EK KORYANI REVIEW

COURSE

Personality Disorders
Jan 13 2016

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Disclosure of Commercial Support

- This program has not received any commercial support
MCQ: Why know anything about PD’s?

A. Because it will show up on the exam
B. Because when you are following patients for longer than 6 months you will not be able to escape from patients with PD
C. So that you can confidently tell people that Prozac Nation (and maybe ‘Wild”) is about BPD and not depression
D. All of the above
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# Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 9:00</td>
<td>Introduction Cluster A, C</td>
</tr>
<tr>
<td>9:00 – 9:10</td>
<td>Questions</td>
</tr>
<tr>
<td>9:10 – 9:30</td>
<td>Cluster B</td>
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<tr>
<td>9:30 – 9:45</td>
<td>Food Break</td>
</tr>
<tr>
<td>9:45 – 10:50</td>
<td>Cluster B</td>
</tr>
<tr>
<td>10:50 – 11:00</td>
<td>Questions</td>
</tr>
</tbody>
</table>
Acknowledgements

- Dr. D McBride, University of Ottawa
- Dr. P Links, Western University
- Dr. J Gunderson Harvard University
- Dr. R Bismil, University of Ottawa/CAMH
Objectives

At the end of this lecture the participant will be able to:

• Discuss current approaches to understanding and measuring normal personality dimensions as well as personality disorders

• Compare and contrast the epidemiology, etiology, and clinical characteristics for different personality disorders

• Select the most appropriate management strategies for a personality disorder

• Discuss the progress in research and treatment of borderline personality disorder.
Books on PD? My top 3 picks

1. **Handbook of Good Psychiatric Management for Borderline Personality Disorder**
   - John G. Gunderson, M.D.
   - Paul Linke, M.D., M.Sc., F.R.C.P.C.

2. **Textbook of Personality Disorders**
   - Second Edition
   - The American Psychiatric Publishing
   - John M. Oldham, M.D., M.S.
   - Andrew E. Skodol, M.D.
   - Donna S. Bender, Ph.D., FIPA

3. **Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders**
   - Second Edition
   - Len Sperry, M.D., Ph.D.
Main References

- Handbook of Good Psychiatric Management for Borderline Personality Disorder. Gunderson and Links 2014
- Handbook of Diagnosis and Treatment of DSM IV-TR Personality Disorders 2nd ed. L Sperry 2003
- Tyrer et al Personality Disorder 1 Classification, assessment, prevalence, and effect of personality disorder. Lancet 2015; 385:717-26
- DSM 5
- Cochrane Reviews
- NICE guidelines (UK)
- NHMRC guidelines (Australia)
- Up to Date
- OVID search
- Clinical Interview for the DSM-IV : Part 2,The Difficult patient. Othmer
- Disordered Personalities: Dave Robinson
- Kaplan and Sadock’s Comprehensive Textbook of Psychiatry 9th edition
- Psychiatric Interviewing: Shawn Shea
- Personality Theory D Crowne 2007
- List of additional references in notes
INTRODUCTION AND
OVERVIEW
Personality Disorders
MCQ # 1

• All of the following are true except:

1. PD diagnosis are more strongly negatively related to quality of life than any other variable
2. People with PD typically live alone
3. OCPD, NPD and HPD have the least functional impairment of all PD’s
4. PD diagnosis are stable over time
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MCQ #2

• Which of the following is not correct?

a) Heritability of PD parallels heritability of normal personality.
b) Heritability of PD is in the range of 0-20%
c) All types of abuse are implicated in the etiology of BPD
d) Improvement in overall functioning of patients with PD is not as robust as improvement in symptoms
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MCQ 3

• Successful treatment of PD’s include all except:

A. Development of a stable and positive sense of self  
B. Modification of expression of personality traits  
C. With new, effective psychotherapies, treatment should be brief (weeks to months)  
D. Establishment of mutually gratifying and enduring relationships
MCQ 3

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A. Development of a stable and positive sense of self
B. Modification of expression of personality traits
C. With new, effective psychotherapies, treatment should be brief (weeks to months)
D. Establishment of mutually gratifying and enduring relationships
Why Should I learn about the DSM 5 Section III “emerging measures and models” Alternative model for PD?

All of the following are true:

a) The DSM5 section III model was developed from insights gained from the past 25 years of research on personality disorders

b) The DSM5 section III model will help me to more reliably diagnose personality disorder

c) The DSM 5 section III model will improve my knowledge of prognosis for my patients with personality disorders

d) Treatment of personality disorder and traits can improve outcome for my patients

e) Preliminary data shows DSM5 Section III model is useful in clinical populations
PERSONALITY AND PERSONALITY DISORDER
Definition of Personality

- Personality represents a complex set of attributes that mediate how each human being experiences his or her self and subsequently understands and interacts with the external world, especially the social world.  
  Oldham, Skodol, Bender 2014
Personality Disorder in DSM

- PD’s more or less permanent problems of behaviour and human interaction, established by early adulthood, unlikely to change throughout the life cycle
- 1923 Schneider described 9 personality types
- DSM I – III: felt to be primarily psychological in origin
- DSM IV: introduced general criteria for PD
  - Early onset, long duration, inflexibility, pervasive
  - Based on expert consensus
- DSM5
  - Keep categorical model or move to dimensional model?
  - Enduring/long duration, inflexible/pervasive?
Theories of personality development and personality disorder

- Psychoanalytic, psychodynamic
- Cognitive Social
- Trait theories
- Biological Approaches
- Integrative
  - Cloninger 7 Factor
  - Millon Evolutionary Social Learning
  - Benjamin Interpersonal
  - Westen Functional Domain
Psychoanalytic, Psychodynamic Theories

- **Freud: “character problem”** Crowne 2009
  - behaviour, overt and covert derives from motive forces – forces that impel us to act and regulatory forces that hold impulsive action back

- **Ego psychology, object relations, self psychology**
  - problems of character run deeper than maladaptive compromises
  - Derailments in personality development reflect the interaction between temperament and early attachment
  - Ego psychology:
    - psychological functions include skills, procedures, processes involved in self regulation that help people function adaptively, attain goals, meet external demands.
    - Personality disorder- various deficits in functioning
    - poor impulse control, difficulty regulating affects, deficits in capacity for self reflection
    - Deficits render individual incapable of behaving consistently in their own best interest or of taking the interest of others appropriately into account.
Psychodynamically based theories of personality/personality disorder

- Object relations, relational, self psychology
  - Cognitive, affective, motivational processes that underlie functioning in close relationships.
- Individuals with personality disorder:
  - Internalize attitudes of hostile, abusive, critical, inconsistent, neglectful parents
  - Are rendered vulnerable to fears of abandonment, self hatred, tend to treat themselves as their parents treated them
  - Develop various “symptoms” ie emotional swings when others are even momentarily disappointing. Are unable to form a realistic balanced view of the self that can weather momentary failures, criticisms and self soothe in the face of loss, failure and threats to self esteem
Kernberg

- Introduced concept of continuum from psychosis ➔ neurosis ➔ normal functioning
- Severe personality pathology on the border between psychosis and neurosis – “borderline personality organization”
  - Maladaptive modes of regulating emotions
    - Immature, reality distorting defenses
  - Difficulty forming mature, multifaceted representations of themselves and others
  - Included paranoid, schizoid, schizotypal; borderline, antisocial and some narcissistic, histrionic and dependent PD
Cognitive Social Theories of Personality

- Social Learning Theory; Cognitive Social Learning Theory; Social Cognitive Theory; Cognitive Behavioural theory.

- Personality is learned:
  - Involves how people encode, transform and retrieve information about themselves and others
  - Reflects interplay between environmental demands and the way a person processes information about the self and the world (Bandura 1986)

- Elements include:
  - Schemas: ie BPD sees self as bad/incomplete
  - Expectancies – DPD believes can’t survive on own, NPD grandiose expectancies regarding what he/she should be able to achieve
  - Skills and competencies- ie all people with PD have low social intelligence/interpersonal problem solving
  - Poor self regulation – setting goals and subgoals, evaluating performance in meeting goals, adjusting behaviour to achieve goals
Cognitive Social Theories of PD

• CBT: Beck – schemas involved in encoding, processing information about self, other
  • Dysfunctional schemas result in the individual
    • Misinterpreting information: ie BPD misreads, misattributes ther’s intentions
    • Attending to and encoding information in biased ways- ie PPD vigilant for perceived slights
    • Views themselves as bad or incompetent
  • Dysfunctional beliefs about the world/relationships, self and others; interpersonal behaviours and cognitive distortions arise from dysfunctional schemas  ie schizoid PD
    • automatic thoughts: self- self sufficient loner; others – unrewarding, intrusive; relationships – messy and undesirable
    • Interpersonal behaviours/strategy : keep distance from others
    • Cognitive distortions: minimize recognition that relationships can be a source of pleasure
Cognitive Social theories

- **DBT: Linehan 1993 – BPD due to deficits in affective regulation**
  - Difficulty inhibiting ineffective behaviour related to intense affect
  - Difficulty organizing oneself to meet behavioural goals
  - Regulating physiological arousal associated with intense emotional arousal
  - Refocusing attention when emotionally stimulated

  - Broad, pervasive themes regarding oneself and one’s relationships with others, developed during childhood and elaborated throughout one’s life.
  - EMS have cognitive, affective, behavioural components
  - 18 EMS with 5 underlying “modes” of interacting – abandoned and abused child, angry and impulsive child, the detached protector, the punitive parent, the healthy adult
Trait theories

- Traits as emotional, cognitive and behavioural tendencies
- Allport 1937  2 separate but complementary meanings
  1. Observed tendency to behave in a particular way
  2. Inferred, underlying personality disposition generates the behavioural tendency
  - Most prominent model: neuroticism, extraversion, openness, agreeableness, conscientiousness (OCEAN)
  - Lexical hypothesis of personality: important personality attributes will naturally find expression in words used in everyday language
  - PD reflects extreme versions of normal personality traits
- Problems?
  - Not clear that extreme variants always pathological – extreme extraversion could be adaptive in some social milieu’s
  - Extreme openness could imply genuinely open attitude to emotions/art
FFM

• Research on FFM shows
  • underlying genetic structure predicts childhood antecedents, temporal stability, universality, functional relevance: work, well being, marital stability, physical health

• Benefits
  • incorporates research on normal personality
  • Development utilized factor analysis – well understood empirical procedure.

