433 Teams

PSYCHIATRY

Personality Disorders

Lecture content:

- Introduction
- How to assess PD
- Definitions
- Cluster A
- Cluster B
- Cluster C
- Cases from the manual
- Summary
- MCQs
- Kaplan cases

Manual of Basic Psychiatry

Doctor's notes

Important

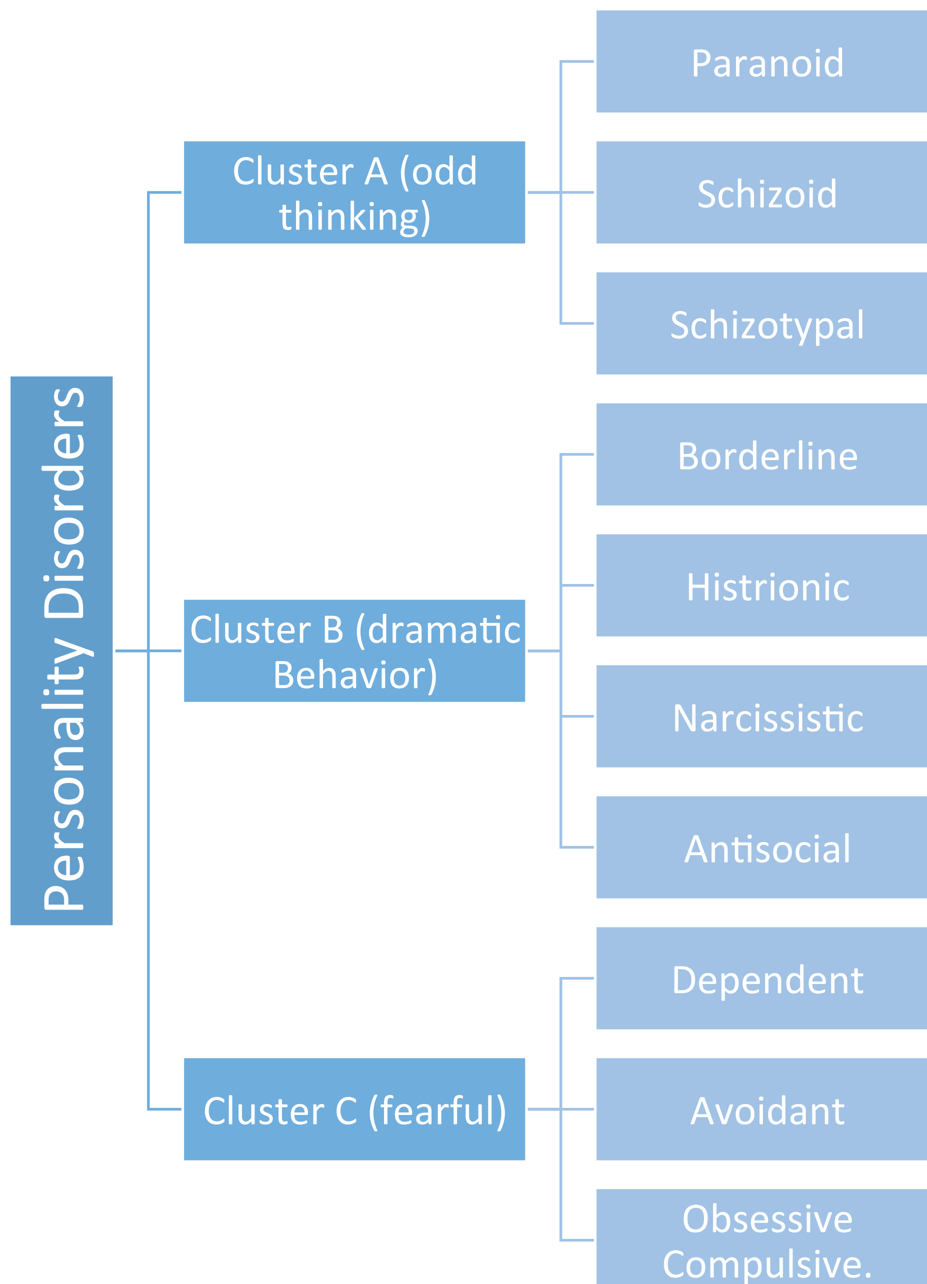
Basic Psychiatry (2nd Edition)

Toronto's Notes

Psychiatry.team433@gmail.com

جامعة الملك سعود
King Saud University

Mind Map



Introduction:

Personality is the distinctive set of characteristics that defines the emotions, thoughts, perception and behavior or an individual's personal style and influences his interactions with the environment.

The development of personality involves a complex interaction of several factors listed bellow, which come together in late adolescence and early adulthood. Factors includes:

- Biological factors (genetics, perinatal injury).
- Family environment (abuse, deprivation).
- Psychological factors (cognitive distortions).
- Social factors (poverty, migration).

