Personality Disorders

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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
<table>
<thead>
<tr>
<th>Condition</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia or Psychotic disorder NOS</td>
<td>Persistent psychotic symptoms, more severe, change in functioning</td>
</tr>
<tr>
<td>Organic brain disorder</td>
<td>Change in functioning</td>
</tr>
<tr>
<td>Autism or Asperger’s</td>
<td>Language difficulties, stereotyped behaviors/interests, more severely impaired social functioning/awareness</td>
</tr>
<tr>
<td>Drug-induced psychosis</td>
<td>Hx of substance use, change in functioning</td>
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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.
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).
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?