• FFM and DSM IV PD’s
  • Some studies showed links between axis II and FFM
  • Other studies show overlap of FFM profiles with disorders that appear quite distinct – ie OCPD and BPD
Schedule of Non-Adaptive and Adaptive Personality

• Clark 1993
• Developed by factor analysis of PD diagnostic criteria along with additional non PD criteria
• CLPS SNAP best predictor functioning (functioning, axis I pathology, medication use) at 10 years
• Limits
  • Does not correspond well with general personality structure
  • 3 fundamental temperaments – positive affect, negative affect, constraint, but confirmatory factor analysis suggests 4 factors – negative affect, positive affect, antagonism, constraint
Biological Approaches

• Earliest example: schizotypal PD arose from family studies of patients with schizophrenia
• Has informed Trait models – genetic contributions to personality traits
• Most twin studies have focused on normal personality
  • FFM, Eysenck 3 factor model
  • Moderate to large heritability 30 – 60% Livesely 1993, Plonin, Caspi 1992
• Similar range in studies that have looked at PD
  • Schizotypal PD Torgeresen 2000 0.61, Kendler 2007 0.72
• Adoption studies – contributions of genetics and environment
  • adult adoptee with bio parent with ASPD: 4X risk ASPD vs adoptee with no ASPD parent
  • Adult adoptee with adoptive parent with ASPD – 3X increased risk of ASPD vs adoptee with no adoptive parent with ASPD
Integrative Approaches

• Cloninger 7 factor model
• Millon Evolutionary Social Learning theory
• Benjamin Interpersonal Theory
• Westen Functional Domains
Cloninger 7 Factor Model

- Temperament and Character
  - Temperament: automatic associative responses to basic emotional stimulus that determines habits and skills
    - develops from associative/procedural learning
    - 4 dimensions, linked to neurotransmitter systems
      - Novelty seeking DA; harm avoidance 5HT, GABA: reward dependence NE, 5HT; persistence glutamate, 5HT
  - Character: self aware concepts that influence voluntary intentions and attitudes
    - develops from insight learning
    - Self directedness, cooperativeness, self transcendence
    - All PD’s low on self directedness and cooperativeness
      - Cluster A: low reward dependence
      - Cluster B: high novelty seeking
      - Cluster C: high harm avoidance
Millon Evolutionary Social Learning Theory

- Personality can be described by 4 polarities
  - Pleasure/pain; Self/other; Passive/active; Thinking/feeling
- 4 basic evolutionary principles underlie each of the polarities
  - Aims of existence: pleasure/pain: life enhancement vs life preservation
  - Modes of adaptation: passive/active: to what extent does one adjust to or modify the environment
  - Strategies of replication or reproduction: self/other: individuation or nurturance of others
  - Processes of abstraction: thinking/feeling polarity: Ability for symbolic thought

Individual with schizoid PD: experience little pleasure; are passive; have little involvement with others; rely on abstract thinking.
Benjamin Interpersonal Model

- Structural Analysis of Social Behaviour
- 3 dimensional circumplex model with 3 “surfaces”
- Children learn to
  1. Respond to themselves and others by identifying with significant others and acting like them
  2. Elicit from others what they have experienced before
  3. “introject” others – treat themselves as others have treated them
- Translates each of the DSM IV PD into interpersonal terms, and specifies the interpersonal antecedents
  - Anger in BPD – due to perceived neglect /abandonment
  - Anger in NPD – due to entitlement
  - Anger in ASPD- cold, detached, aimed at controlling others
Westen Functional Domain Model

- Personality processes and function
  - Types of affect regulation strategies
  - Ways an individual represents self and others mentally
  - Whether an individual engages in impulsive/self destructive behaviours

- Personality Case Formulation: answers 3 questions
  1. Motives: What does the person wish for, fear, value? Are motives conscious or unconscious; collaborating or conflicting
    - Chronic worries about abandonment in BPD; conflict between wish for and fear of closeness in APD
  2. What psychological resources (cognitive processes, affects, affect regulation strategies) and behavioural skills does the person have to meet internal and external demands
    - Poor impulse control, lack of reflective capacities, difficulty regulating affect in BPD
  3. What is the person’s experience of self/other and how able is the person able to sustain meaningful and pleasurable relationships
    - Simplistic, one sided representations of others in all PD
DSMIV TR and DSM 5 Section II

A. An enduring pattern of inner experience that deviates markedly from the expectations of the individual’s culture. This pattern is manifested in two (or more) of the following areas:
   A. Cognition (i.e., ways of perceiving and interpreting self, other people and events)
   B. Affectivity (i.e., the range, intensity, lability and appropriateness of emotional response)
   C. Interpersonal functioning
   D. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood

E. Not better accounted for by another mental disorder, or substance or another medical condition
## DSM 5 Section II

- General Criteria and criteria for one of 10 PD’s

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Type</th>
<th>#criteria required</th>
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</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>PPD</td>
<td>4/7</td>
</tr>
<tr>
<td>Schizoid</td>
<td>SPD</td>
<td>4/7</td>
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<tr>
<td>Schizotypal</td>
<td>STPD</td>
<td>5/9</td>
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<tr>
<td>Antisocial</td>
<td>ASPD</td>
<td>3/7</td>
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<tr>
<td>Borderline</td>
<td>BPD</td>
<td>5/9</td>
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<tr>
<td>Histrionic</td>
<td>HPD</td>
<td>5/8</td>
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<td>Narcissistic</td>
<td>NPD</td>
<td>5/9</td>
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<td>Avoidant</td>
<td>APD</td>
<td>4/7</td>
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<tr>
<td>Dependent</td>
<td>DPD</td>
<td>5/8</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>OCPD</td>
<td>4/8</td>
</tr>
<tr>
<td>Personality change due to another medical condition</td>
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<tr>
<td>PD NOS</td>
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</table>
Criticisms of DSMIV categorical approach

- Extensive co-occurrence of PD’s – most people who have 1 PD meet criteria for other PD’s. Grant 2005, Morey 1988, Oldham 1992
- Extreme heterogeneity among patients with same PD diagnosis “256 ways to be borderline”
- Poor coverage of personality pathology – PD NOS most frequent diagnosis Verheul 2004
- Temporal instability of PD’s inconsistent with the basic definition of PD’s
- Arbitrary diagnostic thresholds with little or no empirical basis
- General criteria based on expert consensus and could apply to any mental disorder
- Poor convergent validity - PD’s diagnosed by other methods only weakly related to one another Oldham 2014, Morey 2014, Clark 1997
- Categorical model with PD present or absent,(like pregnancy) is at odds with generally accepted view that “personality abnormality is best viewed as a set of dimensional constructs” (like height) Tyrer 2015
Consequences of these problems

• “PD assessment on of the most difficult tasks in clinical practice. Practitioners identify the disturbances associated with personality disorder quite accurately, but only record the diagnosis in a few cases”  Tyrer 2015

• PD diagnosis
  • Not used – “Axis II deferred”
  • Underused - PD NOS
  • Erroneously used
    • Diagnosis based on too few criteria
    • Diagnosis based on one PD when there are more than 1 present
  • Oldham Skodol Bender 2014, Newton–Howes 2010
Dump PD’s altogether?

• Despite all of these criticisms….

• 5 main findings from research
  1. PD’s are prevalent
  2. High rates of social and occupational impairment
  3. Slower recovery, shorter time to relapse for co-morbid disorders (MDD, anxiety, SUD)
  4. Increased treatment utilization
  5. Increased suicide risk

Oldham, Skodol, Bender 2014, Skodol 2005
DSM 5 Personality and Personality Disorders Work Group

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Lee Anna Clark, Ph.D.*
Lesley C Morey, Ph.D.*
Larry J. Seiver M.D.
Can we assess PD’s reliably?

- Clinical (unstructured assessments) of personality disorder
  - Zanarini 2000, Zimmerman 2004
  - underestimate the prevalence of PD
  - overestimate (based on one criteria) the prevalence of PD

- Structured assessments
  - Median inter-rater reliability co-efficients ~ 0.7
  - Short interval test-retest~ 0.5
  - Other areas medicine inter-rater reliability 0.4 – 0.6
  - Other psychiatric disorders inter-rater reliability 0.57 – 0.88
# PD assessment tools

<table>
<thead>
<tr>
<th>Method Type</th>
<th>Tool Name</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self report</td>
<td>PDQ -4</td>
<td>Personality D/O Questionnaire 4</td>
<td>Hyler 1994</td>
</tr>
<tr>
<td>McManus Personality</td>
<td>MCMI</td>
<td>Millon Clinical Multiaxial Inventory III</td>
<td>Millon 2009</td>
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<tr>
<td>McManus Personality</td>
<td>MMPI</td>
<td>Minnesota Multiphasic Personality Inventory</td>
<td>Butcher 2001</td>
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<tr>
<td>McManus Personality</td>
<td>PID-5</td>
<td>Personality Inventory DSM 5</td>
<td>Krueger 2012</td>
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<tr>
<td>Semi-structured</td>
<td>SCID II</td>
<td>Structured Clinical Interview Axis II</td>
<td>First 1997</td>
</tr>
<tr>
<td>Clinical</td>
<td>IPDE</td>
<td>International Personality Disorder Exam</td>
<td>Loranger 1999</td>
</tr>
<tr>
<td>McManus Personality</td>
<td>DIPD IV</td>
<td>Diagnostic Interview DSM IV PD</td>
<td>Zan 1996</td>
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<td>McManus Personality</td>
<td>PDI IV</td>
<td>Personality Disorder Interview IV</td>
<td>Widiger 1995</td>
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<td>Widiger 1995</td>
</tr>
</tbody>
</table>

- Oldham Skodol Bender 2014
CLPS: Which assessment is best?