The personality develop early, so the development of a change in personality in middle adulthood or later in life warrants a thorough evaluation to determine the possible presence of personality change due to a general medical condition or an unrecognized substance – related disorders.
A personality is disordered when it causes suffering to the person or to other people. Personality pathology comprises those consistent and chronic traits that persist inflexibility, are exhibited inappropriately and intensify already present difficulties.
Personality disorders by definitions is: Enduring, inflexible, pervasive patterns of behavior or inner experience that deviate markedly from the expectations of individual's culture and lead to clinically significant distress, or impairment in social or occupational functioning.
The features of a personality disorder (PD) usually become recognizable during adolescence or early adult life. Some types of PD (e.g. antisocial and borderline personality disorders) tend to become less evident or to remit with age, whereas some other types (e.g. Obsessive compulsive personality disorder) persist for long time.

How to Asses personality disorders?

The most commonly used tests are:

- Minnesota Multiphasic Personal inventory (MMPI)
- Eysenk Personality Inventory (EPI).
- Five Factor Model of Personality.

Note: Type A personality in cardiology is totally different than type A personality in psychiatry. Its not the same cluster we mean in psychiatry, in cardiology the researchers divided their research sample into 2 groups and to avoid bias they called one A and the other B.
In general the personality has pervasive pattern (A whole continuous pattern, not a situation or two)
In order to say personality we have to pay attention to the pervasive pattern.
Personality develops in the age of 18 to 21. (You can't determine if adolescents have abnormal personality or not). However there are certain traits in adolescents might indicate personality disorder in the future.

Introduction:

We can't put a scale for normal personality, Normality is not a point it is a range.

Criteria to diagnose Personality Disorders:

- ✓ Age at least 18 (personality develops fully at 18-21 years old).
- ✓ Should be pervasive
- ✓ Exclude psychiatric disorders or trauma affecting the brain including substance abuse.
- ✓ Impairment of function.

- **Group A personalities have problem with thinking.**
- **Group B personalities have problem with emotions.**
- **Group C personalities have problem with themselves.**

Definitions:

- ✓ **Personality:** refers to **Patterns** of thinking, emotion, motivation, and behavior that are activated in particular circumstances. It is enduring over one's lifetime. Personality is formed in early adulthood and relatively consistent throughout the life. However, continuous maturation & personality modification in adult life have been observed under the influence of life events, environment, learning ability, and many other factors.
- ✓ **Character:** Personal qualities that represents the individual's adherence to the value and customs of society, a moral standard is applied here.
- ✓ **Traits:** prominent enduring aspects and qualities of a person.
- ✓ **Personality disorders (PD):** *Deviation* of personality from social and cultural expectations. Lifelong pervasive **Pathological Patterns** of thinking, emotion, interpersonal functioning, and impulse control; Leads to functional impairment /significant distress.
  Age: > 18 years (21 years). -Not due to other causes (medical illness, substance abuse, ...).
- ✓ **Splitting:** Self and others are seen as all good or all bad. Because of this splitting, the good person is idealized, and the bad person devalued. Shifts of allegiance from one person or group to another are frequent. Splitting causes patients to alternately love and hate therapists and others in the environment. This defense behavior can be highly disruptive on a hospital ward and can ultimately provoke the staff to turn against the patient.
- ✓ **Denial:** Refusal to admit painful realities.
- ✓ **Projection:** Ascribe to others one's own impulses.
- ✓ **Projective identification:** Project one's impulses plus control of others as a way to control one's own impulses. Projective identification is consist of 3 steps:
  1. An unacceptable aspect of the self (e.g. hatred, rejection, envy) is projected onto someone else (the recipient e.g. a family member, a friend, a physician).
  2. The patient then tries to coerce the recipient into accepting (identifying with) what he/she has projected.
  3. Finally, both the recipient and the patient have the same idea (e.g., the recipient hates, rejects, or envies the patient). Actually it is the opposite.
- ✓ **Isolation of affect:** Thoughts stored without emotion. Intellectualization: Replace feelings with facts.
- ✓ **Fantasy:** obtaining gratification through excessive daydreams.
- ✓ **Acting Out:** Expression in action/behavior rather than in words/emotions. Patients directly express unconscious wishes or conflicts through action to avoid being conscious of either the accompanying idea or the affect. Tantrums, apparently motiveless assaults, child abuse, and pleasureless promiscuity are common examples. Repetitive self-destructive acts (e.g. drug overdose, slash their wrists) to express anger, or to elicit help from others.
- ✓ **Repression:** Involuntary forgetting of painful memories, feelings, or experiences.
- ✓ **Regression:** Subconscious return to childlike state to deal with a distressful situation.
- ✓ **Dissociation:** Disrupted perceptions or sensations, consciousness, memory, or personal identity.
- ✓ **Sexualization:** Functions or objects are changed into sexual symbols to avoid anxieties.

