Personality Disorders
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Personality Disorders

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Definitions

- Personality trait
  - stable, recurring pattern of human behavior
- Personality type
  - constellation of personality traits
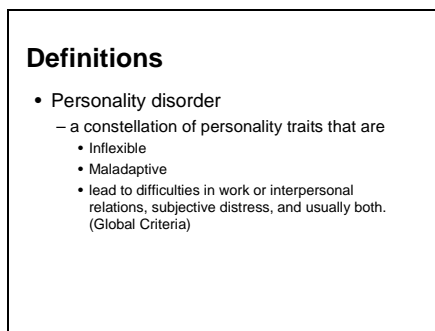 - frequent and familiar combination
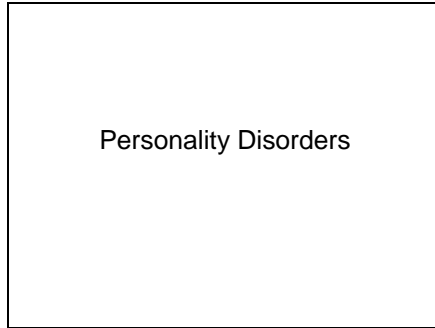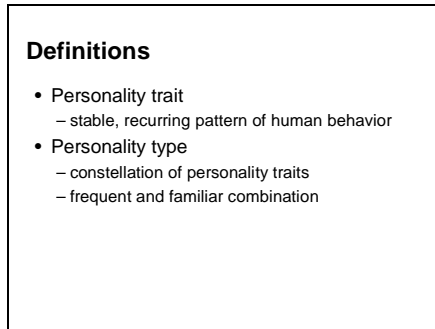
Personality Trait
A stable, recurring pattern of human behavior – e.g. a tendency to joke in serious situations, hypersensitivity to criticism, talkativeness in groups.

Personality Type
A constellation of personality traits recognizable as a frequent and familiar combination – e.g. the compulsive personality, characterized by preoccupations with work, detail, order, time, money, and cleanliness.

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Definitions

- Personality disorder
  - a constellation of personality traits that are
    - Inflexible
    - Maladaptive
    - lead to difficulties in work or interpersonal relations, subjective distress, and usually both. (Global Criteria)

Personality Disorder
A constellation of personality traits that are inflexible and maladaptive, leading to difficulties in work or interpersonal relations, subjective distress, and usually both.

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Why Should We Care?

…as doctors

These are not disorders in the sense of that schizophrenia or major depression is a disorder. They are patterns of human behavior that are maladaptive.

We care about them as doctors because (1) they are frequently a cause of distress for our patients, (2) they tend to predispose patients to other psychiatric disorders and (3) when comorbid with other psychiatric or medical disorders, they have a negative effect on course and outcome, and tend to make these other disorders more difficult to treat.

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Presentation

- In Medical Settings
  - doctor-patient relationship
  - Noncompliance
  - Difficulty coping
    - Hospitalization
    - Disability
    - medical restrictions

How Personality Disorders Present
In Medical Settings
Interpersonal problems in the doctor-patient relationship
Noncompliance with medical or rehabilitative regimens
Difficulty coping with hospitalization, disability, or medically-required restrictions on diet or activity

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Presentation

- In the Family
  - Marital conflicts
  - Sexual dysfunction
  - Child rearing
  - Domestic violence

In The Family
Personality disorders are associated with marital conflicts, sexual dysfunction, problems with child rearing and with domestic violence.

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Presentation

- Within the individual
  – Anxiety
  – Depression
  – External problems/losses
    • resulting from maladaptive behavior
    • Divorce
    • job loss
    • legal troubles
    • poor outcome from a medical condition
    • When prevented from living according to usual style

Within The Individual
Individuals with personality disorders are more likely experience anxiety or depression. They are more likely to experience external problems or losses resulting from their problematic behavior, such as divorce, job loss, legal troubles, and poor outcome from a medical condition.

