Introduction to Personality Disorders

The objective of this lecture is to present an overview of the ten DSM-V-TR personality disorders. Key features of each of the ten personality disorders will be highlighted.

Introduction:

Everyone has a personality or a characteristic manner of thinking, feeling, behaving, and relating to others. Some people are more shy, others more outgoing. Some people are conscientious and dependable whereas others are consistently undependable and negligent. Only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress do they constitute personality disorders.

Almost all the traits of the various personality disorders can be found in isolation or in less extreme form in many normal people. Mixtures of various personality traits even across clusters are much more common than "pure" personality disorders.

Persons with personality disorders commonly have other psychiatric disorders as well. The presence of a personality disorder generally reduces the efficacy of any treatment being provided for any comorbid conditions. Some type of psychotherapy is generally indicated for persons with personality disorders. One study of the antidepressant paroxetine demonstrated some changes in personality traits independent of antidepressant effects.

I. General Features

A. DSM V Criteria

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
   (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events)
   (2) affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
   (3) interpersonal functioning
   (4) impulse control
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

B. Key points

1. Anyone reaching the threshold for one personality disorder is likely to meet the criteria for other personality disorders, even if they are not in the same cluster
2. Genetics accounts for about 50 percent of the variance in normal personality
3. Generally not diagnosed in children, although in rare cases may be (except antisocial which cannot be diagnosed in someone under the age of 18)

C. Epidemiology

1. 15 percent of the general US population have a personality disorder.
2. In clinical settings the prevalence is typically greater than 50%
3. Paranoid, schizotypal, narcissistic, antisocial, and obsessive-compulsive personality disorders are more frequently diagnosed in men
4. Borderline, histrionic, and dependent personality disorders are more frequently diagnosed in women

D. Organization

Cluster A (Odd)	Cluster B (Dramatic)	Cluster C (Anxious)
Schizotypal	Histrionic	Avoidant
Schizoid	Narcissistic	Dependent
Paranoid	Antisocial	Obsessive-compulsive
	Borderline	

II. CLUSTER A (ODD AND ECCENTRIC)

A. ***Paranoid Personality Disorder***

1. DSM-V Criteria

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
(2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
(3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
(4) reads hidden demeaning or threatening meanings into benign remarks or events
(5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
(6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
(7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner
B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder, and is not due to the direct physiological effects of a general medical condition.
Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "paranoid personality disorder (premorbid)."

2. Etiology and Pathology

a. Genetics (heritability) contribute to traits of suspiciousness and mistrust
b. Weak genetic link with schizophrenia
c. Possible link with parental criticism and rejection

3. Differential Diagnosis

a. Paranoid ideation is not absurd, inconceivable, or bizarre
b. Mistrust is generalized rather than isolated to one area
c. Chronic course rather than episodic

4. Epidemiology and Comorbidity

a. 0.5 to 2.5 percent of the general population
b. male > female

5. Treatment

a. Atypical antipsychotic medications such as olanzapine, aripiprazole, or risperidone which target neurotransmitters such as dopamine and serotonin, may help psychotic delusions of persecution but not generalized suspiciousness
b. Neutral, nonconfrontive stance in therapy

B. ***Schizoid Personality Disorder***

1. DSM V Criteria

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) neither desires nor enjoys close relationships, including being part of a family
(2) almost always chooses solitary activities
(3) has little, if any, interest in having sexual experiences with another person
(4) takes pleasure in few, if any, activities
(5) lacks close friends or confidants other than first-degree relatives
(6) appears indifferent to the praise or criticism of others
(7) shows emotional coldness, detachment, or flattened affectivity
B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder and is not due to the direct physiological effects of a general medical condition.
Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizoid personality disorder (premorbid)."

2. Etiology and Pathology

a. Genetic links (heritability) with introversion but not schizophrenia

b. Excessively low ability to experience positive affects

3. Differential Diagnosis

a. Absence of desire for relationships key difference from avoidant personality disorder
b. Closely resembles the negative symptoms of schizophrenia, i.e., flat affect, decreased speech, poor motivation.

4. Epidemiology and Comorbidity

a. Less than 1 percent of the general population
b. One of the most rarely diagnosed personality disorders in clinical settings

5. Treatment

a. Antipsychotic medications such as olanzapine, aripiprazole, or risperidone are typically not beneficial
b. Social skills training and supportive psychotherapy

C. ***Schizotypal Personality Disorder***

1. DSM-V Criteria

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
(1) ideas of reference (excluding delusions of reference)
(2) odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
(3) unusual perceptual experiences, including bodily illusions
(4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
(5) suspiciousness or paranoid ideation
(6) inappropriate or constricted affect
(7) behavior or appearance that is odd, eccentric, or peculiar
(8) lack of close friends or confidants other than first-degree relatives
(9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self
B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder.
Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizotypal personality disorder (premorbid)."