Cluster A

Type/ Comparison	1) Paranoid Personality Disorder "important"	2) Schizoid Personality Disorder	3) Schizotypal Personality Disorder
Features	Excessive mistrust /suspiciousness of others' motives (even friends &associates) without sufficient basis. Exaggerated bearing of grudges persistently (e.g. insults, slights, injuries). They are aggressive with words and they usually revenge. They might become criminals especially when they do drug abuse (drugs increases the paranoid level and make them act on it). They are the worst husband or wife.	Social isolation (with self- sufficiency), indifference to praise, criticism and feelings of others, choosing solitary activities and jobs, and poor social skills. Schizoid person will not complain against you as a doctor (opposite to the paranoid). Their silence doesn't mean they're okay or good, always pay attention to this.	Odd patterns of thinking, speech, belief, behavior or appearance compared to the social norms, unusual perceptual experiences (e.g. bodily illusions), superstitious thinking or claim powers of clairvoyance, and Idea of reference. International European Academy classification considers it type of schizophrenia, however American and Canadian classification still consider it a type of PD.
Differential Diagnosis	Other personality disorders and psychotic disorders.		
Coping style	Guarded and protective of their autonomy, often with arrogant belief in their own superiority.	Inner world insulated from others.	
Defense Mechanisms	**Splitting:** Self and others are seen as all good or all bad. **Denial:** Refusal to admit painful realities. **Projection:** Ascribe to others one's own impulses. **Projective identification:** Project one's impulses plus control of others as a way to control one's own impulses.	**Splitting:** Self and others are seen as all good or all bad. **Denial:** Refusal to admit painful realities. **Isolation of affect:** Thoughts stored without emotion. **Intellectualization:** Replace feelings with facts. **Fantasy:** obtaining gratification through excessive daydreams.	**Regression:** Revert to childlike thoughts, feelings, and behaviors. **Splitting:** Self and others are seen as all good or all bad. **Denial:** Refusal to admit painful realities. **Fantasy:** obtaining gratification through excessive daydreams.
Patient concerns	Exploitation and betrayal.	Violations of privacy.	Exploration of oddities.
Approach to Patient	Acknowledge complaints without arguing and honestly explain medical illness. Paranoid personality: When you have a paranoid patient always document! And don't sign on anything until you know the consequences. They like to sue.	Accept his unsociability and need for privacy. Reduce the patient's isolation as tolerated	Empathize with the patient's oddities without confrontation.
Treatment	Psychotherapy + Antipsychotics (e.g. olanzapine 10 mg).		

Cluster B

Type/ Comparison	1) Borderline Personality Disorder (BPD) "important"
Features	Diagnostic criteria: a pervasive pattern of instability in a variety of contexts, as indicated by ≥ 5 of 9; 1.Instability of affective / mood (e.g., intense dysphoria, irritability). 2.Intense frequent inappropriate anger outbursts (+/- destructive behavior, fights) 3.Instability of interpersonal relationships. 4.Impulsivity with potentially self-damaging behavior (e.g., substance abuse, reckless driving, sex). 5.Recurrent self-mutilating / suicidal behavior, gestures, or threats. 6.Unstable self-image with identity disturbance. 7. Chronic feelings of emptiness 8.Efforts to avoid abandonment. 9.Stress-related paranoid ideation. They may suddenly shift from anger to good mood, they have impulsive behavior with minimal trigger, and they might even kill someone or even themselves. Excessive emotions impair the judgment in borderline personality.
Differential Diagnosis	1.Schizophrenia: unlike patients with schizophrenia, BPD shows brief psychosis (micro-psychotic episodes; transient. However borderline might have other psychiatric disease co-existing with their PD such as schizophrenia. (short-lived, fleeting psychosis) but lack classic schizophrenic signs. 2.Schizotypal personality disorder: show marked peculiarities of thinking, strange ideation, and recurrent ideas of reference. 3.Paranoid personality disorder; BPD shows short-lived suspiciousness.
Defense Mechanisms	1. Splitting. 2. Acting out. 3.Projective identification
Treatment	For best results, pharmacotherapy + psychotherapy. **Pharmacotherapy:** 1.Antipsychotics: (e.g. olanzapine 10 mg) to control brief psychotic episodes, anger, and hostility. 2.Antidepressants (e.g. paroxetine 20 mg or any other SSRI) improve the depressed mood common in patients with borderline personality disorder. 3.Anticonvulsants (e.g. carbamazepine) have successfully modulated mood fluctuation, impulsive and destructive behavior in some patients, and may improve global functioning for some patients. 4.Benzodiazepines: although help anxiety, they may release disinhibition, hostility, and anger. **Psychotherapy:** a particular form of psychotherapy called dialectical behavior therapy (DBT) has been used for patients with borderline personality disorder, especially those with parasuicidal behavior, such as frequent cutting. DBT is eclectic (supportive, cognitive, interpersonal, and behavioral therapies). Patients are seen weekly, with the goal of identifying ambivalent feelings, tolerating frustration /rejection and decreasing self-destructive behavior.
Other Notes	**Epidemiology**: Prevalence: 2% of the population, Women: men = 2:1. **Course and Prognosis:** BPD Patients (axis II diagnosis) have a high incidence of parasuicide /suicide rates, substance abuse, and MDEs (axis I diagnosis), physical complications of their repetitive self-destructive acts (axis III diagnosis), and psychosocial problems (axis IV diagnosis). Longitudinal studies show no progression toward schizophrenia. Borderline has unstable self-image, and they are prone to over evaluation and devaluation.

