CHAPTER 10: Personality Disorders

Chapter Overview/Summary

Personality disorders appear to be inflexible and distorted behavioral patterns and traits that result in maladaptive ways of perceiving, thinking about, and relating to other people and the environment. Difficulties in diagnosing personality disorders occur because even with structured interviews, the reliability of diagnosing personality disorders is less than ideal. Moreover, most researchers agree that a dimensional approach for assessing personality disorders would be preferable to the more categorical approach taken by the DSM system. Difficulties in studying the causes of personality disorders occur because most people with one personality disorder have at least one more, making it difficult to disentangle the causes of one from the other.

Three general clusters of personality disorders have been described in the DSM:

• **Cluster A** includes paranoid, schizoid, and schizotypal personality disorders; individuals with these disorders seem odd or eccentric. Little is known about the causes of paranoid and schizoid disorders, but genetic factors are implicated in schizotypal personality disorder.
• **Cluster B** includes histrionic, narcissistic, antisocial, and borderline personality disorders; individuals with these disorders share a common tendency to be dramatic, emotional, and erratic. Little is yet known about the causes of histrionic and narcissistic disorders. Certain biological and psychosocial causal factors have been identified as increasing the likelihood of developing borderline personality disorder in those at risk because of high levels of impulsivity and affective instability.
• **Cluster C** includes avoidant, dependent, and obsessive-compulsive personality disorders; individuals with these disorders show fearfulness or tension, as in anxiety-based disorders. Children with an inhibited temperament may be at heightened risk for avoidant personality disorder, and individuals high on neuroticism and agreeableness, with authoritarian or overprotective parents, may be at heightened risk for dependent personality disorder.

There is also relatively little research on treatments for most personality disorders. Treatment of the Cluster C disorders seems most promising, and treatment of Cluster A disorders is the most difficult. A new form of behavior therapy (dialectical behavior therapy) shows considerable promise for treating borderline personality disorder, which is in Cluster B.

Although the DSM diagnoses antisocial personality disorder (ASPD), many clinicians continue to use the diagnosis of psychopathy. A person with psychopathy is callous and unethical, without loyalty or close relationships, but often with superficial charm and intelligence. Individuals with a diagnosis of ASPD engage in an antisocial, impulsive, and socially deviant lifestyle. Genetic and constitutional, learning, and adverse environmental factors seem to be important in causing these disorders. There is some evidence that these may be distinct disorders with unique causal pathways. Psychopaths also show deficiencies in aversive emotional arousal, as well as more general emotional deficits. Treatment of ASPD and psychopaths is difficult in part because they rarely see any need for change and tend to blame other people for their problems.

Detailed Lecture Outline

I. **Clinical Features of Personality Disorders**
   A. To be diagnosed with a **personality disorder**, a person’s enduring pattern of behavior must be pervasive, inflexible, stable, and of long duration. The pattern of behavior must lead to clinically significant distress or impairment in functioning and must be manifested in at least two of the areas: cognition, affectivity, interpersonal functioning, or impulse control.
   B. Little evidence on prevalence; estimate that about 10% of the population will meet the criteria for a personality disorder at some time in their lives.
   C. Personality disorders were coded on a separate axis, Axis II of the **DSM-IV TR**, because they were considered different enough from the standard psychiatric syndromes (which were coded on Axis I). The multiaxial system was abandoned in the **DSM-5**, however, and personality disorders are now included with the rest of the disorders.
II. **Difficulties Doing Research on Personality Disorders**

A. **Difficulties in Diagnosing Personality Disorders**
1. Diagnostic criteria are not as sharply defined.
2. Diagnosis relies on inferred traits or consistent patterns of behavior rather than on more objective behavioral standards.
3. Although semi-structured interviews and self-report inventories have been developed, diagnostic reliability and validity is still low.
4. Diagnostic categories are not mutually exclusive.
5. Competing dimensional views: five-factor model has become the most influential model of normal personality.

B. **Difficulties in Studying the Causes of Personality Disorders**
1. High levels of comorbidity among disorders.
2. Very little prospective research on disorders.
3. Temperamental characteristics are possible biological factors.
4. Possible psychological factors include maladaptive habits and maladaptive cognitive styles that may originate in disturbed parent–child attachment relationships, parental psychopathology, ineffective parenting practices, and early emotional, physical, or sexual abuse.
5. Possible sociocultural factors are social stressors, societal changes, and cultural values.

