PERSONALITY DISORDERS

GENERAL INTRODUCTION

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Sophie Rameckers, PhD candidate

S.A.Rameckers@uva.nl

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OVERVIEW

- What are personality disorders?
- Epidemiology
- Course of complaints and symptoms
- Etiology & Trauma
- Diagnosis and Treatment

WHAT DEFINES PERSONALITY DISORDERS?

WHAT DEFINES PERSONALITY DISORDERS?

Psychopathology connected to our personality

- Part of our character/who we are
  - Egosyntonic vs. Egodystonic
- Originates in our early development
- Present since early adulthood

WHAT DEFINES PERSONALITY DISORDERS?

- Rigid, inflexible thoughts, feelings, actions and impulse regulation.
  - More compared to 'normal' personality

- Dysfunctional
  - Sometimes only experienced by others
  - PDs related to high healthcare costs, healthcare consumption, societal costs, & low quality of life!

EPIDEMIOLOGY - PREVALENCE

Prevalence of min. 1 PD

- General population: 9-13%
  - Possibility of overestimation each disorder: 0.5-2%
- Outpatient care: 30-50%
- Inpatient care: 50-70%
- Addiction & forensic setting (prison)

NORMAL PERSONALITY - OLD AND NEW IDEAS

- A habitual way of thinking, feeling and acting
- Consistent across situations
  - However, large situational variance!
- Personality is shaped around 18 years and remains unchanged.
  - This assumption is outdated!

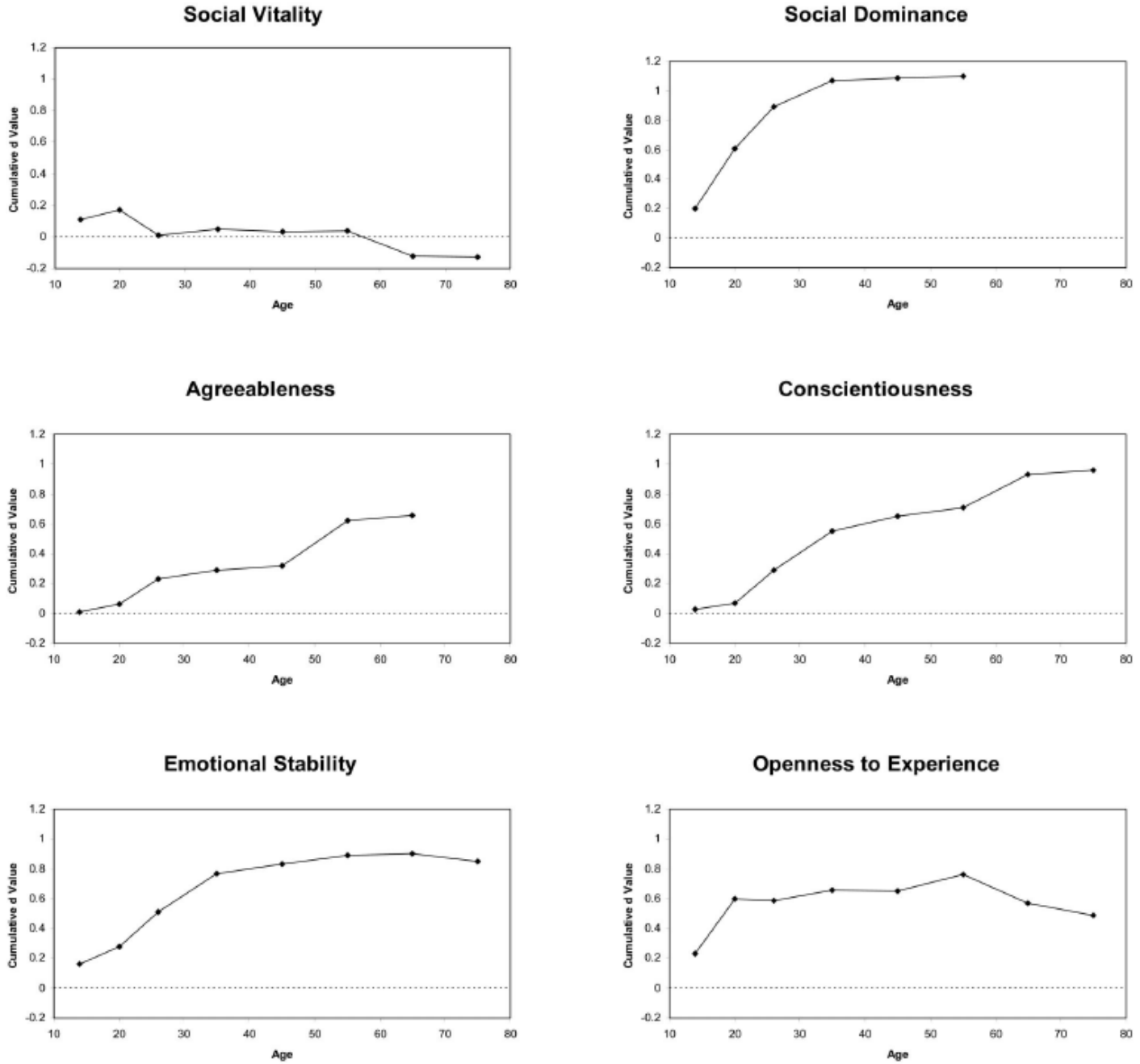


Figure 2. Cumulative *d* scores for each trait domain across the life course.

