Psychiatry 5th year

Chapter 6: Personality Disorders

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A personality disorder is **a way of thinking, feeling and behaving that deviates from the expectations of the culture, causes distress or problems functioning**

Personality disorder criteria:

(CAPRI) 2 or more

Cognition

Affect

Personal relation (Interpersonal Function)

Impulse control

The pattern:

- Is pervasive and inflexible in a broad range of situations.
- Is stable and has an onset no later than adolescence or early adulthood.
- Leads to significant distress in functioning.
- Is not accounted for by another mental/ medical illness or by use of a substance.

- **They are pervasive, maladaptive, and cause significant impairment in social or occupational functioning.**
- Biological, genetic, and psychosocial factors during childhood and adolescence contribute to the development of personality disorders
- prevalence of personality disorders is ~~6–11%~~. (New version: 7-12%)
- The prevalence of some personality disorders in monozygotic twins is several times higher than in dizygotic twins
- **Patients with personality disorders often lack insight about their problems; their symptoms are either ego-syntonic or viewed as immutable.**
- **In addition, individuals with personality disorders have significant comorbidity with other mental disorders.**

TREATMENT

- Personality disorders are generally very difficult to treat, especially since few patients are aware that they need help. The disorders tend to be chronic and lifelong
- In general pharmacologic treatment has limited usefulness except in treating comorbid mental conditions
- Psychotherapy is usually the most helpful

Types of Personality Disorders

Familial association with psychotic disorders.

CLUSTER A:

Odd thinking and eccentric behavior

- ✓ Paranoid personality disorder
- ✓ Schizoid personality disorder
- ✓ Schizotypal personality disorder

Familial association with mood disorders.

CLUSTER B:

Dramatic and erratic behavior

- ✓ Antisocial personality disorder
- ✓ Borderline personality disorder
- ✓ Histrionic personality disorder
- ✓ Narcissistic personality disorder

Familial association with Anxiety disorders.

CLUSTER C:

Severe anxiety and fear

- ✓ Avoidant personality disorder
- ✓ Dependent personality disorder
- ✓ Obsessive-compulsive disorder

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TABLE 6-1. Cluster A Personality Disorders and Classic Clinical Examples	
Personality Disorder	**Clinical Example**
Paranoid personality disorder	A 30-year-old man says his wife has been cheating on him because he does not have a good enough job to provide for her needs. He also claims that on his previous job, his boss laid him off because he did a better job than his boss. He has initiated several lawsuits. He believes the neighbors are critical of him. He refuses couples therapy because he is certain the therapist will side with his wife.
Schizoid personality disorder	A 45-year-old scientist works in the lab most of the day and, according to his coworkers, has no friends. He is at risk of losing this job because of a failure to collaborate with others. He expresses no desire to make friends and is content with his single life. He has no evidence of a thought disorder.
Schizotypal personality disorder	A 35-year-old man dresses in a wizard costume every weekend with friends as part of a live action role-playing community. He spends a great deal of time on his computers set up in his basement for video games and to "detect the presence of extraterrestrial communications in space." He has no auditory or visual hallucinations. He is lonely and sad, feels ostracized by others, and desires an intimate relationship.

PARANOID PERSONALITY DISORDER (PPD)

Is a mental health condition marked by a pattern of distrust and suspicion of others without adequate reason to be suspicious. People with PPD are always on guard believing that others are trying to harm them

They tend to blame their own problems on others and seem angry and hostile.

They are often characterized as being pathologically jealous, which leads them to think that their sexual partners or spouses are cheating on them.

DIAGNOSIS AND DSM-5 CRITERIA

At least four of the following must also be present:

1. Suspicion (without evidence) that others are exploiting him or her
2. Preoccupation with doubts of loyalty or trustworthiness of friends or acquaintances
3. Reluctance to confide in others
4. Interpretation of benign remarks as threatening or demeaning
5. Persistence of grudges
6. Perception of attacks on his or her character that is not apparent toothers; quick to counterattack
7. Suspicions regarding fidelity of spouse or partner

EPIDEMIOLOGY

- Prevalence: ~~2–4%~~ **New Version: 1- 4%**
- More commonly diagnosed in men than in women
- Higher incidence in family members of schizophrenics
- **This personality disorder may be misdiagnosed in minority groups, immigrants, and deaf individuals.**

DIFFERENTIAL DIAGNOSIS

- *Schizophrenia:* Unlike patients with schizophrenia, patients with PPD *do not have any fixed delusions and are not frankly psychotic,* although they may have transient psychosis under stressful situations.

