General Criteria for a Personality D/o

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. cognition (i.e., ways of perceiving and interpreting self, other people, and events)

2. affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)

3. interpersonal functioning

4. impulse control

General Criteria for a Personality D/o

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not attributable to the physiological effects of a substance or another medical condition (e.g., head trauma).

Personality Disorders

Cluster A: Odd

- Schizoid
- Schizotypal
- Paranoid

Cluster B: Emotional Labile

- Antisocial
- Narcissistic
- Borderline
- Histrionic

Cluster C: Anxiety-related

- Dependent
- Avoidant
- Obsessive-Compulsive

Personality Disorders

Currently, given that there are no Axes for DSM5:

e.g.,	296.32	Major Depressive Disorder, Recurrent, Moderate
	301.81	Narcissistic Personality Disorder
e.g.,	301.89	Other Specified Personality Disorder, with Borderline and Histrionic Features
	300.02	Generalized Anxiety Disorder
	307.50	Unspecified Feeding or Eating Disorder

Personality Disorders

Prevalence:

http://www.ncbi.nlm.nih.gov/pubmed/15291684

https://www.nimh.nih.gov/health/statistics/personality-disorders.shtml

Personality Disorders – Etiology

Freudian Psychoanalytic Theories

- Unsuccessful resolution of the challenges of a particular developmental stage (i.e., Freud's oral, anal, oedipal stages) that results with the individual coping with stage issues in both a maladaptive AND inflexible manner (often non-conscious)

  e.g., anal issues are regarded as issues around control (potty training) and so some people are maladaptively afraid they will lose control and so they become very controlled and controlling

  e.g., oedipal issues are regarded as issues around authority and power and so some people are maladpatively rebellious and dismiss everything people say to them

Personality Disorders – Etiology

Object-Relational Theories

- Through interactions with others (usually parents, as they are the first available objects), individual internalizes maladaptive self-representations

e.g., in an interaction with a parent, a child repeatedly refuses to do something that makes them uncomfortable (like go to sleep in their own bed). The parent gets angry and tells the child that his/her behavior is making the parent frustrated and the parent walks away to the kitchen to clear his or her head (count to ten). The child internalizes that they are incompetent (that something they have difficulty doing causes anger in others) and bad (they make people they love angry and leave)

Personality Disorders – Etiology

Behavioral Theories

- Operant Conditioning

Certain behaviors were positively reinforced on a variable schedule in childhood but no longer reinforced in adulthood and may actually be regarded by others as inappropriate

e.g., receiving gifts, money, or praise when being dramatic as a child

e.g., getting attention from parents for negative behavior (hitting a brother, yelling) and being ignored when behaving in other ways

Certain behaviors were negatively reinforced on a variable schedule in childhood and individuals did not learn or care to practice more adaptive ways of removing unpleasantness

e.g., being rude to arguing parents resulted in being sent away from adults (away from the distressing conflict, grounded in room and able to entertain self by reading)

Personality Disorders – Etiology

Cognitive Theories

- Maladaptive core schemas

  e.g., I am bad, I am defective, I am incompetent

- Mindlessness (think inattention or lack of self-awareness or self-monitoring)

  - results in maintenance of the maladaptive schema

    e.g., Someone who has a core schema of "I am incompetent" surrenders all of their decision making abilities to another person (Dependent Personality Disorder) and never allows self to be in situations to practice and experience competency

  - results in fulfillment of the maladaptive schema

    e.g., Someone who has a core schema of "I will always be alone" overcompensates by clinging to and trying to control people, which inevitably incurs being rejected by them (Borderline Personality Disorder)

Cluster A Personality Disorders

Rule out criteria (Criterion B on most diagnostic lists) include rule out for disorders with psychotic symptoms – Why might this be?

Because of the features that reflect an "odd" way of organizing interpersonal information that seems similar to that of individuals with a Psychotic Disorder (or Mood disorders with psychotic features)

i.e., Individuals with Paranoid Personality Disorder interpret interactions with others through the lens of malevolent/harmful intent. Unlike psychotic paranoia, their distrust of others does not abate with the introduction of medication because it is less due to a psychotic process as it is due to deeply-rooted basic distrust

Cluster A Personality Disorders

Schizoid and Schizotypal also include rule out of Autism-Spectrum Disorders – Why might this be?