III. **Cluster A Personality Disorders**

A. **Paranoid Personality Disorder**
1. Typical symptoms are suspiciousness, distrust of others, bear grudges, refuse to forgive insults, can display violent behaviors, rigidity, hypersensitivity, and argumentativeness.
2. The person is constantly “on guard” for attacks from others.
3. Causal factors:
   a. Little is known.
   b. Inconsistent findings on genetic transmission.
   c. Psychosocial factors suspected (parental neglect or abuse, exposure to violent adults).
   d. Heritability of high levels of antagonism and neuroticism.

B. **Schizoid Personality Disorder**
1. Central symptoms are an inability to form social relationships and an indifference toward developing them.
2. This disorder has not been the focus of research.
3. Causal factors:
   a. Early theorists believed this was a precursor to schizophrenia.
   b. Failure to establish hereditary basis or any link to schizophrenia.
   c. Maladaptive underlying schemas with individual as a self-sufficient loner and view of others as intrusive.

C. **Schizotypal Personality Disorder**
1. Extreme introversion, sensitivity, and eccentricity are the central features.
2. Pervasive social and interpersonal deficits.
3. Oddities and eccentricities in communication and behaviors.
4. Other cognitive problems, including ideas of reference, odd speech, and paranoid beliefs.
5. Oddities of thought, perception, and speech are also present and similar to schizophrenia.
8. Causal factors: believed to be moderately heritable with a genetic and biological association with schizophrenia
   a. Deficits in eye tracking.
   b. Attentional deficits.
   c. Deficits in working memory.
   d. Deficit in ability to inhibit attention to a second stimulus rapidly following the first stimulus.
Lecture Launcher 10.1: Personality Disorder as Exaggerated Personality

IV. Cluster B Personality Disorders

A. Histrionic Personality Disorder
   1. Excessive attention-seeking, emotionality, and self-dramatization are key features.
   2. Interpersonal relationships are stormy.
   3. Self-centered, vain, and overly concerned about approval.
   4. Tendency to be seductive and to eroticize situations.
   5. Prevalence in general population is 2%–3% and occurs more often in women than men.
   6. Causal factors:
      a. Possible genetic link with antisocial personality disorder.
      b. Maladaptive schemas involving need for attention to validate self-worth.
      c. Little research has been conducted due to the difficulty in differentiating from other personality disorders.
      d. Comorbidity with borderline, antisocial, narcissistic, and dependent personality disorders.
      e. Involves extreme versions of extraversion and neuroticism.
      f. Need for attention to validate sense of self worth.

B. Narcissistic Personality Disorder
   1. An exaggerated sense of self-importance leading to a sense of entitlement, lack of empathy, and need for attention.
   4. May be hypercritical and retaliatory.
   5. Causal factors:
      a. Parental overevaluation.
      b. Emotional, physical, and sexual abuse.
      c. Intrusive, controlling, and cold parenting.

C. Antisocial Personality Disorder (ASPD)
   1. Persons with this disorder violate the rights of others without remorse.
   2. Intelligence and charm can be found in many antisocial personalities.
   3. Show disregard for the rights of others.
   4. Pattern of irresponsibility.
   5. Deceitful, aggressive, or antisocial behavior.
   6. Impulsivity, irritability and aggression are common features.
   7. Must have symptoms of conduct disorder before the age of 15.

D. Borderline Personality Disorder (BPD)
   1. Common symptoms include impulsivity, anger, instability, and unpredictability.
   2. These persons fail to complete the process of forming a stable self-identity.
   3. Can have a history of stormy, intense relationships.
   4. Mood is highly unstable.
   5. Impulsive self-destructive behavior such as gambling, binge eating, substance abuse, and reckless driving can take place.
   6. Engage in self-mutilation with a repetitive cutting behavior to damage tissue.
   7. 8%–10% complete suicide.
   8. 1%–2% of population meet diagnostic criterion for BPD.
   9. 75% of those diagnosed are women.
   10. Suicide attempts are usually seen as manipulative.
   11. 70%–80% report analgesia (absence of the experience of pain in the presence of a theoretically painful stimulus).
   12. 75% experience relatively short or transient psychotic-like symptoms.
   13. Comorbidity with other Axis I disorders
a. Exists with disorders ranging from mood and anxiety disorders to substance abuse and eating disorders; overlap in symptomatology with depression.

b. Comorbidity with other personality disorders especially histrionic, dependent, antisocial, and schizotypal.

