Definition of a Personality Disorder

- Enduring pattern of inner experience and behavior
- Deviates markedly from expectations of the individual’s culture
- Pervasive and inflexible
- Onset in adolescence or early adulthood
- Stable over time
- Leads to distress or impairment

From DSM-IV-TR
Personality Disorder Clusters

**Cluster A**
(Odd or Eccentric)
- Paranoid
- Schizoid
- Schizotypal

**Cluster B**
(Dramatic, Emotional, Erratic)
- Antisocial
- Borderline
- Histrionic
- Narcissistic

**Cluster C**
(Anxious or Fearful)
- Avoidant
- Dependent
- Obsessive-Compulsive
General Criteria

A. Manifested in 2 or more of the following areas:
   • Cognition
   • Affectivity
   • Interpersonal Functioning
   • Impulsive Control

B. Enduring Pattern is inflexible and pervasive

C. Pattern leads significant distress or impairment

D. Onset in Adolescence or Young Adulthood

   Exercise caution and meticulous judgment before giving a PDO diagnosis to a child or adolescent. Cognitions, beliefs, and behaviors in children and adolescents can have many causes. A diagnosis – whether correct or incorrect -- can follow them for their lifetime and impact every domain of their life.

E. Pattern not better accounted for as a manifestation of another disorder

F. Not due to substance or general medical condition
• Person must meet the general criteria before a specific personality disorder is diagnosed
• Coded on Axis II
• Personality Traits are often *Ego-Syntonic* (Feels like a normal part of oneself, not considered problematic to individual)
• Is often necessary to conduct more than one interview to determine (p. 686 DSM-IV)
• Difficult to treat and can affect treatment of other disorders
Cluster A: Paranoid Personality Disorder (301.0)

Must present with 4 or more of the following:

1) Suspects without sufficient basis that others are exploiting, harming or deceiving him/her
2) Preoccupied with unjustified doubts about loyalty/trustworthiness of friends/associates
3) Reluctant to confide in others; fear info will be used maliciously against him/her
4) Persistently bears grudges
5) Perceives attacks on his/her character or reputation; quick to react angrily
6) Recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner
Differential Diagnosis for Paranoid Personality Disorder

• Does not occur exclusively during:
  – The course of Schizophrenia
  – A mood disorder with psychotic features
  – Another Psychotic Disorder
  – Not due to Direct physiological effects of a general medical condition

• If criteria met prior to onset of Schizophrenia, add the term “premorbid”
**Etiology**

- **Little Research**
- **Genetics** (Kendler et al., 2006)
- “seem[s] to be a relationship with schizophrenia although not clear” (Durand & Barlow, 2010)
- Speculation that parents may teach them to be careful about making mistakes and impress on them they are different than other people (Turkat & Maisto, 1985)
- **susceptible groups** (prisoners, refugees, elderly) (MM O’Brien, Trestman, & Siever, 1993)

**Treatment**

- **Unlikely to seek help** because mistrustful; difficult to establish rapport
- If they do seek help usually due to a crisis or other Axis I problem
- Therapist must develop **atmosphere of trust**
- **Cognitive therapy** (challenge beliefs)
Cluster A: **Schizoid Personality Disorder (301.20)**

Must present with 4 or more of the following:

1) Neither desires or enjoys close relationships
2) Almost always chooses solitary activities
3) Has little, if any, interest in sexual experiences with another person
4) Takes pleasure in few, if any, activities
5) Lacks close friend or confidants other than first-degree relatives
6) Shows emotional coldness, detachment, or flattened affectivity
Etiology
- Childhood shyness reported as precursor
- Abuse and neglect (J.G. Johnson, Bromley & McGeoch, 2005)
- Autism and parents of children with autism both more likely to have this disorder
- Same bio-dysfunction found in autism and schizoid + early learning problems with relationships = social deficits that define schizoid (Wolff, 2000)

Treatment
- Rare for this person to seek out treatment except in response to a crisis
- Therapists point out value in social relationships
- Teach emotions felt by others to help client learn empathy
- Social skills training (role playing)
- Develop and identify social network/supportive people
Cluster A: Schizotypal Personality Disorder (301.22)

Must present with 5 or more of the following:

1) Ideas of reference (e.g., Incorrect interpretation of casual incidents)
2) Odd beliefs or magical thinking that influences behavior and is inconsistent with sub-cultural norms (e.g., Belief of clairvoyance, telepathy, “sixth sense”)
3) Unusual perceptual experiences (e.g., Bodily illusions)
4) Odd thinking and speech
5) Suspiciousness or paranoid ideation
6) Inappropriate or constricted affect
7) Behavior or appearance that is odd, eccentric, or peculiar
8) Lack of close friends or confidants other than first-degree relatives
9) Excessive social anxiety
Etiology

- Viewed as phenotype of a schizophrenia genotype (genetics)
- Many characteristics of schizotypal personality overlap with schizophrenia
- Brain abnormality (Dickey et al; 2000); damage in left hemisphere

Treatment

- 30-50% meet criteria for major depressive disorder → medical and psychological treatment for depression
- Antipsychotic med, community treatment and social skills training reduced symptoms (Nordentoft et al, 2006)
Differential Diagnosis for **Schizoid** & **Schizotypal** Personality Disorder

- Does not occur exclusively during:
  - The course of Schizophrenia
  - A mood disorder with psychotic features
  - Another Psychotic Disorder
  - Rule out Pervasive Developmental Disorder
    (Kaplan & Saddock 1998)
  - Not due to Direct physiological effects of a general medical condition

- If criteria met prior to onset of Schizophrenia, add the term “premorbid”
Cluster B: Antisocial Personality Disorder (301.7)

Pervasive pattern of disregard and violation of the rights of others occurring since age 15, as indicated by 3 or more of the following:

1) Failure to conform to social norms with respect to lawful behaviors
2) Deceitfulness, as indicated by repeated lying, use of aliases, conning others
3) Impulsivity and failure to plan ahead
4) Irritability and aggressiveness (fights/assaults)
5) Reckless disregard for the safety of self or others
6) Consistent irresponsibility (failure to sustain work behavior/honor obligations)
7) Lack of remorse
Differential Diagnosis for Antisocial Personality Disorder

- The individual is at least age 18 years.
- There is evidence of Conduct Disorder with onset before age 15.
- The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.
Etiology

- Genetic predisposition: based on family/twin studies (Waldman & Rhee, 2006)
- Neurobiological influences: 2 theories—underarousal (low level of cortical arousal which leads individuals to seek out stimulation) and fearlessness—hold higher threshold for experiencing fear
  -- Social study: antisocial personality refused to abandon goal even after goal was no longer attainable (Hiatt & Newman, 2006) (study not generalized across race)
- Coercive Family Process: Parents give into problem behaviors displayed by children; inconsistent discipline
- Integrative Model: difficult temperament plus impulsivity—alienates other children, drops out of school
- Trauma in Combat (one study showed increase) (D.H.Barrett, Resnick et. al (1996)

Treatment

- Rarely Identify as needing treatment; manipulate counselors
- "therapeutic communities"—intensive group therapy (in prison) 80 hrs/week; 10 year were less likely to reoffend
- Focus on children (prevention): parent training—teaching parents how to praise/privileges to reduce problem behavior and encourage pro-social behaviors
Cluster B: Borderline Personality Disorder (301.83)

Pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood, indicated by five or more of the following:

1) Frantic efforts to avoid real or imagined abandonment
2) Interpersonal relationships marked by extremes of idealization and devaluation
3) Identity Disturbance; unstable self-image or sense of self
4) Impulsivity in at least two areas that are potentially self-damaging (ex. Spending, SA)
5) Recurrent suicidal behavior, gestures, threats, self-mutilating
6) Affective instability due to marked reactivity of mood
Differential Diagnosis for Borderline Personality Disorder

- Often co-occurs with mood disorders
- Must have documentation of an early onset and long-standing course
- Important to rule out other personality disorders because of similar symptoms
**Etiology**

- More prevalent in families with borderline personality disorder and somehow is linked with mood disorders
- Genetics: high concordance rate among monozygotic twins (Torgersen et al., 2000) → predisposition towards emotional reactivity
- Majority report abuse/neglect from both parents, sexual abuse, physical abuse by others or a combination
- Sexual abuse—women 2-3 times more likely than boys

