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English Teachers On Call

Personality Disorders

significantly in their manifestations, but all are believed to be caused by a combination of genetic and environmental factors. Most gradually become less severe with age. Diagnosis is clinical. Treatment is with psychosocial therapies and sometimes drug therapy.

Personality traits are patterns of thinking, perceiving, reacting, and relating that are relatively stable over time. Personality disorders exist when these traits become so pronounced, rigid, and maladaptive that they impair work and/or interpersonal functioning. These social maladaptations can cause significant distress in people with personality disorders and in those around them. For people with personality disorders (unlike many others who seek counseling), the distress caused by the consequences of their socially maladaptive behaviors is usually the reason they seek treatment, rather than any discomfort with their

own thoughts and feelings. Thus, clinicians must initially help patients see that their personality traits are the root of the problem.

Personality disorders usually start to become evident during late adolescence or early adulthood, and their traits and symptoms vary considerably in how long they persist; many resolve with time.

According to the current *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), personality disorders are primarily problems with

- Self-identity
- Interpersonal relationships

Self-identity problems may manifest as an unstable self-image (eg, people fluctuate between seeing themselves as kind and cruel) or in inconsistencies in values, goals, and appearance (eg, people are deeply religious while in church but profane and disrespectful elsewhere). Interpersonal issues typically manifest as failing to develop or sustain close relationships or as being insensitive to others (eg, unable to empathize).

People with personality disorders often seem inconsistent, confusing, and frustrating to people around them (including clinicians). These people may have difficulty knowing the boundaries between themselves and others. Their self-esteem may be inappropriately high or low. They may have inconsistent, detached, overemotional, abusive, or irresponsible styles of parenting, which can lead to physical and mental problems in their spouse or children. Personality disorders often coexist with mood, anxiety, substance abuse, somatization, and eating disorders. For patients with such comorbid conditions, having a personality disorder usually results in a significantly worse prognosis and makes a response to treatment less likely.

About 13% of the general population has a personality disorder. Overall, there are no clear distinctions in terms of sex, socioeconomic class, and race. However, in antisocial personality disorder, men outnumber women 6:1. In borderline personality disorder, women outnumber men 3:1 (but only in clinical settings, not in the general population). For most personality disorders, levels

of heritability are about 50%, which is similar to or higher than that of many other major psychiatric disorders. This degree of heritability argues against the common assumption that personality disorders are character flaws primarily shaped by an adverse environment.

Classification

The *DSM*, Fourth Edition Text Revision (DSM-IV-TR) divided 10 personality disorders into 3 clusters. The new DSM-5 does not use clusters and recognizes fewer disorders; these disorders are the focus here.

Schizotypal personality disorder: Schizotypal personality disorder, like its historical cousins paranoid and schizoid personality types, involves social withdrawal and emotional coldness. However, schizotypal personality disorder also includes oddities of thinking, perception, and communication, such as magical thinking, clairvoyance, ideas of reference, and paranoid ideation.

http://odlarmed.com/?p=4171

Patients tend to be suspicious of change and frequently misattribute hostile and malevolent motives to others. These oddities suggest a diagnosis of schizophrenia but are never severe enough to meet its criteria. People with schizotypal personality are believed to have a muted expression of the genes that cause schizophrenia.

Borderline personality disorder: Borderline personality disorder is commonly seen in all psychiatric and medical settings. It is marked by instability of self-image, mood, behavior, and relationships.

Histrionic personality disorder may represent a subgroup of borderline personality disorder patients who share the emotional volatility and instability in relationships.

http://www.addictionsearch.com/treatment_articles/article/borderline-personality-disorder-and-substance-abuse_135.html

People with borderline personality disorder are hypersensitive. They tend to believe that they were deprived of adequate care during childhood and consequently feel empty, angry, and entitled to nurturing. As a result, they

relentlessly seek care and are sensitive to its perceived absence. Their relationships tend to be intense and dramatic. When feeling cared for, they appear like lonely waifs who seek help for their depression, substance abuse, eating disorders, somatic complaints, and past mistreatments. When they fear loss of the caring person, they frequently express inappropriate and intense anger. These mood shifts are typically accompanied by extreme shifts in their view of the world, themselves, and other people—eg, from bad to good, from hated to loved. When they are upset or feel self-hatred, they often harm themselves. When they feel abandoned, they dissociate, have brief episodes of psychotic thinking, or become desperately impulsive, sometimes engaging in suicidal acts.

