Department of Psychiatry and Behavioral Neurosciences

Personality Disorders

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Objectives

Goals: Recognize maladaptive traits & interpersonal patterns that typify personality disorders, and discuss strategies for caring for these patients

- Explain the concepts of personality traits and disorders, and describe features common to all personality disorders
- Recognize and discuss common clinical features and maladaptive behaviors suggestive of a personality disorder and make recommendations for further evaluation, referral, and management
- List the three descriptive groupings (clusters) of personality disorders and describe the typical traits of each disorder
- Summarize the principles of management of patients with personality disorders

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Personality Disorders Overview

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Why Do You Need to Know about Personality Disorders

- Approximately 9% to 15% of adults have some type of personality disorder (Lenzenweger, Lane, Loranger, & Kessler, 2007)
  - Higher in clinical samples (~11 to 45%)
- Individuals with personality disorders commonly have comorbid psychiatric conditions
  - Impacts presentation and treatment of individual

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What is a Personality Disorder?

"enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (APA, 2013)

- 3 P's → pervasive, pernicious, and persistent

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What is a Personality Disorder?

- Pattern manifests in 2+ areas of functioning:
  - Cognition (i.e., the ways of perceiving and interpreting self, other people, and events)
  - Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
  - Interpersonal Functioning
  - Impulse Control
- Inflexible and pervasive across a broad range of personal and social situations

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What is a Personality Disorder?

- Causes clinically significant impairment in social, occupation, or other important areas of functioning
- Pattern is stable and of long duration
- Not better accounted for as a manifestation or consequence of another mental disorder
- Not attributable to the physiological effects of a substance or general medical condition

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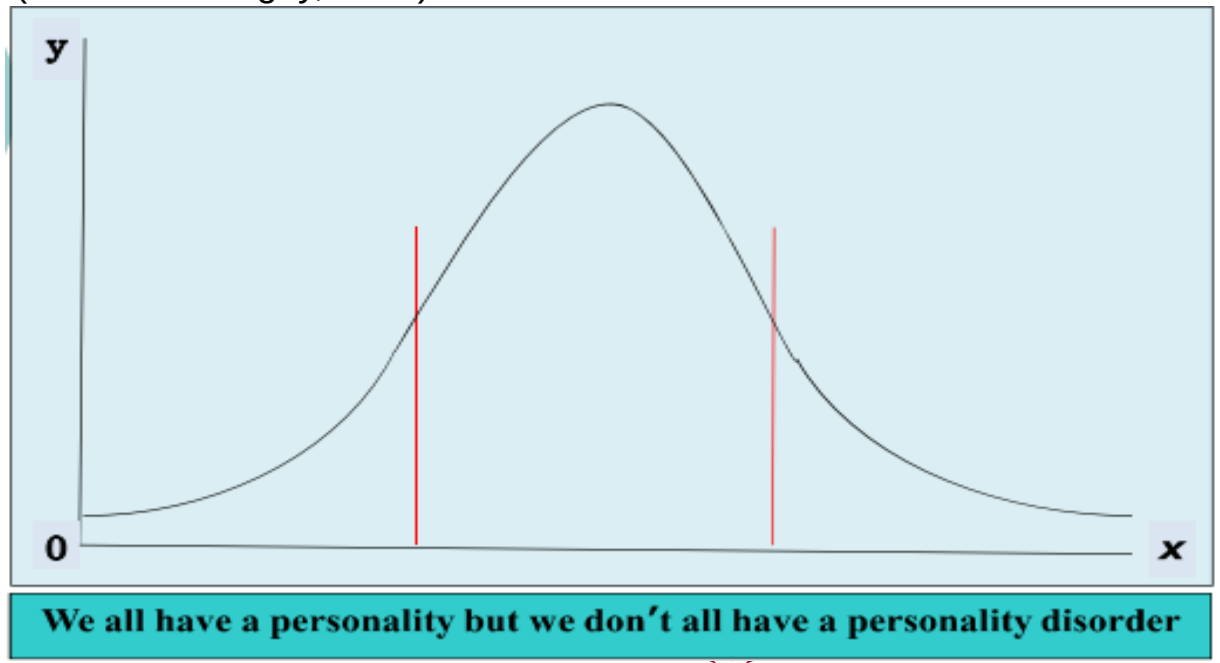
Personality Traits vs Personality Disorder

