Personality disorders
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Introduction
Personality disorders are enduring patterns of behavior and inner experiences that
• deviate significantly from the individual’s cultural standards,
• are rigidly pervasive,
• have an onset in adolescence or early adulthood,
• are stable over time,
• lead to unhappiness and impairment, and
• manifest in at least 2 of the following areas: cognition, affectivity, interpersonal function, or impulse control.

Personality disorders are chronic and common, and occur in **10-20% of the general population**, and 50% of psychiatric patients have a comorbid personality disorder.

Treating patients with personality disorders can be difficult as it complicates the clinical picture. Patients with personality disorders are more likely to refuse psychiatric care, deny their problems, and attempt to adapt to their problems by changing the external environment rather than themselves (i.e. these disorders are “alloplastic”).

Cluster A personality disorders (“weird”)

Schizotypal Presentation
Schizotypal personality disorder is characterized by a lifelong pattern of magical thinking, peculiar notions, ideas of reference, illusions, and derealization on a daily basis. There is an increased frequency of schizotypal personality disorder in family members of schizophrenic patients. It also has a frequent association with females diagnosed with fragile X syndrome.

Clinical Features
• Ideas of reference
• Odd beliefs or magical thinking
• Unusual perceptual experiences (illusions)
• Odd thinking or speech
• Suspiciousness or paranoid ideation
• Inappropriate or constricted affect
• Odd, eccentric, peculiar behavior
• Lack of close friends or relationships
• Excessive social anxiety

Differential Diagnosis
• Schizophrenia
• Schizoid personality disorder
• Avoidant personality disorder
• Borderline personality disorder
• Paranoid personality disorder

Prognosis
Current psychiatric thinking states that the schizotypal personality disorder is the premorbid personality of patients who will develop schizophrenia. However, some patients with schizotypal personality disorder do maintain a stable personality disorder throughout their lives and are able to marry and work successfully, despite their impairments. Long-term studies show that 10% of these patients will commit suicide eventually.

Treatment
Psychotherapy can be helpful and is the first-line treatment recommendation, however, clinicians must be sensitive with patients and their peculiar thought patterns, as some patients are involved in cults, odd religious practices, or the occult. Therapist must remain non-judgmental.

Schizoid Presentation
Schizoid personality disorder is characterized by a lifelong pattern of social withdrawal, and these patients are seen as eccentric, isolated, or lonely. These patients gravitate towards solitary jobs involving little to no contact with others (such as night jobs).
Clinical Features
• Constricted, cold, or aloof affect
• Poor eye contact
• Avoidance of spontaneous conversation
• Fascination with inanimate objects or metaphysical constructs
• Appear quiet, distant, reclusive, and unsociable
• Solitary interests and noncompetitive lonely jobs
• Appear self-absorbed, lost in daydreams

Differential Diagnosis
• Schizophrenia
• Delusional disorder
• Affective disorder with psychotic features
• Autism spectrum disorders
• Paranoid personality disorder
• Obsessive-compulsive personality disorder
• Avoidant personality disorder
• Schizotypal personality disorder

Prognosis
Schizoid personality disorder is a long-lasting but not necessarily lifelong disorder. It is unknown what percentage of patients eventually incur schizophrenia.

Treatment
Psychotherapy is the first-line treatment and these patients can eventually do well in individual psychotherapy as well as group therapy. They will likely sit silent for long periods in group therapy but will eventually become involved, and the group can act as the patient’s only social contact.

Pharmacotherapy with small dosages of antipsychotics, antidepressants, or psychostimulants is of benefit to some patients. Serotonergic agents can make patients less sensitive to rejection and benzodiazepines can be used to diminish interpersonal anxiety.

Paranoid Presentation
Paranoid personality disorder is characterized by
• long-standing suspiciousness and mistrust of people,
• refusal to accept responsibility for their feelings, and
• hostile, irritable, angry emotions.
Higher incidence seen in males and relatives of schizophrenia patients.
Defense mechanisms used include projection.

Clinical Features
• Excessively suspiciousness and distrust of others
• Tendency to interpret actions as deliberately demeaning, malevolent, or deceiving
• Frequently dispute friends’ or associates’ loyalty or trustworthiness
• Pathologically jealous
• Affectively restricted and appear unemotional

Differential Diagnosis
• Delusional disorder
• Schizophrenia, paranoid type
• Borderline personality disorder
• Antisocial personality disorder
• Schizoid personality disorder

Prognosis
No current studies are available, but in most patients, this is a lifelong disorder marked by problems working and living with others. In some patients, it is a harbinger of schizophrenia. Some patients will be able to develop appropriate concern with morality and altruistic concerns as they mature and/or their stresses diminish.