Because of the features that reflect a particularly idiosyncratic way of organizing interpersonal information that seems similar to that of individuals with a of Autism-Spectrum Disorders

i.e., Individuals with Schizoid Personality Disorder interpret interactions with others through the lens of intrusion/unfriendliness/ alienation (e.g., like you're an alien). Individuals with Schizotypal Personality Disorder interpret interactions with others through an idiosyncratic lens that seems foreign/dreamy/"out there"

Paranoid PD

A. 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:

1. suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
2. is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
3. is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
4. reads hidden demeaning or threatening meanings into benign remarks or events
5. persistently bears grudges; i.e., is unforgiving of insults, injuries, or slights
6. perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7. has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

Paranoid PD – Prevalence, etc.

Prevalence

- 2.3-4.4% in general population
- 4.2 % in outpatient settings (Zimmerman, Rothschild, & Chelminski, 2005)
- 10-30% in inpatient settings

Gender

- More common in men than women

Comorbidity

- Incidences of familial psychotic disorders are found to be higher (notably for Schizophrenia and Delusional Disorder, Persecutory Type)

Paranoid PD – Self-concept

People who suspect that people are out to harm them experience themselves (not always conscious) as vulnerable and otherwise defenseless unless they play aggressive offense/defense. If one believes others are malevolent, close relationships are a tremendous challenge.

Interpersonally, these people are viewed as unforgiving, ultra-sensitive, and harshly critical of others

Reactions to these types of people is intensely negative and often immediate.

Paranoid PD – Treatment

Patience and tolerance

Honesty and forthrightness (they're suspicious of you anyway, so you might as well admit their effect on you)

Outcome –

1. that the individual comes to trust you
2. that the individual comes away from the treatment having been able to negotiate with you, be angry and express their anger towards you, and feel accepted by you

Schizoid PD

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. neither desires nor enjoys close relationships, including being part of a family
2. almost always chooses solitary activities
3. has little, if any, interest in having sexual experiences with another person
4. takes pleasure in few, if any, activities
5. lacks close friends or confidants other than first-degree relatives
6. appears indifferent to the praise or criticism of others
7. shows emotional coldness, detachment, or flattened affectivity

Schizoid PD – Prevalence, etc.

Prevalence

3.1-4.9% (from NCSR and NES Alcohol and Related Conditions)

1.4% in outpatient settings

Gender

More common in men than women

Comorbidity

Incidences of familial psychotic disorders are found to be higher (notably for Schizophrenia). Also, thought to have more relatives with Schizotypal PD.

Schizoid PD – Self-concept

People who withdraw from others relationally and emotionally are likely to experience others as (even unintentionally) intrusive and/or overstimulating and the self as somewhat powerless against the whims of others

Interpersonally, these people are viewed as aloof, asocial, withdrawn, perhaps reserved or retiring

Reactions to these types of people is often one of curiosity, subtle criticism/judgment

Schizoid PD – Treatment

Patience

Honesty and some transparency

Outcome –

1. that the individual shares things with you (inviting you in)
2. that the individual comes away from the treatment with increased ability to invite others in/initiate some contact

Schizotypal PD

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by 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:

1. ideas of reference (excluding delusions of reference)
2. odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense")
3. unusual perceptual experiences, including bodily illusions
4. odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
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 that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

Schizotypal PD – Prevalence, etc.

Prevalence

- 0.6-3.9% in general population

Gender

- More common in men than women

Comorbidity

- Incidences of familial psychotic disorders are found to be higher

Schizotypal PD – Self-concept

People who both withdraw from others relationally and emotionally and don't abide by social conventions are likely to experience others as (even unintentionally) judgmental and unsafe and the self as different, not fitting-in, not being understood, possibly lonely

Interpersonally, these people are viewed as odd, eccentric, "different"

Reactions to these types of people is often one of curiosity and a subtle negative judgment

Schizotypal PD – Treatment

Patience

Honesty and some transparency

Willingness and openness to understand their worldview

Outcome –

1. that the individual develops an understanding of why you do what you do and how you understand things (increases understanding of social conventions)
2. that the individual comes away from the treatment with increased ability to interact using these conventions

Case #2

Very nice to see you all coming along in having better understanding about the diagnostic process and differential diagnosis.

Specifiers:

The only specifiers allowed/required are those listed at the end of a diagnosis. So even if you think the severity of a disorder is severe, if severity specifiers are not noted for the diagnosis (and very few diagnoses other than Major Depressive, Persistent Depressive, Bipolar I, and Bipolar II Disorders require severity specifiers)

Case #2

Asking questions for diagnostic clarification:

Try not to ask questions using overly clinical language (e.g., Do you think you have an eating disorder? Do you think you have delusions?) as many people deny the severity of what is going on or they lack the clinical understanding of what is being asked. Not everyone who has Generalized Anxiety Disorder knows that in addition to uncontrollable worry about several different areas of life, that they need to have three symptoms of Criterion C and that they all need to be present for more days than not for at least 6 months. Many people who have delusions tell you they do not because they believe the content of their delusions to be true, not delusional. Many people who have an eating disorder think they are only watching their weight and eating "more healthily." Asking questions in overly clinical language increases the likelihood of false negatives.

