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Personality Disorders and the DSM-5®

Written and Presented by:
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Part I: Creating the Distinction “Personality Disorder”
Part I:
Creating the Distinction
“Personality Disorder”

Late 1800's & Early 1900's
Mental Health Begins as a Science and
Adopts the “Health Care” Approach

1. Step 1: Use descriptive pathology to describe the clinically significant distress or impairment in the person’s life

2. Step 2: Use explanatory pathology to explain the cause of the distress or impairment

3. Step 3: Use interventions to relieve the distress or impairment

Early 1900's
The First Psychiatric Condition is Named:
“Psychotic” Disorders

A descriptive pathology term that means “misperception of consensual reality,” conceptualized by Bleuler, Kraepelin and others, “psychotic” disorders involve distortions of perception to the point of loss of contact with sensory reality in a way that disables someone’s life. Diagnoses include schizophrenia, schizo-affective, and transient psychotic episodes. Cause was yet to be undetermined. Treatment was confinement.

Major features:
1. Misperception of reality
2. Lack of awareness of misperceiving reality
Early 1910's
The Second Psychiatric Condition is Named: “Neurotic” Disorders

An explanatory pathology term that means “internal conflict,” conceptualized first by Freud and then by Jung, Adler and others, “neurotic” disorders involve an unresolved emotional or developmental conflict that produces behavioral or emotional symptoms that are distressing and/or impairing. Diagnoses included depression, phobias, anxiety states, and adjustment disorders. Cause was considered to be aversive early experiences. Treatment was psychoanalysis.

Major Features:
1. Emotional distress as a result of misperception of reality
2. Awareness of the misperception
3. An inability to stop either the misperception or the distress

1930's
The Rise of Freudian Theory

Freudian theory became the predominant theory driving mental health as a science because Freud was the first in the field to develop a theory of cause of psychiatric symptoms.

1952
Psychiatry Separates from Neurology with the Publication of DSM-I®

DSM-I® was the first formal psychiatric diagnostic manual, establishing psychiatry as an independent field. The manual gave global outlines of psychiatric conditions. It contained no diagnostic distinctions involving personality problems, but included some references to them that were included in and indistinct from symptomatic disorders.
1. Personality Pattern Disturbance
2. Personality Trait Disturbance
3. Sociopathic Personality Disturbance
4. Specific Symptom Reaction
5. Transient Situational Personality Disturbance

1968

The American Psychiatric Association Publishes DSM-II®, the First Revision of the Psychiatric Diagnostic Manual

DSM-II® created more refined diagnostic distinctions and moved the diagnostic system into almost exclusively psychoanalytically-based definitions. It did not distinguish personality problems from symptomatic problems and viewed psychiatric dysfunctions as psychological developmental issues with unresolved internal conflicts.

1970's

The American Psychiatric Forms the DSM-III® Committee to Revise the Entire Mental Health Sciences

In the early 1970's the American Psychiatric Association decided that the science was not progressing and had gotten off-track. They asked Robert Spitzer, M.D., Ph.D., to chair a committee to completely rework the science and the diagnostic system.

Spitzer’s committee determined that in order to move the science forward, psychoanalytic theory with its “internal conflict” explanatory pathology needed to be removed as the basis of psychiatric diagnoses, and that a return to descriptive pathology was necessary in order to add the descriptive distinctions that were missed by Freud’s premature jump to explanatory pathology.

Dramatically breaking with long-standing psychoanalytic tradition, the committee sought to:
1. Use experimentally reliable, **scientific methods** and descriptions to describe psychiatric conditions rather than psychoanalytic assumptions of internal processes. These included such procedures as:
   - Clinical trials
   - Behavioral observation
   - Reliability and validity data
   - Professional consensus
   - Cluster analysis

2. **Eliminate** psychoanalytically-based diagnostic labels (with the exception of “**neurotic depression**” which was included in parentheses after the name “Dysthymic Disorder” as per an agreement hammered out with the psychoanalysts dubbed by Spitzer as “The Neurotic Peace Treaty”) in order to remove the assumption that all psychiatric symptoms were caused by an unresolved internal conflict.

3. Use **behavioral** observations and behavioral criteria for diagnosis instead of criteria based on assumptions about intrapsychic processes.

4. Acknowledge the reality of what many clinicians had claimed: **there were patients who did not fit the traditional criteria** for psychiatric disorders but who were still significantly impaired or distressed. These patients were:

   1. “Nearly” psychotic in functioning, but retained intact **reality-testing**.
   2. “Neurotic” in that they showed emotional distress, but showed unusual **chronicity** and **stability** in their symptoms.
   3. **Refractory** to most mental health treatments that had been developed, and did not improve with traditional
psychoanalysis or psychoanalytic psychotherapy.

4. Often continued to function at a consistent level and did not necessarily **deteriorate**.

5. Often appeared to be in low-grade, long-standing, **chronic** distress.

6. Often had **vague** and **poorly defined** complaints of distress.

7. Could be **demanding**, unreasonable, and unpleasant.

8. Were often **avoidant and noncompliant** about treatment and frequently dropped out of treatment.

9. Frequently **blamed** the treatment professional and others for their distress.

10. Often produced **confusion and upset** in others, including professionals.

11. Had traditionally been referred to in psychoanalytic terms and **character** language (where “character” was considered to be a specific cluster of “defense mechanisms”).

12. Were thought to be neurotic but nearly psychotic, sometimes called “**pseudoneurotic**.”

13. Were referred to as having **“character neuroses”** or “**ego-syntonic**” symptoms.

14. Were essentially viewed as “**severely neurotic**” or “**mildly psychotic**.”
1980
DSM-III® is Published

Spitzer’s committee produced the DSM-III®, which introduced four revolutionary elements:

1. An elimination of the idea that all psychiatric symptoms were caused by a Freudian “unresolved internal conflict.”

2. A return to descriptive pathology and the elimination of Freudian explanatory pathology.

3. A mutiaxial diagnostic system designed to acknowledge complexity in the forces impacting psychological functioning and disorders.

4. A specific category and name for the “nonfitting” patients, called Axis II or Personality Disorders. It was separated from other conditions in order to conceptualize it as a unique and distinct dysfunction.

DSM-III®
Axis I vs. Axis II

Axis I - Psychiatric Disorders
1. Similar to an illness
2. Symptomatic
3. Runs a course
4. Distressing due to its presence
5. Dysfunction of a psychological system
6. What someone “gets” or “has”
7. Wide variety of “versions”

Axis II - Personality Disorders
1. Similar to a disorder
2. Characteristic
3. Pervasive and enduring
4. Distressing due to bad consequences
5. Dysfunction of the psychological system called the “person”
6. The way someone “is”
7. Eleven versions

1987

DSM-III-R®, the First Revision of the DSM-III®, was Published

Two changes were made to the Personality Disorders section:

1. Two disorders were added, for a total of 13
   Passive-Aggressive Personality Disorder
   Self-Defeating Personality Disorder

2. A threshold model was adopted:
   An individual was required to only meet a certain number
   (not all) of the diagnostic criteria to be diagnosed with
   a personality disorder.

1994

DSM-IV® was Published

DSM-IV®’s Axis II Personality Disorder section reduced the
number of diagnoses to ten, along with one extra category, Personality
Disorder NOS (“Not Otherwise Specified”).

2000

DSM-IV-TR® was Published

Being “text” revised rather than “criterion” revised, the DSM-IV-
TR did not change any diagnoses or diagnostic criteria, therefore in practical terms it was essentially the same as the DSM-IV®.

May of 2013
DSM-5® was
Published
The DSM-5® Makes Several Changes to Personality Disorders:

1. **Eliminates Axis II** (along with the rest of the multiaxial system) because:
   1. A **multiaxial system is not needed** for effective diagnosis (DSM-IV® had a non-axial option)
   2. We have enough data to **include in each diagnosis** the information that was previously listed on Axis III and Axis IV in each diagnosis
   3. GAF (Axis V) has almost **no psychometric validity**
   4. Personality Disorders are so **well-established as a phenomenon** that a separate category designed to “force” clinicians to think about them is no longer necessary

2. **Removes the names** from the Clusters

3. Makes changes to the **order** of criteria

4. Splits the six **Schizotypal** criteria into nine

5. Includes “**Section 3: Proposed Revision**” in order to encourage further refinement of some diagnostic categories, including Personality Disorders

6. Lists **Schizotypal and Antisocial** in 2 sections
The DSM-5® Left Some Things In Personality Disorders the Same:

1. The categorical model

2. The three Clusters

3. The number of diagnoses

4. The names of diagnoses

5. The diagnostic thresholds

6. The fundamental concept of “Personality Disorder” being distinct from other mental health conditions

“The diagnostic approach used in this manual represents the categorical perspective that personality disorders are qualitatively distinct clinical syndromes.” (DSM-5®, pg 646, emphasis added)

Current Conclusions About Personality Disorders

1. Psychiatric Disorders and Personality Disorders are different

2. Categories and criterion sets are required for accurate diagnosis

   “Without using categories and criterion sets, even experienced mental health professionals vastly underestimate the degree of pathology in their patients’ personalities.”

   Tom Widiger, University of Kentucky

   (Paraphrased, personal communication)

3. Are frequently mistaken for other mental health problems such as:
   Dissociative Identity Disorder
   Bipolar Disorder
   Dysthymia
Post Traumatic Stress Disorder
Attention Deficit Hyperactivity Disorder
Conduct Disorder
Reactive Attachment Disorder

4. Are **more prevalent** than originally thought
   Clinical Population: 39% - 100%
   General Population: 15% - 19%

5. Are often **underdiagnosed** because they can present with vague, general, indistinct, even benign-sounding (although chronic) complaints of distress:
   “I have low self-esteem.”
   “People don’t understand me.”
   “I just can’t do what I need to do.”
   “I guess I’m just not getting enough out of life.”
   “I don’t know why I don’t follow the doctor’s orders.”
   “I know you told me to do that, but I just couldn’t.”

6. Cause much **trouble** both clinically and culturally
   Can produce serious, debilitating, or dangerous behavioral, emotional, and social effects
   Spree killers, Aurora, CO movie theater-type crimes
   Recurrent spouse abuse/failure to leave abusers
   Child abuse
   High-risk health behaviors
   Marital and family distress

7. Are a risk factor for **other** serious life and medical problems:
   **Marital** dysfunction
   **Child** abuse
   **Medical** problems
   Frequent **physical** complaints
   Treatment **noncompliance**
   **High risk** health behaviors
   **Sexual** behavior
Drug behavior
Interpersonal behavior
Organic dysfunctions
1/3 of children with personality disorders show neurological abnormalities
Frequent illnesses
High consumption of health care resources

8. Are seen in all stages of life, including childhood

9. Are often related to other serious behavioral conditions:
   Associated with compulsive and addictive disorders nearly 65% of the time
   Associated with recurrent spouse abuse 80-90% of the time
   Some categories have suicide and homicide rates far above that of the general population, such as:
   Borderline
   Antisocial
   Narcissistic
   Dependent

10. Are a significant cause of chronic behavioral and emotional distress (data from longitudinal diagnostic studies):
    94% show consistency of condition over 6 months
    67-75% retain a diagnosis over 2-7 years
    Only 5% are completely recovered after 2-7 years

11. Frequently fail to comply with treatment regimens

12. Frequent difficulty forming trusting relationships and effective therapeutic alliances

13. Exhibit behavior that is unreasonable and demanding

14. Exhibit behavior that is resistive and avoidant
15. Can have a pattern of shutting down or becoming highly *escalated* when they experience strong feelings

16. Create **upset** and distress in the people around them

17. A presentation that seems **difficult** or “**bad**” rather than clinically dysfunctional or impaired

18. Are often unaffected by **traditional** treatment and behavioral management approaches
Part II:

What a Personality Disorder Is
Part II:
What a Personality Disorder Is

What a "Personality" Is:
Graphic Representation

A Normal Personality
What a “Personality” Is:
Descriptive Representation

1. A “Personality” is a Psychological Toolkit
   1. It contains resources for living
   2. The resources in a personality are called “traits”

2. A “Normal” Personality is a Diverse Set of Tools
   1. Possesses a variety of traits
   2. Enables the person to handle the diverse demands of life
What a Personality “Disorder” Is:
Graphic Representation

A Disordered Personality
What a Personality “Disorder” Is: 
Descriptive Representation

1. A “Psychiatric Disorder” is a Malfunctioning System
   1. Mood disorder: Limbic system/serotonin malfunction
   2. PTSD: Amygdala malfunction
   3. ADHD: Executive function malfunction
   4. Addiction: Dopamine malfunction
   5. Psychotic: Cognitive malfunction

2. A “Disordered” Personality is an Insufficient Personality Toolkit with specific deficiencies:
   1. Insufficiently diverse traits
      1. Inability to “be” and “do”
      2. Excessive use of one way to “be” and “do”
   2. Insufficient productive self-awareness
      1. Inability to change behavior based on consequences
      2. Inability to self-adjust for better consequences

“A personality disorder is a human being who persists in a behavior in the face of clear evidence it is inappropriate, and ongoing bad consequences.”

W. John Livesley, M.D.
(personal communication)
Part III:

What a Personality Disorder Does
Part III: What a Personality Disorder Does

The Primary Characteristics of Normal Personality is the Ability:
1. To be flexible and adaptive
   To be “appropriate”
   To produce more positive than negative consequences
   To handle the unexpected turns life takes

2. To improve one’s results based on
   Observing when one has made a mistake
   Taking corrective action to prevent repeating that mistake

3. When facing something in life, to engage in a process called problem-solving

A Problem-Solving Process Involves:
1. Identifying a problem
2. Defining the problem “operationally”
3. Creating possible alternative solutions
4. Evaluating the alternative solutions
5. Implementing a solution or solutions
6. Evaluating the outcome
7. Making adjustments

Problem ↔️ Possible Actions ↔️ Solutions ↔️ Adjustments

The Primary Characteristics of a Disordered Personality is:
1. Protection and validation of an insufficient identity
2. Avoidance of the internal emptiness
3. Distraction from one’s deficiencies
4. Justification of one’s misbehavior
5. The creation of “Drama”
A Drama Process Involves an Identity-Validation process:
1. A problem is defined “personally” (not operationally)
2. Agreement and disagreement are created
3. Reactions and behaviors are justified or rationalized
4. The original problem remains unaddressed or
5. The original problem is amplified or
6. More problems are created
7. The individual’s identity is validated and gains additional agreement

\[ R \xrightarrow{\text{V}} P \]

R = Rescuer
P = Persecutor
V = Victim

A Drama Process Works By:

1. Someone performing an unexpected or unagreed-upon “switch” in identity/existential position/attachment/collaboration

2. That switch has the covert motive of justifying identity:
   1. The **Rescuer** looks like the “good” person but is actually Demeaning and devaluing others
   2. The **Persecutor** looks “justified” but is actually Inflicting their pain onto others
   3. The **Victim** looks “mistreated” but is actually Denying all responsibility
Summary of the Characteristics of a Personality Disorder

1. A limited set of functioning traits resulting in a failure of flexibility and adaptability and an insufficiency of ways to “be” and “do”

2. A lack of functioning observing ego (lack of productive self-awareness, resulting in failure of self-corrective ability)

3. The creation of Drama (unproductive escalations) instead of problem-solving
PART IV:

Identifying and Diagnosing a Personality Disorder
PART IV:
Identifying and Diagnosing
a Personality Disorder

Screening (Colloquial) Diagnosis

1. **By Group Functioning:**
   Perpetual, repetitive upset, confusion and conflict

2. **By Other Professionals’ Reactions:**
   Referrals preceded by an apology

3. **By Your Internal Experience:**
   When relating to them feeling as though you are the “crazy one.”

4. **By Your Emotional Reaction:**
   Consistent feelings of annoyance or irritation
   Instead of empathy or collaboration

5. **By Agreement on the “Everyday-Language” Diagnosis:**
   A person consistently referred to by others in demeaning terms
   such as “jerk,” “idiot,” “dolt,” “weirdo,” “moron,”
   “creep,” “nincompoop,” “jackass” (etc., etc., you know the other ones - yes, you do; you’ve used them - yes, you have).
Formal (DSM-5®) Diagnosis

A pattern of thinking, feeling, and behaving that has the following characteristics:

1. The pattern is **enduring and inflexible, persists** over time
   
   **Study showed only 5% nondiagnosable at 7 year followup**
   Noticeable in late adolescence or at least early adulthood
   Probably much earlier as well - average age 5

   **Childhood Diagnosis** is valid when it is:
   1. A pattern that is developmentally inappropriate
   2. A pattern that is at least 12 months of consistency
   3. A child cannot be labeled “Antisocial”

2. The pattern is **pervasive**
   Exists across a broad range of personal and social situations

3. The pattern involves **both**:
   - **Inner** experience
     How the person perceives, experiences, and interprets the world
   - **External** behavior
     The methods the person uses to attempt to achieve outcomes

4. The pattern **differs significantly** from the expectations of the individual’s culture
   Breaks social rules and causes bad consequences
   Considered to be “rude” or “offensive” or “strange”

5. The pattern involves two or more **important** areas of functioning:
   - **Thinking**
     Ways of perceiving and interpreting self and others
Feeling
Emotional range, intensity, stability, or appropriateness

Interpersonal Functioning
The style and nature of their relationships

Impulse Control
The ability to restrain, delay, or manage impulses

6. The pattern leads to clinically significant distress or impairment in important areas
   Social areas
   Marriage, friendships, family, acquaintances
   Occupational areas
   Bosses, coworkers, employees, customers, clients
   Other important areas of life skills
   Finances, planning, safety, legalities

7. The pattern is not better accounted for by another mental health condition
   viz. schizophrenia, depression, anxiety, mania

8. The pattern is not better accounted for by the direct physiological effects of a substance
   Drug abuse, steroids, amphetamines, etc.

9. The pattern is not better accounted for by a medical condition
   viz. head trauma, seizure disorder, dementia
Subtype Diagnosis

Diagnostic Clusters

1. **Cluster A** (Formerly called “Odd” or “Mature” Cluster)
   - Paranoid (*not* “Paranoia”)
   - Schizoid
   - Schizotypal

2. **Cluster B** (Formerly called “Dramatic” or “Immature” Cluster)
   - Antisocial
   - Borderline
   - Histrionic
   - Narcissistic

3. **Cluster C** (Formerly called “Anxious” Cluster)
   - Avoidant
   - Dependent
   - Obsessive-Compulsive (*not* Axis I Obsessive/Compulsive Disorder, or “OCD”)

4. **“Other” Personality Disorders** (Formerly called “NOS”)
   - Personality Change Due to Another Medical Condition
   - Other Specified Personality Disorder
     - Problematic, but does not meet full criteria
     - Clinician can document why does not meet full criteria
   - Unspecified Personality Disorder
     - Problematic, but does not meet full criteria
     - Clinician cannot document why does not meet full criteria
Cluster A

Paranoid Personality Disorder

Prevalence:

General Population Prevalence: 1.1% (.5% - 2.7 %)
Clinical Population Prevalence:
    National Comorbidity Survey: 2.3%
    National Epidemiological Survey: 4.4%
Gender Prevalence: Somewhat more common in men

Core Characteristics:

Exclusive Trait: Suspiciousness
    Persistent suspiciousness of other people
    Persistent interpretation of others’ motives as malevolent
    A long-standing interpretive style of suspicion and mistrust (at least from early adulthood)

Most Important Deficiency: Trust
    Cannot trust or partner with others
    Pervasely concerned about possible betrayal despite lack of evidence suggesting a danger of betrayal

Fundamental Pattern: A loner who is angry at the world and ultimately seeks revenge and retaliation

View of the World: Dangerous

View of Themselves: Mistreated

View of Others: Malevolent
Deals with the World by: Secretiveness

Diagnostic Criteria:

Threshold for Diagnosis: At least four out of seven characteristics:
(All without sufficient basis or data indicating it is appropriate to be suspicious in that particular circumstance)

1. Suspects that others are exploiting, harming, or deceiving him or her

2. Is preoccupied with doubts about the loyalty or trustworthiness of those close to him or her

3. Is reluctant to confide in others out of fear the information will be used maliciously against him or her

4. Reads “hidden” demeaning or threatening meanings
   In benign remarks
   In benign events

5. Persistently bears grudges
   Unforgiving of slights, insults, or injuries

6. Perceives attacks on his or her character or reputation that are not apparent to others
   Quick to become angry or to counter-attack

7. Has recurrent suspicions regarding the fidelity of spouse or sexual partner

Not Diagnosable if the Characteristics:

1. Occur exclusively during schizophrenia
2. Occur exclusively during a mood disorder with psychotic features
3. Occur exclusively during another **psychotic disorder**
4. Are due to the direct **physiological effects** of a medical condition

**DSM-5® Changes:**

1. **Criterion** #4 in DSM-IV is #7 in DSM-5®
2. Estimated **prevalence rates** in clinical populations is **increased**

**Typical Behaviors:**

1. Suddenly and without warning **attacks others verbally or physically**
2. **Accuses** others of malfeasance or **malevolent** motives
3. **Out-of-proportion** hostile behavior
4. Unreasonable **controllingness**
5. **Argumentative**
6. **Secretive**
7. **Sarcastic**
8. **Blaming**

**How Others Typically Experience Them:**

1. Take everything ‘personally’’’
2. Question every **motive** or intention
3. Get angry and obsessed over **small things** done wrong
4. Blow small things **out of proportion**
5. Are “**touchy**” or “**thin-skinned**”
6. Seem “**scary**” for no obvious reason
7. Have a “**with me or against me**” attitude
8. Are a “**blaming victim**”
9. Persist in “endless angry **storytelling**”
10. Persist in “**yes-butting**” alternate interpretations of other people’s motives
11. Are **rigid** in their conclusions
12. Dismiss “out-of-hand” possible alternate interpretations of other people’s motives
13. Have a “chip on their shoulder”
14. Are “spoiling for a fight”
15. Are **vindictive**

*How Others Typically React to Them:*

1. **Puzzlement**
2. Anxiety and **fear**
3. **Suspiciousness**
4. Feel a need to “handle them with **kid gloves**”
5. Reluctant to **self-disclose** or to talk openly with them
6. Try to “**protect**” them from bad news
7. Judge them to be “**impossible**”
8. **Gossip** about them
9. Keep them “**out of the loop**” of information/gossip
10. **Avoid** them
11. Use **passive-aggression** rather than direct confrontation

*Mistakes Health Care Workers Often Make About Them:*

1. They are not diagnosable - “they **don’t seem to fit** any category”
2. Their pervasive suspicions are justified
3. They are **quiet, nice, polite people**
4. They have been **mistreated** by others and that’s why they don’t trust
5. One **should not disagree** with or confront them
6. One **should not be honest** with them
7. One **should not admit weakness** or mistakes to them
Drama:

**Type:** Retaliatory

**Identity Validated:** Righteous Victim

“You can’t trust anyone.”
“Nothing is what it seems.”
“They can’t do this to me.”