Roberts et al. (2006). Psychol. Bulletin, 132(1), 1–25.

EXPLANATIONS

- Biological maturation
  - (e.g., decrease in impulsivity)

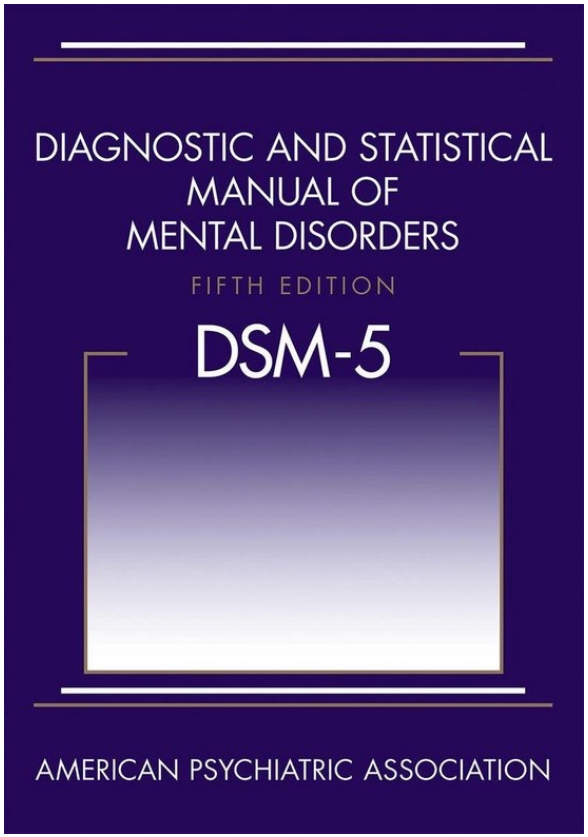
- Environmental influences
  - Increased responsibility
  - Corrective experiences such as feedback from environment (conditioning)

COMORBIDITY

- Co-occurrence PD rule rather than exception

1. **Within personality disorders**
   - Cluster-C (e.g., avoidant and obsessive-compulsive)
   - Cluster-B (e.g., antisocial and borderline)
   - Between Clusters (e.g., borderline and avoidant)
2. **With syndrome disorders**
   - Avoidant PD & depression
   - Obsessive-compulsive PD & burnout/depression
   - Borderline PD & PTSD
   - General comorbidity: PDs with anxiety, depression & addiction

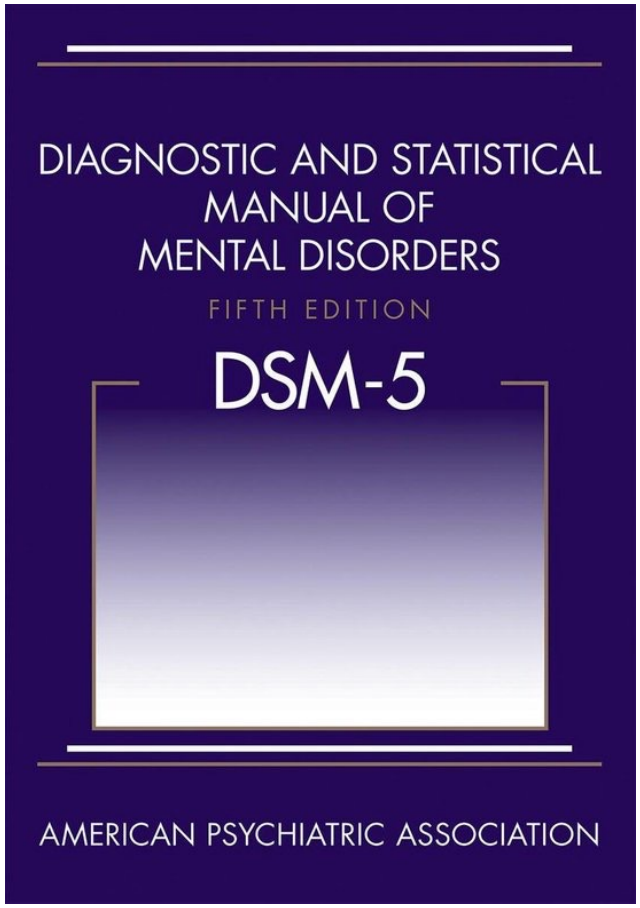
DSM-5 CLASSIFICATION



DSM-5 VS. DSM-IV

- DSM-IV had multi-axis system
  - Axis 1: Syndrome disorders
  - Axis 2: Personality disorders

- Does not longer exist in DSM-5.
- General functioning is assessed with the WHODAS, formally Axis 5.



