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62 PERSONALITY DISORDERS Definition WARDS TIP Many people have odd tendencies and quirks. These are not pathological unless they cause significant distress or impairment in daily functioning. DIAGNOSIS AND DSM-5 CRITERIA KEY FACT Ego-syntonic refers to feelings, thoughts, and/or behaviors that are acceptable to the self; that are consistent with one’s fundamental personality. Ego-dystonic refers to feelings, thoughts, and/or behaviors that are distressing, unacceptable, or inconsistent with one’s self-concept. Clusters WARDS TIP Personality disorder criteria—CAPRI

Cognition Affect Personal Relations Impulse control ● Patients seem anxious or fearful. Personality is one's set of stable, predictable, emotional, and behavioral traits. Personality disorders involve enduring patterns of inner experience and behavior that deviate markedly from expectations of an individual's culture. They are pervasive, maladaptive, and cause significant impairment in social or occupational functioning. Patients with personality disorders often lack insight about their problems; their symptoms are either ego-syntonic or viewed as immutable. In addition, individuals with personality disorders have significant comorbidity with other mental disorders.

1. Enduring pattern of behavior/inner experience that deviates from the person's culture and is manifested in two or more of the following ways: • Cognition • Affect • Interpersonal functioning • Impulse control
2. The pattern: l Is pervasive and inflexible in a broad range of situations. l Is stable and has an onset no later than adolescence or early adulthood. l Leads to significant distress in functioning. l Is not accounted for by another mental/medical illness or by use of a - substance. The international prevalence of personality disorders is approximately 7–12%. Personality disorders vary by gender. Many patients with personality disorders will meet the criteria for more than one disorder; they should be classified as having all of the disorders for which they qualify. Personality disorders are divided into the following three clusters: ■ Cluster A—Schizoid, schizotypal, and paranoid: ● Patients seem eccentric, peculiar, or withdrawn. ● Familial association with psychotic disorders. ■ Cluster B—Antisocial, borderline, histrionic, and narcissistic: ● Patients seem emotional, dramatic, or inconsistent. ● Familial association with mood disorders. ■ Cluster C—Avoidant, dependent, and obsessive-compulsive: ● Familial association with anxiety disorders. Other specified/unspecified personality disorder includes characteristics of a personality disorder that do not meet full criteria for any of the other personality disorders.

ETIOLOGY ■ Biological, genetic, and psychosocial factors during childhood and adolescence contribute to the development of personality disorders. ■ The prevalence of some personality disorders in monozygotic twins is several times higher than in dizygotic twins. TREATMENT ■ Personality disorders are generally very difficult to treat, especially since few patients are aware that they need help. The disorders tend to be chronic and lifelong. ■ In general, pharmacologic treatment has limited usefulness (see individual exceptions below) except in treating comorbid mental conditions (e.g., major depressive disorder). ■ Psychotherapy is usually the most helpful. Cluster A These patients are perceived as eccentric or odd by others and can have psychotic symptoms (see Table 6-1). PARANOID PERSONALITY DISORDER (PPD) Patients with PPD have a pervasive distrust and suspiciousness of others and often interpret motives as malevolent. They tend to blame their own problems on others and seem angry and hostile. They are often characterized as being pathologically jealous, which leads them to think that their sexual partners or spouses are cheating on them. Diagnosis and DSM-5 Criteria ■ Diagnosis requires a general distrust of others, beginning by early adulthood and present in a variety of contexts. TABLE 6-1. Cluster A Personality Disorders and Classic Clinical Examples Personality Disorder Clinical Example Paranoid personality disorder A 30-year-old man says his wife has been cheating on him because he does not have a good enough job to provide for her needs. He also claims that on his previous job, his boss laid him off because he did a better job than his boss. He has initiated several lawsuits. He believes the neighbors are critical of him. He refuses couples therapy because he is certain the therapist will side with his wife. Schizoid personality disorder A 45-year-old scientist

works in the lab most of the day and, according to his coworkers, has no friends. He is at risk of losing this job because of a failure to collaborate with others. He expresses no desire to make friends and is content with his single life. He has no evidence of a thought disorder. Schizotypal personality disorder A 35-year-old man dresses in a wizard costume every weekend with friends as part of a live action role-playing community. He spends a great deal of time on his computers set up in his basement for video games and to “detect the presence of extraterrestrial communications in space.” He has no auditory or visual hallucinations. He is lonely and sad, feels ostracized by others, and desires an intimate relationship. PERSONALITY DISORDERS

