Objectives

- An overview of PD's focused on:
  - Categorize and describe PD's
  - Review etiology & prevalence
  - Examine behavior patterns
  - Provide an overview of management strategies and psychiatric treatments

Why Should You Know About PD's?

International samples: 6%
Community samples US:
  ~ 15% (of adults), 36 million
Psychiatric OP samples:
  31.4% with specific PD
  45.5% with unspecified PD

What is personality?

- Characteristics of a person that are **stable** and **distinctive** across a wide range of social & personal contexts
  - Typical thoughts, beliefs, behaviors, emotional traits, and interpersonal style

What is Personality Disorder?

- An enduring pattern of inner experience and behavior that deviates markedly from the norms of the individual’s culture (DSM 5 definition).
- These patterns tend to be fixed and consistent across situations, and lead to distress or impairment in person’s functioning.

PD Characteristics

- Pt has “always been this way”
- High degree of chaos in pt’s life
- Pt doesn’t see his/her behavior as problematic
- Externalizes and blames others for his/her problems
- You have noticeable reactions to the pt’s behavior
  - Countertransference - frustration, anger, inadequacy, rescue fantasies
  - Reactions can have an impact MD’s interaction w/the pt.
Development of a PD

- Collaborative Longitudinal Personality Disorders Study (1996-2005, N = 43,093)
  - Abuse and neglect linked to 3-4X higher risk
    - Emotional abuse / neglect
    - Physical abuse
    - Sexual abuse – 55% of borderline PD report sexual abuse

DSM-5
GENERAL CRITERIA FOR PERSONALITY DISORDER (PD)

- Pattern of inner experience & behavior that deviates markedly from individual’s culture
- **Pervasive, Pernicious** (harmful effect), and **Persistent** (the 3 P’s)
- Pattern manifests in 2 or > areas of functioning:
  - Cognition (thoughts)
  - Affectivity (emotions)
  - Interpersonal functioning
  - Impulse control

DSM-5
- Clinically significant impairment in functioning
  - Personal, social, occupational or other areas
- Enduring
  - Onset by adolescence or early adulthood
- Not better accounted for as a manifestation or consequence of another mental disorder
- Not due to physiological effects of a substance abuse, or a medical condition
Unspecified PD

PD features, but they do not meet full criteria for any single diagnosis, (i.e. Borderline, or Narcissistic personality features)

R/O Personality Change Due to Medical Condition

Evidence the PD is related to an identifiable medical condition
- Temporal lobe epilepsy, head trauma, brain tumor, Brain Degenerative Diseases (Huntington's, Alzheimer's)

Psychiatric Comorbidity

Comorbidity with other mental disorders
- sub use disorders
- depression, anxiety
- schizophrenia
- social anxiety disorder/social phobia
- Comorbid conditions → higher degrees of impairment & poorer prognosis
Medical Comorbidity

- Major medical conditions, major accidents/injuries, chronic pain: exacerbate PD symptoms
- PD complicates medical care
  - Higher medical utilization
  - May present with physical rather than psychiatric symptoms (i.e., histrionic)
  - Poor adjustment to the illness
  - Compliance issues

Important General Considerations

- May have characteristics of more than 1 PD
- Symptom overlap across PD's: there is not clear cut symptom distinctions across PD's
- Variability in symptoms is common
  - Some PDs improve over time (borderline)
  - Some worsen over time (schizotypal, obsessive compulsive PDs)
- Diagnosis of PD takes time
  - R/O other psychiatric & medical conditions before making dx

DSM-5 Classification:
PD Clusters and Diagnoses

- Cluster: there may be overlapping symptoms within a cluster or across clusters
- Cluster A - Odd & eccentric
  - Paranoid, Schizoid, Schizotypal
- Cluster B – Dramatic, emotional, erratic
  - Anti-Social, Borderline, Histrionic, Narcissistic
- Cluster C – Anxious & fearful
  - Avoidant, Dependent, Obsessive Compulsive PD
Cluster A Personality Disorders
- Paranoid PD
- Schizoid PD
- Schizotypal PD

