I. PERSONALITY & PERSONALITY STYLE

A. The characteristics of an individual that are enduring, pervasive and distinctive.
   1. Consists of a person’s typical thoughts, core beliefs, behavior, emotional traits, temperament, and interpersonal style that assist the individual to cope with, and adapt to, internal/external demands and stressors.

II. PERSONALITY DISORDER (PD) (DSM-5 Criteria, Section II)

A. Enduring pattern of inner experience & behavior that deviates markedly from an individual’s culture.
B. Pattern lacks flexibility, and is pervasive, pernicious, and persistent (the 3 Ps).
C. Pattern manifests in 2 or > areas of functioning:
   1. Cognition – how a person perceives and processes information about him/her, about others, and about events.
   2. Affectivity – range, intensity, lability and appropriateness of emotional response.
   3. Interpersonal functioning – how the person relates to others and maintains relationships.
   4. Impulse control- the degree to which a person does or does not control their impulses.
D. The pattern causes clinically significant impairment for the individual in social, occupational or other important areas of functioning.
E. Onset by adolescence or early adulthood; childhood manifestations possible. If PD is diagnosed before the age of 18 years, features must be present for at least 1 year.
F. Pattern is not attributed to the physiological effects of a substance or to another medical condition.

III. DSM-5: Personality Disorders and Clusters

A. PDs are grouped into categories, or clusters, based on descriptive similarities rather than a unifying theory of personality development. While the descriptive approach is useful, it has limitations and may suggest a clearer delineation between the clusters than actually exists.
      a. Characterized by social withdrawal & deviant modes of social functioning.
      a. Characterized by poor impulse control & excessive emotionality.
      a. Characterized by heightened sensitivity to social rejection, focus on conformity.
   4. Personality change due to another medical disorder; Other specified PD and unspecified PD; e.g., Mixed PD; PDs not yet classified
IV. DEVELOPMENT OF A PD – Biopsychosocial Model

A. PDs are thought to be due to the interaction of biology, genetics, psychological and social factors that amplify the tendency for the disorder.
   1. The Collaborative Longitudinal Personality Disorders Study\(^1\) (1996-2005) screened 43,093 individuals and found:
      i. Physical abuse - antisocial & depressive PDs.
      ii. Sexual abuse – borderline PD (50% – 80% of cases).
      iii. Neglect, including emotional abuse - antisocial, avoidant, borderline, narcissistic, passive-aggressive PDs.
   2. Adolescents with PDs are 2X more likely to have mood disorders and suicidal ideation/behavior\(^2\), and substance abuse as adults\(^3\).
   3. Borderline PD associated with higher rates of childhood stressors such as abuse (>50%), divorce, parental loss, inadequate parenting, frequent moves, institutional placements.

V. PREVALENCE of PDs

A. International samples: 6%
B. Community samples in U.S.: 15% adults (36 million)\(^4\).
C. Psychiatric outpatient samples: 31.4% with a specific PD, 45.5% with PD NOS\(^5\).

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1 Johnson: Arch Gen Psychiatry, 56(7), July 1999:600-606.
2 Johnson: Arch Gen Psychiatry, 56(9), Sept 1999:805-801.
3 Grant B: Arch Gen Psychiatry, 61(4), April 2004:361–368.

VI. COMORBIDITY

A. Psychiatric comorbidity - A patient with PD can also have a clinical syndrome such as major depression, an anxiety disorder, &/or substance use disorder and frequently do.
   1. There may be overlap within and between PD clusters; i.e., > 1 PD diagnosed.
   2. Comorbidity is an indicator of greater impairment and a more negative prognosis.
B. Medical comorbidity
   1. PDs are associated with greater medical comorbidity including pain conditions, obesity and associated problems, sequelae from substance use or risky behaviors, chronic fatigue, and greater medical utilization (e.g., physician and emergency room visits, hospitalizations), poor adjustment to illness and compliance issues.
2. Patients with PDs often present to primary care providers with physical complaints, rather than psychiatric complaints. In addition, when a physical disorder is present, patients with a PD often have difficulty adjusting to the demands of the illness and PD symptoms may become more pronounced. PD often complicates/prolongs medical treatment.

VII. GENERAL CONSIDERATIONS

A. Maladaptive behavior patterns range from mild–severe. Variability in symptoms is not unusual; for example, borderline PD may first present during adolescence, be quite symptomatic during early adulthood, attenuate during mid-life, and recur during times of crises regardless of age. Patient may manifest previously quiescent PDs when faced with crises such as illness, loss, or death of a partner. Some PDs tend to worsen over time; e.g., schizotypal, obsessive compulsive PD.