- DSM IV, SNAP, FFM/NEO-PI
- Best prediction current level of functioning
  - DSM IV  Skodol 2005
- Best predictor functioning (functioning, axis I pathology, medication use) at 10 years
  - SNAP Schedule for Nonadaptive and Adaptive Personality  Morey 2012
- Stability (test-retest) of traits, disorders at 10 yrs  Hopwood 2011
  - SNAP  0.9
  - FFM  0.6
  - DSMIV 0.25-0.65
- *However each model incremented each other and…
  “approaches that integrate normative traits and PD pathology have the greatest predictive validity”  Morey 2012
PD prevalence

- DSM “informed speculation” Lezenweger 2008
  - outpatient 45%
- Since DSM III, 13 epidemiologic studies on PD
- # of people assessed 110 – 2000 Torgersen 2014
- 2 methods
  - Method 1: Trained lay interviewers. AUDADIS-IV
  - Method 2: IPDE, 2 stage procedure, trained clinical interviewers
## Personality Disorders Prevalence

<table>
<thead>
<tr>
<th>Disorder</th>
<th>13 studies: range/median/mean</th>
<th>DSM IV</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any PD</td>
<td>3.9-15.5/11.9/11.0</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Cluster A</td>
<td>1.6-6.2 /3.4 /3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cluster B</td>
<td>0.5-5.8 /3.5 /3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cluster C</td>
<td>2.6-9.2 /7.7 /6.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizotypal</td>
<td>0-4.5 /0.7 /1.3</td>
<td>3</td>
<td>3.9-4.6</td>
</tr>
<tr>
<td>Schizoid</td>
<td>0-4.9 /0.8 /1.3</td>
<td>uncommon</td>
<td>3.1-4.9</td>
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<tr>
<td>Paranoid</td>
<td>0-4.8 /1.8 /1.7</td>
<td>0.5-2.5</td>
<td>2.3-4.4</td>
</tr>
<tr>
<td>ASPD</td>
<td>0-4.5 /1.0 /1.8</td>
<td>3% m 1% w</td>
<td>0.2-3.3</td>
</tr>
<tr>
<td>BPD</td>
<td>0-4.5 /1.7 /1.6</td>
<td>2%</td>
<td>1.6-5.9</td>
</tr>
<tr>
<td>NPD</td>
<td>0-4.4 /0.7 /0.8</td>
<td>&lt; 1%</td>
<td>0-6.2</td>
</tr>
<tr>
<td>HPD</td>
<td>0-3.0 /0.7 /1.2</td>
<td>2-3%</td>
<td>1.84</td>
</tr>
<tr>
<td>Dependent</td>
<td>0.1-1.8 /1.0 /1.0</td>
<td>Most frequently reported</td>
<td>0.46-0.6</td>
</tr>
<tr>
<td>Avoidant</td>
<td>0-5.2 /2.3 /2.7</td>
<td>0.5-1%</td>
<td>2.4</td>
</tr>
<tr>
<td>OCPD</td>
<td>0-7.1 /2.0 /2.5</td>
<td>1%</td>
<td>2.1-7.9</td>
</tr>
</tbody>
</table>

- Adapted from Oldham, Skodol 2014 p 111
PD prevalence

- **Community, point prevalence** Oldham, Skodol, Bender 2014; Tyrer 2015: Huang 2009
  - Any PD 4–15%
    - Cluster A, 3.5%
    - Cluster B 1.5-3.5%
    - Cluster C 2.7-3.5%
    - Avoidant, OCPD ~ 2.5%
    - Paranoid, BPD, ASPD ~ 1.5%
    - Schizoid, Dependent, Schizotypal, Histrionic ~ 1%
  - **Average prevalence 1-1.5%

- **Clinical Population**
  - Primary Care up to 25%, OPD 50% Tyrer 2015
  - All mental health settings: any PD 64%
  - Most common BPD (28%), DPD (15%)
  - NPD (12%), HPD (8.7%), AvPD (9.1%), OCPD (10.5%)
  - Least common PPD (5.6%), ASPD (5.9%), STPD(5.7%)
  - Adapted from Torgersen 2012
PD and Gender

• Mixed findings, some studies M=W, others M>W  Coid 2006
• Men with PD’s tend to be antisocial and narcissistic
• Women with PD’s tend to be histrionic and dependent
• BPD M=W  Oldham, Skodol, Bender 2014
PD: Etiology

• Genetic and environmental contributions to PD
  • Heritability parallels normal personality
    • 20-60% heritability from twin studies*
    • 0% for conduct to 64% for narcissism
  • Additive genetic influences and unique environment, most familial resemblance due to genetic factors?
    • Twin studies are not well powered to pick up subtle parenting effects K Kendler personal communication Nov 2015
    • some data suggests a larger role for “shared environment” or parenting – high levels of perceived parental conflict found to be as significant as genetics in determining negative emotionality  Krueger 2008

• Cluster A: little environmental effects
• Cluster B: BPD and ASPD closest genetic links
• Cluster C: OCPD distinct from others
  • Livesley 1993, Torgersen 2000, Kendler 2008
PD: Etiology

- Environmental risks
  - Low SES, raised by single parent, welfare, parental death, social isolation  
    Cohen 2005

- Abuse (all types) and neglect
  - Multiple studies (prospective and retrospective) show abuse and neglect are associated with development of personality disorders
    - All PD’s: 73% abuse, 82% neglect  
      Battle 2004 Cohen 2005
    - BPD highest rates of abuse and neglect  
      Battle 2004, Zanarini 1997
    - Documented/reported abuse, neglect  4x increased risk of PD  
      Johnson 1999
  
  - Maladaptive parenting, maladaptive school experiences  
    Cohen 2005
PD Prognosis: Studies

- McLean Study of Adult Development (MSAD) Zanarini 2005
  - 362 hospitalized PD patients (290 BPD, 72 other PD)
  - 6 and 10, 20 years.
  - 74% BPD remit by year 6

- Collaborative Longitudinal Personality Disorders Study (CLPS) Skodol 2005
  - 668 treatment seeking individuals
  - STPD, BPD, APD, OCPD, vs MDD
  - Remission rates at 24 months 50-64%

- Children in the Community (CIC) Cohen 2005
  - 1000 families, upper NYState, 700 families at 20 yr F/U
  - Early behavioural disturbance predicts PD in adolescence
  - Mean PD symptoms highest in adolescence, linear decline 9-27
  - PD in adolescence predicts ongoing PD in adulthood, Axis I disorders, suicidality, violence and criminal behaviour

- Longitudinal Study of Personality Disorders (LSPD)
  - 250 Cornell U students. 129 at least one PD.
  - F/U 3 points over 4 years
  - Personality dimensions- significant declines for PD and no PD
PD Prognosis

- William James (1890) “...by the age of 30, the character has set like plaster, and will never soften again”

- Longitudinal studies show
  - Improvement is the norm in studies using DSM PD diagnosis
  - Cluster B improve most, Cluster A and C less robust improvement
  - Traits are more stable* and may be better predictor of outcome
  - DSM diagnosis predicts function acutely but not necessarily long term
  - GAF does not necessarily improve in adults who improved diagnostically

- *Personality traits did decrease in intensity, similar to that found in community based studies that demonstrate a mellowing of personality with age with declines in neuroticism, extraversion, openness and increases in agreeableness and conscientiousness  Terracciano 2010, Roberts 2000, Gutierrez 2012
Impact of PD’s

- **CLPS: PD+MDD vs MDD**  
  - Functional Impairment
    - PD’s more likely to be separated, divorced, never married
    - More unemployed, frequent job changes, disabled
    - BPD, STPD most impaired
  - Treatment Utilization
    - More outpatient, inpatient, meds vs MDD

- **Quality of Life**
  - Oslo, Norway N = 2053  
  - PD more strongly related (negatively) to quality of life than Axis I, somatic health, any other socio-economic, demographic or life situation variable
  - Linear dose response between # criteria and level of dysfunction
PD and function

- Overall impact on function from available studies
  - Most impaired AVPD
  - Moderate- severe STPD, BPD
  - Moderate- PPD SPD, DPD, ASPD
  - Least HPD, NPD, OCPD
PD and co-morbid disorders

- PD predict subsequent onset of other psychiatric disorders  Johnson 1997
- SUD/AUD  McGlashan 2000
  - 700 subjects with PD
    - AUD 40%
    - SUD 37.3%
- NESARC  Grant 2004
  - 43000 subjects, community based
    - AUD
      - 4.5 subthreshold PD
      - 8.2 one PD
      - 14.2 at least 2 PD
Impact of PD on comorbid disorders

- PD’s predict significantly worse course MDD, anxiety disorders, but not ED

  - **Skodol 2011**
    - community based sample, 1996 participants. 3 yr F/U
    - 15.1% persistent MDD, 7.3% recurrence
    - BPD most robust predictor persistent MDD
    - Population attributable risk persistence MDD
      - BPD 57.3%, SPD 47.9%, STPD 45.3%, any anxiety 43%

- **Meta-analysis 32 studies MDD+PD vs MDD** Newton–Howes 2006
  - OR 2.2 for poor outcome MDD with PD

- **BPD comorbid with schizophrenia** Bahorik 2010
  - N= 125, 20% with BPD
  - Baseline: more severe symptoms, anxiety, depression
  - 1 yr F/U : less improvement in symptoms, particularly hostility, suspiciousness, GAF, and more frequent hospitalization
PD Mortality

- Elevated all cause mortality, reduced life expectancy
  - UK psychiatric case register Fok 2012
    - any mental health service, any PD diagnosis n= 1836
    - Years lost: women -18.7 years; Men -17.7 years
    - SMR: women 5.0, men 3.5
  - Danish hospital case register Hoye 2013
    - n=523 inpatients, any PD diagnosis,
    - SMR women 2.9; men 4.3
  - Swedish national case register Bjorkenstam 2015
    - admitted patients, primary dx PD n=23,338
    - SMR women 6.1; Men 5.0
      - 20 years post d/c: 35 % women, 41% men dead vs expected 10, 15%
  - USA : ECA Kessler 2013
    - community based, ASPD only n= 15440 ASPD
    - Years lost: -15 years (adjusted proportional hazard ratio 2.03)
    - SMR= standardized mortality ratio: # actual deaths/# expected deaths
PD suicide

