Personality Disorders: An Overview

- **The Nature of Personality Disorders**
  - Enduring and relatively stable predispositions
  - Inflexible and maladaptive, causing distress and/or impairment
  - Coded on Axis II of the DSM-IV-TR

- **Categorical vs. Dimensional Views of Personality Disorders**

- **DSM-IV-TR Personality Disorder Clusters**
  - Cluster A – Odd or eccentric cluster
  - Cluster B – Dramatic, emotional, erratic cluster
  - Cluster C – Fearful or anxious cluster

**Personality Disorders: Facts and Statistics**

- **Prevalence of Personality Disorders**
  - Affects 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
  - Comorbidity Rates are High

- **Gender Distribution and Gender Bias in Diagnosis**
  - Gender bias exists in the diagnosis
  - Criterion and/or assessment gender bias

**Cluster A: Paranoid Personality Disorder**

- **Overview and Clinical Features**
  - Pervasive and unjustified mistrust and suspicion

- **The Causes**
  - Biological and psychological contributions are unclear
  - 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 of good outcome studies

**Cluster A: Schizoid Personality Disorder**

- **Overview and Clinical Features**
  - Pervasive pattern of detachment from social relationships
  - Very limited range of emotions in interpersonal situations
The Causes
- Etiology is unclear
- Preference for social isolation resembles autism

Treatment Options
- Few seek professional help on their own
- Focus on the value of interpersonal relationships
- Building empathy and social skills
- Lack of good outcome studies

Cluster A: Schizotypal Personality Disorder

Overview and Clinical Features
- Behavior and dress is odd and unusual
- Socially isolated and highly suspicious
- Magical thinking, ideas of reference, and illusions
- Many meet criteria for major depression

The Causes
- A phenotype of a schizophrenia genotype?
- More generalized brain deficits

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

Cluster B: Antisocial Personality Disorder

Psychopathy and Antisocial Personality Disorder

Overview and Clinical Features
- Failure to comply with social norms
- Violation of the rights of others
- Irresponsible, impulsive, and deceitful
- Lack a conscience, empathy, and remorse

Relation with Conduct Disorder and Early Behavior Problems
- Early histories of behavioral problems, including conduct disorder
- Families with inconsistent parental discipline and support
- Families often have histories of criminal and violent behavior

Neurobiological Contributions and Treatment of Antisocial Personality

Prevailing Neurobiological Theories
- Underarousal hypothesis – Cortical arousal is too low
- Cortical immaturity hypothesis – Cerebral cortex is not fully developed
- Fearlessness hypothesis – Fail to respond to danger cues
- Gray’s model of behavioral inhibition and activation
Treatment

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

CLUSTER B: BORDERLINE PERSONALITY DISORDER

- Overview and Clinical Features
  - Unstable moods and relationships
  - Impulsivity, fear of abandonment, very poor self-image
  - Self-mutilation and suicidal gestures
  - Comorbidity rates are high

- The Causes
  - Runs in families
  - Early trauma and abuse seem to play some etiologic role

- Treatment Options – Few Good Outcome Studies
  - Antidepressant medications provide some short-term relief
  - Dialectical behavior therapy is most promising treatment

CLUSTER B: HISTRIONIC PERSONALITY DISORDER

- Overview and Clinical Features
  - Overly dramatic, sensational, and sexually provocative
  - Often impulsive and need to be the center of attention
  - Thinking and emotions are perceived as shallow
  - Common diagnosis in females

- The Causes
  - Etiology is largely unknown: Variant of antisocial personality?

- Treatment Options
  - Focus 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, envious, and arrogant

- The Causes
  - Failure to learn empathy as a child
  - Sociological view – Product of the “me” generation

- Treatment Options
  - Focus on grandiosity, lack of empathy, unrealistic thinking
May also address co-occurring depression
Little evidence that treatment is effective

**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

- **The Causes**
  - Numerous factors have been proposed
  - Difficult temperament and 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**
  - Reliance on others to make major and minor life decisions
  - Unreasonable fear of abandonment
  - Clingy and submissive in interpersonal relationships

- **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
  - Highly perfectionistic, orderly, and emotionally shallow
  - Obsessions and compulsions are rare