64 PERSONALITY DISORDERS Epidemiology ■ Prevalence: 1–4%. Differential Diagnosis Course and Prognosis Treatment WARDS QUESTION Q: What is the key difference between schizoid and avoidant personality disorders? A: Patients with schizoid personality disorder prefer to be alone whereas those with avoidant personality disorder prefer to be in a relationship. SCHIZOID PERSONALITY DISORDER Diagnosis and DSM-5 Criteria ■ At least four of the following must also be present:

1. Suspicion (without evidence) that others are exploiting or deceiving them.
2. Preoccupation with doubts of loyalty or trustworthiness of friends or acquaintances.
3. Reluctance to confide in others.
4. Interpretation of benign remarks as threatening or demeaning.
5. Persistence of grudges.
6. Perception of attacks on their character that is not apparent to others; quick to counterattack.
7. Suspicions regarding fidelity of spouse or partner. ■ More commonly diagnosed in men than in women. ■ Higher incidence in family members of schizophrenics. ■ This personality disorder may be misdiagnosed in minority groups, immigrants, and deaf individuals. ■ Schizophrenia: Unlike patients with schizophrenia, patients with PPD do not have any fixed delusions and are not frankly psychotic, although they may have transient psychosis under stressful situations. ■ Social disenfranchisement and social isolation: Without a social support system, individuals can react with suspicion to others. The differential in favor of PPD can be assisted by collateral history from others in close contact with the person, who may identify what they consider as excess suspicion. ■ The disorder usually has a chronic course, causing lifelong marital and job-related problems. ■ Psychotherapy is the treatment of choice, although, as stated above, patients rarely initiate treatment. ■ Group psychotherapy should be avoided due to mistrust and misinterpretation of others’ statements. ■ Patients may also benefit from a short course of antipsychotics for transient psychosis. Patients with schizoid personality disorder have a lifelong pattern of social withdrawal. They are often perceived as eccentric and reclusive. They are quiet, unsociable, and have a constricted affect. They have no desire for close relationships and prefer to be alone. ■ A pattern of voluntary social withdrawal and restricted range of emotional expression, beginning by early adulthood and present in a variety of contexts. ■ Four or more of the following must also be present:
8. Neither enjoying nor desiring close relationships (including family).
9. Generally choosing solitary activities.
10. Little (if any) interest in sexual activity with another person.
11. Taking pleasure in few activities (if any).

12. Few close friends or confidants (if any).
13. Indifference to praise or criticism.
14. Emotional coldness, detachment, or flattened affect. Epidemiology ■ Prevalence: 3–5%. ■ Diagnosed more often in men than women. ■ May be increased prevalence of schizoid personality disorder in relatives of individuals with schizophrenia. Differential Diagnosis ■ Schizophrenia: Unlike patients with schizophrenia, patients with schizoid personality disorder do not have overt psychotic symptoms such as delusions or hallucinations. ■ Schizotypal personality disorder: Patients with schizoid personality disorder do not have the same eccentric behavior or magical thinking seen in patients with schizotypal personality disorder. Schizotypal patients are more similar to schizophrenic patients in terms of odd perceptions, thought, and behavior. Course Usually chronic course. Treatment ■ Lack insight for individual psychotherapy, and may find group therapy threatening; may benefit from day programs or drop-in centers. ■ Antidepressants if comorbid major depression is diagnosed. SCHIZOTYPAL PERSONALITY DISORDER Patients with schizotypal personality disorder have a pervasive pattern of eccentric behavior and peculiar thought patterns. They are often perceived as strange and odd. The disorder was developed out of the observation that certain family traits predominate in first-degree relatives of those with schizophrenia. Diagnosis and DSM-5 Criteria ■ A pattern of social deficits marked by eccentric behavior, cognitive or perceptual distortions, and discomfort with close relationships, beginning by early adulthood and present in a variety of contexts. ■ Five or more of the following must be present:
15. Ideas of reference (excluding delusions of reference).
16. Odd beliefs or magical thinking, inconsistent with cultural norms.
17. Unusual perceptual experiences (such as bodily illusions).
18. Suspiciousness.
19. Inappropriate or restricted affect.
20. Odd or eccentric appearance or behavior.
21. Few close friends or confidants.
22. Odd thinking or speech (vague, stereotyped, etc.).
23. Excessive social anxiety. ■ Magical thinking may include: • Belief in clairvoyance or telepathy. • Bizarre fantasies or preoccupations. • Belief in superstitions. ■ Odd behaviors may include involvement in cults or strange religious practices. PERSONALITY DISORDERS