B. Diagnosis of PD often takes time. Rule in/out other psychiatric and medical conditions and treat them, before making a final diagnosis of a PD.

C. Possible indicators of a PD:
   1. Patient or significant other reports, he/she has “always been that way”.
   2. There is a high degree of chaos in the patient’s personal life.
   3. Patients present with atypical problems that don’t fit easily into other diagnoses.
   4. The patient has poor insight into how his/her behavior impacts others, and blames others for his/her problems.
   5. The patient has poor compliance with medical care.
   6. You have noticeable reactions to the patient’s behavior (countertransference). Patients with PDs often evoke strong reactions from the people around them, including feelings of frustration, anger, helplessness, depletion, rescue fantasies, anxiety, and inadequacy. Countertransference reactions can complicate a physician’s interaction with a patient and impede care if not recognized.

VIII. CLUSTER A

A. PARANOID PD
   1. Pervasvie mistrust & suspiciousness.
   2. Reluctant to confide in others, fears information will be used against him/her.
   3. Angry, defensive, socially isolated.
   4. Prevalence & Associated Features
      a. 2.3%; > common in males.
      b. Familial link: > common in families with schizophrenia & delusional disorder.

B. SCHIZOID PD
   1. Loners.
   2. Emotionally detached.
   3. Indifferent to the world.
   4. Restricted range of emotional expression.
   5. Prevalence & Associated Features
      a. 3.1%; > common in males.
b. Familial link: > prevalence in relatives of patients with schizophrenia or schizotypal PD.

C. SCHIZOTYPAL PD
1. Eccentricities.
   a. Odd beliefs, magical thinking, superstitious.
   b. Speech - metaphorical, over elaborate.
2. Marked social anxiety, isolated except for 1st degree relatives.
3. Prevalence & Associated Features
   a. ~ 3%.
   b. Familial link - greater prevalence in 1st degree relatives of patients with schizophrenia.
   c. Abnormalities in the temporal cortex.

D. CLUSTER A: Comorbidities
1. Depression and anxiety disorders.
2. Substance abuse disorders.

E. CLUSTER A: Behavior Patterns
1. Paranoid patients fear being exploited, betrayed, and medical procedures are perceived as highly intrusive and threatening. Patients commonly use the defense mechanism of:
   a. projection – acting as if one’s feelings/thoughts are rooted in other person. Manifests as mistrust, anger, hostility, leads to conflicts / confrontations.
2. Schizoid and schizotypal patients are distressed by social contact, caring behavior is perceived as intrusive and stressful. Patients use the defense mechanisms of:
   a. schizoid fantasy - withdrawal into the world of imagination and excessive daydreaming to avoid social interaction and associated anxiety.

F. CLUSTER A: Life Problems
1. Low stress tolerance.
2. Interpersonal issues leading to social isolation, occupational problems, idiosyncratic behaviors that conflict with social norms.
3. Low adherence to medical care.

G. CLUSTER A: Management
1. Countertransference reactions:
   a. paranoid PD patients may elicit feelings of uneasiness, anger; schizoid and schizotypal PD patients test your patience, cause frustration.
2. Trust issues! Prove your trustworthiness through your actions not words. Paranoid PD patients project their anger and are quick to argue; listen to their complaints but avoid confrontation. Cluster A patients are usually not forthcoming with information and seeking collateral information from family is helpful.
3. Empathize with the patient’s concerns, use a neutral approach, explain medical procedures in straightforward manner, accept patient’s unsociability, and recognize their need for privacy.
4. Don’t challenge distortions in the patient’s thinking until if/when firm rapport established.

H. CLUSTER A: Differential Diagnosis
1. Distinguished from schizophrenia, delusional DO, mood DO w/psychotic features by the presence of chronic psychotic symptoms.
2. Age of onset helps to distinguish Cluster A PDs from neurodevelopmental disorders such as mild autism spectrum disorders, communication disorders, chronic substance use disorder or personality change due to another medical condition or other PD.

IX. CLUSTER B

A. ANTISOCIAL PD (must be ≥18 yo for diagnosis)
   1. Disregard for & violation of the rights of others (since at least 15 y/o).
   2. Socially irresponsible behaviors.
   3. Lack empathy and remorse.
   4. Can be glib and charming.
   5. Prevalence & Associated Features
      a. 2-4%; higher rates among the incarcerated.
      b. Higher rates of death by violence, substance use, suicide.
      c. Familial link – diagnosed in 20% of 1st degree relatives.
      d. Serotonin dysfunction, frontal lobe dysfunction, low autonomic arousal and reactivity are some of the associated findings.