Cluster B

Type/ Comparison	2) Histrionic Personality Disorder They love media and media love them "Broadcasters"	3) Narcissistic Personality Disorder "important"
Features	- Attention seeking behavior (verbal and nonverbal). They need attention (not admiration), attention is enough for them. - Excessive superficial emotions (shallow and shifting). And focus on external looks. - Self – dramatization and exaggeration. - Provocative and seductive behavior. They're seducing (either voluntary or involuntary). - Suggestibility with superficial thinking. Which might lead to complications. (A lot of marriages and divorces) - They don't have logic thinking, opposite to the paranoid they're NOT suspicious at all and they get used by other people always. They're afraid of loss of love. As a doctor you have to set limit with your patient, this personality might mistaken your kindness don't go beyond the situation with them, don't be over warm with them.	- Exaggerated self-importance and superiority. Self love at the expense of the situation and others. - Constant seeking of admiration (not only attention); (meetings, media, twitter, facebook, ...) - Preoccupation with entitlement, success and power. - Excessive and unrealistic fantasies. - Excessive concern about appearance more than essence. - With others; exploitative, envious, hypersensitive to criticism (be careful with your patients), and lacks empathy. - Fragile self-esteem. - They're smart and can lead and they might create problems.
Differential Diagnosis	1. Borderline personality disorder. 2. Narcissistic personality disorder. 3. Somatoform disorders (may co-exist as an axis I diagnosis).	1. Histrionic personality disorder. 2.Paranoid personality disorder. 3.Delusional disorders (grandiose type). **Important to differentiate them from manic episode (bipolar disorder).**
Coping Style	Emotion-driven and self-centered thinking and behavior.	Superiority and arrogance, self-aggrandizing, self-centered, self-protecting, demeaning, demanding, critical
Defense Mechanisms	**Repression:** Involuntary forgetting of painful memories, feelings, or experiences. **Dissociation:** Disrupted perceptions or sensations, consciousness, memory, or personal identity. **Sexualization:** Functions or objects are changed into sexual symbols to avoid anxieties. **Regression:** Subconscious return to childlike state to deal with a distressful situation.	**Idealization:** constant seeking to be always the best (No. 1, rank A) with self-inflation to augment self-esteem. **Projection:** bad self components (e.g. incompetence) are projected onto others and followed by devaluation.
Treatment	**Psychological treatment:** supportive and directive approaches to increase awareness of real underneath the histrionic behavior. **Pharmacological treatment:** antianxiety or antidepressant drugs may transiently be used.	They rarely seek or accept treatment as their traits are highly desired and accepted by ego (ego-syntonic) and drive to success. Episodes of anxiety or depression can be treated symptomatically.

Cluster B

Type/ Comparison	4) Antisocial Personality Disorder **"important"**
Features	[Diagnosis is not made before the age of 18]. - Violation of the rights of others and conflicts with the law. **- Lack of remorse and guilt.** - Lack of loyalty (lying, exploiting others...) - Failure to learn from experience. - Impulsive behavior & failure to plan ahead. - Tendency to violence & - Consistent irresponsibility.
Differential Diagnosis	**1.Substance abuse:** it may be comorbidity primary or secondary to antisocial behavior. 2.Mental sub normality. 3. Borderline personality disorder (coexistence is common). 4.Psychotic disorders (e.g. mania, schizophrenia...).
Coping Style	Seeks advantage, freedom, and autonomy.
Defense Mechanisms	Splitting, Isolation of affect. Acting out: Expression in action/behavior rather than in words/emotions.
Treatment	Psychological treatment (group therapy is more helpful than individual therapy particularly if patients are immobilized, e.g. placed in hospitals), firm limits are essential. Therapeutic community or long-term hospitalization is sometimes effective. Treatment of substance abuse often effectively reduces antisocial attitude and tendency.

Cluster C

Type/ Comparison	1) Dependent Personality Disorder
Diagnostic Criteria	Diagnostic criteria: a pervasive dependence, clinging behavior, and fears of separation indicated by ≥ 5 of: 1. Difficulty making personal decisions without excessive amount of advice and reassurance from others. 2. Needs others to assume responsibilities for most areas of his/ her life. 3. Difficulty expressing disagreement because of fear of loss of support and approval (unassertive). 4. Difficulty doing things on his/her own or initiating projects because of lack of self-confidence. 5. Goes to excessive lengths to obtain support from others (doing unpleasant things). 6. Feels uncomfortable or helpless when alone. 7. Urgently seeks another relationship as a source of support when one ends. 8. Preoccupied with fears of being left to take care of self. Anyone in an abusive relationship, typically has the dependent PD
Epidemiology	Prevalence=1%. Women > men. Persons with chronic physical illness in childhood may be most susceptible to the disorder.
Differential Diagnosis	1.Avoidant Personality Disorder. 2. Agoraphobia, they're prone to have agoraphobia (it may coexist).
Defense mechanisms	1-Idealization of others (protective...). 2-Regression. 3-Projective Identification.
Treatment	1.Insight-oriented therapies & behavior therapy enable patients to become more independent, assertive, and self-reliant. 2.Medications; to deal with specific symptoms, such as anxiety and depression, which are common associated features.