GENERAL DSM-5 DEFINITION

Manifested in 2 (or more) of 4 domains:

- Cognition
- Affect
- Interpersonal functioning
- Impulse control

Exclusion

- Not better accounted for as another mental disorder
- General medical condition

THE 3 P'S

1. **Pervasive**: across most situations (and inflexible)

2. **Problematic:** causes distress and/or impairment

3. **Persistent:** Stable and long duration, since early adulthood

DSM-5 PD CLUSTERS

Cluster A: Strange, bizarre

- Variant of psychosis

Cluster B: Dramatic, emotional, impulsive

- Variant of externalizing disorders

Cluster C: Fearful, anxious

- Variant of internalizing disorders (neurosis)

CLUSTER A

Strange, bizarre

- Paranoid PD *(Distrust)*
- Schizotypal PD *(Ideas of reference, psychotic fear)*
- Schizoid PD *(isolation; No desires or flattened affectivity)*

CLUSTER B

Dramatic, emotional, impulsive

- Histrionic PD *(Theatrical, attention-seeking)*
- Narcissistic PD *(superiority)*
- Borderline PD *(instability)*
- Antisocial PD *(No conformation social norms, criminal)*

CLUSTER C

Fearful, anxious

- Avoidant PD *(Avoiding)*
- Dependent PD *(Clinging helper)*
- Obsessive-compulsive PD

OTHER CATEGORIES

1. **Personality Change Due to Another Medical Condition**
   - E.g., a stroke, brain trauma

2. **Other Specified Personality Disorder (OSPD)**
   - Diagnosis can be specified
   - E.g., Satisfies multiple criteria of various PDs, but does not satisfy criteria 1 single PD.
   - E.g., none-DSM PDs, such as sadistic PD

3. **Unspecified Personality Disorder**

TYPE OF DIAGNOSIS

Polythetic vs. monothetic

Dimensional vs. Categorical

POLYTHETIC DIAGNOSIS FOR SPECIFIC CATEGORIES

- **Monothetic:**
  - Members must meet the same properties of criteria

- **Polythetic:**
  - Meeting a minimal number of symptom criteria from 1 criterion set.
  - Developed by Wittgenstein for biological classifications/family resemblance

WHAT DEFINES A CHAIR?

AVOIDANT PD (4 OUT OF 7 CRITERIA)

1. Avoids occupational activities involving significant interpersonal contact, due to fears of criticism, disapproval, or rejection
2. Unwilling to get involved with people unless certain of acceptance
3. Shows restraint within intimate relationships due to fears of shame, ridicule or rejection.
4. Preoccupied with fears of receiving criticism or rejection in social situations
5. Inhibited in new interpersonal situations due to feelings of inadequacy
6. Considers his or herself as inferior to others, socially inept, or personally unappealing
7. Reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

CATEGORICAL VS. DIMENSIONAL

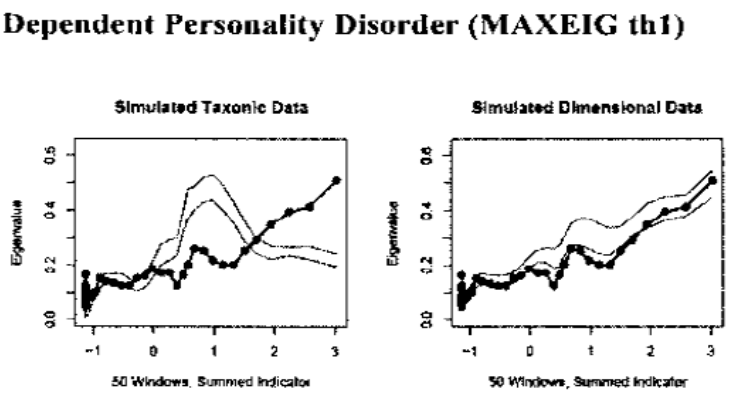
- Research shows that most disorders are dimensional
  - Syndrome- and personality disorders
  - Arbitrary cut-off

- Dimensional diagnosis is very difficult
  - People naturally think in different categories
  - Insurance 'real' disorders

TAXON VS. DIMENSIONS

- Personality disorders are dimensional Arntz et al., (2009) Personality Disorders are Dimensional. *Journal of Personality Disorders, 23(6), 606–628.*

