Personality disorders

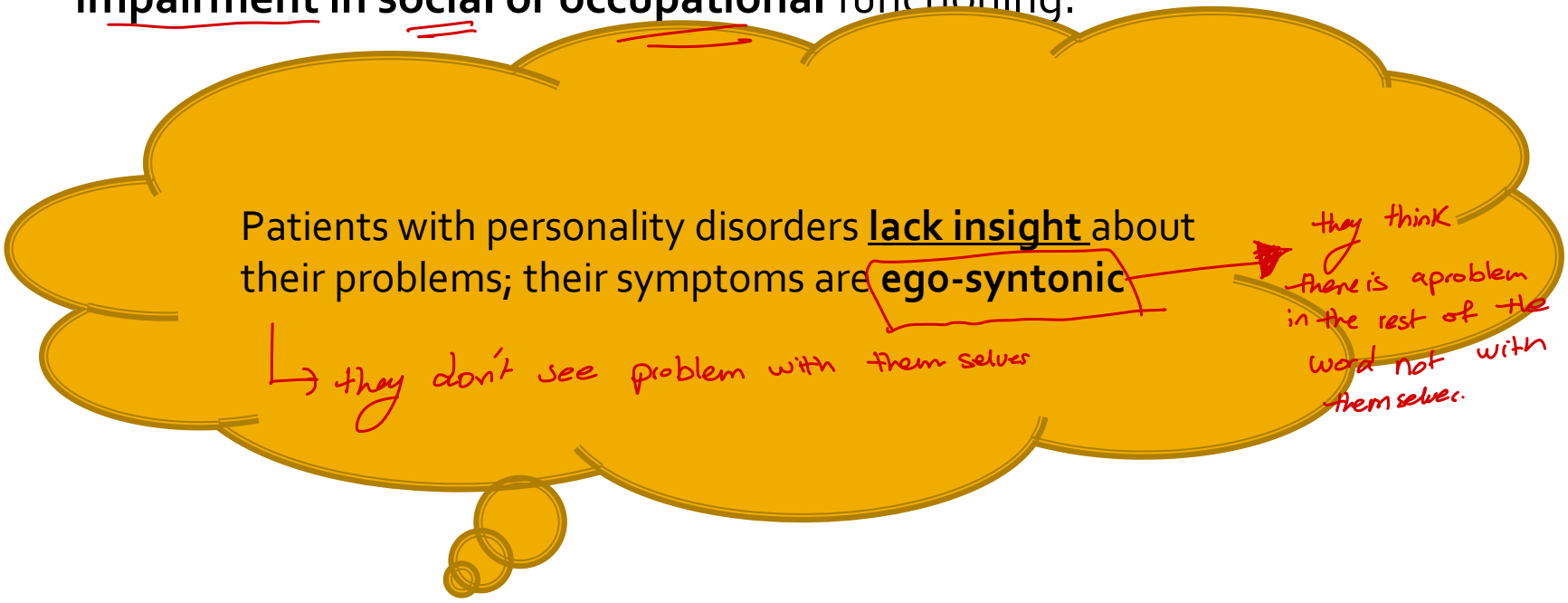
- borderline
- anti social
- paranoid

- their behavior traits are maladaptive to the society around them → result in difficulty with interactions over long term.

Personality disorders

- **Personality:-**one's set of stable, predictable emotional and behavioral traits.
- **Personality *disorders:-***deeply ingrained, inflexible patterns of relating to others that are **maladaptive and cause significant impairment in social or occupational** functioning.

Patients with personality disorders **lack insight** about their problems; their symptoms are **ego-syntonic**



DIAGNOSIS AND DSM-IV CRITERIA

1. Pattern of behavior/inner experience that deviates from the person's culture and is manifested in two or more of the following ways:

- Cognition
- Affect
- Personal relations
- Impulse control

2. The pattern:

- Is **pervasive and inflexible in a broad range of situations**
- Is **stable and has an onset no later than adolescence or early adulthood**
- Leads to significant distress in functioning
- Is not accounted for by another mental/medical illness or by use of a substance.

