

18 - Personality Disorders

Personality Disorders

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Personality Disorders This chapter begins with a general definition of personality disorder that applies to each of the 10 specific personality disorders. A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the norms and expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. With any ongoing review process, especially one of this complexity, different viewpoints emerge, and an effort was made to accommodate them. Thus, personality disorders are included in both Sections II and III. The material in Section II represents an update of text associated with the same criteria found in DSM-5 (which were carried over from DSM-IV-TR), whereas Section III includes the proposed model for personality disorder diagnosis and conceptualization developed by the DSM-5 Personality and Personality Disorders Work Group. As this field evolves, it is hoped that both versions will serve clinical practice and research initiatives, respectively. The following personality disorders are included in this chapter. Paranoid personality disorder is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent. Schizoid personality disorder is a pattern of detachment from social relationships and a restricted range of emotional expression. Schizotypal personality disorder is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior. Antisocial personality disorder is a pattern of disregard for, and violation of, the rights of others, criminality, impulsivity, and a failure to learn from experience. Borderline personality disorder is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity. Histrionic personality disorder is a pattern of excessive emotionality and attention seeking. Narcissistic personality disorder is a pattern of grandiosity, need for admiration, and lack of empathy. Avoidant personality disorder is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. Dependent personality disorder is a pattern of submissive and clinging behavior related to an excessive need to be taken care of. Obsessive-compulsive personality disorder is a pattern of preoccupation with orderliness, perfectionism, and control. Personality change due to another medical condition is a persistent personality disturbance that is judged to be the direct pathophysiological consequence of another medical condition (e.g., frontal lobe lesion). Other specified personality disorder is a category provided for two situations: 1) the individual's personality pattern meets

734 the general criteria for a personality disorder, and traits of several different personality disorders are present, but the criteria for any specific personality disorder are not met; or 2) the individual's personality pattern meets the general criteria for a personality disorder, but the

individual is considered to have a personality disorder that is not included in the DSM-5 classification (e.g., passive-aggressive personality disorder). Unspecified personality disorder is for presentations in which symptoms characteristic of a personality disorder are present but there is insufficient information to make a more specific diagnosis. The personality disorders are grouped into three clusters based on descriptive similarities. Cluster A includes paranoid, schizoid, and schizotypal personality disorders. Individuals with these disorders often appear odd or eccentric. Cluster B includes antisocial, borderline, histrionic, and narcissistic personality disorders. Individuals with these disorders often appear dramatic, emotional, or erratic. Cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders. Individuals with these disorders often appear anxious or fearful. It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated. For instance, two or more disorders from different clusters, or traits from several of them, can often co-occur and vary in intensity and pervasiveness. A review of epidemiological studies from several countries found a median prevalence of 3.6% for disorders in Cluster A, 4.5% for Cluster B, 2.8% for Cluster C, and 10.5% for any personality disorder. Prevalence appears to vary across countries and by ethnicity, raising questions about true cross-cultural variation and about the impact of diverse definitions and diagnostic instruments on prevalence assessments.

Dimensional Models for Personality Disorders

The diagnostic approach used in this manual represents the categorical perspective that personality disorders are qualitatively distinct clinical syndromes. An alternative to the categorical approach is the dimensional perspective that personality disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another. See Section III for a full description of a dimensional model for personality disorders. The DSM-5 personality disorder clusters (i.e., odd-eccentric, dramatic-emotional, and anxious-fearful) may also be viewed as dimensions representing spectra of personality dysfunction on a continuum with other mental disorders. The alternative dimensional models have much in common and together appear to cover the important areas of personality dysfunction. Their integration, clinical utility, and relationship with the personality disorder diagnostic categories and various aspects of personality dysfunction continue to be under active investigation. This includes research on whether the dimensional model can clarify the cross-cultural prevalence variations seen with the categorical model.

General Personality Disorder

Criteria A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
 2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
 3. Interpersonal functioning.
 4. Impulse control.
- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations. C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood. E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder. F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a

medication) or another medical condition (e.g., head trauma). Diagnostic Features Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute personality disorders. The essential feature of a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the norms and expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control (Criterion A). This enduring pattern is inflexible and pervasive across a broad range of personal and social situations (Criterion B) and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood (Criterion D). The pattern is not better explained as a manifestation or consequence of another mental disorder (Criterion E) and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, exposure to a toxin) or another