CLPS Yen 2003, 2004, 2005
- First 2 years F/U (all PD’s)
  - 9% at least one suicide attempt; 44% multiple suicide behaviours
- BPD, SUD at baseline predicted suicide attempts
- Within BPD group, the following predicted suicide:
  - Worsening MDD, SUD
  - Affective instability, childhood sexual abuse
  - Negative life events related to love/marriage, crime/legal
- Swedish National Case Register Bjorkenstam 2015
- All PD, at least one psychiatric admission
- SMR suicide women 32.8; men 16.4
- Suicide most common cause of death 34% women, 28% men
- One admission SMR women 25.8, 2+ admits 39.6
PD and physical health

- Increased rates of physical health problems and increased rates of health care utilization
  - CLPS PD increased medical resources compared with MDD Bender 2001
  - MSAD: BPD increased rates of medical services Zanarini 2005
  - NESARC: BPD increased cardiovascular disease, hepatic, GI, arthritis, sexually transmitted disease. El-Gabalawy 2010
  - NESARC: DSM IV PD associated with 26% increased odds of coronary heart disease Pietrzak 2007
  - St Louis Personality and Aging Network SPAN: PD associated with worse physical functioning, role limitations, fatigue, pain and increased health care utilization and medication use at follow-up Power 2012
  - Ginkgo Evaluation of Memory Study (GEM) high neuroticism, low conscientiousness associated with increased risk alzheimer disease Johansson 2014
Personality Disorder in Childhood

- **Children in the Community Study** Cohen 2005
  - Mean PD symptoms highest in early adolescence, linear decline age 9 – 27, but 21% show overall increase in PD symptoms
  - Mean stability coefficient for all 3 clusters 0.55 – similar to normal personality traits. Adolescents maintain similar rankings in PD symptoms relative to peers.
  - Child characteristics predicting PD: behaviour problems, depressive symptoms, low IQ, repeating grades
  - Demographic risk factors: low SES, single parent family, welfare support, parental death, social isolation
  - Parental risk factors:
    - parental conflict, sociopathy, illness
    - “maladaptive parenting”
      - neglect and abuse emotional, physical, sexual, extreme punishment
      - low closeness to parents, having been the product of an unwanted pregnancy
  - Secure attachment negatively correlated with all PD’s
  - Presence of PD in adolescence predicts in adulthood:
    - MDD, dysthymia, SUD
    - strongest predictor of treatment for mental illness and psychotropic drug use
    - Lower quality of life as adult into 4th decade
    - Effects comparable to or larger than Axis I disorders
Personality Disorder in Later Life

- Longitudinal personality disorder studies have not followed subjects beyond age 50
- PD may arise in later life because of environmental or interpersonal changes interacting with personality traits
- Trait based personality studies: normal personality more stable, more adaptive in later life; extrapolating this data suggests should see lower frequency PD in the geriatric age range, but when PD is present it is likely to be stable
- Studies:
  - NESARC Wave 1 adults >65 PD 8.07% Schuster 2013
  - National Psychiatric Morbidity Study (NPMS) N= 626
    - At least 1 PD 16-34 11.4%; 55-74 7.4% Coid 2006
  - NESARC Wave II adults 55+ PD 14.5%, but OR of any PD decreased with increasing age adjusted OR 55 – 64 2.25,75-84 1.03 Reynolds 2015
  - PD persisting into later life associated with ongoing functional impairment, non-suicidal self injury (NSSI), substance use and depressive disorders Newton Hawes 2015
a diagnosis possesses utility if “it provides non-trivial information about prognosis and likely treatment outcomes, and/or testable hypothesis about biological and social correlates….Diagnostic categories provide invaluable information about the likelihood of future recovery, relapse, deterioration and social handicap; they guide decisions about treatment; and they provide a wealth of information about similar patients encountered in clinical populations or community surveys throughout the world.….”
Dump PD’s altogether?

• Despite all of these criticisms….

• 5 main findings from research
  1. PD’s are prevalent
  2. High rates of social and occupational impairment
  3. Slower recovery, shorter time to relapse for co-morbid disorders (MDD, anxiety, SUD)
  4. Increased treatment utilization
  5. Increased suicide risk

Oldham, Skodol, Bender 2014, Skodol 2005
DSM 5 : IMPROVING ON DSM IV
DSM 5 Section III: PD

• The essential features of a personality disorder are:

  A. Moderate or greater impairment in personality (self/interpersonal) functioning

  B. One or more pathological personality traits

  C. The impairments in personality functioning and the individual’s personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations

  D. The impairments in personality functioning and the individual’s trait expression are relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood

  E. …not better accounted for by another mental disorder or substance use or another medical condition

  F. The impairments in personality functioning and the individual’s trait expression are not better understood as normal for an individual’s developmental stage or sociocultural environment.
DSM 5 Section III

• General Criteria
  A. Moderate or greater impairment in personality (self/interpersonal) functioning Level of Personality Functioning Scale
  B. One or more pathological personality traits
    • 6 specific personality disorders; ASPD, APD, BPD, NPD, OCPD, STPD
    • PD trait specified: one or more pathological personality trait domains, or specific trait facets, considering ALL of the following domains: Negative affectivity, Detachment, Antagonism, Disinhibition, Psychoticism
Severity as a “Core Dimension”?

• High comorbidity of PD suggests underlying similarities shared by all PD’s

• In personality assessment research the possibility of a single personality dimension has repeatedly emerged using various empirical approaches
  • studies of PD using the FFM - PD’s have similar FFM profiles – high neuroticism, low conscientiousness, low agreeableness  Morey 2000, 2002; Saulsman, Page 2004, Zweig-Frank, Paris 1995

• Measures of personality functioning (self and clinician reported) suggest components central to effective personality functioning are concerned with identity, self direction, empathy and intimacy
  • Reliability estimates for these constructs > 0.75 Bender 2011
Severity as a “Core Dimension” of PD

• Impairment in self and interpersonal functioning key aspect of personality functioning in all major theories of personality disorder Oldham, Skodol Bender 2014

• Measures of self, interpersonal functioning shown to determine existence, type, severity of personality pathology

• CLPS Generalized severity most important predictor of concurrent and prospective dysfunction Hopwood 2011

• General personality functioning can be distinguished from personality traits
  • 3 large studies, 4,000 patients and community recruits Verhuel 2008, Fenestra 2011, Berghuis 2012
Level of Personality Functioning Scale

- Personality functioning discriminates PD’s from other disorders [Morey 2011]
- ICD 11 severity of personality disturbance the central element of PD [Tyrer 2015].

- Why moderate level of impairment in a minimum 2 of 4 areas? [Morey 2013]
  - When compared to a DSM IV PD diagnosis
    - Moderate levels of impairment
      - sensitivity 0.85, specificity 0.73
    - Mild levels of impairment
      - sensitivity 0.99, specificity 0.15
LPFS: “Self” functioning

• **Identity:**
  - sees self as unique, clear boundaries between self and other
  - Stability of self esteem, accuracy of self appraisal
  - Capacity for and ability to regulate range of emotional experience

• **Self direction**
  - Pursuit of coherent and meaningful short term and long term goals
  - Utilization constructive and prosocial internal standards of behaviour
  - Ability to self reflect productively   APA 2013
LPFS: Interpersonal Functioning

- **Empathy**
  - Comprehension and appreciation of others’ experiences and motivation
  - Ability to tolerate differing perspectives
  - Understanding the effects of one’s own behaviour on others

- **Intimacy**
  - Depth, duration, connection with others
  - Desire, capacity for closeness
  - Mutuality of regards reflected in interpersonal behaviour

- American Psychiatric Association 2013
Level of Personality Functioning

• Clinician rates patient’s current personality functioning

• LPFS provides an overall score from 0-4
  • 0 = little or no impairment
  • 4 = extreme impairment

• Each of the 6 retained DSMIV PD’s have LPFS description consistent with the DSMIV PD’s
B: Pathological personality traits

• SNAP, FFM or DSMIV?
  • None on their own are perfect, each increments the other

• Model needed to meet the following:
  • Encompass 4 major domains of personality variation
  • Explicit measurement of psychoticism
  • Freely available and can be published in DSM5
  • Applicable to research and clinical practice

Oldham, Skodol, Bender 2014
DSM 5 Trait Model

Considered 18 dimensional models

37 proposed facets (individual traits)

Two waves of Testing
1028 “mental health seeking” community volunteers

Final set of 25 empirically derived, reliable facets

Tested on a population representative sample
Not “mental health seeking” 264 individuals

All facets; Chronbach’s alpha 0.72-0.96, median 0.86

• Krueger 2012
DSM 5 trait model

- 5 domains, each with 5 facets
  - Negative Affectivity (NA), Detachment (DET), Antagonism (ANT), Disinhibition (DIS), Psychoticism (PSY)
  - Can be rated by clinician or patient – PID-5
  - PID-5 brief, informant versions available
  - Free, available on-line DSM5 website

Limits

- based on self report data, limited to adults, limited to maladaptive traits, requires further analysis, replication

*Should supplement, not replace, clinical judgment*
DSM 5 PD or PD trait specified

• 2 options for “B” criteria “

1. Meets criteria for Personality Disorder
   • ASPD, AVPD, BPD, NPD, OCPD, STPD
   • Retained because research documenting
     • Prevalence in community and clinical populations
     • Functional impairment, treatment, prognostic significance
     • Neurobiological, genetic studies
   • 84% of PD’s seen in clinical practice

2. At least one pathological personality trait
How does this perform in clinical practice?

- DSM 5 field trials  Reiger 2013
- CAMH, Houston VA, Menninger
- Pooled Test- retest reliability

<table>
<thead>
<tr>
<th>DSM 5 diagnosis</th>
<th>Intraclass kappa</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Neurocognitive Disorder</td>
<td>0.78</td>
<td>Very good</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>0.67</td>
<td>Very good</td>
</tr>
<tr>
<td>Bipolar I Disorder</td>
<td>0.56</td>
<td>good</td>
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<tr>
<td><strong>Borderline Personality Disorder</strong></td>
<td><strong>0.54</strong></td>
<td><strong>good</strong></td>
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<tr>
<td>Schizophrenia</td>
<td>0.50</td>
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<tr>
<td>Mild Neurocognitive Disorder</td>
<td>0.48</td>
<td>good</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>0.28</td>
<td>questionable</td>
</tr>
<tr>
<td>Mixed Anxiety Depressive Disorder</td>
<td>0.004</td>
<td>unacceptable</td>
</tr>
</tbody>
</table>
The “Morey Study” 2013