**Drama Pattern:**

**Drama Entry Point:** Victim

“People are no darn good; I must be vigilant and careful.”

**Drama Switch 1:** Victim to Persecutor

“You are one of those people who is up to no good.”

**Drama Switch 2:** Persecutor to Victim

React to others by distancing or counter-attacking

“See - I knew you would turn on me, now I have to show you.”

**Drama Switch 3:** Victim to Persecutor

Retaliation - can include murder/suicide if third degree or after a major loss - “That’s it. You are evil and you must pay!”

**Drama Triangle Switch:**

Victim to Persecutor to Victim to Persecutor

1 2 3
Summary:

Pervasive fear and suspicion

Offensive, attacking, or accusatory behavior

“Validation” of suspicions due to others’ bad reactions

Retaliation

Examples:

Real World:
Joseph Stalin
J. Edgar Hoover
Richard Nixon
James Holmes (Aurora, Colorado movie theater shooter)

Literature:
Movies:
Chief of Security (Wilford Brimley) in “The Firm”
The Main Character (Gene Hackman) “The Conversation”
Francis/Psycho in “Stripes”
Female Combatant/SWAT Officer in “Mortal Kombat”
Ripley (Sigourney Weaver) in “Alien” movies
Ricky’s father (Chris Cooper) in “American Beauty”
Schizoid Personality Disorder

**Prevalence:**

General Population Prevalence: .6 (0% - .9%)
The least common Cluster A diagnosis

Clinical Population Prevalence:
- National Comorbidity Survey: 4.9%
- National Epidemiological Survey: 3.1%

Gender Prevalence: Significantly more common in men - estimated to be as much as 6 times more common in men

**Core Characteristics:**

**Exclusive Trait: Indifference**
A pervasive pattern of detachment from social relationships
A restricted range of expression of emotions with others
Beginning by early adulthood, and present in a variety of contexts.

**Most Important Deficiency: Attachment**
Does not attach or ally with
People
Activities
Involvements
Not loyal to anyone or anything

**Fundamental Pattern:** A loner who seems entirely detached from people

**View of the World:** Uninteresting

**View of Themselves:** Self-sufficient

**View of Others:** Impersonal
Deals with the World by: Solitude - or possibly one consuming, solitary interest

Diagnostic Criteria:

Threshold for Diagnosis: At least **four** out of **seven** characteristics:

1. Neither desires nor enjoys close relationships, including being part of a family
2. Chooses solitary activities
3. Little, if any, interest in having sexual experiences with another person
4. Pleasure in few, if any, activities
5. Lacks close friends or confidants
6. Indifferent to praise or criticism
7. Emotionally cold, detached or flat affect

Not Diagnosable if the Characteristics:

1. Occur exclusively during a schizophrenic episode
2. Occur exclusively during a mood disorder with psychotic features
3. Occur exclusively during another psychotic disorder
4. Are the result of a pervasive developmental disorder
5. Is due to the direct physiological effects of a medical condition

DSM-5® Changes:

1. Increased clinical prevalence rates
Typical Behaviors:

1. Excessive solitude and social distancing
2. Over-attention to technical or intellectual tasks
3. A “bland” approach to most activities and people

How Others Typically Experience Them:

1. Cold
2. Aloof
3. “Blank”
4. “Zombie”-like
5. “Dead”
6. Forgettable
7. Impossible to talk to or interview
8. Their problem or complaint hardly seems to matter to them
9. Uncommunicative
10. Boring

How Others Typically React to Them:

1. Exclude them
2. Get angry with them
3. Become passive-aggressive with them
4. Exasperation
5. Devaluation

Mistakes Health Care Workers Often Make About Them:

1. They are depressed
2. They are so emotional that they are highly repressed
3. They are dissociative
4. They just need lots of care and encouragement
5. They are just introverted
6. They have been **traumatized** and that’s why they’re distant

**Drama:**

**Type:** Empty

**Identity Validated Through Drama:** Self-Sufficient

“I don’t need anyone.”

“Relationships are messy and undesirable”

“Who cares, anyway?”

**Drama Pattern (Created in Other People)**

**Other People’s Drama Entry Point:** Rescuer

(“You’re just sad/depressed/repressed and if I try hard enough you’ll heal.”)

**Other People’s Drama Switch 1:** Rescuer to Victim

“I must be doing something wrong because nothing is working.”

**Other People’s Drama Switch 2:** Victim to Persecutor

“What’s your problem anyway!?”

**Other People’s Drama Switch 3:** Persecutor to Victim

“I guess you just don’t care about me, do you?”

**Drama Triangle Switch (Other People’s Switches):**

Rescuer to Victim

Rescuer to Persecutor

Rescuer to Victim
Summary:
(Other People’s Switch):

- Unmet desires for responsiveness/closeness
- “Trying hard” to connect with them/change them
- Feelings of frustration
- Anger
- Hopelessness

Examples:

Real World:
Ted Kaczynski (The Unabomber)

Literature:
- Movies:
  - Main Character (Sandra Bullock) in “The Net”
  - Chance the Gardener (Peter Sellers) in “Being There”
  - Ghost Dog (Forest Whitaker) “Ghost Dog, Way of the Samurai”
Schizotypal

Prevalence:

General Population Prevalence: 1.8% (.3%-5.1%)
Clinical Population Prevalence: 0%-1.9%
  National Epidemiological Survey: 3.9%
Gender Prevalence: Slightly more common in men

Core Characteristics:

Exclusive Trait: Eccentricity
  A pervasive pattern of social and interpersonal deficits, often including:
  Eccentricities of behavior
  Cognitive or perceptual distortions
  Acute discomfort with close relationships
  Little capacity for close relationships
  Beginning at least by early adulthood

Most Important Deficiency: Conformity, or the ability to “Fit”
  Don’t fit into social convention of most situations
  Almost take pride in being unique and different

Fundamental Pattern: Someone who does odd things

View of the World: Fascinating

View of Themselves: Gifted/Insightful/Perceptive

View of Others: Ordinary

Deals with the World by: Eccentric, grandiose ideas or plans
Diagnostic Criteria:

Threshold for Diagnosis: At least five of nine characteristics:

1. Ideas of reference (not delusions)

2. Odd beliefs
   Magical thinking that influences behavior that is inconsistent with subcultural norms

3. Unusual perceptual experiences
   Bodily illusions

4. Odd thinking and speech

5. Suspiciousness or paranoid ideas

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
   Is associated with paranoid fears, rather than negative judgments about self
   Beginning in adulthood

Not Diagnosable if the Characteristics:

1. Occur exclusively during the course of schizophrenia
2. Occur exclusively during a mood disorder with psychotic features
3. Occur exclusively during another psychotic disorder
4. Occur exclusively in conjunction with a pervasive developmental disorder
**DSM-5® Changes:**

1. Split the 6 DSM-IV® criteria into 9 criteria
2. Altered clinical prevalence estimates
3. The diagnosis is also listed in “Schizophrenic Spectrum Disorders”

**Typical Behaviors:**

1. Suspiciousness
2. Claiming special or unique abilities or powers
3. Nervousness in social situations
4. Isolating behaviors
5. Odd topics of conversation
6. Changes topic of conversation without warning

**How Others Typically Experience Them:**

1. Weird
2. Strange
3. Eccentric
4. Oddly anxious
5. “Inside their own head”
6. “Different”
7. “Crazy or a genius”
8. Entertaining
9. Full of odd non-sequiturs
10. Confusing

**How Others Typically React to Them:**

1. Amusement
2. Annoyed toleration
3. Sarcasm
4. “Humoring” them
5. “Wondering” about them
6. Gossiping about them
7. Treating them as “benign weirdos”

Mistakes Health Care Workers Often Make About Them:

1. They are psychotic
2. They are just a “creative” type of person
3. They are, indeed exceptionally gifted or talented or smart
4. They are benignly eccentric

Drama:

Type: Strange

Identity Validated Through Drama: Persecutor

“I’m special.”
“I understand things that you and other people do not.”
“I’m smarter than everyone else.”

Drama Pattern:

Drama Entry Point: Persecutor

“You just don’t understand the way things really work.’’

Drama Switch: Persecutor to Victim

“Darn. Why didn’t that work out?”
Drama Triangle Switch:

Persecutor to Victim

Summary:

Strangeness

Failure and Social Marginalization

Examples:

Real World:
  Andy Kaufman (comedian)
  Albert Einstein

Literature:
  Movies:
    The Professor (Christopher Lloyd) in “Back to the Future”
    The Caretaker (Bill Murray) in “Caddyshack”
    Donnie Darko (Jake Guentheral) in “Donnie Darko”
    The Jerk (Steve Martin) in “The Jerk”
    Main Character (Nicholas Cage) in “Raising Arizona”
    The Ricky character in “American Beauty”

  Television Shows:
    Cosmo Kramer (Michael Richards) in “Seinfeld”
    Phoebe Gates (Lisa Kudrow) in “Friends”
Cluster B

Antisocial Personality Disorder

**Prevalence:**

- **General Population Prevalence:** 1.2% (0% - 3.7%)
- **Clinical Population Prevalence:** 3% - 30% (depending on setting)
- **Gender Prevalence:** 3 times more common in men:
  - 3% of men, 1% of women
- **Highest Prevalence Rates in:**
  1. Severely chemically abusing population (78% comorbidity)
  2. Populations in adverse socioeconomic conditions

**Core Characteristics:**

- **Exclusive Trait:** Exploitation
  - A pervasive pattern of disregard for and violation of the rights of others occurring since **age 15**

- **Most Important Deficiency:** Honor or Integrity
  - Does not keep word; no regard for right and wrong
  - Recurrent violation of agreements for their own ends

- **Fundamental Pattern:** Pervasive agreement violations

- **View of the World:** Dog-Eat-Dog

- **View of Themselves:** Superior

- **View of Others:** Suckers or Marks

- **Deals with the World by:** Exploitive Opportunism
Diagnostic Criteria:

Threshold for Diagnosis: At least three of seven characteristics:

1. Failure to conform to social norms regarding lawful behaviors
   Repeatedly performing acts that are grounds for arrest

2. Deceitfulness
   Repeated lying, use of aliases, or conning others for personal profit or pleasure

3. Impulsivity or failure to plan ahead

4. Irritability and aggressiveness
   Repeated physical fights or assaults

5. Reckless disregard for the safety of self or others

6. Consistent irresponsibility
   Repeated failure to sustain consistent work behavior
   Repeated failure to honor financial obligations

7. Lack of remorse
   Indifferent to or rationalizing having hurt, mistreated, or stolen from others

And:

1. At least 18 years of age
2. Evidence of Conduct Disorder with onset before age 15
3. Not seen exclusively during mania or psychosis

Not Diagnosable if the Characteristics:

1. Occur exclusively during schizophrenia
2. Occur exclusively during a manic episode
DSM-5® Changes:

1. Also listed in “Impulse Disorders” Section

Typical Behaviors:

1. Cocky, glib
2. Verbally facile
3. Superficial charm
4. Rationalization and justification
5. Promiscuity

How Others Experience Them:

1. Charming (at first)
2. Untrustworthy (later)
3. Immature
4. Self-centered
5. Sincere (at first)
6. Duplicitious (later)
7. Manipulative
8. Dangerous and Rageful
9. Cognitively inflexible
10. Externally oriented (everything is everyone else’s fault)
11. Rationalizing and justifying
12. Haughty and contemptuous

How Others Typically React to Them:

1. Fear
2. Anger
3. Bargaining
4. Denial
5. Avoidance
6. Desire to hurt them and get back at them
7. Glee at their misfortune

Mistakes Health Care Workers Often Make About Them:

1. They surely can’t be that bad
2. “Deep down” they are good people
3. They are only this way because they learned it where they grew up

Drama:

Type: Exploitive and Violating

Identity Validated: Superiority
  “Look what a fool you are.”
  “I can get away with anything I want.”

Drama Pattern:

Drama Entry Point: Rescuer
  “I promise! I mean it this time! You can trust me! It’ll be OK!”
  -or-
Drama Entry Point: Victim
  “Can’t you make an exception just this once?”

Drama Switch: Rescuer to Persecutor
  “It’s not my fault - I had to do this bad thing, ha ha ha on you.”
  -or-
Drama Switch: Victim to Persecutor
  “It’s not my fault - I had to do this bad thing, ha ha ha on you.”
Drama Triangle Switch:

Rescuer to Persecutor
-or-
Victim to Persecutor

Summary:

Facade of trustworthiness or neediness

Creates opening for exploitation

Examples:

Real World:
- John Gotti
- Ted Bundy
- Saddam Hussein
- Whitey Bulger

Literature:

Movies:
- Main Character (Richard Gere) in “Breathless”
- Main Character (Jeff Bridges) in “The Jagged Edge”
- The Devil (Al Pacino) in “The Devil’s Advocate”
- Aaron/Roy (Edward Norton) character in “Primal Fear”
Steve (Edward Norton) in “The Italian Job”
Psychiatric Patient (Angelina Jolie) in “Girl, Interrupted”
Hannibal Lecter (Anthony Hopkins) in “Silence of the Lambs”
Main Character (John Travolta) in “Broken Arrow”
Main Character (John Travolta) in “Swordfish”
Maddie (Kathleen Turner) in “Body Heat”
Hit Man (Kevin Klein) in “A Fish Called Wanda”
Bishop (Laurence Fishburn) in “Assault on Precinct 13”
Main Character (Sharon Stone) in “Basic Instinct”
Sidekick Character (Joe Pesci) in “Casino”
Gang Leader (Malcolm McDowell) in “A Clockwork Orange”
Vincent (Tom Cruise) in “Collateral”
All of the Main Characters in “Kill Bill,” Vol 1 and 2
(John Malkovich) in “Line of Fire”
All the Main Characters in “Seven Psychopaths”

**Television Shows:**
Tony Soprano (James Gandolfini) in “The Sopranos”
James Spader in “The Black List”
Borderline Personality Disorder

*Prevalence:*

General Population Prevalence: 1.6% (.4% - 5.5%)
Clinical Population Prevalence:
  - 10% of psychiatric outpatients
  - 20% of psychiatric inpatients
  - 6% of patients in primary care settings
Gender Prevalence: Slightly more common in women
  - Estimated to be 54% women, 46% men
  - Diagnostic population (treatment population) 74% women

*Core Characteristics:*

*Exclusive Trait: Changeability and instability*
  - A pervasive pattern of instability of:
    - Mood, interpersonal relationships and self-image
  - Beginning at least by early adulthood

*Most Important Deficiency: Consistency and “proportionality”*

*Fundamental Pattern: Love, then hate, then love, then hate*

*View of the World: Rejecting and Hurtful*

*View of Themselves: Vulnerable and Worthless*

*View of Others: Angels or Devils*

*Deals with the World by: Emotional Justification*

*Diagnostic Criteria:*

Threshold for Diagnosis: At least five of nine characteristics: 46
1. Frantic efforts to avoid real or imagined abandonment

2. **Unstable** and overly intense interpersonal relationships that **alternate** between the extremes of:
   - **Overidealization** and **devaluation**
   (“Splitting” or “Dichotomous” thinking)

3. **Identity** disturbance
   Significant and persistent unstable **self-image** or sense of self

4. **Impulsiveness** in at least two areas that are potentially self-damaging such as:
   - Spending
   - Sex
   - Substance use
   - Shoplifting
   - Reckless driving
   - Binge eating

5. Recurrent **suicidal** behavior
   - Gestures
   - Threats
   - Attempts
   - Parasuicidal acts (non-lethal self-damaging behaviors)
   - Self-mutilation

6. Affective **instability**
   - Dramatic **shifts** from base-line mood to
     - Depression, irritability, and anxiety
   - Moods rarely last more than a few **hours**
   - Rarely more than a few **days**

7. Chronic feelings of **emptiness**

8. Inappropriate, intense **anger** or lack of control of anger
   - Frequent displays of **temper**
   - **Constant** anger
Recurrent physical fights

9. Transient, stress-related **paranoid** ideation
   Severe **dissociative** symptoms

**Important Differential Diagnosis:**
**Bipolar Disorder vs. Borderline Personality Disorder**

Gunderson: The conditions are **different** and are **only comorbid in 18.1% of cases**

**Differential Diagnosis:**
1. What **triggers** their mood swings:
   - Bipolar: Mood swings are entirely **neurological** and **autonomous**, no consistent environmental trigger
   - Borderline: Always **environmentally** triggered, usually by interpersonal sensitivity

2. How do they react when they are **depressed**:
   - Bipolar: **Disabled** by depression symptoms
   - Borderline: Can still be **impulsive** even when depressed

3. What is their **thinking pattern**:
   - Bipolar **does not use dichotomous thinking**
   - Borderline **uses dichotomous thinking**

4. The **depth** of their affect:
   - **Bipolar lacks depth** and pain and is hard to empathize with
   - **Borderline is deep, intense pain**, evokes a strong empathetic response

5. Their **care-seeking** behavior:
   - **Bipolar self-initiates** impulsively and ultimate leaves others to follow up (or clean up) afterward
   - **Borderline seeks** care and exclusivity and is sensitive to rejection
6. How they handle conflict:
   Bipolar ignores undesirable realities; if confronted denies emotional significance
   Borderline splits, and if challenged becomes angry and/or adopts opposite view

7. The length of their intense mood states:
   Bipolar experiences enduring mood states
   Borderline experiences mood states that last a few hours or a few days

8. The nature of their shifting emotional states
   Bipolar shifts in both mood and psychic energy
   Borderline shifts in mood without energy shift

Not Diagnosable if the Characteristics:

No specific excluding conditions

DSM-5® Changes:

1. Increase in prevalence estimates
2. Data show offspring of Borderline disordered parents are five times more likely to be Borderline disordered
3. Bipolar criteria include shift in “energy,” where Borderline shift is in “mood”

Typical Behaviors:

1. Exaggerating
2. Verbal outbursts
3. Over-reacting
4. Saying things that are not true (uncertain if this is actual “lying”)

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How Others Typically Experience Them:

1. Unreasonable
2. Hostile while also dependent
3. Chronic emotional pain and discomfort
4. Overly intense
5. Vaguely threatening
6. Dramatic
7. Manipulative (viz. Masterson; Linehan disputes this)
8. All-or-nothing, black/white thinker
9. Rageful
10. Vicious, spiteful, sharp-tongued
11. Never apologizes unless desperate to avoid abandonment
12. Emotionally inconsistent
13. Changeable, overly intense and moody
14. Extremely thin-skinned
15. Extreme abandonment and separation fears
16. Sees others as all-good or all-bad (splitting)
17. Stormy or violent relationships
18. Intolerant of both separation and intimacy
19. Frequently depressed or agitated

Special Characteristic:

Circadian rhythm disruption
Sleep disorders
   Intractable insomnia
   Inconsistency of sleep habits
   Repeated waking
   Hypersomnia
   Sleep-interrupting nightmares

How Others Typically React to Them:

1. Anger
2. Fear
3. Placating
4. Distancing
5. Exasperation
6. “Feel sorry for”
7. Want to merge with/get approval from
8. Make excuses for
9. “Damned if I do, damned if I don’t”
10. Enamored at first, angry and confused later

Mistakes Health Care Workers Often Make About Them:

1. It is a type of PTSD
2. They are just depressed
3. They are bipolar
4. They are just passionate
5. They are this way because they have been hurt
6. Everything they say is factually accurate
7. Everyone else in their life is awful

Drama:

Type: Chaos

Identity Validated: Victim
“I am have been SO mistreated!”

