Introduction to Personality Disorders

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• What is personality?
• Theories of personality development.
• What is a personality disorder?
• Why are personality disorders important?
What is personality?

• Personality encompasses a person’s underlying pattern of behaviour, thought, and emotion and the ways these interact to help or hinder how a person relates to other people and to different situations.

• The characteristic way in which a person thinks, feels, and behaves.
Theories to explain personality

• Aetiology- How does personality develop?
  – Unconscious motivations (psychodynamic theories)
  – External stimuli (behavioural theories)
  – Ways of thinking (cognitive theories)
  – Properties of the brain (trait theories)

• Genetic factors and past experiences can influence how we think and respond to our environment and social interactions and in turn our environment and social interactions can influence how we behave, think and respond and all these are important is what we call our personality.

• The perspectives used to study personality have then influenced interventions to help people who are reported to have personality disorders. Most interventions have developed from the cognitive theories of personality development.
Psychodynamic theories

- **The past determines our personality**
- **Sigmund Freud** (1856–1939) asserted that the human mind could be divided into three significant components—*the id, the ego, and the superego*—which work together (or come into conflict) to shape personality. Freud focused on *infantile sexuality and the Oedipus complex* as being important drivers to neurosis (and personality development).
- **Alfred Adler** (1870–1937) maintained that feelings of helplessness during childhood can lead to an *inferiority complex* which could be overcome through *positive social interaction*.
- **Carl Jung** (1875-1961) advanced the concepts of the *introvert and extravert* personality, archetypes, and the *collective unconscious* (the pool of human experience passed from generation to generation).
- **Erik Erikson** (1902-1994) focused on *8 stages of development* and the conflicts at these stages which influenced personality development.
Behavioural and social learning theories

• Society and our response to it determines our personality.
• Burrhus Frederick Skinner (1904-1990) proposed that our behaviour (and by extension of this our personality) is shaped and influenced by our response to reward and punishment (and by extension of this by society).
• Julian Rotter (1916) believed that personality was not connected to our psychological instincts and drives and that personality is a representation of contact between an individual and society.
Cognitive theories

• Our personalities are based on how we process and organise information/ how we think
  - George Kelly (1905-1967) reported that we continually examine the environment and use **Template matching to help us predict and make sense of events**.
  - Walter Mischel (1930) proposed that personality is a **set of cognitive strategies that we use to obtain a reward**
  - Albert Bandura (1925)said that personality is expressed as an **interaction between behaviour and the environment** which in turn is influenced by how we **process information** from our environment.
Trait theories

- Genetic factors influence brain properties e.g. cortisol levels which influence level of arousal.
- Most trait theories are descriptive.
- Gordon Allport (1897-1967) rejected psychoanalytic and behavioural explanations of personality. Personality based on traits - cardinal (dominant) secondary (only seen in certain situations) central (found to some extent in everybody)
- Hans Eysenck (1916-1997) was interested in temperament. He identified 3 dimensions neuroticism, introversion vs extroversion and psychoticism. He was a behaviourist who believed that the most fundamental characteristics were inherited.
- Tupes & Cristal, Lewis Goldberg, Costa and McCrae described personality as 5 personality traits Openness, conscientiousness, extraversion, agreeableness, neuroticism.
Function of personality

• To solve problems of life
• Involves processes designed and adapted to function in a social context
• Personality expresses itself through
  – Development of a sense of self
  – Development of a capacity to function socially and develop relationships (including intimate relationships)
Relationship between normal and abnormal personality

- **Categorical approach** (DSM IV, ICD 10)
  - Disorders are distinct entities that are distinct from each other and normal personality.

- **Dimensional approach** (traits)
  - Disorders are maladaptive extensions of the same traits described in normal personality.
Personality disorder

- Failure to establish an adaptive sense of self (identity and self direction)
- Failure to develop the ability to function adaptively in a social context (including within intimate relationships) empathy and intimacy.
- (in DSM V identified 5 pathological pd trait domains- antagonism, disinhibition, detachment, negative affectivity, psychotics)
Personality disorder

• **Is not** - achieving a threshold number of characteristics.

• Pure forms of a personality disorder are rare.

• When using a classification like ICD 10 or DSMIV the most important diagnostic features are that the person **MUST** fulfil the criteria for the diagnosis of a personality disorder.
Personality disorder

- Characteristic and **enduring patterns** of behaviour that differ markedly from the expected norm and have an adverse impact on the person or their social environment.