- 334 clinicians, on line survey, anonymous information on a patient with whom they had a minimum 5 hours contact
- Rated patients on psychosocial function, short term risk, optimal level treatment intensity, estimated prognosis, suitability for various psychotherapy and pharmacotherapy
- Asked to rate patients according to DSM IV or DSM 5 PD, and then asked 6 questions on perceived clinical utility of the information.
- Clinicians (88 psychiatrists) rated DSM 5 as more clinically useful than DSM IV with respect to: ease of use, communication with patients, treatment formulation, comprehensiveness, global descriptions
Section II vs Section III: Final Thoughts

• Why do we have 2 models in DSM5?
  • You Tube: 2014 Master Lecture II: DSM 5 and Personality Disorders. Society for Personality Assessment

• ICD 11
  • Due sometime before 2017
  • Proposed essential features of personality disorders
    1. Measure of severity: mild, moderate, severe
    2. Domain Traits
      • Negative Affect: broad range of distressing emotions in response to even minor stressors
      • Dissocial features: disregard for social obligations, conventions and rights and feeling of others
      • Features of disinhibition: persistent tendency to act impulsively
      • *Anakastic features: narrow focus on control/regulation of one’s own and other’s behaviour in order to confirm to the individual’s particularistic ideal
      • Features of detachment: emotional and interpersonal distance
    3. Late onset qualifier: no symptoms prior to age 25
The “Mercer Study”

• Which of the following will you do?

1. Use DSM5 Section II for the exam and clinical practice
2. Use DSM5 Section II for the exam and will consider Section III for clinical practice
3. Use DSM5 Section II for the exam and will try out Section III in clinical practice
Treatment: Research Issues

- Lots!
- Heterogenous study populations
- Comorbidity significant – with PD’s and other mental disorders (depression, anxiety, AUD, SUD)
  - Symptomatic improvement of co-morbid disorder vs underlying personality change?
- Lack of agreement on core outcomes/measures makes meta-analysis hard to do
- Essential features of personality disorder are hard to measure: impairment in interpersonal function, identity problems, social dysfunction
- Few studies with long term follow up
  - Bateman 2015
General Treatment Principles

- Most evidence for psychosocial treatment of BPD
- No meds approved for treatment of personality disorder
  - 70% of med studies are for BPD, almost all were pharma sponsored
    Duggan 2008
- Goal is rehab not cure
  - but research suggests we are better at treating symptoms than improving function (social and vocational adaptation) Bateman 2015
- Realistic
  - Modify expression of traits
- Time
  - many years but can be intermittent
- Goal Oriented
  - Collaborative
  - Realistic achievable goals
  - Crisis to Crisis vs Big Picture
Treatment: Psychotherapy

• Psychotherapy treatment of choice for PD, most evidence for BPD

• 2 meta-analysis show psychotherapy (psychodynamic or CBT) more effective than TAU
  • Leichsenring 2003 14 psychodynamic, 11 CBT studies
    • Psychodynamic ES 1.46, CBT ES 1.00
  • Leichsenring 2008 psychodynamic 5 studies, 134 patients
    • overall ES 1.1

• Supportive psychodynamic - fewer dropouts

• Some evidence for inpatient, day hospital, group psychodynamic  Verhuel 2007
Defenses

• Cluster A
  • Projection, fantasy, denial

• Cluster B
  • Splitting, dissociation, denial, acting out, projective identification

• Cluster C
  • Isolation, passive aggression, hypochondriasis, undoing
CLUSTER A

Schizoid PD (SPD)
Schizotypal PD (STPD) (not a PD in ICD 10)
Paranoid PD (PPD)
Cluster A PD

• Family Studies
  • Significant familial relationship with scz
  • Schizotypal > Schizoid
  • STPD: prototypical schizophrenia spectrum disorder
  • Avoidant PD also occurs more frequently in families of schizophrenics

• Treatment
  • No studies of psychotherapy/psychosocial treatments
  • Few, small, usually open label studies of antipsychotics in schizotypal PD. No RCT’s for schizoid, paranoid PD
Cluster A : suicide

- Suicide attempters (assessed in ER)
  - 3-5% schizoid
  - 9% schizotypal
  - 8-10% PPD  Links 2005

- Suicide attempters (inpatient)
  - Cluster A: 27%  Links 2005
  - Follow up study 44% schizoid PD, 47% paranoid PD made subsequent suicide attempts  Ahrens 1996

- Suicide completers
  - National Suicide Prevention Project, Finland  Isometsa 1996
    - 1397 suicides: 1% PPD,
  - Chestnut Lodge Follow up  Fenton 1997
    - Schizotypal PD 3%
Pictures of famous People with Schizoid Personality Disorder
MCQ # 4

- Regarding Schizoid PD which of the following is incorrect? :

  a) Possible biological etiologies of SPD include: familial link to schizophrenia, schizotypal PD, and research that shows that introversion is highly heritable.
  
  a) Patients with SPD rarely seek treatment despite adequate insight into associated problems and moderate capacity for relationships.
  
  a) Symptoms of SPD are similar to negative symptoms of schizophrenia but SPD patients do not display full blown positive symptoms.
  
  b) Patients with SPD take pleasure in few, if any, activities and lack close friends or confidants other than first degree relatives.
MCQ # 4

• Regarding Schizoid PD which of the following is incorrect?

a) Possible biological etiologies of SPD include: familial link to schizophrenia, schizotypal PD, and research that shows that introversion is highly heritable.

a) Patients with SPD rarely seek treatment despite adequate insight into associated problems and moderate capacity for relationships.

a) **Symptoms of SPD are similar to negative symptoms of schizophrenia but SPD patients do not display full blown positive symptoms.**

b) Patients with SPD take pleasure in few, if any, activities and lack close friends or confidants other than first degree relatives.
Core features: detached from relationships, restricted range of emotional expression

Emotional: lack of pleasure in activities, emotionally cold, detached, indifferent to praise or criticism

Behavioural: prefers solitary activities

Relationship: no desire/enjoyment in close relationships, including family, no/little interest in sexual experiences, no close friends other than first degree relatives

Optimal DSM criteria: Neither desires or enjoys close relationships including being part of a family. (Allnut, Links 1996)

DSM 5 Section III, PD TS: withdrawal (DET), Intimacy avoidance (DET) Anhedonia (DET), Restricted Affectivity (DET)
Schizoid PD: Clinical Features

- Very brief (minutes to hours) psychotic symptoms under stress
- “Asocial” not antisocial
- Not involved, not concerned
- Prefer solitary pursuits
- Bland, distant, lack social graces, rarely marry
- Invest in non human objects and the abstract
- Low insight
- Observers, not participants
- Triggering Event: close interpersonal relationships

Othmer 2002
Schizoid Etiology

• Biological
  • Possible familial link to schizophrenia and schizotypal PD
  • Introversion highly heritable \textit{Kendler 2008}
  • Heritability (twin studies) 0.34, 0.28 \textit{Torgersen 2000, Kendler 2008}

• Developmental
  • parents experienced as cold, neglectful, leading to belief that relationships are not worth pursuing
Schizoid PD DDX

• Other PD’s
  • Schizotypal - more eccentric with disturbed perception and thought form
  • Paranoid - more engaged, hostile, and aggressive
  • OCPD - more involved, past relationships, sensitive to criticism
  • Avoidant - lonely, despite companions, feel inadequate

• *Autism/ Aspergers
  • Autism, Aspergers, schizoid PD similar impairment in social interactions
  • Schizoid has less impaired communication, and fewer stereotypical behaviours

• Schizophrenia
  • Similar to some negative symptoms but at most brief psychotic episodes/ not full blown positive symptoms.
Schizoid PD: Course

- Onset tends to be early childhood
- Reduced quality of life, all measures vs other PD, no PD
  Cramer 2006
- Improves over time CIC, LSPD
- Resembles premorbid schizophrenia, but the actual number that go on to have schizophrenia is not known
- Co-morbid
  - brief psychotic episodes
  - MDD, STPD, PPD, APD
Schizoid PD: Clinical Tips

• Challenges
  • Emotional withdrawal
  • Aloofness, Indifference
  • Yes/No answers with no elaboration

• Technique
  • Patient is not sensitive to technique
    • One can use any means to get information
  • Abrupt transitions are fine
  • Unlikely to establish rapport

• Clinical Interview for the DSM IV Part 2, Othmer 2002
Schizoid Treatment

- Rarely seek treatment
- Low insight into associated problems. Low capacity for relationships. Low motivation. Degree of suffering

Psychodynamic Psychotherapy Gabbard 1990
- Occasionally suitable
- May get highly involved in therapy → intense fears of dependency. Therapeutic distance is required for patient to tolerate therapy relationship. Helpful if therapist sees silence as a non-verbal way of relating, rather than resistance.
- As trust increases, may be able to access wealth of fantasies to be used in therapy

CBT Beck 2003
- Core Beliefs: I am basically alone. Relationships are messy - focus on increasing social interaction

Medications Low dose antipsychotic, antidepressants, psychostimulants have all been used - success
Schizotypal Personality Disorder
MCQ # 5

• Which of the following is correct regarding Schizotypal personality disorder?

a) While patients with schizotypal PD have odd thoughts or ideas they do not typically have odd behaviour or appearance
b) Patients with Schizotypal PD do not have close relationships with first degree relatives
c) Suspiciousness and paranoid ideation is restricted to patients with paranoid personality disorder
d) Patients with schizotypal PD have odd beliefs and magical thinking that influence behaviour and are not consistent with cultural norms
MCQ  # 5

- Which of the following is correct regarding Schizotypal personality disorder?

a) While patients with schizotypal PD have odd thoughts or ideas they do not typically have odd behaviour or appearance
b) Patients with Schizotypal PD do not have close relationships with first degree relatives
c) Suspiciousness and paranoid ideation is restricted to patients with paranoid personality disorder
d) *Patients with schizotypal PD have odd beliefs and magical thinking that influence behaviour and are not consistent with cultural norms*
MCQ # 6

