

Personality Disorders

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- each of us has repertoire (formed in childhood!) of coping devices or defenses that allows us to maintain equilibrium between our internal drives and world around us; this repertoire is personality.

Coping Mechanisms:

Projection - attribution of person's unacknowledged feelings to other people.

Splitting - black-or-white, all-or-nothing perceptions or thinking, in which people are divided into all-good idealized saviors or all-bad evildoers.

Acting out - direct behavioral expression of unconscious wish or impulse that enables person to avoid being conscious of accompanying painful or pleasurable effect (e.g. self-mutilation).

Turning aggression against self - turning angry feelings toward other people toward self; when indirect, called *passive aggression*, when direct, called *self-mutilation*.

Fantasy - tendency to use imaginary relationships and private belief systems to resolve conflict and relieve loneliness.

Hypochondriasis - use of physiologic complaints to gain attention.

Regression - retreat to earlier defenses.

PERSONALITY - enduring pattern of distinctive traits and tendencies that characterize individual's reaction to specific circumstances.

PERSONALITY DISORDER is present when personality traits are **inflexible**, **immature** and **maladaptive**, causing either significant **subjective distress** or **impairment in** social or occupational **functioning**.

- personality disorders are classified as **Axis II disorders** (as opposed to Axis I classification of more overt major psychiatric disorders).
- personality disorders affect **interpersonal relationships** more than **intrapsychic symptoms of single individual** (as in Axis I disorders).

Characteristics of **type A personality** (twice risk for coronary artery disease!):

1. Competitiveness, ambition, drive for success
2. Impatience, sense of time urgency
3. Abruptness of speech and gesture
4. Hostility

DEFINITIONS, CLINICAL FEATURES

PERSONALITY DISORDER - enduring (lifelong) pattern of inner experience and behavior that **differs markedly from expectations of individual's culture**.

PERSONALITY DISORDER - long-standing, pervasive, inflexible*, and **maladaptive pattern of perceiving and responding** to other people and to stressful circumstances.

*but behavior is often unpredictable

→ wide-ranging problems in **social relationships** and **mood regulation**.

N.B. disorder occurs in all settings (e.g. social as well as vocationally) - not limited to one sphere of activity!

- affect **10-15% of adult US population**.
- **onset** in early adulthood.
N.B. personality disorders should not be diagnosed in children and adolescents because personality development is not complete! (rule of thumb is that personality diagnosis cannot be made until person is **at least 18 years**)
- **course** - **stable over time**.
cluster A and B disorders tend to become less severe in middle age and late life.
cluster C disorders tend to become exaggerated in later life.
- individuals may have more than one personality disorder!
- higher risk than general population for many **comorbid Axis I psychiatric disorders** (esp. mood disorders and substance abuse).
 - Axis I disorders make assessment of personality disorder more difficult.
e.g. diagnosis of personality disorder should not be made in person with schizophrenia unless personality disorder clearly preceded onset of schizophrenia
- patients tolerate stress poorly (they seek help to alleviate outside stress rather than to change their character).

Psychological tests (none has been reliably validated against *DSM-IV* diagnoses):

1. **Minnesota Multiphasic Personality Inventory** (MMPI)
 2. **Eysenck Personality Inventory** and **Personality Diagnostic Questionnaire**.
- often, physicians suspect personality disorder based on their own discomfort, typically if they begin to feel angry or defensive.

CATEGORICAL CLASSIFICATION

- 10 personality disorders (grouped into 3 clusters) are defined in *DSM-IV*:

CLUSTER A (ODD, ECCENTRIC)

Use defense mechanisms of projection and fantasy and may have tendency toward psychotic thinking (i.e. vulnerability to cognitive disorganization when stressed).

Paranoid personality disorder (0.5-2.5% of general population) - pervasive **distrust and suspiciousness** → coldness and distancing in relationships.

- common beliefs:
 - 1) others are exploiting or deceiving person.
 - 2) friends and associates are untrustworthy.
 - 3) information confided to others will be used maliciously.
 - 4) there is hidden meaning in remarks or events others perceive as benign.
 - 5) spouse or partner is unfaithful.
- patients hold grudges (about insults, slights, etc).
- usually work efficiently but in relative isolation.
- patients tend to group themselves in esoteric religions and pseudoscientific and quasipolitical groups.
- may appear as prodrome to delusional disorder or frank schizophrenia.

Schizoid personality disorder (uncommon) - person is **markedly detached from others** and has **little desire for close relationships**.

- live solitary life; little, if any, interest in having sexual experiences with another person.

- enjoyment of few, if any, activities (prefer theoretical speculation to practical action).
- patient appears indifferent to praise or criticism of others and often seems cold or aloof.
- may develop major depression.

Schizotypal personality disorder (3% men, 1% women in general population) - marked *eccentricities of thought, perception, and behavior* (i.e. "strange" or "odd" behavior, appearance, thinking).

N.B. peculiarities are not so severe to be termed schizophrenic, and there is no history of psychotic episodes.