Drama Pattern:

Drama Entry Point: Victim
“I never get a fair shake.”
-or-

Drama Entry Point: Rescuer
“I’ll save you from those bad people!”
**Drama Switch: Victim to Persecutor**

“I’ll upset you for mistreating me.”

-or-

**Drama Switch: Rescuer to Persecutor**

“I’ll get them for mistreating you.”

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**Drama Triangle Switch:**

![Diagram](image)

Victim and Persecutor
-or-
Rescuer and Persecutor

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**Summary:**

Feelings of victimization of self or others

Self-righteous retribution

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**Examples:**

**Real World:**

Marilyn Monroe as portrayed in “My Week with Marilyn”
Princess Diana as described in “Diana in Search of Herself”
Eva Peron
Adolf Hitler
Jim Jones
David Koresh

**Literature:**

**Movies:**
- Alex (Glen Close) in “Fatal Attraction”
- Main Character (Jessica Walter) in “Play Misty for Me”
- Girlfriend (Jean Triplehorn) in “Sliding Doors”
- Robert DeNiro’s wife (Sharon Stone) in “Casino”
- Female Lead Character (Glen Close) in “Dangerous Liaisons”
- Willie Loman in “Death of a Salesman”
- Sonny’s Daughter in “Ghost Dog”
- Main Character (Diane Keaton) in “Looking for Mister Goodbar”
- Lady Macbeth in “Macbeth”
- Main Character (Mickey Rourke) in “9 ½ Weeks”
- Blanche (Vivian Leigh) in “A Streetcar Named Desire”
- Travis (Robert DeNiro) in “Taxi Driver”

**Books:**
- Lead female character (“Mildred”) in “Of Human Bondage”
Histrionic Personality Disorder

Prevalence:

General Population Prevalence: 2% (1.6% - 3.9%)
Most common Immature type
Clinical Population Prevalence: 10% - 15%
National Epidemiological Survey: 1.8%
Gender Prevalence: More-or-less equal between men and women
Yes, really

Core Characteristics:

Exclusive Trait: Expressiveness
A pervasive pattern of excessive emotionality and attention-seeking
Beginning at least by early adulthood

Most Important Deficiency: Shame
No sense of propriety or discretion

Fundamental Pattern: Attention seeking and emotional coerciveness

View of the World: Impressionistic

View of Themselves: Fetching, appealing, and deserving

View of Others: Admirers and servants

Deals with the World by: Performing

Diagnostic Criteria:

Threshold for Diagnosis: At least five of eight characteristics:
1. Discomfort when not the **center of attention**

2. Relationships are characterized by inappropriately sexually **seductiveness** or provocativeness

3. Rapidly shifting and **shallow** expression of emotions

4. Consistent use of physical **appearance** to draw attention to self

5. Speech is excessively **impressionistic** and lacking in detail

6. Self-dramatizing, **theatrical**, exaggerated emotional expression

7. **Suggestible** - easily influenced by others or by circumstances

8. Thinks relationships are **more intimate** than they actually are

**Not Diagnosable if the Characteristics:**

No specific excluding conditions

**DSM-5® Changes:**

1. Estimated clinical prevalence rate increased

**Typical Behaviors:**

1. **Flirting**
2. Fishing for **compliments**
3. Obvious **bids for attention**
4. **Vague** language
5. **Making scenes**
6. **Suicidal “gestures”** (nevertheless may be dangerous and must be taken seriously)
7. **Physical** complaints

**How Others Typically Experience Them:**

1. Needy
2. Showy
3. Superficial
4. Overly emotional
5. Melodramatic
6. Seductive
7. Shallow
8. Childlike
9. Impulsive and **thematic** rather than analytic and precise
10. Relentlessly demanding of **attention**
11. Rapport is difficult to establish
12. Vague, dramatic **exaggerations**
13. Sidetracks
14. Overly **body**-oriented

**How Others Typically React to Them:**

1. Sexual aggression
2. Irritation
3. Talking **down to** (like a child)
4. Dismissive
5. Impatience

**Mistakes Health Care Workers Often Make About Them:**

1. They are “**deeply feeling**” people
2. They are simply “**free spirits**”
3. They **never got their needs** met as children
4. They have **PTSD**
5. Other people have **mistreated** them
Drama:

Type: Emotional Blackmail

Identity Validated: Victim
“But I can’t! You have to!”

Drama Pattern:

Drama Entry Point: Victim
“Look at me!”

Drama Switch 1: Victim to Persecutor
“You’re a meanie!”

Drama Switch 2: Persecutor to Victim
“How can you treat me like this?!”

Drama Triangle Switch:

Victim to Persecutor to Victim

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R ← P
V
```

1 2
Summary:

Childlike neediness
  → Excessive demands
  → Whiny complaints

Examples:

Real World:
  Mae West

Literature:
  Movies:
    Scarlett O’Hara in “Gone With the Wind”
    Albert (Nathan Lane) in “The Birdcage”
    The main characters (fashion designers) in “Ready to Wear”
    Lillian Lust (Racquel Welch) in “Bedazzled”
    Rodney Dangerfield in “Caddyshack”
    Sigourney Weaver in “Galaxy Quest”
    Holly Hunter in “Raising Arizona”

  Television Shows:
    George Costanza (Jason Alexander) in “Seinfeld”
Narcissistic Personality Disorder

**Prevalence:**

General Population Prevalence: 1% (.4% - 5.5%)
Least common Immature Type
Clinical Population Prevalence: 2% - 16%
Community Samples: 0%-6.2%
Gender Prevalence: 50%-75% men

**Core Characteristics:**

*Exclusive Trait:* Self-aggrandizement
Pervasive pattern of grandiosity
In behavior or fantasy
A need for admiration
A lack of empathy
Beginning at least by early adulthood

*Most Important Deficiency:* Equality

*Fundamental Pattern:* Arrogant and demeaning contempt

*View of the World:* Exists solely to serve them

*View of Themselves:* Special, exempt, and entitled

*View of Others:* Inferior underlings

*Deals with the World by:* Image-management and rage
**Diagnostic Criteria:**

Threshold for Diagnosis: At least **five** of **nine** characteristics:

1. **Grandiose sense of self-importance**
   - Exaggerates achievements and talents
   - Expects to be recognized as **superior** without achievements

2. Preoccupied with fantasies of **unlimited** success, power, brilliance, beauty or ideal love

3. Believes he or she is **special** and unique
   - Can only be understood by other special people

4. Requires excessive **admiration**

5. Sense of **entitlement**
   - (Such as expectations of especially **favorable** treatment)

6. Interpersonally **exploitative**

7. Lacks **empathy**
   - Unwilling to recognize or identify with the **feelings** and needs of others

8. **Envious** of others
   - Believes others are envious of him or her

9. **Arrogant**, haughty behaviors or attitudes

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**Not Diagnosable if the Characteristics:**

No specific conditions
DSM-5® Changes:

No changes

Typical Behaviors:

1. Fishing for compliments
2. Rage when entitlement or special treatment not received
3. Excessive discussion of self
4. Competitive
5. Contemptuous and demeaning references to others

How Others Typically Experience Them:

1. Selfish, self-centered
2. Presumptuous
3. Uncaring
4. Demanding
5. Manipulative
6. Unsatisfiable
7. Demeaning
8. Rageful
9. Self-righteous
10. Power-mad
11. Insensitive
12. Arrogant

How Others Typically React to Them:

1. Irritation
2. Fear
3. Placating/pacifying them
4. Avoiding them
5. Resisting them
6. Passive-aggression
7. Hating them
8. Trying to please them

Mistakes Health Care Workers Often Make About Them:

1. They secretly have low self-esteem
2. They are secretly insecure
3. Their abilities or success justify their self-righteousness

Drama:

Type: Hurtful

Identity Validated: Persecutor
“I’m everything and you’re nothing.”

Drama Pattern:

Drama Entry Point: Rescuer
“Don’t you think well of me?”

Drama Switch: Rescuer to Persecutor
“Too bad you are inferior to me.”

Drama Triangle Switch:

Rescuer to Persecutor
Summary:

Being important

Others devalued

Examples:

Real World:
General George S. Patton
General Douglas MacArthur
Bill Clinton (as stated in “Newsweek”)

Literature:
Movies:
Griffin Mill (Tim Robbins) in “The Player”
Secondary Male Lead Character (Alan Alda) in “Crimes and Misdemeanors”
Gordon Gecko (Michael Douglas) in “Wall Street”
Main Character (Nicole Kidman) in “To Die For”
John Winger (Bill Murray) in “Stripes”
Dean of the University in “Animal House”
Country Club President (Ted Knight) in “Caddyshack”
Male Lead (Dabney Coleman) in “Nine to Five”
Joe Gideon (Roy Scheider) in “All That Jazz”
Main Character (Richard Gere) in “American Jigolo”
Willey Beaman (Jamie Foxx) in “Any Given Sunday”
Robert Hanssen (Chris Cooper) in “Breach”
Buckaroo Banzai (Peter Weller) in “Buckaroo Banzai”
Flamboyant Club Member (Rodney Dangerfield) in “Caddyshack”
Charles Foster Kane (Orson Welles) in “Citizen Kane”
Main Character (Tim Allen) in “Galaxy Quest”

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Venkman (Bill Murray) in “Ghostbusters”
Phil Connors (Bill Murray) in “Groundhog Day”
Agent Smith after being “unplugged” (Hugo Weaving) in “The Matrix” movies
The Marovingian in “The Matrix” movies
Agent J (Will Smith) in “Men in Black”
Danny Ocean (George Clooney) in “Oceans Eleven”
Jack Sparrow (Johnny Depp) in “Pirates of the Caribbean”
Main Character (Clint Eastwood) in “Play Misty for Me”
John (Peter Gallagher) in “sex, lies, and videotape”
Nicholas Cage in “Snake Eyes”
Tony Roberts in “Annie Hall”

Television Shows
Jerry (Jerry Seinfeld) in “Seinfeld”
Newman (“Hello.....Newman”) in “Seinfeld”
Mr. Burns in “The Simpsons”
Cluster C

Avoidant Personality Disorder

Prevalence:

General Population Prevalence: 1.2% (0% - 4%)  
  Least common Anxious Type
Clinical Population Prevalence: 10 %  
  National Epidemiological Study: 2.4%
Gender Prevalence: About equal in Men and in Women

Core Characteristics:

Exclusive Trait: Timidity  
  A pervasive pattern of social inhibition  
  Feelings of inadequacy  
  Hypersensitivity to negative evaluation  
  Beginning at least by early adulthood

Most Important Deficiency: Resilience  
  Do not “bounce back” from the normal bumps of everyday life

Fundamental Pattern: Fearful flight from possible wounding

View of the World: Scary

View of Themselves: Incompetent and inferior

View of Others: Dangerous and critical

Deals with the World by: Avoidance
Diagnostic Criteria:

Threshold for Diagnosis: At least **four** of **seven** characteristics:

1. Avoids occupational activities that involve significant **interpersonal** contact due to fears of **criticism, disapproval**, or **rejection**

2. Unwilling to get involved with people unless **certain** of being **liked**

3. **Inhibited in intimate relationships** due to fear of shame or ridicule

4. Preoccupation with being **criticized** or rejected

5. Inhibited in new interpersonal situations due to feelings of **inadequacy**

6. View of self is as being socially **inept**, personally **unappealing**, or **inferior** to others

7. Unusually **reluctant** to take risks or engage in new activities due to fears of **embarrassment**

*Not Diagnosable if the Characteristics:*

No specific characteristics

*DSM-5® Changes:*

1. **Prevalence** estimates increased
**Typical Behaviors:**

1. **Quiet**, inhibited  
2. **Deflects attention**  
3. Don’t talk much about **themselves**  
4. Complains of **anxiety**  
5. **Shy**  
6. **Hypervigilant** to threats

**How Others Typically Experience Them:**

1. **Inadequate**  
2. Anxious and **fearful**  
3. **Timid**  
4. A “**wallflower**”  
5. Overly **sensitive**  
6. **Inhibited**  
7. **Hypervigilant**  
8. **Sad**, lonely, tense  
9. A “**daydreamer**”

**How Others Typically React to Them:**

1. Solicitous **caretaking**  
2. **Discounting**  
3. **Irritation**  
4. **Controlling**  
5. **Derisiveness**  
6. **Pity**

**Mistakes Health Care Workers Often Make About Them:**

1. They are just normal, “**shy**” people  
2. They just need **sympathy** and support
3. They just need encouragement
4. They need to be pushed
5. They just need to have things explained to them

**Drama:**

**Type:** Distancing

*Identity Validated Through Drama: Victim*

“Please don’t hurt me even though I know you will.”

**Drama Pattern:**

**Drama Entry Point:** Victim

“Are you going to hurt me?”

**Drama Switch 1:** Victim to Rescuer

“I won’t give you any reason to hurt me.”

**Drama Switch 2:** Rescuer to Victim

“I’m too scared to be close.”

**Drama Triangle Switch:**

Victim to Rescuer to Victim

1 2

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Summary:

Timidity

Attempts to be pleasing to other

Even "normal" interpersonal difficulties renew feelings of timidity

Examples:

Literature:

Movies:
Calvin Jarod (Donald Sutherland) in "Ordinary People"
Max (Jamie Foxx) in "Collateral"
Tripp (Matthew McCounaghey) in "Failure to Launch"
The Mouse character in "The Matrix"

Television
All of Moe’s Bar’s Bar Flies in “The Simpsons”
Dependent Personality Disorder

**Prevalence:**

General Population Prevalence: 2.2 % (0% - 7.9%)
Clinical Population Prevalence:
  - National Epidemiological Survey: .49%
  - National Comorbidity Survey: .6%
Gender prevalence: About equal between men and women

**Core Characteristics:**

*Exclusive Trait: Submissiveness*

A pervasive and excessive need to be taken care of
  - Submissive, clinging behavior
  - Fear of separation
Beginning at least by early adulthood

*Most important deficiency: Independence and thinking for themselves*

*Fundamental Pattern: Help-seeking*

*View of the World: Overwhelming*

*View of Themselves: Uncertain/confused*

*View of Others: Competent*

*Deals with the World by: Following Instructions*
Diagnostic Criteria:

Threshold for Diagnosis: At least five of eight characteristics:

1. Has difficulty making everyday decisions
   Needs excessive advice and reassurance

2. Requires others to assume responsibility for most major areas of his or her life

3. Difficulty disagreeing with others due to fears of loss of support or approval (When there is no realistic danger of retribution)

4. Difficulty initiating projects or doing things on his or her own
   Lack of confidence in own judgment
   Not lack of motivation or energy

5. Goes to excessive lengths to obtain nurturing and support
   Will volunteer to do unpleasant things to get this

6. Uncomfortable or helpless when alone
   Exaggerated fears of being unable to care for him or herself

7. Urgently seeks a new relationship for care and support whenever a relationship ends

8. Unrealistically preoccupied with fears of being left to take care of him or herself

Not Diagnosable if the Characteristics:

No specific conditions
DSM-5® Changes:

Prevalence rates lowered

Typical Behaviors:

1. Regularly asking for advice
2. Clingy
3. Overly agreeable

How Others Typically Experience Them:

1. Clingy
2. Wishy-washy
3. Generally fearful
4. Manipulative
5. Passive-aggressive
6. Inviting exploitation
7. Can’t see their own capabilities and strengths
8. Desperate for caretaking
9. Naive

How Others Typically React to Them:

1. Nurturing
2. Passive-aggression
3. Distancing
4. Derision
5. Commanding
6. Demanding
7. Condescension
Mistakes Health Care Workers Often Make About Them:

1. **Other people** are not treating them well
2. They need lots of **sympathy**
3. Their **needs** have never been met

**Drama:**

*Type:* Needy

*Identity Validated:* Victim

“You know better, and I can’t do it myself.”

**Drama Pattern:**

**Drama Entry Point:** Victim

(“Tell me what to do.”)

**Drama Switch 1:** Victim to Persecutor

(“I’m your responsibility.”)

**Drama Switch 2:** Persecutor to Victim

(In response to others reacting to them by distancing - “Tell me what to do!”)

**Drama Triangle Switch:**

Victim to Persecutor to Victim
Summary:

Requests for help

Demands for help

Others resist, refuse, or distance

Examples:

Real World:
Members of the “Heaven’s Gate” and other cults

Literature:

Movies:
Flounder in “Animal House”
Louie in “Ghost Dog, Way of the Samurai”
Sidekick (Jeff Goldblum) in “Buckaroo Banzai”
Sister (Mia Farrow) in “Hanna and Her Sisters”
Seymour (Rick Moranis) in “Little Shop of Horrors”
Female Lead Character (Jessica Lange) in “Tootsie”
Bob (Bill Murray) in “What about Bob?”

Television Shows:
The “Smithers” character in “The Simpsons”
Obsessive-Compulsive Personality Disorder

Prevalence:

General Population Prevalence: 4.3% (2.1% - 7.9%)
Most common Cluster C
Most common of all personality disorders
Clinical Population Prevalence: 3% - 10 %
Gender Prevalence: Twice as common in men

Core Characteristics:

Exclusive Trait: Rigidity/Tightness
Pervasive preoccupation with orderliness, perfectionism, mental and interpersonal control at the expense of flexibility, openness, and efficiency
Beginning at least by early adulthood

Most Important Deficiency: Flexibility

Fundamental Pattern: Demanding and controlling

View of the World: Contaminated

View of Themselves: Righteous

View of Others: Lax

Deals with the World by: Control

Diagnostic Criteria:

Threshold for Diagnosis: At least four of eight characteristics:

1. So preoccupied with details, rules, lists, order, organization, or
schedules that the major **point** of the activity is lost

2. Perfectionism that **interferes** with task completion

3. **Excessively devoted** to work and productivity
   To the exclusion of leisure activities and friendships

4. **Overconscientious**, scrupulous, and inflexible about morality, ethics, and values
   Not accounted for by cultural or religious beliefs

5. Is unable to **discard** worn-out or worthless objects even when they have no sentimental value

6. Is reluctant to **delegate** tasks
   Unless others submit to his or her way of doing things

7. Has a **miserly** spending style toward both self and others
   Money is viewed as something to be hoarded for the future to prepare for future catastrophes

8. Rigid and **stubborn**

   **Not Diagnosable if the Characteristics:**

   No specific conditions

   **DSM-5® Changes:**

   None

   **Typical Behaviors:**

   1. Tangential speech
2. Overly detailed speech
3. Procrastinating
4. List-making
5. Perseveration
6. Workaholic

How Others Typically Experience Them:

1. Stingy
2. Perfectionistic
3. Indecisive
4. Cold and unemotional
5. Hoarding
6. Anxious
7. Tangential
8. Controlling
9. Lacking a sense of proportion
10. Workaholic
11. Demanding

How Others Typically React to Them:

1. Anger
2. Derision
3. Sarcasm
4. Provocativeness
5. Trying to please

Mistakes Health Care Workers Often Conclude About Them:

1. They need more explanation
2. They are moralistic
3. They are “control freaks”
4. Nothing will ever satisfy them
Drama:

Type: Controlling

Identity Validated: Persecutor
“You’re not doing it right”

Drama Pattern:

Drama Entry Point: Rescuer
(“Let me handle it.”)

Drama Switch 1: Rescuer to Persecutor
(“That’s not right.”)

Drama Triangle Switch:

Rescuer to Persecutor
Summary:

Helpfulness

Controllingness

Examples:

Real World:
Timothy McVeigh (as described in “American Terrorist”)

Literature:

Movies:
Beth Jarod (Mary Tyler Moore) in “Ordinary People”
Agent Smith - before being unplugged (Hugo Weaving) in “The Matrix”
Main Character (Jack Nicholson) in “As Good as it Gets”
Senator Keeley (Gene Hackman) in “The Birdcage”
Main Character (Robert DeNiro) in “Casino”
Agent K (Tommy Lee Jones) in “Men in Black”

Television Shows:
Niles Crane (David Hyde Pierce) in “Frazier”
Monica Gellar (Courtney Cox) in “Friends”
Gil Grissom (William Petersen) in “CSI”
# Summary of Prevalence Rates

## Estimated Prevalence of Personality Disorders

(Using the conservative estimates)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>General</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid Personality Disorder</td>
<td>1.1%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Schizoid Personality Disorder</td>
<td>.6%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Schizotypal Personality Disorder</td>
<td>1.8%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>1.2%</td>
<td>3-30%</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>1.6%</td>
<td>10-20%</td>
</tr>
<tr>
<td>Histrionic Personality Disorder</td>
<td>2.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Narcissistic Personality Disorder</td>
<td>1.0%</td>
<td>2-16%</td>
</tr>
<tr>
<td>Avoidant Personality Disorder</td>
<td>1.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Dependent Personality Disorder</td>
<td>2.2%</td>
<td>.6%</td>
</tr>
<tr>
<td>Obsessive Compulsive PD</td>
<td>4.3%</td>
<td>3-10%</td>
</tr>
</tbody>
</table>

Total: 17% 34.1%-100%
Advantages and Disadvantages of the Categorical Threshold Model

Advantages

1. Clear thinking helps keep you out of the drama
2. Matches the categorical way people think about things
3. Thirty years of research behind it
4. Good data on differential effects of intervention models on different diagnoses

Disadvantages

1. No gradation of severity is inaccurate
2. 30% of people who meet criteria for one diagnosis meet criteria for more than one diagnosis
3. Purely descriptive - no underlying “model” of understanding
4. No model of cause
Part V:

Interventions
Part V: 
Interventions

Most Important Issue:
Do Not Let Interventions be Misguided by an Inaccurate Assumption About the Cause of Personality Disorders

The Cause of Personality Disorders

1. The “Aversive Childhood” Theory:
Distortions in or disruptions to the relationship of a young child to significant others (often involving impediments to attachment) result in the establishment of a personality structure that produces distorted experience and dysfunctional behavior.

**Strengths** of the early childhood theory:
- Often consistent with patient reports
- Can lead to useful treatment approaches

**Problems** with the early childhood theory:
- Lacks validity
  - Anecdote based, not data based
  - Research data are unsupportive, viz.
    - 80% of those with a history of sexual abuse do not develop a personality disorder
    - Only a .27 correlation exists between sexual abuse and Borderline Personality Disorder (about 9% of the variance)
  - Fully 1/3 show no childhood trauma
  - Another 1/3 show mild trauma
  - Only 1/4 show severe trauma
Based in **poor science**
- Patient self-report
- Assuming clinical population equals general population
- Confusing correlation with causation
- Assuming the same experience affects everyone the same way

**Conclusion about the “aversive childhood” theory:**
Has produced some useful clinical treatment models, but is not an accurate model of cause

“*Abuse alone is neither necessary nor sufficient to develop Borderline or other severe personality disorders.*”
Bleiberg, 2001, pg 17

“A large percentage, perhaps even the majority of survivors of childhood abuse, do not grow up to develop a severe personality disorder.”
Bleiberg, 2001 pg 86

“You cannot assume there is trauma in the lives of these patients; they don’t all have trauma.”
Linehan, 1993 (paraphrased)

“*Most children are resilient, so abuse and trauma are risk factors, but not causes.*”
Paris, 2006

2. **The Genetic Theory:**
Hereditary transmission of neurological abnormalities in the parts of the brain that form “personality” result in a neurologically-based pattern of distorted experiences and dysfunctional behaviors.

**Strengths** of the genetic theory:
- Accounts for the **chronicity** and **stability** of the disorders
- Accounts for the **early** appearance of personality disorders

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Accounts for the difficulty of traditional “talking therapy” to alter the disorders

Scattered data have shown neurological abnormalities in some patients with severe personality disorders

**Problems** with the genetic theory:

Identical twins do **not** have 100% concordance rates

Concordance rates:
- Schizotypal: 69%
- Borderline: 78%
- Histrionic: 70%
- Dependent: 69%
- Narcissistic: 77%
- Conduct Disorder (APD) 80%

**Conclusion about the Genetic Theory:**

Biological factors are the fundamental cause

And there are other variables, as yet undefined, that contribute

3. **The Biopsychosocial Theory:**

**Cause of personality disorders:**

Temperament factors (heredity/neurology) and character factors (psychological/environmental/experiential) **combine** to create a pattern of distorted experience and dysfunctional behavior

**Strengths** of the biopsychosocial theory:

Accounts for both the neurological-like chronicity **and** the frequently seen early **experiential** disruptions

Accounts for the **early** appearance of the disorders

Accounts for the **unpredictability** of the “inheritance” patterns of the disorders
Problems with the biopsychosocial theory:
Leaves unanswered the issue of what the “other” factors are and which combine with the genetic factors

Conclusion about the Biopsychosocial Theory:
It is supported by both experience and data.

“Let’s start with a fact: People don’t come preassembled, but are glued together by life. And each time one of us is constructed, a different result occurs. One reason for this is that we all start out with different sets of genes; another is that we have different experiences. What’s interesting about this formulation is not that nature and nurture both contribute to who we are, but that they actually speak the same language. They both ultimately achieve their mental and behavioral effects by shaping the synaptic organization of the brain. The particular patterns of synaptic connections in an individual’s brain, and the information encoded by these connections, are the keys to who that person is.”

LeDoux, 2001 page 3

The conclusion is that Personality Disorders are primarily, but not exclusively, caused by inborn biology - biology is necessary and the fundamental cause, but there are additional variables that add to the biology that are as yet unaccounted for

Strengths of current theory:
Accounts for chronicity
Accounts for early onset
Accounts for lack of insight
Accounts for nature of these disorders as “different” from other disorders
Accounts for the variability and unpredictability of genetic or experiential “transmission” of the disorders

Problems with the current theory
Failure to identify the nature of the “other” factors

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Unclear precisely how the genetics work

The Bottom Line:

*It works much better to think of personality disorders as a biological, “neurological” entity than a historical “experiential” entity because:*

1. *The cause is primarily biological*
2. *Any environmental causative factors are not yet identified*
3. *Any environmental causative factors are not consistent, even within a diagnosis*

Therefore:

*Interventions need to focus on repairing the neurological and psychological deficiencies of the self, and avoid getting caught up in an unproductive loop about a bad childhood.*
Interventions Part I: Prepare

Step 1:
Assess this Particular Patient for the Presence of a Personality Disorder

Formal Diagnostic Assessment

1. DSM-5® general criteria assessment

2. DSM-5® subtype criteria assessment

3. Additional Characteristics to look for:

   1. Irresponsibility
      Cannot acknowledge or accept their part in things going wrong
      Reason, rationalize, justify, defend themselves instead of seeking solutions

   2. Deficits in Empathy
      Cannot effectively resonate to others’ feelings
      Driven by own needs
      Too little reaction
      Over-reaction

   3. Deficient Problem-Solving Behaviors
      Disordered patterns interfere with adopting solutions

   4. External Locus of Control
      Sees issues, control, and power “out there”
      Sees themselves as “reactive” out of necessity, given “the way the world is”
5. **Generation of Upset and Internal Conflict in Others**
   Conflict and upset appropriate to their own behavior is experienced by others

6. **Unproductive Escalations**
   - Thoughts
   - Feelings
   - Events
   - Relationships
   - Fantasies

**Interview Content to Watch for:**

- **No self-report** of having a personality disorder
- **Vague, general** complaints of unhappiness
- Difficulty **adequately defining the problem** even when pushed
- **Exacting**, **rigid**, and self-righteous about the problem
- Defining the problem as strictly **someone else**
- Overtly **blaming** of self or others
- Discounting of **the role their own behavior** in causing trouble
- Complaints of others consistently **“letting them down”**
- Complaints about own behavior **without changing**
Interview Behavior to Watch for:

Displays more or less distress than appropriate to content

Communicates oddly or with difficulty

Behavior and self-report don’t match

Strange or incongruent nonverbal behavior

Any behavioral excesses:
- Excessive fidgeting
- Excessive intensity
- Excessive indifference
- Excessive subject changes
- Excessive recounting and story-telling
- Excessive details
- Excessive avoidance

Interview Demeanor to Watch for:

Presenting themselves as a “victim”

An air of helplessness

Self-righteousness

Rigidity

Demandingness

Arrogance

Lack of ambivalence, uncertainty

Having “an answer for everything”
Odd, confusing, **puzzling**

**History Elements to Watch for:**

**Chronic difficulties** and dysfunctional patterns

**Multiple** previous psychiatric **diagnoses**

“**Therapist-hopping**” or “**System-abuser**”

Chronic, **repetitive marital difficulties**

**Multiple marriages**

**Shifting** friendships and relationships

**Abusive/abusing relationships**

**Personal and Family Characteristics Watch for:**

**First-degree biological relatives** with personality disorder

**Addictive disorder** in self or first-degree relative

**Eating disorder** in self or first-degree relative

**Self-destructive** behavior

**Suicide** attempts

**Legal** difficulties
Interviewer Reactions to Watch for:

**Repulsion/Horror/Disgust**

Feeling like you are “**doing all the work**”

Feeling like “**they’re not really listening**” (or consistent “yes, but’s”)

Intense emotions that seem **contradictory** to the content

**Boredom**

**Irritation** or annoyance

**Puzzlement**

Lack of ability to **empathize**

Desire to **take care of/take over for**

Feeling **afraid** of them

Reactions of Significant Others to Watch for:

**Confusion**

**Exasperation**

**Anger**

**Hopelessness**

Labeling them as “**bad**”

**Gossiping** about them
Leaving them “out of the loop”

Saying “They’ve always been a problem”

Testing Instruments:
(See Appendix A for publishers’ addresses and phone numbers; there are some new ones being developed, but these are the established ones)

**Millon Clinical Multiaxial Inventory III (MCMI III)**
- Written
- 175 true/false items
- 25 minutes
- 18 years of age +
- Available from: NCS

**Structured Clinical Interview for DSM-IV-TR® Personality Disorders IV (SCID IV)**
- Semi-structured interview
- 18 years of age +
- Available from: MHS, American Psychiatric Press

**Personality Disorder Interview IV (PDI)**
- Semi-structured interview
