CLUSTER A PERSONALITY DISORDERS

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INTRODUCTION

- "Personality" refers to the pattern of thoughts, feelings, and behaviour that makes each of us the individuals that we are.

- This is flexible and our behaviour differs according to the social situations in which we find ourselves.

- People with personality disorder seem to have a persistent pervasive abnormality in social relationships and social functioning in general.

INTRODUCTION

- People with personality disorder have a more limited range of emotions, attitudes, and behaviours with which to cope with the stresses of everyday life.

- Personality disorder is viewed as different from mental illness because it is more persistent throughout adult life, whereas mental illness results from a morbid process of some kind and has a more recognizable onset and time course.

INTRODUCTION

- People with personality disorders experience considerable distress, suffering, and stigma.

- They can also cause distress to others around them.

- Epidemiological research has shown that comorbid mental health problems, such as depression, anxiety, and substance misuse, are more common in people with personality disorder, are more difficult to treat, and have worse outcomes.

INTRODUCTION

DEFINATION

- Allport defined personality as the "dynamic organization within the individual of those psychophysical systems that determine his/her unique adjustment to his/her environment."

CLASSIFICATION OF PERSONALITY DISORDERS

ICD-10 : F60 Specific personality disorders

F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.2	Dissocial personality disorder
F60.3	Emotionally unstable personality disorder
F60.4	Histrionic personality disorder
F60.5	Anankastic personality disorder
F60.6	Anxious (avoidant) personality disorder
F60.7	Dependent personality disorder
F60.8	Other specific personality disorders
F60.9	Personality disorder, unspecified

CLASSIFICATION OF PERSONALITY DISORDERS

DSM5

1. Cluster A Personality Disorders- Paranoid, Schizoid, Schizotypal PD
2. Cluster B Personality Disorders- Antisocial, Borderline, Histrionic, Narcissistic
3. Cluster C Personality Disorders- Avoidant , Dependent, Obsessive-compulsive PD
4. Other Personality Disorders- Personality change due to another medical condition
5. Other specified personality disorder and unspecified personality disorder

PARANOID PERSONALITY DISORDER

- Persons with paranoid personality disorder are characterized by long-standing suspiciousness and mistrust of persons in general.
- Refuse responsibility for their own feelings and assign responsibility to others.
- Often hostile, irritable, and angry.
- Bigots, injustice collectors, pathologically jealous spouses, and litigious cranks often have paranoid personality disorder.

EPIDEMIOLOGY

- Prevalence rates of 0.5 to 4.4 % in the general population
- 10 to 30% for psychiatric inpatients
- 2 to 10 % for psychiatric outpatients are reported in DSM-IV-TR and DSM-5
- According to DSM-5, this disorder is more commonly diagnosed in males then females

EPIDEMIOLOGY

- PPD is one of the most common personality disorders in the general population. Data from the National Epidemiologic Survey on Alcohol and Related Conditions (Grant 2004) found a prevalence of 4.4%, with higher rates in women than men.

- Other studies have described rates ranging from 0.9% to 2.4% (Torgersen 2001; Coid 2006).

ETIOLOGY

Genetic Factors

- Monozygotic twins, the concordance for personality disorders was several times that among dizygotic twins.
- More common in the biological relatives of patients with schizophrenia than in control groups.
- More relatives with schizotypal personality disorder occur in the F/H of persons with schizophrenia than in control groups.

ETIOLOGY

Platelet Monoamine Oxidase

- Low platelet monoamine oxidase (MAO) levels have been associated with activity and sociability in monkeys.
- College students with low platelet MAO levels report spending more time in social activities than students with high platelet MAO levels.
- Low platelet MAO levels have also been noted in some patients with schizotypal disorders.

ETIOLOGY

Smooth Pursuit Eye Movements

- Smooth pursuit eye movements are saccadic (i.e., jumpy) in persons who are introverted, who have low self-esteem and tend to withdraw, and who have schizotypal personality disorder.

- These findings have no clinical application, but they do indicate the role of inheritance

ETIOLOGY

Neurotransmitters

- Studies of personality traits and the dopaminergic and serotonergic systems indicate an arousal-activating function for these neurotransmitters.