- Taxa only for schizotypy, autism and SUDs
  - **Meta-analysis** by Haslam et al (2012). *Psychological Medicine, 42*, 903–920



COURSE OF PD PATHOLOGY

- **Develops in adolescence**
  - Recently, more often diagnosis in adolescence

- **Improves during development**
  - Not more chronic compared to chronic syndrome disorders (schizophrenia/ bipolar)
  - However, quality of life and participation in society lacking behind

- **Treatable!**
  - Much better than previously assumed
  - Medication does not cure symptoms (only dampens them)
  - Specialized psychotherapy is effective (5 x faster than natural course)

COURSE

Life expectancy (e.g., Fok et al. (2012) Journal of Psychosomatic Research, 73, 104–107)

- On average, 18 years shorter (excluding suicides)
- Risk highest before 44 years (10x mortality rate)
- Cardiovascular diseases
- Reasons: Lifestyle, chronic stress, medication

- **Risk intergenerational transmission**

ETIOLOGY - CHILDHOOD TRAUMA

- In childhood, trauma (abuse and neglect) is common
- Between 11% (sexual abuse) and 26.7% (emotional abuse)
  - Poorer mental health
  - PTSD
  - Physical diseases
  - Personality disorders
- **General** and **unique** correlations with childhood trauma types

Raw Correlations

Personality disorder	Sexual abuse	Physical abuse	Emotional abuse	Emotional neglect	Physical neglect
Cluster A					
Paranoid	.27**	.24**	.29**	.26**	.12*
Schizotypal	.19**	.25**	.29**	.21**	.11*
Schizoid	.21**	.22**	.24**	.23**	.12*
Cluster B					
Histrionic	.08	.19**	.18**	.20**	.12*
Narcissistic	.08	.18**	.15*	.14*	.07
Borderline	.40**	.33**	.42**	.39**	.16*
Antisocial	.14*	.28**	.15*	.18**	.10*
Cluster C					
Avoidant	.20**	.15*	.28**	.20**	.09*
Dependent	.13*	.15*	.32**	.28**	.08
Obsessive-Compulsive	.07	.09*	.21**	.14*	.06

Lobbestael et al. (2010) J Personal Dis

Path coefficients, adjusted for other traumata

Personality disorders	Sexual abuse	Physical abuse	Emotional abuse	Emotional neglect	Physical neglect
Cluster A					
Paranoid	.17*	.05	.15	.08	-.02
Schizotypal	.07	.10	.19*	.01	-.008
Schizoid	.11	.08	.09	.10	-.006
Cluster B					
Histrionic	-.04	.12	.02	.14	.03
Narcissistic	-.008	.14	.03	.07	-.02
Borderline	.26**	.07	.19*	.17*	-.07
Antisocial	.04	.29**	-.12	.12	-.01
Cluster C					
Avoidant	.11	-.06	.28**	.01	-.01
Dependent	-.001	-.09	.30**	.14	-.05
Obsessive-Compulsive	-.006	-.07	.25*	.02	-.004

Lobbestael et al. (2010) J Personal Dis

EXPLANATIONS

- Attachment
  - Insecure attachment and distrust of others
- Emotion regulation
- Coping
- Memory encoding
  - Distortions and fragmented memories (schizotypy)

PROTECTIVE FACTORS

- Around 70% of adults experienced ACE, but not everyone develops psychopathology/PD
- Upbringing/behaviour caregivers might have an effect on **vulnerability**
- Difference between PDs or general negative effects?