- **The Causes**
  - Are largely unknown

- **Treatment Options**
  - Data supporting treatment are limited
  - Addresses fears related to the need for orderliness
  - Rumination, procrastination, and feelings of inadequacy

**Summary of Personality Disorders**

- **Personality Disorders**
  - Long-standing patterns of behavior
  - Begin early in development and run a chronic course

- **Disagreement Exists Over How to Categorize Personality Disorders**
  - Categorical vs. dimensional, or some combination of both

- **DSM-IV-TR Includes 10 Personality Disorders**
  - Fall into cluster A, B, or C

- **The Causes of Personality Disorders**
  - Start in childhood, but are difficult to specify

- **Treatment Is Difficult and Prognosis Poor**

**Psychotherapie voor PS**

The use of psychological treatments for people with personality disorder: A systematic review of randomized controlled trials

Conor Duggan, Nick Huband, Nadija Smalagic, Michael Ferriter and Clive Adams, University of Nottingham, Duncan Macmillian House, Perchister Road, Nottingham, NG3 6AA, UK

When in doubt, randomise.  

Archie Cochrane (1972)
- 27 publicaties
  - 14 over BPS
  - 6 gemengd
  - 3 vermijdende
  - 2 anti-sociale
  - 1 cluster B
  - 1 cluster C
- Verdubbeling tussen 2002-2006!
- Vooral community, niet inpatient
- 15 RCT’s significant beter dan TAU of wachtlijst
- Underpowered (gem n=28; med n=22)
- Grote variabiliteit
  - bv duur: 6 wk – 3 jr
  - Meer dan 100 outcome-maten

**Psychoterpapie voor PS (niet BPS): resultaten t.o.v. TAU**
- CBT voor vermijdende PS
- Brief adaptive psychotherapy voor gemengde PS
- Short-term dynamic psychotherapy voor gemengde PS
- Manual assisted CBT voor gemengde PS

**Psychotherapie voor PS (niet BPS): resultaten t.o.v. actieve therapie**
- Contingency management > methadone substitutie voor AS PS met opioïde afhankelijkheid
- DBT > gespecialiseerde gemeenschapstherapie voor gemengde PS
- Psychoeducatie + farmaca > farmaca voor gemengde PS
- CBT > brief dynamic therapy voor vermijdende PS
- Short psychodynamic supportive psychotherapy + farmac > farmaca voor gemengde PS
- Wellness + lifestyle group > creative coping voor gemengde PS

**Psychoterapie voor BPS: resultaten t.o.v. actieve therapie**
- SFT > TFT voor BPS
- DBT-oriented therapy > client-centered therapy voor BPS

**Natural course of personality disorders Zanarini et al., 2007**
**Evidence Based Treatments of PD**

- Schema Focused Therapy (SFT)
- Dialectical Behaviour Therapy (DBT)
- Transference Focused Psychotherapy (TFP)
- Mentalisation Based Therapy (MBT)

**Pathological Mechanisms in BPD**

- Emotional dysregulation
- Deficient impulse control
- Instability of relationships and self-image

Hyperactivation of the amygdala and a dysfunctioning of prefrontal structures and anterior cingulus.

**Negative Affect Stimulation, Reaction in BPS compared with Normals (Herpertz et al., 2001)**
**SCHEMA FOCUSED THERAPY (SFT) (YOUNG ET AL., 2003)**

*Model of pathology:*
- PD are fixed in rigid cognitive structures and dysfunctional belief systems.

*Deduced model of change*
- 18 scheme’s + 5 modes of functioning
- (abandoned child, angry impulsive child, detached protector, punitive parent, healthy adult)

*Treatment technique* (integrative therapy: behavioral and psychodynamic)
- reparenting,
- experiential imagery,
- cognitive restructuring,
- behavioral pattern breaking.

**RCT: TFP vs SFT**

**Giesen- Bloo et al., 2006**: Results in SFT better than in TFP

**Spinhexen et al., 2007**: difference in results correlates with difference in therapeutic alliance. (TFP, interpretation of neg.transference)

**TRANSFERENCE FOCUSED PSYCHOTHERAPY (TFP) (KERNBERG, CLARKIN, YEOMANS)**

*Model of pathology:*
- BPO is caused by emotional dysregulation which results in weak ego-functioning and primitive defences as splitting.
- Split object and self representations result in unstable relationships and identity diffusion.