- *Social disenfranchisement and social isolation:* Without a social support system, individuals can react with suspicion to others. The differential in favor of PPD can be assisted by collateral history from others in close contact with the person, who may identify what they consider as excess suspicion.

TREATMENT

- Psychotherapy is the treatment of choice
- Group psychotherapy should be avoided due to mistrust
- antipsychotics for transient psychosis

SCHIZOID PERSONALITY DISORDER

People with schizoid personality disorder have a lifelong pattern of indifference toward others and social isolation and They are quiet and have a constricted affect

A pattern of voluntary social withdrawal and restricted range of emotional expression, beginning by early adulthood and present in a variety of contexts.

Course: **Usually chronic course.**

DIAGNOSIS AND DSM-5 CRITERIA

Four or more of the following must also be present:

1. Neither enjoying nor desiring close relationships
2. Generally choosing solitary activities
3. Little interest in sexual activity with another person
4. Taking pleasure in few activities
5. Few close friends
6. Indifference to praise or criticism
7. Emotional coldness detachment or flattened affect

EPIDEMIOLOGY

- Prevalence: 3–5%
- Diagnosed more often in men than women
- May be increased prevalence of schizoid personality disorder in relativesof individuals with schizophrenia

DIFFERENTIAL DIAGNOSIS

- ***Schizophrenia:*** Unlike patients with schizophrenia, patients with Schizoid *do not have overt psychotic symptoms such as delusions or hallucinations*

- ***Schizotypical personality disorder :*** Patients with schizoid personality disorder do not have the same eccentric behavior or magical thinking seen in patients with schizotypal personality disorder. Schizotypal patients are more similar to schizophrenic patients in terms of odd perceptions, thought, and behavior.

TREATMENT

- Antidepressants if comorbid major depression is diagnosed
- **Lack insight for individual psychotherapy, and may find group therapy threatening; may benefit from day programs or drop-in centers.**

SCHIZOTYPAL PERSONALITY DISORDER

People with schizotypal personality disorder have **odd behavior speech patterns thoughts and perceptions**

The disorder was developed out of the observation that certain family traits predominate in first-degree relatives of those with schizophrenia.

DIAGNOSIS AND DSM-5 CRITERIA

- Five or more of the following must be present:

1. Ideas of reference
2. Odd beliefs or magical thinking
3. Unusual perceptual experiences (such as bodily illusions)
4. Suspiciousness
5. Inappropriate or restricted affect
6. Odd or eccentric appearance
7. Few close friends
8. Odd thinking or speech
9. Excessive social anxiety

Epidemiology

Prevalence: 4%.

Differential Diagnosis

- *Schizophrenia:* Unlike patients with schizophrenia, patients with schizotypal personality disorder are not frankly psychotic (though they can become transiently so under stress), nor do they have delusions.
- *Schizoid personality disorder:* Patients with schizoid personality disorder do not have the same eccentric behavior seen in patients with schizotypal personality disorder.

Course

- Course is chronic, with a small minority developing schizophrenia.
- Premorbid personality type for a patient with schizophrenia.

TREATMENT

- Psychotherapy is the treatment of choice to help develop social skills training
- Short course of low-dose antipsychotics if necessary

TABLE 6-2. Cluster B Personality Disorders and Classic Clinical Examples	
Personality Disorder	**Clinical Example**
Antisocial personality disorder	A 30-year-old unemployed man has been accused of killing three senior citizens after robbing them. He is surprisingly charming in the interview. In his adolescence, he was arrested several times for stealing cars and assaulting other kids.
Borderline personality disorder	A 23-year-old medical student attempted to cut her wrist because things did not work out with a man she had been dating over the past 3 weeks. She states that guys are jerks and "not worth her time." She often feels that she is "alone in this world."
Histrionic personality disorder	A 33-year-old provocatively dressed woman comes to your office complaining that her fever feels like "she is burning in hell." She vividly describes how the fever has affected her work as a teacher but displays superficial expressions of emotion.
Narcissistic personality disorder	A 48-year-old company CEO is rushed to the ED after an automobile accident. He does not let the residents operate on him and requests the Chief of trauma surgery as he is "vital to the company." He makes several business phone calls in the ED to stay on "top of his game."