It can also cause problems when circumstances prevent living according to one's usual personality style, for example with the dependent personality who has no one to depend on, the antisocial personality in a tough, consistent therapeutic community or the compulsive personality on weekends or vacations.

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Comorbidity

These disorders are frequently comorbid with the other psychiatric disorders, particularly depression, anxiety and substance abuse. The more severe personality disorders can occasionally become psychotic. In the case of each of these, we generally treat the comorbid disorder with typical treatments for that disorder, however it appears that individuals with comorbid Axis I and II disorders do not respond as well to treatment.

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Making a Personality Diagnosis

- Collateral sources
- Social and developmental history
- Personality tests (ex. MMPI)
- current strengths and weaknesses

Reliability is enhanced by interviewing collateral sources such as family members. The social and development history is crucial. Personality tests, such as the MMPI, complement the clinical interview and are a useful preventive against the clinician's biases and blind spots.

For acute management, an assessment of current strengths and weaknesses is often more pertinent than precise categorical diagnosis.

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Speculations on Etiology

Speculations on Etiology
Personality in general is formed through an interaction of genetic and developmental influences. Severe personality disorders generally imply a mood disorder, mild neurological abnormality (such as attention deficit disorder or learning disability), or a family history of alcoholism or personality disorder, plus some kind of early loss, trauma, or abuse. If the developmental history is apparently benign, the likelihood of an affective or organic factor is even greater. Personality traits that are maladaptive in adulthood may have been more adaptive in childhood. In some cases, it is possible to see how troublesome personality traits were reinforced by the family environment. However, we must still understand what maintains this behavior once it is no longer adaptive. Are there critical periods for personality development, or is personality change always possible?

Appreciation of the Role of Early Trauma in Severe Personality Disorders
Several studies show increased prevalence of childhood abuse, incest, or neglect, early loss, or family alcoholism in hospitalized patients with severe personality disorders.
Chronic post-traumatic stress disorder may produce symptoms that aggravate the personality disorder. Developmental histories of patients with severe personality disorder

must attend to potential trauma, abuse, and neglect. Specific therapeutic attention to traumatic events may be crucial to success of treatment.

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DSM-IV Personality disorders

- **Categorical**
- **Arranged by Cluster**

Approaches to Describing Personality
Dimensional
Personality traits, such as hostility or extroversion, are scaled. Disorder is defined in terms of statistical deviance from the norm.
Advantages
Possibly more reliable, because it avoid arbitrary all-or-none decision
Permits greater appreciation of individual differences
Disadvantages
A statistical criterion for normality will depend on the normative sample
Dimensional ratings are based on standardized tests, and are vulnerable to biases in test design
Does not facilitate recognition of personality types

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Other Approaches

• Dimensional Approaches

Approaches to Describing Personality
Categorical
Specific personality disorders are defined by diagnostic criteria, as are other mental disorders.

Advantages: Consistent with the DSM-IV approach to other mental disorders, Convenient for follow-up studies, family studies, etc.

Disadvantages: Draws an arbitrary line between normal and pathological. Personality disorders overlap, so multiple diagnoses are common. Categorically defined groups may actually be heterogeneous, so diagnosis may not have predictive value. Categorical diagnoses may encourage destructive labeling and stigmatization (ex. Borderline). They may lead to a lack of appreciation of disorders not meeting categorical criteria

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DSM and Personality

The Multiaxial System

This is a convenient place for a quick word about DSM's multiaxial approach to psychiatric assessment.

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"Axis II"

- "Lifelong problems"
- Reserved for
  - Personality Disorder
  - Mental Retardation
- Why divide from Axis I?

DSM uses a multiaxial system. Most of the major mental disorders are recorded on Axis I. Axis II is reserved for Personality Disorders and Mental Retardation. DSM is careful to specify that dividing it out into another axis is not meant to say anything about etiology or treatment, and that the division is one of convenience to be sure that personality and premorbid factors are not ignored when making a psychiatric diagnosis.

