433 Teams

PSYCHIATRY

Lecture (11)

Personality Disorders

Psychiatry.team433@gmail.com

جامعة الملك سعود
King Saud University

Introduction

- Personality refers to patterns of thinking, emotion, motivation, and behavior that are activated in particular circumstances.
- 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.

Personality disorders

- Deviation of personality from social and cultural expectations.
- Lifelong pervasive pathological patterns of thinking, emotion, interpersonal functioning, and impulse control.
- Lead to functional impairment /significant distress
- Age: > 18 years (21 years).
- Not due to other causes (medical illness, substance abuse, ...)

Classification of personality disorders

- **Cluster A** (Odd thinking)
    1. Schizoid,
    2. Paranoid,
    3. Schizotypal.
- **Cluster B** (Dramatic behavior)**;**
    1- Borderline.
    2- Antisocial.
    3- Narcissistic .
    4- Histrionic.
- **Cluster C** (Fearful):
    1. Avoidant.
    2. Dependent.
    3. Obsessive Compulsive.

Cluster A

Type of Personality Disorder	Paranoid Personality Disorder	Schizoid Personality Disorder	Schizotypal Personality Disorder
Definition	-Excessive mistrust /suspiciousness of others' motives (even friends &associates) without sufficient basis. -Exaggerated bearing of grudges persistently (e.g. insults, slights, injuries).	-Social isolation (with self- sufficiency), indifference to praise, criticism and feelings of others, choosing solitary activities and jobs, and poor social skills.	-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.
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.	*Denial and splitting:* See above. *Isolation of affect:* Thoughts stored without emotion. *Intellectualization:* Replace feelings with facts. *Fantasy:* obtaining gratification through excessive day dreams.	*Regression:* Revert to childlike thoughts, feelings, and behaviors. *Denial, splitting, and fantasy:* See above.
Patient concern	Exploitation and betrayal.	Violations of privacy.	Exploration of oddities.
Approach	Acknowledge complaints without arguing and honestly explain medical illness.	Accept his unsociability and need for privacy. Reduce the patient's isolation as tolerated	Empathize with the patient's oddities without confrontation.

For All Cluster A Personality Disorders :

DDx: other personality disorders and psychotic disorders.

Treatment : Psychotherapy + Antipsychotics (e.g. olanzapine 10) mg).

Cluster B

1-Borderline Personality Disorder (BPD)

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.

Differential Diagnosis :

1. **Schizophrenia**: unlike patients with schizophrenia, BPD shows brief psychosis (micro-psychotic episodes; transient 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 :

A. **Splitting** : by considering each person to be either 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

B. **Acting Out:** 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.

C. **Projective identification**: it consists 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.

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.

Treatment :

- **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 Para suicidal 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.

  *** For best results, pharmacotherapy + psychotherapy**

Cluster B

2-Histrionic Personality Disorder

Main Features :

- Attention seeking behavior (verbal and nonverbal).
- Excessive superficial emotions (shallow and shifting)
- Self – dramatization and exaggeration.
- Provocative and seductive behavior.
- Suggestibility with superficial thinking.

Coping style :

- Emotion-driven and self-centered thinking and behavior.

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.

DDX :

1. Borderline personality disorder.
2. Narcissistic personality disorder.
3. Somatoform disorders (may co-exist as an axis I diagnosis).

Treatment :

- Psychological treatment: supportive and directive approaches to increase awareness of the real feelings underneath the histrionic behavior.
  Pharmacological treatment: antianxiety or antidepressant drugs may transiently be used.

Cluster B

3-Narcissistic Personality Disorder

Main Features:

- Exaggerated self-importance and superiority.
- Constant seeking of admiration (not only attention); (meetings, media,…)
- Preoccupation with entitlement, success and power.
- Excessive and unrealistic fantasies.
- Excessive concern about appearance more than essence.
- With others; exploitative, envious, hypersensitive to criticism, and lacks empathy.
- Fragile self-esteem

Coping style：

- Superiority and arrogance, self-aggrandizing, self-centered, self-protecting, demeaning, demanding, critical.

Defense Mechanisms:

- **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.

DDX：

1. Histrionic personality disorder.
2. Paranoid personality disorder.
3. Delusional disorders (grandiose type).

Treatment：

- 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

4-Antisocial Personality Disorder

Main 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.

Coping style：

- Seeks advantage, freedom, and autonomy.

Defense Mechanisms:

- Splitting, isolation o affect, and acting out.(See above**).**
- Acting out: Expression in action/behavior rather than in words/emotions

DDX:

1. Substance abuse: it may be a comorbidity primary or secondary to antisocial behavior.
2. Mental abnormality.
3. Borderline personality disorder (coexistence is common).
4. Psychotic disorders (e.g. mania, schizophrenia..)

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

1-Dependent Personality Disorder

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.

Epidemiology :

- Prevalence=1%. Women > men. Persons with chronic physical illness in childhood may be most susceptible to the disorder.

Defense Mechanisms:

1. Idealization of others (protective...).
2. Regression.
3. Projective Identification.

DDX:

1. Avoidant Personality D.
2. Agoraphobia(may coexist).

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

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
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 .

Defense Mechanisms:

1- Repression / inhibition.
2- Isolation of affect.
3- Avoidance

DDX:

1. Social phobia (may coexist).
2. Depression (may coexist).
3. Dependent personality D.
4. Schizoid personality D.

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

3-Obsessive Compulsive Personality Disorder (OCPD)

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 catastrophes.
8- rigidity and stubbornness

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.

Defense Mechanisms:

1- Isolation of affect.
2- Displacement.
3- Reaction Formation.
4- Undoing.

Course & 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.

DDx：

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. AxisII; 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.

Treatment:

- **Psychological:** supportive and directive individual or group therapy.
- **Pharmacological:** clomipramine or any SSRI have been found useful (+Psychotherapy).

Summery

Cluster	Disorder	Treatment
A: Odd and eccentric	Schizoid, paranoid and schizotypal.	Psychotherapy + antipsychotics.
B: Dramatic and emotional	Histrionic, antisocial, borderline and narcissistic	Narcissistic persons rarely seek or accept treatment. Psychotherapy for the rest and antipsychotics, antidepressants, anticonvulsants, benzodiazepines for borderline
C: Anxious and fearful	Avoidant, dependent and obsessive compulsive	Mainly psychotherapy and pharmacotherapy for specific symptoms

Done By:

Abdulaziz ALSudairi	Feras AL-Fawaz