Personality disorders are divided into three clusters:

- **Cluster A—schizoid, schizotypal, and paranoid:**
  - Patients seem eccentric, peculiar, or withdrawn.
  - Familial association with psychotic disorders.
- **Cluster B—antisocial, borderline, histrionic, and narcissistic:**
  - Patients seem emotional, dramatic, or inconsistent.
  - Familial association with mood disorders.
- **Cluster C—avoidant, dependent, and obsessive–compulsive:**
  - Patients seem anxious or fearful.
  - Familial association with anxiety disorders

Personality disorder not otherwise specified (NOS) includes disorders that do not fit into clusters A, B, or C (including passive–aggressive personality disorder).

ETIOLOGY

- ✓ Biological.
- ✓ Genetic.
- ✓ psychosocial factors
- The prevalence of personality disorders in monozygotic twins is several times higher than in dizygotic twins.

TREATMENT

- Personality disorders are generally very difficult to treat, especially since few patients are aware that they need help.
- The disorders tend to be chronic and lifelong. In general, pharmacologic treatment has limited usefulness (see individual exceptions below) except in treating coexisting symptoms of depression, anxiety, and the like. Psychotherapy and group therapy are usually the most helpful.

CLUSTER A

- **Paranoid Personality Disorder (PPD):-**

pervasive distrust and suspiciousness of others, They tend to blame their own problems on others and seem angry and hostile.

DIAGNOSIS AND DSM-IV CRITERIA:-

- Diagnosis requires a general distrust of others, beginning by early adulthood and present in a variety of contexts. At least four of the following must also be present:

- Suspicion (without evidence) that others are exploiting or deceiving him or her.
- Preoccupation with doubts of loyalty or trustworthiness of acquaintances.
- Reluctance to confide in others.
- Interpretation of benign remarks as threatening or demeaning.
- Persistence of grudges.
- Perception of attacks on his or her character that are not apparent to others; quick to counterattack.
- Recurrence of suspicions regarding fidelity of spouse or lover.

Paranoid Personality Disorder (PPD

- **EPIDEMIOLOGY:-**
- ✓ Prevalence: 0.5 to 2.5%
- ✓ Men are more likely to have PPD than women.
- ✓ Higher incidence in family members of schizophrenics.

- **DIFFERENTIAL DIAGNOSIS:-**
- **Paranoid schizophrenia. But unlike** schizophrenic patients *do not have any fixed delusions and are not frankly psychotic.*
- **COURSE AND PROGNOSIS:-**
- ❖ Some patients with PPD may eventually be diagnosed with schizophrenia.
- ❖ The disorder usually has a chronic course, causing lifelong marital and job-related problems.
- **TREATMENT**
- Psychotherapy is the treatment of choice. Patients may also benefit from antianxiety medications or short course of antipsychotics for transient psychosis.

Schizoid Personality Disorder

- lifelong pattern of social withdrawal. They are often perceived as eccentric and reclusive. They are quiet and unsociable and have a constricted affect. They have *no desire for close relationships and prefer to be alone*.
- **DIAGNOSIS AND DSM-IV CRITERIA**

A pattern of voluntary social withdrawal and restricted range of emotional expression, beginning by early adulthood and present in a variety of contexts. Four or more of the following must also be present:-

- ✓ Neither enjoying nor desiring close relationships (including family).
- ✓ Generally choosing solitary activities.
- ✓ Little (if any) interest in sexual activity with another person.
- ✓ Taking pleasure in few activities (if any).
- ✓ Few close friends or confidants (if any).
- ✓ Indifference to praise or criticism.
- ✓ Emotional coldness, detachment, or flattened affect.

- **EPIDEMIOLOGY**
  - Prevalence: Approximately 7%
  - Men are two times as likely to have schizoid personality disorder as women.
  - There is not an increased incidence of schizoid personality disorder in families with history of schizophrenia.
- **DIFFERENTIAL DIAGNOSIS**
  - *Paranoid schizophrenia:- but unlike schizophrenic patient they* do not have any fixed delusions, although these may exist transiently in some patients.
- *Schizotypal personality disorder:* do not have the same eccentric behavior or magical thinking seen in patients with schizotypal personality disorder.

- **COURSE**

Usually chronic course, but not always lifelong.

- **TREATMENT**

Similar to paranoid personality disorder:

- Psychotherapy is the treatment of choice; group therapy is often beneficial.
- Low-dose antipsychotics (short course) if transiently psychotic, or antidepressants if comorbid major depression is diagnosed.

Schizotypal Personality Disorder

a pervasive pattern of eccentric behavior and peculiar thought patterns. They are often perceived as strange and eccentric.

