

Personality disorder

1. An enduring (not the result of physical, psychiatric illness, or personal catastrophic experience, nor the acute or withdrawal effects of substance abuse) pattern of maladaptive behaviour in several significant areas of functioning of an adult person's life
2. This behaviour can be traced back to childhood or adolescence
3. It is abnormal within the patient's cultural or religious group
4. It causes distress to the patient or others

Historical Aspects

1801 Pinel's **manie sans delire**

1835 Prichard's **moral insanity**

1906 Kraepelin's **psychopathic personality**

Theophrastus' Characters (After Tyrer 1988)

- dissimilar
- flatterer
- chatterer
- rustic
- complaisant
- reckless cynic
- loquacious man
- newsmonger
- unscrupulous man
- penurious man
- gross man
- unreasonable man
- stupid man
- surly man
- superstitious man
- grumbler
- distrustful man
- offensive man
- unpleasant man
- vain man
- boaster
- arrogant man
- coward
- oligarch
- later learner
- slanderer
- friend of the rabble
- avaricious man
- mean man

Schneider's Ten different psychopathic personalities (1920s)

- **hyperthymic** - cheerful, lively, overoptimistic, uncritical but shallow
- **depressive** - continuous dark mood, pessimistic, anxious, mistrustful and no capacity for fun
- **anankast** - ridden with scruples, defended with conventional punctiliousness
- **fanatic** - overvalued ideas, will fight for their rights, but can have a tendency to paranoia and jealousy
- **attention-seeking** - hungry for attention, will do anything to impress, *pseudologica phantastica*, sad tale of shallow relationships
- **labile** - rapid changing moods, with episodes of impulsive behaviour
- **explosive** - pugnacious, sharp tempered, who explode at the slightest provocations

- **affectionless** - cold, lacking compassion, shame or honour, and can be utterly ruthless
- **weak willed** - compliant and open to any influence, good influences are transient, eventually becoming feckless and socially unstable
- **asthenic** - weak and complaining, prone to hypochondriasis, anxious over failure, easily fatigues, *neurasthenic*

Henderson

- aggressive psychopaths
- passive & inadequate personalities
- creative psychopaths

Kretschmer (1936)

- attempted to link psychological types to body build:
- **pyknic** (stocky and rounded)
 - linked to cyclothymic personality type, characterized by varying moods and sociability
 - said to be associated with manic-depression
- **athletic** (strong development of muscles and bones)
 - associated with epilepsy
- **asthenic** (lean and narrow)
 - related to the schizotypal personality type, which is cold, aloof, and self-sufficient

Sheldon *et al* (1940)

- rated body build on three dimensions:
- **endomorphism** (predominance of softness and rounded)
 - linked with manic-depression
- **mesomorphism** (predominance of muscle, bone, and connective tissue)
 - linked with aggression and criminality
- **ectomorphism** (predominance of linearity and fragility)
 - linked with schizophrenia

Kretschmer	Sheldon	Linked with: (note no links proved)
pyknic	endomorph	manic depression
athletic	mesomorph	epilepsy, aggression, criminality
asthenic	ectomorph	schizophrenia

Prevalence

- UK prevalence rates:
 - general population = 13 %
 - attending GP with psychiatric symptoms = 30 %
 - outpatient and inpatient psychiatric patients = 50 %

- parasuicidal population (mainly antisocial or borderline):
 - male = 26-83 %
 - female = 16-64 %
- prison population (mainly antisocial) = 40-75 %
- those with discipline problems = up to 90 %

Paranoid

- increased incidence in families with schizophrenia and persecutory delusions
- prevalence:
 - 0.5-2.5 % in general population
 - 2-10 % outpatient psychiatry
 - 10-30 % inpatient psychiatry

Schizoid

- diagnosed slightly more commonly in males
- non-demonstrated co-morbidity with schizophrenia
- prevalence:
 - 0.5-1 % in general population

Schizotypal

- family aggregation, with increase among first degree relatives with schizophrenia
- commoner in USA
- prevalence:
 - 0.5-5 % in general population

Antisocial

- more commonly diagnosed with low socioeconomic status
- prevalence:
 - 3 % males general population
 - 1 % females general population
 - 3-30 % clinical setting, with higher rates with substance abuse and forensic settings (up to 60 % of prison population)