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The 5 Axes

- I. Clinical Disorders
- II. Personality Disorders
- III. General Medical Conditions
- IV. Psychosocial and Environmental Problems
- V. Global Assessment of Functioning.

These are the 5 Axes and what they contain. The 1st two are what were dealing with when we discuss psychiatric disorders. Axis III is meant to be a place reserved for assessing relevant medical problems. On axis 4, we are supposed to note significant stresses or other problems that may be contributing to the disorders. Axis 5 is a global assessment scale (1-100).

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Example

- I
  - 296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features.
  - 305.00 Alcohol Abuse.
- II
  - Dependent Personality Disorder
- III
  - None
- IV
  - Threat of divorce
- V
  - GAF = 35 (current)

This would be an example of a patient with a dependent personality disorder, who is fearing a divorce, has begun drinking, and has become depressed. The score of 35 would indicate major impairment in social or occupational functioning (ex. Skipping work, staying home in bed).

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The Personality Diagnoses

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The Clusters

- **A: Odd**
- **B: Dramatic**
- **C: Anxious**

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The Odd Cluster (A)

- **Paranoid**
- **Schizoid**
- **Schizotypal**

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Paranoid Personality Disorder

- Paranoid personality
- Mistrustful of everyone
- + test reality

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
(2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
(3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
(4) reads hidden demeaning or threatening meanings into benign remarks or events
(5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
(6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
(7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

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Schizoid personality

- Lacks intimate relationships
- Frightened by closeness
- Incapable of warmth
- Anxious about any closeness

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) neither desires nor enjoys close relationships, including being part of a family
(2) almost always chooses solitary activities
(3) has little, if any, interest in having sexual experiences with another person
(4) takes pleasure in few, if any, activities
(5) lacks close friends or confidants other than first-degree relatives
(6) appears indifferent to the praise or criticism of others
(7) shows emotional coldness, detachment, or flattened affectivity

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Schizotypal personality

- Odd and eccentric ideas
- Influence daily behavior
- But not psychotic

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) ideas of reference (excluding delusions of reference)

(2) odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)

(3) unusual perceptual experiences, including bodily illusions

(4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)

(5) suspiciousness or paranoid ideation

(6) inappropriate or constricted affect

(7) behavior or appearance that is odd, eccentric, or peculiar

(8) lack of close friends or confidants other than first-degree relatives

(9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

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The Anxious Cluster (C)

- **Avoidant**
- **Obsessive-Compulsive**
- **Dependent**

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Avoidant personality

- Social inhibition
- Feelings of inadequacy
- Hypersensitivity to criticism

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

(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection

(2) is unwilling to get involved with people unless certain of being liked

(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed

(4) is preoccupied with being criticized or rejected in social situations

(5) is inhibited in new interpersonal situations because of feelings of inadequacy

(6) views self as socially inept, personally unappealing, or inferior to others

(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

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Obsessive-Compulsive Personality

- Preoccupied w/ work/duty
- Not enjoying life
- Often rigid and inflexible

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost

(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)

(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)

(4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

(5) is unable to discard worn-out or worthless objects even when they have no sentimental value

(6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things

(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes

(8) shows rigidity and stubbornness

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The Dependent Personality

- Clings to stronger person
- Submissive
- Seeks help/advice
- Anxious when having to make decision

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

(1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others

(2) needs others to assume responsibility for most major areas of his or her life

(3) has difficulty expressing disagreement with others because of fear of loss of support or approval.

Note: Do not include realistic fears of retribution.