medical condition (e.g., head trauma) (Criterion F). Specific diagnostic criteria are also provided for each of the personality disorders included in this chapter. The diagnosis of personality disorders requires an evaluation of the individual's long-term patterns of functioning, and the particular personality features must be evident by early adulthood. The personality traits that define these disorders must also be distinguished from characteristics that emerge in response to specific situational stressors or more transient mental states (e.g., bipolar, depressive, or anxiety disorders; substance intoxication). The clinician should assess the stability of personality traits over time and across different situations. Although a single interview with the individual is sometimes sufficient for making the diagnosis, it is often necessary to conduct more than one interview and to space these over time. Assessment can also be complicated by the fact that the characteristics that define a personality disorder may not be considered problematic by the individual (i.e., the traits are often ego-syntonic). To help overcome this difficulty, supplementary information from other informants may be helpful. Development and Course The features of a personality disorder usually become recognizable during adolescence or early adult life. By definition, a personality disorder is an enduring pattern of thinking, feeling, and behaving that is relatively stable over time. Some types of personality disorder (notably, antisocial and borderline personality disorders) tend to become less evident or to remit with age, whereas this appears to be less true for some other types (e.g., obsessive-compulsive and schizotypal personality disorders). Personality disorder categories may be applied with children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or attributable to another mental disorder. It should be recognized that the traits of a personality disorder that appear in childhood will often not persist unchanged into adult life. For a personality disorder to be diagnosed in an individual younger than 18 years, the features must have been present for at least 1 year. The one exception to this is antisocial personality disorder, which cannot be diagnosed in individuals younger than 18 years. Although, by definition, a personality disorder requires an onset no later than early adulthood, individuals may not come to clinical attention until relatively late in life. A personality disorder may be exacerbated following the loss of significant supporting persons (e.g., a spouse) or previously stabilizing social situations (e.g., a job). However, the development of a

change in personality in middle adulthood or later life warrants a thorough evaluation to determine the possible presence of a personality change due to another medical condition or an unrecognized substance use disorder. Culture-Related Diagnostic Issues Core aspects of personality like emotion regulation and interpersonal functioning are influenced by culture, which also provides means of protection and assimilation and norms for acceptance and denunciation of specific behaviors and personality traits. Judgments about personality

Other mental disorders and personality traits. functioning must take into account the individual's ethnic, cultural, and social background. Personality disorders should not be confused with problems associated with acculturation following migration or with the expression of habits, customs, or religious and political values based on the individual's cultural background or context. Behavioral patterns that appear to be rigid and dysfunctional aspects of personality disorder may reflect instead adaptive responses to cultural constraints. For example, reliance on an abusive relationship in a small community where divorce is proscribed may not reflect pathological dependence; conscientious political protest that puts friends and family members at risk with authorities or in conflict with legal norms does not necessarily reflect pathological callousness. There are marked variations in the recognition and diagnosis of personality disorders across cultural, ethnic, and racialized groups. Accuracy of diagnosis can be enhanced by attention to culturally patterned conceptions of self and attachment, assessment biases resulting from clinicians' own cultural backgrounds or use of diagnostic instruments that are not normed to the population being assessed, and the impact of social determinants such as poverty, acculturative stress, racism, and discrimination on feelings, cognitions, and behaviors. It is useful for the clinician, especially when evaluating someone from a different background, to obtain additional information from informants who are familiar with the person's cultural background. Sex- and Gender-Related Diagnostic Issues Certain personality disorders (e.g., antisocial personality disorder) are diagnosed more frequently in men. Others (e.g., borderline, histrionic, and dependent personality disorders) are diagnosed more frequently in women; however, in the case of borderline personality disorder, this may be due to higher help-seeking among women. Nonetheless, clinicians must be cautious not to overdiagnose or underdiagnose certain personality disorders in women or in men because of social stereotypes about typical gender roles and behaviors. There is currently insufficient evidence on differences between cis- and transgender individuals with respect to the epidemiology or clinical presentations of personality disorders to draw meaningful conclusions. Differential Diagnosis Many of the specific criteria for the personality disorders describe features (e.g., suspiciousness, dependency, insensitivity) that are also characteristic of episodes of other mental disorders. A personality disorder should be diagnosed only when the defining characteristics appeared before early adulthood, are typical of the individual's long-term functioning, and do not occur exclusively during an episode of another mental disorder. It may be particularly difficult (and not particularly useful) to distinguish personality disorders from persistent mental disorders such as persistent depressive disorder that have an early onset and an enduring, relatively stable course. Some personality disorders may have a "spectrum" relationship to other mental disorders (e.g., schizotypal personality disorder with schizophrenia; avoidant personality disorder with social anxiety disorder) based on phenomenological or biological similarities or familial aggregation. Personality disorders must be distinguished from personality traits that do not reach the