Borderline

- 75 % diagnosed in females
- 5 times more common in first degree relatives with the disorder
- frequent co-morbidity with other psychiatric disorders
- prevalence:
 - 1-4.5 % in general population
 - 10 % outpatient psychiatry
 - 20 % inpatient psychiatry
 - 20-60 % clinical population with personality disorder
 - 55 % of patients with bulimic symptoms, 50 % of these with history of child sexual abuse

Histrionic

- diagnosed more commonly in females

- prevalence:
 - 1.5-3 % in general population
 - 10-15 % outpatient psychiatry
- dissociation and somatization syndrome more commonly seen in this group

Narcissistic

- 50-70 % diagnoses in males
- prevalence:
 - less than 0.5 % in general population
 - 2-16 % outpatient psychiatry

Avoidant

- equal sex prevalence
- prevalence:
 - 0.5-1 % in general population
 - 10 % of psychiatric patients
- association with depression, anxiety, and phobias

Dependent

- more common in female psychiatric patients, but overall has equal sex incidence
- prevalence:
 - 1.5-6.5 % in general population
 - 3-10 % of psychiatric patients
- co-morbidity with generalized anxiety, phobias, hypochondriasis, and long standing non-psychotic psychiatric illness

Obsessive-Compulsive

- twice as common among males
- prevalence:
 - 1.5-6.5 % in general population
 - 3-10 % of psychiatric patients

The Neurophysiological basis of personality

- Eysenck (1970) suggested that differences in neuroticism are related to differences in the activity of the visceral brain, while differences in introversion-extroversion are related to differences in arousal system
- Cloninger (1986) proposed that three brain functions are relevant to personality, and that personality traits could be the expression of these basic dispositions:
 1. *behavioural activation*
 - associated with a disposition to seek novelty, avoid monotony, and avoid punishment or non-reward
 2. *behavioural inhibition*
 - associated with harm avoidance
 3. *behavioural maintenance*
 - associated with reward dependence

F60 Personality disorder

1. There is evidence that the individual's characteristic and enduring patterns of inner experience and behaviour as a whole deviate markedly from the culturally expected and accepted range. Such deviations must be manifest in more than one of the following areas:
 - i) cognition (i.e. ways of perceiving and interpreting things, people and events, forming attitudes and images of self and others)
 - ii) affectivity (range, intensity and appropriateness of emotional arousal and response)
 - iii) control over impulses and gratification of needs
 - iv) manner of relating to others and of handling interpersonal situations
2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations
3. There is personal distress, or adverse impact on the social environment, or both
4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence
5. The deviation cannot be explained as a manifestation or consequence of other adult mental disorders
6. Organic brain disease, injury, or dysfunction must be excluded as the possible cause of the deviation

The diagnosis of personality disorder (in DSM an Axis II disorder)

1. Cluster A - odd or eccentric
 - paranoid
 - schizoid
2. Cluster B - dramatic, emotional, erratic
 - dissocial
 - emotionally unstable
 - histrionic
3. Cluster C - anxious, fearful
 - anxious/ avoidant
 - dependent
 - anankastic

F60.0 Paranoid personality disorder

Aetiology

- Freud suggested that paranoid thinking results from the projection of unacceptable feelings and impulses onto others
- Cameron (1963) suggested that a central feature of the disorder is a basic absence of trust which results from a lack of consistent parental affection and mistreatment in childhood

Diagnostic criteria

- At least four of the following must be present:

- 1. Sensitive** Excessive sensitivity to setbacks and rebuffs
- 2. Grudging** Tendency to bear grudges persistently, e.g. refusal to forgive insults, injuries, or slights
- 3. Suspicious** Suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous
- 4. Argumentative** A combative and tenacious sense of personal rights out of keeping with the actual situation
- 5. Jealous** Recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner
- 6. Self-centred** Persistent self-referential attitude, associated particularly with excessive self importance
- 7. Mistrustful** Preoccupation with unsubstantiated 'conspiratorial' explanations of events either immediate to the patient or in the world at large

Treatment

- patients with this disorder do not engage well in psychological treatment because they are touchy and suspicious

F60.1 Schizoid personality disorder

Aetiology

- psychodynamic ideas focus on the inability to give or receive love
- Klein (1952) suggested that all infants pass through a 'schizoid position' during development in which oral and sadistic impulses are experienced as dangerous and are projected onto the parent
- people with a schizoid personality have retained some of these projective defences