Cluster B Personality Disorders

Often comorbid with Mood Disorders – Why might this be?

Because symptoms of these PDs reflect poor and maladaptive coping responses to emotional experiences. Coping responses manifest as behaviors done to others, which results in interpersonal conflict.

e.g., Individuals with Narcissistic Personality Disorder have significant difficulties tolerating the experience of shame and thus expresses grandiosity to ward off this experience.

e.g., Individuals with Antisocial Personality Disorder have significant difficulties tolerating not getting what they want (frustration tolerance) and thus take what they want without regard for others (e.g., stealing).

Antisocial PD

A. A pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

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

Antisocial PD

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or Bipolar Disorder.

WHY D.?

Antisocial PD – Prevalence, etc.

Prevalence

- 3% males, 0.3-1% females (3:1 to 10:1 M:F ratios)
- 3-30% in clinical settings
- 3.6% in community samples (Grant et al., 2004)
- higher in prisons, forensic settings, and among those with Alcohol Use Disorder, substance abuse clinics (over 70%)
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2044500/table/T1/

Gender

- MUCH more common in men than women

Comorbidity

- High comorbidity with Substance-Related Disorders (differential diagnosis requires rule in of Conduct Disorder prior to age 15 and that APD features are present even when not trying to obtain the substance (e.g., stealing to get money for drugs))

Antisocial PD – Self-concept

People who disregard the rights of others have little motivation to put off getting/taking what they want and are likely to experience others as weak/vulnerable and the self as independent and dominant

Interpersonally, these people are experienced as capricious, distrustful, and intimidating

Reactions to these types of people is often one of wariness, submission, maybe deference

Antisocial PD – Treatment

Prayer

Delineating accountability and consequences

Outcome –

1. that the individual will submit themselves to authority
2. that the individual will choose not egress on the rights of others for gain (e.g., not breaking property in order to stay out of jail)
3. if possible, to experience remorse

Borderline PD

A. A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment.

   Note: do not include suicidal or self-mutilating behavior covered in Criterion 5.

2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. identity disturbance: markedly and persistently unstable self-image or sense of self

4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

   Note: do not include suicidal or self-mutilating behavior covered in Criterion 5.

Borderline PD

A. as indicated by five (or more) of the following:

5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. 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)
7. chronic feelings of emptiness
8. inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. transient, stress-related paranoid ideation or severe dissociative symptoms

Borderline PD – Prevalence, etc.

Prevalence

- estimated to be about 2% in general population
- 10-20% in clinical settings (outpatient and inpatient settings, respectively)

Incidence

- estimated to be approximately 0.07% annually

Gender

- More common in women than men (75% female)

Comorbidity

- Other Cluster B Personality Disorders
- Major Depressive Disorder, Persistent Depressive Disorder
- Substance-Related Disorders (i.e., feeling “good”)
- Childhood trauma-related, PTSD, Dissociative-Spectrum Disorders
- Eating Disorders, particularly Bulimia Nervosa

Borderline PD – Self-concept

People who care to be a part of the larger social world and whose internal sense of identity is unstable often become reliant on how others treat them as a reflection of their identity (and worth). This can produce a lot of emotional lability. So when they experience people in a more open and extending mood as compassionate, wonderful and amazing, they experience the self as worthwhile, but if they experience these same people in a burdened and irritable mood as uncaring and awful, their experience of the self shifts to being worthless and rejected

Interpersonally, these people are viewed as difficult, “crazy”, moody, manipulative

Reactions to these types of people often includes rejection/abandonment (running/getting away from them), or provoking them (passive-aggression)

Borderline PD – Treatment

Patience

Tolerance of criticism, devaluation, rage, while setting pre-defined limits

Stability, consistency

Validation of their emotional experience

Outcome –

1. that the individual develops a sense of self-worth that is relatively stable and not dependent on being in a relationship
2. that the individual develops a sense of their impact on others and can appreciate that impact by demonstrating adaptive behaviors (e.g., apologizing)
3. that the individual comes to value others and treats them accordingly

Narcissistic PD

A. A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. 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)
4. requires excessive admiration
5. has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

Narcissistic PD

A. as indicated by five (or more) of the following:

6. is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
7. lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
8. is often envious of others or believes that others are envious of him or her
9. shows arrogant, haughty behaviors or attitudes

Narcissistic PD – Self-concept

People whose worth and self-image depends solely on how others see them (real or imagined) are likely to surround themselves with admirers and dismiss others as lacking. The dismissiveness of others as inferior and of low worth serves the purpose of supporting their self-esteem. In turn, they are likely to develop a sense of and experience of the self as superior, deserving of respect, deference, and praise

Interpersonally, these people are viewed as arrogant, entitled, dismissive, and offensive

Reactions to these types of people often includes criticism, ridicule, or dismissiveness of them

Narcissistic PD – Prevalence, etc.