Cluster A
PARANOID PD (2.3%; > men)
- Pervasive mistrust & suspiciousness
- Reluctant to confide in others, fear the information will be used against him/her
- Read hidden meanings into benign
- Angry, defensive

Matusiewicz et al., 2010
Grant et., 2004

Cluster A
SCHIZOID PD (3.1%)
- Loners
- Emotionally / socially detached
- Restricted range of emotional expression
- Indifferent to praise or criticism
Cluster A
SCHIZOTYPAL PD (3%)

- Eccentricities
  - Odd beliefs, behaviors, appearance
  - Magical thinking, superstitious
  - Speech, metaphorical, over elaborate
- Loners, social anxiety, suspiciousness

Cluster A
Life Problems

- Low stress tolerance
- Interpersonal issues
  - Social isolation
  - Occupational problems
- Low level of adherence to norms

Cluster A
Behavior Patterns

- Paranoid PD expects to be exploited & betrayed
  - Autonomy is crucial
  - Medical procedures are intrusive, threatening
  - Manifests as mistrust, hostility, conflicts, confrontations & low compliance
- Schizoid / schizotypal
  - Highly stressed by social contact, difficult to engage in tx, tend to withdraw and disconnect
  - Odd beliefs about their symptoms
Cluster A Comorbidities
- Depression and anxiety disorders
- Substance use disorders
- Schizophrenia (familial link)

Cluster A Differential Diagnosis
- Mental disorders with psychotic sx
  (schizophrenia, delusional DO, mood DO w/psychotic features)
  Distinguished by chronic psychotic symptoms and change from pre-morbid state
- Neurodevelopmental disorders
  Autism spectrum (mild); communication disorders
- Substance use disorders
- Personality change due to another medical condition

Cluster A - Management
- Countertransference
  Uneasiness, frustration (test your patience!)
- Trust issues
  Use actions not words to demonstrate trustworthiness
  Listen → avoid confrontation, empathize, give straightforward explanations, accept unsociability (don’t challenge it head on)
- Don’t challenge pt’s cognitive distortions unless firm rapport is established
- Include family to increase compliance
Clinical Vignette

- The pt has unusual ideas about the cause of his symptoms
- The pt is a loner
- The pt is superstitious and suspicious
- Overall, the encounter with the pt seems odd

--- Make the diagnosis?

Cluster B Personality Disorders

- Antisocial PD
- Borderline PD
- Histrionic PD
- Narcissistic PD

Cluster B
ANTISOCIAL PD (2-4%; > males)

- Disregard for the rights of others (since 15 y/o, 18 to dx)
- Socially irresponsible
- Impulsive, irritable, can be aggressive
- Lack empathy & remorse
- Can be glib and charming

- Familial link: dx in ~20% of 1st degree relatives
- Serotonin dysfunction, frontal lobe dysfunction, low autonomic arousal and reactivity
Cluster B
BORDERLINE PD (1.6% - 5.9%; > women)
- Instability
  - Relationships – stormy, fear abandonment
  - Self image – identity disturbance, chr emptiness
  - Affects – can have marked mood changes in a single day
- Impulsivity - $, sub use, sex, binge eating
- Cognition – impairment in attention, cog flex, processing speed, planning (all related to frontal lobe)
- Recurrent suicidal behavior (8-12%), self-injury
  - Familial link: 5X > common in 1st degree relatives

Cluster B
HISTRIONIC PD (2-3%)
- Dramatic! Attention seeking
- Entertaining..."the life of the party"
- Rapidly shifting, shallow emotions
- May be provocative, seductive
  - > frequent dx in women, underdx in men

Cluster B
NARCISSTIC PD (6.2%; > men)
- Pathological/ grandiose sense of self-importance
- Sense of entitlement, "special"
- Interpersonally exploitative
- Lack empathy, arrogant
- Fragile self-esteem, sensitive to criticism
Cluster B
Life Problems
- Impulsivity & substance use → problems with relationships, $$, employment, legal issues, injury/death
- Anti-social and narcissistic patients fear dependence, have difficulty asking for/accepting help