DIAGNOSIS AND DSM-IV CRITERIA

- A pattern of social deficits marked by eccentric behavior, cognitive or perceptual distortions, and discomfort with close relationships, beginning by early adulthood and present in a variety of contexts. **Five** or more of the following must be present:
- **1. Ideas of reference (excluding delusions of reference)**
- **2. Odd beliefs or magical thinking, inconsistent with cultural norms**
- **3. Unusual perceptual experiences (such as bodily illusions)**
- **4. Suspiciousness**
- **5. Inappropriate or restricted affect**
- **6. Odd or eccentric appearance or behavior**
- **7. Few close friends or confidants**
- **8. Odd thinking or speech (vague, stereotyped, etc.)**
- **9. Excessive social anxiety**

- Magical thinking may include:
  - Belief in clairvoyance or telepathy
  - Bizarre fantasies or preoccupations
  - Belief in superstitions

Odd behaviors may include involvement in cults or strange religious practices.

EPIDEMIOLOGY

- Prevalence: 3.0%
- More prevalent in monozygotic than dizygotic twins.

- **DIFFERENTIAL DIAGNOSIS:-**
- *Paranoid schizophrenia:-* patients with schizotypal personality disorder are not frankly psychotic.
- *Schizoid personality disorder:* Patients with schizoid personality disorder do not have the same eccentric behavior seen in patients with schizotypal personality disorder.
- **COURSE**

Course is chronic or patients may eventually develop schizophrenia.

- **TREATMENT**
- Psychotherapy is the treatment of choice.
- Short course of low-dose antipsychotics if necessary (for transient psychosis)

CLUSTER B

- **Antisocial Personality Disorder:-**

refuse to conform to social norms and lack remorse for their actions. They are impulsive, deceitful, and often violate the law. However, they often appear charming and normal to others who meet them for the first time and do not know their history.

DIAGNOSIS AND DSM-IV CRITERIA

- Pattern of disregard for others and violation of the rights of others since age 15. Patients must be **at least 18 years old for this diagnosis; history of behavior** as a child/adolescent must be consistent with **conduct disorder** Three or more of the following should be present:-

- **1. Failure to conform to social norms by committing unlawful acts**
- **2. Deceitfulness/repeated lying/manipulating others for personal gain**
- **3. Impulsivity/failure to plan ahead**
- **4. Irritability and aggressiveness/repeated fights or assaults**
- **5. Recklessness and disregard for safety of self or others**
- **6. Irresponsibility/failure to sustain work or honor financial obligations**
- **7. Lack of remorse for actions**

- **EPIDEMIOLOGY:-**
- Prevalence: 3% in men and 1% in women
- Higher incidence in poor urban areas and in prisoners
- Genetic component: Five times increased risk among first-degree relatives
- **DIFFERENTIAL DIAGNOSIS:-**
- *Drug abuse:* It is necessary to ascertain which came first. Patients who began abusing drugs before their antisocial behavior started may have behavior attributable to the effects of their addiction.
- **COURSE:-**
- Usually has a chronic course, but some improvement of symptoms may occur as the patient ages. Many patients have multiple somatic complaints, and coexistence of substance abuse and/or major depression is common.

- **TREATMENT:-** Psychotherapy is the treatment of choice. Pharmacotherapy may be used to treat symptoms of anxiety or depression, but use caution due to high addictive potential of these patients.

Borderline Personality Disorder (BPD)

- unstable moods, behaviors, and interpersonal relationships.They feel alone in the world and have problems with self-image. They are impulsive and may have a history of repeated suicide attempts/gestures or episodes of self-mutilation.

DIAGNOSIS AND DSM-IV CRITERIA

- Pervasive pattern of impulsivity and unstable relationships, affects, self-image, and behaviors, present by early adulthood and in a variety of contexts. At least five of the following must be present:
- **1. Desperate efforts to avoid real or imagined abandonment**
- **2. Unstable, intense interpersonal relationships**
- **3. Unstable self-image**
- **4. Impulsivity in at least two potentially harmful ways (spending, sexual**activity, substance use, etc.)
- **5. Recurrent suicidal threats or attempts or self-mutilation**
- **6. Unstable mood/affect**
- **7. General feeling of emptiness**
- **8. Difficulty controlling anger**
- **9. Transient, stress-related paranoid ideation or dissociative symptoms.**

