WPA/ISSPD Educational Program on Personality Disorders Module I

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1. ANCIENT HISTORICAL IDEAS ON PERSONALITY

Hippocrates in the 4th century BC proposed types based on imbalances of bodily humours, notably yellow bile, black bile, blood, phlegm.

Theophrastus in the 3rd century BC detailed over 30 types of "characters," many familiar to personalities seen today.

Physiognomy, which identifies personality by facial configurations and expressions, was a popular belief beginning in the days of the early Greeks.

2. EARLY 20TH CENTURY PERSONALITY DISORDER IDEAS

Koch, proposed at the turn of the century that all "mental irregularities" whether congenital or acquired, be labelled "psychopathic inferiorities", especially troublesome personalities.

Kraepelin, although preceded by others, addressed personality dispositions and temperaments in his 1913 textbook (eighth edition), such as "cyclothymics" and "autistics".

Schneider and Kretschmer, mid- European psychiatrists, each proposed innovative personality types and constitutional dispositions.

Freud, Abraham, and Reich, major psychoanalytic theorists, proposed "psychosexual" development characters similar to current personality types.

3. CONTEMPORARY PERSONALITY DISORDER PROPOSALS

Kernberg, an analyst, has expanded PD notions in terms of levels of structural cohesion and organization.

Benjamin, focusing on PD interpersonal and cognitive themes, integrates them with analytic ideas.

Cloninger has offered a well-regarded neurobiologic model based on 3 temperaments.

Millon, drawing on evolutionary theory, posits a comprehensive spectrum of 15 personality types.

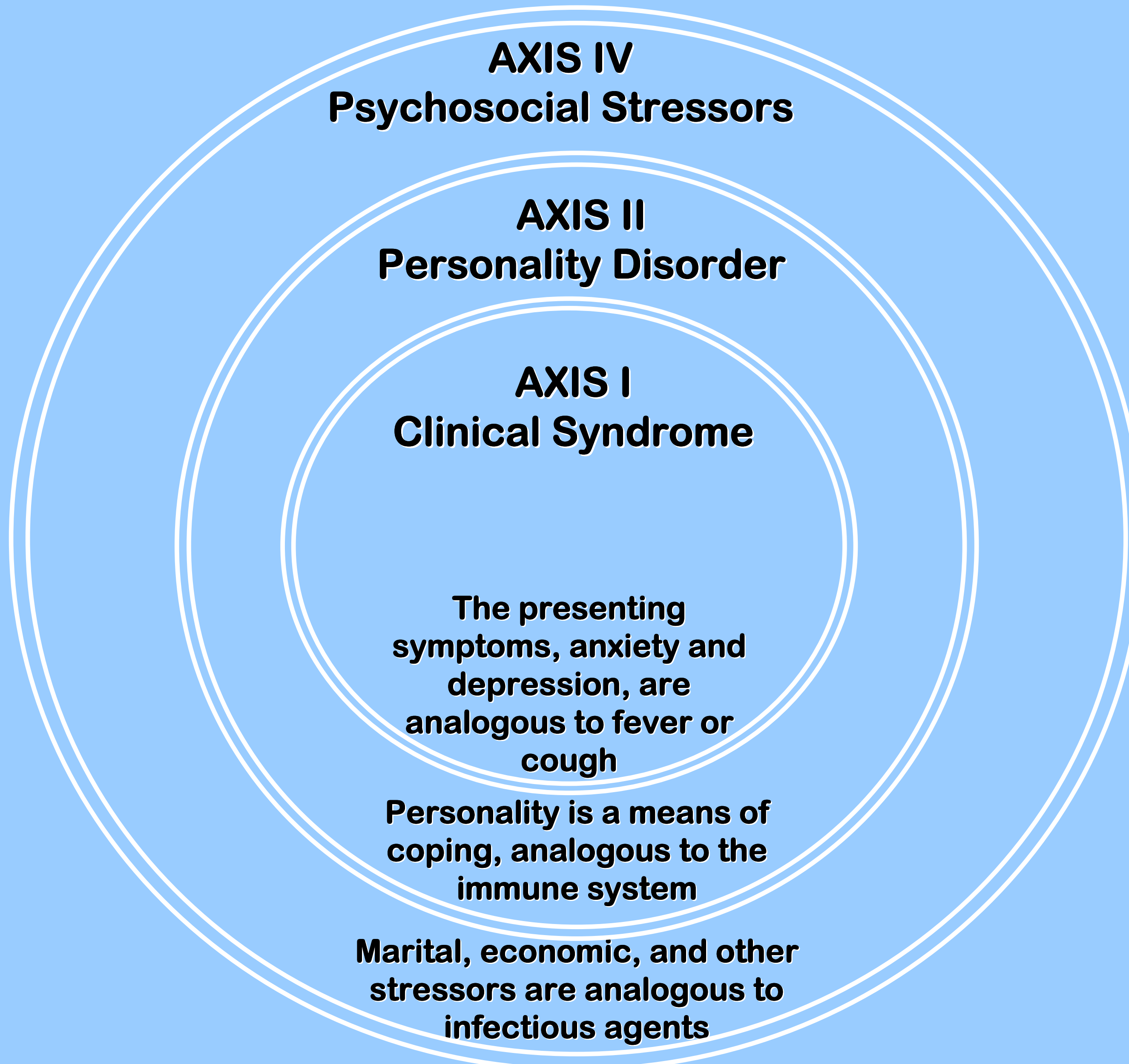
4. THE MEANING OF PERSONALITY HAS CHANGED THROUGH HISTORY

