Preliminary Issues

Personality Disorders
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Disclosure
• Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
• No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
• No funny business.
Personality Disorders in Case Management

• Your job is to assess safety, stabilize crisis situations, provide logistical and emotional support, and help the client marshal personal and interpersonal resources to work toward short and long-term goals.
• Personality disorders may complicate that process at every step.

DSM-5

• Cluster A: odd and eccentric (cognitive)
  • Paranoid
  • Schizoid
  • Schizotypal
• Cluster B: dramatic, emotional (externalizing)
  • Antisocial
  • Borderline
  • Histrionic
  • Narcissistic
• Cluster C: anxious, fearful (internalizing)
  • Avoidant
  • Dependent
  • Obsessive

Personality Disorders

• One way that we can think about personality disorders is that certain people, for various reasons, become stuck in repetitive, maladaptive patterns of behaviors. Their behavioral repertoire for problem solving is limited. They try the same things, over and over, whether they are helpful or not. They end up facing the same frustrations and obstacles every time they confront a problem.
Personality Disorders

- We can call these repetitive behaviors their “agenda” because there is always an unspoken, sometimes unconscious goal motivating them. It may be useful for case managers and support staff to consider this agenda as you work toward your various goals.

Personality Disorder Agendas

- Antisocial: to control/avoid being controlled
- Borderline: to be understood perfectly enough that the emptiness and pain will end
- Narcissistic: to be adored
- Histrionic: to elicit favors by being attractive/entertaining or by being ill
- Obsessive Compulsive: to follow the rules and avoid blame

Personality Disorder Agendas

- Avoidant: to avoid being hurt (think social phobia)
- Dependent: to assure love and protection at any personal cost
- Paranoid: to stay safe in a dangerous world
- Schizotypal: agenda is unclear - this is more of a thought disorder than personality disorder (ambulatory schizophrenia)
- Schizoid: clueless to the world of other people (ambulatory autism)
Relationship Seeking?
- Antisocial: No, only for usefulness
- Borderline: Yes
- Narcissistic: When insecure
- Histrionic: Yes
- Obsessive Comp: Sort of
- Dependent: Yes
- Avoidant: Yes, but afraid
- Paranoid: No
- Schizotypal: No
- Schizoid: No

Treatment Seeking?
- Antisocial: No
- Borderline: Yes
- Narcissistic: Yes, when injured
- Histrionic: Yes, when lonely
- Obsessive Comp: Yes, when depressed
- Dependent: Yes
- Avoidant: Maybe, if anxious enough
- Paranoid: No
- Schizotypal: No
- Schizoid: No

Remember:
- If clients have problems with relationships in their lives outside therapy, they will have problems with their relationship to you.
- It is seldom useful to confront “head on” a lifelong personality disorder in the first week on contact. However, research from psychotherapy suggests that if change is going to happen, it happens early in the treatment.
Treatment

• If you are aware of what is going on, you will be better prepared to offer useful, non-reactive guidance and insight.
• Ego-syntonic disorders result in lack of motivation for treatment. Clients have lots of goals for others, but not themselves. However, a crisis situation often can push people into being willing to consider a radical way of looking at the problem – maybe I have something to do with what is happening.

Our Agenda

• Antisocial Personality
  • Description and Agenda
  • Dangerousness
  • Intervention tips
• Borderline Personality
  • Description and Agenda
  • Suicidality, short and long-term
  • Intervention tips

Our Agenda

• Dependent Personality
  • Description and Agenda
  • Countertransference
  • Treatment tips
DSM 5 Definition

- DSM 5 requires a disregard of the rights of others since 15, indicated by 3 or more of these:
  - Getting arrested
  - Lying
  - Conning
  - Impulsivity
  - Aggression
  - Reckless
  - Irresponsibility
  - No remorse.
- For adults who are simply criminal, we diagnose Adult Antisocial Behavior.