66 PERSONALITY DISORDERS Epidemiology Prevalence: 4%. Differential Diagnosis WARDS TIP Course Q: What is the premorbid personality seen in schizophrenia? A: Schizotypal personality disorder. Treatment Cluster B ■ Schizophrenia: Unlike patients with schizophrenia, patients with schizotypal personality disorder are not frankly psychotic (though they can become transiently so under stress), nor do they have delusions. ■ Schizoid personality disorder: Patients with schizoid personality disorder do not have the same eccentric behavior seen in patients with schizotypal personality disorder. ■ Course is chronic, with a small minority developing schizophrenia. ■ Premorbid personality type for a patient with schizophrenia. ■ Psychotherapy is the treatment of choice to help develop social skills training. ■ A short course of low-dose second-generation antipsychotic may help with the cognitive-perceptual disturbances. Includes antisocial, borderline, histrionic, and narcissistic personality disorders. These patients are often emotional, impulsive, and dramatic (Table 6-2). Mr. Harris is a 35-year-old man with no prior psychiatric history who was arrested for assaulting his pregnant girlfriend. While in jail, he reports feeling depressed, and you

are called in for a psychiatric evaluation. Mr. Harris is cooperative during the evaluation and presents as friendly and likeable. He reports that he is innocent of his charges and expresses feeling sad and tearful since his incarceration 2 days ago. He requests that you transfer him to the mental health unit at the correctional facility. However, you perform a thorough evaluation, and you do not find symptoms suggestive of a mood or psychotic disorder. When asked if he has been incarcerated before, he reports a history of multiple arrests and convictions for robbery and gun possession. He reports that he is unemployed because he has been “in and out of jail” during the past 5 years. He provides rationalizations for his limited involvement in these past crimes and does not appear remorseful. Mr. Harris reveals a pattern of repeated fights since childhood and says that he quit school while in the ninth grade after being suspended for smoking pot on school grounds. Mr. Harris reports that throughout his childhood he bullied others, and laughs when recounting an episode during which he threw his cat against the wall to see if it would bounce back. He denies any family history of psychiatric illnesses, but reports that his father is currently incarcerated for drug trafficking. What is his diagnosis? Mr. Harris’s diagnosis is antisocial personality disorder. His history shows a pervasive pattern of disregard for and violation of the rights of others since age 15, and there is evidence of conduct disorder with onset before age 15 years. Remember that, although it is common, not all criminals have antisocial personality disorder. What are some associated findings? Antisocial personality disorder is more prevalent in males, is associated with low socioeconomic background, and has a genetic predisposition. It has been found that the children of parents with antisocial personality disorder have an increased risk for this disorder, somatic symptom disorder, and substance use disorders.

TABLE 6-2. Cluster B Personality Disorders and Classic Clinical Examples Personality Disorder Clinical Example Antisocial personality disorder A 30-year-old unemployed man has been accused of killing three senior citizens after robbing them. He is surprisingly charming in the interview. In his adolescence, he was arrested several times for stealing cars and assaulting other kids. Borderline personality disorder A 23-year-old medical student attempted to cut her wrist because things did not work out with a man she had been dating over the past 3 weeks. She states that guys are jerks and “not worth her time.” She often feels that she is “alone in this world.” Histrionic personality disorder A 33-year-old provocatively dressed woman comes to your office complaining that her fever feels like “she is burning in hell.” She vividly describes how the fever has affected her work as a teacher but displays superficial expressions of emotion. Narcissistic personality disorder A 48-year-old company CEO is rushed to the ED after an automobile accident. He does not let the residents operate on him and requests the Chief of trauma surgery as he is “vital to the company.” He makes several business phone calls in the ED to stay on “top of his game.” ANTISOCIAL PERSONALITY DISORDER Patients diagnosed with antisocial personality disorder often exploit and violate the rights of others, and break rules to meet their own needs. They lack empathy, compassion, and remorse for their actions. They are impulsive, deceitful, and often violate the law. They are frequently skilled at reading social cues and can appear charming and normal to others who meet them for the first time and do not know their history. Diagnosis and DSM-5 Criteria ■ Pattern of disregard for and violation of the rights of others since age 15. ■ Patients must be at least 18 years old for this diagnosis; history of behavior as a child/adolescent must be consistent with conduct disorder (see Chapter 10, “Psychiatric Disorders in Children”). ■ Three or more of the following should be present:

1. Failure to conform to social norms by committing unlawful acts.

2. Deceitfulness/repeated lying/manipulating others for personal gain.
3. Impulsivity/failure to plan ahead.
4. Irritability and aggressiveness/repeated fights or assaults.
5. Recklessness and disregard for safety of self or others.
6. Irresponsibility/failure to sustain work or honor financial obligations.
7. Lack of remorse for actions. Epidemiology ■ Prevalence: 1–4% of the general population. ■ Males are three to five times as likely to be diagnosed as women. ■ Males with alcoholic parents are at increased risk. ■ There is a higher incidence in poor urban areas and in prisoners but no racial difference. ■ Genetic component: Increased risk among first-degree relatives. Differential Diagnosis Substance use disorder: It is necessary to ascertain which came first. Patients who began abusing drugs before their antisocial behavior started may have behavior attributable to the effects of their addiction. PERSONALITY DISORDERS WARDS TIP Symptoms of antisocial personality disorder—CORRUPT Cannot follow law Obligations ignored Remorselessness Reckless disregard for safety Underhanded (deceitful) Planning deficit (impulsive) Temper (irritable, aggressive)

68 PERSONALITY DISORDERS Course KEY FACT Antisocial personality disorder begins in childhood as conduct disorder. Patient may have a history of being abused (physically or sexually) as a child or a history of hurting animals or starting fires. It is often associated with violations of the law. Treatment ■ Psychotherapy is generally ineffective. WARDS QUESTION Q: What is the most commonly diagnosed personality disorder in psychiatric inpatients? A: Borderline personality disorder. Diagnosis and DSM-5 Criteria WARDS TIP Symptoms of BPD—IMPULSIVE Impulsive Moody Paranoid under stress Unstable self-image Labile, intense relationships Suicidal Inappropriate anger Vulnerable to abandonment Emptiness Epidemiology ■ Lifetime prevalence: 6%. ■ Suicide rate: 10%. WARDS QUESTION Differential Diagnosis Q: What is a common defense mechanism used by patients with BPD? A: Splitting—They view others and themselves as all good or all bad. ■ Usually has a chronic course, but some improvement of symptoms may occur as the patient ages. ■ Many patients have multiple somatic complaints, and coexistence of substance use disorders and/or major depression is common. ■ There is increased morbidity from substance use, trauma, suicide, or homicide. ■ Pharmacotherapy may be used to treat symptoms of anxiety, depression, or aggression, but use caution given the high comorbidity with substance use disorders in these patients. BORDERLINE PERSONALITY DISORDER (BPD) Patients with BPD have unstable moods, behaviors, and interpersonal relationships. They fear abandonment and have poorly formed identity. Relationships begin with intense attachments and end with the slightest conflict. Aggression is common. They are impulsive and may have a history of repeated suicide attempts/gestures or episodes of self-mutilation. They have higher rates of childhood physical, emotional, and sexual abuse than the general population. ■ Pervasive pattern of impulsivity and unstable relationships, affects, self-image, and behaviors, present by early adulthood and in a variety of contexts. ■ At least five of the following must be present:

1. Frantic efforts to avoid real or imagined abandonment.
2. Unstable, intense interpersonal relationships (e.g., extreme love–hate relationships).
3. Unstable self-image.
4. Impulsivity in at least two potentially harmful ways (spending, sexual activity, substance use, binge eating, etc.).

5. Recurrent suicidal threats or attempts or self-mutilation.
6. Unstable mood/affect.
7. Chronic feelings of emptiness.
8. Difficulty controlling anger.
9. Transient, stress-related paranoid ideation or dissociative symptoms. ■ Diagnosed three times more often in women than men in clinical settings. ■ Schizophrenia: Unlike patients with schizophrenia, patients with BPD do not have frank psychosis (may have transient psychosis, however, if they decompensate under stress or substances of abuse). ■ Bipolar I/II: Mood swings experienced in BPD are rapid, brief, moment-to-moment reactions to perceived environmental or psychological triggers.