Originally meant a theatrical mask of a dramatic player, the false surface appearance of an actor.

Meanings shifted to represent the real person, his/her explicit or manifest features.

Recently, it has begun to signify the inner, less-revealed attributes, the hidden or veiled traits of the person.

5. IN THE DSM MULTIAXIAL FORMAT, THE PDS ARE AKIN TO THE BODY'S IMMUNE SYSTEM



6. HOW DO WE DIFFERENTIATE NORMALITY FROM ABNORMALITY?

Distinction between them are a function of cultural artefacts or social constructions.

They should be seen as relative concepts, arbitrary points on a continuum.

Normality signifies the capacity to function competently within one's social milieu and to fulfil one's potential.

7. WHY ARE PERSONALITY DISORDERS IMPORTANT?

Clinical syndromes (e.g., Mood disorders, Substance abuse, Eating disorders) occur more often among personality disordered patients.

Patients with multiple clinical syndromes often have personality disorders.

Even patients with modest personality disturbances display clinically significant pathology in relationships, self-image, etc.

8. KNOWING THE PERSONALITY DISORDER HELPS PLAN THERAPY

A depressed patient with a Borderline personality has a different past history and needs than a depressed patient with another personality disorder.

Though similar, the self-image of an Avoidant personality is different than a person with a Schizoid or Dependent personality.

Though similar, the cognitive misinterpretations of an Antisocial personality differs from patients with a Narcissistic personality.

9. PERSONALITY DISORDERS HAVE ACHIEVED CONSIDERABLE SIGNIFICANCE IN THE DSM AND ICD

PDs have a contextual role in multiaxial diagnosis.

PDs are one of two required axes in the DSM.

PDs comprise 12-15 % or more of the general population.

PDs are often causally connected to and help explain suicides, unemployment, family disruptions, medical disorders, crime, child abuse, substance abuse, delinquency, and institutionalization.

PDs may be more costly to society than all other mental disorders.

10. THE DSM IS THE OFFICIAL CLASSIFICATION SYSTEM IN THE UNITED STATES

The PDs in DSM-IV are grouped into 3 clusters based on superficially descriptive similarities.

The “odd’ cluster A includes the schizoid, paranoid, and schizotypal PDs.

The ‘emotional” cluster B includes the borderline, histrionic, narcissistic, and antisocial PDs.

The “anxious” cluster C includes the avoidant, dependent, and obsessive-compulsive PDs.

Personalities “not otherwise specified” and the depressive and passive-aggressive (negativistic) PDs round out the current list.

11. THE ICD IS THE OFFICIAL CLASSIFICATION SYSTEM AROUND THE WORLD

Eight PDs are specified: paranoid, schizoid, dissocial, emotionally unstable, histrionic, anxious, anankastic, and dependent.

The schizotypal and narcissistic PDs of the DSM are not assigned in the ICD PD list.

12. ISSUES AND CONFLICTS BETWEEN DSM AND ICD

Is the DSM's Axis I and II distinction justified?

Should the diagnostic criteria for the PDs overlap?

Why are some PDs in the DSM not in the ICD?

How many criteria should comprise a PD Dx?

Do the PD syndromes really exist or are they a product of tradition, research orientations, sociocultural values and contexts, or theoretical expectations?

13. CATEGORICAL MODEL ADVANTAGES AND DISADVANTAGES

Categorical Advantages: ease of use; alerts clinicians to unobserved traits; integrates diverse elements into coherent syndromes.

Categorical Disadvantages: assumes discrete boundaries between disorders; Dx thresholds are arbitrary; implies distinct etiologies.