- typical examples:
 - 1) ideas of reference (believing that public messages are directed personally at them)
 - 2) odd beliefs or magical thinking
 - 3) vague, circumstantial, or stereotyped speech
 - 4) excessive social anxiety that does not diminish with familiarity (associated with paranoid fears rather than negative judgments about self).
 - 5) idiosyncratic perceptual experiences or bodily illusions
- like schizoid personality, involves social withdrawal and emotional coldness.
- muted expression of genes that cause schizophrenia (patients may develop brief psychotic disorder, schizophreniform disorder, or delusional disorder).
- 30-50% have concurrent major depression.

CLUSTER B (DRAMATIC, EMOTIONAL, UNSTABLE)

Poor impulse control, dramatic and unstable characteristics!

Antisocial personality disorder (3% men, 1% women in general population) - disregard for and *violation of RIGHTS OF OTHERS and RULES OF SOCIETY* (i.e. lifelong inability to conform to social norms)

- onset with conduct disorder before age 15 years (conduct disorder is childhood pattern of antisocial and oppositional behavior).
- includes following features:
 - 1) repeated violations of law
 - 2) pervasive lying and deception
 - 3) physical aggressiveness
 - 4) reckless disregard for safety of self or others
 - 5) consistent irresponsibility in work and family environments
 - 6) do not anticipate consequences of their behaviors and typically do not feel remorse or guilt afterward.
- terms "**sociopath**" and "**psychopath**" are applied to particularly deviant antisocial personalities.
- risk for anxiety disorders, substance abuse, somatization disorder, and pathological gambling.
- impulsivity may lead to fights, suicide attempts, or other injuries (ED is common site of interaction between physicians and antisocial personality).

Borderline personality disorder (1% men, 3% women in general population) - *unstable interpersonal relationships, self-perception, moods; markedly impaired impulse control* (patients transiently may appear psychotic because of intensity of their distortions).

– term "borderline" originated with concept that this disorder was *on border between neurosis and psychosis*.

- one of most commonly overused diagnoses in *DSM-IV*.
- diagnostic criteria require at least 5 of following features:
 - 1) frantic efforts to avoid expected abandonment
 - 2) unstable but intense interpersonal relationships (alternate between extremes of idealization and devaluation)
 - 3) markedly and persistently unstable self-image
 - 4) impulsivity in at least 2 areas that are potentially self-damaging (e.g. sex, substance abuse, reckless driving, spending, binge eating)
 - 5) recurrent suicidal behaviors or threats or self-mutilation
Motivation for self-mutilating act is not adopting sick role but rather relieving psychological distress
 - 6) affective instability
 - 7) chronic feelings of emptiness
 - 8) inappropriate and intense anger
When patients fear loss of caring person, they frequently express inappropriate and intense anger
 - 9) transient paranoia or dissociation
In severe cases, psychotic features may appear in response to stress
- 90% patients also have one other psychiatric diagnosis, and 40% have two other diagnoses: substance abuse, eating disorders (particularly bulimia), posttraumatic stress disorder, suicide!

Histrionic personality disorder (2-3% of general population; women >> men*) - *excessive emotionality and attention-seeking behavior* (i.e. attempts to be center of attention through use of theatrical and self-dramatizing behavior).

– formerly called "hysterical personality," but term was discarded because of many meanings of word "hysterical".

*men who exhibit similar behavior patterns are often diagnosed as narcissistic

- indicated by at least 5 of following:
 - 1) discomfort in situations in which she is not **center of attention**.
 - 2) interaction with others that is often characterized as **inappropriately sexually seductive or provocative**.
 - 3) **insincere affect** (i.e. rapidly shifting and shallow emotions)
 - 4) consistent **use of physical appearance to draw attention** to herself.
 - 5) **speech that is excessively impressionistic** and lacking in detail.
 - 6) **self-dramatization**, with theatrical and exaggerated expression of emotion.
 - 7) **suggestibility** (i.e. easily influenced by others or circumstances).
 - 8) **exaggeration of importance** of relationships and acquaintances.
- tendency to vague and impressionistic speech.
- patients are quite dramatic and often sexually provocative or seductive, overly concerned with their appearance (patients tend to eroticize any relationship).
- emotions are labile.
- may display *la belle indifférence* (seemingly indifferent detachment while describing dramatic physical symptoms).
- associated particularly with *somatoform disorders*.

Behind seductive behaviors and exaggeration of somatic problems (i.e. hypochondriasis) often lie more basic wishes for dependency and protection

Narcissistic personality disorder (< 1% of general population; 50-75% patients are male) - patients are *grandiose* and *require admiration from others*.

- in classic model, narcissism functions as defense against awareness of low self-esteem (patients are extremely sensitive to criticism, failure, or defeat).
- particular features:
 - 1) exaggeration of their own talents or accomplishments
 - 2) sense of entitlement
 - 3) exploitation of others
 - 4) lack of empathy
 - 5) envy of others
 - 6) arrogant, haughty attitude
- risk for anorexia nervosa and substance abuse.

CLUSTER C (ANXIOUS, FEARFUL)

Avoidant personality disorder (0.5-1% of general population) - patients are *very shy* (social inhibition, feelings of inadequacy, hypersensitivity to rejection).