- 2 hours
- 18 years of age +
- Available from: MD Angus and Associates

**Adolescent Psychopathology Scale (APS)**
- Written
- 346 items
- 45-60 minutes
- 5 Personality Disorder scales
- 12-19 years of age
- Available from: Pro-Ed, PAR
Personality Diagnostic Questionnaire -4 (PDQ 4)
Written
99 true/false items
15-20 minutes
18 years of age +
Available from: AlphaLogic

Schedule of Nonadaptive and Adaptive Personality - (SNAP)
Written
375 items
1 hour
18 years of age +
Available from: University of Minnesota Press

Wisconsin Personality Disorders Inventory - IV (WISPI-IV)
Written
214 items

Hare Psychopathy Checklist - Revised (Hare PCL-R)
Semi-structured interview
20 interview items; collateral information review
1.5-3 hours
18 years of age +
Available from: NCS, Psychological Corporation, WPS
Step 2:
Assess the Patient’s “Treatability”

Positive Signs for Treatability:

1. Ability to form relationship with health care worker
   *Most Important Element*

2. High intelligence
   Except Antisocial Personality Disorder

3. An unusual talent

4. Attractive

5. Obsessive/Compulsive traits
   (But does not meet criteria for Obsessive Compulsive Personality Disorder)

6. If substance abuser, attends AA or is sober

7. Motivated
   Not “what” the motivation is, but “how strong” the motivation is

8. Can talk about own weaknesses

9. Can trust or be loyal

10. Can weigh contingencies

Negative Signs for Treatability:

1. Unresponsive depression

2. Unresponsive substance abuse
3. History of felony arrests

4. History of lying

5. History of conning
Step 3:
Assess Your Risks and Resources

1. The nature and goals of the setting and situation

2. The current stress and caseload of the worker

3. The skill and knowledge of the worker
   Caseworker drama tendencies

4. The availability of consultation

5. The severity of the personality disorder

6. Health and safety risks to worker and others

7. The other people involved and affected

8. The ability to take on long-term vs. short-term commitment

9. The availability of backup/inpatient/medical support
Step 4: Assess Your Personal Abilities

You Need to be Able to:

1. Be **Active and Responsive**
   As opposed to reactive or passive

2. Use an **“Altered Traditional”** Approach
   Must make changes to traditional approaches

3. Be **Multimodal**
   Alteration in each model results in using methods from more than one “traditional” approach
   (The lower the treatability, the more important this becomes)

4. Maintain **Active Empathetic Neutrality**
   (Do not confuse with lack of emotion or minimal responding)
   Refusal to take assigned position in the drama
   Refusal to take things personally

5. Maintain a Position of **Freedom and Power**
   Must “need” less than the individual
   Must have no ulterior self-serving motive
   Must have lower intensity of personal drama

6. Accept and Tolerate the **Transference and Countertransference**
   Awareness of personal reactions and meanings of reactions
   Must be able to not react to own reactions

7. Have **Consultation** Available
   Team
   Supervisor
   Colleague
   Consultant
8. Be Comfortable Using Silence; Going Slowly

9. Have the Willingness to Accept Success and Failure
   Use the “paradox of power” by being willing to succeed or fail

10. Have an Ability to Admit Mistakes

11. Be Comfortable with Reality-Based Confrontations

12. Comfort with Saying No (limit-setting)

13. Have a Willingness to Break the “Rules” of the Drama
   To be defined as “wrong
Step 5:  
Choose Treatment or Management

1. Treatment  
   Treatment is designed to repair the disordered self  
   **Advantages** of Treatment:  
   - Can *improve patient’s ongoing functioning*  
   - Structured and **specific** conversational **techniques** used  
   - Fits definition of formal “*psychotherapy*”  
   **Disadvantages** of Treatment:  
   - Socially *inappropriate* conversation  
   - Psychologically *intrusive* conversation  
   - Requires patient **make and keep agreements**  
   - Can be *stressful* for the patient

2. Management  
   Management is designed to reduce the harm created by the disordered self  
   **Advantages** of Management:  
   - Not socially *inappropriate* conversation  
   - Not psychologically *intrusive* conversation  
   - Flexible  
   - Useful in a **broad range of settings**  
   - **Does not require agreements** on the part of the patient  
   **Disadvantages** of Management:  
   - Does not repair a disordered self  
   - Does not usually create self-propagating change  
   - Does not sound like traditional “*psychotherapy*”
Step 6:
If Treating, Establish Goal of “Get Them Better”
(If Managing, skip to Managing Section)

Treatment

Goal: Get the Patient “Better”
Produce Some Combination of Four Changes

1. **More flexibility and adaptability** in the way they think, feel, and behave
   Enable them to **handle life’s messiness** and changing circumstances
   Stop them from “Persisting in a behavior in the face of clear evidence it’s inappropriate and ongoing bad consequences.”
   **Improved resilience** due to a more broad set of psychological resources to use to cope with situations
   Able to **self-adjust** to get better consequences

2. **Improved Self-Management Capability**
   Goal is to **install a working “observing ego”**
   Enable them to successfully **manage their own internal arousal**
   Enable them to **manage their own behavior** for good consequences
   Enable them to **learn from their mistakes** and get better consequences

3. **Fewer and Less Severe Unproductive Escalations**
   Goal is to **lower the “Drama”** in their life
   Enable a more **proportional approach** to life
   **Lower** the frequency of **upsets, arguments, and inappropriate behaviors**

4. **Increased use of Problem Solving to Deal with Life**
   Goal is for them to **think of life in terms of solvable problems**
   Enable them to **consider a variety of options and possibilities**
Interventions Part II: Treat

Step 1:
Engage the Treatment Relationship

Metaphor for the Treatment Relationship:
Surgery

Personality Disorder psychotherapy is you being the psychological equivalent of a surgeon
1. Being empathetic, caring, amenable, collaborative with them
2. Being technical, focused, willing to “do things to them” psychologically
3. Making a clear set of agreements about what is going to happen in the therapy sessions, how long the treatment is expected to last, how missed appointments are handled, etc.

Targets of the Psychological “Surgery”

1. Their Incomplete Self
   Goal is to expand the self and the resources of the self
   Energize new thoughts, feelings, behaviors
   Increase the traits and elements that make up their “self”

2. Their Insufficient Observing Ego
   Goal is to create an internal, objective, “observational” voice
   Enable an objective “meta” observational position inside the patient’s head
Step 2: 
Use the Two Fundamental Treatment Techniques

1. Connections of Cause-and-Effect that They Don’t See
   “You think this, then this is what you feel”
   “They do this, then this is what you do”
   “When you do this, that is the response of the environment”
   You must describe connections that they aren’t seeing
   You must not get distracted by “content”
   You must never lose your own observing ego function

2. Observations About Them that They Don’t See
   “This is what you’re feeling”
   “You’re doing that”
   “Did you notice that...”
   You must make observations of what they’re not seeing
   You must be simple, direct, and easily understood

Why Treatment Conversations are More Difficult Than They Seem in the Above Description:

1. In a treatment conversation **you are not talking about the same topic as the patient is**, and that is an unusual conversation

2. Describing cause and effect to another person is a more **primitive** conversation than everyday conversation

3. In a treatment conversation you are **talking into what they “don’t” have and “are not”** rather than talking “with” them about a conversational topic

4. The connections and observations must be made **regularly and repetitively** in order to raise the interventions to therapeutic level and hold it there for long enough to produce the therapeutic effect
5. Treatment conversations are **intrusive and stressful** for the patient and can cause upset feelings.

6. Treatment conversations are only safe to do when the patient has granted you the right to be conversationally intrusive by declaring themselves to be your psychotherapy patient.
Step 3: Use a Specific Category of Treatment

These Categories are Generally Based on and are an Expansion of Len Sperry’s Terms and Categories (see the references for his books)

1. **Profound Treatment for Optimal Functioning**
   These are Analytic-Style Treatments such as:
   - Mentalization-Based Treatment
   - Transference Focused Psychotherapy
   - Interpersonal Reconstructive Psychotherapy
   - Object Relations Developmental Psychotherapy
   - Self-Psychology Psychotherapy

2. **Stylistic Treatment for Adequate Functioning**
   These are Cognitive-Behavioral-Style Treatments such as:
   - Dialectical Behavior Therapy
   - Schema-Based Psychotherapy
   - Personality-Guided Psychotherapy

3. **Focal Treatment for Targeted Improvement**
   These are Brief Psychotherapy Treatments such as:
   - Tactical Therapy
   - Strategic Therapy
   - Structural Therapy
Specifics of Profound Treatment for Optimal Functioning

**Name:** Treatment for Significant Personality Change  
**Goal:** Stop dramas & replace with problem-solving  
**Treatment model:** “Here and Now” Comments  
**Outcome sought:** “Cure”  
**Colloquial name:** “Fixing” them

**Functional method:** Here-and-Now “Transference” Comments  
**Connections:**  
Cause and effect comments about what is occurring in the session  
**Observations:**  
Observations about how they are being in the session

**Only highly treatable individuals with personality disorders are appropriate for Profound Treatment for Optimal Functioning**

Profound Treatment for Optimal Functioning addresses all levels of the self and is the most rigorous and demanding of all treatments and is the most difficult and carries the most risk of escalation

Profound Treatment for Optimal Functioning is the only model shown to successfully restructure personality functioning and get someone’s functioning within normal limits in all areas

As with any form of health care “treatment,” Profound Treatment for Optimal Functioning does not always work and should be applied only after the professional has determined that this particular patient is an appropriate candidate
Specifics of Stylistic Treatment for Adequate Functioning

Name: Treatment for Moderation of Disordered Functioning
Goal: Diminish severity of dramas and bad consequences
Treatment model: “There and Then” Interpretations
Outcome sought: “Improvement” or “Compensation”
Colloquial name: “Calming Things Down”

Functional method: “There-and-Then” Comments

Connections:
Cause and effect comments about their life outside the session

Observations:
Observations about what is occurring outside the session

Moderately treatable individuals with personality disorders are appropriate for Stylistic Treatment for Adequate Functioning

Stylistic Treatment for Adequate Functioning primarily addresses behavior and cognition and often does not address affect, making it less complete in effect than Profound Treatment for Optimal Functioning, but also less rigorous, demanding, and difficult and therefore carries less risk of escalation

Stylistic Treatment for Adequate Functioning has been shown to lower bad consequences and add resources to the self in the areas of behavior and cognition but may not result in functioning within normal limits in all areas

As with any form of health care “treatment,” Stylistic Treatment for Adequate Functioning does not always work and should be applied only after the professional has determined that this particular patient is an appropriate candidate
Specifics of Focal Treatment for Targeted Improvement

Name: Focal Treatment for Targeted Improvement

Goal: Target for Improvement one “thing” in the patient or their life

Treatment model: Conversation only about the one “thing” until it changes

Outcome sought: Improvement of the one “thing”

Colloquial name: “Dealing with Something”

Functional method: Comments about one topic that is the focus of treatment until that issue changes

Connections:
- Cause and effect comments about that topic

Observations:
- Observations about that topic

Many individuals with personality disorders are appropriate for Focal Treatment for Targeted Improvement

Focal Treatment for Targeted Improvement addresses one issue at a time and is not a “general” treatment for Personality Disorder

Focal Treatment for Targeted Improvement has been shown to effectively lower bad behavior and consequences and add resources to the self in a single area at a time - do not expect it to generalize into other areas of the patient’s life

As with any form of health care “treatment,” Focal Treatment for Targeted Improvement does not always work and should be applied only after the professional has determined that this particular patient is an appropriate candidate
**Step 4:**
**Apply the Approach to the Patient’s Diagnosis and the Treatment Goals**

**Paranoid**

**General Treatment Goals:**
Note: These are adapted from Sperry, 1995, 2004

<table>
<thead>
<tr>
<th>Characteristics of Disordered Functioning</th>
<th>Characteristics of Adequate Functioning</th>
<th>Characteristics of Optimal Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reluctant to confide in others; fears information used maliciously against them</td>
<td>Confident in making decisions and managing their life</td>
<td>Alert and sensitive to environment; flexible</td>
</tr>
<tr>
<td>Reads ulterior meanings into benign remarks and events</td>
<td>Very sensitive to interpersonal cues and possible meanings</td>
<td>Can entertain a variety of possible interpretations of motivation and behavior</td>
</tr>
<tr>
<td>Bears grudges; unforgiving of slights, insults</td>
<td>Can make use of constructive criticism</td>
<td>Understands others’ actions</td>
</tr>
<tr>
<td>Questions fidelity of spouse and friends without data</td>
<td>Cautious and thorough in dealings with others; Highly values loyalty</td>
<td>Attentive to others’ behavior and feelings; notices moods, feelings</td>
</tr>
<tr>
<td>Expects to be exploited without data</td>
<td>Good at sizing people up</td>
<td>Empathetic with others</td>
</tr>
<tr>
<td>Easily slighted and quick to counterattack</td>
<td>Good at assessing people’s areas of weakness</td>
<td>Thinks of others</td>
</tr>
<tr>
<td></td>
<td>Assertive and can defend self in a moderated fashion</td>
<td>Stands up for the rights of self and others in an appropriate way</td>
</tr>
</tbody>
</table>
General Treatment Considerations:

**Drama Switch for Therapist to Avoid:**
Rescuer to Victim
   Trying to get too emotionally close and then becoming the target of their retaliatory drama

**How to Avoid the Drama Switch:**
Do not “try too hard”!
Remain neutral regarding their fears, conclusions, accusations
   Taking an implied “so what” or “gee, no kidding” stance
Express empathy for their distress
Do not confront with intense interpretations early on
Do not try to get emotionally close to them
Acknowledge the accuracy of their observations without validating their distorted conclusions and fears
Relate in a manner able to be described as “respectful”
Do not patronize them

**Profound Treatment for Optimal Functioning**

**Usage rating:**
Yellow (Caution: infrequently appropriate - use only if highly treatable, functional, and *not* highly escalated, life-threatening Drama in life pattern or degree of behavioral risk)

**Primary Targets of Connections and Observations:**
Pervasive suspiciousness and mistrust
Lack of ability to trust
Lack of observing ego (reflective function)
Inappropriate consistency of conclusions about other people
Their here-and-now feelings of mistrust toward the therapist
The consistency of their mistrust of the therapist with their typical “suspicion” thought patterns (i.e., their thinking does not respond to varying data or circumstances)
Their discounting of disconfirming data
The accuracy of their observations contrasting with the rigidity of their paranoid interpretation

**Stylistic Treatment for Adequate Functioning**

**Usage rating:**
Green (Proceed: useful in many cases)

**Primary Targets of Connections and Observations:**
- Repetitive thought pattern of suspiciousness and mistrust of others
- Fear-based behavior arising from their suspiciousness
- Bad outcomes produced by their defensive behavior
- Other people’s bad reactions to their defensive behavior
- Detail of pattern of suspicious thinking and defensive behavior
- Suggest alternate reasons for others’ behavior
- Enable alternative behaviors to their offensive “defensive” behaviors
- Offer more effective behaviors for handling situations
- Point out the improbability of such an unwavering paranoid interpretation always being accurate

**Focal Treatment for Targeted Improvement**

**Usage rating:**
Green (Proceed: useful in many cases)

**Primary Targets of Connections and Observations:**
- A specifically defined situation, problem, or issue
  - Avoid getting sidetracked onto other issues!
- Observations of how this situation is unique
- Creating a *just this one-time* “reasonable doubt exception”
- Present more effective responses to this “unique” situation
- Behaviors specific to this one circumstance
Additional Issues to Consider as Targets:
(All Treatment Types)

Their view of themselves as righteous and mistreated by others
Their view of others as interfering, devious, treacherous, covert
Their view of themselves as a victim
Their lack of trust
A possible “defended” (resisted) feeling of depression
## Schizoid

### General Treatment Goals:

<table>
<thead>
<tr>
<th>Characteristics of Disordered Functioning</th>
<th>Characteristics of Adequate Functioning</th>
<th>Characteristics of Optimal Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not enjoy or desire close relationships; no close friends or confidants except for relatives</td>
<td>Most comfortable when alone</td>
<td>Able to relate effectively even though most happy alone</td>
</tr>
<tr>
<td>Exclusively chooses solitary activities</td>
<td>Self-sufficient, can enjoy life without a great deal of interpersonal interaction</td>
<td>Able to relate to others without taking responsibility for them</td>
</tr>
<tr>
<td>Absence of strong emotions</td>
<td>Is emotionally calm</td>
<td>Is emotionally peaceful</td>
</tr>
<tr>
<td>Absence of desire for sexual experiences</td>
<td>Can enjoy sex but does not “need” it</td>
<td>Approaches sex as one of many options of life interest</td>
</tr>
</tbody>
</table>

### General Treatment Considerations:

**Drama Switch for Therapist to Avoid:**

Rescuer to Persecutor

Trying hard and then getting frustrated and angry at their lack of responsiveness

**How to Avoid the Drama Switch:**

Use a slow, patient style

(If you ever wanted to be a Biblical character now is a good time, and Job is a wise choice)

Accept unusual amounts of silence

Be alert for any pain, distress, or motivation to change that you can focus on

(Something - anything - anything at all - understand?)
Profound Treatment for Optimal Functioning

Usage rating:
Red (Avoid: generally inappropriate unless there is credible case-specific evidence indicating otherwise)

Primary Targets of Connections and Observations:
- Lack of reaction to stimuli
- Lack of emotional engagement in response to others’ engagement
- Feelings of emptiness
- Possible covert paranoid-type fears of emotional involvement
- Patience in the use of connections and observations
- Gradualness in interpretations
- Comment on anything that creates affect for them in the here-and-now
- Observations of their detachment in the present moment
- The prevalence of silence in their responding
- Their minimal expressions of empathy

Stylistic Treatment for Adequate Functioning

Usage rating:
Yellow (Caution: infrequently appropriate - use only if highly treatable and functional)

Primary Targets of Connections and Observations:
- Lack of overall functioning in life
- Thought patterns regarding other people being undesirable to be involved with
- Unexpressed fears
- Patience and gradualness
- Statements of understanding of their experience
- Behavioral options
- Focusing on anything that matters to them
- Gently pushing them to try new things
- Whatever they are dependent on or care about - to keep them

113
The simple generation of social and verbal behavior

**Focal Treatment for Targeted Improvement**

**Usage rating:**
Yellow (Caution: useful if highly treatable and functional)

**Primary Targets of Connections and Observations:**
One specific need or desire or feeling  
Offer practical help and advice  
Focus on their behavior and its consequences  
Rather than affect and cognition  
Look for whatever contingencies will help generate necessary behavior

**Additional Issues to Consider as Targets:**
(All Treatment Types)
Their stance of being entirely self-sufficient  
Their view of all relationships as messy and undesirable.  
Their behavior that keeps other people away  
Their denial of the missing elements in their life  
Their dysfunctional thought patterns  
Their need to increase social interactions
Schizotypal

General Treatment Goals:

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</tr>
</thead>
<tbody>
<tr>
<td>Ideas of reference and paranoid ideation</td>
<td>Sensitive to own feelings</td>
<td>Sensitive to others’ feelings</td>
</tr>
<tr>
<td>Excessive social anxiety</td>
<td>Prefers people they are familiar with</td>
<td>Comfortable in a variety of social situations</td>
</tr>
<tr>
<td>Odd or strange beliefs that are culturally inconsistent</td>
<td>Skilled at abstract and conceptual thinking</td>
<td>Creative</td>
</tr>
<tr>
<td>Eccentric, odd behavior, odd speech</td>
<td>Independent in lifestyle</td>
<td>Individualistic</td>
</tr>
<tr>
<td>No close friends other than family</td>
<td>Independent</td>
<td>Self-confident</td>
</tr>
</tbody>
</table>

General Treatment Considerations:

Drama Switch for Therapist to Avoid:
Rescuer to Persecutor
“Making sense” and then being annoyed that it comes back as “non”sense

How to Avoid the Drama Switch:
Maintain a tolerant, open attitude
Treat them as “normal” despite their strange thinking
Gather information while not getting caught up in their strangeness
Neither validate nor invalidate their odd ideas
Confront judiciously and carefully
Profound Treatment for Optimal Functioning

**Usage rating:**
Red (Avoid: generally inappropriate unless they are):
1. Highly functional
2. Highly motivated
3. Highly treatable
4. Taking medication that is successfully diminishing their illogical thinking

**Primary Targets of Connections and Observations:**
Their illogical thinking and odd emotional reactions to topics discussed in the session
The reaction of the therapist and significant others to their strange behavior connecting their reactions to countertransference
Medication
The only Personality Disorder with a fundamental medication response:
   Often low-dose antipsychotics or SSRI’s
Reflections of the consequences of their behavioral oddities on the therapy itself
Confrontation of their tangential or superstitious thinking during the session
Illogic of their conclusions in the session
How other people react the same way the therapist is reacting

Stylistic Treatment for Adequate Functioning

**Usage rating:**
Yellow (Caution: use if treatable, functional, and motivated)

**Primary Targets of Connections and Observations:**
Their most obvious and impairing social behaviors
The distress and impairment caused by their odd behaviors
Their lack of common sense
Their misreading of social cues
Interpreting others’ reactions to them
Options of different behaviors that can produce better outcomes

**Focal Treatment for Targeted Improvement**

**Usage rating:**
Green (Proceed: useful in many cases)

**Primary Targets of Connections and Observations:**
One specific dysfunctional behavior or situation
Confront and make suggestions of better behaviors
Persuasion to try something new
Focus on their desired outcome in this particular circumstance

**Additional Issues to Consider as Targets:**
(All Treatment Types)

Their “not fitting in”
Reactions of others to their strangeness
Finding a place for them to fit
Practical, mundane life-skills
Antisocial

General Treatment Goals:

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<tbody>
<tr>
<td>Fail to conform to social norms as regards lawful rules and restrictions</td>
<td>Not overly controlled by rules and restrictions</td>
<td>Able to take others’ reactions into account</td>
</tr>
<tr>
<td>Irritable and aggressive</td>
<td>High-spirited</td>
<td>Appropriately assertive</td>
</tr>
<tr>
<td>No regard for the truth; repeated lying</td>
<td>Engaging</td>
<td>Uses engaging qualities for general good</td>
</tr>
<tr>
<td>Disregard for own and others’ safety</td>
<td>Strong, courageous</td>
<td>Stands up for the underdog</td>
</tr>
<tr>
<td>Lacks remorse</td>
<td>Guilt-free</td>
<td>Sense of personal integrity</td>
</tr>
<tr>
<td>Does not honor financial obligations</td>
<td>Lack of “money issues”</td>
<td>Generous</td>
</tr>
</tbody>
</table>

General Treatment Considerations:

Drama Switch for Therapist to Avoid:

Rescuer to Victim
Believing their cons and then getting taken advantage of

How to the Avoid Drama Switch:

Give and engender their respect:
“Shoot straight” with them
Take nothing on “faith” or based only on their word

Make no exceptions
“Play along” as needed to make it easier to get information
Do not resist manipulations - expose them as manipulations
Remain indifferent to their praise or hostility
Present a skeptical “yeah, yeah, yeah, sure - tell me another” attitude
Diminish any need to feel special to them or to be liked by them

Specific Indications for Usefulness of Psychotherapy:

Positive:
Narcissistic features (investment in image)
Dependency needs
Depression

Negative:
History of sadistic and/or violent behavior
Total absence of remorse
Long-standing incapacity to develop emotional attachments
Intelligence very high or very low
Severe countertransference reactions