Course ■ Variable, but many develop stability in middle age. ■ High incidence of coexisting major depression and/or substance use disorders. ■ Increased risk of suicide. Treatment ■ Dialectical behavior therapy (DBT) is the treatment of choice—includes cognitive-behavioral therapy, mindfulness skills, and group therapy. ■ Other psychotherapies found to be beneficial include mentalization-based therapy, transference-focused therapy, and schema-focused therapy. ■ Pharmacotherapy should be considered an adjunct to psychotherapy. Mood stabilizers and low-dose antipsychotic medications have been found to be more effective than antidepressants in the treatment of mood swings/lability. HISTRIONIC PERSONALITY DISORDER (HPD) Patients with HPD exhibit attention-seeking behavior and excessive emotionality. They are dramatic, flamboyant, and extroverted, but are unable to form long-lasting, meaningful relationships. They are often sexually inappropriate and provocative. Diagnosis and DSM-5 Criteria ■ Pattern of excessive emotionality and attention seeking, present by early adulthood and in a variety of contexts. ■ At least five of the following must be present:

1. Uncomfortable when not the center of attention.
2. Inappropriately seductive or provocative behavior.
3. Rapidly shifting but shallow expression of emotion.
4. Uses physical appearance to draw attention to self.
5. Speech that is impressionistic and lacking in detail.
6. Theatrical and exaggerated expression of emotion.
7. Easily influenced by others or situation.
8. Perceives relationships as more intimate than they actually are. Epidemiology ■ Prevalence in the general population: <2%. ■ Women are more likely to have HPD than men. Differential Diagnosis BPD: Patients with BPD are more likely to suffer from depression, brief psychotic episodes, and to attempt suicide. HPD patients are generally more functional. Course Usually chronic, with some improvement of symptoms with age. Treatment ■ Psychotherapy (e.g., supportive, problem-solving, interpersonal, group) is the treatment of choice. ■ Pharmacotherapy to treat associated depressive or anxious symptoms as necessary. PERSONALITY DISORDERS WARDS TIP Pharmacotherapy has been shown to be more useful in BPD than in any other personality disorder. WARDS TIP Histrionic patients often use the defense mechanism of regression—they revert to childlike behaviors.

70 PERSONALITY DISORDERS Diagnosis and DSM-5 Criteria WARDS TIP Narcissism is characterized by an inflated sense of entitlement. People with narcissistic personality are often “fishing for

compliments” and become irritated and anxious when they are not treated as important. Epidemiology Prevalence: Approximately 6%. WARDS QUESTION Q: Which personality disorder has an overlap with social anxiety disorder (social phobia)? A: Avoidant personality disorder (may be same syndrome/ spectrum). Treatment ■ Psychotherapy is the treatment of choice. WARDS TIP Symptoms of avoidant personality disorder—AFRAID Avoids occupation with others Fear of embarrassment and criticism Reserved unless they are certain that they are liked Always thinking rejection Isolates from relationships Distances self unless certain that they are liked Cluster C AVOIDANT PERSONALITY DISORDER NARCISSISTIC PERSONALITY DISORDER (NPD) Patients with NPD have a sense of superiority, a need for admiration, and a lack of empathy. They consider themselves “special” and will exploit others for their own gain. Despite their grandiosity, however, these patients often have fragile self-esteem. ■ Pattern of grandiosity, need for admiration, and lack of empathy beginning by early adulthood and present in a variety of contexts. ■ Five or more of the following must be present:

1. Exaggerated sense of self-importance.
2. Preoccupation with fantasies of unlimited money, success, brilliance, etc.
3. Believe that they are “special” or unique and can associate only with other high-status individuals.
4. Requires excessive admiration.
5. Has sense of entitlement.
6. Takes advantage of others for self-gain.
7. Lacks empathy.
8. Envious of others or believes others are envious of them.
9. Arrogant or haughty. Differential Diagnosis Antisocial personality disorder: Both types of patients exploit others, but NPD patients want status and recognition, while antisocial patients want material gain or simply the subjugation of others. Narcissistic patients become depressed when they don’t get the recognition they think they deserve. Course Usually has a chronic course; higher incidence of depression and midlife crises since these patients put such a high value on youth and power. ■ Psychotropics may be used if a comorbid psychiatric disorder is also diagnosed. Includes avoidant, dependent, and obsessive-compulsive personality disorders. These patients appear anxious and fearful (see Table 6-3). Patients with avoidant personality disorder have a pervasive pattern of social inhibition and an intense fear of rejection. They will avoid situations in which they may be rejected. Their fear of rejection is so overwhelming that it affects all aspects of their lives. They avoid social interactions and may seek jobs in which there is little interpersonal contact. These patients desire companionship but are extremely shy and easily injured.