Cluster C

Type/ Comparison	2) Avoidant Personality Disorder
Diagnostic Criteria	A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, as indicated by ≥ 4 of the following: 1. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection. (Their biggest problem is the fear of 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 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.
Epidemiology	Men=women. Prevalence: 1% in the general population &10% of psychiatric clinics
Differential Diagnosis	1. Social phobia. 2. Depression (may coexist). 3. Dependent personality Disorder. 4. Schizoid personality Disorder. They're prone to have social phobia (may coexist).
Defense mechanisms	1- Repression / inhibition. 2- Isolation of affect. 3- Avoidance
Treatment	**Psychological treatment:** posting self-confidence and self- acceptance, assertiveness training social skills, and group therapy. **Pharmacological treatment** to manage anxiety or depression when present.

Cluster C

Type/ Comparison	3) Obsessive Compulsive Personality Disorder (OCPD) "important"
Diagnostic Criteria	A pervasive pattern of preoccupation with orderliness, perfectionism, and interpersonal control, at the expense of flexibility, openness, and efficiency, as indicated by ≥ 4 of 8: 1. Excessive preoccupation with details, organization, or rules to the extent that the major point of the activity is lost. 2. Excessive perfectionism that interferes with task completion. 3. Excessive devotion to work and productivity to the exclusion of leisure activities and friendships. 4. Inflexibility and scrupulousness about matters of morality, health, ethics, or values. 5. Inability to discard worthless or worn-out objects even when they have no sentimental value. 6. Reluctance to delegate tasks or to work with others unless they submit to exactly his/her way of doing things. 7. Adoption of a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophic. 8. Rigidity and stubbornness. Unlike Obsessive Compulsive Disorder (OCD), OCPD don't repeat things as compulsions, they **desire repeating it**. They can't go from one task to the other. They're prone to depression and OCD.
Epidemiology	The prevalence in the general population is 1 %. Men > women (2:1). OCPD is found more frequently within professions requiring strict dedication to duty and meticulous attention to details.
Differential Diagnosis	**1-Obsessive-compulsive disorder (OCD):** although OCPD and OCD have similar names, the clinical manifestations of these disorders are quite different; OCPD is not characterized by the presence of obsessions or compulsions and instead involves pervasive pattern of preoccupation with orderliness, perfectionism, and control and must begin by early adulthood. The most difficult distinction is between some obsessive-compulsive traits and OCPD. The diagnosis of personality disorder is reserved for those with significant functioning impairments. Comorbidity is common. If an individual manifests symptoms of both OCPD and OCD, both can be given. Axis I; OCD. Axis II; OCPD. **2-Narcissistic personality disorder** patient seeks perfectionism motivated by status and more likely to believe that he has achieved it, whereas OCPD patient is motivated by the work itself and more likely to believe that he has not achieved perfectionism.
Defense mechanisms	1. Isolation of affect. 2. Displacement. 3. Reaction Formation. 4. Undoing.
Treatment	Psychological: supportive and directive individual or group therapy. Pharmacological: clomipramine or any SSRI have been found useful (+ Psychotherapy).
Course and Prognosis	OCPD patients may flourish in professions demanding devotion to work, meticulous attention to details, and productivity, but they are vulnerable to depressive disorders & OCD.

Cases from the Manual:

- **Cluster A:**
  Shadi has a chronic sense of insecurity, suspiciousness towards others, and difficulties in initiating and maintaining relationships.

- **Cluster B:**
  Ms. Nouf is a 24 year-old female has long history of instability in mood, behavior, and relationships. She had several intense anger outbursts with destructive behavior.

- **Cluster C** (this specific scenario is about Obsessive Compulsive Personality Disorder):
  Mr. Kamal is a 33-year-old married employee, sought treatment at his wife's insistence. She could no longer tolerate his rigidity, scrupulousness about matters of health, excessive perfectionism, and excessive devotion to productivity to the exclusion of leisure activities.

Mixture of Personality Disorders:

All personalities disorder might be contaminated with each other, common mixtures are:

- Borderline personalities when put under stress they start to have paranoid ideation.
- Narcissistic personalities sometimes have a bit of borderline personality traits, such as impulsivity.
- Narcissistic personalities may have paranoid ideation sometimes.

We asked Prof. Alsughayir about delusions and PD since some personality disorders might have delusions, his answer was:

Delusions are not criteria to diagnose any personality disorder. The issue is what personality disorders prone to delusions/psychosis & what types?

I. Paranoid PD patients are prone to paranoid delusions which can be transient (brief psychosis for 1month) or paranoid delusional disorder prolonged paranoid delusion on top of paranoid PD.
II. Schizotypal PD patients are prone to many types of delusions (mostly delusion of reference and influence with paranoid flavor) and hallucinations which can be transient (brief psychosis for 1month) or schizophreniform (more than 1 month but less than 6 months).
III. Borderline PD patients are prone to paranoid delusions with depressive features, which can be transient (brief psychosis for 1month) or schizophreniform (more than 1 month but less than 6 months).
IV. Narcissistic PD patients rarely they develop delusions unless they have mood disorder (in manic episode they show grandiose type delusions which is self-limited & ends after disappearance of the manic episode). However, they may develop delusional disorder – grandiose type (prolonged delusion on top of their narcissistic PD).