Diagnostic criteria

- At least four of the following must be present:

- 1. Humourless** Few, if any, activities provide pleasure
- 2. Emotionally cold** Display of emotional coldness, detachment or flattened affectivity
- 3. Detached** Limited capacity to express either warm, tender feelings, or anger towards others
- 4. Indifferent** An appearance of indifference to either praise or criticism
- 5. Loveless** Little interest in having sexual experiences with another person
- 6. Solitary** Consistent choice of solitary activities
- 7. Introspective** Excessive preoccupation with fantasy and introspection
- 8. Friendless** No desire for, or possession of, any close friends or confiding relationships (or only one)
- 9. Unconventional** Marked insensitivity to prevailing social norms and conventions, disregard for such norms and conventions is unintentional

Treatment

- the patient tends to avoid close personal contact
- process is slow and often not successful

F60.2 Dissocial (Antisocial) Personality Disorder

Aetiology

1. **Biological**

- a) *genetic causes:*
 - i) a twin study by Lange (1931) looking at criminal offending as indicator of antisocial personality disorder found that out of 13 MZ twins, 10 had offended; of 17 DZ twins, only 2 had offended
 - ii) similar conclusions were drawn by an Australian study by Rosanoff *et al.* (1934) - 33 MZ twins (22 had co-twins who had offended) and 23 DZ twins (only 3 had a co-twin who had offended)
 - iii) a number of studies have suggested that antisocial behaviour is increased amongst the adopted children of antisocial biological parents (Crowe 1974; Cadoret *et al.* 1975)
- b) *cerebral pathology:*
 - i) no convincing evidence linking antisocial behaviour in adulthood with brain injury in childhood
 - ii) EEG abnormalities consistent with maturational delays have been reported in people with antisocial personalities (Hill 1952)
 - a) bilateral excess of slow waves (θ activity)
 - b) foci of 3-5 Hz in the posterior temporal regions
 - c) abnormalities more frequent on the right hand side
 - iii) Williams (1969) found abnormalities most often in the anterior temporal region
- c) *5-HT and aggression:*
 - i) low levels of 5-HIAA (a metabolite of serotonin) have been found in the CSF of subjects who have just committed acts of unpremeditated violence (Linnoila & Virkkunen 1992)
 - ii) studies have shown lower 5-HT mediated prolactin release in subjects with histories of impulsive aggressiveness (Coccaro *et al.* 1989)
 - iii) there is a negative correlation between levels of CSF 5-HIAA and aggressive behaviour in rhesus monkeys (Dee Hingley *et al.* 1992)

2. **Psychosocial**

- a) strong evidence for a continuity between behavioural disorders in childhood and antisocial behaviour in adulthood (Isle of Wight study - Rutter *et al.* 1970)
 - i) Rutter (1972) showed that the association between separation and antisocial behaviour in sons is determined by disharmony in the marriage
- b) Bowlby (1944) suggested that separation of a young child from its mother leads to a personality characterized by antisocial behaviour, and failure to form close relationships
- c) Eysenck (1970) suggested that antisocial personality disorder is more likely to develop in people who condition slowly and so fail to learn normal social behaviour

- d) Scott (1960) proposed four ways in which repeated antisocial behaviour could develop:
 - i) growing up in antisocial families
 - ii) no opportunity to learn because they were not presented with consistent rules of behaviour in the family
 - iii) as a way of overcoming emotional problems
 - iv) a learning disability may result in poor ability to sustain attention

- At least three of the following must be present:

- | | |
|-------------------------------------|---|
| 1. Callous | Callous unconcern for the feelings of others |
| 2. Irresponsible | Gross and persistent attitude of responsibility and disregard for social norms, rules, and obligations |
| 3. Short relationships | Incapacity to maintain enduring relationships, though with no difficulty in establishing them |
| 4. Low frustration tolerance | Very low tolerance to frustration and a low threshold for discharge of aggression, including violence |
| 5. Lack of guilt | Incapacity to experience guilt, or to profit from adverse experience, particularly punishment |
| 6. Blames others | Marked proneness to blame others, or to offer plausible rationalizations for the behaviour that has brought the individual into conflict with society |