- Levels of 5-hydroxyindoleacetic acid (5-HIAA), a metabolite of serotonin, are low in persons who attempt suicide and in patients who are impulsive and aggressive.

- Raising serotonin levels with serotonergic agents such as fluoxetine can produce dramatic changes in some character traits of personality.

ETIOLOGY

- Many persons, serotonin reduces depression, impulsiveness, and rumination, and can produce a sense of general well-being.
- Increased dopamine concentrations in the central nervous system, produced by certain psychostimulants (e.g., amphetamines) can induce euphoria.
- Effects of neurotransmitters on personality traits have generated much interest and controversy about whether personality traits are inborn or acquired.

ETIOLOGY

Electrophysiology

- Changes in electrical conductance on the EEG occur in some patients with personality disorders, most commonly antisocial and borderline types; these changes appear as slow-wave activity on EEGs.

DIAGNOSIS

- **A.** A pervasive distrust and suspiciousness of others such that their motive are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
- Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
- Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
- Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.

DSM 5

- Reads hidden demeaning or threatening meanings into benign remarks or events.
- Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
- Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
- Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

DSM5

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

ICD 10

(a) Excessive sensitiveness to setbacks and rebuffs

(b) Tendency to bear grudges persistently

(c) Suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous

(d) A combative and tenacious sense of personal rights out of keeping with the actual situation

ICD 10

(e) Recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner

(f) Tendency to experience excessive self-importance, manifest in a persistent self-referential attitude

(g) Preoccupation with unsubstantiated "conspiratorial" explanations of events both immediate to the patient and in the world at large

CLINICAL FEATURES

- Excessive suspiciousness and distrust
- Hypersensitivity to and unforgiveness of insults, slights, and rebuffs
- Unwarranted tendency to question the loyalty of friends or the fidelity of spouse or sexual partners
- Reluctance to confide in others because of unwarranted fear that the information will be used against him or her

CLINICAL FEATURES

- Preoccupation with "conspiratorial" explanations of and hidden demeaning or threatening meanings in benign events or remarks
- Unwarranted tendency to perceive attacks on his or her character or reputation with angry reactions or counterattacks
- Excessive need to be self-sufficient, and strong sense of autonomy
- Pervasive inability to relax and compromise
- Frequent involvement in legal disputes

COMORBIDITY

- Major Depression
- Obsessive-Compulsive Disorder
- Agoraphobia
- Substance Abuse or Dependence

The most common co-occurring-

- Personality disorders are Schizotypal, Schizoid, Narcissistic, Avoidant, and Borderline.
- PPD has been postulated to be a premorbid antecedent of Delusional Disorder, paranoid type.

Impairment

- Frequently only mild, and typically includes occupational and social difficulties.

Sex Ratio

- According to the DSM-IV-TR, this disorder is more commonly diagnosed in males.

DIFFERENTIAL DIAGNOSIS

Differential Diagnosis

- Paranoid Personality Disorder is distinguished from:-
- Schizophrenia (especially paranoid type),
- Delusional Disorder, paranoid type, and
- Affective Disorder with Psychotic features based on periods with positive psychotic symptoms, such as delusions and hallucinations, in the latter.
- When a brief reactive psychosis with delusions complicates the clinical picture of Paranoid Personality Disorder this distinction is far more difficult.

COURSE AND PROGNOSIS

- No adequate, systematic long-term studies of paranoid personality disorder have been conducted.
- In some, paranoid personality disorder is lifelong; in others, it is a harbinger of schizophrenia.
- In general, however, those with paranoid personality disorder have lifelong problems working and living with others.
- Occupational and marital problems are common.

TREATMENT

- Psychotherapy is the treatment of choice for PPD.
- Therapists should be straightforward in all their dealings with these patients.
- If a therapist is accused of inconsistency or a fault, such as lateness for an appointment, honesty and an apology are preferable to a defensive explanation.

TREATMENT

- Therapists must remember that trust and toleration of intimacy are troubled areas for patients with this disorder.

- Individual psychotherapy, thus, requires a professional and not overly warm style from therapists.