The Second question we asked was:

Regarding Narcissistic Personality Disorder:
In the manual its written in the features' section they have fragile self esteem, however I find this different than what I understood during the lecture, at the lecture I understood that they have inflated self esteem that might be even confused with grandiose delusion in bipolar disease, and now I'm confused.

This is a good question:
Fragile and inflated are not mutually exclusive
(غير متناقضين وجود أحدهما لا يعني انتفاء الآخر)
Inflated= abnormal sense of self-importance with superiority (this is their usual self-esteem that is apparent to others= outer self).
Fragile= prone to self de-evaluation when encountered with a major crisis beyond control (they realize their reality which disappointing).
تذكري الزجاج القوي والحديد الزهر كلاهما فيه قوة لكنه قابل للكسر في بعض الظروف.

Compare avoidant personality with schizoid personality:

- Avoidant is sensitive. Schizoid is not.
- Avoidant don't want to be alone but he is alone. Schizoid wants and enjoy being alone. However they both are isolated.

Borderline Personality have problem in controlling their emotions, due to a problem in their limbic system or amygdala.

Doctor said this table is included in the lecture although it was in the psychosomatic medicine lecture:

Dealing with physically-ill patients who have difficult personalities (see details of personality disorders later):

	Personality	Traits /Attitude	Patient concern/worries	Approach
A	**1.Paranoid**	Mistrustful, guarded and hypervigilant.	Exploitation and betrayal.	Acknowledge complaints without arguing and honestly explain medical illness.
	2.Schizoid	Enjoys to be alone	Violations of privacy	Accept his unsociability and need for privacy. Reduce the patient's isolation as tolerated
	3.Schizotypal	Odd feelings, perception, &beliefs.	Exploration of oddities.	Empathize with the patient's oddities without confrontation.
B	**1.Antisocial**	Dishonest, deceptive, and exploiting.	Exploitation and loss of self-esteem	Verify symptoms & discover malingering. Control wish to punish patient. Explain that deception results in patient poor care.
	2.Histrionic	Excessively seeking attention and admiration.	Loss of love.	Set limits and avoid being too warm. Use logic thinking to counteract an emotional style of relationship.
	3.Borderline	Fluctuating emotions, extreme views, impulsivity, self-harm, and unstable relationships.	Abandonment & loss of support.	Empathize and set limits. Use logic thinking to counteract an emotional style of relationship.
	4.Narcissistic	Sense of superiority and priority	Devaluation and loss of prestige, or self-esteem	Do not confront self-inflation. Do not devalue the patient. If the patient devalues you, you may offer a referral as an option, not as punishment.
C	**1.Avoidant**	Shy, oversensitive to criticism, embarrassment and humiliation.	Exploration of low self-esteem, inadequacy shame, and rejection.	Empathize, support self-esteem, and encourage assertiveness.
	2.Dependent	Over-dependant seeks constant support and reassurance.	Independence	Explore why independence is so frightening and encourage independence and assertiveness.
	3.Obsessive-compulsive	Perfection seeker, over-meticulous, rigid, and self-blaming.	Imperfection and guilt.	Tolerate the patient's critical judgments and unnecessary details. Beware of his controlling behavior.

Summary (from Toronto's Notes 2016):

- Pattern of Personality Disorder is stable and well established by adolescence or early adulthood (NOT sudden onset)
- Associated with many complications, such as depression, suicide, violence, brief psychotic episodes, multiple drug use, and treatment resistance
- Mainstay of treatment is psychotherapy with the addition of pharmacotherapy to treat associated axis I disorders (i.e. depression, anxiety, substance abuse).
- Personality disorders with familial associations are: Schizotypal, Antisocial, and Borderline.

Table 10. Description and Diagnosis of Personality Disorders

Cluster A "Mad" Personality Disorders
- Patients seem odd, eccentric, withdrawn
- Familial association with psychotic disorders
- Common defense mechanisms: intellectualization, projection, magical thinking

Paranoid Personality Disorder (0.5-3%)	Schizotypal Personality Disorder (3-5.6%)
Pervasive distrust and suspiciousness of others, interpret motives as malevolent Blame problems on others and seem angry and hostile Diagnosis requires 4+ of: **SUSPECT** 1. **S**uspicious that others are exploiting or deceiving them 2. **U**nforgiving (bears grudges) 3. **S**pousal infidelity suspected without justification 4. **P**erceive attacks on character, counterattacks quickly 5. **E**nemies or friends? Preoccupied with acquaintance trustworthiness 6. **C**onfiding in others is feared 7. **T**hreats interpreted in benign remarks	Pattern of eccentric behaviours, peculiar thought patterns Diagnosis requires 5+ of: **ME PECULIAR** 1. **M**agical thinking 2. **E**xperiences unusual perceptions (including body illusions) 3. **P**aranoid ideation 4. **E**ccentric behaviour or appearance 5. **C**onstricted or inappropriate affect 6. **U**nusual thinking/speech (e.g. vague, stereotyped) 7. **L**acks close friends 8. **I**deas of reference 9. **A**nxiety in social situations (Note: Rule out psychotic/pervasive developmental disorders - this is not part of the criteria)

