# Personality Disorders

# Personality Disorder

Def.: Enduring pattern of inner experience and behaviour that deviates markedly from the expectations od the individual's culture

- Prevalence in the general population is 10-20%
- Prevalence in the outpatient population is 30-50%-
- 15% of the hospitalized patients has problems caused primary by personality disorders, and to half of them secondarily – of which we are usually confirmed during treatment

- The pattern is stable and of long duration
- The personality traits are ego-synton and alloplastic in nature (only the environment perceives them as abnormal manifestations, the patient does not)
- The pattern is manifested in cognition, affectivity, interpersonal functioning and impulsivity
- The impairments start adolescent or early adult age, and and are stabilized in adult age, leading to impairments in functioning.

People with personality disorders are also at risk in their daily lives, their way of life is more uneven:

- higher number of divorces
- they are more likely to become unemployed or homeless
- higher prevalence of child abuse
- they are more prone to accidents
- are more frequently hospitalized
- higher chance of criminal acts
- higher chance autodestructive acts
- alcohol and drug addiction

# Etiology -Genetics

- Twin studies:
  - In monozygotic twins, greater concordance was observed than in dizygotic twins, even when raised separately
  - Cluster “A” shows a genetic link to schizophrenia (mainly schizotypal disorder), and is more common among biological relatives of patients with schizophrenia

- Borderline personality disorder
  - Depression is more common in the family of patients with borderline personality disorder
  - bipolar affective disorder overlaps - similar traits, but should appear as a separate category!

# Etiology -Biology

- Neurobiological
  - the role and function of the amygdala in emotional regulation and emotional qualification
- HPA axis, the role of prefrontal-orbitofrontal eldersregions - stress, anxiety, impulsivity

- patients with high impulsivity - high testosterone and 17-estradiol levels
- Schizotypal personality disorder - low platelet MAO levels
  - saccadic eye movement abnormalities were described, similar to that in schizophrenic patients
- borderline personality disorder - similar dexamethasone suppression test results as in depression

# Etiology - psychological factors

- According to the classical psychodynamic approach: trauma in the early stages of personality development → regression, self-defect → later abnormalities in adaptive functions

- in the light of recent infant research, this is not supported, the role of psychological causes is rather non-specific

- the role of biological, psychological and social risk factors in the etiology of personality disorders is thus emphatically non-specific, and it will be their unique interactional pattern that outlines the pathogenesis of a particular patient's disease.

# Diagnostics

- The most accepted method is a semi-structured interview by an experienced, psychodynamically trained professional.

- The questions focus on five areas:
  - social adaptation
  - self-destructive impulsivity (accident proneness, self harm)
  - affectivity (feelings of depression and anger)
  - dissociative self-states
  - interpersonal relationships

- Using self-characteristic methods, we do not get reliable answers

# Classification - DSM-IV.

- DSM-IV. distinguishes 3 main groups (cluster A-B-C), descriptively - characterized by the symptom description and not by focusing on the causes of development or treatment

  **Cluster A** - the strange, eccentric: paranoid, schizoid, schizotypal
  **Cluster B** - dramatic: histrionic, borderline, narcissistic, antisocial
  **Cluster C** - anxious: avoidant, obsessive-compulsive, dependent

# Classification - DSM-5

- Defines personality disorders based on different methods:
  - Categorical classification (10 disorders, in three beams) builded on descriptive symptomatic similarities
  - A novel Dimensional model - based on personality traits ("Emerging Measures and Models") grouped in two categories:
    - level of personality functioning
    - Interpersonal functions

➢ Each of these areas is measured on a 5-point scale

# Therapy

- Personality disorders, due to their early origin, usually require long treatment, often with only moderate results.
- Group therapies and sociotherapeutic treatments can help to correct maladaptive behavior patterns, and help the patient integrate into the social environment.
- Cognitive and behavioral therapies can also play a role: For Borderline patients, Dialectical Behavioral Therapy (DBT) developed by Marsha Linehan may be effective

# Cluster A - the strange, eccentric

- **Paranoid personality disorder**
- **Schizoid personality disorder**
- **Schizotypal personality disorder**

# Paranoid peronality disorder

The patient is characterized by a paranoid-sensitive stance  and projection - he is constantly afraid of being deceived and exploited, as he feels that everyone just wants to harm him.