Patients with borderline personality initially tend to evoke intense, nurturing responses in caregivers, but after repeated crises, vague unfounded complaints, and failures to adhere to therapeutic recommendations, these patients can evoke hostile, negative responses.

Borderline personality disorder is likely to remit (in about 50% by 2 yr and 85% by 10 yr), and once it remits, it usually does not relapse. However, this reduction of symptoms is not associated with a comparable improvement in social functioning. After 10 yr, only about 20% have stable relationships or full-time employment.

Antisocial personality disorder: Antisocial personality disorder (and the historically related disorder of psychopathic personality disorder) is marked by a callous disregard for the rights and feelings of other people. Affected people exploit others for materialistic gain or personal gratification. They become frustrated easily and tolerate frustration poorly. Characteristically, they act out their conflicts impulsively and irresponsibly, sometimes with hostility and violence. Typically, they do not anticipate the consequences of their behaviors and do not feel remorse or guilt afterward. Many of them have a well-developed capacity for glibly rationalizing their behavior and/or blaming it on others. Dishonesty and deceit permeate their relationships. Punishment rarely modifies their behavior or improves their judgment.

http://suite101.com/article/signs-and-symptoms-of-antisocial-personality-disorder-a367830

Antisocial personality often leads to alcoholism, drug addiction, promiscuity, failure to fulfill responsibilities, frequent relocation, and difficulty abiding by laws. Life expectancy is decreased, but the disorder tends to diminish or stabilize with age.

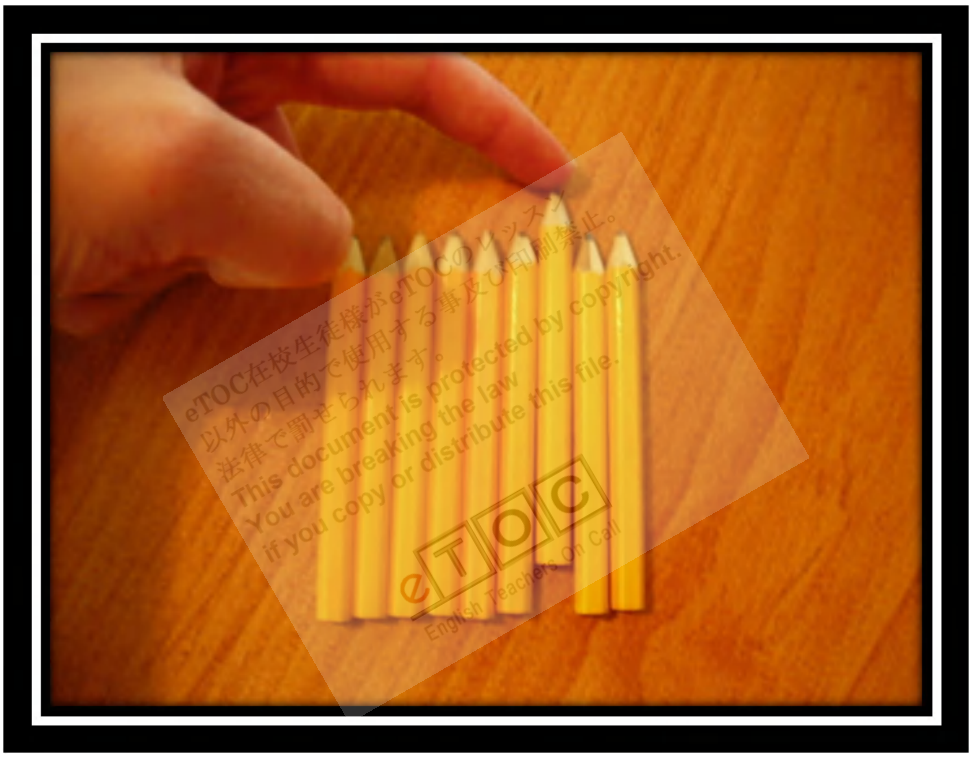
Narcissistic personality disorder: The central trait in narcissistic personality disorder is grandiosity. Affected people have an exaggerated sense of superiority and expect to be treated with deference. They may exploit others because they think their superiority justifies it. Their relationships are characterized by a need to be admired. They often believe other people envy them, and they are extremely sensitive to criticism, failure, or defeat. When confronted with a failure to fulfill their high opinion of themselves, they can become enraged or seriously depressed and suicidal.

