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Personality Disorders

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History

With DSM-III (APA, 1980), the multiaxial system was introduced

Included Axis II, devoted (mostly) to personality dysfunction

Why?

- Prevalence of maladaptive personality traits in clinical practice (above 50% in clinical settings)
- Impact of these traits on the course and treatment of other mental disorders

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General Information

A Personality Disorder

- Is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture
- Is pervasive and inflexible
- Has onset in adolescence or early adulthood
- Is stable over time
- Causes distress or impairment

(APA, 2001; Torgersen, 2005; Torgersen et al., 2001)

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General Information

Three clusters based on behavioral similarities

Cluster A (odd or eccentric)
Paranoid, Schizoid, Schizotypal

Cluster B (dramatic, emotional, or erratic)
Antisocial, Borderline, Histrionic, Narcissistic

Cluster C (anxious or fearful)
Avoidant, Dependent, Obsessive-Compulsive

(APA, 2001)

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PD Prevalence Rates

Above 50% in clinical settings

50% of inmates meet criteria for ASPD

10-15% of the total population

High co-morbidity, both with Axis I and other PD's

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Diagnostic Features

Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in social and personal contexts

To constitute a personality disorder, personality traits must:

- Be inflexible
- Be maladaptive
- Cause functional impairment or subjective distress

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DSM-IV Criteria

Deviates from the expectations of the individual's culture

Manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control

Pattern is inflexible and pervasive across range of personal and social situations

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DSM-IV Criteria

Leads to clinically significant distress or impairment

Pattern is stable and of long duration

Onset in adolescence or early adulthood

Another mental disorder, medical condition, or substance use does not account for pattern

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DSM-IV-TR PD's

Three clusters of PD's based on behavioral similarities

Cluster A (odd or eccentric)
- Paranoid, Schizoid, Schizotypal

Cluster B (dramatic, emotional, or erratic)
- Antisocial, Borderline, Histrionic, Narcissistic

Cluster C (anxious or fearful)
- Avoidant, Dependent, Obsessive-Compulsive

Cluster A: Paranoid PD

A pervasive distrust and suspiciousness of others such that motives are seen as malevolent

Begins in early adulthood, present in a number of contexts

Indicated by four or more of the following behaviors

Cluster A: Paranoid PD

1. Suspects that others are exploiting, harming, or deceiving
2. Is preoccupied with unjustified doubts
3. Is reluctant to confide in others
4. Reads hidden demeaning or threatening meanings into benign remarks or events
5. Persistently bears grudges
6. Perceives attacks on his or her character or reputation
7. Has recurrent suspicions, regarding fidelity of spouse or sexual partner

Etiology

Involves environmental responses of criticism, blame, and hostility

Linked to caregivers

Restricts ability to trust

Promotes belief that hateful criticism or abuse may result from interpersonal interactions
- Leads to withdrawal from such interactions
- May later be compensated for with rage

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Prevalence & Familial Patterns

0.5% - 2.5%, 2% - 4% in the general population

10% - 30% among inpatient psychiatric settings

2% - 10%, 4% among outpatient

Evidence for increased prevalence in relatives of individuals with chronic Schizophrenia

More specific familial relationship with Delusional Disorder

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Cluster A: Schizoid PD

Marked by detachment from social relationships

Restricted range of expression of emotions in interpersonal settings

Onset in early adulthood

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Schizoid PD

Indicated by four of the following:

1. Neither desires nor enjoys close relationships
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

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Etiology

Possible links to Asperger's syndrome, autism, and pervasive developmental disorder

Individuals with Schizoid PD believed to be undersocialized and deficient in interpersonal or coping skills

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Prevalence and Familial Patterns

Between 1% and 3% in general population

Around 1% in outpatient psychiatric setting

Somewhat of a clinical rarity

May be more prevalent in relatives of individuals with Schizophrenia or Schizotypal PD

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Cluster A: Schizotypal PD

Marked by acute discomfort with and reduced capacity for close relationships

Cognitive or perceptual distortions and eccentricities of behavior

Begins by early adulthood and presents in a variety of contexts

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Schizotypal PD

Indicated by five of the following:

1. Ideas of reference
2. Odd beliefs or magical thinking
3. Unusual perceptual experiences
4. Odd thinking and speech
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
9. Excessive social anxiety

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Etiology

Genetic predisposition link to schizophrenic spectrum disorders

Little is known about contributing environmental factors

Has relatively stable course

Few go on to develop Schizophrenia or another Psychotic Disorder

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Prevalence & Familial Patterns

3% in general population

Less than 1% in outpatient psychiatric setting

More prevalent in first-degree biological relatives of individuals with Schizophrenia than in general population

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Cluster B: Antisocial PD

Pervasive pattern of disregard for and violation of the rights of others

Evidence of Conduct Disorder with onset by age 15

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Antisocial PD

Indicated by three of the following:

1. failure to conform to social norms
2. deceitfulness
3. impulsivity or failure to plan ahead
4. irritability and aggressiveness
5. reckless disregard for safety of self or others
6. consistent irresponsibility
7. lack of remorse

At least 18 years of age

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Etiology

Highly heritable general vulnerability contributes to transmission of externalizing disorders

Disorder-specific effects are related to environmental factors

History of caregiver hostility, deficient role models, and reinforcement of vindictive behaviors

Childhood abuse

(Hicks et al., 2004; Sperry, 2003)

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Prevalence & Familial Patterns

Between 1% and 4% in general population

Around 3% to 4% in outpatient psychiatric setting

More common among first-degree biological relatives of those with the disorder; risk to biological relatives of females is higher