*Deduced model of change*
- integration of polarised representations of self and others / increase of affect regulation + reflective functioning
Treatment technique
- transference interpretations in the here and now within structured therapeutic relationship

RCT: TFP, DBT, SPT (Levy, Clarkin et al., 2006)

No difference in coherence, dealing with losses ... but difference in change in Reflective Functioning (interpreting one’s own and other’s behaviour in terms of mental states)
DIALECTICAL BEHAVIOUR THERAPY (DBT) (LINEHAN)

Model of pathology:
- BPD caused by ineffective actions linked with dysregulated emotions.

Deduced model of change
- dialectical balance between acceptance and change

Treatment technique
- classical behavioral techniques
- targeting on self-destructive actions
- mindfulness

MINDFULNESS

Observation of what one feels with a radical acceptance of it

Figure 1. The influence of mindfulness on defensive and appetitive emotional responses.
Differences of BPD and normals in brain response to negative stimuli, before and after DBT (Herpertz et al., 2007)

**RCT:** DBT VS EXPERT COMMUNITY TREATMENT OF BPS (Linehan et al., 2006)

- DBT (n=52) vs Expert Community Treatment (n=49)
- 24 months, assessment each 4 m.
- Differences in change (regression slopes)
  - less suicide attempts and self-injury in DBT: p<.04
• suicide ideation: n.s.
• hamilton depression scale: n.s.

**MENTALISATION BASED TREATMENT (MBT)**
(Fonagy, Bateman)

*Model of pathology:*
- BPD caused by a hyperactivation of the attachment system and a decreased mentalisation.

*Deduced model of change*
- Increasing mentalisation

*Treatment technique*
- Here and now relationship (stop and rewind)
- Not focused on insight or content
- Stimulating the RF (interpreting of own and others behaviour in terms of mental states) in the patient
- Titrating of attachment activation

*BPS: disorganised attachment, hyperactivation of the mesolimbic attachment system*
BPS: decrease of mentalisation: perceiving and interpreting human behaviour in terms of intentional mental states (Fonagy, 2007) (Medial prefrontal cortex)

**Measuring Mentalisation**

- Reflective functioning scale
- Reading the mind in the eyes test (RMTE)
- Trust game

Example from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)
Performance on Eyes Test and Early Physical, Sexual and Psychological Abuse

![Bar chart showing the relationship between eye test scores and levels of early abuse.](chart1.png)

R² (all CECA subscales) = .35, p < .005

(Fonagy, Stein, Allen & Vrouva, submitted)

Performance on Eyes Test and Late Physical, Sexual and Psychological Abuse

![Bar chart showing the relationship between eye test scores and levels of late abuse.](chart2.png)

R² (all CECA subscales) = .43, p < .005

(Fonagy, Stein, Allen & Vrouva, submitted)

Deficit of Reflective Function in Violent and Non-violent Prisoners with PD (Fonagy, 2007)
**RCT study**: Bateman & Fonagy  
(partial hospitalisation- mentalisation based treatment of BPD  
(99, 01))

Suicide attempts

Selfmutilation

BeckDepressionInventory  

anxiety

**RCT, 8 yr FU: VOCATIONAL STATUS (Bateman, Fonagy, 2007)**
Percent making at least one suicide attempt during study period (Bateman, Fonagy, 2007)

RCT: intensive outpatient treatment: MBT (n=70) vs. Social Supportive Cognitive (n=58) Suicide attempts in 6 month period

Suicide attempts
- The self-report measures (GSI, BDI, STAI, SAS, IIP) were quite highly correlated so we converted scores on all the measures to scores and aggregated them to fit a single multilevel growth curve model with patients random linear
- We fitted a two-level model with individual growth curves being fitted to each case
  - There is significant heterogeneity between subjects
  - The intercepts of the groups do not differ significantly
  - However there is a very significant difference between the slopes
    - The control group decreases in their score between occasions on average only by about .05 of a standard deviation unit
    - The MBT group decreases by about a 3rd of SD over each 6 month period (.351)
    - The aggregate slopes are very significantly different from each other – the MBT slope is almost .3 steeper
  - The effect size associated with the difference between the slopes is about 1.2
  - The effect size associated with the difference at the end of treatment based on estimated SDs is 1.46
BDI Scores