Schizotypal PD shares all of the following biological abnormalities with schizophrenia except:

a) Loss of frontal lobe volume and striatal dopamine activity
b) Temporal lobe volume reductions
c) Impaired smooth pursuit eye movements
d) Impaired tests of executive functioning
MCQ # 6

- Schizotypal PD shares all of the following biological abnormalities with schizophrenia except:
  a) *Loss of frontal lobe volume and striatal dopamine activity*
  b) Temporal lobe volume reductions
  c) Impaired smooth pursuit eye movements
  d) Impaired tests of executive functioning
Core symptoms:

1. **Acute discomfort with and reduced capacity for close relationships**
2. **Cognitive and perceptual distortions**
3. **Eccentric Behaviours**

- Optimal DSMIV TR Criteria: Odd thinking and speech; behaviour or appearance that is odd, eccentric or peculiar
  
  Allnut and Links 1996
DSM-5 Section II : Reorganized

• Cognitive
  • Ideas of reference
  • Odd beliefs, magical thinking which influences behaviour / not consistent with subcultural norms: superstitious, clairvoyance, sixth sense. In kids, teens: bizarre fantasies, preoccupations
  • Unusual perceptions and experiences, bodily illusions
  • Odd thinking and speech: vague, circumstantial, metaphorical, overelaboration, stereotyped
  • Suspiciousness, paranoid ideation

• Impulsivity/Behavioural - Odd, eccentric, peculiar
• Relationship- lacks close friends other than 1st degree relatives
DSM 5 Section II: Reorganized

- Emotional
  - Inappropriate or constricted affect
  - Excessive social anxiety that does not improve with familiarity. Associated with paranoid fears/mistrust rather than negative judgments about self

- Associated features: Transient psychotic episodes under stress

- DSM 5 Section III: STPD, 4 or more of
  - Cognitive/Perceptual dysregulation (PSY), Unusual beliefs and experiences (PSY), Eccentricity (PSY), Restricted Affectivity (DET), Withdrawal (DET) Suspiciousness (DET)
Schizotypal PD: Clinical Tips

• Triggering event: close interpersonal relationships

• Challenge
  • Irrationality
  • Difficult to empathize
  • Reactions of amusement/surprise by interviewer

• Technique
  • Try to share the autistic world that the client lives in
  • Use clarification, continuation, active listening
  • Verbalize your empathy

Clinical Interview for DSM IV Othmer 2002
Etiology

- Higher rates schizotypal PD in relatives of schizophrenia probands
  - 14% vs. 2% in controls
- Higher rates of schizophrenia in families of schizotypal probands
- Monozygotic twins show greater concordance than dizygotic 33% vs. 4%
- Estimated heritability 0.61, 0.26 Torgersen 2000, Kendler 2008
- Not related to psychotic affective disorder, MDE or anxiety
Schizotypal PD Etiology

- Primarily felt to be biological- Psychotic disorder in ICD 10
- Temporal lobe volume reductions in both STPD and schizophrenia Kirrane 2000
- CSF HVA concentrations SCZ > STPD > other PD
- Impaired smooth pursuit eye movements Siever 1990, Thaker 1996
- Preservation of frontal lobe volume and striatal DA activity vs schizophrenia Siever 2004
Schizotypal PD DDX

- Delusional Disorder, schizophrenia, MDD with psychotic features
  - Greater intensity and persistence of psychosis
- Paranoid and schizoid PD
  - Lack consistent perceptual, cognitive disturbances. Not so odd
- Borderline PD
  - Brief psychosis tends to be more dissociative, closely related to affective state. Social isolation related to interpersonal failures/ conflicts/ burned bridges. Socially anxious in regards to rejection
- Avoidant PD
  - Share social isolation but desire closeness in avoidant
- In children
  - Autism / Aspergers
- Cultural/ sub cultural norms
Course

- 10 – 20% develop schizophrenia but this is unlikely if no psychosis by age 30  McGlashan 1986
- Increase risk of schizophrenia with magical thinking, paranoid ideation, social isolation
- 10% suicide
- Global functional impairment, does not improve to the same degree as symptoms over time  Cramer 2006, Skodol 2005
- Symptom improvement over time CLPS 33% remission at 2 years  Grilo 2004, LSPD, CIC
- Frequent co-morbidity: MDD, PPD, SPD, BPD, APD, Brief psychotic d/o
Schizotypal PD Treatment

- Psychodynamic Gunderson 1988, Gabbard 1990
  - Little is known about dynamics, may be similar to schizoid
  - Avoid interpretation of conflict, see silence as a non-verbal form of relating
- CBT Beck 2003
  - Cognitive distortions- emotional reasoning and personalization – belief that they are responsible for external situations out of their control. Focus on increasing social network, Social Skills training
- Supportive therapy best
  - Be patient, flexible, give advice
  - Social Skills training
  - Encourage activity, does not have to be social
- Medications
  - Treat comorbidities
  - Low dose antipsychotics: mild to moderate improvement social anxiety and suspicion
    - open study olanzapine (9.32 mg/d), small RCT risperidone (2 mg/d)
Paranoid Personality Disorder

"No-one calls me a litigious bastard and gets away with it!"
MCQ # 7

Which of the following is true in paranoid personality disorder?:

A. Patients with PPD rarely have suspicions about the fidelity of their spouse
B. Paranoid PD responds well to weekly CBT
C. There is an increased prevalence of PPD in the hearing impaired, new immigrants, minority groups
D. The delusions seen in paranoid PD are well encapsulated, systematized
MCQ # 7

Which of the following is true in paranoid personality disorder?

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DSM 5 Section II: Reorganized

Core features: **suspiciousness, distrust** of others, others motives interpreted as **malevolent**

- **Cognitive**
  - Suspects others are exploiting him/her
  - Unjustified doubts re: loyalty/trustworthiness of friends/associates
  - Reads hidden meanings into benign remarks
- **Emotion**
  - Pathological jealousy
- **Relationships**
  - Reluctant to confide in others, bears grudges
  - Perceives attacks that are not apparent to others, quick to counterattack
- **Optimal DSM IV-TR criteria:** Suspects, without sufficient basis, that others are exploiting, harming, deceiving him/her  
  [Allnut, Links 1996]
- **DSM 5 Section III, PD-TS:** Suspiciousness (DET), Hostility (ANT)
Epidemiology PPD

- Inpatients 10-30%
- Outpatients 2-10%
- Increased prevalence in
  - Hearing impaired, new immigrants, minority groups
    - Don’t make dx if symptoms make sense in cultural context
  - Not increased in homosexuality as once thought
  - Increased in relatives of delusional disorder>schizophrenia>general population
Etiology: Biological

- Schizophrenia Spectrum
  - ? Decreased cortical DA
- Temperament: Chess and Thomas- irregularity, non-adaptability, intense reactions, negative mood, tendency to hyperactivity
- Developmental handicaps: Paranoid Traits associated with impaired vision, hearing, traumatic brain injury
- Heritability twin studies 0.28 Kendler 2008, Torgersen 2000
Etiology: Psychological

- Adaptive: ability to perceive and react to danger in our environment
- Suspiciousness: immigrants, minority groups
  - Lack of familiarity, language, perceived rejection
- Pathological
  - Deficits in early developmental stages
  - Lack of protective care and support in childhood
  - Excessive parental rage and humiliation → inadequacy and vulnerability → projection of hostility and rage onto others
  - Previous theories of projection of homosexual impulses not supported and currently out of date
Paranoid PD DDX

- Delusional Disorder
  - delusions well encapsulated, systematized vs PPD no delusions, pervasive
- Schizophrenia
  - positive and negative symptoms
- Depression with Psychotic features
  - More episodic, less pervasive, more psychotic
- Chronic substance use
- Borderline PD
  - More tumultuous, splitting
- Schizoid PD
  - More indifferent
- Narcissistic PD
  - More entitled than suspicious, need for praise
- Antisocial PD
  - Secondary gain, exploitation
- Avoidant PD
  - Lack of self confidence/fear of embarrassment lead to fears to confide
Paranoid PD Course

• Can be hypersensitive as kids with poor peer relationships and eccentric which causes them to be picked on and therefore aggravates the disorder

• Some premorbid schizophrenia

• Increased risk of: brief psychotic episodes, MDD, agoraphobia, OCD, AUD/SUD, other PD: STPD, SPD, NPD, APD, BPD

• Marked reduction quality of life (along with APD, STPD, SPD, BPD). Cramer 2006

• Improves with time, symptoms more than function. CIC, LSPD Chen 2006, Lezenweger 2004
Paranoid PD : Clinical Tips

- Triggering Event: Close interpersonal relationships and/or personal queries
- Problems
  - Suspiciousness
  - Fear of being taken advantage of
- Technique
  - Not to be too friendly
  - Stick to smooth transitions. No abruptness
  - Avoid confrontation

Clinical Interview for the DSM-IV : Othmer 2002
Paranoid PD Treatment

- Rarely seek help, others seen as the problem
- Insufficient trust to engage in process, not able to tolerate groups

**Psychodynamic**
- Defense mechanisms: projection, projective identification Shapiro 1965
- Therapeutic alliance difficult
- Clinician needs to be seen as a benign, disinterested, friendly helper Salzman 1980
- Avoid interpretations, agree to disagree, model humour towards yourself and life’s circumstances

**CBT Beck 2003**
- Respect, integrity, tact, patience are key
- Core beliefs: others are malicious and deceptive, I will be okay only if I do not let my guard down. Expectation of hostility and attack → elicits hostility and distrust from others
- Approach: refrain from speaking about sensitive issues early on. Hold off on thought records, give more control over session, homework, session interval q 2 to 3 weeks
Paranoid PD: Medications

• Clinical recommendations:
  • Antidepressant as indicated
  • Low dose antipsychotic for brief psychotic episodes
CLUSTER C

Dependent PD (DPD)

Avoidant PD (APD) ICD 10: Anxious PD

Obsessive Compulsive PD (OCPD) ICD 10

Anankastic PD
Cluster C Etiology

• Heritability estimates
  • Any cluster C: 0.62
  • OCPD: 0.78, 0.29 Torgersen 2000, Kendler 2008
    • OCPD has highest disorder specific genetic loading – suggests genetic factors specific to this PD
  • Dependent: 0.57, 0.34 Torgersen 2000, Kendler 2008
  • APD: 0.28, 0.37 Torgersen 2000, Kendler 2008

• Little research on neurobiology: ?↓DA, ↑5HT
Cluster C psychotherapy: RCT’s

• **Short term dynamic vs supportive psychotherapy vs WL**
  - Winston 1994
  - N = 81
  - both active treatments equally effective

• **CBT and Psychodynamic**
  - Shea 1990, Hardy 1995
  - N=352
  - equal response to CBT, psychodynamic therapy
  - Less robust than MDD without PD

• **Interpersonal psychotherapy vs CBT**
  - Svartberg 2004
  - N=50
  - both treatments effective for symptoms and functioning

• **Brief Dynamic vs CBT vs WL for APD**
  - Emmelkamp 2006
  - N= 62
  - CBT>BDT>WL

• **Meta-analytic**
  - Simon  2009
  - 15 studies, CBT or psychodynamic
  - therapy gains usually maintained at follow up
DEPENDENT PD (DPD)

over-reliance on others to meet needs
MCQ # 13

Which of the following is not a feature of DPD?

a) difficulty making everyday decisions without an excessive amount of advice and reassurance from others
b) A recurrent pattern of abuse or dependence on alcohol or other substances
c) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
d) uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
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MCQ # 14

• In psychodynamic therapy with DPD patients, which of the following are true?