TABLE 6-3. Cluster C Personality Disorders and Classic Clinical Examples Personality Disorder Clinical Example Avoidant personality disorder A 30-year-old postal worker rarely goes out with her coworkers and often makes excuses when they ask her to join them because she is afraid they will not like her. She wishes to go out and meet new people but, according to her, she is too “shy.” Dependent personality disorder A 40-year-old man who lives with his parents has trouble deciding how to get his car fixed. He calls his father at work several times to ask very trivial things. He has been unemployed over the past 3 years. He has been in several long-term but abusive relationships. Obsessive-compulsive personality disorder A 40-year-old secretary has been recently

fired because of her inability to prepare some work projects in time. According to her, they were not in the right format and she had to revise them six times, which led to the delay. This has happened before but she feels that she is not given enough time to “get it perfect.” Diagnosis and DSM-5 Criteria ■ A pattern of social inhibition, hypersensitivity, and feelings of inadequacy since early adulthood. ■ At least four of the following must be present:

1. Avoids occupation that involves interpersonal contact due to a fear of criticism and rejection.
2. Unwilling to interact unless certain of being liked.
3. Cautious of interpersonal relationships.
4. Preoccupied with being criticized or rejected in social situations.
5. Inhibited in new social situations because he or she feels inadequate.
6. Believes they are socially inept and inferior.
7. Reluctant to engage in new activities for fear of embarrassment. Epidemiology ■ Prevalence: Approximately 2%. Differential Diagnosis ■ Schizoid personality disorder: Patients with avoidant personality disorder desire companionship but are extremely shy, whereas patients with schizoid personality disorder have little or no desire for companionship. ■ Social anxiety disorder (social phobia): See Chapter 5, “Anxiety Obsessive-Compulsive, Trauma, and Stressor-Related Disorders.” Both involve fear and avoidance of social situations. If the symptoms are an integral part of the patient’s personality and have been evident since adolescence, personality disorder is the more likely diagnosis. Social anxiety disorder involves a fear of embarrassment in a particular setting (speaking in public, urinating in public, etc.), whereas avoidant personality disorder is an overall fear of rejection and a sense of inadequacy. However, a patient can have both disorders concurrently and should carry both diagnoses if criteria for each are met. ■ Dependent personality disorder: Avoidant personality disorder patients cling to relationships, similar to dependent personality disorder patients; however, avoidant patients are slow to get involved, whereas dependent patients actively and aggressively seek relationships. PERSONALITY DISORDERS KEY FACT Schizoid patients prefer to be alone. Avoidant patients want to be with others but are too scared of rejection.

72 PERSONALITY DISORDERS Course WARDS TIP Symptoms of dependent personality disorder—OBEDIENT Obsessive about approval Bound by other’s decisions Enterprises are rarely initiated due to their lack of self-confidence Difficult to make own decisions Invalid feelings while alone Engrossed with fears of self-reliance Needs to be in a relationship Tentative about decisions Treatment ■ Group therapy may also be beneficial. DEPENDENT PERSONALITY DISORDER (DPD) KEY FACT Diagnosis and DSM-5 Criteria Regression is often seen in people with DPD. This is defined as going back to a younger age of maturity. WARDS QUESTION Q: What childhood conditions predispose to later development of DPD? A: Medical illness and separation anxiety disorders. Epidemiology ■ Prevalence: Approximately 2%. Differential Diagnosis Course ■ Usually has a chronic course. ■ Course is usually chronic, although may remit with age. ■ Particularly difficult during adolescence, when attractiveness and socialization are important. ■ Increased incidence of associated anxiety and depressive disorders. ■ If support system fails, patient is left very susceptible to depression, anxiety, and anger. ■ Psychotherapy, including assertiveness and social skills training, is most effective. ■ Selective serotonin reuptake inhibitors (SSRIs) may be prescribed for comorbid social anxiety disorder or major depression. Patients with DPD have poor

self-confidence and fear of separation. They have an excessive need to be taken care of and allow others to make decisions for them. They feel helpless when left alone. ■ A pattern of excessive need to be taken care of that leads to submissive and clinging behavior. ■ At least five of the following must be present:

1. Difficulty making everyday decisions without reassurance from others.
2. Need others to assume responsibilities for most areas of their life.
3. Difficulty expressing disagreement because of fear of loss of approval.
4. Difficulty initiating projects because of lack of self-confidence.
5. Goes to excessive lengths to obtain support from others.
6. Feels helpless when alone.
7. Urgently seeks another relationship when one ends.
8. Preoccupied with fears of being left to take care of self. ■ Women are more likely to be diagnosed with DPD than men. ■ Childhood medical illness or separation anxiety disorder may increase the likelihood of developing DPD. ■ Avoidant personality disorder: See discussion above. ■ BPD and HPD: Patients with DPD usually have a long-lasting relationship with one person on whom they are dependent. While patients with borderline and histrionic personality disorders are often dependent on other people, they are unable to maintain long-lasting relationships. ■ Patients are prone to depression, particularly after loss of person on whom they are dependent. ■ Difficulties with employment since they cannot act independently or without close supervision.

Treatment ■ Psychotherapy, particularly cognitive-behavioral, assertiveness, and social skills training, is the treatment of choice. ■ Pharmacotherapy may be used to treat associated symptoms of anxiety or depression. OBSESSIVE-COMPULSIVE PERSONALITY DISORDER (OCPD) Patients with OCPD have a pervasive pattern of perfectionism, inflexibility, and orderliness. They become so preoccupied with unimportant details that they are often unable to complete simple tasks in a timely fashion. They appear stiff, serious, and formal, with constricted affect. They are often successful professionally but have poor interpersonal skills. Diagnosis and DSM-5 Criteria ■ Pattern of preoccupation with orderliness, control, and perfectionism at the expense of efficiency and flexibility, present by early adulthood and in a variety of contexts. ■ At least four of the following must be present:

1. Preoccupation with details, rules, lists, and organization such that the major point of the activity is lost.
2. Perfectionism that is detrimental to completion of task.
3. Excessive devotion to work.
4. Excessive conscientiousness and scrupulousness about morals and ethics.
5. Will not delegate tasks.
6. Unable to discard worthless objects.
7. Miserly spending style.
8. Rigid and stubborn. Epidemiology ■ Prevalence: 2–7%. ■ Men are two times more likely to be diagnosed with OCPD than women. Differential Diagnosis ■ Obsessive-compulsive disorder (OCD): Patients with OCPD do not have the recurrent obsessions or compulsions that are present in OCD. In addition, the symptoms of OCPD are ego-syntonic rather than ego-dystonic (as in OCD); OCD patients are aware that they have a problem and wish that

their thoughts and behaviors would go away. ■ NPD: Both disorders entail assertiveness and achievement, but NPD patients are motivated by status, whereas OCPD patients are motivated by perfectionism and the work itself. Course ■ Unpredictable course. ■ A significant number have comorbid OCD (most do not, however). Treatment ■ Psychotherapy is the treatment of choice. Cognitive-behavior therapy may be particularly useful. ■ Pharmacotherapy may be used to treat associated symptoms as necessary. PERSONALITY DISORDERS

74 PERSONALITY DISORDERS OTHER SPECIFIED PERSONALITY DISORDER UNSPECIFIED PERSONALITY DISORDER PERSONALITY CHANGE DUE TO ANOTHER MEDICAL CONDITION This refers to a persistent personality change from a previous pattern due to the direct pathophysiological result of a medical condition (e.g., head trauma, stroke, epilepsy, central nervous system infection, or neoplasm). Subtypes include labile, disinhibited, aggressive, apathetic, or paranoid. This diagnosis is reserved for a personality disorder that does not meet the full criteria for any of the disorders, but where the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific personality disorder (e.g., “mixed personality disorder”). This diagnosis is used for a personality disorder that does not meet the full criteria for any of the disorders, but where the clinician chooses not to specify the reason that the criteria are not met for any specific personality disorder (e.g., not enough information to make a more specific diagnosis).