Personality Disorders

Patricia Mumby, Ph.D.
Department of Psychiatry and Behavioral Neurosciences
Loyola University Medical Center

Why Do You Need to Know About Personality Disorders?

- It is estimated that approximately 9% of adults have some type of personality disorder (Lenzenweger, Lane, Loranger, & Kessler, 2007).
  - Higher in clinical samples- range from 11-45%
- Individuals with personality disorders are very likely to have Axis I disorders as well.
  - Will likely impact presentation and treatment

Objectives

- Personality disorders: an overview
- Classifying/Describing personality disorders
- Treatment of personality disorders

Personality Disorders: An Overview

Personality Disorders

- Long-lasting **inflexible and pervasive** patterns of thought and actions.
- Can cause serious problems and impairment of functioning.
- They are coded in Axis II of DSM-IV-TR
- Symptoms of Axis I disorders might be the reason for the consultation.
- In that case, the clinician needs to consider the personality disorder as a background.

WHAT IS A PERSONALITY DISORDER?

DSM-IV-TR

- Enduring pattern of inner experience & behavior that deviates markedly from individual's culture
- Pattern manifests in 2 or > areas of functioning:
  - **Cognition**
  - **Affectivity**
  - **Interpersonal functioning**
  - **Impulse control**

Possible Indicators of a PD

- Pt has “always been this way”
- High degree of chaos in pt’s life
- Symptoms don’t easily fit an Axis I diagnosis
- Patient lacks insight into his/her behavior
- Typically blames others for his/her problems
- Low compliance with treatment plan
- You have noticeable reactions to the patient’s behavior
  - PDs elicit strong countertransference reactions
    - Frustration, anger, inadequacy, rescue fantasies, depletion
  - Countertransference can seriously impact the MD’s interaction w/the pt. and compromise care

DSM-IV-TR
Axis Classification System

Axis I: CLINICAL DISORDERS

Any symptoms of Axis I disorder must be resolved before diagnosis of Axis II disorder can be considered.

Axis II: PERSONALITY DISORDERS and MR
"Deferred" - STIGMA

Axis III: GENERAL MEDICAL CONDITION

Medical condition should be as stable as possible when considering an Axis II diagnosis.

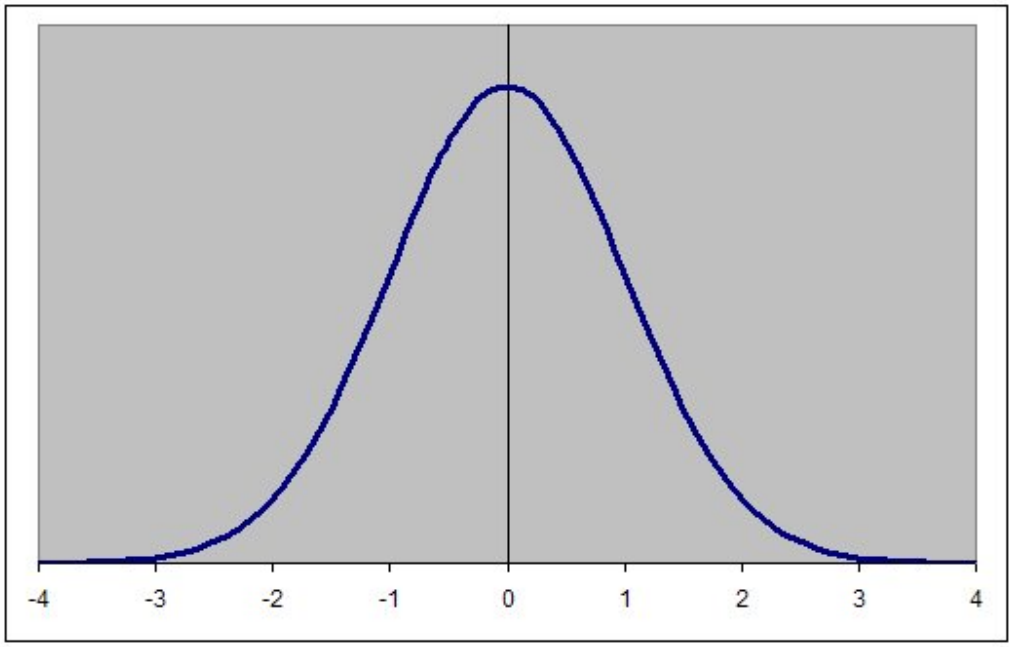
Axis IV: PSYCHOSOCIAL/ENVIRONMENTAL

Axis V: GLOBAL ASSESSMENT OF FUNCTIONING

1=persistent danger to self/ others

100=superior functioning

PD Traits Fall on a Continuum



Description of Personality Disorders

In DSM-IV-TR 10 personality disorders are classified in three different clusters:

- Odd or Eccentric behaviour (Cluster A)
- Dramatic, Erratic, or Emotional behaviour (Cluster B)
- Anxious or Fearful behaviour (Cluster C)

Odd/Eccentric Cluster

- **Paranoid:** Distrust and suspiciousness of others, including interpreting their motives as malicious.
  - Interpersonal Functioning:
    - Have problems in close relationships, appear cold & 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

Odd/Eccentric Cluster

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

Odd/Eccentric Cluster

- **Schizotypal:** Social and interpersonal deficits and eccentricities 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 major issues

Differential Diagnosis For Cluster A

- Schizophrenia or Psychotic disorder NOS
  - Persistent psychotic symptoms, more severe, change in functioning
- Organic brain disorder
  - Change in functioning
- Autism or Asperger's
  - Language difficulties, stereotyped behaviors/interests, more severely impaired social functioning/awareness
- Drug-induced psychosis
  - Hx of substance use, change in functioning

Dramatic/Erratic Cluster

- **Antisocial (*Psychopathy*):** Disregard for and violation of the rights of others.
  - Interpersonal Functioning:
    - Possible superficial charm but lack of concern for rights of others; irresponsibility; aggressive
  - Affectivity:
    - Absence of empathy for others, lack of guilt after transgressions
  - 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

Dramatic/Erratic Cluster

- **Borderline:** Instability in interpersonal relationships, self-image, affect and marked impulsivity.
  - Interpersonal Functioning:
    - Unstable and intense relationships alternating between idealization and devaluation
  - Affectivity:
    - Affective instability due to mood reactivity; difficulty controlling anger; recurrent suicidality and self-mutilating behavior; chronic feelings of emptiness
  - Cognition:
    - Black and white thinking; “splitting”
  - Impulse Control:
    - Impulsivity in potentially self damaging areas

Dramatic/Erratic Cluster

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

Dramatic/Erratic Cluster

- **Narcissistic:** Grandiosity, need for admiration, and lack of empathy.
  - Interpersonal Functioning:
    - Lack empathy with others; expect others to recognize their superiority/want to be admired; exploitive
  - Affectivity:
    - Overly sensitive to criticism, judgement and defeat (shame, humiliation), fragile self-esteem
  - Cognition:
    - Overestimate abilities, preoccupied with fantasies of unlimited success
  - Impulse Control:
    - May react poorly to criticism

Differential Diagnosis for Cluster B

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

Anxious/Fearful Cluster

- **Avoidant Personality Disorder:** Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
  - Interpersonal Functioning:
    - Social inhibition; assume others are disapproving; avoid situations that have 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

Anxious/Fearful Cluster

- **Dependent Personality Disorder:** Excessive reliance on others resulting submissive, clinging behavior and fears of separation.
  - Interpersonal Functioning:
    - Dependent and submissive behaviors; rely on others for even 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 relationships when old ones end

Anxious/Fearful Cluster

- **Obsessive-Compulsive Personality Disorder:**
  Preoccupation with orderliness, perfectionism, and control, resulting in severely limited flexibility, openness, and efficiency.
  - Interpersonal Functioning:
    - Excessive devotion to work that impedes friendships
  - Affectivity:
    - Self-critical of own mistakes; angered by disruptions to order/rules
  - 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 to change; rigid and stubborn

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

Treatment of personality disorders

Transference & Countertransference

- **Transference:** the redirection of feelings and desires and especially of those unconsciously retained from childhood toward a new object.

- **Countertransference:** is a condition where the therapist, as a result of the therapy sessions, begins to transfer the therapist's own unconscious feelings to the patient.

Treatment of Personality Disorders

- Traditionally, personality disorders have been considered to be extremely difficult to treat.
- The first problem of treating personality disorders is that treatment is required for comorbid disorders in Axis I of DSM.
- Even treatment of disorders in Axis I are difficult because people with a disorders in Axis I and Axis II are more seriously disturbed.
- In some cases, it is a widely held belief that treatment is useless.

Treatment continued…

- Admittedly, the traits that characterise personality disorders are probably too ingrained to change thoroughly.
- Although a thorough change can be seen as a non-realistic objective, with treatment a disorder can be **turned into a style**, or can endow the patient with resources to adopt **a more adaptative way of approaching life** (Millon, 1996).

Treatment Continued…

- Intensive and extensive therapy have been shown to successfully improve the life style of people that suffer personality disorders.
- This evidence comes from research on two of the disorders that have been traditionally considered as untreatable:
  - Borderline Personality Disorder
  - Psychopathy

Final Points

- Most patients with PD seek behavioral health services at urging of family or employer or for Axis I problems
- 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

Final Points

- Constantly strive for empathy and to understand the pt's behavior
  - while the behavior is often maladaptive, the patient's goal is to minimize internal distress & to meet personal needs
  - survival mechanism
- New behavior can be learned! Have patience

Questions/ Comments?