A. The therapist explores fears of autonomy, but ignores signs of overly compliant behaviour
B. While earlier psychodynamic theories stressed over gratification in the oral phase, current theories emphasize authoritarian or overprotective parents who prohibit independent activity
C. “transference longing”: the secret longing to attach themselves to therapist forever is an uncommon form of resistance in therapy with DPD patients
D. The therapist must avoid the development of dependent transference
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DSM-5 Section II : Reorganized

• Core: pervasive, excessive need to be taken care of → submissive, clinging behaviour, fears of separation

• Optimal DSM IV TR criteria: Needs others to assume responsibility for most major areas of his/her life Allnut, Links 1996

• Relationship
  • difficulty making everyday decisions without excessive advice, reassurance from others
  • needs others to assume responsibility for most major areas of life
  • difficulty expressing disagreement with others because of fear of loss of support or approval. Note: Do not include if realistic fears of retribution.
  • urgently seeks another relationship when a close relationship ends
  • goes to excessive lengths to obtain nurturance and support from others - volunteers to do things that are unpleasant
Behavioural
• difficulty initiating projects or doing things on his or her own
• lack of self-confidence in judgment or abilities (not lack of motivation or energy)

Emotional
• uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
• unrealistically preoccupied with fears of being left to take care of himself or herself

DSM 5 Section III
• PD- TS Submissiveness (NA), Anxiousness (NA), Separation Insecurity (NA)
DPD

• Factors analysis shows 3 independent factors
  • Strong emotional reliance on close attachments and others
  • Lack of self confidence in social situations, accompanied by submissive behaviour
  • Avoidance of autonomy

• Co-morbid disorders
  • depressive d/o, anxiety d/o, adjustment d/o. Other PD: BPD, APD, HPD.
Dependent PD Etiology

- **Environmental**
  - Originally thought due to over gratification in the oral phase
  - Now felt to be more connected with authoritarian or overprotective parenting – prevents children from learning through trial and error. Bornstein 1996
  - Preoccupied attachment style Lyddon, Sherry 2001

- **Biological**
  - Twin studies
    - Suggest biological component to submissiveness
    - Heritability 0.57 0.34 Torgersen 2000 Kendler 2008,
  - Chronic Physical illness, separation anxiety disorder in childhood may predispose to DPD
DPD DDX

Other mental d/o

• MDD, panic D/O, Agoraphobia, Social phobia can all lead to dependent behavior but limited to the context of the axis I disorder

Other PD

• Borderline PD
  • Shares fear of rejection and abandonment
  • BPD anger, emptiness dramatic vs. DPD submissiveness and clinging
  • DPD wants to be controlled / BPD reacts strongly to efforts to control. DPD lacks rage.
  • BPD chaotic relationships

• Avoidant PD
  • Share low self esteem, need for reassurance, high sensitivity for rejection
  • APD reacts by avoiding and where DPD seeks out relationships

• Histrionic PD
  • Share adjusting actions to please others
  • HPD more seductive, flamboyant, manipulative to get attention rather than caretaking
Dependent PD : Clinical Tips

• Triggering event: expectations of self reliance and/or being alone
• Problem
  • Submissiveness, rapport is easy, but exploration is difficult
• Technique
  • Support to meet dependency needs
  • Pursuing/Confronting origins of dependency is difficult
    • Client will feel bad and will show the suffering
    • Soothe the pain
  • Tolerates all types of interviewing techniques
  • Easy interview, but expect transference-counter transference to occur and avoid boundary violations

Clinical Interview for the DSM-IV Othmer 2002
Dependent Tx Overview

- Psychoanalysis if motivated, do well in psychodynamic, CBT, social skills training, group, family, and couples
- Therapy designed to increase self-esteem, self-confidence, sense of efficacy, assertiveness
- Explore fears of autonomy
- Use therapeutic relationship
Psychodynamic Rx

• Gabbard 1990
  • “transference longing”: formidable resistance, secret longing to attach themselves to therapist forever. Difficult because presents a paradox, must develop dependency on therapist in order to be independent.
  • Hostile dependency: dependency as a way to manage anger and aggression.
    • ++ pressure on therapist to tell them what to do
    • Repeated requests for advice, help
  • Compliance in order to preserve the therapeutic relationship

• Sperry 2003
  • Failure to mourn losses – goal is to cope better with previous separations and object losses
DPD psychodynamic treatment Gabbard 1990

• Ensure that dependent transference promotes emotional growth
• Therapy should be used to promote self expression, assertiveness, decision making and independence
• Avoid taking directive roles in patient’s life
• Expect “help rejecting, complaining behaviour” when patient confronted with situations which require more autonomous behaviour.
• Extra sessions may be helpful early on, but need to be tapered off in order for therapy to be effective
• Need to learn skills to self soothe, rather than seeking reassurance from others
• Need to work through mourning process before termination
DPD: CBT Beck 2003

• Sees self as inadequate, helpless, world as cold, lonely and dangerous.
• Assumes best strategy is to find someone who is capable of protecting him/her.
• Cognitive Distortion: “If I rely on myself I will fail, if I rely on others I will succeed”
• Goal is increased autonomy and self efficacy
• Graded exposure to anxiety provoking situations to challenge patient’s belief about incompetence
Avoidant Personality Disorder
MCQ # 15

Which of the following criteria occurs only in Social Phobia?

A. shows restraint within intimate relationships because of the fear of being shamed or ridiculed
B. views self as socially inept, personally unappealing, or inferior to others
C. recognizes that the fear of social situations is excessive or unreasonable
D. is preoccupied with being criticized or rejected in social situations
• Which of the following criteria occurs only in Social Phobia?

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C. recognizes that the fear of social situations is excessive or unreasonable
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MCQ # 16

• Which is not correct regarding APD?

a) Urgently seeks another relationship as a source of care and support when a close relationship ends.

b) Maladaptive avoidance develops as a defense against shame, embarrassment and failure

c) Normal shyness in children tends to decrease in adolescence and early adulthood but will increase in avoidant PD due to increased role of relationships

d) Patients with APD are felt to display anxious attachment: they are ambivalent about close relationships and feel very vulnerable to potential punishment and neglect of others
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DSM 5 Section II : Reorganized

• Core: Social inhibition, feelings of inadequacy, hypersensitivity to negative evaluation

• Optimal DSM IV TR criteria- “avoids occupational activities that involve significant interpersonal contact fearing criticism, disapproval or rejection” Allnut, Links 1996

• Behavioural
  • avoids occupational activities that involve significant interpersonal contact because fears criticism, disapproval, or rejection
  • unusually reluctant to take personal risks, engage in new activities because they may prove embarrassing

• Emotional
  • restrained in intimate relationships due to fear of being shamed or ridiculed
DSM-5 Section II: Reorganized

Relationship
• unwilling to get involved with people unless certain of being liked
• inhibited in new interpersonal situations because of feelings of inadequacy

Cognitive
• is preoccupied with being criticized or rejected in social situations
• views self as socially inept, personally unappealing, or inferior to others

DSM 5 Section III: Avoidant PD
• 3 or more, anxiousnessness required
• Anxiousness (NA), Withdrawal (DET), Anhedonia (DET), Intimacy avoidance (DET)
APD = Social Phobia?

• APD with SP: 42%
• SP with APD: 62%
• Large twin study: APD/SP shared genetic, but unique environmental variance
  Reichborn-Kjennerud 2007, Reich 2009
• Co-morbidity
  • Other mental d/o: MDD, bipolar, anxiety-social phobia in particular, scz, psychotic disorders
  • Other PD: DPD, BPD, Cluster A
Avoidant PD Etiology

- **Temperament**
  - Children as young as 21 months manifest increased arousal and avoidant behavior
  - Genetic vulnerability to high neuroticism and low extraversion
    - Kendler 2008
  - Shared genetic vulnerability with Social phobia
  - Heritability: twin studies 0.28, 0.37
    - Torgersen 2000, Kendler 2008

- **Attachment**
  - Anxious attachment: wants to have close relationships and feels very vulnerable to potential punishment, neglect
  - Anxious/avoidant: pervasive avoidance of situations that stir up affect
  - Anxious/ambivalent: co-morbid DPD, cling to others but fear getting too close.
Avoidant PD Etiology

• Psychodynamic

• parents who were inconsistent, absent, abusive.
  • Retrospective studies: fewer demonstrations of parental love, parents who were discouraging and rarely showed pride in their children, higher rates of rejection and isolation than control groups.