- Clinicians' overzealous use of interpretation-especially interpretation about deep feelings of dependence, sexual concerns, and wishes for intimacy increase patients' mistrust significantly.

TREATMENT

- Patients who are paranoid usually do not do well in group psychotherapy, although it can be useful for improving social skills and diminishing suspiciousness through role playing.

- Many cannot tolerate the intrusiveness of behavior therapy, also used for social skills training

TREATMENT

Pharmacotherapy

- For PPD it can be argued that antipsychotic medication may be effective in treating psychotic symptoms found in psychoses as well as personality disorders on the same continuum.
- Serotonergic agents are now thought to affect not only depressive mood states but to have a wider role in social interaction.
- Administration of the SSRI Paroxetine over 4 weeks increased cooperation and reduced hostility and negative affect in healthy volunteers (Knutson 1998), while ingestion of the serotonin precursor L-tryptophan enhanced social functioning (Moskowitz 2001).
- On this basis, it may be hypothesised that serotonergic agents might impact upon negative mood states in PPD, such as hostility.

TREATMENT

Types of interventions

- Any drugs with psychotropic properties, including those falling within the following classes of pharmacological interventions (as defined by the British National Formulary (BNF 2010)

1. Hypnotics, anxiolytics and barbiturates
2. Antipsychotic drugs (including depot injections)
3. Antimanic drugs
4. Antidepressant drugs: tricyclic and related, monoamine-oxidase inhibitors, SSRIS and related, and other antidepressant drugs
5. Central nervous system stimulants
6. Antiepileptics/mood stabilising agents
7. Drugs used in substance dependence

TREATMENT

- Pharmacotherapy is useful in dealing with agitation and anxiety.
- In most cases, an antianxiety agent such as Diazepam suffices.
- Use an antipsychotic such as Haloperidol in small dosages and for brief periods to manage severe agitation or quasi-delusional thinking.
- Antipsychotic drug Pimozide has successfully reduced paranoid ideation in some patients.

SCHIZOID PERSONALITY DISORDER

- Schizoid personality disorder is diagnosed in patients who display a lifelong pattern of social withdrawal.

- Their discomfort with human interaction, their introversion, and their bland, constricted affect are noteworthy.

- Persons with schizoid personality disorder are often seen by others as eccentric, isolated, or lonely.

EPIDEMIOLOGY

- Prevalence of SPD is not clearly established, but the disorder may affect 5 % of the general population.

- Sex ratio of the disorder is unknown

- Some studies report a 2:1 male-to-female ratio.

Familial Pattern and Genetics

- An increased prevalence of this personality disorder is found among the first-degree relatives of probands with Schizophrenia.

- Increased prevalence of Schizophrenia and other psychoses in the relatives of probands with Schizotypal Personality Disorder.

- Disorder tends to aggregate in families (DSM-IV-TR).

DIAGNOSIS DSM 5

A. Pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Neither desires nor enjoys close relationships, including being part of a family.
2. Almost *always* chooses solitary activities.
3. Has little, if any, interest in having sexual experiences with another person.
4. Takes pleasure in few, if any, activities.

DIAGNOSIS DSM 5

5. Lacks close friends or confidants other than first-degree relatives.
6. Appears indifferent to the praise or criticism of others.
7. Shows emotional coldness, detachment, or flattened affectivity.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

ICD 10

(a) few, if any, activities, provide pleasure

(b) emotional coldness, detachment or flattened affectivity

(c) limited capacity to express either warm, tender feelings or anger towards others

(d) apparent indifference to either praise or criticism

(e) little interest in having sexual experiences with another person (taking into account age)

ICD 10

f) almost invariable preference for solitary activities

(g) excessive preoccupation with fantasy and introspection

(h) lack of close friends or confiding relationships (or having only one) and of desire for such relationships

(i) marked insensitivity to prevailing social norms and conventions

Complications

- Very brief reactive psychosis, particularly in response to stress.

Comorbidity

- Personality disorder sometimes appears as the premorbid antecedent of Delusional Disorder, Schizophrenia, or rarely Major Depression.
- Most common co-occurring personality disorders are Paranoid, Schizotypal, and Avoidant.