2. Etiology and Pathology

a. Strong genetic link with schizophrenia
b. Signs of central nervous system dysfunction:

i. Impaired smooth pursuit eye movements
ii. Abnormalities in galvanic skin orienting responses and evoked potential responses
iii. Increased ventricular-brain ratio on brain imaging
iv. Smaller superior temporal gyrus

3. Differential Diagnosis

a. Closely resembles the prodromal or residual phases of schizophrenia where psychotic symptoms are present in an attenuated form
b. Key is no deterioration of functioning

4. Epidemiology and Comorbidity

a. 3 percent of the general population
b. male > female
c. 10-20% develop schizophrenia

5. Treatment

a. Antipsychotic medications such as olanzapine, aripiprazole, or risperidone are beneficial
b. Social skills training and supportive psychotherapy

III. CLUSTER B (DRAMATIC –EMOTIONAL – ERRATIC)

Patients with cluster B traits are commonly seen in clinical and forensic settings. They consume a disproportionate share of clinical and legal resources. The most common personality disorder that I see in my clinical practice is ***Borderline Personality Disorder.*** *The most common personality disorders that I see in my forensic practice are* ***Paranoid, Borderline*** *and* ***Antisocial Personality Disorders.***

A. *Antisocial Personality Disorder*

1. DSM-V Criteria

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as

indicated by three (or more) of the following:
(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.
C. There is evidence of conduct disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.

2. Etiology and Pathology

a. Twin, family, adoption studies support strong genetic component
b. Low MAO-A activity combined with childhood maltreatment increases risk of violent behavior
c. Hyporeactive electrodermal responses associated with deficits in anticipatory anxiety and worrying
d. Smaller prefrontal cortex and amygdala

3. Differential Diagnosis

a. Psychopathy Checklist –Revised (PCL-R)
b. Women often misdiagnosed as histrionic or borderline
c. Male borderlines may be misdiagnosed as antisocial

4. Epidemiology and Comorbidity

a. 3-6% in males, 1% in females
b. High risk for substance-related disorders

5. Treatment

a. Most difficult personality disorder to treat
b. Mood stabilizers (Lithium, valproate, carbamazepine) may help curb impulsive aggression
c. Prolonged incarceration may be only solution as antisocial behavior does decline significantly after age 40

B. ***Borderline Personality Disorder***

1. DSM-V Criteria

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity

beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
(1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
(3) identity disturbance: markedly and persistently unstable self-image or sense of self
(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
(7) chronic feelings of emptiness
(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
(9) transient, stress-related paranoid ideation or severe dissociative symptoms

2. Etiology and Pathology

    a. Childhood abuse, neglect, and past trauma
    b. Parental conflict and abandonment
    c. Smaller hippocampi and amygdala
    d. Self mutilation is a cardinal symptom
    e. Can project their internal dysphoria onto others including treatment providers

3. Differential Diagnosis

    a. Comorbid mood disorders very common
    b. Chronicity helps to distinguish from bipolar disorder

4. Epidemiology and Comorbidity

    a. 1-2% general population
    b. 15% of psychiatric inpatients
    c. 8% of all psychiatric outpatients
    d. Mood Disorders, Posttraumatic Stress Disorder, Bulimia, Dissociative Identity Disorder, and substance abuse

5. Treatment

    a. Dialectical Behavior Therapy (manualized group and individual therapy program which combines cognitive behavioral therapy, mindfulness, and interpersonal effectiveness training)

    b. Mood stabilizers (Lithium, valproate, carbamazepine), antipsychotic medications (olanzapine, aripiprazole, risperidone) and antidepressants (sertraline, citalopram, and venlafaxine) have all been helpful in targeting specific symptoms

c. Benzodiazepines (alprazolam, diazepam, lorazepam) are best avoided due to further disinhibition

C. ***Histrionic Personality Disorder***

1. DSM-V Criteria

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
(1) is uncomfortable in situations in which he or she is not the center of attention
(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
(3) displays rapidly shifting and shallow expression of emotions
(4) consistently uses physical appearance to draw attention to self
(5) has a style of speech that is excessively impressionistic and lacking in detail
(6) shows self-dramatization, theatricality, and exaggerated expression of emotion
(7) is suggestible, i.e., easily influenced by others or circumstances
(8) considers relationships to be more intimate than they actually are

2. Etiology and Pathology

a. May share some genetic components of impulsivity and sensation-seeking with antisocial personality disorder
b. Families may reinforce attention-seeking behaviors
c. Affective instability may be associated with hyperresponsive noradrenergic system
d. Maladaptive variants of *stereotypically* feminine traits

3. Differential Diagnosis

a. Cultural bias may lead to misdiagnosis of antisocial females
b. Males may present with exaggerated masculinity