Coefficient of difference between slopes = -4.6, $\chi^2 = 46.8$, df = 1, $p < .0001$, $d = 1.46$

- three level model with group, patients and occasions, generating slope for each patient across occasion
- 3 level levels patient randomly vary across occassions
- Group and group.occasion are fixed
- ISGL (iterative generalized least squares)
- There is very significant heterogeneity in both intercepts and slopes across occasions between patients
- The intercepts of the groups do not differ significantly
- However there is a very significant difference between the slopes
  - The control group decreases in their score between occasions on average only by about .5 points on the BDI which is not significant
  - The MBT group decreases by about 5 points of BDI over each 6 month period (5.1)
  - The aggregate slopes are very significantly different from each other – the MBT slope is 4.6 steeper
**Summary**

Broad range of PD
- SFT: relation with mechanism of change less studied, more effective than TFP by stronger therapeutic alliance
- TFP: interpretation of negative feelings in the therapeutic relationship from the beginning: more drop-out but pos.results on chronic anger and reflective functioning (broad range of PD)

Specific for BPD
- DBT: dealing with intense affects by mindfulness training. change in self-destructive behaviour
- MBT: increasing reflective capacities within therapeutic relationship, sustained improvement in long term FU of self-destructive behaviour but also of vocation, depression, anxiety...

**Personality Disorders**

**II. Antisocial Personality Disorder (ASPD)**

**A. Background**

- ASPD diagnosis stems from Cleckley’s description of psychopathy:
  - Superficial charm
  - Absence of delusions and irrational thinking
  - Absence of “nervousness”
  - Unreliability
  - Untruthfulness and insincerity
  - Lack of remorse or shame
  - Inadequately motivated antisocial behavior
Poor judgment and failure to learn by experience
Pathological egocentricity and incapacity for love
General poverty in major affective reactions
Specific loss of insight
Unresponsiveness in general interpersonal relations
Fantastic and uninviting behavior with drink
Suicide rarely carried out
Sex life impersonal, trivial, and poorly integrated
Failure to follow any life plan

- ASPD definition based on Cleckley’s view appeared in DSM-II
- Psychopathy is now a separate construct with an antisocial (ASPD-like) component
- Lee Robins’ work in mid-1960’s formed basis of current ASPD criteria
  • Found that most antisocial adults were antisocial in childhood
  • Most antisocial children are not antisocial as adults

- ASPD vs. criminality
  • “criminal” is a legal term denoting conviction for breaking a law:
    o Not all people with ASPD are criminals (or in jails)
    o Not all people in jail or considered criminal have ASPD
    o Not all people with ASPD are psychopaths

B. CRITERIA AND FEATURES OF ASPD

Case of George

1. DSM-IV criteria (p. 433)
   A. Pattern of disregard for and violation of the rights of others occurring since age 15 as indicated by 3 or more:
      (1) failure to conform to social norms
      (2) repeated lying/conning
      (3) impulsivity or failure to plan ahead
      (4) irritability and aggressiveness
      (5) reckless disregard for safety
      (6) consistent irresponsibility
      (7) lack of remorse
   B. Individual is at least 18 years old
   C. Evidence of Conduct Disorder before age 15
   D. Occurrence of antisocial behavior not exclusively during course of schizophrenia or a manic episode

2. Course and statistics
   - Prevalence is 3% in men; lower in women
     • Sex difference is probably real, but may be inflated by clinician bias
- onset in childhood (by definition)
  - CD portion may start as early as age 3-5
- Course of all PDs is chronic, but overt antisocial behavior seems to age out after 40
  - could still show ASPD features (e.g., lying; poor work habits)

3. **Causal influences**
- twin, family, and adoption data show strong genetic influence
- CD also appears to have shared environment influence
- poor socialization due to low fearfulness may account for some cases

**C. Treatment**
- Most don’t seek treatment for ASPD (usually substance abuse)
- No treatment shown to be efficacious
- More likely to end up in jail than in treatment
- Focus is on prevention – target antisocial children