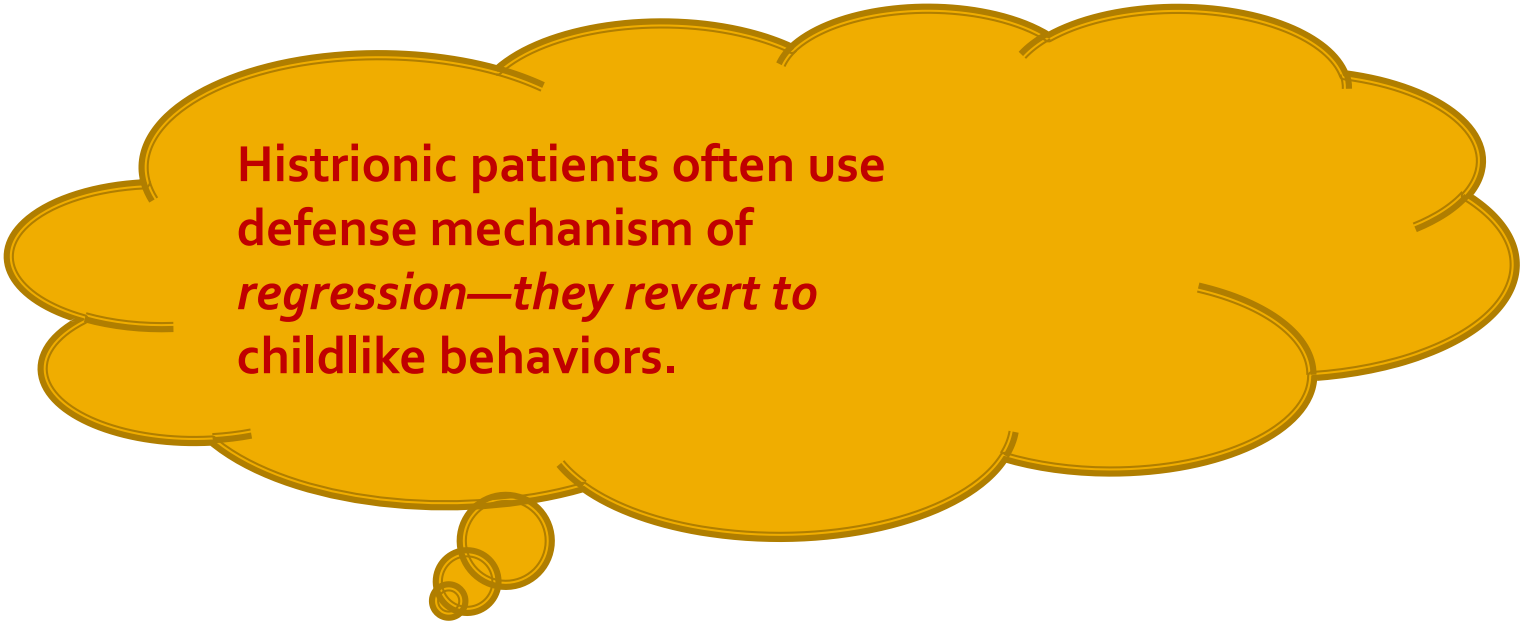
- **EPIDEMIOLOGY**
- Prevalence: **1 to 2%**
- Women are two times as likely to have BPD as men.
- 10% suicide rate.

- **DIFFERENTIAL DIAGNOSIS**
- *Schizophrenia: Unlike patients with schizophrenia, patients with borderline* personality disorder do not have frank psychosis (may have transient psychosis, however, if decompensate under stress).

- **COURSE**
- Usually has a stable, chronic course. High incidence of coexisting major depression and/or substance abuse; increased risk of suicide (often because patients will make suicide gestures and kill themselves by accident).
- **TREATMENT**
- Psychotherapy is the treatment of choice—behavior therapy, cognitive therapy, social skills training, and the like.
- Pharmacotherapy to treat psychotic or depressive symptoms as necessary

Histrionic Personality Disorder (HPD)

- attention-seeking behavior and excessive emotionality, They are dramatic, flamboyant, and extroverted but are unable to form long-lasting, meaningful relationships. They are often sexually inappropriate and provocative.