Relatives also at increased risk for Somatization Disorder and Substance-Related Disorders

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Comorbidity

Anxiety Disorders, Depressive Disorders, Substance-Related Disorders, Somatization Disorder, Pathological Gambling

Other impulse control problems

Often have personality features that meet criteria for other Personality Disorders

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Cluster B: Borderline PD

Instability of interpersonal relationships, self-image, and affects

Marked impulsivity beginning by early adulthood and present in a variety of contexts

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Borderline PD

Indicated by five of the following:

1. frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships
3. Identity disturbance
4. Impulsivity in at least two areas that are potentially self-damaging
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

Borderline PD

6. Affective instability due to a marked reactivity of mood
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

Etiology

Association between reduction in serotonin and impulsive aggression due to individual genetic differences

Experiences in childhood that lead to trauma

Biosocial theory suggests BPD is a dysfunction in emotion regulation system that results from both biological predisposition and environmental factors

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Prevalence & Familial Patterns

Around 1% in general population

Around 9% in in outpatient psychiatric setting

Around 30%-60% in clinical populations with Personality Disorders

Five times more common in first-degree biological relatives of those with Borderline Personality Disorder

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Comorbidity

Mood Disorders

Substance-Related Disorders

Eating Disorders (notably Bulimia)

Posttraumatic Stress Disorder

Attention-Deficit/Hyperactivity Disorder

Frequently co-occurs with other Personality Disorders

One of the most lethal psychiatric disorders; 10% complete suicide

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Cluster B: Histrionic PD

Excessive emotionality and attention seeking, as indicated by five of the following:

1. uncomfortable in situations in which they are 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

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Histrionic PD

4. Consistently uses physical appearance to draw attention to self
5. Speech is excessively impressionistic and lacking in detail
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion
7. Is suggestible
8. Considers relationships to be more intimate than they actually are

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Etiology

Interaction of biological predispositions and environmental responses

Lack of caregiver attention during formative years

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Prevalence & Familial Patterns

Around 2% in general population

Around 1% in outpatient psychiatric setting

No significant familial patterns

Cluster B: Narcissistic PD

Grandiosity, need for admiration, lack of empathy as indicated by five of the following:

1. Grandiose sense of self-importance
2. Preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. Believes that he or she is "special" and unique
4. Requires excessive admiration
5. Has a sense of entitlement

Narcissistic PD

6. Is interpersonally exploitative
7. Lacks empathy
8. Is often envious of others or believes that others are envious of him or her
9. Shows arrogant, haughty behaviors or attitudes

Etiology

Product of overindulgent parenting styles

Genetic influence may play a part:

- Hypersensitivity
- Aggression
- Low Frustration Tolerance
- Problems in Affect Regulation

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Prevalence & Familial Patterns

Slightly less than 1% in general population

Around 2% in outpatient psychiatric setting

No significant familial patterns

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Cluster C: Avoidant PD

Social inhibition, feelings of inadequacy, and extremely sensitive to criticism, as indicated by four of the following:

1. Avoids activities that involve significant interpersonal contact
2. Unwilling to get involved with people unless certain of being liked
3. Shows restraint within intimate relationships
4. Preoccupied with being criticized or rejected

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Avoidant PD

5. Inhibited in new interpersonal situations because of feelings of inadequacy
6. Views self as socially inept, personally unappealing, or inferior to others
7. Unusually reluctant to take personal risks or to engage in any new activities

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Etiology

Linked to biogenetic tendencies toward a lowered autonomic arousal threshold

Shyness believed to be genetically linked

Parental or peer rejection and/or ridicule

(Millon & Davis, 1996; Kagan, Reznick, & Snidman, 1988)

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Prevalence & Familial Patterns

Between 2% and 5% in general population

Around 15% in outpatient psychiatric setting

No significant familial patterns

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Cluster C: Dependent PD

Excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation as indicated by five of the following:

1. Difficulty making everyday decisions
2. Needs others to assume responsibility for most major areas of life
3. Difficulty expressing disagreement with others
4. Difficulty initiating projects or doing things on his or her own

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Dependent PD

5. Goes to excessive lengths to obtain nurturance and support from others
6. Feels uncomfortable or helpless when alone
7. Urgently seeks another relationship as a source of care and support when a close relationship ends
8. Unrealistically preoccupied with fears of being left to take care of himself or herself

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Etiology

Authoritarian parenting styles

Restricted development of self-efficacy

Depression in early-adolescent girls

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Prevalence & Familial Patterns

Among the most frequently reported PDs

Recent studies show 0.5%-1.5% in general population

Around 1.4% in outpatient psychiatric setting

No significant familial patterns

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Cluster C: Obsessive-Compulsive PD

Preoccupation with orderliness, perfectionism, and mental and interpersonal control as indicated by four of the following:

1. Preoccupied with details, rules, lists, order, organization, or schedules
2. Shows perfectionism that interferes with task completion
3. Excessively devoted to work and productivity
4. Overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values

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Obsessive-Compulsive PD

5. Unable to discard worn-out or worthless objects
6. Reluctant to delegate tasks or to work with others
7. Adopts a miserly spending style toward both self and others
8. Shows rigidity and stubbornness

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Etiology

Individuals were often punished for failing to be perfect and received no rewards for success

Affection and emotions were expected to be controlled or remain unexpressed

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Prevalence & Familial Patterns

Between 2% and 8% in general population

Between 8% and 9% in outpatient psychiatric setting

No significant familial patterns

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Treatments and Outcomes

Generally very difficult to treat

Treatment of the Cluster C disorders seems most promising, Cluster A least so