4. Epidemiology and Comorbidity

a. 1-3% general population
b. More commonly diagnosed in women

5. Treatment

a. Individual and group psychotherapy
b. Antidepressants (sertraline, citalopram, and venlafaxine) may help with intense affectivity and rejection sensitivity

D. ***Narcissistic Personality Disorder***

1. DSM-V Criteria

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
(4) requires excessive admiration
(5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
(8) is often envious of others or believes that others are envious of him or her
(9) shows arrogant, haughty behaviors or attitudes

2. Etiology and Pathology

a. Cultural factors such as Western society's emphasis on materialism instead of family and religious values
b. Parental factors ranging from unempathic and neglectful to overly idealizing stances
c. Self-esteem is dependent on success, accomplishment, or status
d. May present quietly with more internal narcissism

3. Differential Diagnosis

a. May appear to be high functioning on the surface
b. Overlap with antisocial traits = psychopathy

4. Epidemiology and Comorbidity

a. Among the least frequently diagnosed personality disorders
b. Prone to mood disorders, anorexia, and substance abuse (especially cocaine)

5. Treatment

c. Often enter treatment due to occupational and relational problems
d. Psychodynamic and other types of psychotherapy

IV. CLUSTER C (ANXIOUS-FEARFUL)

A. ***Avoidant Personality Disorder***

1. DSM-V Criteria

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation,

beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
(2) is unwilling to get involved with people unless certain of being liked
(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
(4) is preoccupied with being criticized or rejected in social situations
(5) is inhibited in new interpersonal situations because of feelings of inadequacy
(6) views self as socially inept, personally unappealing, or inferior to others
(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

2. Etiology and Pathology

a. Shyness, introversion, and social anxiousness all have substantial heritability
b. Parental overprotection and cautiousness may also contribute
c. May have excessive autonomic arousal, fearfulness, and inhibition due to
    i. Elevated peripheral sympathetic activity
    ii. Enhanced adrenocorticol responsiveness
    iii. Exaggerated amygdala activation

3. Differential Diagnosis

a. Pervasiveness distinguishes from social phobia
b. Unlike cluster A they strongly desire relationships
c. More shy than asocial

4. Epidemiology and Comorbidity

a. 1-2% general population
b. More common in clinical populations 5-25%
c. Much overlap with social phobia

5. Treatment

a. Behavioral anxiety reduction techniques
b. Anti-anxiety medications (buspirone and benzodiazepines) as well as antidepressants (sertraline, citalopram, and venlafaxine) are helpful

B. ***Dependent Personality Disorder***

1. DSM-V Criteria

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
(2) needs others to assume responsibility for most major areas of his or her life
(3) has difficulty expressing disagreement with others because of fear of loss of support or approval. **Note:** Do not include realistic fears of retribution.
(4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
(5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
(6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
(7) urgently seeks another relationship as a source of care and support when a close relationship ends
(8) is unrealistically preoccupied with fears of being left to take care of himself or herself

2. Etiology and Pathology

a. Parents may be clinging and interfere with normal separation
b. Insecure attachment and helplessness is the result

3. Differential Diagnosis

a. Dependent behavior may develop in persons with debilitating medical or psychiatric conditions
b. Dependent personality traits must be present by late childhood or early adolescence to make the diagnosis

4. Epidemiology and Comorbidity

a. 2-4% general population
b. 5-30% of patient populations
c. Vulnerable to depression

5. Treatment

a. Primary concern is avoidance of development of overdependence on treatment provider
b. Supportive group therapy

C. ***Obsessive-Compulsive Personality Disorder***

1. DSM-V Criteria

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of

the activity is lost
(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
(4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
(5) is unable to discard worn-out or worthless objects even when they have no sentimental value
(6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
(8) shows rigidity and stubbornness

2. Etiology and Pathology

    a. Obsessionality and conscientiousness are heritable
    b. A variety of psychodynamic theories have been proposed

3. Differential Diagnosis

    a. Distinct from Obsessive Compulsive Disorder (OCD)
    b. Patients can have both disorders but most do not
    c. Lacks intrusive obsessions and compulsive rituals

4. Epidemiology and Comorbidity

    a. 1-2% general population
    b. More common in males

5. Treatment

    a. Individual cognitive or psychodynamic psychotherapy
    b. Medications usually only impact comorbid psychiatric conditions

V. CONCLUSIONS:

The hallmark of a personality disorder is repetitive patterns of problematic interpersonal relationships. ***A classic sign of when one is dealing with a personality disorder is when one feels angry, frustrated, defeated, manipulated, or irritated by the patient.*** *An objective analysis of the patient's behavior can usually only be obtained when one "backs off", gains some distance, and reviews the situation with a colleague or psychiatric consultant.*