Primary Interpersonal Features

- Preoccupation with control: insist on being right and rarely concede an issue
- Rebelliousness: contempt for authority

The Psychological Inventory of of Criminal Thinking Styles (PICTS)

- 8 thinking styles
  - Mollification: externalization of blame
  - Cutoff: “Screw it” when one is frustrated
  - Entitlement: wants are seen as needs
  - Power orientation: control through aggression
  - Sentimentality: A “good deed” will compensate for wrongdoing
  - Superoptimism: one can get away with it
Demographics and Natural History

- NESARC: 3.63%
- Males 3:1
- Lower socioeconomic groups, urban
- Onset before 15 with symptoms of conduct disorder, cannot be diagnosed before 18
- Observed remission in symptoms after 40. Persistence is predicted by not being married, low income, less education, drug use disorders, ADHD.

Psychopathy

- Demographics
  - Present in both genders, all races, cultures, historical periods. Not well studied in females.
  - In maximum security prisons, 75% will be antisocial, 33% of these will be psychopathic.
  - Begin criminal careers earlier, commit more offenses, re-offend at a higher rate.
  - More dangerous, habitually engage in predatory rather than affective violence.

Description

- Aggressive narcissism
  - Devalues others, retaliates for insults
- Chronic emotional detachment
  - Unable to bond, uses power instead
- Chronic lying
  - Delights in deceiving others
- Cognitive problems
  - Can’t plan ahead, lack of empathy, impulsive, language processing deficits, poor aversive learning
Description

• Psychopathy is more than simply lacking empathy. Many people lack empathy. It also involves callousness and antisocial behavior.

• Some research indicates that callousness is not so much “hard-heartedness” as a very high threshold for recognizing distress in themselves and others. A long history of indifference to others could easily lead to antisocial behavior when certain rewards are present.

The Problem

• Mental health professionals are only a little better than chance at predicting who will be violent.

20 Epidemiologic Risk Factors for Violence

• History of violence
• Male gender
• Late teens, early 20’s
• Below average IQ
• Low socioeconomic status
• Instability in housing or employment
• History of property destruction
• Substance abuse
• Mental illness
• Personality disorder (antisocial, borderline)
20 Immediate Risk Factors for Violence

• Intoxication
• Withdrawal
• Psychotic symptoms
• Command hallucinations
• Persecutory delusions
• Paranoia
• Physical agitation
• Verbal aggression
• Access to weapons
• Anger (in response to narcissistic injury)

A Risky Profile

• Young adults with severe mental illness, with trauma and violence in the past, substance abuse in the present, and no interest in treatment in the future.
• In one small study, patient’s own assessment of their risk of becoming violent was a better predictor than two other assessment tools

Context

• Context is as important as the individual in determining dangerous situations. Particular people are dangerous in particular situations. It is often the context that can be controlled (substance abuse, treatment adherence) where individual characteristics cannot (gender, age, violent history)
Violent Fantasy

- A violent fantasy is a thought in which the subject imagines physically harming another person in some way. It is not an intention (immediately aimed at guiding action) or delusion (the distinction between imagination and reality is lost.) An intention would be considered a “threat.”
- In one study, 68% of undergraduate students had at least 1 homicidal fantasy - 30% of men and 15% of women had such fantasies frequently.

Violent Fantasy

- Violent fantasies are present in a large number of “normal” individuals.
- The presence of violent fantasy is not proven to signal potentially violent behavior.
- However, the nature and quality of violent fantasies, and the degree of preoccupation with them is probably important risk assessment information. This data should be used in conjunction with data about the client’s history and present behaviors.

Dr. Mays’ Approach to Risk Management:
Don’t Worry Alone.

Transference and Boundaries

• Antisocials are better at manipulating than therapists are at being on guard.
• Therapists need to beware of feeling that the client is getting a bad deal from legal system, family members, etc.
• Expect manipulation and dishonesty.
• Therapists need to understand principles of violence risk assessment and management.

Recommendations for Workers

• Clearly reinforce boundaries and set limits on behavior.
• Always address a patient’s inappropriate comments or behaviors. Always. These may be boundary probes.
• Do not self-disclose. Do not talk about your personal life within earshot of the patients.
• Maintain a healthy social life outside of work.
Treatment

• Results for all forms of treatment for APD are generally dismal. Clients are not usually interested in treatment. Their dishonesty, sensitivity to power issues, and constant manipulating make them poor candidates for therapy.
• There is no evidence for the efficacy of any medications.
• Other treatments such as milieu, empathy, self-esteem training, or anger management, are problematic or have not shown any consistent benefit.