Cluster B
Behavior Patterns
- Controlling – manipulation of people & events to reduce inner tension
- Acting out – dealing with conflicts & anxiety through actions rather than talking or problem solving
- Splitting – compartmentalizing emotions, behavior & people into all good/all bad categories
- Self injury – use of physical pain to ↓ emotional arousal or alternately to ↓ emotional numbing
- Somatization – expressing distress through physical symptoms

Cluster B
Comorbidities
- Depression, anxiety disorders (e.g., PTSD in BPD)
- Eating disordered behaviors
- Substance use disorders
- ADHD (antisocial PD)
- Antisocial & borderline disorders
  - dysregulation of serotonergic/dopaminergic systems
  - E.g., serotonergic activity is reduced in impulsive aggression
  - > frequency of brain injury/trauma due to high risk taking behaviors
Cluster B Differential Diagnosis

- Substance use, bipolar disorder
  - Stimulant use or hypomanic/manic states may mimic grandiosity of NPD & affective instability of BPD
- Depressive and anxiety disorders (may co-occur)
- Head trauma (frontal lobe injury)
  - Associated with impulsivity, aggression, affective lability
- Personality change due to another medical condition

Cluster B - Management

- Countertransference reactions to Cluster B PDs are strong & run the gamut
  - anger...sympathy...amusement...inadequacy
- Empathize with the patient’s fears
  - Fears are strong & not expressed directly
- Be consistent, set limits & attempt to satisfy reasonable requests

Clinical Vignette

- The pt thinks they are better than most other people
- The pt manipulates others to achieve what s/he wants
- The pt thinks they deserve special treatment
- The pt looks down on others

--Make the diagnosis?
Cluster C Personality Disorders

- Avoidant PD
- Dependent PD
- Obsessive-Compulsive PD

Cluster C
AVOIDANT PD (2.4%)

- Socially inhibited
- Hypersensitive to negative evaluation
- Low self esteem
- Feels socially inadequate

  May start in childhood, and remit with age

Cluster C
DEPENDENT PD (0.5%)

- Great difficulty making decisions
- Difficulty expressing disagreement with others
- Urgently seeks new relationship when close relationship ends
- Feels unable to care for self, helpless
Cluster C
OBSESSIVE-COMPULSIVE PD
(2.1% - 7.9%; dx > in men)

- Preoccupied with rules, details, order
- Perfectionism, inflexibility & high need for control
- Over conscientious, micromanagers
- Rigidity and stubbornness

Cluster C
Life Problems

- Interpersonal issues
- OCPD patients are extreme perfectionists
  - Great difficulty making decisions & getting things done
  - Problems at work/home

Cluster C
Behavior Patterns

- Patients are anxiety prone, rigid
  - Inhibition – of emotions and thoughts to avoid conflicts
  - Avoidance – of people and situations to reduce anxiety
  - Intellectualization – isolation of feelings from thoughts
  - Somatization – expressing distress through physical symptoms
Cluster C Comorbidities

- Anxiety and depressive disorders
- Substance use disorders

Cluster C Differential Diagnosis

- Avoidant PD
  - May overlap w/Social phobia; is distinguished from schizoid PD (pt lacks interest in social relations)
- OCPD vs Obsessive Compulsive Disorder (OCD)
  - OCD - obsessions / compulsions, rituals in thought or behavior
  - OCPD is egosyntonic, OCD is egodystonic
- Personality change due to another medical condition

Cluster C - Management

- Countertransference reactions
  - Frustrated or angry
- Foster autonomy & shared decision making
  - Avoid telling the patient what to do
  - Verbalize willingness to provide care
  - Avoid power struggles with OCPD, provide thoughtful explanations/ feedback
Clinical Vignette

- The pt has a lot of trouble making decisions
- The pt rarely voices an opinion that is at odds with what others think
- The pt elicits feelings of protectiveness from his/her physician
- The pt has low self efficacy

-- Make the diagnosis?