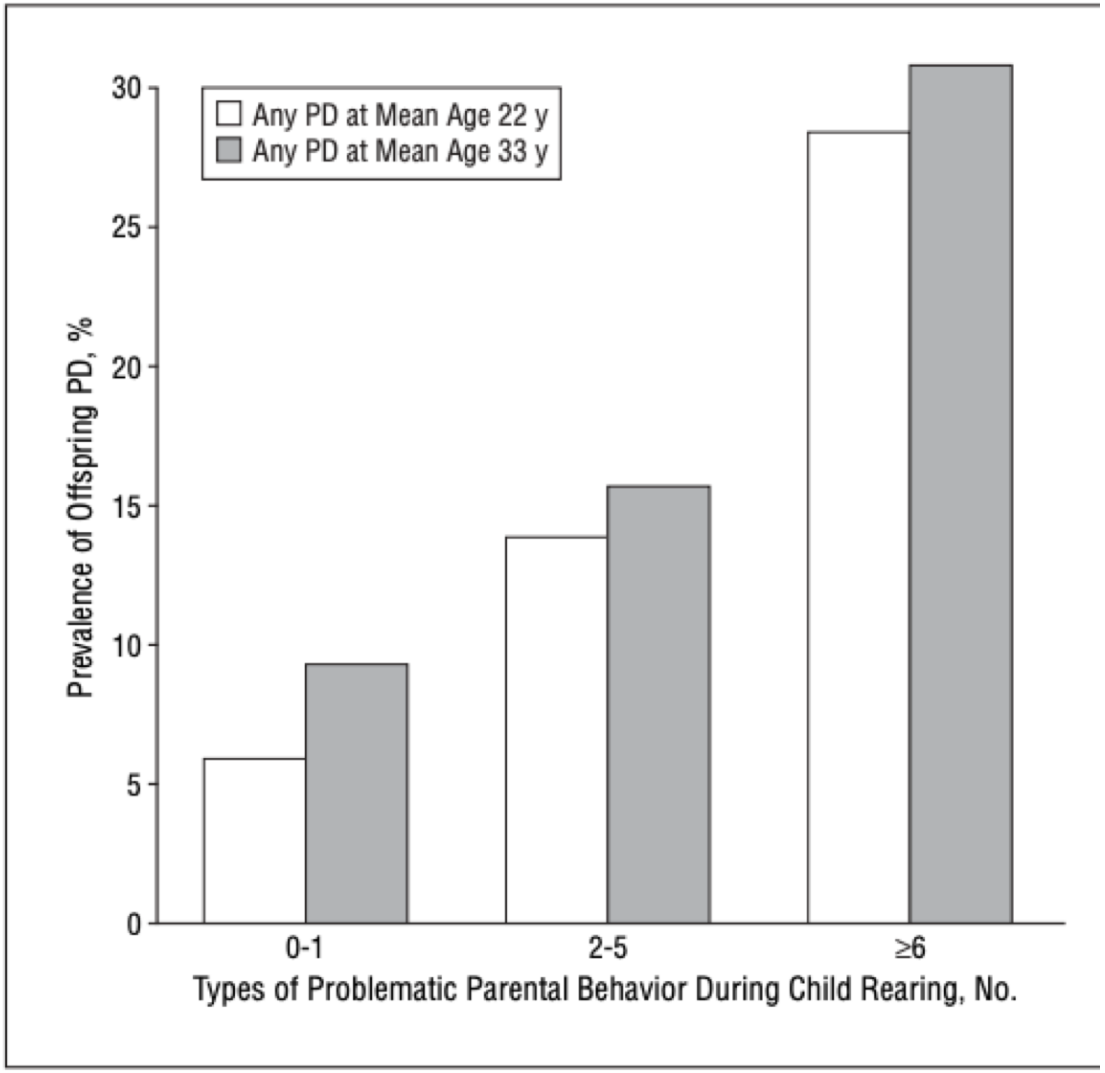


Figure 1. Association of problematic parental behavior in the home by a mean offspring of age 16 years with risk for any offspring personality disorder (PD) at a mean age of 22 or 33 years.