http://www.treatment4addiction.com/conditions-disorders/personality/narcissistic/
http://blog.sunbeltstaffing.com/therapy/narcissistic-personality-disorder/

Avoidant personality disorder: Avoidant personality disorder is marked by withdrawal from people or situations where rejection, failure, or conflict might occur. Affected people fear starting relationships or anything else new because of the risk of failure or disappointment. Because affected people have a strong conscious desire for affection and acceptance, they are openly distressed by their isolation and inability to relate comfortably to other people.

http://helpingpsychology.com/avoidant-personality-disorder

Obsessive-compulsive personality disorder: Obsessive-compulsive personality disorder is characterized by conscientiousness, orderliness, and reliability. However, affected people are often also inflexible and thus unable to adapt to change. They take responsibilities seriously, but because they hate mistakes and incompleteness, they can become **entangled** with details and forget their purpose. As a result, they have difficulty making decisions and completing tasks. Such problems make having responsibilities a source of anxiety, and they rarely enjoy much satisfaction from their achievements.



http://suite101.com/article/obsessivecompulsive-personality-a28671

Nonetheless, most obsessive-compulsive traits are adaptive; as long as the traits are not too marked, people with these traits often achieve much, especially in the sciences and other academic fields that benefit from organization, **perfectionism**, and **perseverance**. However, feelings and interpersonal conflict may make them uncomfortable, as may situations that they lack control of, that require them to rely on other people, or that are unpredictable.

Diagnosis

- Clinical criteria from DSM-5

Patients with a personality disorder often **lack insight** into their condition and present with complaints such as anxiety, depression, substance abuse, or other issues not obviously related to personality. Thus, clinicians should be alert for signs that such complaints are due to an underlying personality disorder. One early clue can be the clinician's reactions to the patient. A sense of discomfort (eg, **annoyance**, anger, **defensiveness**) when interacting with a patient often signals the presence of a personality disorder; however, because such reactions are subjective, clinicians should seek confirmatory evidence from others who interact with the patient. Other clues can be the sense that the patient's problems are self-generated (sometimes leading the clinician to wonder "why don't they just stop doing that?") or that the problems appear to be bad habits, such as social withdrawal, **over conscientiousness**, impulsivity, or **excessive hostility.**

Pearls & Pitfalls

Be alert to complaints that appear unrelated to personality but may reflect distress caused by socially maladaptive behaviors due to a personality disorder.

Treatment

- Psychosocial therapy
- A comprehensive approach, often requiring prolonged treatment

Treatment is primarily psychosocial—ie, with individual psychotherapy (psychodynamic or cognitive-behavioral), group therapy, or family therapy. Personality traits and their manifestations typically are not very responsive to drugs. Prolonged treatment is often required.

General principles of treatment: In general, treatment aims to

- Reduce subjective distress
- Enable patients to understand that their problems are internal to themselves
- Decrease significantly maladaptive and socially undesirable behaviors
- Modify problematic personality traits

Reducing subjective distress (eg, anxiety, depression) is the first goal. These symptoms often respond to increased psychosocial support, which often includes moving the patient out of highly stressful situations or relationships. Drug therapy may also help. Reduced stress makes treating the underlying personality disorder easier.