14. Causal factors
   a. Genetic factors play a significant role; personality traits of impulsivity and affective instability are partially heritable.
   b. Biological
      (1) Lowered functioning of the neurotransmitter serotonin may explain their impulsivity–aggression.
      (2) Disturbances in the regulation of noradrenergic transmitters may explain their hypersensitivity to environmental changes.
      (3) Certain parts of 5-HTT gene is involved.
      (4) Reduction in both hippocampal and amygdala volume.
   c. Psychosocial (negative, even traumatic, childhood events).
   d. 90% report some type of abuse.
   e. Paris’s Diathesis–Stress model: high levels of impulsivity and affective instability combined with psychological risk such as trauma, loss, or parental failure. (See Figure 10.1 for a diagram of the multidimensional Diathesis–Stress model of borderline personality disorder.)

V. Cluster C Personality Disorders
   A. Avoidant Personality Disorder
      1. These persons fear rejection and show extreme social inhibition, introversion, and hypersensitivity.
      2. They desire affection and are lonely; desire interpersonal contact but avoid it out of fear of rejection.
      3. Some hypothesize that avoidant personality disorder is a more extreme form of generalized social phobia.
      4. Causal factors:
         a. Inhibited temperament.
         b. Evidence that fear of being negatively evaluated is moderately heritable.
         c. Emotional abuse and rejection from parents.
         d. Anxious and fearful attachment.
         e. Modest genetic influence shared with social phobia.
         f. Introversion and neuroticism elevated.
   B. Dependent Personality Disorder
      1. Extreme dependency on others and panic when alone are central symptoms.
      2. Self-confidence is lacking and will show clinging and submissive behavior.
      3. They allow others to take over decision-making.
      4. 1.5% of population; more common in women than men.
      5. An indiscriminate selection of mates can take place.
      6. May accept abuse in order to remain in relationship.
      7. Personality traits such as neuroticism and agreeableness.
      8. Comorbidity with mood and anxiety disorders.
      9. Causal factors
         b. Authoritarian and overprotective parents.
         c. Maladaptive schemas about weakness and competence and needing others to survive.
   C. Obsessive-Compulsive Personality Disorder (OCPD)
      1. Perfectionism and excessive concern with maintaining order and control are essential characteristics.
      2. Mental and interpersonal control is maintained.
      3. Repeatedly check work for mistakes.
4. Perfectionism is often dysfunctional in that they cannot finish tasks and become overly involved in details.
5. Leisure activities are sacrificed.
6. Rigidity, stubbornness, and a lack of warmth are common.
7. Differences with obsessive-compulsive disorder
   a. Intrusion of thoughts in OCPD.
   b. Extreme anxiety in OCPD due to thoughts and images.
8. Some overlap with narcissistic, antisocial, and schizoid personality disorders.
9. Causal factors
   a. Dimensional approach—individuals have excessively high levels of conscientiousness, high level of assertiveness, and a low level of compliance.
   b. Biological dimensional approach—individuals have low levels of novelty seeking and reward dependence, but high levels of harm avoidance.

VI. General Sociocultural Causal Factors for Personality Disorders
1. The possible factors are poorly defined.
2. Less variance across cultures than within cultures.
3. Emphasis is on impulse gratification, instant solutions, and pain-free benefits.
4. Increase in emotional dysregulation and impulsive behaviors lead to prevalence of BPD and antisocial personality disorder.
5. Change in culture’s priorities and activities may influence the development of personality disorders.
   a. Narcissistic personality disorders more common in Western cultures.
   b. Histrionic less common in Asian cultures and more common in Hispanic cultures.
   c. Borderline is more common among Hispanic Americans than African Americans or Caucasians.
   d. Schizotypal personality disorder is more common among African Americans than among whites.