Johnson et al. (2006). Arch Gen Psychiatry, 163, 579-587

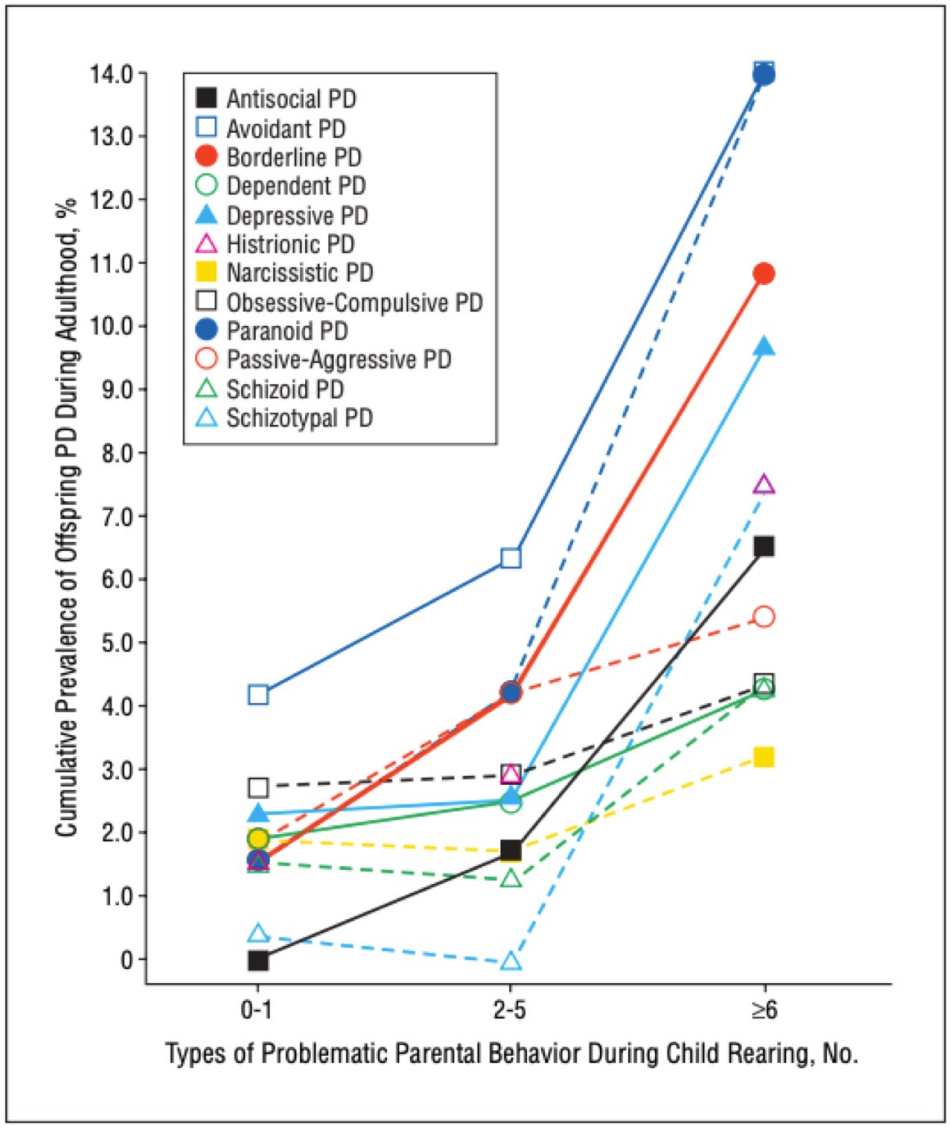


Figure 2. Association of problematic parenting behavior in the home by a mean offspring age of 16 years with risk for specific types of offspring personality disorders (PDs) at a mean age of 22 or 33 years. The composite index of problematic parental behavior was significantly associated with risk for offspring antisocial (P=.003), avoidant (P=.005), borderline (P<.001), depressive (P=.002), histrionic (P=.02), paranoid (P<.001), and schizotypal (P<.001) PDs at a mean offspring age of 22 or 33 years.

