
• Prevention through preschool programs
(1)


BORDERLINE
tumultuous
instability
Biological Influences
• Familial link to mood disorders
• Possibly inherited tendencies (impulsivity)
Psychological Influences
• Suicidal
• Erratic moods
• Impulsivity
Social/Cultural Influences
• Early trauma, especially sexual/physical abuse
• Relationship problems
• Rapid cultural changes (immigration) may trigger symptoms
Treatment
• Dialectical behavior therapy (DBT)
• Medication
– tricyclic antidepressants
– minor tranquilizers
– lithium
(2)


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
Social/Cultural Influences
• Insufficient parental affection
Treatment
• Behavioral intervention techniques sometimes successful
–systematic desensitization
–behavioral rehearsal
• Improvements usually modest
(1)


Biological Influences
• Distant relation to OCD
• Probable weak genetic role
–predisposition to structure combined with parental reinforcement
OBSESSIVE-
COMPULSIVE
fixation on
details
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
(2)


DEPENDENT pervasive need to be taken care of
Biological Influences
• Each of us born dependent
–protection
–food
– nurturance
Psychological Influences
• Early "loss" of care-taker (death, rejection, or neglect) leads to fear of abandonment
Social/Cultural Influences
• Agreement for the sake of avoiding conflict
• Similar to avoidant
– 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
(3)