Personality traits: “enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts” (APA, 2013)

Personality disorders: dysfunctional amplification of normal personality traits

(Freeman & Rigby, 2003)



Development of PDs

- Combination of biological/genetic, psychosocial, and cultural factors
- Collaborative Longitudinal Personality Disorders Study
  (Grant et al., 1996-2005, N=43,093)
  - Abuse and neglect linked to 3-4x higher risk of PD
    - Physical abuse: antisocial PD
    - Sexual abuse: 55% of borderline PD report SA
    - Neglect: antisocial, avoidant, borderline, narcissistic PDs (Siever & Weinstein, 2009)

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Comorbidity

- High overlap within and between PDs
- Medical comorbidity: pain conditions, obesity, substance abuse
  - May present with physical sxs rather than psychiatric sxs
  - Complicates medical care
    - Greater medical utilization
    - Illness is a stressor that strains pt's limited coping skills
    - Poor adjustment to illness compliance issues
- Comorbidity = greater impairment and poorer prognosis

Possible Indications of a PD

- Pt has “always been this way”
- High degree of chaos in pt’s life
- Sxs don’t easily fit into a different psychiatric diagnosis
- Pt lacks insight into their behavior and/or blames others
- Low compliance with treatment plan
- Elicit strong countertransference reactions within provider
  - Ex: frustration, anger, inadequacy, rescue fantasies, depletion
  - Recognizing and managing internal reactions is critical

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General Considerations

- Continuum of severity
- Variability in sxs is common
  - Some tend to improve over time (e.g., borderline)
  - Some tend to worsen over time (e.g., schizotypal, obsessive compulsive)
- PDs may not be as chronic as previously thought
- Diagnosis takes time
  - Rule out other mental health and medical conditions first

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Description of Personality Disorders in DSM

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Personality Clusters

- Odd and Eccentric behavior **(Cluster A)**
  - Paranoid PD
  - Schizoid PD
  - Schizotypal PD
- Dramatic, Erratic, or Emotional behavior **(Cluster B)**
  - Antisocial PD
  - Borderline PD
  - Histrionic PD
  - Narcissistic PD
- Anxious or Fearful behavior **(Cluster C)**
  - Avoidant PD
  - Dependent PD
  - Obsessive-compulsive PD

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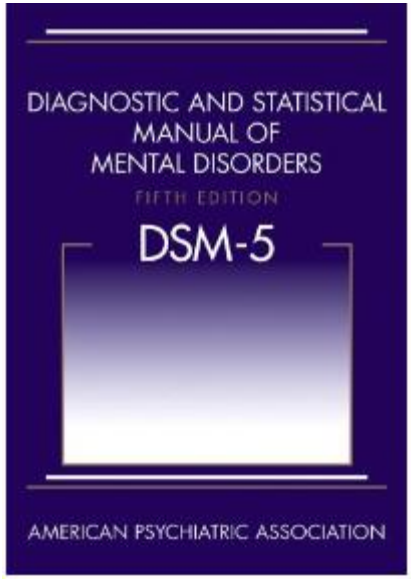
Changes to DSM

DSM-IV came out in 1994 (TR edition released 2000)

- Multiaxial system
  - Axis I: Clinical Disorders
  - Axis II: Personality Disorders and Mental Retardation
  - Axis III: General Medical Condition
  - Axis IV: Psychosocial and Environmental Problems
  - Axis V: Global Assessment and Functioning

DSM-5 came out in **2013** (TR edition released 2022)

- Monoaxial system
- Personality disorders unchanged from DSM-IV



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Cluster A: Paranoid PD

- Distrust and suspiciousness of others, including interpreting their motives as malicious
  - Interpersonal Functioning
    - Have problems in close relationships, appear cold and distant, difficulty trusting others
  - Affectivity
    - May appear unemotional or labile (hostile, stubborn, irritable)
  - Cognition
    - Paranoid ideation
  - Impulse Control
    - Quick to react to perceived attacks by others – can become violent if threatened