- unlike schizoid personality disorder, patients actually desire relationships with others but are paralyzed by their fear and sensitivity into social isolation.
- associated with *anxiety disorders* (esp. social phobia).

Dependent personality disorder - *excessive need to be taken care of* → submissive and clinging behavior, regardless of consequences.

- diagnosis requires at least 5 of following features:
 - 1) difficulty making decisions without guidance and reassurance
 - 2) need for others to assume responsibility for most major areas of person's life
 - 3) difficulty expressing disagreement with others
 - 4) difficulty initiating activities because of lack of confidence
 - 5) excessive measures to obtain nurturance and support
 - 6) discomfort or helplessness when alone
 - 7) urgent seeking for another relationship when one has ended
 - 8) unrealistic preoccupation with fears of being left to fend for themselves.
- risk for *anxiety disorders* and *adjustment disorder*.

Obsessive-compulsive personality disorder (1% of general population) - marked preoccupation with *orderliness, perfectionism, and control*.

- perfectionism + lack of flexibility interfere with efficiency (despite high focus on tasks).
- scrupulous and inflexible about matters of morality, ethics, and values beyond cultural norms.
- reluctance to delegate tasks or to work with others.
- often stingy and stubborn; unable to discard worn out or worthless objects (even when they have no sentimental value).
- patients recognize that they have problems (unlike those with other personality disorders).
- risk for myocardial infarction because of type A lifestyles.
- not at increased risk for obsessive-compulsive disorder! (and vice versa)

DIMENSIONAL CLASSIFICATION

- places various personality traits along continuum (vs. strict categories).

Dimensions of Personality:

1. **Neuroticism** - tendency toward anxiety, depression, sense of self-consciousness, and vulnerability.
 - neurotic individuals tend to be worriers, and they often magnify and augment normal somatic sensations.
 - neurotics are particularly frightened by normal side effects of treatments.
2. **Extroversion** (vs. **introversion**) - outgoing, sociable personality; - solitary and aloof personality.
3. **Agreeableness** - readiness or willingness to consent.
 - overly agreeable patients agree to all treatments suggested, but not comply.
4. **Openness** (vs. **conservativeness**) - willingness to hear and consider or to accept and deal with;
 - overly open patient may be attracted to variety of alternative therapies that have no basis for efficacy.
5. **Conscientiousness** [angl. *sążiningumas*] - organized, goal-directed behavior in completing tasks.

ETIOPATHOPHYSIOLOGY

- a) result of *dysfunctional early environments* that prevent evolution of adaptive patterns of perception, response, and defense.
- b) *genetic* and *psychobiologic* contributions.

N.B. genetic factors play major role in *PERSONALITY TRAITS*, but less certain role in *PERSONALITY DISORDERS*!

TREATMENT

Alcoholism and **drug abuse** are not merely complications, they are also aggravating factors!

Personality disorders are particularly difficult to treat!!!

Psychotherapy is at core of treatment / care for personality disorders!

- early effort should be made to get patients to see that problem is really based on who they are (i.e. to help patient to increase his awareness of dysfunctional interpersonal traits so that conscious control of their adverse effects can increase).

N.B. patients often feel that disturbance in their lives is caused by outside world – patients do not recognize that anything is wrong with them that needs to be changed (so-called “**ego-syntonic**” symptoms).
- involvement of *family members* and *friends* is helpful and often essential.
- because personality disorders produce symptoms as result of poor or limited coping skills, psychotherapy *aims to improve perceptions of and responses to social and environmental stressors*.
- treatment may extend over course of several years (repetitious confrontation in prolonged psychotherapy or by peer encounters).

Medications are in no way curative for any personality disorder.

- used (in small doses for short periods) as adjunct to psychotherapy.
- focus is on treatment of **symptom clusters** (such as cognitive-perceptual symptoms, affective dysregulation, impulsive-behavioral dyscontrol) - assumption is that neurotransmitter abnormalities underlie these symptom clusters.
- strongest evidence for pharmacologic treatment is for **borderline personality disorder**.

1. Antidepressants

- overdose risk - tricyclics and MAO inhibitors are usually not prescribed for personality disorders!
- SSRIs and newer antidepressants are safe and reasonably effective.
- because depression stems from limited range of coping capacities, antidepressants are less effective than in major depression.

2. Anticonvulsants, β -blockers, SSRI - efficacy in suppressing **impulsive** and **aggressive** behavior in patients with personality disorder.**3. Antipsychotics** – for transient psychotic periods (e.g. in borderline personality disorder) or for chronic idiosyncratic ideations of nearly psychotic proportions (e.g. in schizotypal personality disorder).

- response is less dramatic than in true psychotic Axis I disorders, but symptoms such as anxiety, hostility, and sensitivity to rejection may be reduced.

BIBLIOGRAPHY for ch. "Psychiatry" → follow this [LINK](#) >>

Viktor's NotesSM for the Neurosurgery Resident
Please visit website at www.NeurosurgeryResident.net