Profound Treatment for Optimal Functioning

Usage rating:
Red (Avoid: at least if you value your life - no profound method has ever been shown to work, and they can lead to the bad consequences)

Primary Targets for Connections and Observations:
If you’re still reading this you haven’t gotten the message I just gave you: don’t try this treatment type with this population OK, I will assume you get the idea.

Stylistic Treatment for Adequate Functioning

Usage rating:
Yellow (Caution: use only if there is extensive evidence of and consensus that an individual is treatable and genuinely motivated; when in doubt, don’t)
Primary Target of Connections and Observations:
View of the world as “every man for himself” and “dog eat dog”
View of themselves as superior
The negative consequences their behavior produces
Confrontation of the bad consequences of their behavior
Consistent and repetitive pointing out of bad consequences
Challenging them to do better
Observations of their denial of responsibility
Observations of their impulsivity and lack of thinking things through
Their duplicity and lying
The practical consequences of their behavior to them
Suggestions of behaviors that will improve their consequences
Their blaming of others
Their insufficient self-control

Focal Treatment for Targeted Improvement

Usage rating:
Yellow (Caution: use only if there is sufficient leverage or control over them to be able to effectively follow through on contingencies and consequences)

Primary Targets of Connections and Observations:
One specific behavior and/or its consequences
Pointing out consequences and contingencies in the situation
Consequences, consequences, consequences

Additional Issues to Consider as Targets:
(All Treatment Types)

Short-sighted, self-defeating style of behavior
Considering their desires and impulses to be objective truth
Considering their actions to be invariably right or good
Considering their thoughts or beliefs to always be accurate
Confusing feelings with facts
Being totally present-oriented
Feeling they are cunning and entitled to get whatever they want
Feeling they are strong, life is hostile, rules prevent them from getting their needs met
Feel that breaking rules is justified
Their irresponsibility
Their inability to keep agreements
## General Treatment Goals:

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<th>Characteristics of Optimal Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstable and overly intense relationships with extremes of valuation and devaluation</td>
<td>Passionate, serious about relationship</td>
<td>Thoughtful and measured in relationships</td>
</tr>
<tr>
<td>Impulsive and self-damaging in two or more areas</td>
<td>Active and intense</td>
<td>Responsible for own impulses</td>
</tr>
<tr>
<td>Unstable and rapidly shifting moods</td>
<td>Uninhibited, fun-loving</td>
<td>Spontaneous and sensible</td>
</tr>
<tr>
<td>Issues with intensity of anger and appropriateness of anger expression</td>
<td>Assertive</td>
<td>Takes initiative and responsibility</td>
</tr>
<tr>
<td>Identity disturbance</td>
<td>Free to try new things</td>
<td>Flexible in social roles</td>
</tr>
<tr>
<td>Abandonment fears</td>
<td>Able to be involved in intense relationships</td>
<td>Arranges supportive relationships</td>
</tr>
</tbody>
</table>

## General Treatment Considerations:

### Drama Switch for Therapist to Avoid:
Rescuer to Victim
Joining with their covert belief that you can take away all of their pain, and then becoming the target of their wrath when they discover you cannot

### How to Avoid the Drama Switch:
Resist temptation to “jump in with both feet” and:
- Rescue, Persecute, or identify with their Victim stance
- Be consistent, firm, and unequivocal in limits and responses
- Make limits and consequences for unacceptable behavior clear from the beginning of treatment
Avoid being goaded into arguments
Be understanding and firm
Be confrontive and supportive

Profound Treatment for Optimal Functioning

Usage rating:
Yellow (Caution: use only if treatable, functional, motivated and does not have unmanageable life-threatening patterns or an unbroken history of quitting or misusing treatment or self-harm)

Primary Targets of Connections and Observations:
Their pure, dichotomous thinking
The underlying reasons for their reactions as opposed to their conclusions about the reasons for their reactions
Their lack of sense of proportion
“Some things are a hassle, not a horror” (from Linehan)
Their inappropriate reactions to the therapist
Their attempts to avoid feelings
Clarifying their behavior with the therapist and the reasons for it
Consistent limit-setting and confrontation of violation of limits
Relationships with the therapist and how it mirrors their relationship with others

Stylistic Treatment for Adequate Functioning

Usage rating:
Yellow (Caution: use only if they can commit to a course of treatment and do not have life-threatening behaviors)

Primary Targets of Connections and Observations:
Their most serious life-interfering behaviors
Their lack of impulse control
Their behavioral excesses
Their extreme cognitions
Their lack of self-regulation
The presence of possible alternative behaviors
Encouraging logic and analysis even while experiencing feelings
Alternative coping behaviors to replace inappropriate behaviors
Substitution of better behaviors for distress-propagating behaviors
The need to increase their ability to delay impulses
The need to increase their ability to tolerate affect

Focal Treatment for Targeted Improvement

Usage rating:
Green (Proceed: useful in many cases, especially when there are self-harm or life-threatening behaviors, such as in Linehan’s model)

Primary Targets of Connections and Observations:
Specific self-damaging or self-destructive behaviors
Alternatives to the self-damaging or self-destructive behaviors
Suggestions about options
Validation of feelings (very important - validate the nature and the existence of their feelings, not necessarily the accuracy of their feelings)
Practical, immediate solutions for consequences and affect tolerance
Building a pattern of responses not involving self-harm or life-threatening behaviors

Additional Issues to Consider as Targets:
(All Treatment Types)
Fears of abandonment
Feelings of being powerless and vulnerable
Conclusion that they are inherently unacceptable
View of the world as dangerous and malevolent
Histrionic

General Treatment Goals:

<table>
<thead>
<tr>
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<th>Characteristics of Optimal Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely focused on physical appearance</td>
<td>Makes self attractive</td>
<td>Concerned with substance</td>
</tr>
<tr>
<td>Exaggerated expression of emotions; shallow</td>
<td>Fun-loving and appropriate</td>
<td>Clever and insightful</td>
</tr>
<tr>
<td>Seeks a great deal of approval or praise</td>
<td>Enjoys positive reactions</td>
<td>Can give and take</td>
</tr>
<tr>
<td>Impressionistic in speech and lacking in detail</td>
<td>More conceptual than specific</td>
<td>Can be thoughtful</td>
</tr>
</tbody>
</table>

General Treatment Considerations:

Drama Switch for Therapist to Avoid:
Rescuer to Victim or Persecutor
Mistaking their emotional expressiveness for improvement

How to Avoid the Drama Switch:
Express calm, appropriate interest and empathy
Do not challenge them harshly
Push for semantic clarification as often as necessary, even if it’s nearly every sentence
Do not let them just talk on, and on, and on, and on...

Profound Treatment for Optimal Functioning

Usage rating:
Yellow (Caution: use if they are highly functional, motivated, and have some obsessive-compulsive traits)

125
Primary Targets of Connections and Observations:
Their “emotional” reasoning rather than “logical” reasoning
Their lack of logical thinking
Seductiveness
Their posturing, performing, “putting on a show” in the session
Their seductiveness (in the broad sense) with the therapist
Confront all inappropriate behaviors
Label their seductiveness
Investigate their motives for the way they are talking
Interpret their bids for, and neediness for, attention
Confront their manipulative use of affect
Point out their need for control
Point out their overgeneralizations
Point out their catastrophizing thinking

Stylistic Treatment for Adequate Functioning

Usage rating:
Green (Proceed: useful in many cases)

Primary Targets of Connections and Observations:
Their impulsive reactions
Their provocativeness
Their seductiveness
Their lack of clarity in thinking and speaking
Clarifying their behaviors and the consequences they produce
Point out their logical fallacies
Use reasoning about what they are talking about
Be semantically specific at all times
Point out their lack of logical thinking
Point out their overemotional displays
Interpret their demandingness and emotional coercion
Interpret others’ reactions to them
Focal Treatment for Targeted Improvement

Usage rating:
Green (Proceed: useful in many cases)

Primary Targets of Connections and Observations:
One problematic situation
One behavior that is inappropriate or that produces negative consequences
Be reassuring that they can get better results
Focus almost exclusively on practical alternatives

Additional Issues to Consider as Targets:
(All Treatment Types)

Their conclusion that they are inadequate and unable to handle life
Their need to be loved by everyone in order to be worthwhile
Exaggerated thinking
Their “emotional reasoning”
Their excessive controllingness, reactiveness, and overexpressiveness
# Narcissistic

## General Treatment Goals:

<table>
<thead>
<tr>
<th>Characteristics of Disordered Functioning</th>
<th>Characteristics of Adequate Functioning</th>
<th>Characteristics of Optimal Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandiose</td>
<td>Can promote self and ideas</td>
<td>Able to engage with others</td>
</tr>
<tr>
<td>Exploits others for own ends</td>
<td>Insightful and shrewd</td>
<td>Able to collaborate</td>
</tr>
<tr>
<td>Rage or humiliation in response to criticism</td>
<td>Appropriately handles negative feedback</td>
<td>Appreciates constructive criticism</td>
</tr>
<tr>
<td>Believes they and their problems are unique</td>
<td>Good competitors</td>
<td>Able to share with others</td>
</tr>
<tr>
<td>Sense of entitlement</td>
<td>Believe in themselves</td>
<td>Believe in others</td>
</tr>
<tr>
<td>Demand admiration</td>
<td>Enjoy accomplishments and positive results</td>
<td>Enjoys own and others’ achievements</td>
</tr>
<tr>
<td>Lacks empathy</td>
<td>Encourages others to go beyond perceived limits</td>
<td>Aware of own and others’ feelings</td>
</tr>
<tr>
<td>Strong feelings of envy</td>
<td>Behaves in ways designed to encourage others to treat them well</td>
<td>Appreciates others</td>
</tr>
</tbody>
</table>

## General Treatment Considerations:

### Drama Switch for Therapist to Avoid:

**Rescuer to Victim**

Being seduced into thinking it’s “everyone else” and then being rendered ineffective as a result

### How to Avoid the Drama Switch:

Allow (at least initially) without actually believing, their stance that their being seen is only to enhance self-importance or to fix “other” people

Be self-assured, friendly, but not overly solicitous or nurturing
Remain indifferent to one’s own perspective during interviews
Avoid defending oneself or trying to “prove a point”
Avoid confronting their feelings of being “special” too early on
(Unless you don’t want them to come back, in which case feel free)
Use open-ended questions, allow them to expound
Use mirroring and soothing prior to confrontations
Show interest in accomplishments, appropriate appreciation of talents and abilities
Allow them to “teach” you about themselves
Maintain “polite indifference” of their need to impress you

Profound Treatment for Optimal Functioning

Usage rating:
Yellow (Caution: use only if highly treatable, motivated, and suffering sufficiently to be able to tolerate challenges to their self-image)

Primary Targets of Connections and Observations:
Their demand for agreement
Their saying things that are not true or are only part of the story
Their need for the therapist to admire them
Demeaning and devaluing tones and terms
Their coldness
Their self-centeredness
Their ulterior motives
  To be admired
  To feels “special”
  To punish the other when experiencing negative affect
Their unproductive behaviors in the session
How they feel about the therapist
Their fears about the therapist
Their feelings of envy (as opposed to jealousy, very important distinction)
Stylistic Treatment for Adequate Functioning

Usage rating:
Green (Proceed: useful in many cases)

Primary Targets of Connections and Observations:
Their arrogant behavior
Their distorted self-assessment
Their distorted assessment of others
Detail their thinking style
Confront their satisfaction with conclusions they’re right rather than conclusions that resolve problems
Explain others’ reactions
Confront their exaggerations
Confront behavioral excesses
Note their opinion of themselves as special
Point out their need for empathy and understanding of others
Interpret their mean, angry, rageful, passive-aggressive behavior

Focal Treatment for Targeted Improvement

Usage rating:
Green (Proceed: useful in many cases)

Primary Targets of Connections and Observations:
One behavioral excess or deficit
One situation where their conclusions do not produce good results
Behavioral options for that situation
Use facts, data, actions, and consequences
Brainstorm solutions defined as “getting them what they want” or “dealing with troublesome others”
Additional Issues to Consider as Targets:
(All Treatment Types)

Their lack of empathy
Their devaluing of others
Evaluating themselves as special and uniquely important
Denial of weaknesses, problems, deficiencies
Unrealistic fantasies of unlimited power, wealth, love, etc.
Discrepancy between accomplishments and self-evaluation
Avoidant

General Treatment Goals:

<table>
<thead>
<tr>
<th>Characteristics of Disordered Functioning</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Unwilling to be involved with others unless certain of being liked</td>
<td>“Tuned in” to what others think of them</td>
<td>Can evaluate and accept or reject others’ opinions of them</td>
</tr>
<tr>
<td>Inhibited in social situations from fear of being foolish</td>
<td>Reserved</td>
<td>Thoughtful</td>
</tr>
<tr>
<td>Has exaggerated sense of risk in many activities</td>
<td>Cautious</td>
<td>Comfortable with change</td>
</tr>
<tr>
<td>Few close friends or confidants</td>
<td>Selective about associates</td>
<td>Socially flexible</td>
</tr>
</tbody>
</table>

General Treatment Considerations:

Drama Switch for Therapist to Avoid:
Rescuer to Persecutor
It’s very easy to get angry with them because they initially seem totally amenable and then won’t do anything or take any action to solve problems

How to Avoid the Drama Switch:
Keep your expectations in check - being a “nice” person does not always mean someone is a “competent” person
Use a gentle, nonconfrontive or a gently confrontive style
Maintain an accepting, interested demeanor
Share and use self-disclosure to encourage openness and experimentation
Profound Treatment for Optimal Functioning

Usage Rating:
Yellow (Caution: use only if highly treatable and functional - data suggest this is a very difficult condition to treat profoundly, and it can very easily scare them off)

Primary Targets of Connections and Observations:
Their consistent affect of fear
Their trouble using anger as a tool
Passive-aggression
Agreement to try things and then not following through
Feelings of shame
Put words to their motivations for avoidance
Comment on their unproductive behaviors
Be reassuring
Connect in-session behavior to needed life skills
Interpret the avoidance behind their agreeableness
Confront their catastrophizing thinking

Stylistic Treatment for Adequate Functioning

Usage Rating:
Yellow (Caution: use only when they are able to commit to a course of treatment)

Primary Targets of Connections and Observations:
Catastrophizing thinking style
Affect intolerance
Use gentle confrontation
Use gentle encouragement to try new things
Use support and empathy and encouragement
Use cost-benefit analysis of facing things versus avoiding things
Focal Treatment for Targeted Improvement

Usage Rating:
Green (Proceed: possibly the most useful of the treatment types for this disorder)

Primary Targets of Connections and Observations:
One specific area of avoidance that is causing distress
Support, empathy, and encouragement
Presenting realistic options
Taking the area out of the realm of scary, catastrophic fantasy
Emphasize the unavoidable need to find a way to handle the situation

Additional Issues to Consider as Targets:
(All Treatment Types)

Pervasive fears
Feelings of inadequacy
Conclusion that life is unfair
View of others as rejecting
Reliance on fantasizing and daydreaming for solace
## Dependent

### General Treatment Goals:

<table>
<thead>
<tr>
<th>Characteristics of Disordered Functioning</th>
<th>Characteristics of Adequate Functioning</th>
<th>Characteristics of Optimal Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs a great deal of reassurance in everyday decisions</td>
<td>Collaborative</td>
<td>Can be independent</td>
</tr>
<tr>
<td>Excessive fear of rejection, overly agreeable</td>
<td>Promotes harmonious relationships</td>
<td>Skilled in conflict management</td>
</tr>
<tr>
<td>Difficulty initiating</td>
<td>Collaborative</td>
<td>Initiates</td>
</tr>
<tr>
<td>Uncomfortable alone</td>
<td>Likes being with one or two other people</td>
<td>Productive when alone</td>
</tr>
<tr>
<td>Easily hurt by others’ negative reactions</td>
<td>Thoughtful about criticism</td>
<td>Welcomes constructive criticism</td>
</tr>
</tbody>
</table>

### General Treatment Considerations:

**Drama Switch for Therapist to Avoid:**
- Rescuer to Victim to Persecutor
- Letting them be so demanding and clingy that the therapist gets mad and behaves passive-aggressively

**How to Avoid the Drama Switch:**
- Have realistic expectations that progress will be slow
- Accept more silence than usual
- Use a pleasant, supportive style
- Maintain an empathetic approach regarding indecisiveness and failure to follow through
- Use only gentle confrontations
Profound Treatment for Optimal Functioning

Usage Rating:
Yellow (Caution: use only when affect tolerance is high)

Primary Targets of Connections and Observations:
Their paralyzing ambivalence
Whatever affect they are experiencing - fear, anger, guilt
Interpreting their motives
Point out their resistance to taking responsibility
Point out their lack of initiation
Highlight their self-doubts and fears
Point out their passive controllingness of others

Stylistic Treatment for Adequate Functioning

Usage Rating:
Green (Proceed: useful in many cases)

Primary Targets of Connections and Observations:
Catastrophizing thinking
Poor problem-solving
Overadaptation to others’ opinions
Reassurance
View of themselves as inadequate
Fear of making mistakes
Their lack of decision-making
The dangers of inaction
The dangers of letting others decide

Focal Treatment for Targeted Improvement

Usage Rating:
Green (Proceed: useful in many cases)
Primary Targets of Connections and Observations:
One problematic situation
One area of avoidance of decision
One area of giving in to others
Give advice about alternatives
Brainstorm solutions
Offer realistic and tolerable ways of handling the situation
Encourage a willingness to make mistakes

Additional Issues to Consider as Targets:
(All Treatment Types)
View of self as helpless and inadequate
View of world as too dangerous for them to cope with
Desperate need to find “protector” who is strong
Relinquishment of responsibility for their life
Dichotomous thinking regarding independence:
Feelings they must be totally connected or totally alone and independent
Dichotomous thinking regarding success and failure
Their belief in “absolute” or “final” success or failure
Catastrophizing thinking
### Obsessive-Compulsive

#### General Treatment Goals:

<table>
<thead>
<tr>
<th>Characteristics of Disordered Functioning</th>
<th>Characteristics of Adequate Functioning</th>
<th>Characteristics of Optimal Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perfectionism that is problematic</td>
<td>High standards</td>
<td>Flexible standards</td>
</tr>
<tr>
<td>Overly concerned with rules and order</td>
<td>Tidy, organized</td>
<td>Flexible</td>
</tr>
<tr>
<td>Insist others submit to their way of doing things</td>
<td>High standards</td>
<td>Understanding</td>
</tr>
<tr>
<td>Excessive involvement in work activities</td>
<td>Hard worker</td>
<td>Takes time for fun</td>
</tr>
<tr>
<td>Indecisive</td>
<td>Good at considering alternatives</td>
<td>Decisive</td>
</tr>
<tr>
<td>Restricted affect and affection</td>
<td>Appropriately restrained</td>
<td>Affectionate</td>
</tr>
<tr>
<td>Stingy, miserly</td>
<td>Frugal</td>
<td>Generous</td>
</tr>
<tr>
<td>Unable to throw things away</td>
<td>Retains things of value</td>
<td>Free to throw away</td>
</tr>
</tbody>
</table>

#### General Treatment Considerations:

**Drama Switch for Therapist to Avoid:**
- **Rescuer to Persecutor**
  - Their lack of empathy, criticalness, and need for control can be annoying

**How to Avoid the Drama Switch:**
- Keep interviews moving and addressing different topics
- Don’t get bogged down in details
- Initiate subject changes as needed
- Take control of the interviews
Interrupt as necessary in order to gather necessary information
Don’t let them ramble!

**Profound Treatment for Optimal Functioning**

**Usage Rating:**
Yellow (Caution: use when therapist can tolerate slower progress than “it seems like there should be” and the patient is able to tolerate lack of therapist-induced structure in sessions)

**Primary Targets of Connections and Observations:**
- Their affect, especially guilt and anger
- Their fears of catastrophe
- Their rigidity of thinking
- Their excessive self-protectiveness
- Use reflections of affect
- Point out their avoidance and control of affect

**Stylistic Treatment for Adequate Functioning**

**Usage Rating:**
Yellow (Caution: they are already too cognitive, so cognitive work such as homework assignments can simply fit their pattern and not generate productive changes)

**Primary Targets of Connections and Observations:**
- Their rigidity
- Their demandingness
- Their lack of empathy
- Their tension
- Their unrealistic expectations
- Detail their compulsive thought patterns
- Point out their need for control
Focal Treatment for Targeted Improvement

Usage Rating:
Green (Proceed: useful in many cases - they tend to like this one)

Primary Targets of Connections and Observations:
One area of dissatisfaction
Help them to have perspective, to “see the big picture” about the topic being targeted
Point out their lack of perspective on the topic

Additional Issues to Consider as Targets:
(All Treatment Types)
Perfectionism and sense of total responsibility
Their view that life expects too much
Their need for certainty
Their rigidity and “absolutistic” thinking
Their desperate need for control
Interventions Part III: Manage

Management
If You Are Not Treating, You Are Managing

Definition of “Management”

“Management” in the health care meaning of the term (rather than the business meaning of the term) is having as your goal reducing the harm created by a disorder or getting better behavior from the person who has the disorder while not attempting to get rid of the disorder itself. Differences between treatment and management include:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>vs.</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have sanction to perform psychotherapeutic interventions</td>
<td>You have no sanction to perform psychotherapeutic interventions</td>
<td></td>
</tr>
<tr>
<td>The individual is defined as your psychotherapy patient</td>
<td>The individual is not defined as your psychotherapy patient</td>
<td></td>
</tr>
<tr>
<td>The individual is not a coworker, boss, employee, or family member</td>
<td>The individual may be a boss, employee, or family member</td>
<td></td>
</tr>
<tr>
<td>Your goal is improving the individual’s life</td>
<td>Your goal is managing a situation - at home, at work, medically, etc.</td>
<td></td>
</tr>
<tr>
<td>Your goal is to diminish the individual’s distress or impairment</td>
<td>Your goal is to diminish harm or bad consequences</td>
<td></td>
</tr>
</tbody>
</table>
The Three Categories of Management Techniques for Personality Disorders

1. **Behavioral Techniques**
   Behavioral techniques are methods of diminishing the disordered pattern’s ability to function without using “insight” or “understanding” but rather using behavioral methods from behaviorism, such as reinforcement, extinction, punishment, etc.

2. **Conversational Techniques**
   Conversational techniques are methods of trying “to get the point across” to someone whose “listening” tends to screen out the data you are trying to communicate.

3. **Diagnostic Reframing Techniques**
   Diagnostic reframing techniques are methods of using the disorder to produce better behavior by reframing the behavior as a better version of being disordered

**Contexts That Typically Involve Management:**

Case management  
Medical treatment (emergency room, dialysis, surgery, general medicine, etc.)  
Vocational counseling  
Administration and leadership  
Teams  
Teaching  
Sales  
Customer service  
Academic advising  
Hospice  
Extended (medical) care programs  
Assisted living (medical) programs  
Personal life
How to Manage Personality Disordered Behavior

Step 1:
For All Disorders, Lay a Foundation that Inhibits Disordered Behavior

1. Make sure all agreements are clear & specific
   Use sensory, behaviorally specific words
   Avoid conceptual labels and euphemisms
   Define conditions of satisfaction clearly

2. Use a team approach when possible
   Teamwork dilutes emotional intensity and keeps people from becoming fatigued and thereby vulnerable to the drama

3. Promptly address all upsets, problems, difficulties, or broken agreements

4. “Pick your battles”
   Do not get sidetracked onto irrelevant issues
   Let some things slide by in service of your primary objective

5. Set and maintain firm, reasonable, conscious limits
   Beware of attempts to talk you out of them or make “exceptions”

6. Be willing to “let go” at any time
   Over-attachment to outcomes creates vulnerability to drama