Example: Richard Nixon

Cluster A: Schizoid PD

- Indifference to interpersonal relationships and restricted range of emotions in social settings
  - Interpersonal Functioning
    - Neither desires nor enjoys close relationships
  - Affectivity
    - Constricted affect
  - Cognition
    - Tend to prefer mechanical, abstract, or solitary tasks
  - Impulse Control
    - No issues

Example: Mr. Spock, Batman

Cluster A: Schizotypal PD

- Social and interpersonal deficits and eccentricates in cognition, perception, and behavior
  - Interpersonal Functioning
    - Lack of close relationships; social anxiety associated with paranoid fears
  - Affectivity
    - Constricted or inappropriate affect
  - Cognition
    - Cognitive or perceptual distortions and eccentricities in behavior
  - Impulse Control
    - No issues

Example: Willy Wonka, Phoebe from *Friends*

Differential Diagnosis for Cluster A

- Schizophrenia or Unspecified Schizophrenia Spectrum and other Psychotic Disorder
  - Persistent psychotic symptoms, more severe, change in functioning
- Organic brain disorder
  - Change in functioning, potentially known cause
- Autism Spectrum Disorder
  - Language difficulties, stereotyped behaviors/interests, more severely impaired social functioning/awareness
- Drug-induced psychosis
  - Hx of substance use, change in functioning

Cluster B: Antisocial PD

- Disregard for and violation of the rights of others
  - Interpersonal Functioning
    - Possible superficial charm but lack of concern for rights of others, irresponsible, aggressive
  - Affectivity
    - Absence of empathy for others, don't feel guilty
  - Cognition
    - Lack of remorse, rationalizes hurting others, inflated self-appraisal
  - Impulse Control
    - Reckless disregard for safety of self and others; impulsivity and failure to plan ahead

Example: The Talented Mr. Ripley, Sons of Anarchy, The Grinch

Cluster B: Borderline PD

- Instability in interpersonal relationships, self-image, affect, and marked impulsivity
  - Interpersonal Functioning
    - Unstable and intense relationships alternating between idealization and devaluation
  - Affectivity
    - Reactivity; difficulty controlling anger; recurrent suicidality and self-mutilating behavior; chronic feelings of emptiness; abandonment issues
  - Cognition
    - Black and white thinking; “splitting”
  - Impulse Control
    - Impulsivity in potentially self-damaging areas

Example: Fatal Attraction, Girl Interrupted, Single White Friends

Cluster B: Histrionic PD

- Emotionality and attention-seeking behavior
  - Interpersonal Functioning
    - Uncomfortable when not center of attention; inappropriately seductive or provocative behavior; relationships are superficial
  - Affectivity
    - Pervasive and excessive emotionality; theatrical and exaggerated expression of emotion; shallow and labile
  - Cognition
    - Suggestible, superficial thought processes
  - Impulse Control
    - May do dramatic things to make self center of attention

Example: Mean Girls, Derek Zoolander

Cluster B: Narcissistic PD

- Grandiosity, need for admiration, and lack of empathy
  - Interpersonal Functioning
    - Lack empathy; expect others to recognize their superiority; sense of entitlement; exploitative
  - Affectivity
    - Overly sensitive to criticism, judgment, and defeat (shame, humiliation); fragile self-esteem
  - Cognition
    - Overestimate abilities; preoccupied with fantasies of unlimited success
  - Impulse Control
    - React poorly to criticism

Example: Bill Murray in *Groundhog Day*; House

Differential Diagnosis for Cluster B

- Mood disorders (Major Depressive Disorder, Bipolar Disorder)
  - Impulsivity or grandiosity occurs during manic or hypomanic episode
- Seizure disorder
  - Impulsivity increases prior to seizure
- Organic brain disorder
  - Change in functioning/impulsivity
- Frontal lobe injury
  - Increased difficulty in planning, initiating, and thinking after head injury (change in functioning)
- Substance-induced disorder
  - Hx of substance use, change in functioning after use/abuse