- The deviations must be manifest in more than one of the following areas
  - Cognition
  - Affectivity
  - Impulse control
  - Interpersonal functioning

- The deviation must be:
• The deviation must be:
  – **Pervasive** across a broad range of personal and social situations
  – **Inflexible and stable**
  – **Maladaptive / dysfunctional**
  – Of **long duration** (starting in late childhood or adolescence)
  – Not be explained by another mental disorder or injury
Prevalence rates

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<tbody>
<tr>
<td>6.7-28.2% M &gt; F Y &gt; O</td>
<td>30-40% (OP) 40-50% (IP)</td>
<td>65-78% (M) 42-50% (F) 12-15% psychopathic</td>
<td>66% (M) 75% (F) 39% (M) psychopathic 15% (F) psychopathic</td>
</tr>
<tr>
<td>OC/ anankastic and paranoid</td>
<td>Borderline / EU</td>
<td>Antisocial/ Dissocial</td>
<td>Antisocial/ Dissocial</td>
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<td></td>
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<td>Narcissistic (M) EU/ borderline (F)</td>
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Personality clusters

• Cluster A
  – Behaviour / thinking **odd and eccentric**
  – (schizoid, schizotypal, paranoid)

• Cluster B
  – Behaviour / thinking **dramatic, erratic, threatening/disturbing**
  – (borderline, antisocial, histrionic, narcissistic)

• Cluster C
  – Behaviour / thinking **fearful and anxious**
  – (avoidant, dependent, obsessive-compulsive)
### DSM IV vs ICD 10

#### DSM IV
- Schizoid
- Paranoid
- Schizotypal
- **Anti-social**
- **Borderline**
- Histrionic
- Narcissistic
- **Avoidant**
- Dependent
- **Obsessive compulsive**
- (Passive aggressive in annex)
- (Depressive in annex)

#### ICD 10
- Schizoid
- Paranoid
- *(Schizotypal = MI)*
- **Dissocial**
- Emotionally unstable impulsive/borderline types
- Histrionic
- *(Narcissistic = in annex)*
- **Anxious**
- Dependent
- **Anankastic**
- (Passive aggressive in annex)
- *(no depressive)*
Dissocial personality disorder

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<th>Cognition</th>
<th>Impulse control</th>
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<td>Gross and persistent attitude of irresponsibility and disregard for social norms, rules &amp; obligations.</td>
<td>Very low tolerance to frustration</td>
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<td>Incapacity to experience guilt, or to profit from adverse experience, particularly punishment.</td>
<td>Low threshold for the discharge of aggression, including violence</td>
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<td>Marked proneness to blame others, or to offer plausible rationalisations for the behaviour that has brought the individual into conflict with society.</td>
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<th>Interpersonal functioning</th>
<th>Affect</th>
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<td>Incapacity to maintain enduring relationships, though with no difficulty establishing them</td>
<td>Callous unconcern for the feelings of others</td>
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Emotionally unstable personality disorder

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<th>Cognition</th>
<th>Affect</th>
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<td>Disturbance and uncertainty about self image, aims and internal preferences (including sexual)</td>
<td>Chronic feelings of emptiness</td>
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<td>Unstable and capricious mood</td>
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<td>Liability to become involved in intense and unstable relationships often leading to emotional crises</td>
<td>Recurrent threats or acts of self harm</td>
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<td>Excessive efforts to avoid abandonment</td>
<td>Marked tendency to act unexpectedly and without consideration of the consequences</td>
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<td>Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticised</td>
<td>Liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions</td>
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<td>Difficulty in maintaining a course of action that offers no immediate reward</td>
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Why are personality disorders important?

• They are common in those presenting to psychiatric services and the criminal justice system.
• They make a person vulnerable to developing other clinical syndromes (paranoid pd- psychosis, Eupd- mood disorders, substance misuse, anxious- somatoform and mood disorders)
• Some clinical syndromes can lead to the development of personality disorder/pathology (PTSD- Eudp)
• PD complicates the treatment of clinical syndromes (Eudp and mood disorder or substance misuse)
• PD can be a treatment target (esp Eudp, avoidant, Ocpd)
• Therefore identify personality when present and understand how they are likely to affect the therapeutic relationship and affect how your patient will respond to you and to therapeutic interventions.
Thank you