• Maladaptive avoidance develops as a defense against shame, embarrassment and failure.
Avoidant DDx

Other Mental d/o
- Social Phobia - Generalized
  - ? same condition
  - The impairment and distress in social situations is more impairing
  - More low self esteem in avoidant pd
- Agoraphobia
  - Tends to occur in context of panic do. Avoidant PD more stable
- Depression/ Dysthymia
  - Negative self evaluation limited to mood context

Other PD
- Dependant PD
  - Share rejection sensitivity, low self esteem, need for reassurance. Common comorbidity
  - Avoidant PD avoids contact while Dependent PD focuses on being cared for
- Schizoid Pd
  - Accepting of isolation
- Schizotypal PD
  - Isolated but odd
- Paranoid
  - Isolate due to lack of trust in others not self
Avoidant Course

- Normal shyness in children tends to decrease in adolescence and early adulthood but will increase in APD due to increased role of relationships.
- Can do well in environment with known people and not exposed to new people.
- Moderate-Severe functional impairment vs other PD, normal population.
- APD and depression: High drop out, but if stay in treatment have same Δ as patient without PD.
Avoidant PD : Clinical Tips

- **Triggering Event:** demands for close interpersonal relating and/or social, public appearances
- **Challenges**
  - Hypersensitivity
  - Easily embarrassed
- **Technique**
  - Avoid criticism, be protective to enable rapport
  - Client will identify fears as silly. Do not reflect these. Client will feel ridiculed and withdraw
  - Remember to bolster client’s self esteem throughout the encounter

Clinical Interview for the DSM-IV : Part 2 : The Difficult patient : Othmer
Shyness, shame, avoidant behaviours – defenses against embarrassment, humiliation, rejection, failure

Focus on transference enactments of wanting but fearing to get close to therapist

Also need to gain exposure to feared situations: gained in-vivo in the therapeutic relationship- discussing highly emotional material, building open, trusting relationship with therapist

Therapist needs to be more directive for therapy to be effective
APD: CBT Beck 2003

• Risk: resources model
  • APD: magnify risks of situations, minimize coping resources.

• Core beliefs:
  • If I get close people will discover the real me and reject me
  • It is better not to do something than to try something and fail
  • If I ignore a problem it will go away
  • Keeping things to myself is good, talking leads to trouble

• Skills deficits often perceived accurately because person avoids learning, practicing and refining

• Can examine therapeutic alliance

• Exposure plus rational responding (DTR’s)
Obsessive Compulsive Personality Disorder
MCQ # 17

• Which of the following is correct regarding OCPD?

A. DSM 5 Section II requires that the preoccupation with details, rules, lists, order, organization, schedules seen in OCPD occur to the extent that the major point of the activity is lost

B. Perfectionism rarely interferes with task completion (patients can complete projects despite overly strict standards)

C. Adolescents with strong OCPD traits rarely grow out of the diagnosis

D. While research is limited, one study suggests that CBT may be better than psychodynamic psychotherapy for OCPD.
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DSM-5 Section II : Reorganized

• Core: orderliness, mental and interpersonal control, perfectionism, at the expense of flexibility, openness, and efficiency

• Optimal DSMIV TR criterion: “shows perfectionism that interferes with task completion” Allnut and Links 1996

• Relationships
  • Excessively devoted to work, productivity to exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
  • Reluctant to delegate tasks, work with others unless they submit to exactly his/her way of doing things

• Cognitive
  • Miserly spending style toward both self and others; money viewed as something to be hoarded for future catastrophes
DSM-5 Section II : Reorganized

Emotional
- Scrupulous, inflexible re: morality, ethics or values (not accounted for by culture or religion)
- Shows rigidity and stubbornness

Behavioural
- Preoccupied with details, rules, lists, order, organization, schedules → major point of the activity is lost
- Perfectionism interferes with task completion (can’t complete projects due to overly strict standards)
- Unable to discard worn-out or worthless objects even when no sentimental value

DSM 5 Section III: OCPD
- 3 or more: rigid perfectionism trait is required.
- Rigid perfectionism(C), Perseveration(NA), Intimacy Avoidance (DET), Restricted affectivity (DET)
OCPD Core Features

- Clinical observation, empirical studies
  - Rigidity and perfectionism core features
  - Rigidity: interpersonal control, resistance to change
  - Perfectionism: cognitive and interpersonal control
  - Perfectionism increases vulnerability to depression

- Rigidity, perfectionism and reluctance to delegate most stable criteria over 2 yr F/U
OCPD Etiology

- **Freud**
  - Anal stage of development. Toilet training problems. Not supported

- **Erickson’s stage of Autonomy vs. Shame**
  - Excessive parental control, criticism causes insecurity
  - Defended against by perfectionism, orderliness, control

- **Learning: Expressions of emotions shaped by parental response**
  - Shame, criticism
  - Children praised for what they did, not who they were
  - Feelings experienced as weakness
  - Not taught healthy expressions of anger

  - 0.78, 0.28.
  - Genetic risk factors which are specific to OCPD.
**OCPD DDx**

**Other mental d/o**

- OCD
  - More clearly defined obsessions, compulsions
  - OCPD can have a lot of checking, attention to detail, hoarding that looks like OCD, also pathological doubt with poor insight.
  - OCPD more egosyntonic

- GAD
  - Emphasis is excessive worry
  - More egodystonic

**Other PD**

- NPD
  - Perfectionism and entitlement can lead to lack of compromise
  - Tend to believe in accomplishments and not hypercritical of self
  - Often feel they deserve leisure

- Schizoid
  - Constricted affect, not warm
  - OCPD does this to maintain control, not a fundamental lack of capacity
OCPD Course

- Adolescents with strong OCPD traits can grow out of the diagnosis
- Least –equivalent to MDD Skodol 2002, or no Cramer 2006 - reduction in quality of life
- Increased comorbidity with depression, anxiety disorders, bipolar, eating d/o.
- MDD
  - Increased time to remission Grilo 2005
  - Increased risk of suicide attempts Zaheer 2008
- 30% OCPD have OCD
- Increased levels mental health and medical treatment
OCPD : Clinical Tips

• Triggering Event: “authority; unstructured situations, and/or demands of intimate and close relations”

• Challenge
  • Circumstantiality and perfectionism
  • patient does not like empathy

• Technique
  • Remember: open ended questions are confusing to patient, and circumscribed questions will produce detailed descriptions without emotional valency
  • Remember: patient perceives self as neutral, objective, logical and efficient
  • Keep the room organized so as not to distract the patient

Clinical Interview for the DSM-IV Othmer 2002
Challenges in treatment

- “perfect patient”
- Competition with therapist: do not want to be told things that they feel they should already know, want therapist to be “perfect”
- Countertransference boredom due to absence of affect and spontaneity
- Important to empathize with shame and guilt associated with unacceptable aspects of the self
- CBT: too detail oriented, reluctant to explore emotions
OCPD Therapy

- Psychodynamic, CBT
- Active therapist
- Challenge intellectualization
- Increase emotional awareness
- Modify harsh superego – accept being human
- Mindful to fun
- Improve tolerance of imperfection and error, leave tasks once “good enough”
OCPD: Psychodynamic Sperry 2003

- Intimacy raises possibility that they will be overwhelmed by wishes to be taken care of. If wishes not met possibly will lead to frustration and resentment. → feel out of control.
- Self doubt and low self esteem → belief that if others really knew them would loathe them.
- If could only be flawless will finally receive the esteem and approval they missed as children→ even if do achieve this are rarely satisfied.

- Therapy goals
  - understanding defenses as protection against feelings of uncertainty and insecurity
  - switching from impossible expectations for self to realistic, achievable goals
  - Encourage risk taking and decision making
Defenses
- Reaction formation, intellectualization, undoing, isolation of affect

Defenses tone down powerful affective states so patient is not in danger of losing control

Patient presents as responsible, dutiful, unfailingly courteous in order that no trace of aggression is revealed. In order to do well must overcome anxieties about being in control
OCPD: CBT Beck 1990

- Schemas: Perfectionism, Control
- Cognitive Distortions
  - It is important to do a perfect job on everything
  - Any flaw, defect of performance may result in a catastrophe
  - People should do things my way
  - Details are extremely important
- Extreme behaviours driven by anxiety, routines reduce anxiety
- Treatment
  - Establish openness to new ideas
  - Use humour
  - Challenge perfectionism
  - Teach relaxation strategies
Personality Change due to another medical condition

A. Persistent personality disturbance that represents a change from the individual’s previous characteristic personality pattern.
   • In children disturbance involves a marked deviation from normal development or a significant change in the child’s usual behavior patterns, lasting at least 1 year

B. Evidence from hx, physical, lab that the disturbance is due to another medical condition

C. Not better explained by another mental disorder

D. Does not occur exclusively during the course of a delirium

E. Causes clinically significant distress or impairment in social, occupational or other important areas of functioning
   • Specify whether
      • Labile type: predominant feature affective instability
      • Disinhibited type: predominant feature poor impulse control ie sexual indiscretion
      • Aggressive type: predominant feature is aggressive behaviour
      • Apathetic type: predominant feature marked apathy, indifference
      • Paranoid type: predominant feature suspiciousness or paranoid ideation
      • Other: none of the above subtypes; combined: more than one feature; unspecified
Personality Change due to another medical condition

- Individual’s often characterized as “not himself”
- For example: Injury to frontal lobes may yield symptoms such as lack of judgment, facetiousness, disinhibition, euphoria.

- Common associated medical conditions
  - Neurological: CNS neoplasm, epilepsy, head trauma, huntingtons, HIV,
  - Endocrine: hypo/hyperthyroidism, hypo/hyperadrenocortism
  - Autoimmune with CNS involvement: SLE

- Differential diagnosis
  - Chronic medical conditions associated with pain and disability
  - Delirium, major neurocognitive disorder
  - SUD
Other/un Specified Personality Disorder

• **Other Specified Personality Disorder**
  • Symptoms characteristic of a personality disorder, but do not meet full criteria for any PD
  • Cause clinically significant distress or impairment
  • Indicate specific reason why presentation does not meet criteria for a specific PD
    • Other specified personality disorder; mixed personality features

• **Unspecified Personality Disorder**
  • Symptoms characteristic of a personality disorder, but do not meet full criteria for any PD
  • Cause clinically significant distress or impairment
  • Used when clinician chooses not to specify the reason that the criteria are not met, ie insufficient information to make diagnosis