Cluster C: Avoidant PD

- Social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation
  - Interpersonal Functioning
    - Social inhibition; assume others are disapproving; avoid situations that are potential for conflict
  - Affectivity
    - Overly sensitive to criticism and perceived judgement; bothered by isolation
  - Cognition
    - Preoccupied with concerns about criticism or rejection; believe they are inadequate socially
  - Impulse Control
    - Reluctant to take personal risks

Example: Charlie Brown

Cluster C: Dependent PD

- Excessive reliance on others resulting in submissive, clinging behavior and fears of separation
  - Interpersonal Functioning
    - Dependent and submissive behaviors; rely on others for basic needs; difficulty disagreeing with others
  - Affectivity
    - Fears of separation or being alone because believes unable to care for self; lack self-confidence
  - Cognition
    - Difficulty making minor decisions without input/support from others
  - Impulse Control
    - Quickly seek new relationship when old ones end

Example: Edith Bunker from *All in the Family*, Buster Bluth from *Arrested Development*

Cluster C: Obsessive-Compulsive PD

- Preoccupation with orderliness, perfectionism, and control, resulting in severely limited flexibility, openness, and efficiency
  - Interpersonal Functioning
    - Excessive devotion to work; stilted friendships
  - Affectivity
    - Self-critical of own mistakes; angered by disruptions to order/rules; not emotionally expressive
  - Cognition
    - Try to maintain control through extreme attention to rules/details; inflexible to change; rigid and stubborn; perfectionism interferes with task completion
  - Impulse Control
    - Inflexible, rigid, stubborn

Example: Detective Monk

Differential Diagnosis for Cluster C

- Obsessive Compulsive Disorder
  - Presence of obsessions and compulsions
- Major Depressive Disorder
  - Change in functioning
- Adjustment Disorder
  - Presence of recent stressor
- Anxiety Disorder
  - Presence of panic attacks; avoidance of social situations after development of panic attacks

Other PDs

- Personality Change Due to Another Medical Condition
  - Change from individual's previous personality as a direct pathophysiological consequence of another medical condition
- Other Specified Personality Disorder or Unspecified Personality Disorder
  - Features of PD present but do not meet full criteria for a single disorder

Treatment

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Considerations & Strategies for Cluster A

- Countertransference
  - Uneasiness, frustration (test your patience!), inadequacy, urge to avoid
- Trust issues → huge!
  - Prove trustworthiness with actions, not words
  - Listen to complaints while avoiding confrontation
- Empathize, give straightforward explanations, accept pt's unsociability
- Avoid challenging distortions in patient's thinking unless solid rapport has been established first
- Include family to increase pt compliance

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Considerations & Strategies for Cluster B

- Countertransference are very strong!
  - Aversion, anger, sympathy, amusement, feelings of inadequacy
- Empathize with patient's fears
  - Fears are strong and may not be directly expressed
- Be consistent
- Set limits that are upheld across medical staff members
- Verbalize that you want to help and attempt to satisfy reasonable requests

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Considerations & Strategies for Cluster C

- Countertransference
  - Over-protective and powerful, frustrated, angry
- Strive to empathize with pt's fears and cognitive style
- Foster autonomy and shared decision-making
  - Avoid telling the patient what to do regardless of how frustrated you feel
  - Verbalize willingness to care for avoidant and dependent pts
- Avoid power struggles, provide thoughtful explanations

Treatment

- Treatment of PD sxs take longer, better outcomes come from treating comorbidities
- High attrition rate: 21% - 31%
- Therapy > medication

Treatment Modalities	Cognitive/ Behavioral	Supportive Psycho-Ed	Interpersonal	Psychodynamic	Psychopharm
Cluster A	√	~	?	?	X (for comorbidities)
Cluster B	√ (DBT)	√	√	√	X (for comorbidities)
Cluster C	√	√	√	√	X (for comorbidities)

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Treatment

- Most patients with PD seek behavioral health services at urging of family or employer, or to treat different mental health condition
- **Don't personalize the patient's behavior!**
- Goal is to establish a good, working relationship with the patient
  - Develop an alliance based on trust, acceptance, and confidence
- Constantly strive for **empathy** and to understand the pt's behavior
  - While the behavior is often maladaptive, it is often a survival mechanism
  - Patient's goal is to minimize internal distress and to meet personal needs
- New, more adaptive behavior can be learned!

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