Treatment of Personality Disorders

- ~30% or > of patients who receive psychiatric treatment have at least 1 PD
- Treatment of PD typically takes long time
- Treatment of comorbidities results in better outcomes
- Drop out rates range 21% - 31%
- Past pessimism about treatment now replaced with > cautious optimism

Psychotherapy Treatment

- Cognitive behavioral therapy (CBT)
  - PDs are maintained by
    - Maladaptive beliefs about self & others
    - Contextual / environmental factors that reinforce problematic behavior (or undermine effective behavior)
    - Coping skills deficit
- CBT uses a range of techniques
  - Cognitive restructuring, behavior modification, psychoeducation, coping skills training
CBT for PDs
Matusiewicz et al., 2010

- Review of 45 Randomized Controlled Trials (RCT), mostly 5 wks. – 1.5 yrs
- Individual and group CBT vs other approaches
- Research generally supports CBT as a more effective treatment modality vs other treatment approaches, for patients with PDs

Dialectical Behavioral Therapy (DBT) for BPD and other PDs

- DBT teaches pt to balance acceptance & change, create a life worth living
- Standard OP DBT includes:
  - Analysis of problematic behaviors, management of triggers, cognitive restructuring to problematic thoughts, feelings, behaviors
  - Coping skills training teaches pt’s to respond effectively in situations by instruction in mindfulness, interpersonal effectiveness, emotional regulation and distress tolerance
- Efficacy of DBT treatment demonstrated in multiple RCTs
  - ↓ in self injury, anger, ED visits, hospitalization, depression & impulsiveness, and greater + social adjustment

Pharmacotherapy for PDs

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>PD cluster</th>
<th>Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cognition / perceptual organization related to dysfunction in dopaminergic system</td>
<td>Cluster A &amp; B</td>
<td>Antipsychotic medications</td>
</tr>
<tr>
<td>2. Impulsive and aggressive behaviors related to dysfunction in serotonergic system</td>
<td>Cluster B</td>
<td>SSRIs can be considered, augmentation with a mood stabilizer (if needed)</td>
</tr>
</tbody>
</table>
| 3. Mood stability and dysphoria related to dysfunction in serotonergic or noradrenergic systems | Cluster B | SSRIs considered 1st, augmentation with long-acting benzos, e.g., clonazepam, carefully regulated
  - If rage is a prominent, an antipsychotic |
| 4. Anxiety related to dysfunction in serotonergic and noradrenergic neurotransmitter systems | Cluster C | SSRIs for anxiety, augmentation with a long-acting anxiolytic, e.g., clonazepam, under careful supervision to prevent dose escalation |
Pharmacotherapy for PDs

- Meta-analysis of 21 placebo controlled RCTs with BPD & Schizotypal pts
  - Antipsychotics
    - Moderate effect on cognitive-perceptual symptoms
    - Moderate → large effect on anger
  - Antidepressants
    - No effect on impulsive behavior, small but significant effect on anxiety, low effect on depressive symptoms
  - Mood stabilizers
    - Very large effect on impulsive-behavior and anger
    - Large effect on anxiety
    - Moderate effect on depression

Take Home Points

- Most patients with PD seek behavioral health services at urging of family or employer
- Strive for empathy and to understand the pt’s behavior
  - While behavior is maladaptive, patient’s goal is to minimize internal distress, and meet personal needs
  - Survival mechanism
- Don’t personalize the patient’s behavior
- Refer patients for psychotherapy and consider evidence based psychopharm for targeted symptoms

Examples of PDs in films

- Schizoid PD
  - James Spader (1989)
- Borderline PD
  - Antisocial Personality Disorder, Ezra Miller, (2011)
- Fatal Attraction: Michael Douglas (Dan) & Glenn Close (Alex), 1987