Treatment
Psychotherapy is the treatment of choice. Therapists must be straightforward and honest, and not overly warm. Individual psychotherapy is usually more appropriate than group therapy, although groups can help improve social skills and diminish suspiciousness in some cases.

Pharmacotherapy can be useful to deal with agitation and anxiety, such as with the use of diazepam. Sometimes it is necessary to use antipsychotics like haloperidol or pimozide in small dosages for brief times to manage severe agitation or quasi-delusional thinking.
Cluster B personality disorders (“wacky”)

Narcissistic Presentation
Narcissistic personality disorder is characterized by patients who have a heightened sense of self-importance, lack of empathy, and grandiose feelings of uniqueness. Underneath, their self-esteem is incredibly fragile and vulnerable, however.

Clinical Features
- Grandiose sense of self-importance
- Preoccupied with fantasies of success, power, brilliance, beauty, ideal love
- Believe they are special
- Believe they should only associate with “special” people
- Require excessive admiration
- Sense of entitlement
- Exploitative of others
- Lacks empathy
- Envious of others
- Arrogant

Differential Diagnosis
- Borderline personality disorder
- Histrionic personality disorder
- Antisocial personality disorder

Prognosis
Narcissistic personality disorder is a chronic, lifelong condition that is difficult to treat. Patients handle aging poorly, as they value beauty, strength, and youth, and are therefore more vulnerable to midlife crises.

Treatment
Treatment is difficult as patients must renounce their narcissism in order to make progress. Psychoanalytic psychotherapy may be of some benefit, as well as group therapy so patients can learn to share with and develop empathic responses to other individuals.

Lithium has been used in narcissistic patients who also have mood swings. Antidepressants may also be of use since these patients are susceptible to depression.

Borderline Presentation
Borderline personality disorder is characterized by extremely unstable affect, mood, behavior, object relations, and self-image. These patients almost always appear to be in a state of crisis, and exhibit mood swings, unpredictable behavior, and repetitive self-destructive acts. It is more common in women.

Defense mechanisms used include projective identification (projection of intolerable aspects of the self onto another individual), splitting.

Clinical Features
- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable, intense interpersonal relationships
- Identity disturbance
- Impulsivity
- Recurrent suicidal behavior, gestures, threats
- Self-mutilating behavior
- Marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate, intense anger

Differential Diagnosis
- Schizophrenia
- Schizotypal personality disorder
- Paranoid personality disorder

Prognosis
This disorder is a fairly stable, lifelong illness, with no longitudinal progression towards schizophrenia. However, patients will have a higher incidence of depression. Patients tend to have problems dealing with the normal stages of the life cycle.

Treatment
Psychotherapy is the treatment of choice, specifically structured dialectical behavior therapy, which helps patients learn how to recognize and regulate their emotions. Other psychotherapy options include mentalization-based therapy and transference-focused psychotherapy.

Pharmacotherapy can be used to deal with personality features that interfere with overall
functioning. Antipsychotics are used for anger, hostility, and brief psychosis episodes. Antidepressants are used in patients with concurrent depressed mood.

**Antisocial Presentation**
Antisocial personality disorder is an inability to conform to social norms that ordinarily govern many aspects of a person’s adolescent and adult behavior. It is characterized by continued antisocial or criminal acts, but is not synonymous with criminality. The prevalence is as high as 75% in prisons and 70% in males with alcohol use disorder.

**Clinical Features**
- Failure to conform to social norms
- Deceitfulness (lying, conning others, etc.)
- Impulsivity
- Irritability and aggression
- Reckless disregard for safety
- Consistent irresponsibility
- Lack of remorse for actions

**Differential Diagnosis**
- Criminal behavior
- Substance abuse
- Neurological disorders
- Intellectual disability
- Schizophrenia

**Prognosis**
Antisocial personality disorder has an unremitting course, with height of behavior occurring usually in late adolescence. Prognosis varies, and some research reports that symptoms can decrease as the patient ages. Comorbid disorders are common including depression and substance abuse.

**Treatment**
Psychotherapy is the treatment of choice if the patient is amenable, and group therapy such as self-help groups where antisocial patients can be among their peers are the most beneficial. Firm limit-setting is essential in treatment.

**Histrionic Presentation**
Histrionic personality disorder is characterized by persons who are excitable and emotional, and behave in a very dramatic and extroverted manner. They also tend to lack an ability to maintain deep, long-lasting attachments with others. This disorder is more common in women, and may be associated with somatization disorder and alcohol use disorder. Defense mechanisms used include repression and dissociation.

**Clinical Features**
- Uncomfortable when not the center of attention
- Inappropriate sexual or provocative behaviors
- Rapidly shifting shallow expression of emotions
- Use of physical appearance to draw attention to self
- Excessively impressionistic style of speech
- Exaggerated expression of emotion
- Easily suggestive
- Considers relationships more intimate than they actually are

**Differential Diagnosis**
- Somatization disorder
- Brief psychotic disorder
- Dissociative disorder
- Borderline personality disorder

**Prognosis**
As patients with histrionic personality disorder age, they tend to show fewer symptoms because they lack the same energy of their younger years. These patients may get into trouble with the law, abuse substances, and act promiscuously.