Prevalence

- 0.2-6.2% in general population
- 2-16% in clinical settings

Gender

- More common in men than women (50-75% male)

Comorbidity

- Other Cluster B Personality Disorders
- Major Depressive Disorder, Persistent Depressive Disorder
- Hypomania, Substance-Related Disorders (i.e., feeling “good”)

Narcissistic PD – Treatment

Patience

Tolerance of criticism and devaluation

A willingness to have lots of positive regard

Outcome –

1. that the individual develops a sense of value that is relatively stable and not easily destroyed in the face of criticism
2. that the individual develops a sense of their impact on others and can appreciate that impact by demonstrating adaptive behaviors (e.g., apologizing)
3. that the individual comes to value others (at least as equal to the self) and treats them accordingly

Histrionic PD

A. 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:

1. is uncomfortable in situations in which he or she is not the center of attention
2. interaction with others is 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 detail
6. shows self-dramatization, theatricality, and exaggerated expression of emotion
7. is suggestible, i.e., easily influenced by others or circumstances
8. considers relationships to be more intimate than they actually are

Histrionic PD – Prevalence, etc.

Prevalence

- estimated to be 2% in general population
- 10-15% in clinical settings (inpatient and outpatient respectively)

Gender

- More common in women than men, apprx. 2:1

Comorbidity

- Other Cluster B Personality Disorders
- Conversion Disorders, Hypochondriasis
- Dissociative Disorders
- Mood Disorders

Histrionic PD – Self-concept

People whose measure of worthwhileness is through the attention of others end up viewing others as powerful beings that they need to constantly entertain/seduce in order to affirm the self (bolstering their self-esteem). Thus, the underlying sense of self is likely to be an insecure individual who is only worthwhile through their external actions/appearance (and not character, intelligence, etc.).

Interpersonally, these people are experienced as attention-seeking and immature

Reactions to these types of people often includes dismissiveness and subtle rejection (the eye-rolling “drama queen” reaction)

Histrionic PD – Treatment

Patience

Consistent expectation of their ability

No advice-giving, no patronizing

Outcome –

1. that the individual develops a sense of competency
2. that the individual develops a sense of their significance apart from external attention

Cluster C Personality Disorders

Often comorbid with Anxiety Disorders – Why might this be?

Because symptoms of these PDs reflect maladaptive coping responses to experiences of anxiety. Coping responses manifest as behaviors done to others, which results in interpersonal conflict.

e.g., Individuals with Dependent Personality Disorder have significant difficulties tolerating the experience of anxiety related to separation and self-sufficiency/independence and they express clinging and dependence to ward off this experience.

e.g., Individuals with Obsessive-Compulsive Personality Disorder have significant difficulties tolerating anxiety stemming from guilt and being imperfect/wrong and thus try to be perfect and moralistic to ward off this experience.

Avoidant PD

A. A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
2. is unwilling to get involved with people unless certain of being liked
3. shows restraint within intimate relationships because of the fear of being shamed or ridiculed
4. is preoccupied with being criticized or rejected in social situations
5. is inhibited in new interpersonal situations because of feelings of inadequacy

Avoidant PD

A. as indicted by four (or more) of the following:

6. views self as socially inept, personally unappealing, or inferior to others
7. is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Avoidant PD – Prevalence, etc.

Prevalence

- frequently encountered in clinical settings (as high as 14.7%)
- 2.4% (Grant et al., 2004) to 5.2% (Lenzenweger et al., 2007) in general population

Gender

- Occurs similarly across men and women

Comorbidity

- Increased incidence of Anxiety Disorders, particularly Social Anxiety Disorder and Agoraphobia
- Also comorbid with Depressive Disorders, Schizoid Personality Disorder, and Dependent Personality Disorder

Avoidant PD – Self-concept

People whose sense of self is one of inadequacy and lacking any appeal to others experience people as challenging/intimidating and rejecting and often withdraw from interactions with people to avoid rejection/anxiety

Interpersonally, these people are viewed as shy, reserved, unfriendly, aloof, arrogant, anxious

Reactions to these types of people is often one of avoidance (because of fearing intrusiveness or disliking stand-offishness)