Treatment

• There is a spectrum of antisocial clients, some less damaged than others, who may be willing and able to form a treatment alliance.
• Any worthwhile treatment must include strict limits and no opportunity for deception. Compassion and flexibility will usually be interpreted as weakness.

Borderline Personality Disorder
### Description

- **Interpersonal problems**
  - Turbulence, fear of abandonment, self-esteem dependent on important others
- **Affective instability**
  - Reactivity, intense negative emotions, pervasive dysphoria
- **Behavioral difficulties**
  - Impulsive, self-destructive, addictions, recklessness
- **Cognitive problems**
  - Lack of stable sense of self, psychosis and dissociation
- **Comorbidity**
  - Substance abuse, impulse control disorders, mood disorders, eating disorders, anxiety disorders, PTSD, ADHD

### Demographics and Natural History

- 5.9% of the population, seen worldwide
- Most prevalent personality disorder in clinical settings: 10% of outpatients, 20% of inpatients.
- 75% female in clinical settings, 50% in general
- Onset is in adolescence with chronic instability and high use of mental health resources
- Diagnosis is unstable, improvement over time is the norm, hospitalization is uncommon after the first few years of illness.

### Interpersonal Agenda

- The person’s primary concern is to find someone who can understand them perfectly enough so that their sense of isolation will abate and their misery will stop. It is a kind of “Golden Fantasy” – by finding the one person who can help them, all of their needs will be met.
- A strong fear of abandonment arises when something seems to disrupt the developing relationship. Abandonment fear is expressed with “rage” as a kind of hostile dependence.
Caveat

- There are many reasons why people do things to their bodies that may seem deviant to mainstream observers. Not everyone is manifesting psychiatric pathology.
- Causes for concern:
  - Injury to face or genitals
  - Carving words or messages on the body
  - Indifference or odd affect
  - Severe injury

Some Reasons for SIB

- Affect regulation
  - Reconnection with the body
  - Calming the body during periods of arousal
  - Validating inner pain
  - Avoiding suicide
- Communication
  - Express things which cannot be said out loud
- Control/punishment
  - Trauma re-enactment
  - Bargaining and magical thinking
  - Self-control/manipulation

Suicide and SIB in Borderline Personality

- SIB is reported by 43-78%.
- The act of self-abuse has little overt suicidal ideation, but the probability of suicide is increased 2x in the future.
- Clinicians and family members see self-harm as manipulative (about us), but BPD’s see the acts as an attempt to control their inner experience (about them.)
Suicidality

- Most suicide attempts in BPD are triggered by interpersonal crises. This should be interpreted within the framework of three signs often recognized before a suicide:
  - Precipitating event
  - Intense affective state other than depression
  - Changes in behavior patterns
- When faced with overwhelming internal stimuli, BPD have difficulty articulating how they feel and problem-solving. Clinicians can de-escalate by validating distress and modeling appropriate behavior.

Suicide Risk

- Impulsivity is associated with number of attempts but not lethality.
- Manipulative suicide attempts decrease from 56.4% at year 2 to 4.2% by year 10.
- Suicide death occurs after many years of illness, failure to benefit from treatment, loss of supportive relationships, and social isolation.
- They are no longer involved in active treatment.

Long-Term Interventions

- This is confirmed by a recent study that shows in borderline personality, acute stressors such as depression may contribute to a short-term risk of suicidal behavior, but long-term risk is more related to poor psychosocial outcomes.
Borderline Personality Disorder

- The clinician must decide if the suicidality is chronic or acute. Acute suicidality may benefit from the protection of a hospital. Chronic suicidality requires long-term management of affect, conflict, and impulsivity.
- Chronic suicidality is treated by outpatient therapy. In the hospital, every suicidal act is rewarded by more, not less, nursing care.
- Medication has not proven useful in either case. DBT has proven useful for reducing SIB.