Impairment

- Frequently severe problems in social relations; occupational problems develop when interpersonal involvement is required; solitary work sometimes favourably affects overall performance.

CLINICAL FEATURES

- Pervasive pattern of social detachment and a restricted range of expressed emotions in interpersonal settings,
- Indifference to praise and criticism
- Preference for solitary activities and fantasy (“loner”)
- Lack of interest for sexual interactions
- Lack of desire or pleasure in close relationships

CLINICAL FEATURES

- Emotional coldness, detachment, or flattened affectivity
- No close friends or confidants other than family members
- Pleasure experienced in few, if any, activities

Some of the associated features include the following:

- Difficulty in expressing anger, even in response to direct provocation, which contributes to the impression of flattened affect
- Severe lack of social skills

DIFFERENTIAL DIAGNOSIS

- SPD is distinguished from Schizophrenia, Delusional Disorder, and Affective Disorder with Psychotic features based on periods with positive psychotic symptoms, such as delusions and hallucinations, in the latter.

- When a brief reactive psychosis complicates a clinical picture of Schizoid Personality Disorder this distinction is far more difficult.

DIFFERENTIAL DIAGNOSIS

- The duration of the latter and its frequent association with stress is usually sufficient for differential diagnosis.

- Schizoid Personality Disorder is distinguished from Autistic Disorder and Asperger's Disorder by more severely impaired social interactions and stereotypic behaviors and interests in the latter two disorders

COURSE AND PROGNOSIS

- Onset of schizoid personality disorder usually occurs in early childhood.
- As with all personality disorders, schizoid personality disorder is long lasting, but not necessarily lifelong.

TREATMENT

Psychotherapy

- Treatment of patients with SPD is similar to that of those with paranoid personality disorder.
- Patients who are schizoid tend toward introspection, however, these tendencies are consistent with psychotherapists' expectations, and such patients may become devoted, if distant, patients.
- As trust develops, patients who are schizoid may, with great trepidation, reveal a plethora of fantasies, imaginary friends, and fears of unbearable dependence even of merging with the therapist.

TREATMENT

- In group therapy settings, patients with schizoid personality disorder may be silent for long periods; nonetheless, they do become involved.

- With time, the group members become important to patients who are schizoid and may provide the only social contact in their otherwise isolated existence.

TREATMENT

- Pharmacotherapy with small dosages of antipsychotics, antidepressants, and psychostimulants has benefitted some patients.
- Serotonergic agents may make patients less sensitive to rejection.
- Benzodiazepines may help diminish interpersonal anxiety

SCHIZOTYPAL PERSONALITY DISORDER

- Persons with schizotypal personality disorder are strikingly odd or strange, even to laypersons.

- Magical thinking, peculiar notions, ideas of reference, illusions, and derealization are part of a schizotypal person's everyday world.

EPIDEMIOLOGY

- Schizotypal personality disorder occurs in about 3% of the population.
- Sex ratio is unknown; however, it is frequently diagnosed in females with fragile X syndrome.
- DSM-5 suggests the disorder may be slightly more common in males.
- A greater association of cases exists among the biological relatives of patients with schizophrenia than among control participants and a higher incidence among monozygotic twins than among dizygotic twins (33 % vs. 4 %) in one study).

DIAGNOSIS DSM 5

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Ideas of reference (excluding delusions of reference).

2. Odd beliefs or magical thinking that influences behavior and is inconsistent with

subcultural norms (e.g., superstitiousness, telepathy, or “sixth sense”: in children and adolescents, bizarre fantasies or preoccupations).

DIAGNOSIS DSM 5

3. Unusual perceptual experiences, including bodily illusions.
4. Odd thinking and speech.
5. Suspiciousness or paranoid ideation.
6. Inappropriate or constricted affect.
7. Behavior or appearance that is odd, eccentric, or peculiar.
8. Lack of close friends or confidants other than first-degree relatives.
9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

DIAGNOSIS DSM 5

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

CLINICAL FEATURES

- Social and interpersonal deficits as indicated by pervasive discomfort with reduced capacity for close relationships,
- Cognitive and perceptual distortions and eccentric behavior
- Ideas of reference (not delusions)
- Odd beliefs and magical thinking (superstitiousness, beliefs in clairvoyance, telepathy, “sixth sense”; in children and adolescents—bizarre fantasies or preoccupation)
- Unusual perceptual disturbances (illusions including bodily illusions, sensing a presence of a person nearby)