ANTISOCIAL PERSONALITY DISORDER

People with antisocial personality disorder have a long-term pattern of manipulating exploiting or violating the rights of others without any remorse or empathy.

Regret

Course

- Usually has a chronic course, but some improvement of symptoms may occur as the patient ages.
- Many patients have multiple somatic complaints, and coexistence of substance use disorders and/or major depression is common.
- There is increased morbidity from substance use, trauma, suicide, or homicide.

KEY FACT

Antisocial personality disorder begins in childhood as conduct disorder. Patient may have a history of being abused (physically or sexually) as a child or a history of hurting animals or starting fires. It is often associated with violations of the law.

DIAGNOSIS AND DSM-5 CRITERIA

(Three or more)

1. Failure to conform to social norms by committing unlawful acts
2. Deceitfulness/repeated lying/manipulating others for personal gain
3. failure to plan ahead
4. Irritability and aggressiveness
5. Recklessness and disregard for safety of self or others
6. Irresponsibility/failure to sustain work or honor financial obligations
7. Lack of remorse for actions

- **Pattern of disregard for and violation of the rights of others since age 15.**
- **Patients must be at least 18 years old for this diagnosis; history of behavior as a child/adolescent must be consistent with conduct disorder**

EPIDEMIOLOGY

- Prevalence: 3% in men and 1% in women
- Males with alcoholic parents are at increased risk
- **Prevalence: 1–4% of the general population.**
- **Males are three to five times as likely to be diagnosed as women.**
- **There is a higher incidence in poor urban areas and in prisoners but no racial difference.**
- **Genetic component: Increased risk among first-degree relatives.**

TREATMENT

- Psychotherapy is generally ineffective
- Pharmacotherapy may be used to treat symptoms of anxiety or depression

Differential Diagnosis

Substance use disorder: *It is necessary to ascertain which came first. Patients who began abusing drugs before their antisocial behavior started may have behavior attributable to the effects of their addiction.*

BORDERLINE PERSONALITY DISORDER (BPD)

People with BPD have extreme mood swings unstable relationships and trouble controlling their emotions

The name borderline comes from the patient's being on the borderline of neurosis and psychosis

They are impulsive and may have a history of repeated suicide attempts/gestures or episodes of self-mutilation. They have higher rates of childhood physical, emotional, and sexual abuse than the general population

DIAGNOSIS AND DSM-5 CRITERIA

At least five of the following must be present:

1. Frantic efforts to avoid real
2. Unstable intense interpersonal relationships
3. Unstable self-image
4. Impulsivity in at least two potentially harmful ways
5. Recurrent suicidal threats
6. Unstable mood/affect
7. Chronic feelings of emptiness
8. Difficulty controlling anger
9. Transient stress-related paranoid ideation or dissociative symptoms

EPIDEMIOLOGY

- Prevalence Up to 6%
- Diagnosed three times more often in women than men
- Suicide rate10%

Course

- Variable, but many develop stability in middle age.
- High incidence of coexisting major depression and/or substance use disorders.
- Increased risk of suicide.

TREATMENT

Mood stabilizers and low-dose antipsychotic medications have been found to be more effective than antidepressants in the treatment of mood swings/lability

- Dialectical behavior therapy (DBT) is the treatment of choice
- psychotherapies found to be beneficial include mentalization-based therapy transference-focused therapy and schema-focused therapy
- Pharmacotherapy (e.g., mood stabilizers, antipsychotics, antidepressants)

Differential Diagnosis

- *Schizophrenia:* Unlike patients with schizophrenia, patients with BPD do not have frank psychosis (may have transient psychosis, however, if they decompensate under stress or substances of abuse).
- *Bipolar I/II:* Mood swings experienced in BPD are rapid, brief, moment-to-moment reactions to perceived environmental or psychological triggers.

HISTRIONIC PERSONALITY DISORDER (HPD)

Patients with histrionic personality disorder (HPD) exhibit attention-seek- ing behavior and excessive emotionality and they are dramatic

Differential Diagnosis

BPD: Patients with BPD are more likely to suffer from depression, brief psychotic episodes, and to attempt suicide. HPD patients are generally more functional.

Course: Usually chronic, with some improvement of symptoms with age.