Schizoid Personality Disorder
Neither desires nor enjoys close relationships including being a part of a family; prefers to be alone
Lifelong pattern of social withdrawal
Seen as eccentric and reclusive with restricted affect
Diagnosis requires 4 of: **DISTANT**
1. **D**etached/flat affect, emotionally cold
2. **I**ndifferent to praise or criticism
3. **S**exual experiences of little interest
4. **T**asks done solitarily
5. **A**bsence of close friends (other than first-degree relatives)
6. **N**either desires nor enjoys close relationships (including family)
7. **T**akes pleasure in few (if any) activities

Table 10. Description and Diagnosis of Personality Disorders (continued)

Cluster B "Bad" Personality Disorders
- Patients seem dramatic, emotional, inconsistent
- Familial association with mood disorders
- Common defense mechanisms: denial, acting out, regression (histrionic PD), splitting (borderline PD), projective identification, idealization/devaluation

Borderline Personality Disorder (2-4%)
Unstable moods and behaviour, feel alone in the world, problems with self-image. History of repeated suicide attempts, self-harm behaviours. Inpatients commonly report history of sexual abuse. Tends to fizzle out as patients age. DBT is the principal treatment (see *Psychotherapy*, PS43)
10% suicide rate
Diagnosis requires 5+ of: **IMPULSIVE**
1. **I**mpulsive (min. 2 self-damaging ways, e.g. sex/drugs/spending)
2. **M**ood/affect instability
3. **P**aranoia or dissociation under stress
4. **U**nstable self-image
5. **L**abile intense relationships
6. **S**uicidal gestures / self-harm
7. **I**nappropriate anger
8. a**V**oiding abandonment (real or imagined, frantic efforts to)
9. **E**mptiness (feelings of)

Narcissistic Personality Disorder (2%)
Sense of superiority, needs constant admiration, lacks empathy, but with fragile sense of self. Consider themselves "special" and will exploit others for personal gain
Diagnosis requires 5+ of: **GRANDIOSE**
1. **G**randiose
2. **R**equires excessive admiration
3. **A**rrogant
4. **N**eeds to be special (and associate with other specials)
5. **D**reams of success, power, beauty, love
6. **I**nterpersonally exploitative
7. **O**thers (lacks empathy, unable to recognize feelings/needs of)
8. **S**ense of entitlement
9. **E**nvious (or believes others are envious)

Antisocial Personality Disorder (M: 3%, F: 1%)
Lack of remorse for actions, manipulative and deceitful, often violate the law. May appear charming on first impression. Pattern of disregard for others and violation of others' rights must be present before age 15; however, for the diagnosis of ASPD patients must be at least 18. Strong association with Conduct Disorder, history of trauma/abuse common (see *Child Psychiatry*)
Diagnosis requires 3+ of: **CORRUPT**
1. **C**annot conform to law
2. **O**bligations ignored (irresponsible)
3. **R**eckless disregard for safety
4. **R**emorseless
5. **U**nderhanded (deceitful)
6. **P**lanning insufficient (impulsive)
7. **T**emper (irritable and aggressive)

Histrionic Personality Disorder (1.3-3%)
Attention-seeking behaviour and excessively emotional. Are dramatic, flamboyant, and extroverted. Cannot form meaningful relationships. Often sexually inappropriate
Diagnosis requires 5+ of: **ACTRESSS**
1. **A**ppearance used to attract attention
2. **C**enter of attention (else uncomfortable)
3. **T**heatrical
4. **R**elationships (believed to be more intimate than they are)
5. **E**asily influenced
6. **S**eductive behaviour
7. **S**hallow expression of emotions (which rapidly shift)
8. **S**peech (impressionistic and vague)

Cluster C "Sad"
- Patients seem anxious, fearful
- Familial association with anxiety disorder
- Common defense mechanisms: isolation, avoidance, hypochondriasis

Avoidant Personality Disorder (0.5-1.6%)
Timid and socially awkward with a pervasive sense of inadequacy and fear of criticism. Fear of embarrassing or humiliating themselves in social situations so remain withdrawn and socially inhibited
Diagnosis requires 4+ of: **CRINGES**
1. **C**riticism or rejection preoccupies thoughts in social situations
2. **R**estraint in relationships due to fear of being shamed
3. **I**nhibited in new relationships due to fear of inadequacy
4. **N**eeds to be sure of being liked before engaging socially
5. **G**ets around occupational activities requiring interpersonal contact
6. **E**mbarrassment prevents new activity or taking risks
7. **S**elf-viewed as unappealing or inferior