CLINICAL FEATURES

- Paranoid ideation and suspiciousness
- Odd, eccentric, peculiar behavior
- Lack of close friends, except family members
- Odd thinking and speech without incoherence
- Inappropriate or constricted affect
- Social anxiety that does not diminish with familiarity and is associated with paranoid fears

Complications

- Transient psychotic episodes, particularly in response to stress.
- Symptoms sometimes become so significant that they meet criteria for Schizophreniform Disorder, Delusional Disorder, and Brief Psychotic Disorder.

Comorbidity

- More than a half of these patients have had at least one episode of Major Depression, and 30 to 50% have Major Depression concurrent with this personality disorder.
- Most common co-occurring personality disorders are Schizoid, Paranoid, Avoidant, and Borderline.

Impairment

- Typically includes occupational and social difficulties.

TREATMENT

Psychotherapy

- Principles of treatment of schizotypal personality disorder do not differ from those of schizoid personality disorder, but clinicians must deal sensitively with the former.
- These patients have peculiar patterns of thinking, and some are involved in cults, strange religious practices, and the occult.
- Therapists must not ridicule such activities or be judgmental about these beliefs or activities.

TREATMENT

- The most frequently studied drug was Risperidone and the most frequently studied class of drugs were the antipsychotics followed by the antidepressants.
- Most of the studies on an antipsychotic drug intervention found a positive effect in STPD
- Thiothixine reduced general symptoms (especially illusions, ideas of reference, paranoid ideation, cognitive deficits, and anxiety) in cohorts of mixed BPD and STPD patients, but the respective studies found no significant relationship between diagnosis and outcome of treatment.
- Risperidone was the only drug that was evaluated in studies that fulfilled relevant study quality criteria, such as reporting effect sizes, being randomized, and using quantitative measures and standardized questionnaires.

TREATMENT

- It was evaluated in four independent studies: Koenigsberg et al. showed a reduction in the PANSS score in STPD but no difference in the STPD-specific SPQ
- Rabella et al. reported an improvement in reaction time after treatment with Risperidone.
- McClure et al. found no beneficial effect of Risperidone in either the PANSS or cognitive measurements, and the open-label study by Rybakowski et al. found an increase in social and occupational functioning and cognitive tests after risperidone treatment.

TREATMENT

- In an open-label augmentation trial, a small cohort (*n* = 11) of patients with STPD had significant improvements in psychosis and depression ratings when treated with olanzapine.
- In an open-label study in patients with comorbid OCD and STPD, a combination of fluvoxamine and olanzapine showed beneficial effects, i.e., it reduced the YBOCS score, and the concomitant diagnosis of STPD was significantly associated with a positive response.
- In a retrospective study, Di Lorenzo et al. reported a decrease of general symptoms when patients with schizophrenia spectrum disorder were treated with aripiprazole; patients with STPD were included, but no specific results were mentioned.
- In one case report, clozapine treatment reduced symptoms in a patient with comorbid OCD and STPD.

TREATMENT

- In an open-label trial of fluoxetine, Markovitz et al. measured a reduction of general symptoms in patients with BPD, STPD, or both, regardless of the diagnosis.
- In another study, clomipramine showed no significant effects on OCD symptoms in a cohort of patients with OCD and STPD, and the authors reported a worse treatment outcome in patients with comorbid STPD than in those with other PD diagnoses.
- One case report described a patient with STPD who developed psychotic symptoms after treatment with fluoxetine, and other case reports showed positive effects of clomipramine, paroxetine, and buspirone on depressive or OCD symptoms