Suspicious, distrustful, overestimating certain comments - atributes pathological importance to small things (paranoid traits)

Sensitive, has no sense of humor, aloof, emotionless, rigid, unforgiving (sensitive traits)

Its prevalence in the average population is between 0.5-2.5%, more common among men, minority and in emigrant groups, in patients with sensory impairment, and in family members of patients with schizophrenia.

In the treatment of paranoid peronality disorder psychotherapy may be burdened by the patient’s distrust. Group therapy, cognitive-behavioral therapy can be effective.
Medication may also be required, in which case, in addition to anxiolytics, low-dose antipsychotics may be involved.

# Schizoid peronality disorder

The patient is emotionally cold, isolated, aloof, humorless, introverted, does not want a social relationship - he has no close friends, remains lonely during his life (save the closest family members), and he usually chooses lonely activities and pastimes.

This personality disorder is characterized by chronic unhappiness. The sexual drive of the patient is usually decreased.
The patient tends to fantasize, but they usually lack emotional content (more preoccupied with intellectual problems)

This personality disorder may affect  5% of the population, the male-female ratio is 2: 1

Therapy: cognitive and behavioral therapy, group therapy is recommended.

# Schizotypal peronality disorder

This disorder is characterized by eccentric appearance, behavior, and thinking, and often by wearing strange, extravagant clothes. The patient has poor communication skills, becomes isolated, and has poor interpersonal relationships and may act inappropiately. In addition to strange beliefs or magical thinking, suspicion or paranoid overemphasised thoughts, sometimes delusion-like, may also be present.
In addition, unusual sensory experiences, somatosensory or other illusions, depersonalization, derealization may occur. The range of the patient's affect is often narrowed, or affects may not be appropriate to the situation. Occasionally, transient psychotic states (without external provocation) may develop.
The disorder occurs in 2-3% of the population, and is more common among relatives of patients with schizophrenia.

Aspects of its therapy are similar to those of schizoid personality disorder, a supportive, reality-based therapeutic relationship may be beneficial in these patients. In cases of transient psychotic states, it may also be necessary to use antipsychotics.

# Cluster B – the dramatic

- **Histrionic personality disorder**
- **Borderline personality disorder**
- **Narcissistic personality disorder**
- **Antisocial personality disorder**

# Histrionic personality disorder

The personality disorder is characterized by being dramatic, theatrical, and by seeking novelty and experiences in life - they feel good when life is bubbling around them. The patient is too egocentric, requiring constant external reinforcement.
Their appearance is often attractive, seductive (the sexually provocative behavior is often coupled with frigidity), they are unable to be themselves, because of their constant acting, due to wanting to please others first and foremost. They become tiring over time; by blackmailing their surroundings with outbursts, emotional scenes, and demonstrative suicide attempts.
the incidence of this personality disorder is around 2-3%, and is more common among women.
In the treatment individual psychodynamic psychotherapies, group therapies may be considered. Symptomatic pharmacotherapy - antidepressant, anxiolytic - may be used.

# Borderline personality disorder

The most common personality disorder - makes up 12-15% of the patient population, its frequency in the general population is 2-3%. The patient is characterized by mood lability, unpredictable, varied emotional and emotional reactions. They constantly escape into action to avoid the frequent depressive mood, emptiness, and boredom. Their social relationships are characterized by ambivalence (idealization and underestimation / hatred), a huge need for care, and at the same time an inability to maintain a stable relationship with others. Separation provokes anxiety in them, so they do everything they can to avoid these situations.
their tempers and anxieties are difficult to control, characterized by impulsive behavior, self-harm, recurrent suicide threat or attempts. Autodestructive behavior (alcohol, drugs), eating disorders, promiscuity may be present. Transient - stress-related - psychotic (paranoid) dissociative symptoms may occur.
Their treatment is based on psychotherapeutic methods. In addition to Kernberg's *Transference Focused Psychotherapy*, and Marsha Linehan's *Dialectical Behavioral Therapy* (DBT), another therapeutic approach is the mentalization-based psychotherapy developed by Fonagy. In addition to psychotherapeutic methods, medication for aggression, mood swings, impulsivity, and anxiety (anxiolytics, antidepressants, antipsychotics) may also be required.