Obsessive-Compulsive Personality Disorder (3-10%)
Preoccupation with orderliness, perfectionism, and mental and interpersonal control. Is inflexible, closed-off, and inefficient
Diagnosis requires 4+ of: **SCRIMPER**
1. **S**tubborn
2. **C**annot discard worthless objects
3. **R**ule/detail obsessed (to point of activity lost)
4. **I**nflexible in matters of morality, ethics, values
5. **M**iserly
6. **P**erfectionistic
7. **E**xcludes leisure due to devotion to work
8. **R**eluctant to delegate to others

Dependent Personality Disorder (1.6-6.7%)
Pervasive and excessive need to be taken care of, excessive fear of separation, clinging and submissive behaviours. Difficulty making everyday decisions. Useful to set regulated treatment schedule (regular, brief visits) and being firm about in between issues. Encourage patient to do more for themselves, engage in own problem-solving
Diagnosis requires 5 of: **RELIANCE**
1. **R**eassurance required for everyday decisions
2. **E**xpressing disagreement difficult
3. **L**ife responsibilities assumed by others
4. **I**nitiating projects difficult (because no confidence)
5. **A**lone (feels helpless and uncomfortable when alone)
6. **N**urturance (goes to excessive lengths to obtain)
7. **C**ompanionship sought urgently
8. **E**xaggerated fears of being left to care for self

MCQ's

1. A 28-year-old woman has a dedicated seeking of approval, preoccupation with entitlement, wealth and power. Her fantasies have always been excessive and unreasonable. What is the most likely personality disorder he has?

A. Dependent PD.
B. Histrionic PD.
C. Narcissistic PD.
D. Antisocial PD.

2. A 31-year-old man has been self-sufficient person with emotional coldness and little interest in interpersonal relationship. What is the most likely personality disorder he has?

A. Borderline PD.
B. Schizotypal PD.
C. Avoidant PD.
D. Schizoid PD.

3. A 29-year-old woman has long history of instability in mood, behavior, and relationships. She had several intense anger outbursts with destructive behavior. What is the most likely personality disorder he has?

A. Schizoid PD.
B. Borderline PD.
C. Schizotypal PD.
D. Avoidant PD.

4. A 33-year-old man has excessive perfectionism that interferes with task completion, and excessive devotion to productivity to the exclusion of leisure activities. What is the most likely personality disorder he has?

A. Borderline PD.
B. Schizotypal PD.
C. Obsessive-compulsive PD.
D. Schizoid PD.

5. A 32-year-old woman has excessive preoccupation with fears of being left to take care of self. She has difficulty making personal decisions and requires excessive amount of advice and reassurance from others. What is the most likely personality disorder he has?

A. Schizotypal PD.
B. Dependent PD.
C. Obsessive-compulsive PD.
D. Schizoid PD.

1. C, 2. D, 3. B, 4. C, 5. B.

Case 1

A 57-year-old man living in a condominium complex constantly accuses his neighbors of plotting to avoid paying their share of maintenance. He writes angry letters to other owners and has initiated several lawsuits. He lives alone and does not socialize.

Case 2

A 43-year-old man dreads an upcoming holiday party because he believes that he is incapable of engaging in social conversation or dancing. He believes that he will become an object of pity or ridicule if he attempts such things. He anticipates yet another lonely holiday.

Case 3

A 20-year-old nurse was recently admitted after reporting auditory hallucinations which have occurred during the last few days. She reports marriage difficulties and believes her husband is to blame for the problem. She has several scars on her wrists and has a history of substance abuse.

Case 4

A 30-year-old man is completely preoccupied with the study and brewing of herbal teas. He associates many peculiar powers with such infusions and says that plants sometimes whisper to him. He spends all of his time alone, often taking solitary walks in the wilderness for days at a time, collecting plants for teas. He has no history of disorganized behavior.

Case 5

A famous actor is outraged when a director questions his acting abilities during rehearsal for a play. The actor responds by walking off the stage and not returning to the stage unless the director apologizes publicly for her behavior.

Case 6

A 24-year-old man lives alone and works as a security guard. He ignores invitations from coworkers to socialize and has no outside interests.

Case 7

A 37-year-old woman seeks psychotherapy as a result of an impending divorce. She says that her demands that the house be kept spotless, that extremely detailed and fixed work and recreational schedules be maintained, and that rigid dietary habits be observed have driven her spouse away.

Case 8

A 30-year-old woman presents to the doctor's office dressed in a sexually seductive manner and insists that the doctor comment on her appearance. When the doctor refuses to do so, she becomes upset.

Case 9

A 22-year-old man was recently arrested after he set his mother's house on fire. He has had numerous problems with the law, which started at an early age when he was sent to a juvenile detention center for his behavior at home and school. He lacks remorse for setting the fire and expresses the desire that his mother should have died in the fire.

Case 10

A 26-year-old man is brought to the emergency room after sustaining severe rectal lacerations during a sadistic sexual episode with his partner. The patient is extremely concerned that the police not be informed because he does not want to upset his partner and cause the partner to leave.

1.Paranoid 2.Avoidant 3.Borderline 4.Schizotypal 5.Narcissistic 6.Schizoid 7.OCPD 8.Histrionic 9.Antisocial 10.Dependent

Done By:

Latifa Alanazi

Nada Dammas