B. BORDERLINE PD
   1. Pervasive pattern of instability:
      a. Interpersonal relationships.
      b. Identity or self-image.
      c. Affects – marked anger, rage, fear.
      d. Impulsivity.
   2. Fear of abandonment, struggle with feelings of emptiness.
   3. Increased rates of suicidal behavior and self injury (completed suicides in 8-10%).
   4. Under stress, paranoid ideation and dissociative symptoms emerge.
   5. Prevalence & Associated Features
      a. 1.6-%5.9% (> commonly diagnosed in women).
      b. Familial pattern – 5 times more common in 1st degree relatives.

C. HISTRIONIC PD
   1. Dramatic with excessive emotionality.
   2. Attention seeking.
   3. Entertaining...“the life of the party”.
   4. Poor frustration tolerance.
   5. Prevalence & Associated Features
      a. 2 - 3%.
      b. More frequently diagnosed in women, underdiagnosed in men.

D. NARCISSISTIC PD
   1. Pathological sense of self-importance.
   2. Sense of entitlement, see self as “special”, and believe they are best understood by other high status people.
   3. Lack empathy and are arrogant.
   5. Prevalence & Associated Features
      a. 6.2% (more common in men).

E. CLUSTER B: Comorbidities
   1. Depression, anxiety disorders occur frequently (e.g., PTSD in BPD).
2. Somatoform disorders, anorexia/eating disordered behaviors.
3. Substance abuse.
4. ADHD (antisocial PD).
5. Neurobiological correlates of antisocial and borderline PDs; dysregulation of serotonergic and dopaminergic systems (e.g., serotonergic activity is reduced in impulsive aggression).
6. Reduced amygdala volume on fMRI in some studies of borderline PD patients.
8. Greater comorbidity within Cluster B.

F. CLUSTER B: Behavior Patterns
1. Cluster B patients have low self esteem; fear exploitation, loss of status, love or abandonment and tend to use the following defense mechanisms:
   a. controlling – manipulation of people/events to reduce inner tension.
   b. acting out – dealing with conflicts / stress through actions rather than talking, leading to impulsive behavior.
   c. splitting – compartmentalizing emotions, behavior, and people into all good / all bad categories.
   d. self injury – use of physical pain to ↓ emotional arousal or ↓ emotional numbing.
   e. somatization – expressing emotional distress through physical symptoms.

G. CLUSTER B: Life problems
1. Impulsivity → interpersonal, economic, employment, legal issues, injury/death.
2. Substance use disorders.
3. Anti-social and narcissistic patients fear dependence on others, have great difficulty asking for or accepting help.
4. Illness or an injury threatens the patient’s sense of personal integrity in narcissistic PD.
5. Borderline patients exhibit chronic self defeating behaviors.

H. CLUSTER B: Management
1. Countertransference reactions are usually strong for Cluster B patients and the range includes; anger, sympathy, amusement, and feelings of inadequacy.
2. Work to empathize with the patient’s fears (which the patient will not express directly).
3. Be consistent and set appropriate limits but don’t be punitive, and take precautions if there is a h/o violence.
4. Verbalize your intention to help the patient and attempt to satisfy reasonable requests.

I. CLUSTER B: Differential Diagnosis
1. Rule out substance use disorder and bipolar affective disorder (e.g., stimulant abuse, or hypomanic/manic states may mimic the grandiosity of narcissistic PD & the affective instability of borderline PD), other mood disorders.
2. Rule out any head trauma / frontal lobe injury which can be associated with impulsivity, aggression, and affective instability.
3. Personality change due to another medical condition or other PD.

X. CLUSTER C

A. AVOIDANT PD
1. Socially inhibited & feel inadequate.
2. Hypersensitive to negative evaluation.
3. Avoid interpersonal contact, avoid conflict.
4. Low self esteem.
5. Prevalence & Associated Features
   a. 2.4%, equal frequency in men/women.

B. DEPENDENT PD
   1. Submissive behavior.
      a. Go to great lengths to obtain nurturance & support.
   2. Want others to assume responsibility for major areas of his/her life.
   3. Feels unable to care for him/herself.
   4. Low self-efficacy.
   5. Prevalence & Associated Features
      a. 0.5%.

C. OBSESSIVE-COMPULSIVE PD
   1. Perfectionism, inflexibility & high need for mental/interpersonal control.
   2. Preoccupied with rules, efficiency, details and procedures.
   3. Over conscientious, micromanagers.
   4. Prevalence & Associated Features
      a. 2.1%-7.9%.
      b. Men diagnosed 2X more often than women.

D. CLUSTER C: Comorbidities
   1. Anxiety disorders; social phobia, panic disorder w/agoraphobia.
   2. Depression.
   3. Substance use disorder.

