Personality Disorders

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

Public Health Concerns

- More than 1 in 10 adults in the community meet diagnostic criteria for at least one PD.
- Relatively few evidence-based treatments are available for PDs.
- PD diagnoses are associated with:
  - Hospitalizations
  - Criminal behavior
  - Dysfunction at work and in relationships
  - Suicidal behavior

Personality Disorder: *DSM-IV* Definition

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

Personality Disorder Clusters

- Cluster A
  - Schizotypal
  - Schizoid
  - Paranoid
- Cluster B
  - Antisocial
  - Borderline
  - Histrionic
  - Narcissistic
- Cluster C
  - Avoidant
  - Dependent
  - Obsessive-compulsive

Personality Traits

- Enduring features of personality that are:
  - Universal
  - Heritable
  - Linked to specific neurobiological structures and pathways
  - Well-characterized in terms of content and course
  - Valid for predicting a host of important life outcomes
  - Capable of reliable assessment, particularly via self-report questionnaires

Cluster A Personality Disorders

- These disorders are associated with psychotic disorders phenomenologically and etiologically.
- Distinguished by their lack of persistent psychotic symptoms (i.e., hallucinations and delusions).

Cluster A *DSM-IV-TR*

- **Paranoid Personality Disorder**
  - A pervasive pattern of distrust and beliefs that others' motives are malevolent
  - Suspiciousness and consequent social dysfunction
  - Loose and hypervigilant thinking
  - Resentment

Cluster A *DSM-IV-TR*

- **Schizoid Personality Disorder**
  - A pervasive pattern of social detachment and restricted emotional expression
  - Disinterest in relationships and preference for solitude
  - Limited pleasure in sex or other activities commonly regarded as pleasurable
  - Emotional flatness

Cluster A *DSM-IV-TR*

- **Schizotypal Personality Disorder**
  - A pervasive pattern of interpersonal deficits, cognitive or perceptual distortions, and eccentric behavior
  - Loose or eccentric perceptions and cognitions
  - Flat affect
  - Mistrustfulness
  - Profound social dysfunction

Cluster B Personality Disorders

- Regarded as the "dramatic, erratic, and emotional" group
- Individuals with these disorders tend to experience emotional dysregulation and behave impulsively.

Cluster B *DSM-IV-TR*

- **Antisocial Personality Disoder**
  - Pervasive pattern of disregard for the rights and wishes of others
  - Requires evidence of childhood conduct disorder
  - Socially non-normative behavior
  - Dishonesty
  - Impulsivity
  - Aggression
  - Lack of empathy
  - Irresponsibility

Cluster B *DSM-IV-TR*

- **Borderline Personality Disorder**
  - "Stable instability" in emotions, interpersonal behavior, and identity
  - Emotional dysregulation including anger
  - Emptiness is thought to be triggered by concerns about abandonment, which is followed by maladaptive coping, including impulsive and suicidal behavior.

Cluster B *DSM-IV-TR*

- **Histrionic Personality Disorder**
  - Excessive emotionality and attempts to obtain attention from others
  - Often, attempts to gain attention are made via sexually provocative/flirtatious attire and behaviors
  - Desire to be the center of attention often comes at the cost of deep and meaningful interpersonal relationships
  - Tend to have relatively superficial interpersonal interactions and shallow emotions

Cluster B *DSM-IV-TR*

- **Narcissistic Personality Disorder**
  - Grandiose thoughts and behaviors
  - Need for excessive admiration from others
  - Lack of empathy
  - Commonly believed that arrogant and haughty behavior is undergirded by extreme feelings of vulnerability and inadequacy.

Cluster C Personality Disorders

- Grouped together based on their common thread of anxiety and fearfulness

Cluster C *DSM-IV-TR*

- **Avoidant Personality Disorder**
  - Social inhibition rooted in feelings of inadequacy and fears of negative evaluations from others
  - Avoidance of social and occupational opportunities
  - Fears of shame and ridicule
  - Negative self-concept

Cluster C *DSM-IV-TR*

- **Dependent Personality Disorder**
  - Excessive need to be cared for by others that leads to submissive, clingy behavior
  - Difficulties with making autonomous decisions or expressing disagreement with others
  - Nonassertiveness
  - Preoccupation with abandonment
  - Maladaptive or self-defeating efforts to seek and maintain relationships

Cluster C *DSM-IV-TR*

- **Obsessive-Compulsive Personality Disorder**
  - Preoccupation with order, perfection, and control in which flexibility, efficiency, and even task completion are often sacrificed
  - Preoccupation with rules, work, interpersonal inflexibility, frugality, and stubbornness

Etiology

- Genetics
  - Heritability of personality pathology and disorders remains very ambiguous.
  - Rates of schizotypal and borderline PDs are higher among family members of individuals with those disorders.
  - Rates of Cluster C PDs are increased among individuals who have relatives with Axis I anxiety disorders.

Etiology

- Neurobiology
  - Endophenotypes
    - Cognitive dysregulation
    - Emotional regulation
    - Impulsivity
- Learning and cognition
  - Automatic thoughts, cognitive distortions, and interpersonal strategies

Course and Prognosis

- Most personality disorders tend to decline in middle age.
- Stability of personality disorders seems to be lower than was once thought.
- Treatments have shown benefit for at least some personality disorder symptoms.

Treatment

- Limited evidence that psychopharmacology is effective for treating PDs
  - Likely to benefit certain symptom constellations (e.g., the emotional lability of borderline PD or the cognitive slippage of schizotypal PD)
- Issues with effectiveness of psychosocial treatments
  - Relatively high rates of early dropout, particularly in borderline PD
  - Substantial diagnostic complexity
  - Tendency for PD treatment to be unpleasant for clinicians, who may consequently exhibit *iatrogenic behavior*

Treatment

- Borderline PD
  - Dialectical behavior therapy
  - Transference-focused therapy
  - Schema-focused therapy
  - Psychiatric management
  - Mentalization-based therapy

DSM-5 Changes

- Major changes