# Narcissitic personality disorder

Patients with narcissistic personality disorder are characterized by self-centeredness, a sense of entitlement, pride, and grandiose fantasies about their own uniqueness. Their relationships are superficial, one-way, they are barely capable of empathy, theye expecs only recognition and praise from others, in extreme cases they completely ignore the other person's thoughts and feelings. Their behavior is often envious, making the observer feel they want to get everything for themselves.
They respond to even mild criticism by becoming enraged, they can easily become offensive and hostile. They are also most likely to seek help if they have a personal failure, and are experiencing depressive symptoms as a result.
The prevalence of narcissistic personality disorder is around 1% in the general population, but ranges from 2-16% in the clinical population.

In addition to individual therapies with a psychodynamic background, group therapy is considered.

# Antisocial personality disorder (DSM-5)/dissocial personality disoerder (ICD-10)

Was described by Cleckley (1964) as a psychopathic personality (psychopathic triad: “does not love, lack of anxiety, does not learn from experience”). The prevalence of antisocial personality disorderis 3% among men, 1% among women, and 75% in the prison population!

This personality disorder is an extreme case of egocentrism that does not shy away from immoral acts and exploits the other person unscrupulously, without remorse for its own purposes. The patient ignores the other's feelings – and is unable of intimacy. Persons with antisocial personality disorder are characterized by low tolerance for frustration, impulsivity, aggression, and it is difficult for them to adhere to social norms. They often communicate well, easily build trust, which are used for manipulative purposes, to exploit and mislead others.

The pattern of symptoms of the disorder often begins before the age of 15, in childhood they often miss school, torture animals, as an adult they drink alcohol, use drugs, and tend to have numerous forensic cases.

There is also a probable genetic factor in the background of the disorder, which is supported by twin research and adoption studies.

Their treatment by psychotherapy may be successful in prison or in a military setting, and self-help groups may be considered. When using pharmacotherapy, the risk of drug abuse must be taken into account! Attempts have been made to control impulsive behaviour by antiepileptic drugs (valproate, carbamazepine), especially in the presence of EEG-abnormalities.

# Cluster C – the anxious

- **Avoidant peronality disorder**
- **Obsessive-compulsive peronality disorder**
- **Dependent peronality disorder**

# Avoidant peronality disorder

Persons with Avoidant peronality disorder are pathologically afraid of rejection and criticism. HeThey are emotionally resonant, low in self-esteem, making them hypersensitive, easily embarrassed, afraid of social connections, so they avoid them and exclude them from their life, but at the same time they are not asocial, and show a great desire for companionship (unlike persons with schizoid personality disorder). Prevalence of Avoidant peronality disorder is between 1-10%. In the background of its developement, the early rejections of the parents and later that of their peers can be assumed.
Therapy: supportive psychotherapy, social skills training, group therapies. As pharmacotherapy anxiolytics, and, if necessary, SSRIs.

# Obsessive-compulsive peronality disorder

Persons with obsessive-compulsive peronality disorder are characterized by a rigid adherence to the rules. They are persistent in their tasks and performance, they carry out their work according to very high expectations, driven by perfectionism, although they are often lost in the details. Hesitant and frustrated in decision situations, persons with obsessive-compulsive peronality disorder constantly asks for advice.
They arevery sensitive to criticism, but always try to control his emotions and shows little resentment and anger.

Dynamically oriented psychotherapy, behavioral therapy and group therapy can be effective in the treatment of obsessive-compulsive peronality disorder. SSRI antidepressants or clomipramine are shown to be effective as pharmacotherapy.

# Dependent peronality disorder

Dependent peronality disorder is characterized by a pervasive need for care, a lack of self-confidence, and dependent and submissive behaviour. They are helpless, avoid responsibility, and always need someone ‚strong' to support them.

The patients are afraid of expressing their opinions, decisions, loneliness, or to refuse anything. Their relationship is affected by the need for the other, and if they get married, the partner will usually take on a complementary role.

Treatment: individual psychotherapy, group therapy, cognitive-behavioral therapy. They tend to seek help mainly because of their depressive, anxious symptoms, and often look for a dependent relationship with the therapist (the therapist's overprotective behavior may reinforce it)