E. CLUSTER C: Behavior Patterns
   1. Cluster C patients are anxiety prone and rigid and tend to use the following defense mechanisms:
      a. inhibition – of emotions and thoughts in order to avoid conflicts with others.
      b. avoidance – of people and situations to reduce anxiety.
      c. somatization – expressing emotional distress through physical symptoms.
      d. intellectualization – isolation of feelings from thoughts.

F. CLUSTER C: Life problems
   1. Interpersonal issues; OCPD patients are perfectionists, have difficulty making decisions and getting things done, can lead to problems at work and at home.

G. CLUSTER C: Management
   1. Countertransference reactions – may feel overprotective, frustrated or angry.
   2. Empathize with patient’s fears and cognitive style.
   3. Foster autonomy and shared decision making, avoid telling the patient what to do, no matter how frustrated you become.
   4. Verbalize your willingness to care for avoidant and dependent patients.
   5. Avoid power struggles with obsessive compulsive PD, provide w/thoughtful explanations.

H. CLUSTER C: Differential Diagnosis
   1. Avoidant PD may overlap w/Social phobia.
   2. Obsessive Compulsive PD - distinguish from Obsessive Compulsive Disorder by screening for obsessions, compulsions, rituals in thought or behavior that are present in OCD but are not seen in OCPD.
   3. Hoarding disorder.
   4. Personality change due to another medical condition or other PD.

XI. OTHER CATEGORIES
A. Personality change due to another medical condition: Evidence that the PD is related to an identifiable medical condition; temporal lobe epilepsy, head trauma, brain tumor, Huntington’s, SLE with CNS involvement.

B. Other Specified PD: mixed personality features. Unspecified PD: PD that do not meet full criteria for a single disorder or insufficient information is available to make a diagnosis..

XII. TREATMENT of PERSONALITY DISORDERS

A. Approximately 30% or > of patients who receive psychiatric services have at least 1 PD.

B. Treatment of a PD often takes longer than treatment of other psychiatric conditions.

C. Treatment of comorbidities results in better outcomes.

D. Past pessimism about treatment now replaced with cautious optimism.

E. Dropout rates range 21% - 31%.

F. Cognitive behavioral therapy

1. Research generally supports CBT as an effective treatment modality for PD.

2. More research is needed to further understanding of how best to apply CBT principles and to provide more specific recommendations.

G. Dialectical behavioral therapy (DBT) for borderline PD (BPD)

1. Biopsychosocial model of BPD – individual has a biological predisposition to emotional intensity and reactivity coupled with an invalidating childhood environment.

2. DBT places value on balancing acceptance and change, creation of a life worth living (dialectical philosophy and Eastern spiritual traditions).

3. Standard OP DBT includes: Individual DBT, group skills training, phone consultation for coaching.

4. Skills training improves pt’s ability to respond effectively in difficult situations by teaching mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance.

5. Efficacy of full DBT treatment has been demonstrated in multiple RCTs; e.g., decreased self-injury, anger, fewer ED visits and hospitalizations, decreased depression and impulsiveness, better social adjustment.

E. Psychopharmacological treatments.

1. Antipsychotics can be used to treat cognitive and perceptual organization problems related to dysfunction in dopaminergic system (e.g., common in Cluster A and B disorders).

2. Selective serotonin reuptake inhibitors (SSRIs) can be considered for treatment of impulsive and aggressive behaviors related to dysfunction in serotonergic system (e.g.,
common in Cluster B disorders). Augmentation with a mood stabilizer or anticonvulsant if needed.
3. SSRIs with careful augmentation can be considered for treatment of mood stability and dysphoria related to dysfunction in serotonergic, cholinergic, noradrenergic systems (e.g., common in Cluster B disorders). Augmentation with anxiolytics as needed, but must be closely and carefully regulated.
4. SSRI for anxiety related to dysfunction in serotonergic and noradrenergic systems (e.g., common in Cluster C), careful augmentation with long acting anxiolytic if needed.

XIII. TAKE HOME POINTS

A. Most patients with PD seek behavioral health services at urging of family or employer because of interpersonal difficulties.
B. Goal is to establish a good, working relationship with the patient, regardless of your area of practice.
C. Work to develop an alliance based on trust, acceptance and confidence.
D. Strive for empathy and to understand the patient’s behavior. While the patient’s behavior is maladaptive, his/her goal is to minimize internal distress & meet personal needs. For the patient, the behavior usually feels like a survival mechanism.
E. Don’t personalize the patient’s behavior.
F. Refer patients for psychotherapy and consider evidence based medications for targeted symptom management.