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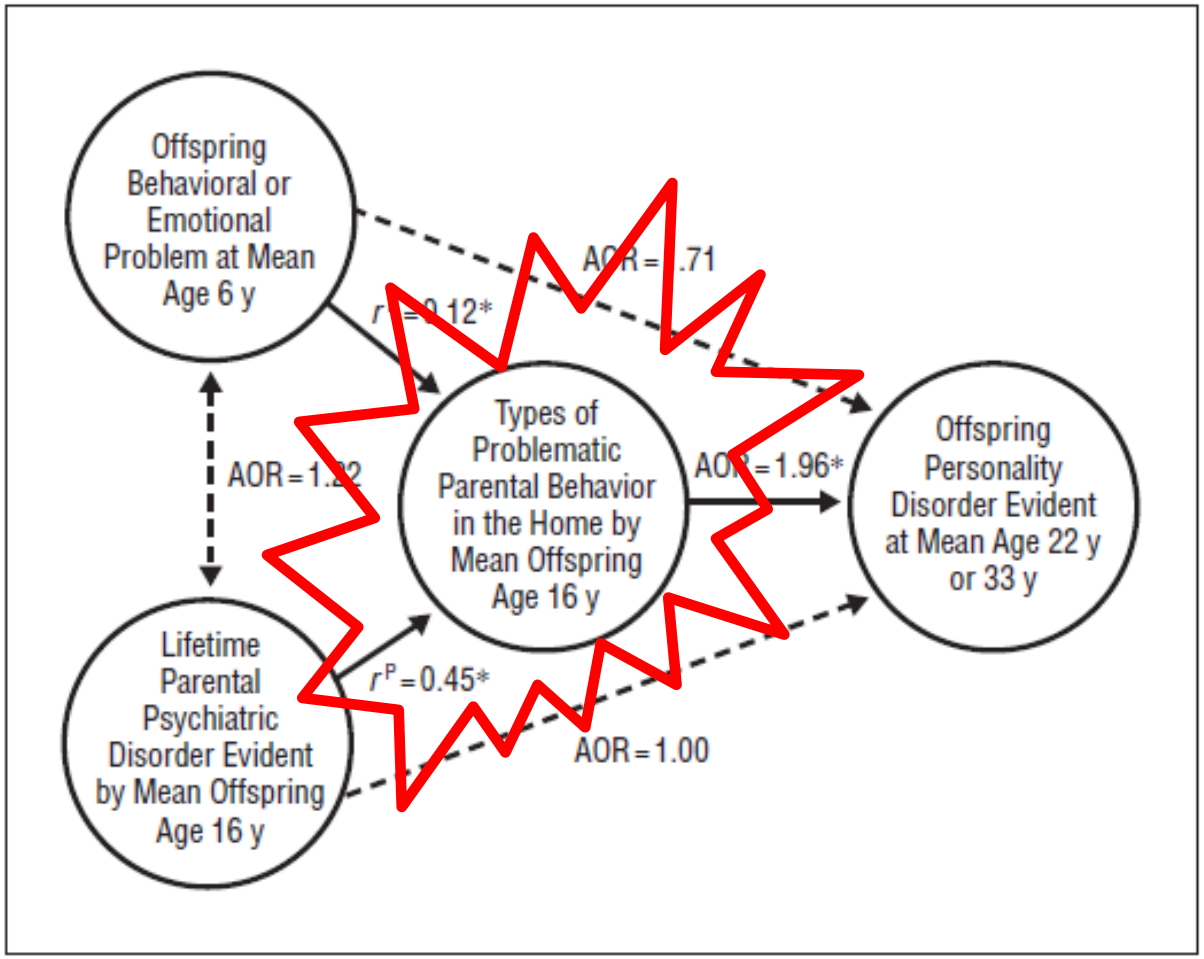
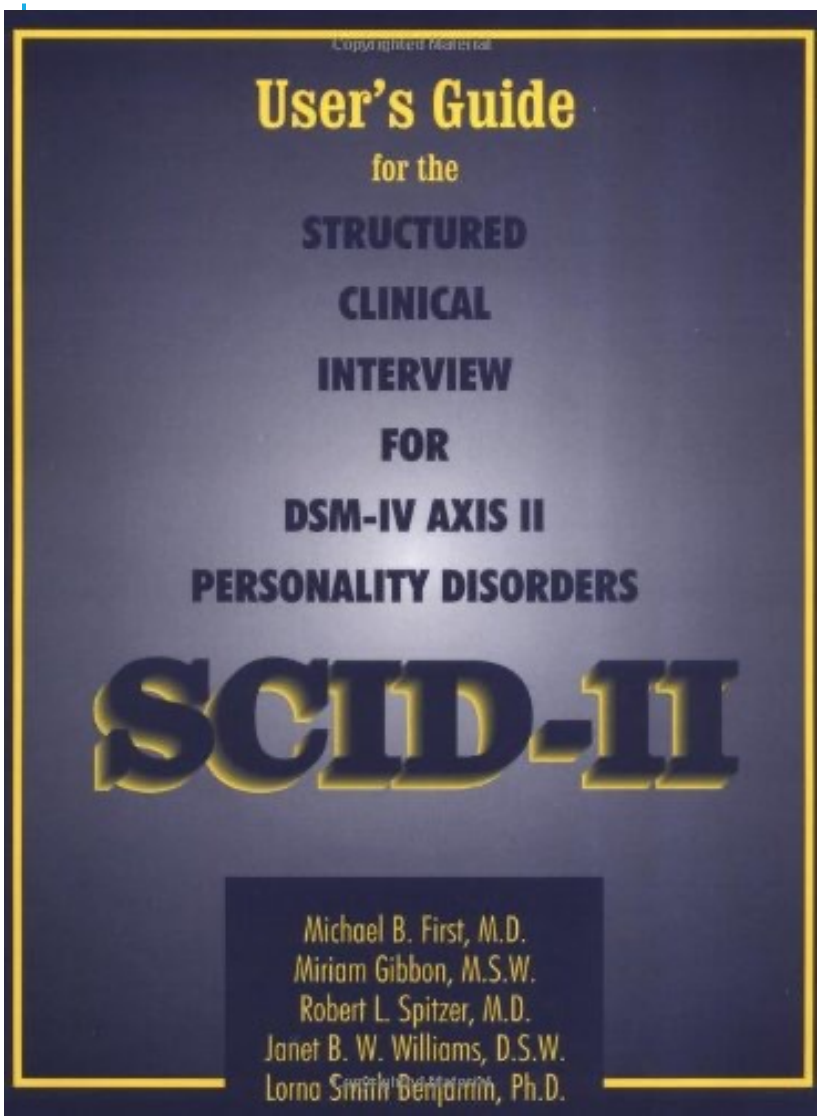


Figure 5. Association of offspring behavioral or emotional problems during childhood, parental psychiatric disorders, and problematic parental behavior in the home by a mean age of 16 years with risk for offspring personality disorder at a mean age of 22 or 33 years. The covariates were age, sex, parental psychiatric disorders evident by a mean offspring age of 16 years, and the presence of 1 or more offspring behavioral or emotional problems at a mean offspring age of 6 years. AOR indicates adjusted odds ratio; r^P, partial correlation coefficient. *$P<.05$.