VII. Treatments and Outcomes for Personality Disorders
A. In general, personality disorders are difficult to treat.
1. Personality disorders represent relatively enduring, pervasive, and inflexible patterns of behavior.
2. Different possible goals of therapy.
3. Many people with personality disorders come to therapy only at the request of someone else.
4. Many people with personality disorders (especially those with Cluster A or Cluster B diagnoses) will have difficulty forming a therapeutic relationship.

B. Adapting Therapeutic Techniques to Specific Personality Disorders
1. May need to be careful not to encourage dependence.
2. Acting-out behavior may need to be constrained.
3. Specific therapeutic techniques are a central part of the cognitive approach to personality disorders; techniques include: monitoring automatic thoughts, challenging faulty logic, and assigning behavioral tasks to challenge dysfunctional assumptions and beliefs.

C. Treating Borderline Personality Disorder
1. Biological treatments
   a. Controversial because using medications increases suicide risk.
   b. SSRIs used to treat rapid mood shifts, anger, and anxiety.
   c. Low doses of antipsychotic drugs.
   d. Mood-stabilizing drugs may reduce irritability, suicidality, and impulsive aggressive behavior.
   e. Consensus is that drugs offer mild benefits for borderline personality disorder.
2. Psychosocial treatments
   a. Linehan’s dialectical behavior therapy
      (1) A promising new approach.
      (2) Combines individual and group components as well as phone coaching.
A form of cognitive and behavioral treatment that is problem-focused and based on a clear hierarchy of five goals:
(a) Decreasing suicidal and other self-harming behavior.
(b) Decreasing behaviors that interfere with therapy.
(c) Decreasing escapist behaviors that interfere with a stable lifestyle.
(d) Increasing behavioral skills in order to regulate emotions, to increase interpersonal skills, and to increase tolerance of distress.
(e) Other goals the patient chooses.
(f) Appears to be an efficacious treatment.

b. Traditional treatment is psychodynamic.
(1) Primary goal is strengthening weak egos.
(2) Focus is the defense mechanism of splitting.

D. Treating Other Personality Disorders
1. Treating Other Cluster A and B disorders
   a. Antipsychotic medications have only modest success, especially with schizotypal.
   b. Antidepressants from the SSRI category may be useful.
   c. No systemic studies exist for paranoid or schizoid disorders.

2. Treating Cluster C disorders
   a. Active and confrontational short-term therapy shows improvement.
   c. Antidepressants and MAO inhibitors have been used.

VIII. Antisocial Personality Disorder and Psychopathy

A. Psychopathy and Antisocial Personality Disorder
1. Two dimensions of psychopathy:
   a. Affective and interpersonal core.
   b. Behavioral aspects such as antisocial, impulsive, and socially deviant lifestyle.

2. DSM focuses on behavioral factors:
   a. Leads to 70%–80% of prison inmates qualifying for a diagnosis of ASPD.
   b. Only about 25%–30% of prison inmates meet the criteria for psychopathy.
   c. 3% of males and 1% of females meet the diagnostic criterion.

3. Many use the Cleckley/Hare psychopathy diagnosis rather than the DSM ASPD diagnosis.
4. Need for stimulation, peer behavior control, irresponsibility, and a parasitic lifestyle.
5. Diagnosis of psychopathy is the single best predictor of violence and recidivism.
6. ASPD may be omitting those who do not show violent behavior:
   a. Widom—advertisements.
   b. Experimental findings of possible biological differences between these two groups.

B. The Clinical Picture in Psychopathy and Antisocial Personality Disorder
1. Inadequate conscience development.
2. Irresponsible and impulsive behavior
   a. They take what they want.
   b. Prone to thrill-seeking actions.
   c. High rates of alcohol and other substance abuse related to ASPD but not necessarily psychopathy.
   d. Likewise ASPD, but not psychopathy, is related to elevated rates of suicide attempts and completed suicides.
3. Ability to impress and exploit others
   a. They are frequent liars.
   b. They understand and use the weaknesses of others.
   c. Rejection of authority.
   d. They can easily win “friends,” but seldom keep close friends.
e. They can be violent toward “friends” and family.