DIAGNOSIS AND DSM-5 CRITERIA

At least five of the following must be present:

1. Uncomfortable when not the center of attention
2. Inappropriately seductive or provocative behavior
3. Rapidly shifting but shallow expression of emotion
4. Uses physical appearance to draw attention to self
5. Speech that is impressionistic and lacking in detail
6. Theatrical and exaggerated expression of emotion
7. Easily influenced by others
8. Perceives relationships as more intimate than they actually are

EPIDEMIOLOGY

- Prevalence 2%
- Women are more likely to have HPD than men

TREATMENT

- Psychotherapy (e.g., supportive, problem-solving, interpersonal, group) is the treatment of choice
- Pharmacotherapy to treat associated depressive or anxious symptoms

NARCISSISTIC PERSONALITY DISORDER (NPD)

is a mental condition in which people have an inflated sense of their own importance a deep need for excessive attention and admiration troubled relationships and a lack of empathy for others

NARCISSISTIC PERSONALITY DISORDER (NPD)

Epidemiology

Prevalence: Approximately 6%.

Differential Diagnosis

Antisocial personality disorder: Both types of patients exploit others, but NPD patients want status and recognition, while antisocial patients want material gain or simply the subjugation of others. Narcissistic patients become depressed when they don't get the recognition they think they deserve.

Course

Usually has a chronic course; higher incidence of depression and midlife crises since these patients put such a high value on youth and power.

DIAGNOSIS AND DSM-5 CRITERIA

Five or more of the following must be present:

1. Exaggerated sense of self-importance
2. Preoccupation with fantasies of unlimited money success
3. Believes that he or she is “special” or unique and can associate onlywith other high-status individuals
4. Requires excessive admiration
5. Has sense of entitlement
6. Takes advantage of others for self-gain
7. Lacks empathy
8. Envious of others or believes others are envious of him or her
9. Arrogant or haughty

TREATMENT

- Psychotherapy is the treatment of choice

TABLE 6-3. Cluster C Personality Disorders and Classic Clinical Examples	
Personality Disorder	**Clinical Example**
Avoidant personality disorder	A 30-year-old postal worker rarely goes out with her coworkers and often makes excuses when they ask her to join them because she is afraid they will not like her. She wishes to go out and meet new people but, according to her, she is too "shy."
Dependent personality disorder	A 40-year-old man who lives with his parents has trouble deciding how to get his car fixed. He calls his father at work several times to ask very trivial things. He has been unemployed over the past 3 years. He has been in several long-term but abusive relationships.
Obsessive-compulsive personality disorder	A 40-year-old secretary has been recently fired because of her inability to prepare some work projects in time. According to her, they were not in the right format and she had to revise them six times, which led to the delay. This has happened before but she feels that she is not given enough time to "get it perfect."

AVOIDANT PERSONALITY DISORDER

Patients with avoidant personality disorder have a pervasive pattern of social inhibition and an intense fear of rejection

Their fear of rejection is so overwhelming that it affects all aspects of their lives

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Course

- Course is usually chronic, although may remit with age.
- Particularly difficult during adolescence, when attractiveness and socialization are important.
- Increased incidence of associated anxiety and depressive disorders.
- If support system fails, patient is left very susceptible to depression, anxiety, and anger.

DIAGNOSIS AND DSM-5 CRITERIA

At least four of the following must be present:

1. Avoids occupation that involves interpersonal contact due to a fear of rejection
2. Unwilling to interact unless certain of being liked
3. Cautious of interpersonal relationships
4. Preoccupied with being criticized or rejected in social situations
5. Inhibited in new social situations
6. Believes he or she is socially inept and inferior
7. Reluctant to engage in new activities for fear of embarrassment

EPIDEMIOLOGY

- Prevalence 2.4%
- Equally frequent in males and females

KEY FACT

Schizoid patients *prefer* to be alone. Avoidant patients want to be with others but are too scared of rejection.

Differential Diagnosis

Schizoid personality disorder: Patients with avoidant personality disorderdesire companionship but are extremely shy, whereas patients with schizoid personality disorder have little or no desire for companionship.

Social anxiety disorder (social phobia): Both involve fear and avoidance of social situations. If the symptoms are an integral part of the patient's personality and have been evident since adolescence, personality disorder is the more likely diagnosis. Social anxiety disorder involves a fear of embarrassment in a particular setting (speaking in public, urinating in public, etc.), whereas avoidant personality disorder is an overall fear of rejection and a sense of inadequacy. However, a patient can have both disorders concurrently and should carry both diagnoses if criteria
for each are met.