14. DIMENSIONAL MODEL ADVANTAGES AND DISADVANTAGES

Dimensional Advantages: little clinical information is lost; permits inclusion of atypical cases; traits are gauged aquantitatively; normality-abnormality is on a continuum.

Dimensional Disadvantages: no agreement as to which dimensions exist; difficult to integrate data; grouping of dimensions in effect become categories.

15. PROTOTYPAL MODEL ADVANTAGES AND DISADVANTAGES

Prototypal Advantages: a synthesis of categorical and dimensional attributes; recognizes the heterogeneity of PD patients; includes only a few core common features of a prototypal group; encourages subtypes.

Prototypal Disadvantages: not essentially different than categorical models; clinicians and researchers unreceptive to this innovative model.

16. ARE DEVELOPMENTAL COURSES OR ETIOLOGIES TRACEABLE IN PDS?

Little agreement exists as to which developmental factors are critical.

Complex of interacting variables difficult to disentangle.

Incidental/random events can have marked and unanticipated effects.

Similar influences can effect/produce different PD types.

17. ROLE OF BIOGENIC INFLUENCES

Role of biogenic factors does not negate a role for social experiences and learning.

Perhaps 40-50% of personality variance may be attributed to genetic factors.

PDs may represent minimally expressed defective genes.

PD traits partially derive from complex and circular feedbacks of diverse brain activity.

18. ROLE OF PSYCHOGENIC FACTORS

No single aspect of life experience is sufficient to produce a PD.

Much of what is learned comes from casual, repetitive and incidental aspects of life experience.

Children are exposed to and often learn different and contrasting attitudes and feelings from parents, sibs, and others.

19. ROLE OF SOCIOGENIC INFLUENCE

Cultures set the general norms for self-identity and social relationships.

Socioeconomic influences are a significant element in shaping the goals and roles of people, as well as the means for achieving or undoing them.

The complexities of culture and the rapidity of change in values and goals are increasingly important influences on contemporary lives.

The prevalence of antisocial and borderline PDs is markedly influenced by social conditions.

20. ASSESSING PERSONALITY DISORDERS

Major types of instruments include; observation; interviews; rating checklists; self-report inventories; projective techniques.

Major formal clinical /research instruments include: IPDE; SCID-II; SIDP-IV; MMPI-II; MCMI-III; NEO-PI-R; TAT; Rorschach.

21. DIRECTION OF MODERN PERSONALITY-CHANGE THERAPY

Rather than fit therapy to the patient, clinicians in the past fit the patient to their preconceived therapeutic school of thought.

Dissatisfaction with school-oriented therapy has led to the integration of several coordinated modalities.

However, increasingly it is economic and political forces that have begun to determine what therapies are to be used, e.g., brief, simple pharmacologically-oriented treatment.

22. PROBLEMS OF PERSONALITY- CHANGE THERAPIES

The PDs are long standing and pervasive, requiring comprehensive multimodal therapies.

Focus on the Axis I Clinical Syndromes alone is like neutralizing the symptoms without treating the underlying disease.

A combination of several therapies (e.g., group, individual, psycho-educational) are often necessary to facilitate and extend the value of pharmacologic treatments.

23. PSYCHODYNAMIC THERAPY OF THE PDS

Dynamic therapies insist on treating the “inner egg” rather than simply smoothening the overt roughness of the surface shell.

Unconscious mental functions, such as the person’s defence mechanisms, are seen as responsible for the patient’s problematic behaviours and emotional troubles.

In addition to face-to-face interviews, dreams and free association are employed to decode “the unconscious”.

The patient’s relationship to the therapist, known as transference, serves as a guide for how the patient relates problematically to others.

24. COGNITIVE THERAPY OF THE PDS

PDs are characterized by specific distortions and erroneous beliefs about self and others.

Cognitive misinterpretations and misconceived expectations mislead the patient into repeated difficulties.

Cognitive-Behavioural approaches help patients identify and invalidate their automatic troublesome thoughts.

Using an active-problem-solving approach, cognitive therapists seek to guide the patient to more realistic ideas and adaptive behaviours.

25. BIOLOGIC THERAPY OF THE PDS

Medication is most helpful in treating current clinical syndromes associated with PDs.

Medication has the potential to calm the patient and to enhance the treatment alliance.

The neurobiology of personality traits may soon provide a theoretical basis for the selective treatment of the PD patient.

Weaving pharmacological and dynamic/cognitive therapies are likely to be the most effective approaches to successful PD therapy.