Boundary and Transference Problems

- Borderline Personality
  - Demand for “specialness”
  - Boundary diffusion on the part of the client
  - Impulsivity and drama that pressures the therapist for rapid action
  - Posture of victimization that brings out rescue fantasies in the therapist
  - Intimidation through rage
  - Testing the therapist to see if he really cares

Individual Psychotherapy

- The best way to avoid transference and countertransference disasters with a BPD is to keep very firm boundaries, both physical and verbal.
Lessen the Pain

• Validation: someone understands the pain and is not frightened or disgusted by it.
• Try to keep clients functional in the world so they don’t feel like they are failures. Clients often view failure as an indictment of who they are as a human being – that they are a bad person who should be dead.

Becoming More Adaptive in Relationships

• Clarify how the client feels and how they are responding to others (translating attacks into statements of distress, for example)
• Encourage experience in the world where the client can see what behaviors get rewarded and what do not.
• Patients with BPD usually first learn from friends, then make peace with family members, then, sometimes they are able to form successful romantic relationships.
• Therapy is an adjunct, not substitute for life.

Give Up Their Commitment to the Past

• Clients may become so attached to their past, because of their bitterness, and their strong identification with their pain, they cannot move on. They want “restoration” – the caring that will make them “whole.” Trying to coerce restoration from others will only lead to defeat and humiliation.
• Clients need to “get a life” and take responsibility for their present. Real life can offer better reparations than therapy.
Demographics and Natural History

• According to DSM-5, dependent personality is among the most frequent personality disorders encountered in mental health clinics.
• Incidence is 0.3% with women at higher risk, no ethnic differences, and higher incidence in uneducated, less affluent, single young people.

Demographics and Natural History

• The course of the disorder is unknown, but appears to be chronic. There is some evidence of deterioration over time, with increased isolation and withdrawal, anxiety, and depression.
• People with intense dependency needs can function well if they have a supportive environment, good social skills, and are somewhat flexible.

Demographics and Natural History

• It should be pointed out that dependence does not mean passivity. Dependent individuals may ingratiate themselves, exploit others' guilt, promote themselves, and even intimidate and control others to get their needs met. Some men with pathological dependence become jealous and violent, even to the point of murder.
Comorbidity

• There may be an increased incidence of mood and adjustment disorder. There is co-occurrence with borderline, avoidant, and histrionic personality disorders.

Description

• Need for attachment
• Dependency on approval
• Submissiveness and feelings of inadequacy
• Depressive affect
• Naive and uncritical

Interpersonal Agenda of the Dependent Personality

• The dependent personality believes that he/she must be taken care of by a powerful person because he/she is unable to take care of herself.
Other Observations

• Clinicians emphasize depression and dysphoria in their observations of dependent clients.
• Lack of confidence is not the primary finding, rather pathological use of relationships to deal with the deficiency.
• A real problem with diagnosis is the threshold for clinical significance. There must be significant distress or impairment. People can choose to subordinate themselves without being ill. Also, lack of confidence is not enough. There must also be maladaptive behaviors.

Transference and Boundary Issues

• Dependent personalities will be friendly and compliant. They will see the therapist as powerful and will be quite content to rely on the therapist to make everything better. Their submissiveness can give the false appearance of a treatment alliance.
• If the therapist assumes a dominant role, which the client desires, a very pathological co-dependency can develop.
• These clients are rejected for therapy more than any other disorders because of their transparent wish for unconditional care.
• Countertransference: fantasies of insatiability and permanence

Treatment

• There is no research regarding medications, although an antidepressant may be called for.
• Clients are likely to stay in therapy, since they place no value on independence or initiative.
• The process of giving up dependency is a long slow process. Self-esteem is built bit by bit. Clients need to learn to differentiate from others, which is an alien concept for them.
• Group therapy, with a mix of support and confrontation, may be useful.
Treatment

• The most effective interventions emphasize replacing unhealthy, maladaptive dependency with flexible, adaptive dependency.
• Five interventions have been shown to be effective:
  • Look for relationships that reinforce dependency
  • Examine the helpless self-concept
  • Identify self-denigrating statements
  • Point out maladaptive behaviors and offer alternatives
  • Role play and homework