**Treatment**

- Individuals appear quite distressed and are more likely to seek treatment even than people with anxiety and mood disorders (Ansell, Sanislow, McGlashan, & Grilo, 2007)
- SSRI and lithium---help
- Treatment can be complicated by drug use, suicide attempts, noncompliance with treatment
- DBT Dialectical Behavior Therapy (Linehan)—help people cope with stressors; patients taught how to identify & regulate their emotions; learn to trust own responses rather than dependent on others
Cluster B: Histrionic Personality Disorder (301.50)

Pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood, indicated by 5 or more:

1) Uncomfortable in situations which he or she is not the center of attention
2) Interactions with others are often characterized by inappropriate sexually seductive or provocative behavior
3) Displays rapidly shifting and shallow expression of emotions
4) Consistently uses physical appearance to draw attention to self
5) Has a style of speech that is excessively impressionistic and lacking in details
6) Shows self-dramatization, theatricality, and exaggerated expression of emotion
7) Is suggestible (easily influenced by others)
8) Considers relationships to be more intimate than they actually are
Differential Diagnosis for Histrionic Personality

- Must be differentiated from other personality disorders
- Must not be due to a general medical condition
- Must be distinguished from symptoms that may develop in association with chronic substance abuse
Etiology

- High rate of diagnosis among women versus men (may be bias among psychologists when diagnosing) (Sprock, 2000)
- Little known regarding causes
- Roughly 2/3 people with histrionic personality also met criteria for antisocial personality disorder; theory of sex-typed alternative expressions

Treatment

- Little research demonstrates success (Horowitz, 2001)
- Treatment spent on trying to modify attention-getting behavior
- Focus on problematic interpersonal relationships: often try to manipulate others through emotional crises using charm, sex, seductiveness or complaining
Cluster B: Narcissistic Personality Disorder (301.81)

Pervasive pattern of grandiosity, need for admiration, and lack of empathy indicated by 5 or more of the following:

1) Has a grandiose sense of self importance
2) Is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love
3) Believes that he or she is “special”
4) Requires excessive admiration
5) Has a sense of entitlement (unreasonable expectations)
6) Is interpersonally exploitative
7) Lacks empathy
8) Often envious of others or believes others are envious of him/her
9) Shows arrogant, haughty behaviors or attitudes
Differential Diagnosis for Narcissistic Personality

• Must rule out another personality disorder (e.g., OCPD’s want perfectionism but Narcissists believe they can achieve perfectionism)
• Grandiosity must not be due to manic or hypomanic episodes
• Must not be due to symptoms associated with chronic substance abuse
Etiology

- Failure by parents to model empathy; as a consequence, child remains fixated at a self-centered, grandiose stage of development → individual attempts to search for the ideal person who will meet these unfulfilled empathetic needs (Kohut, 1977) *(sometimes known as “Narcissistic wound”)*
- Cultural causes: culture’s emphasis on hedonism, individualism, competitiveness, and success

Treatment

- Therapy focuses on grandiosity, hypersensitivity to evaluation, and lack of empathy towards others (Beck, 2007)
- Cognitive therapy: focus on day to day pleasures that are attainable
- Focus on feelings of others/empathy
- Depression can occur, typically in middle age: treat depression
- Little research known on treatment outcomes for narcissistic personality disorder
Cluster C: Avoidant Personality Disorder (301.82)

Pervasive pattern of social inhibition, feelings of inadequacy, hypersensitivity towards negative evaluation, indicated by 4 or more:

1) Avoids activities for fear of criticism, disapproval or rejection
2) Is unwilling to get involved with people unless certain of being liked
3) Shows restraint within intimate relationship because of fear of being shamed or ridiculed
4) Is preoccupied with being criticized or rejected in social situations
5) Is inhibited in new situations - fears inadequacy
6) Views self as socially inept, personally unappealing, or inferior to others
7) Unusual reluctant to take risks/engage in new activities
Differential Diagnosis for Avoidant Personality Disorder

• Must rule out another personality disorder such as Schzoid Personality Disorder (*Schzoids* do not want relationships; *Avoidants* want them but are frightened of them)
  • Must rule out phobias (agoraphobics, people who have simple phobias, and people with social phobias, will have the same avoidant mechanisms).
• Must rule out Axis I Anxiety Disorders
• Must rule out Depression
• Must rule out Hearing Impairment
• Must rule out Pervasive Developmental Disorder or Autism
**Etiology**