Treatment

1. **Therapeutic community**
 - a) work done by Jones (1952) in the Social Rehabilitation Unit at Belmont Hospital
 - b) Rapoport (1960) suggested four aspects of treatment that may be important in bringing about change:
 - i) permission to act on feelings without the usual social restraints
 - ii) sharing of tasks and responsibilities
 - iii) group decision-making to involve patients in making rules as well as breaking them
 - iv) confrontation of each person with the effects of his actions on others

F60.3 Emotionally unstable personality disorder

Aetiology

- psychoanalytic explanations propose that widespread problems in personal relationships result from severe disturbance of early relationships with parents
- people with borderline P.D. are more likely than controls to report physical and sexual abuse in childhood (Berelowicz and Tarnopolsky 1993)
- Beck and Freeman (1990) proposed a cognitive model in which borderlines have three inappropriate beliefs:
 1. that the world is dangerous
 2. that the person is vulnerable and powerless
 3. that the person is 'inherently unacceptable'

Impulsive type (F60.30)

- At least three of the following must be present, one of which must be (2):
 1. **Unpredictable** Marked tendency to act unexpectedly and without consideration of the consequences
 2. **Quarrelsome** Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized
 3. **Explosive** Liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions
 4. **Desultory** Difficulty in maintaining any course of action that offers no immediate reward
 5. **Capricious** Unstable and capricious mood

Borderline type (F60.31)

- At least three symptoms of Impulsive type and at least two of the following must be present:
 1. **Poor self image** Disturbances in and uncertainty about self-image, aims and internal preferences (including sexual)
 2. **Relationship crisis** Liability to become involved in intense and unstable relationships, often leading to emotional crises
 3. **Fear of abandonment** Excessive efforts to avoid abandonment
 4. **Self-harm** Recurrent threats or acts of self harm
 5. **Feelings of emptiness** Chronic feelings of emptiness

Treatment

- patients do not generally respond to exploratory psychotherapy
- group treatment has the advantages that the transference relationships are spread over the group

- interpersonal therapy (Weissman & Klerman 1993)
 - time-limited, not long term
 - focused, not open-ended
 - current, not past interpersonal relationships
 - interpersonal, not intrapsychic
 - interpersonal, not cognitive-behavioural
 - personality recognized, but not the focus

F60.4 Histrionic Personality disorder

Aetiology

- psychoanalytic explanations relate this disorder to failure to resolve either Oedipal conflicts or oral conflicts
- excessive use of repression as a mechanism of defence

Diagnostic criteria

- At least four of the following must be present:

- 1. Dramatic** Self-dramatization, theatrically, or exaggerated expression of emotion
- 2. Suggestibility** The individual is easily influenced by others or by circumstances
- 3. Affective** Shallow and labile affectivity
- 4. Stimulus seeking** Continual seeking for excitement and activities in which the individual is the centre of attention
- 5. Seductive** Inappropriate seductiveness in appearance or behaviour
- 6. Vanity** Over-concern with physical attractiveness

Treatment

- difficulties arising:
 - unreasonable requests for medication
 - repeated seeking for assurances of continuing help
 - telephoning at unreasonable times
 - attempts to impose impractical conditions on treatment
 - seductive behaviour
 - threats of dangerous actions

F60.5 Anankastic personality disorder (Obsessive compulsive)

Aetiology

- psychoanalytic theory suggests that obsessional personality disorder originates in the same disturbances of early development (those at the anal stage) as those that cause obsessional symptoms
- a set of defence mechanisms is proposed which includes regression, reaction formation, and isolation

Diagnostic criteria

- At least four of the following must be present:

- | | |
|-----------------------------|---|
| 1. Cautious | Feelings of excessive doubt and caution |
| 2. Orderliness | Preoccupation with details, rules, lists, order, organization, or schedule |
| 3. Perfectionist | Perfectionism that interferes with task completion |
| 4. Conscientiousness | Excessive conscientiousness and scrupulousness |
| 5. Productivity | Undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships |
| 6. Pedantic | Excessive pedantry and adherence to social conventions |
| 7. Rigid | Rigidity and stubbornness |
| 8. Martinette | Unreasonable insistence by the individual that others submit to exactly his or her way of doing things, or unreasonable reluctance to allow others to do things |