Dependent personality disorder: Avoidant personality disorder patients cling to relationships, similar to dependent personality disorder patients; however, avoidant patients are slow to get involved, whereas dependent patients actively and aggressively seek relationships.

TREATMENT

- Psychotherapy including assertiveness and social skills training is most effective
- Group therapy may also be beneficial
- Selective serotonin reuptake inhibitors (SSRIs) may be prescribed for comorbid social anxiety disorder or major depression

DEPENDENT PERSONALITY DISORDER (DPD)

Patients with dependent personality disorder (DPD) have poor self-confidence and fear of separation

Differential Diagnosis

- *Avoidant personality disorder:* See discussion above.
- *BPD and HPD:* Patients with DPD usually have a long-lasting relationship with one person on whom they are dependent. While patients with borderline and histrionic personality disorders are often dependent on other people, they are unable to maintain long-lasting relationships.

Course

- Usually has a chronic course.
- Patients are prone to depression, particularly after loss of person on whom they are dependent.
- Difficulties with employment since they cannot act independently or without close supervision.

DIAGNOSIS AND DSM-5 CRITERIA

At least five of the following must be present:

1. Difficulty making everyday decisions without reassurance from others
2. Needs others to assume responsibilities for most areas of his or her life
3. Difficulty expressing disagreement because of fear of loss of approval
4. Difficulty initiating projects because of lack of self-confidence
5. Goes to excessive lengths to obtain support from others
6. Feels helpless when alone
7. Urgently seeks another relationship when one ends
8. Preoccupied with fears of being left to take care of self

EPIDEMIOLOGY

- Prevalence Approximately <1%
- Women are more likely to be diagnosed with DPD than men
- Childhood medical illness or separation anxiety disorder may increase thelikelihood of developing DPD

TREATMENT

- Psychotherapy particularly cognitive-behavioral assertiveness and social skills training is the treatment of choice
- Pharmacotherapy may be used to treat associated symptoms of anxiety or depression

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER (OCPD)

Patients with obssesive-compulsive personality disorder (OCPD) have a pervasive pattern of perfectionism inflexibility and orderliness

They become so preoccupied with unimportant details that they are often unable to complete simple tasks in a timely fashion. They appear stiff, serious, and formal, with constricted affect. They are often successful professionally but have poor interpersonal skills.

DIAGNOSIS AND DSM-5 CRITERIA

At least four of the following must be present:

1. Preoccupation with details, rules, lists, and organization
2. Perfectionism that is detrimental to completion of task
3. Excessive devotion to work
4. Excessive conscientiousness and scrupulousness about morals
5. Will not delegate tasks
6. Unable to discard worthless objects
7. Miserly spending style
8. Rigid and stubborn

EPIDEMIOLOGY

- Prevalence 2–7%
- Men are two times more likely to have OCPD than women

Differential Diagnosis

- *Obsessive-compulsive disorder (OCD):* Patients with OCPD do not have the recurrent obsessions or compulsions that are present in OCD. In addition, the symptoms of OCPD are **ego-syntonic** rather than ego-dystonic (as in OCD); OCD patients are aware that they have a problem and wish that their thoughts and behaviors would go away.
- *NPD:* Both disorders entail assertiveness and achievement, but NPD patients are motivated by status, whereas OCPD patients are motivated by perfectionism and the work itself.

Course

- Unpredictable course.
- A significant number have comorbid OCD (most do not, however).

TREATMENT

- Psychotherapy is the treatment of choice
- Pharmacotherapy may be used to treat associated symptoms

PERSONALITY CHANGE DUE TO ANOTHER MEDICAL CONDITION

This refers to a persistent personality change from a previous pattern due to the direct pathophysiological result of a medical condition (e.g., head trauma, stroke, epilepsy, central nervous system infection, or neoplasm). Subtypes include labile, disinhibited, aggressive, apathetic, or paranoid.

OTHER SPECIFIED PERSONALITY DISORDER

This diagnosis is reserved for a personality disorder that does not meet the full criteria for any of the disorders, but where the clinician *chooses* to communicate the specific reason that the presentation does not meet the criteria for any specific personality disorder (e.g., "mixed personality disorder").

UNSPECIFIED PERSONALITY DISORDER

This diagnosis is used for a personality disorder that does not meet the full criteria for any of the disorders, but where the clinician chooses *not* to specify the reason that the criteria are not met for any specific personality disorder (e.g., not enough information to make a more specific diagnosis).

Thank you