- Some evidence suggests its related to other subschizophrenia disorders (Fogelson et al, 2007)
- Theories: person is born with difficult temperament therefore parents reject them or not provide them with enough “uncritical love”. Some evidence does support this: those with disorder remember their parents as more rejecting and less affectionate than control group (Durand & Barlow, 2010)

**Treatment**

- Behavioral intervention techniques for anxiety and social skill difficulties has shown to be effective (similar treatment to social phobia)
- Therapeutic alliance “appears to be an important predictor for treatment success with this group” (Strauss et al., 2006)
Cluster C: Dependent Personality Disorder (301.82)

Pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation as indicated by 5 or more:

1) Difficulty making everyday decisions without advice and reassurance from others
2) Needs others to assume responsibility for most major areas of his or her life
3) Difficulty expressing disagreement with others because of fear of loss of support/approval
4) Difficulty initiating projects and doing things on his/her own because of lack of self-confidence
5) Goes to excessive lengths to obtain nurturance and support from others
6) Feels uncomfortable or helpless when alone
7) Urgently seeks another relationship as a source of care and support when a close relationship ends
8) Unrealistically preoccupied with fears of being left to take care of self
Differential Diagnosis of Dependent Personality Disorder

- Mood Disorders
- Panic Disorder
- Agoraphobia
- Borderline Personality Disorder
- Avoidant Personality Disorder
- Personality Change Due to a General Medical Condition
- Symptoms that may develop in association with chronic substance use.
Etiology
- Theory: disruptions (such as early death of parent or neglect) may cause people to grow up fearing abandonment (M.H. Stone, 1993)
- Attachment Theory: speculates that any disruption in bonding will cause individuals to be constantly anxious that they will lose people close to them.

Treatment
- Individuals present as “ideal” clients because of attentiveness and eagerness
- Want to give responsibility for problems to therapist
- Treatment: progressively help foster independence by helping clients become confidence in their ability to make decisions (A.T. Beck et al., 2007)
Cluster C: Obsessive-Compulsive Personality Disorder (301.40)

Pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency, as indicated by 4 or more:

1) Preoccupation with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
2) Perfectionism that interferes with task completion
3) Excessive devotion to work and productivity to the exclusion of leisure activities and friendships
4) Overly conscientious, scrupulous, and inflexible about matters of morality, ethics, or values
5) Inability to discard worn-out of worthless objects even when they have no sentimental value
6) Reluctance to delegate tasks or to do work with others unless they submit to exactly his or her way of doing things
7) A miserly spending style toward both self and others largely out of fear of future catastrophes
8) Rigidity and stubbornness
Differential Diagnosis of Obsessive-Compulsive Personality

- **Obsessive-Compulsive Disorder (OCPD)** tends to be ego-syntonic whereas OCD is ego-dystonic and includes intrusive obsessional thoughts that result in some type of ritual/compelled behavior.
- Rule out other Personality Disorders such as Narcissistic, Antisocial, or Schizoid Personality,
- Personality Change due to General Medical Condition
- Symptoms that may develop due to substance abuse
**Etiology**

- Largely Unknown
- Some speculation of parental reinforcement of conformity and neatness  
  (Durand & Barlow, 2010)

**Treatment**

- Address fears that underlie need for orderliness
- Use of relaxation or distraction techniques to redirect compulsive thoughts
- Cognitive Behavior Therapy (CBT) effective for this personality disorder  
  (Svartber et al., 2004)
Spiritual Integration

• Even though personality disorders are pervasive, counselors must refrain from labeling individuals by the disorder. God has “labeled them” in His Image.
• Christian counselors must not give up hope when they see an Axis II client.
• Christian counselors are encouraged to support family members dealing with loved ones that have a personality disorder in a way that builds up the Kingdom of God, rather than divides it through scape-goating the identified patient (IP).
• Keep in mind: There tends to be great “woundedness” in those that have personality disorders.
Fogelson et. al. (2007). Avoidant personality disorder is a separable schizophrenia-spectrum personality disorder even when controlling for the presence of paranoid and schizotypal personality disorders: The UCLA family study. *Schizophrenia Research, 91*, 192-199.


References