(4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)

(5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant

(6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself

(7) urgently seeks another relationship as a source of care and support when a close relationship ends

(8) is unrealistically preoccupied with fears of being left to take care of himself or herself

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The Dramatic Cluster

- Narcissistic
- Antisocial
- Borderline
- Histrionic

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Narcissistic personality

- Towards Self
  – Exaggerated sense of self
  – Unrealistic fantasies
  – Wants recognition
  – Arrogant
  – Entitled
  – Requires admiration
- Towards Others
  – Exploitative
  – Envious
  – Unconcerned

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

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love

(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)

(4) requires excessive admiration

(5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends

(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others

(8) is often envious of others or believes that others are envious of him or her

(9) shows arrogant, haughty behaviors or attitudes

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Antisocial personality

- The "psychopath"
- Violates laws/social conventions
- Dishonest
- Unconcerned about effect on others

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

(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest

(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure

(3) impulsivity or failure to plan ahead

(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults

(5) reckless disregard for safety of self or others

(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.

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

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

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Borderline personality

- Emotionally intense
- Unstable
- Impulsive behavior
- Self-destructive
- Inner emptiness
- Intolerance of being alone

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

(1) frantic efforts to avoid real or imagined abandonment.

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

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

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

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

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

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms

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Histrionic personality

- Dramatic
- Attention-seeking
- Caricature of femininity/masculinity

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) is uncomfortable in situations in which he or she is not the center of attention

(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior

(3) displays rapidly shifting and shallow expression of emotions

(4) consistently uses physical appearance to draw attention to self

(5) has a style of speech that is excessively impressionistic and lacking in detail

(6) shows self-dramatization, theatricality, and exaggerated expression of emotion

(7) is suggestible, i.e., easily influenced by others or circumstances

(8) considers relationships to be more intimate than they actually are

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Treatment

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Consider the Differential
• Could this be an Axis I disorder
• Is that Axis I disorder really an Axis II?

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Treatment: Psychotherapy

- Acute symptom focused
  – Ex. Dialectic behavioral therapy
- Fundamental
  – Focused on changing personality
  – Long term psychotherapy

Like most disorders, one can take one of two approaches in treating patients with personality disorders. One can take a symptomatic approach, or a more fundamental approach. In the symptomatic approach, the goal is to decrease specific problematic symptoms. For example, Dialectic behavioral therapy is a therapy specifically designed to decrease suicidal ideation, and is frequently used as treatment of patients with borderline personality disorder.

Fundamental therapies include most of the longer term psychodynamic psychotherapies, which focus in helping a person to change their coping style or "defenses" less to more healthy ones. In that sense, they are intent on "changing personality."

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Treatment: Pharmacotherapy

- **Symptom Focused**
- **Ex.**
  - **Depression**
  - **Anxiety**
  - **Psychosis**
- **More fundamental treatment?**
  - *Forme frustre* approach

Similarly pharmacotherapy can be symptomatic or more fundamental. Typical target symptoms for acute symptomatic treatment include depression, anxiety, violence or agitation, and psychotic ideation.

As most personality disorders are very complex, it is difficult to imagine our currently available medications can fundamentally change disorders. At times however, some of the disorders look like the major psychiatric disorders. For example, some patients with borderline personality disorder have mood fluctuations that resemble bipolar disorder, and at times physicians attempt to use antimanic drugs to treat these disorders. Occasionally they report some success, though this approach has rarely been subject to rigorous testing.

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Treatment In Medical Settings

- Identify and treat problems acute symptoms
  - Separate medical diagnosis from behaviors

In Medical Settings, one rarely tries to treat these disorders per se. When one tries to treat personality disordered patients for their medical or surgical problems and ignore the personality factors (i.e., "I'm just the surgeon, I don't deal with that stuff") the result is usually failure and frustration.

Some useful approaches to treating patients with personality disorders in the medical setting:
-Identify and treat problems of pain, anxiety, and depression.
-Identify and resolve problems covering medical diagnosis or treatment.
-Tailor the management plan and patient education to the patient's personality style: ex—Give information to compulsives, but reassure dependent and histrionic patients, set firm, consistent, and unambiguous limits with antisocial and borderline patients.