Avoidant PD – Treatment

Patience

Talking about day-to-day things (rather than inspecting the self), use of metaphors, scrupulous respect for things that are shared, unconditional acceptance, and over time, some gentle teasing

Outcome –

1. that the individual will experience self as worthwhile and not flawed
2. that the individual will improve social skills and social confidence

Dependent PD

A. A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. needs others to assume responsibility for most major areas of his or her life
3. has difficulty expressing disagreement with others because of fear of loss of support or approval. Note: Do not include realistic fears of retribution.
4. 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)
5. goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant

Dependent PD

A. as indicted by five (or more) of the following:

6. feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7. urgently seeks another relationship as a source of care and support when a close relationships ends
8. is unrealistically preoccupied with fears of being left to take care of himself or herself

Dependent PD – Prevalence, etc.

Prevalence

- 0.5% in community samples (Grant et al., 2004)
- 1.4% in outpatient samples (Zimmerman et al., 2005)

Gender

- Seen more commonly in women than men (so are most disorders, in general, as women utilize clinical services more than men) but reported use of structured assessment measures report similar prevalence rates for men and women

Comorbidity

- Increased incidence of Depressive and Anxiety Disorders

Dependent PD – Self-concept

People who have deep anxiety and self-doubt about their ability to take care of themselves have a sense of self as immature and incapable and view others as capable caretakers and security objects

Interpersonally, these people are viewed as passive, submissive, and often needy

Reactions to these types of people is often one of dominance and telling them what to do (including to go away)

Dependent PD – Treatment

Patience

Delineating expectations of the individual and adopting a more passive, highly reflective and non-directive approach

Outcome –

1. that the individual will experience frustration of not having needs met and initiate activity (vs. active passivity) movement towards having needs met
2. that the individual will engage in decision making

Obsessive-Compulsive PD

A. 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:

1. is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
2. 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)
3. is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
4. is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

Obsessive-Compulsive PD

A. as indicted by four (or more) of the following:

5. is unable to discard worn-out or worthless objects even when they have no sentimental value
6. is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
7. adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
8. shows rigidity and stubbornness

O-CPD – Prevalence, etc.

Prevalence

- 2.1% to 7.9% in community samples (Grant et al., 2004)
- 8.7% in outpatient samples (Zimmerman et al., 2005)

Gender

- DSM5 states 2:1 M:F ratio
- Grant et al., (2004) states 1:1

Comorbidity

- Increased incidence of Major Depressive Disorder, Eating Disorders, and Substance Use Disorders

O-CPD – Self-concept

People who are preoccupied with perfection and order often have a self-image as someone who is organized, responsible, and correct (usually, if not all the time) and often view others as disorganized or lacking in discipline and exactitude

Interpersonally, these people are viewed as controlling, rigid, and stubborn

Reactions to these types of people is often one of rebellion and confrontation/struggle

O-CPD – Treatment

Patience

Not engaging in power struggles with them

Questioning the idea of perfect order and rationality, highlighting the value of things that operate without rules (e.g., emotions)

Outcome –

1. that the individual will increase spontaneous experience of emotions and not only tolerate them, but value them
2. that the individual will increase acceptance of both self and others

Personality Disorders – Treatment

Cognitive Therapy

- Exploration of automatic self-related thoughts and identification of the core schema(s)
- Self-monitoring of thoughts, increased mindfulness so that the schemas are not automatically assumed
- Cognitive Restructuring so that schemas can be challenged and reframed (e.g., “I am defective” to “I’m not defective, but I don’t do some things well and not everyone will like me.”)

Behavioral Therapy

- Improve emotional regulation skills
- Improve tolerance skills
- Improve communication skills (role plays) and other adaptive interpersonal behaviors

Personality Disorders – Treatment

Interpersonal Therapy

- Exploration of relationships with others (not just the therapeutic one)
- Reframing of interpersonal experiences and roles
- Improve communication skills (role plays) and other adaptive interpersonal behaviors

Marital/Family Therapy

- Exploration and revelation of the impact of the disorder (and behaviors) on the family
- Processing of emotions and perceptions of each spouse/family member from marital/family conflicts/behavioral exchanges
- Agreement about the problematic behaviors and subsequent actions taken by each spouse/family members

Personality Disorders – Treatment

Psychodynamic Therapy

- Focuses on the relationship between therapist and patient and the immediate interpersonal and dynamic processes between them
- Uses the therapeutic relationship as a place to practice more adaptive interpersonal ways of being and relating
- Assumes personality organization stems from childhood interactions with parents and that those patterns are enacted with all persons due to “repetition compulsion” (trying to resolve the original conflict)