Treatment

- poor response to treatment
- unskilled treatment can lead to excessive morbid introspection

F60.6 Anxious (avoidant) personality disorder

Aetiology

- a cognitive model proposes fear of rejection, self-criticism, and inaccurate evaluations of the reactions of other people

Diagnostic criteria

- At least four of the following must be present:

- 1. Anxiety** Persistent and pervasive feelings of tension and apprehension
- 2. Inferiority feelings** Belief that one is socially inept, personally unappealing, or inferior to others
- 3. Fear of rejection** Excessive preoccupation with being criticized or rejected in social situations
- 4. Afraid to trust** Unwillingness to become involved with people unless certain of being liked
- 5. Restricted life** Restrictions in lifestyle because of need for physical security
- 6. Social avoidance** Avoidance of social or occupational activities that involve significant interpersonal contact, because of fear of criticism, disapproval, or rejection

F60.7 Dependent personality disorder

Aetiology

- fixation at the oral stage of development, or as a regression to that stage because of a failure to resolve Oedipal conflicts

Diagnostic criteria

- At least four of the following must be present:

- 1. Dependence** Encouraging or allowing others to make most of one's important life decisions
- 2. Subordination** Subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes
- 3. Undemanding** Unwillingness to make even reasonable demands on the people one depends on
- 4. Helplessness** Feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself
- 5. Fear of not coping** Preoccupation with fears of being left to care for oneself
- 6. Need for reassurance** Limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others

Treatment

- patients are usually helped by problem solving counselling in which they are encouraged to take responsibility for themselves

F60.8 Other specific personality disorders - Narcissistic

- At least five of the following must be present:

- 1. Grandiose** A grandiose sense of self-importance (e.g. the individual exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- 2. High ideals** Preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- 3. Self-opinionated** Belief that he or she is 'special' and unique and can be understood only by, or should associate only with, other special or high-status people (or institutions)
- 4. Needs admiration** Need for excessive admiration
- 5. Expects privilege** A sense of entitlement, unreasonable expectations of especially favourable treatment, or automatic compliance with his or her expectations
- 6. Exploits others** Exploitation of interpersonal relationships, taking advantage of others to achieve his or her own ends
- 7. Lacks empathy** Lack of empathy; unwillingness to recognize or identify with the feelings and needs of others
- 8. Envy** Frequent envy of others or belief that others are envious of him or her
- 9. Arrogant** Arrogant, haughty behaviour, or attitudes

F21 Schizotypal disorder

- At least four of the following must be present over at least two years: The subject must never have met the criteria for any disorder in F20.- schizophrenia

- 1. Aloof** Inappropriate or constricted affect, with the individual appearing cold and aloof
- 2. Odd** Behaviour or appearance that is odd, eccentric, or peculiar
- 3. Solitary** Poor rapport with others and a tendency to social withdrawal
- 4. 'Magical thinking'** Odd beliefs or magical thinking, influencing behaviour and inconsistent with subcultural norms
- 5. Suspiciousness** Suspiciousness or paranoid ideas
- 6. Ruminations** Ruminations without inner resistance, often with dysmorphophobic, sexual, or aggressive contents
- 7. Unusual perceptions** Unusual perceptual experiences including somatosensory or other illusions, depersonalization, or derealization
- 8. Vague** Vague, circumstantial, metaphorical, over-elaborate, or often stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence
- 9. Delusions** Occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations, and delusion-like ideas, usually occurring without external provocation

Drug Treatment of personality disorder

Antipsychotic drugs

- short term beneficial effects for patients with borderline personality disorder
- given in doses smaller than those used for psychosis
- beneficial effects for periods of increased disturbance

Tricyclic Antidepressants

- tricyclic antidepressants sometimes appear to worsen borderline personality disorder (Soloff *et al.* 1986)
- FLUOXETINE may be helpful for borderline personality disorder even when there is no associated depressive disorder (Marcovitz & Schultz 1993)

MAOIs

- one small study found that they helped patients with borderline personality disorder (Cowdrey & Gardner 1988)

Lithium carbonate

- appears to reduce mood variation in some patients with cyclothymic personality disorder
- some reports of decreased aggression in many types of personality disorder - effect usually takes 2 weeks

Antiepileptic drugs

- CARBEMAZEPINE has been used to control behavioural dyscontrol