7. Stay focused on your purpose

8. Manage your energy
   Fatigue is a risk factor for involvement in drama
   Deal with individuals in small “chunks” of time, periods (“dose”)
9. Be judicious about **criticism**
   Personality disorders limit individuals’ adaptability of response to criticism

10. Resist “**feelings transfers**”
    Don’t echo their feelings (viz. if they get angry you do, too)
    If you get emotionally escalated, retreat and calm down prior to proceeding

11. Be aware of and **responsible** for your own “counter-transferences”
    Take responsibility for your behavior despite their provocations
    Keep looking for ways to handle the situation
    Don’t justify misbehavior on your part by their bad behavior

12. Don’t get caught in the need to be “**right**”
    Be willing to be defined as “wrong” if it forwards your purpose
    Stand on “principle” only as it serves your commitments

13. Don’t “**pull any fast one’s**”
    Beware the common tendency to be duplicitous

14. Watch out for your feelings of “**I’m crazy**”
    “Danger, Will Robinson!” (That’s a joke - it’s from “Lost in Space.” Just trying to keep the conversation lively. And that one’s from “The Big Chill.”)
    It is a sign you are caught in a drama

15. Limit or avoid “**exceptions**” to established rules and procedures

16. Beware of and careful about the “**perennial victim**”
    Respond judiciously and carefully
    Do not “race to the rescue”

17. Keep your expectations **moderate** and appropriate

18. When in doubt, think “**give them attention**”
    Signs of attention and importance can help avoid dramas or
calm current ones down
Make them feel special

19. When in doubt, think “de-escalate”
   Always seek to diminish intensity

20. When in doubt, get an outside opinion
   It is easy to lose perspective and get caught in drama
Step 2:

Look for a Contingency to Use

Find a consequence that matters to them and that can be linked to their behavior that will require them to correct, adapt, or adjust their behavior

Make the connection between their behavior and the consequences clear and distinct
Be direct and non-punitive in communication style
   Remember - this is not a threat, it is a “contingency”
Be empathetic to their discomfort while also being firm about the connection between their behavior and the consequences
Do not get sidetracked into “reasons”
   Listen understandingly yet without yielding
Emphasize the over-riding importance of the outcome you are trying to achieve
Emphasize whatever positive benefit that will accrue to them if they successfully correct, adapt, or adjust their behavior
And finally - be prepared to follow through!
The procedure is the same for all diagnoses
Step 3: 
Apply a Specific Management Approach 
Appropriate to the Patient’s Diagnosis

Paranoid

1. Behavioral
   1. Repeatedly interrupt them when they get off onto a jag of 
      storytelling about how other people are bad, untrustworthy, 
      etc. This can be done apologetically or in a matter-of-fact 
      manner.
      - Change the subject
      - Stop the conversation
      - Ask about a different topic
   2. Look away and don’t give attention when they are engaged in 
      a behavior that is inappropriate or complaining. Begin 
      looking at them and giving them attention when they are 
      being appropriate.
   3. Ask a question that throws off the pattern
      “So what does that mean you’re going to do?”
      “And what will you do when that doesn’t work?”
      “And what’s the downside of doing it that way?”

2. Communication
   1. Ask permission to tell them something before you tell them, and 
      belabor the point of getting permission. Say things like “are 
      you sure it’s OK if I tell you something?”
   2. Tell them they’re probably not going to agree with something 
      that you’re going to tell them (apply paradox to their 
      oppositionality)
   3. Use Kreisman and Straus’s “SET” technique
      A statement of SUPPORT
      A statement of EMPATHY
      The TRUTH you want them to hear
3. **Diagnostic Reframing**

Tell them they are right to be suspicious/worried/whatever, that they need to be wary, and that the way you’re suggesting they handle the situation (appropriate behavior) is actually more effective in handling the potential betrayal or difficulty of the other person or the situation.
Schizoid

1. **Behavioral**
   1. Out-wait them, reducing your activity level in an attempt to increase theirs
   2. Ask questions very, very nicely to reinforce their engagement with you

2. **Communication**
   There aren’t very effective techniques at talking in ways that get improved responses from people with a Schizoid pattern. Any way you can find to empathize with them, and that can get verbal behavior from them is useful. This could be talking about something they’re actually interested in or something mundane. Then you can steer the conversation around to the topic you’re interested in talking with them about

3. **Diagnostic Reframing**
   The Diagnostic Reframing techniques are not very useful with people with a Schizoid pattern.
Schizotypal

1. Behavioral
   1. Use yourself as a reinforcer for both appropriate behavior and appropriate verbal behavior. Attend and empathize when they are being appropriate.

   2. Interrupt the conversation when they are being inappropriate

   3. Any behavioral methods used will likely need to be fairly direct, as the data show that people with a Schizotypal pattern are not good at reading subtle social cues.

2. Communication
   1. Agreeing with the possibility of there being truth in what they’re saying can make them more amenable to listening to things you want to tell them.

3. Diagnostic Reframing
   1. Tell them that what you’re telling them is something that many people cannot understand, that it is unique and special, and that you wouldn’t tell this to “just anyone.”

   2. Frame what you’re telling them to do as a better way to handle the people in the world who don’t understand everything that they do, because those people can unfortunately misunderstand things and so the people need to be “handled” carefully by them.
Antisocial

1. Behavioral
   About the only thing that works behaviorally with people with an Antisocial pattern is repetitive, immediate, coercive consequences. Management of antisocial means confining their behavior so that it cannot cause harm to others. So the behavioral techniques are all based in control, confinement, and coercive consequences.

2. Communication
   Communication methods don’t work very well with an Antisocial pattern, as they are busy trying to figure out what you’re doing so they can use it exploitively. When you talk with them it is important to be direct and straightforward, while being neutral in tone and “respectful” in not adopting their abusive ways.

3. Diagnostic Reframing
   Diagnostic reframing does not work with people with an Antisocial pattern. Avoid it.
Borderline

1. **Behavioral**
   1. People with Borderline patterns are often very sensitive to behaviorist interventions, which can work very well.
      1. Reinforce desired behavior with
         - Attention
         - Empathy
         - Extra time and concern
      2. Extinguish undesired behavior with
         - Removal of attention
         - Interruptions
         - An “empty” response
      3. “Punish” undesired responses by
         - Interrupting
         - Being distant and unempathetic

2. **Communication**
   1. Kreisman and Straus originally created their SET technique for use with Borderline patterns, so it can work exceptionally well:
      - A statement of SUPPORT
      - A statement of EMPATHY
      - The TRUTH you’re trying to communicate
   2. Maintain Linehan’s “Dialectic” by using two techniques in relatively equal proportion:
      - Support and validation
      - Confrontation and challenge

3. **Diagnostic Reframing**
   Validate the sense in their response, and then frame “better” behaviors as better ways to achieve their desired outcome (here’s the key - you have to frame it appropriate to their *covert* motivation, such as revenge, or punishment, etc., which they may be denying or may be unpleasant for you to try to ally with.
Histrionic

1. **Behavioral**
   - Don’t let them go on and on - interrupt them
   - Ask for details when their language is overly impressionistic
   - Slow down the conversation, create some silence

2. **Communication**
   - Be very specific when talking with them
   - Be reassuring
   - If you need to say no, do so simply and directly, without waffling

3. **Diagnostic Reframing**
   - Adopt the frame that they/someone/something IS wonderful/awful/astonishing, etc., and then attach your behavior to that meaning
Narcissistic

1. **Behavioral**
   Don’t directly challenge them, let things calm down naturally
   Don’t compete for attention
   Remain even-toned and low-key
   Keep interactions with them short

2. **Communication**
   SET works with them:
   A statement of SUPPORT
   A statement of EMPATHY
   The TRUTH you are trying to get across

3. **Diagnostic Reframing**
   Frame what you want them to do as evidence of their specialness and being “better”
Avoidant

1. **Behavioral**
   Be reassuring
   Treat them like they are always scared

2. **Communication**
   SET works with them
   A statement of SUPPORT
   A statement of EMPATHY
   The TRUTH you are trying to get across

3. **Diagnostic Reframing**
   Diagnostic reframing doesn’t work very well with Avoidant - you can try reframing things as making them safer or less vulnerable, but it is difficult for them to absorb new behaviors
Dependent

1. **Behavioral**
   Treat them with the demeanor that they’re competent and capable
   Use “I don’t really know” or “I’m not really sure” when they ask for too much advice
   Be reassuring

2. **Communication**
   SET works with them
   A statement of SUPPORT
   A statement of EMPATHY
   The TRUTH you are trying to get across

3. **Diagnostic Reframing**
   Reframe confusion, or uncertainty, or fear, as a positive thing, that it means they are trying new things and experimenting and that they are doing the right thing
Obsessive-Compulsive

1. **Behavioral**
   Don’t let them go on endlessly with details
   Say back to them “so the bottom line is...”
   Remind them of elements they are overlooking that make
   the situation more fluid than they realize

2. **Communication**
   Offer alternatives, but they will need TIME to consider them and
   to be comfortable with them
   Their first response to most things will likely be “no,” so don’t
   give up on the first attempt, and give them time to get
   used to something

3. **Diagnostic Reframing**
   Frame what you’re suggesting as the “right” way or the “best”
   way or the way it “should” happen
Part VI:

Special Cases and Topics
Part VI: Special Cases and Topics

Adolescence

Normal Adolescence vs. Personality Disordered Adolescence:

1. Similarities:
   1. Exaggerated responses
   2. Rigidity
   3. Behavior counter to general (adult) culture
   4. Unusual thinking
   5. Provocative and difficult behavior

2. Differences:
   1. Adolescent behavior diminishes with time
      Personality Disordered behavior continues
   2. Personality Disordered behavior can be seen from childhood
      Adolescent behavior begins in adolescence
   3. Any substance use begins after adolescence begins
      Substance use begins prior to adolescence
   4. Adolescent drama is episodic and can be limited
      Personality Disordered drama is persistent and can be highly escalated

3. Primary differential characteristic:
   Degree of escalation
   “Normal” adolescence does not involve life-threatening behaviors,
   repeated involvement of law enforcement, or physically harming themselves or others
   Personality Disordered Adolescence can involve any of the above
   Presence of physical abuse/injury
   Presence of legal difficulties
Common Marriage Pairings - Who Typically Finds Each Other

1. Paranoid & Dependent
   Paranoid & Avoidant
   Paranoid & Histrionic

2. Schizoid & Nobody

3. Schizotypal & Schizotypal
   Schizotypal & Obsessive-Compulsive

4. Antisocial & Borderline
   Antisocial & Histrionic

5. Borderline & Narcissistic

6. Histrionic & Narcissistic
   Histrionic & Obsessive-Compulsive

7. Avoidant & Obsessive-Compulsive

8. Dependent & Obsessive-Compulsive
   Dependent & Borderline
Aging

1. There is a lack of consensus regarding age-related manifestations of personality disorders
   “The prevalence of personality disorders in the second half of life remains essentially unknown.”
   Abrams and Horowitz, 1996

2. Personality disorders appear to exist in the elderly
   Fogel and Westlake (1990) - largest study of its kind -
   Showed of 2332 older inpatients with depression, 15.8%
   showed criteria for personality disorders (this is consistent with findings at younger ages)
   Kunik et al (1993) found that 24% of elderly met criteria for personality disorder

3. Epidemiological studies show significant prevalence rates of personality disorders in the elderly

4. Fewer personality disorder diagnoses are made in older age - theories as to why:
   1. DSM® has an age bias
   2. Cognitive changes alter the diagnosability
   3. Personality disorders calm down as one ages
   4. Most assessment personnel do not know how to diagnose for personality disorders
   5. As individuals age, have less work involvement and so DSM® criteria are less applicable
   6. Mature disorders remain stable:
      OC, schizotypal, schizoid, paranoid
   7. Immature disorders “calm down:”
      borderline, antisocial, narcissistic, histrionic
   8. Personality Disordered patients tend to die off and thus leave fewer in old age
   9. Some personality factors attributed to old age may actually be symptoms of personality disorders:
      Dependency, social withdrawal, odd thinking,
emotional lability

5. **Most frequent** personality disorder diagnoses in over 50 population
   - Obsessive-Compulsive (3%)
   - Dependent (2%)
   - NOS (2%)
   - All others under 1% combined

   Most frequent in under 50 population
   - Dependent (6%)
   - Antisocial (3%)
   - OC (3%)
   - Histrionic (2%)

   Elderly score lower on measures of antisocial, borderline, histrionic, narcissistic, paranoid, passive aggressive schizotypal, sadistic, and self-defeating scales on the CATI (Coolidge Axis II inventory)

6. **Persons who develop depression in old age** have a greater lifetime level of personality dysfunction
   - 63% of depressed had PD (Molinari, 1994)
   - Early onset elderly depression is the condition most associated with personality disorders
Families

Dealing with the Families of Personality Disordered Individuals:

The goals of family therapy with families of personality disordered individuals include:

Give sense of relief and hope
Create a positive environment with the family
Encourage collaborative interaction
Encourage creative problem-solving
Encourage doing the best they can under the circumstances
Encourage tolerance for themselves and their family member without passivity about the problems

Basic family therapy method:

Train the other family members how to deal with the disordered member(s)
Be wary of using diagnostic labels with family members
Describe the process/characteristics without (usually, at least) using the formal diagnostic names

Notes on Family Therapy:

Families have often received contradictory information and advice about “what’s wrong” with their family member
Most have never heard the term “personality disorder”
The norm is for depression, anxiety disorders, substance abuse, to occur concurrently, so they don’t know how to distinguish between the disorders
The result is often that the personality disorder is not addressed, but instead sabotages treatment of the other conditions

In the Ontario Whitby Psychiatric Hospital Survey:
80% of families requested information about the condition
They wanted to know about the disorder
93% requested information about the treatment
   They cared about what could be done to help
67% wanted information about risk of other members
devolving it
   They worried about the family

The basic principles of family consultation include:
   Education
   Alliance
   Support
   Training

The practical structure of working with families includes:
   An educational format
       Teaching about the phenomenon
   Dealing separately with the patient and their family
       Discussing questions, issues, problems
       Adopting a problem-solving approach

The behavior of professional with families should include:
   A neutral, nonaffective stance
   Nonjudgmental listening to family’s presentation of the
   problems
   A nonperjorative stance toward the patient while also
   acknowledging the troublesomeness of their behavior and
   its need to change
      Remember that many family members have discounted
   problems or attributed them to their own pathology
Part VII:

References and Bibliography
Part VII:
References and Bibliography

Part I:
Books Quoted in the Manual
Highly Recommended Readings On Personality Disorders
(With some editorial annotations)

This is the standard diagnostic manual from which I took and adapted the “professional” diagnostic section. It is not perfect but it is also not stupid or useless. There is also an expanded edition with case examples and additional references. If you don’t have a DSM in your personal library you certainly need to get one.

This is the “Bible” of personality disorder information. It’s a huge text, very expensive, and carries a comprehensive set of chapters on many aspects of personality disorders, from the clinical to the neurological. The chapters are written by the experts in the field, and the actual authors of most of the models used to understand and intervene in the disorders.

This is the companion and followup book to the APPI textbook listed above. It expands and updates some of the information and is a much more concise text and also very good.

One of only three books written on personality disorders in children, Bleiberg’s is a fine text. Be ready for some heavy-duty, sometimes head-spinning, object-relations language in the “cause” part of the book. The “treatment” section is not that way at all and is practical and easy to understand.

The third book written on personality disorders in children. The advantage of Freeman’s book is that it is an edited manual, so it contains a wide variety of theoretical viewpoints. The downside is that some of the chapters have inaccurate information about the cause of personality disorders, so you have to take those sections with a grain of salt.

The second book written on personality disorders in children, Kernberg’s book is excellent. It is very practical, especially on diagnosis (less heavy object-relations language than Bleiberg’s). It scrimps a bit on treatment, however, so Bleiberg’s book’s got it beat there.

LeDoux, J. (2002) *Synaptic self: how our brains become who we are.* New York: Viking Press. (Available at bookstores and from Amazon.com, 29.95.)

While not a text on personality disorders per se, LeDoux’s book is the best I’ve seen at describing in understandable terms how the genetic and the experiential combine to form the “functional biological” (which LeDoux calls “synaptic”). Despite the technical-sounding title, it is written in everyday, easy-to-read, layman’s language. It is a fascinating read if you are as into these things as much as I am. If you’re not, I understand - so go read a novel already.


Widely regarded as the reigning guru of borderline personality disorder, Linehan’s model is practical, realistic - and dauntingly demanding. If you want to understand borderline conditions from a cognitive-behavioral perspective (even if you lack the resources to institute her model), hers remains the essential text. Extensive, densely packed and detailed, it can be hard to read but is well worth the effort. She not only taught me a thing or two that I needed to know, but you gotta admire her guts - she works primarily with suicidal and parasuicidal borderline disordered patients. Tough specialty.


When people ask me for the one book that contains the best summary overview of personality disorders, I always send them to Sperry’s book. Perhaps I like him so much because he sees the conditions in ways that are largely similar to the ways I see them, or because I have taken the liberty of adapting some of his work to my own. But for whatever reason I always find Sperry’s work to be an impressive mix of the practical, realistic, easy to understand with the sophisticated. Millon’s books are similar in scope but are much more complex and detailed (is there anything in this field that man does not understand?). Sperry, on the other hand, is a “bottom line” kind of guy, so he’s a bit easier for most of us, and I like that.


If you can still manage to deny the important role of biology in the creation of personality and personality disorders, this book will show you the error of your ways. Interesting and at times even a little spooky, Wright chronicles the trials and tribulations of those investigating the role of genes and biology in behavior. Nine words: The data will drag you there, I guarantee it.
Part II:
Biographical Literature Containing Depictions of “Real” People that are Consistent with Personality Disorder Diagnoses
(This is a list based solely on the depiction presented; the accuracy of the depictions is unknown)

“The best training for therapists is to have lunch with novelists and sea captains.”
Eric Berne, origin unknown

Narcissist

Antisocial

Douglas, J.E. (2000) The anatomy of motive; the fbi’s legendary mind hunter explores the key to understanding and catching violent criminals. (Available from Amazon.com)
Paranoid (among others)

Narcissist

Schizotypal

Layton, D. (date?) Seductive poison: a jonestown survivor’s story of life and death in the people’s temple. (Available from Amazon.com)
Borderline

Levy, S. (date?) Rat pack confidential: frank, dean, sammy, peter, joey, and the last great showbiz party. (Available at bookstores and from Amazon.com)
Narcissist, Borderline

Obsessive-Compulsive/PTSD

Borderline
Rule, A. (date?) *The stranger beside me - ted bundy, the classic case of serial murder.*
(Available from Amazon.com)

Antisocial

(Available at bookstores and Amazon.com)

Borderline

(Available at bookstores and from Amazon.com)

Narcissist


Narcissist

Watts, C., & Shors, D. (date?) *Unabomber: the secret life of ted kaczynski.* (Available from Amazon.com)

Schizoid

**Part III:**

**Additional Recommended Readings on Personality Disorders**


Part III:
Professional Journals’ Coverage of Personality Disorders

I recently completed a study of the major professional psychiatry/psychology/mental health journals to determine the degree of coverage each gives to personality disorder topics. Most vary substantially in their frequency of coverage of personality disorders, but to give you a general sense of how much each tends to focus on personality disorders (so you can plan your study time appropriately if you want to keep up on the literature) here are the results of my review of the following journals:

<table>
<thead>
<tr>
<th>Journal/Publisher</th>
<th>Approximate Coverage Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Journal of Psychiatry</strong></td>
<td>8% (8 of 103 articles, 0-15% of each issue)</td>
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<tr>
<td>American Psychiatric Association</td>
<td></td>
</tr>
<tr>
<td>202/682-3503</td>
<td></td>
</tr>
<tr>
<td>Subscription about $128.00</td>
<td></td>
</tr>
<tr>
<td><strong>American Journal of Psychoanalysis</strong></td>
<td>0% (0 articles - surprised me, too)</td>
</tr>
<tr>
<td>Association for the Advancement of</td>
<td></td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td></td>
</tr>
<tr>
<td>Human Services Press</td>
<td></td>
</tr>
<tr>
<td>212/620-8468</td>
<td></td>
</tr>
<tr>
<td>Subscription about $50.00</td>
<td></td>
</tr>
<tr>
<td><strong>American Journal of Psychotherapy</strong></td>
<td>2% (1 of 45 articles, 0-10% of each issue)</td>
</tr>
<tr>
<td>Association for the Advancement of</td>
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<tr>
<td>Psychotherapy</td>
<td></td>
</tr>
<tr>
<td>718/430-3503</td>
<td></td>
</tr>
<tr>
<td>Subscription price unknown</td>
<td></td>
</tr>
<tr>
<td><strong>Archives of General Psychiatry</strong></td>
<td>7% (4 of 54 articles, 0-20% of each issue)</td>
</tr>
<tr>
<td>American Medical Association 800/262-2350</td>
<td></td>
</tr>
<tr>
<td>Nonmember subscription about $175.00</td>
<td></td>
</tr>
<tr>
<td><strong>Behavior Therapy</strong></td>
<td>0% (0 articles, but many articles on related or</td>
</tr>
<tr>
<td>Association for the Advancement of</td>
<td>comorbid conditions such as anger, addictive</td>
</tr>
<tr>
<td>Behavior Therapy</td>
<td>behavior, interpersonal conflict, etc.)</td>
</tr>
<tr>
<td>305 7th Ave</td>
<td></td>
</tr>
<tr>
<td>New York, NY 10001</td>
<td></td>
</tr>
<tr>
<td>Subscription about $42.00-$75.00</td>
<td></td>
</tr>
<tr>
<td><strong>Journal of Clinical Psychiatry</strong></td>
<td>0% (0 articles; each edition is devoted to a</td>
</tr>
<tr>
<td>Physicians’ Post-Graduate Press</td>
<td>special topic, and none during the years I reviewed</td>
</tr>
<tr>
<td>PO Box 752810</td>
<td>were on personality disorders)</td>
</tr>
<tr>
<td>Memphis, TN 38175</td>
<td></td>
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</tbody>
</table>
**Part IV:**

**Work Authored by Me or Based on My Work**


Darling, Tammy (1998) Five problem co-workers and how to deal with them (interview with Dr. Lester), *EEO Bimonthly*, Jan/Feb 1998.


Part VIII:
Appendices
Part VIII:
Appendices

Appendix A

Publishers of Personality Disorders
Assessment Instruments

PAR - Psychological Assessment Resources, Inc.
16204 N. Florida Ave.
Lutz, Florida 33549
800/331-8378
www.parinc.com

Pro-Ed
8700 Shoal Creek Blvd.
Austin, Texas 78757-6897
800/897-3202
www.proedinc.com

WPS - Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025-1251
800/648-8857
www.wpspublish.com

MHS - Multi-health Systems
PO Box 950
North Tonawanda, New York 14120-0950
800/456-3003
www.mhs.com

The Psychological Corporation
555 Academic Court
San Antonio, Texas 78204-2498
800/211-8378
www.psychcorp.com

NCS - National Computer Systems
PO Box 1416
Minneapolis, Minnesota 55440
800/627-7271