C. Causal Factors in Psychopathy and Antisocial Personality
1. Genetic influences.
   a. Moderate heritability for antisocial or criminal behavior, early signs of callous/unemotional traits.
   b. Genotype-environment interaction: Adopted away children of biological parents with ASPD were more likely to develop antisocial personalities if their adoptive parents exposed them to adverse environments (marital conflict or divorce, legal problems, parental psychopathology).
   c. Monoamine oxidase—a gene—breakdown of neurotransmitters like norepinephrine, dopamine, and serotonin.
   d. Significant genetic involvement in co-morbidity of alcoholism and ASPD.

2. Low-fear hypothesis and conditioning
   b. This deficient conditioning of fear seems to stem from having a deficient behavioral inhibition system.
   d. Normal or hypernormal active avoidance of punishment (behavioral activation system) when actively threatened with it.
   e. Dominant response set for reward.
   f. Passive avoidance learning—one learns to avoid punishment by not making a response.

3. More general emotional deficits
   a. Reduced responsiveness to aversive visual images consistent with findings that they are low on empathy.
   b. Small startle responses when viewing unpleasant images might also be related to lack of empathy.
   c. Hare has suggested that these findings represent only a subset of a larger problem with processing and understanding the meaning of affective stimuli—“as if emotion is a second language …”
   d. Dysfunction in the amygdale.

4. Early parental loss, parental rejection, and inconsistency
   a. Early studies pointed to early parental loss and emotional deprivation as causal agents.
   b. Parental rejection and inconsistency alone insufficient as causal agents.

D. A Developmental Perspective on Psychopathy and Antisocial Personality
1. Begins in early childhood
   a. The number of antisocial behaviors exhibited in childhood is the single best predictor of who develops an adult diagnosis of ASPD.
   b. The younger the symptoms develop, the higher the risk.

2. Oppositional defiant disorder
   a. Early onset before 6.
   b. Conduct disorder by 9.
   c. Children who develop conduct disorder in adolescence do not typically develop ASPD.

3. Attention Deficit Hyperactivity Disorder (ADHD)
   a. When ADHD occurs with conduct disorder, high likelihood of ASPD and even psychopathy.
   b. Lynam refers to these children as “fledging psychopaths.”

4. Other psychosocial and sociocultural contextual variables also contribute: parents’ own antisocial behaviors, divorce, poverty, crowded inner-city neighborhoods, parental stress, poor and ineffective parenting skills.

5. Sociocultural causal factors and psychopathy (see Figure 10.4).
a. Disorder appears in various cultures: Inuit of Northern Alaska and Yorubas of Nigeria.

b. Socialization forces impact expression of aggressive impulses.

c. Distinguishing between individualistic and collectivist societies.

E. Treatments and Outcomes in Psychopathic and Antisocial Personality

1. Traditional psychotherapeutic approaches are not effective.

2. Individuals have little motivation to take medication.

3. Biological treatments.

a. ECT and drugs not systematically studied.

b. Lithium and anticonvulsants to treat bipolar have had some success in treating aggressive and impulsive behavior.

4. Cognitive-behavioral treatments

a. Targets: increasing self-control, self-critical thinking, and social perspective taking; victim awareness; anger management; changing antisocial attitudes; curing drug addiction.

b. Interventions require a controlled situation.

c. Even the best programs show only modest improvements; psychopathy more difficult to treat than ASPD.

5. Many antisocial personalities show improvement as they age

a. They achieve insight into their self-defeating actions.

b. Cumulative effect of social conditioning.

c. Only ASPD changes with age, not psychopathy.

6. Prevention would seem to be more effective

a. Prevention program targeted to developmental and environmental risk factors.

b. Intelligence.

c. Positive influence by schooling.

d. Training for at risk mothers.

e. Parent training.

IX. Unresolved Issues: DSM-5: How Can We Improve the Classification of Personality Disorders?

A. The problem of a categorical system.

a. Overlap in the characteristics and traits of personality disorders.

b. No discrete breaks from normal behavior found.

B. Benefits and challenges of dimensional system.

a. Allows for many different patterns of elevations on traits.

b. Difficulty creating a valid system that is also clinically useful.

Key Terms

antisocial personality disorder (ASPD) obsessive-compulsive personality disorder (OCPD)
avoidant personality disorder paranoid personality disorder
borderline personality disorder (BPD) personality disorders
dependent personality disorder psychopathy
dialectical behavior therapy schizoid personality disorder
histrionic personality disorder schizotypal personality disorder
narcissistic personality disorder