

**PENAL REFORM INTERNATIONAL
PRISON MENTAL HEALTH – TRAINING WORKSHOP JUNE 2007**

Introduction to personality disorders

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Session objectives

- **To provide an overview of concepts used in defining “personality disorder”**
- **To highlight some principal findings**
- **To identify some key controversies**
- **To survey (briefly) currently used treatment approaches**
- **To consider issues arising in clinical management of clients with dysfunctional personality patterns**

Approaches to conceptualising personality disorder

- **Categorical classification (diagnostic / nosological systems)**
- **Dimensional classification (measurable traits or tendencies)**
- **Structural-dynamic classification**
- **Prototypical classification**
- **Relational classification**

DSM-IV categories

- **Cluster A (“odd, eccentric”)**
 - Paranoid, Schizoid, Schizotypal
- **Cluster B (“erratic, emotional, dramatic”)**
 - Antisocial, Borderline, Histrionic, Narcissistic
- **Cluster C (“anxious, fearful”)**
 - Avoidant, Dependent, Obsessive-compulsive

Diagnostic systems: overlaps and divergences

ICD-10

Paranoid
Schizoid
Schizotypal
Dissocial
Emotionally unstable, borderline type
Emotionally unstable, impulsive type
Histrionic
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Anxious
Dependent
Anankastic
Enduring personality change after:
catastrophic experience; psychiatric
illness
Organic personality disorder
Other specific and mixed disorders

DSM-IV

Paranoid
Schizoid
Schizotypal
Antisocial
Borderline
Histrionic
Narcissistic
Avoidant
Dependent
Obsessive-compulsive
Personality change due to medical
condition
Personality disorder not otherwise
specified

Overlaps of conceptual approaches

DSM-IV SCHEMATIC FRAMEWORK:

Cluster A → Cluster B → Cluster C → non-clinical range

STRUCTURAL-PSYCHODYNAMIC FRAMEWORK:

Psychotic → Borderline → Neurotic → “normal/adaptive”

Reflected in the personality system’s structural integrity, i.e. how well it can handle anxiety, conflict or other emotional experience without becoming overloaded and symptomatic (= “ego-adaptive capacity”)

Critiques of the nomenclature

“Nobody is fully satisfied with, or lacks valid criticisms of, the DSM-IV and ICD-10 classification of personality disorders...however, few persons suggest that all official diagnostic nomenclatures be abandoned. The benefits... do appear to outweigh the costs... everybody finds fault with this language, but at least everyone has the ability to communicate this disagreement” (Widiger, 2001, p.77).

Co-morbidity / Co-occurrence

- The term ‘co-morbidity’ implies usage of a medical model, i.e. the possibility of identifying ‘distinct disease entities’
- Dolan-Sewell et al (2001) propose using the term ‘co-occurrence’ as an alternative
- The percentage of personality-disordered clients who meet criteria for an Axis I disorder ranges from 66% to 97%
- The percentage of those with Axis I disorders who meet criteria for Axis II ranges from 13% to 81%

Aetiological factors

- **Genetic predisposition / multiple genes**
- **Attachment experiences**
- **Traumatic events**
- **Family constellation and dysfunction**
- **Socio-cultural and political forces**

Clinical assessment

- **Initial assessment interview**
 - *Focus on problems and symptoms, but also on dysfunctional patterns*
- **Specially designed structured interviews, e.g.**
 - *International Personality Disorder Examination (IPDE)*
 - *Diagnostic Interview for Borderlines*
- **Self-report psychometrics, e.g.**
 - *Millon Clinical Multiaxial Inventory (MCMI-III)*
 - *Minnesota Multiphasic Personality Inventory (MMPI-2)*
- **Case-file examination**
 - *Psychopathy Check List (Revised)*

Current therapeutic approaches

- **Interpersonal therapy**
- **Interpersonal reconstructive therapy**
- **Cognitive therapy**
- **Schema-focused therapy**
- **Dialectical behaviour therapy**
- **Cognitive-behavioural therapy**
- **Cognitive-analytic therapy**
- **Therapeutic communities**

Interpersonal issues

- **The presence of personality disorders may explain difficulties with ‘hard-to-reach’ or ‘non-responsive’ clients**
- **Challenges may arise from aspects of interpersonal/interactional style**
- **Focus on processes of engagement & developing alliance**
- **Focus on interpersonal skills of therapists**
- **Re-conceptualisation of phases of therapy**

Interpersonal Reconstructive Therapy - 1

(Benjamin, 2003)

- **Identification of key “copy processes”**
 - Be like him/her (*identification*)
 - Act as if he/she is still there and in control (*recapitulation*)
 - Treat yourself as he/she treated you (*introjection*)
- **Case formulation**
 - Identify presenting problems
 - Link presenting problems to key figures via copy processes
 - Connect problem personality patterns (Axis II) to associated symptoms or symptom clusters (Axis I)

Interpersonal Reconstructive Therapy - 2

(Benjamin, 2003)

- **The “Core Algorithm”**
 - Accurate empathy
 - Support the green rather than the red
 - Link every intervention to the case formulation
 - Elicit detail about input, response, impact on self
 - Elicit ABCs associated with the story
 - Relate the intervention to the five steps...
- **Five steps in IRT**
 - Collaborate: develop and preserve a good working alliance
 - Learn about patterns, where they are from, and what they are for
 - Block maladaptive patterns
 - Enable the will to change
 - Learn new patterns

Supportive interventions: client personality styles and therapist interactional styles (Choca, 2004)

Schizoid	Accept interpersonal distance Problem solve in practical matters Do not emphasize insight, or relationships Reassure Be careful with negative interpretations Be relaxed
Avoidant	Be dominant, but protective Allow client to be centre of attention Be emotionally demonstrative Allow client to be dominant Be careful with negative interpretations Accept competitive assumption Show how client is not competing well in psychological functioning Be firm when limits are tested be on time; be organised
Dependent	Accept a hierarchical view of the world Avoid telling the client what to do; any controls will become an issue Tolerate and interpret moods
Histrionic	
Narcissistic	
Antisocial	
Compulsive	
Negativistic	