http://assessments.ncspearson.com
## Appendix B

### Media Examples

<table>
<thead>
<tr>
<th>Movie/Book/TV Show</th>
<th>Actor/Character</th>
<th>Personality Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Fish Called Wanda</td>
<td>Kevin Kline</td>
<td>Antisocial</td>
</tr>
<tr>
<td>Alien/Aliens</td>
<td>Ripley/Sigourney Weaver</td>
<td>Paranoid</td>
</tr>
<tr>
<td>All That Jazz</td>
<td>Joe Gideon/Roy Scheider</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>American Beauty</td>
<td>Ricky</td>
<td>Schizotypal</td>
</tr>
<tr>
<td></td>
<td>Ricky’s Father/Chris Cooper</td>
<td>Paranoid</td>
</tr>
<tr>
<td></td>
<td>Daughter’s Friend</td>
<td>Histrionic</td>
</tr>
<tr>
<td></td>
<td>Richard Gere</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>Animal House</td>
<td>Flounder</td>
<td>Dependent</td>
</tr>
<tr>
<td>Annie Hall</td>
<td>Tony Roberts</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>Any Given Sunday</td>
<td>Willy Beaman/Jamie Foxx</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>As Good As It Gets</td>
<td>Jack Nicholson</td>
<td>Obsessive-Compulsive</td>
</tr>
<tr>
<td>Assault on Precinct 13</td>
<td>Laurence Fishburn</td>
<td>Antisocial</td>
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<tr>
<td>Back to the Future</td>
<td>The Professor/Christopher Lloyd</td>
<td>Schizotypal</td>
</tr>
<tr>
<td>Basic Instinct</td>
<td>Sharon Stone</td>
<td>Antisocial</td>
</tr>
<tr>
<td>Bedazzled (Original)</td>
<td>Raquel Welch</td>
<td>Histrionic</td>
</tr>
<tr>
<td>Bedazzled (Remake)</td>
<td>The Devil/Elizabeth Hurley</td>
<td>Antisocial</td>
</tr>
<tr>
<td>Being There</td>
<td>Chauncy Gardner/Peter Sellers</td>
<td>Schizoid</td>
</tr>
<tr>
<td>The Birdcage</td>
<td>Albert/Nathan Lane</td>
<td>Histrionic</td>
</tr>
<tr>
<td></td>
<td>Senator Keeley/Gene Hackman</td>
<td>Obsessive-Compulsive</td>
</tr>
<tr>
<td></td>
<td>Houseboy/Hank Azaria</td>
<td>Histrionic</td>
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<tr>
<td>Body Heat</td>
<td>Maddie/Kathleen Turner</td>
<td>Antisocial</td>
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<tr>
<td></td>
<td>William Hurt</td>
<td>Dependent</td>
</tr>
<tr>
<td>Breach</td>
<td>Robert Hanssen/Chris Cooper</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>Breathless</td>
<td>Richard Gere</td>
<td>Antisocial</td>
</tr>
<tr>
<td>Broken Arrow</td>
<td>John Travolta</td>
<td>Antisocial</td>
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<td>Buckaroo Banzai</td>
<td>Jeff Goldblum</td>
<td>Dependent</td>
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<td></td>
<td>Buckaroo Banzai/Peter Weller</td>
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<tr>
<td>Movie</td>
<td>Character</td>
<td>Antisocial</td>
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<tr>
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</tr>
<tr>
<td>Casino</td>
<td>Joe Pesci</td>
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<tr>
<td></td>
<td>Robert De Niro</td>
<td>Antisocial</td>
</tr>
<tr>
<td></td>
<td>Sharon Stone</td>
<td>Borderline</td>
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<tr>
<td>Citizen Kane</td>
<td>Charles Foster Kane</td>
<td>Narcissistic</td>
</tr>
<tr>
<td></td>
<td>Orson Welles</td>
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<tr>
<td>Cliffhanger</td>
<td>John Lithgow</td>
<td>Antisocial</td>
</tr>
<tr>
<td>A Clockwork Orange</td>
<td>Malcolm McDowell</td>
<td>Antisocial</td>
</tr>
<tr>
<td>Collateral</td>
<td>Vincent/Tom Cruise</td>
<td>Antisocial</td>
</tr>
<tr>
<td></td>
<td>Max/Jamie Foxx</td>
<td>Avoidant</td>
</tr>
<tr>
<td>The Conversation</td>
<td>Gene Hackman</td>
<td>Paranoid</td>
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<tr>
<td>Crimes and Misdemeanors</td>
<td>Alan Alda</td>
<td>Narcissistic</td>
</tr>
<tr>
<td></td>
<td>Martin Landau</td>
<td>Narcissistic</td>
</tr>
<tr>
<td></td>
<td>Angelica Houston</td>
<td>Borderline</td>
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<td>CSI</td>
<td>Gil Grissom/William Peterson</td>
<td>Obsessive-Compulsive</td>
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<tr>
<td>Dangerous Liaisons</td>
<td>Glenn Close</td>
<td>Borderline</td>
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<tr>
<td></td>
<td>John Malkovich</td>
<td>Narcissistic</td>
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<td>Death of a Salesman</td>
<td>Willie Lowman</td>
<td>Borderline</td>
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<td>Defending Your Life</td>
<td>Albert Brooks</td>
<td>Histrionic</td>
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<tr>
<td>Dexter</td>
<td>Dexter</td>
<td>Antisocial</td>
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<tr>
<td>Donnie Darko</td>
<td>Donnie/Jake Gyllenhaal</td>
<td>Schizotypal</td>
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<tr>
<td>Double Jeopardy</td>
<td>Bruce Greenwood</td>
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<td>Tommy Lee Jones</td>
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<td>Fatal Attraction</td>
<td>Glenn Close</td>
<td>Borderline</td>
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<td>Failure to Launch</td>
<td>Tripp/Matthew McCounaghey</td>
<td>Avoidant</td>
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<td>Fatal Attraction</td>
<td>Alex/Glenn Close</td>
<td>Borderline</td>
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<td>The Fifth Element</td>
<td>The Fifth Element/Mila Jovovich</td>
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<td>The Firm</td>
<td>Wilford Brimley</td>
<td>Paranoid</td>
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<td>Frazier</td>
<td>Frazier/Kelsey Grammar</td>
<td>Narcissistic</td>
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<td></td>
<td>Niles/David Hyde Pierce</td>
<td>Obsessive-Compulsive</td>
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<tr>
<td>Friends</td>
<td>Monica Geller/Courtney Cox</td>
<td>Obsessive-Compulsive</td>
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<td>Phoebe/Lisa Kudrow</td>
<td>Schizotypal</td>
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<tr>
<td>From the Corner of His Eye</td>
<td>Junior</td>
<td>Antisocial</td>
</tr>
<tr>
<td>The Fugitive/U.S. Marshalls</td>
<td>Sam Gerard/Tommy Lee Jones</td>
<td>Obsessive-Compulsive</td>
</tr>
</tbody>
</table>
Galaxy Quest
  Tim Allen  Narcissistic
  Sigourney Weaver  Histrionic
  Tony Shaloub  Obsessive-Compulsive
  Serus  Antisocial

Ghost Dog
  Ghost Dog/Forrest Whitaker  Schizoid
  Louie  Dependent
  Sonny’s Daughter  Borderline

Ghostbusters
  Venkman/Bill Murray  Narcissistic
  Egon/Harold Ramos  Obsessive-Compulsive

Girl, Interrupted
  Angelina Jolie  Antisocial
  (A good example, by the way, of how movies are not always accurate-the main character is diagnosed as Borderline, but in the movie she actually only shows Major Depressive Disorder criteria)

The Godfather
  Don Corleone/Marlon Brando  Antisocial

Gone With the Wind
  Scarlett  Histrionic

The Good Son
  McCauley Caulkin  Antisocial

The Great Santini
  Robert Duvall  Obsessive-Compulsive

Grosse Point Blank
  John Cusak  Antisocial

Groundhog Day
  Phil Conners/Bill Murray  Narcissistic

Hannah and Her Sisters
  Max von Sydow  Narcissistic
  Mia Farrow  Dependent

House
  Gregory House/Hugh Laurie  Narcissistic

I Love Lucy
  Lucille Ball  Histrionic
  Dezi Arnaz  Obsessive-Compulsive

In Treatment
  Laura/Melissa George  Borderline

Jagged Edge
  Jeff Bridges  Antisocial

The Jerk
  Steve Martin  Schizotypal

Just Shoot Me
  Nina  Histrionic
  Finch  Narcissistic

Kill Bill Vol’s I & II
  Bill/David Carradine  Antisocial
  Lucy Liu  Antisocial
  Daryl Hannah  Antisocial
  Michael Madsen  Antisocial

Killing Pablo
  Pablo Escobar  Antisocial

La Strada
  Gelsomina  Borderline
  Anthony Quinn  Narcissistic

Lawrence of Arabia
  Lawrence  Narcissistic

Line of Fire
  John Malkovich  Antisocial
<table>
<thead>
<tr>
<th>Film</th>
<th>Actor/Character</th>
<th>Personality Disorder</th>
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<tbody>
<tr>
<td>Little Shop of Horrors</td>
<td>Seymour/Rick Moranis</td>
<td>Dependent</td>
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<tr>
<td>Looking for Mr. Goodbar</td>
<td>Diane Keaton</td>
<td>Borderline</td>
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<tr>
<td>Macbeth</td>
<td>Lady Macbeth</td>
<td>Borderline</td>
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<tr>
<td>The Matrix</td>
<td>“Mouse”/Hugo Weaving</td>
<td>Avoidant</td>
</tr>
<tr>
<td>The Matrix Reloaded/Revolutions</td>
<td>“Agent Smith”/Hugo Weaving</td>
<td>Narcissistic (post being unplugged)</td>
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<td>Men in Black</td>
<td>Will Smith/Tommy Lee Jones/Rip Torn</td>
<td>Narcissistic/Obsessive-Compulsive</td>
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<td>Moby Dick</td>
<td>Gregory Peck</td>
<td>Obsessive-Compulsive</td>
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<td>Mortal Kombat</td>
<td>Wilson/Sonya Blade</td>
<td>Paranoid</td>
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<td>The Net</td>
<td>Sandra Bullock</td>
<td>Schizoid</td>
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<tr>
<td>9 ½ Weeks</td>
<td>Mickey Rourke</td>
<td>Borderline</td>
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<td>Oceans Eleven</td>
<td>Danny Ocean/George Clooney</td>
<td>Narcissistic</td>
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<td>Of Human Bondage</td>
<td>Mildred</td>
<td>Borderline</td>
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<td>Ordinary People</td>
<td>Beth/Mary Tyler Moore/Calvin/Donald Sutherland</td>
<td>Obsessive-Compulsive/Avoidant</td>
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<tr>
<td>Pirates of the Caribbean</td>
<td>Jack Sparrow/Johnny Depp</td>
<td>Narcissistic</td>
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<tr>
<td>Play Misty for Me</td>
<td>Jessica Walter/Clint Eastwood</td>
<td>Borderline/Narcissistic</td>
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<td>The Player</td>
<td>Tim Robbins</td>
<td>Narcissistic</td>
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<td>Primal Fear</td>
<td>Roy/Edward Norton</td>
<td>Antisocial</td>
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<td>Raising Arizona</td>
<td>Nicholas Cage/John Goodman/Holly Hunter/Lone Biker of the Apocalypse</td>
<td>Schizotypal/Antisocial/Histrionic/Antisocial</td>
</tr>
<tr>
<td>The Recruit</td>
<td>Al Pacino</td>
<td>Antisocial</td>
</tr>
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<td>Scarface</td>
<td>Tony Montana/Al Pacino</td>
<td>Antisocial</td>
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<td>School of Rock</td>
<td>Dewey/Jack Black/Joan Cusak</td>
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<td>Scrubs</td>
<td>Bob Kelso/Perry Cox/The Janitor</td>
<td>Narcissistic/Narcissistic/Paranoid</td>
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<td>Movie/Show</td>
<td>Character(s)</td>
<td>Personality Disorder(s)</td>
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<tr>
<td>Seinfeld</td>
<td>George/Jason Alexander, Kramer/Michael Richards, Jerry Seinfeld</td>
<td>Dependent/Histrionic, Schizotypal, Narcissistic</td>
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<td>Sex and the City</td>
<td>Charlotte/Kristen Davis, Samantha/Kim Cattrell, &quot;Mr. Big&quot;/Chris Noth</td>
<td>Obsessive-Compulsive, Histrionic, Avoidant</td>
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<td>Sex, lies, and videotape</td>
<td>James Spader, Ann/Andie McDowell, John/Peter Gallagher, Laura San Giacomo</td>
<td>Avoidant, Obsessive-Compulsive, Narcissistic, Antisocial</td>
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<td>Silence of the Lambs</td>
<td>Hannibal Lecter/Anthony Hopkins</td>
<td>Antisocial</td>
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<td>The Simpsons</td>
<td>Smithers, Mr. Burns, &quot;Bar Flies&quot; (at Moe’s)</td>
<td>Dependent, Narcissistic, Avoidant</td>
</tr>
<tr>
<td>Sliding Doors</td>
<td>Jean Triplehorn</td>
<td>Borderline</td>
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<tr>
<td>Snake Eyes</td>
<td>Nicholas Cage</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>Star Trek (Next Generation)</td>
<td>Data/Brent Spiner, Worf/Michael Dorn, The Borg</td>
<td>Obsessive-Compulsive, Paranoid, Obsessive-Compulsive</td>
</tr>
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<td>A Streetcar Named Desire</td>
<td>Blanche/Vivian Leigh</td>
<td>Borderline</td>
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<td>Stripes</td>
<td>John Laroquette, John Winger/Bill Murray, The Drill Sergeant, Frances</td>
<td>Schizotypal, Narcissistic, Obsessive-Compulsive, Paranoid</td>
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<td>Superman Returns</td>
<td>Lex Luther’s Girlfriend, Lex Luther/Kevin Spacey</td>
<td>Histrionic, Antisocial</td>
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<td>Swordfish</td>
<td>John Travolta</td>
<td>Antisocial</td>
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<td>Taxi Driver</td>
<td>Travis</td>
<td>Borderline</td>
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<tr>
<td>Ten</td>
<td>Bo Derek</td>
<td>Histrionic</td>
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<tr>
<td>Terms of Endearment</td>
<td>Shirley MacLaine</td>
<td>Histrionic</td>
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<tr>
<td>The Great Santini</td>
<td>Robert Duvall</td>
<td>Obsessive-Compulsive</td>
</tr>
<tr>
<td>Tomorrow Never Dies</td>
<td>Terri Hatcher</td>
<td>Histrionic</td>
</tr>
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<td>Tootsie</td>
<td>Dabney Coleman, Terri Garr, Jessica Lange</td>
<td>Narcissistic, Histrionic, Dependent</td>
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<td>Unstrung Heroes</td>
<td>John Turturro</td>
<td>Obsessive-Compulsive</td>
</tr>
<tr>
<td>Wall Street</td>
<td>Gordon Gecko/Michael Douglas</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>What About Bob</td>
<td>Bob/Bill Murray</td>
<td>Dependent</td>
</tr>
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</table>
Appendix C

DSM-5® Section 3: “Alternative Model” for Personality Disorders

A unique aspect of the DSM-5® is that it contains an “Emerging Measures and Models” section of proposed revisions and additional diagnoses for further study. The models presented in Section 3 are insufficiently established or empirically supported to adopt at this time, but they are designed to promote further study and research on how best to conceptualize various disorders, including personality disorders.

The reason for Personality Disorders being included in the “Emerging Models’ section is the known shortcomings in the current model:

1. It has no gradation of severity - the more criteria you meet beyond threshold does not mean the more severe your disorder is; it means it is more probable that you fit that category
2. It has excessive comorbidity between subtypes - estimated at about 30%
3. It is strictly descriptive, and provides no cohesive model for understanding the unique nature of personality disorders

How the proposed revision addresses the current model’s shortcomings:

1. Disturbances in “self” and “interpersonal” functioning are considered to be the core issue in personality pathology (making it more specific than the current model)

2. Six diagnoses are included (reducing comorbidity from the current model):
   1. Antisocial
   2. Avoidant
   3. Borderline
   4. Narcissistic
   5. Obsessive-Compulsive
   6. Schizotypal

3. Each diagnosis is evaluated in four areas:
   1. The presence of impairment in four functional areas:
      1. Identity
      2. Self-direction
      3. Empathy
      4. Intimacy

2. The degree of impairment in each area (giving it the needed gradation of severity):
   0 - Little or no impairment
   1 - Some impairment
   2 - Moderate impairment
3. The presence and degree of five “pathological trait domains” (giving it a model called a “pathological trait” model):
   1. Negative Affectivity
   2. Detachment
   3. Antagonism
   4. Disinhibition
   5. Psychoticism

4. Each trait “domain” is then broken down into a variety of “facets”
   Negative Affectivity - Emotional lability, Anxiousness, Separation insecurity, Submissiveness, Hostility, Perseveration
   Detachment - Withdrawal, Intimacy avoidance, Anhedonia, Depressivity, Restricted affectivity, Suspiciousness
   Antagonism - Manipulativeness, Deceitfulness, Grandiosity, Attention seeking, Callousness, Hostility
   Disinhibition - Irresponsibility, Impulsivity, Distractability, Risk taking, Rigid perfectionism (lack of)
   Psychoticism - Unusual beliefs and experiences, Eccentricity, Cognitive and perceptual dysregulation

My impression of this proposed alternative model is that it is a useful proposal because it has the advantages listed above, and overcomes some of the shortcomings present in the current model. The downside is that it is much more complex than the current model and appears to me that it will be substantially more laborious to use than the current model. As a result it may be more difficult and cumbersome for clinicians to use. I think it needs to be tested in clinical trials for validity, reliability, and clinical utility to see how well it works before considering its adoption.
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2. **DO NOT** bend or fold your Scan Evaluation Form.
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4. Complete your first and last name in ALL CAPS (if you do not have enough space for you full name, simply use all boxes that are available.)
5. Write in your registration number in the appropriate box.
6. Mark your profession.
7. Fill in license number.
8. Clearly mark all boxes appropriately.
9. Complete the back page of the evaluation; your Seminar Evaluation Objectives are on the following page for you.
10. Return your completed Scan Evaluation form back to the instructor.
Seminar Evaluation Objectives

*Personality Disorders and the DSM-5®: Diagnosis, Treatment, and Management of PD*

*Speaker: Greg Lester, Ph.D.*

The purpose/goal of this activity is to gain new understanding of personality disorders and gain multiple powerful interventions for the management and treatment of the most difficult and frustrating cases.

Objectives:

1. Identify and properly assess various personality disorders listed in the diagnostic manual and how they differ from other psychiatric disorders.

2. Examine the DSM-5®’s Section 2 and Section 3 in regard to personality disorders.

3. Analyze specific techniques for effective screening, treatment, and management for clients with personality disorders.

4. Examine the effects personality disorders can have on a family unit and create strategic methods how to help these family members.

5. Determine how to maintain your own effectiveness with clients by reviewing common mistakes made by the majority of practitioners.
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Personality Disorders and the DSM-5: Diagnosis, Treatment, and Management of PD- On-Demand
Presented by Greg Lester, PhD

TEST

1. The first step in a “Health Care” approach is to use “Descriptive Pathology”
   A. True
   B. False

2. The manual that was designed to revise the entire mental health sciences was:
   A. DSM-I
   B. DSM-II
   C. DSM-III
   D. DSM-IV

3. DSM-5 eliminated “Axis II” for personality disorders
   A. True
   B. False

4. “Normal” personality is:
   A. A psychological “toolkit”
   B. A mood system
   C. A cognitive system
   D. A physical system

5. “Disordered” personality is an insufficient personality
   A. True
   B. False

6. When facing something in life, “normal” personality creates a pattern of:
   A. Withdrawal
   B. Problem-solving
   C. Depressed mood
   D. Defensiveness

7. A “Drama” is a problem-solving process
   A. True
   B. False

8. In the formal DSM-5 diagnosis, a personality is:
   A. A pattern of thinking, feeling, and behaving
   B. A pattern that is enduring and inflexible
   C. A pattern that is pervasive
   D. All of the above
9. Paranoid Personality Disorder means someone is deficient in trust
   A. True
   B. False

10. Schizoid Personality Disorder:
    A. Is the least common Cluster A diagnosis
    B. Is the most common Cluster A diagnosis
    C. Is the same thing as a mood disorder
    D. Has the exclusive trait of dependence

11. Schizotypal Personality Disorder has a diagnostic threshold of five of nine characteristics
    A. True
    B. False

12. Antisocial Personality Disorder is:
    A. A mood disorder
    B. A disorder of reality-testing
    C. Is a pervasive pattern of disregard for and violation of the rights of others
    D. Is a pattern of compulsively keeping agreements

13. Borderline Personality Disorder is 90% women
    A. True
    B. False

14. Histrionic Personality Disorder has as its exclusive trait:
    A. Mistrust
    B. Expressiveness
    C. Avoidance
    D. Rigidity

15. In the Drama, Narcissistic Personality Disorder switches from Victim to Rescuer
    A. True
    B. False

16. The change made in Avoidant Personality Disorder in DSM-5 is:
    A. It was removed
    B. It was combined with Paranoid Personality Disorder
    C. Its prevalence estimates were increased
    D. There were no changes made

17. Cult members could be a real-world example of Dependent Personality Disorder
    A. True
    B. False
18. Obsessive-Compulsive Personality Disorder:
   A. Is the least common of all personality disorders
   B. Is the most common of all personality disorders
   C. Is not in the DSM-5
   D. Has as its exclusive trait warmth

19. Interventions for personality disorders focus on the cause, which is an aversive childhood
   A. True
   B. False

20. The most important positive factor for “treatability” is:
   A. The ability to form a relationship with the health care worker
   B. Unresponsive depression
   C. Unresponsive substance abuse
   D. History of lying

21. In assessing your personal abilities, you need to know how to do Motivational Interviewing
   A. True
   B. False

22. Treatment for personality disorder is designed to:
   A. Repair the disordered self
   B. Treat a mood disorder
   C. Treat their anxiety
   D. Reduce the harm created by the disordered self

23. If you are treating, you establish the goal of “getting them better”
   A. True
   B. False

24. “Getting them better” involves some combination of:
   A. One change
   B. Two changes
   C. Three changes
   D. Four changes

25. The metaphor for a treatment relationship is “teacher”
   A. True
   B. False

26. One of the “fundamental” techniques for treatment is:
   A. Connections of cause-and-effect they don’t see
   B. Rogerian unconditional positive regard
   C. Behavioral Chain Analysis
   D. Interpretation of unconscious motives
27. The second of the “fundamental” techniques for treatment is making observations
   A. True
   B. False

28. “Categories” of treatment include:
   A. Profound treatment for optimal functioning
   B. Stylistic treatment for adequate functioning
   C. Focal treatment for targeted improvement
   D. All of the above

29. Focal Treatment for Targeted Improvement has as its goal improving “one thing” in their life.
   A. True
   B. False

30. In Antisocial Personality Disorder, Profound Treatment is:
   A. The best treatment to use
   B. The method that always works
   C. A method that has never been shown to work
   D. A secondary choice after Stylistic Treatment

31. In treating Borderline Personality Disorder, the therapist must avoid switching from Victim to Rescuer.
   A. True
   B. False

32. For Histrionic Personality Disorder, Profound Treatment:
   A. Can be used if they are highly functional, motivated, and have some obsessive-compulsive traits
   B. Is never useful
   C. Can be used with anyone
   D. None of the above

33. In Narcissistic Personality Disorder, an additional issue to consider as a target is oddities
   A. True
   B. False

34. In Dependent Personality Disorder, Stylistic Treatment for Adequate Functioning:
   A. Is never useful
   B. Is useful in many cases
   C. Should be used only when they are obsessive
   D. Should be used only if they are depressed
35. If you are not treating, you are managing:
   A. True
   B. False

36. “Management” means:
   A. Administrate
   B. Reduce the harm created by the disorder
   C. Repair the disordered self
   D. Tell them what to do

37. The first category of management techniques is insight-oriented psychotherapy:
   A. True
   B. False

38. The second category of management techniques is:
   A. Group therapy
   B. Family therapy
   C. Conversational techniques
   D. Bioenergetic techniques

39. The third category of management techniques is “diagnostic reframing” techniques
   A. True
   B. False

40. The first step in managing is to:
   A. Begin psychotherapy
   B. Establish a treatment frame
   C. Teach them about their diagnosis and disorder
   D. Lay a foundation that inhibits disordered behavior

41. In managing Antisocial Personality Disorder, about the only thing that works is repetitive, immediate, coercive consequences:
   A. True
   B. False

42. When managing Histrionic Personality Disorder you should not let them go on and on
   A. True
   B. False

43. When managing Obsessive-Compulsive Personality Disorder:
   A. Don’t let them go on endlessly with details
   B. Encourage them to be MORE detailed
   C. Don’t use confrontation
   D. Deal with them as though they are Antisocial
44. A similarity between adolescence and personality disorder is:
   A. Exaggerated responses
   B. Rigidity
   C. Unusual thinking
   D. All of the above

45. The primary difference between adolescence and personality disorder is the degree of escalation
   A. True
   B. False

46. Schizoids commonly marry:
   A. Paranoids
   B. Schizophrenics
   C. Depressed individuals
   D. Nobody

47. We know the precise prevalence of all personality disorders in the elderly
   A. True
   B. False

48. The basic principles of family consultation include:
   A. Education
   B. Alliance
   C. Support
   D. All of the above

49. One reason the DSM-5 contains an “alternative model” for personality disorders is the lack of graduation of severity in the current model
   A. True
   B. False

50. Of the following which diagnosis is NOT included in the “alternative” DSM-5 model:
   A. Paranoid
   B. Antisocial
   C. Avoidant
   D. Borderline