Target Symptom	Drug/Treatment of Choice	Not Recommended
I. Mood dysregulation and anxiety		
Anxiety		
Chronic cognitive	PSYCHOTHERAPY SSRIs, SNRIs, MAOIs LOW-DOSE NOVEL PSYCHOTROPICS (aripiprazole, quetiapine) Valproates and other GABA analogs clonazepam, buspirone	Benzodiazepines and ethanol (risk of abuse/addiction)
Chronic somatic	MAOIs, SNRIs (duloxetine, milnacipran) Pregabalin and other GABA analogs TCAs, beta-blockers	If used—benzodiazepines with long half-life and short trials preferred
Obsessions	SSRIs, PSYCHOTROPICS (quetiapine) TCAs (clomipramine) Mild NMDA antagonists (riluzole, memantine)	
Acute and severe	MIRTAZAPINE, NOVEL PSYCHOTROPICS (quetiapine, aripiprazole, clozapine) TCAs, clonazepam, valproates, lithium	
Depression		
Atypical depression/dysphoria	MAOIs, SSRIs, SNRIs, ARIPIPRAZOLE Lurasidone, ziprasidone, quetiapine	TCAs
Classical depression	STANDARD ANTIDEPRESSANTS TCAs (males) SSRI (females) Atypical psychotropics (as monotherapy or augmentation)	
Emotional lability/rapid cycling	LITHIUM, LAMOTRIGINE, VALPROATES Lower-dose novel psychotropics (olanzapine, aripiprazole, clozapine, ziprasidone)	TCAs ("catecholamine stress") Standard antidepressants (risk of switching to mania)

II. Behavior dyscontrol		
Aggression/impulsivity		
Affective aggression "Hot temper" with normal EEG	LITHIUM, SSRIs, ANTICONVULSANTS Low-dose novel psychotropics	Benzodiazepines (disinhibition)
Predatory aggression (cold blooded revenge/cruelty)	NO EFFECTIVE PHARMACOLOGICAL Tx Novel psychotropics, lithium, valproates, beta-blockers	BENZODIAZEPINES (disinhibition)
Organic-like aggression (traumatic brain injury)	BETA-BLOCKERS, VALPROATES, QUETIAPINE, CARBAMAZEPINE TCAs, cholinesterase inhibitors (donepezil)	BENZODIAZEPINES (disinhibition, delirium)
Ictal aggression (abnormal EEG)	CBMZ, DIPHENYLHYDANTOIN, VALPROATES Benzodiazepines (clonazepam)	TCAs LOW-POTENCY TYPICALS (both increase risk of seizures)
III. Social and emotional detachment		
Chronic asociality and disinterest Blunted affect	LOW-DOSE PSYCHOTROPICS (aripiprazole, olanzapine, low-dose clozapine, sulpiride)	
IV. Cognitive-perceptual distortions/psychotic symptoms		
Acute and brief psychotic episodes	NOVEL PSYCHOTROPICS (Risperdal, olanzapine) Typical neuroleptics (for the duration of psychosis)	
Chronic and low-level psychotic-like symptoms	NOVEL PSYCHOTROPICS	

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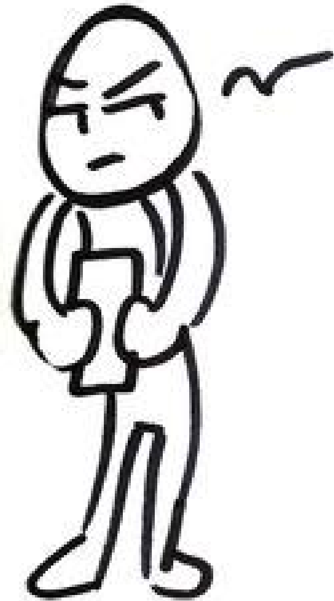

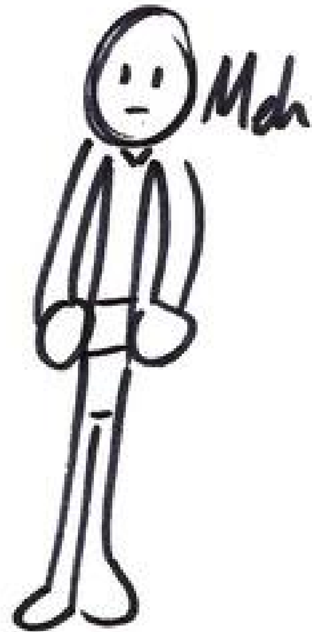

THANK YOU