**Treatment**
Psychotherapy such as psychoanalytically-oriented psychotherapy can help patients to become aware of and clarify their inner feelings.

Pharmacotherapy can be used as an adjunct, such as antidepressants for depression and somatic complaints, antianxiety agents for anxiety symptoms, and antipsychotics for illusions and derealization.
Cluster C personality disorders (“worried”)

**Obsessive-compulsive**

**Presentation**
Obsessive-compulsive personality disorder is characterized by emotional constriction, orderliness, perseverance, and stubbornness. There is a pervasive pattern of perfectionism and inflexibility. It is more common in men. Defense mechanisms include isolation of affect, rationalization, isolation, intellectualization, reaction formation, undoing.

**Clinical Features**
- Stiff, formal, rigid demeanor
- Preoccupied with details, rules, lists, order, etc.
- Perfectionism that interferes with task completion
- Excessively devoted to work
- Overconscientious and inflexible in ethical matters
- Unable to discard worn-out or worthless objects
- Reluctant to delegate tasks or work with others
- Rigid and stubborn
- Hoards money and has a miserly spending style

**Differential Diagnosis**
- Obsessive-compulsive disorder
- Delusional disorder

**Prognosis**
The course is variable and unpredictable. Some people may progress to obsessive-compulsive disorder, some patients will evolve into warm and compassionate adults, and other patients will progress to schizophrenia or depression. These patients will remain vulnerable to unexpected changes, and depression is common.

**Treatment**
Psychotherapy should value free association, such as in psychoanalytic psychotherapy. Pharmacotherapy such as clonazepam, clomipramine, or fluoxetine are used to help reduce symptoms in patients with severe obsessive-compulsive disorder, however, it is unclear if these are of benefit in obsessive-compulsive personality disorder.

**Dependent**

**Presentation**
Dependent personality disorder is characterized by individuals who subordinate their own needs to the needs of others, lack self-confidence, and have intense discomfort when alone for more than a brief period of time. It is more common in women and individuals with history of chronic childhood physical illness.

**Clinical Features**
- Dependent and submissive behavior
- Difficulty making everyday decisions without advice
- Need others to assume responsibility for most major areas in their life
- Difficulty expressing disagreement with others
- Difficulty initiating projects or doing things on their own
- Feels uncomfortable or helpless when alone
- Urgently seeks a new relationship when an old one ends
- Unrealistically preoccupied with fears of being left to take care of themselves

**Differential Diagnosis**
- Schizoid personality disorder
- Schizotypal personality disorder
- Agoraphobia

**Prognosis**
Little is known about the prognosis. Social relationships are limited to those on whom the patient can depend, and many patients suffer physical or mental abuse because they are unable to assert themselves.

**Treatment**
Insight-oriented psychotherapy can help patients to understand the antecedents of their behavior, and allow patients to become more independent, assertive, and self-reliant. Behavioral therapy and assertiveness training are other therapy options. Therapists must be careful not to encourage patients to change the dynamics of a pathological relationships as patient could become anxious and unable to cooperate in therapy as they will feel torn between the two relationships.

Pharmacotherapy is useful in dealing with symptoms of anxiety and depression. Imipramine may be helpful with high levels of separation anxiety.
Avoidant
Presentation
Avoidant personality disorder is characterized by extreme sensitivity to rejection that can lead to socially withdrawn lives. Although these patients are shy, they still show desire for companionship.

Clinical Features
- Avoidance of activities with significant interpersonal contact
- Fear of criticism, disapproval or rejection
- Shows restraint with intimate relationships
- Preoccupied with being criticized or rejected
- Inhibited in new interpersonal situations
- Feelings of inadequacy
- Views self as socially inept and unappealing
- Reluctant to take personal risks or engage in new activities

Differential Diagnosis
- Schizoid personality disorder
- Borderline personality disorder
- Histrionic personality disorder
- Dependent personality disorder
- Social phobia

Prognosis
Many patients with avoidant personality disorder are able to function well in a protected environment. However, if their support system fails, they are subject to depression, anxiety and anger. Social phobia is common in these patients.

Treatment
Psychotherapy must include strong alliance between patient and therapist. Group therapy is helpful in some patients to allow them to understand how their sensitivity to rejection affects them and others. Assertiveness training is a form of behavioral therapy that can teach patients to express their needs openly and strengthen their self-esteem.

Pharmacotherapy is used to manage anxiety and depression. Autonomic hyperactivity can be addressed with a beta-blocker such as atenolol.