DIAGNOSIS AND DSM-IV CRITERIA

- Pattern of excessive emotionality and attention seeking, present by early adulthood and in a variety of contexts. At least five of the following must be present:
- **2. Inappropriately seductive or provocative behavior**
- **3. Uses physical appearance to draw attention to self**
- **4. Has speech that is impressionistic and lacking in detail**
- **5. Theatrical and exaggerated expression of emotion**
- **6. Easily influenced by others or situation**
- **7. Perceives relationships as more intimate than they actually are**

- **EPIDEMIOLOGY**
- Prevalence: 2 to 3%
- Women are more likely to have HPD than men.
- **DIFFERENTIAL DIAGNOSIS**
- *Borderline personality disorder: Patients with BPD are more likely to suffer from* depression and to attempt suicide. HPD patients are generally more functional.
- **COURSE**

Usually has a chronic course, with some improvement of symptoms with age.

- **TREATMENT**
- Psychotherapy is the treatment of choice.
- Pharmacotherapy to treat associated depressive or anxious symptoms as necessary

Narcissistic Personality Disorder (NPD)

- sense of superiority, a need for admiration, and a lack of empathy. They consider themselves "special" and will exploit others for their own gain. Despite their grandiosity, however, these patients often have fragile self-esteems.

DIAGNOSIS AND DSM-IV CRITERIA

- Pattern of grandiosity, need for admiration, and lack of empathy beginning by early adulthood and present in a variety of contexts. Five or more of the following must be present:-
- **1. Exaggerated sense of self-importance**
- **2. Preoccupied with fantasies of unlimited money, success, brilliance, etc.**
- **3. Believes that he or she is "special" or unique and can associate only** with other high-status individuals
- **4. Needs excessive admiration**
- **5. Has sense of entitlement**
- **6. Takes advantage of others for self-gain**
- **7. Lacks empathy**
- **8. Envious of others or believes others are envious of him or her**
- **9. Arrogant or haughty**

- **EPIDEMIOLOGY**

Prevalence: < 1%

- **DIFFERENTIAL DIAGNOSIS**
- *Antisocial personality disorder: Both types of patients exploit others, but NPD* patients want status and recognition, while antisocial patients want material gain or simply the subjugation of others. Narcissistic patients become depressed when they don't get the recognition they think they deserve.
- **COURSE**
- Usually has a chronic course; higher incidence of depression and midlife crises since these patients put such a high value on youth and power.
- **TREATMENT**
- Psychotherapy is the treatment of choice.
- Antidepressants or lithium may be used as needed (for mood swings if a comorbid mood disorder is diagnosed).

CLUSTER C

- **Avoidant Personality Disorder:-**
- Patients with avoidant personality disorder **have a pervasive pattern of social inhibition and an intense fear of rejection.** They will avoid situations in which they may be rejected. Their fear of rejection is so overwhelming that it affects all aspects of their lives. They avoid social interactions and seek jobs in which there is little interpersonal contact. These patients *desire companionship* but are extremely shy and easily injured.

DIAGNOSIS AND DSM-IV CRITERIA

- A pattern of social inhibition, hypersensitivity, and feelings of inadequacy since early adulthood, with at least four of the following:
- **1. Avoids occupation that involves interpersonal contact due to a fear of** criticism and rejection
- **2. Unwilling to interact unless certain of being liked**
- **3. Cautious of intrapersonal relationships**
- **4. Preoccupied with being criticized or rejected in social situations**
- **5. Inhibited in new social situations because he or she feels inadequate**
- **6. Believes he or she is socially inept and inferior**
- **7. Reluctant to engage in new activities for fear of embarrassment.**

- **EPIDEMIOLOGY**
- Prevalence: 1 to 10%
- Sex ratio not known
- **DIFFERENTIAL DIAGNOSIS**
- *Schizoid personality disorder:* Patients with avoidant personality disorder desire companionship but are extremely shy, whereas patients with schizoid personality disorder have no desire for companionship.
- *Social phobia (social anxiety disorder).*
- *Dependent personality disorder.*

- **COURSE :-** Course is usually chronic. Particularly difficult during adolescence, when attractiveness and socialization are important Increased incidence of associated anxiety and depressive disorders.
- **TREATMENT:-** Psychotherapy, including assertiveness training, is most effective.
- Beta blockers may be used to control autonomic symptoms of anxiety, and selective serotonin reuptake inhibitors (SSRIs) may be prescribed for major depression.

Dependent Personality Disorder (DPD)

- poor self-confidence and fear separation. They have an excessive need to be taken care of and allow others to make decisions for them. They feel helpless when left alone.