An early effort should be made to enable patients to see that their problems with work or relationships are internal—ie, caused by their problematic ways of relating to the world (eg, to tasks, to authority, or in intimate relationships). Achieving such understanding requires a substantial amount of time, patience, and commitment on the part of a clinician. Clinicians also need a basic understanding of the patient's areas of emotional sensitivity and usual ways of coping. Family members and friends can help identify problems that patients and clinicians would otherwise be unaware of.

Maladaptive and undesirable behaviors (eg, recklessness, social isolation, lack of assertiveness, temper outbursts) should be dealt with quickly to minimize ongoing damage to jobs and relationships. Behavioral change is most important for patients with borderline, antisocial, or avoidant personality disorder. Behavior can typically be improved within months by group therapy and behavior modification; limits on behavior must often be established and enforced. Sometimes patients are treated in a day hospital or residential setting. Self-help groups or family therapy can also help change socially undesirable behaviors. Because family members and friends can act in ways that either reinforce or diminish the patient's problematic behavior or thoughts, their involvement is helpful; with coaching, they can be allies in treatment.

Modifying problematic personality traits (eg, dependency, distrust, arrogance, manipulativeness) takes a long time—typically > 1 yr. The cornerstone for effecting such change is individual psychotherapy. During therapy, clinicians try to identify interpersonal problems as they occur in the patient's life. Clinicians then help patients understand how these problems are related to their personality traits and provide skills training to develop new, better ways of interacting. Typically, clinicians must repeatedly point out the undesirable behaviors and their consequences before patients become aware of them to

help them change their maladaptive behaviors and mistaken beliefs. Although clinicians should act with sensitivity, they should be aware that kindness and sensible advice by themselves do not change personality disorders.

Treatment of specific disorders: **Schizotypal personality disorder** may be treated with antipsychotic drugs and individual counseling focusing on reality testing, situational management, and support. Benefit with these treatments is modest.

Borderline personality disorder can be effectively managed by experienced clinicians; inexperienced clinicians often do not help, or they make the disorder worse. Borderline personality disorder should be the primary target of treatment when it occurs with major depressive, panic, bipolar, or eating disorders. It is the secondary target when it occurs with substance use disorders. Many **modalities**, including individual, group, family, and drug therapy, are effective in reducing **suicidality**, hospital and emergency department use, and depression. The most widely used is dialectical behavior therapy, which combines individual and group sessions; therapists act as behavior coaches and are available on call around the clock. Another equally effective treatment is general psychiatric management, which uses individual therapy once a week and sometimes drugs. The mood stabilizers, particularlytopiramate and lamotrigine, may be useful, particularly for anger management and mood instability.

Antisocial personality disorder currently has no effective treatment. Patients can be **noncompliant** or **exploitative**. Clinicians need to be very aware of these tendencies and not allow patients to use treatment as an excuse to avoid social responsibilities.

Narcissistic personality disorder can often be managed by individual psychotherapy but requires therapists who emphasize empathy and do not challenge their patient's perfectionism, feelings of entitlement, and grandiosity.

Avoidant personality disorder often responds to individual (preferably cognitive-behavioral) and group therapy. However, patients can be very resistant to change because avoiding it spares them conflicts and unwanted feelings (eg, of failure or rejection).

Obsessive-compulsive personality disorder often responds to individual psychotherapy aimed at helping patients tolerate uncertainty and accept their world.

Key Points

- Personality disorders involve rigid, maladaptive personality traits that are marked enough to impair work and/or interpersonal functioning.
- Treatments become effective only after patients see that their problems are within themselves, not just externally caused.
- Psychosocial therapies are the main treatment.
- Drugs are helpful only in selected cases—eg, to control significant anxiety, angry outbursts, and depression.
- Personality disorders are often resistant to change, but many gradually become less severe over time.

Reference: http://www.merckmanuals.com