DIAGNOSIS

- Semi-structured interviews (SCID-5)
  - Diagnosis based on clinical expertise is problematic: **Low reliability**
- **Stereotypes**
  - (e.g., Depression was under classified and antisocial PD was overclassified in homeless persons (Rogers, 2003))
- **Premature closure**
- **Confirmation bias**
  - Semi-structured interviews force disconfirmation. Rogers (2003) Standardizing DSM-IV Diagnoses: The Clinical Applications of Structured Interviews, *Journal of Personality Assessment, 81:3, 220-225*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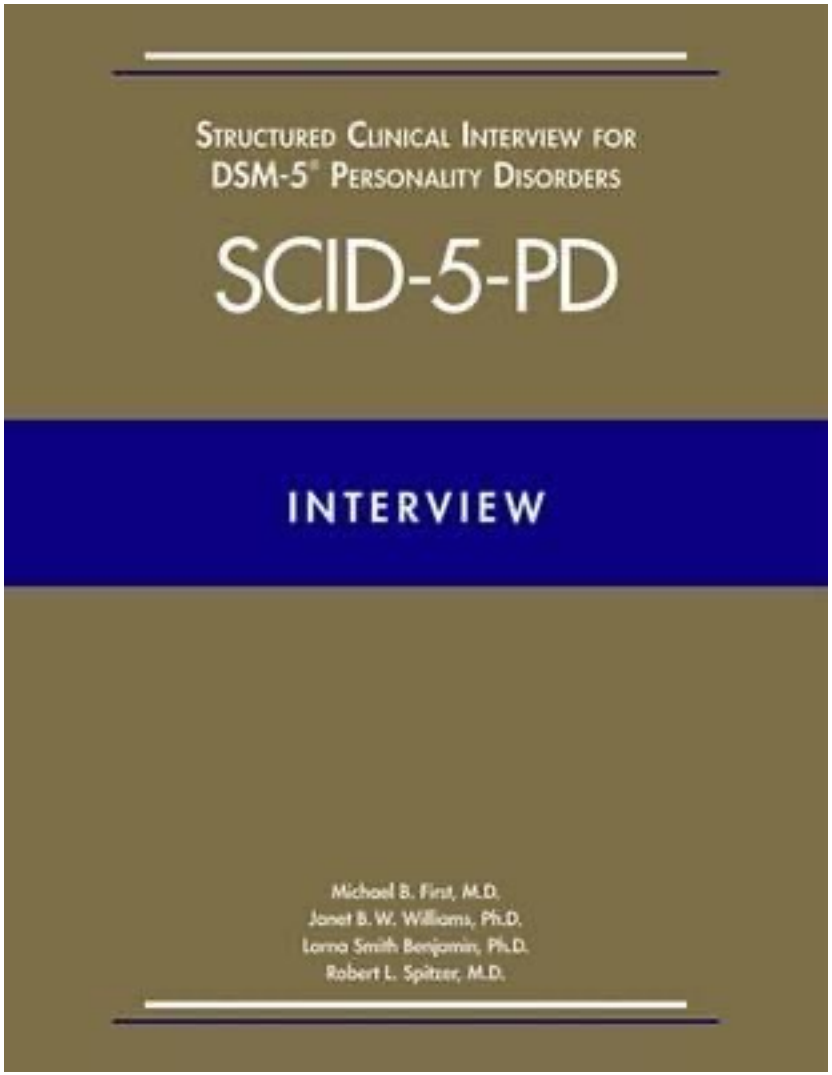
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SCID-5-PD

- In clinical practice, but also important in research
  - New version is currently being validated

- Disadvantage = takes a lot of time
- Can be used together with a screener

- Practice with the **SCID-II** in the second tutorial

TREATMENT GUIDELINES

- **First choice: Specialized Psychotherapy**
  - Additional treatment can be effective
- **Second choice** (if first choice is not possible, lack of motivation):
  - Social psychiatric treatment
- **Pharmacotherapy?** Not useful for treatment personality disorders
  - Possible for comorbid disorder or specific symptoms
  - For support psychotherapy, not interfere (too much sedation)
  - Prevent polypharmacy

THREE TYPES OF CBT

Dialectical behaviour therapy (DBT)

- Mainly for Borderline PD
- Sem Simon will give lecture about DBT

Cognitive Behaviour Therapy (C(B)T)

- Mainly for Cluster C PDs
- CBT also used in treatment syndrome disorders

Schema Therapy

- For almost all personality disorders
- Broad effectiveness
- Lecture by Arnoud Arntz

CONCLUSIONS

- Important clinical group with a high disease burden and high health care utilization/consumption
- Comorbidity is the rule
- Dimensional, but in clinical practice classification based on categories
- Environmental influences on the development (childhood)
- Not unchangeable – just like 'regular' personality
- Specialized psychotherapy is the treatment of choice

THANK YOU!

- Any questions can be asked during the next PD lecture

Next time (Friday 10-06, 11:00 at REC-C 1.04):

- **Cognitive models**
- **Cluster C**