DIAGNOSIS AND DSM-IV CRITERIA

- A pattern of **submissive and clinging behavior due to excessive need to be taken care** of. At **least five** of the following must be present:
- **1. Difficulty making everyday decisions without reassurance from others**
- **2. Needs others to assume responsibilities for most areas of his or her life**
- **3. Cannot express disagreement because of fear of loss of approval**
- **4. Difficulty initiating projects because of lack of self-confidence**
- **5. Goes to excessive lengths to obtain support from others**
- **6. Feels helpless when alone**
- **7. Urgently seeks another relationship when one ends**
- **8. Preoccupied with fears of being left to take care of self**

- **EPIDEMIOLOGY:-**
- Prevalence: Approximately 1%
- Women are more likely to have DPD than men.
- **DIFFERENTIAL DIAGNOSIS:-**
- *Avoidant personality disorder.*
- *Borderline and histrionic personality disorder: Patients with DPD usually* have a long-lasting relationship with one person on whom they are dependent. Patients with borderline and histrionic personality disorders are often dependent on other people, but they are unable to maintain a long-lasting relationship.

- **COURSE:-**
  - Usually has a chronic course
  - Often, symptoms decrease with age and/or with therapy.
  - Patients are prone to depression, particularly after loss of person on whom they are dependent.

TREATMENT

- Psychotherapy is the treatment of choice.
- Pharmacotherapy may be used to treat associated symptoms of anxiety or depression.

Obsessive–Compulsive Personality Disorder (OCPD

- pervasive pattern of perfectionism, inflexibility, and orderliness. They get so preoccupied with unimportant details that they are often unable to complete simple tasks in a timely fashion. They appear stiff, serious, and formal with constricted affect. They are often successful professionally but have poor interpersonal skills

DIAGNOSIS AND DSM-IV CRITERIA

- Pattern of preoccupation with orderliness, control, and perfectionism at the expense of efficiency, present by early adulthood and in a variety of contexts. At least four of the following must be present:
- **1. Preoccupation with details, rules, lists, and organization such that the** major point of the activity is lost
- **2. Perfectionism that is detrimental to completion of task**
- **3. Excessive devotion to work**
- **4. Excessive conscientiousness and scrupulousness about morals and** ethics
- **5. Will not delegate tasks**
- **6. Unable to discard worthless objects**
- **7. Miserly**
- **8. Rigid and stubborn**

- **EPIDEMIOLOGY:-**
- Prevalence unknown
- Men are more likely to have OCPD than women.
- Occurs most often in the oldest child
- Increased incidence in first-degree relatives.
- **DIFFERENTIAL DIAGNOSIS**

Obsessive–compulsive disorder (OCD): Patients with OCPD do not have the recurrent obsessions or compulsions that are present inobsessive–compulsive disorder. In addition, the symptoms of OCPD are **ego-syntonic rather than ego-dystonic (as in OCD). That is, OCD patients** are aware that they have a problem and wish that their thoughts and behaviors would go away.

Narcissistic personality disorder: Both personalities involve assertiveness

- and achievement, but NPD patients are motivated by status, whereas
- OCD patients are motivated by the work itself.

- **COURSE**
- Unpredictable course
- Some patients later develop obsessions or compulsions (OCD), some
- develop schizophrenia or major depressive disorder, and others may improve or remain stable.
- **TREATMENT**
- Psychotherapy is the treatment of choice. Group therapy and behavior therapy may be useful.
- Pharmacotherapy may be used to treat associated symptoms as necessary.

PERSONALITY DISORDER NOT OTHERWISE SPECI FIED (NOS)

- This diagnosis is reserved for personality disorders that do not fit into categories A, B, or C. It includes passive–aggressive personality disorder, depressive personality disorder, sadomasochistic personality disorder, and sadistic personality disorder. Only passive–aggressive personality disorder.

Passive–Aggressive Personality Disorder

- Passive–aggressive personality disorder was once a separate personality disorder like those listed above but was relegated to the NOS category when DSMIV was published. Patients with this disorder are stubborn, inefficient procrastinators. They alternate between compliance and defiance and passively resist fulfillment of tasks. They frequently make excuses for themselves and lack assertiveness. They attempt to manipulate others to do their chores, errands, and the like, and frequently complain about their own misfortunes. Psychotherapy is the treatment of choice.