Psychotic disorders. Anxiety and depressive disorders. Posttraumatic stress disorder. Substance use disorders. Personality change due to another medical condition. F60.0 threshold for a

personality disorder. Personality traits are diagnosed as a personality disorder only when they are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress. For the three personality disorders that may be related to the psychotic disorders (i.e., paranoid, schizoid, and schizotypal), there is an exclusion criterion stating that the pattern of behavior must not have occurred exclusively during the course of schizophrenia, a bipolar or depressive disorder with psychotic features, or another psychotic disorder. When an individual has a persistent mental disorder (e.g., schizophrenia) that was preceded by a preexisting personality disorder, the personality disorder should also be recorded, followed by “premorbid” in parentheses. The clinician must be cautious in diagnosing personality disorders during an episode of a depressive disorder or an anxiety disorder, because these conditions may have cross-sectional symptom features that mimic personality traits and may make it more difficult to evaluate retrospectively the individual’s long-term patterns of functioning. When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of posttraumatic stress disorder should be considered. When an individual has a substance use disorder, it is important not to make a personality disorder diagnosis based solely on behaviors that are consequences of substance intoxication or withdrawal or that are associated with activities in the service of sustaining substance use (e.g., antisocial behavior). When enduring changes in personality arise as a result of the physiological effects of another medical condition (e.g., brain tumor), a diagnosis of personality change due to another medical condition should be considered.

Cluster A Personality Disorders

Paranoid Personality Disorder

Diagnostic Criteria A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
 2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
 3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
 4. Reads hidden demeaning or threatening meanings into benign remarks or events.
 5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
 6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
 7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.
- 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. Note: If criteria are met prior to the onset of schizophrenia, add “premorbid,” i.e., “paranoid personality disorder (premorbid).”
- Diagnostic Features
- The essential feature of paranoid personality disorder is a pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent. This pattern begins by early adulthood and is present in a variety of contexts. Individuals with this disorder assume that other people will exploit, harm, or deceive them, even if no evidence exists to support this expectation (Criterion A1). They suspect on the basis of little or no evidence that others are plotting against them and may attack them suddenly, at any time and without reason.

They often feel that they have been deeply and irreversibly injured by another person or persons even when there is no objective evidence for this. They are preoccupied with unjustified doubts about the loyalty or trustworthiness of their friends and associates, whose actions are minutely scrutinized for evidence of hostile intentions (Criterion A2). Any perceived deviation from trustworthiness or loyalty serves to support their underlying assumptions. They are so amazed when a friend or associate shows loyalty that they cannot trust or believe it. If they get into trouble, they expect that friends and associates will either attack or ignore them. Individuals with paranoid personality disorder are reluctant to confide in or become close to others because they fear that the information they share will be used against them (Criterion A3). They may refuse to answer personal questions, saying that the information is “nobody’s business.” They read hidden meanings that are demeaning and threatening into benign remarks or events (Criterion A4). For example, an individual with this disorder may misinterpret an honest mistake by a store clerk as a deliberate attempt to shortchange, or view a casual humorous remark by a coworker as a serious character attack. Compliments are often misinterpreted (e.g., a compliment on a new acquisition is misinterpreted as a criticism for selfishness; a compliment on an accomplishment is misinterpreted as an attempt to coerce more and better performance). They may view an offer of help as a criticism that they are not doing well enough on their own.

Individuals with this disorder persistently bear grudges and are unwilling to forgive the insults, injuries, or slights that they think they have received (Criterion A5). Minor slights arouse major hostility, and the hostile feelings persist for a long time. Because they are constantly vigilant to the harmful intentions of others, they very often feel that their character or reputation has been attacked or that they have been slighted in some other way. They are quick to counterattack and react with anger to perceived insults (Criterion A6). Individuals with this disorder may be pathologically jealous, often suspecting that their spouse or sexual partner is unfaithful without any adequate justification (Criterion A7). They may gather trivial and circumstantial “evidence” to support their jealous beliefs. They want to maintain complete control of intimate relationships to avoid being betrayed and may constantly question and challenge the whereabouts, actions, intentions, and fidelity of their spouse or partner. Paranoid personality disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder, or if it is attributable to the physiological effects of a neurological (e.g., temporal lobe epilepsy) or another medical condition (Criterion B). Associated Features Individuals with paranoid personality disorder are generally difficult to get along with and often have problems with close relationships. Their excessive suspiciousness and hostility may be expressed in overt argumentativeness, in recurrent complaining, or by hostile aloofness. They display a labile range of affect, with hostile, stubborn, and sarcastic expressions predominating. Their combative and suspicious nature may elicit a hostile response in others, which then serves to confirm their original expectations. Because individuals with paranoid personality disorder lack trust in others, they need to have a high degree of control over those around them. They are often rigid, critical of others, and unable to collaborate, although they have great difficulty accepting criticism themselves. They may blame others for their own shortcomings. Because of their quickness to counterattack in response to the threats they perceive around them, they may be litigious and frequently become involved in legal disputes. Individuals with this disorder seek to confirm their preconceived negative notions

regarding people or situations they encounter, attributing malevolent motivations to others that are projections of their own fears. They may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups distinct from their own. Attracted by simplistic formulations of the world, they are often wary of ambiguous situations. They may be perceived as “fanatics” and form tightly knit “cults” or groups with others who share their paranoid belief systems. Prevalence The estimated prevalence of paranoid personality based on a probability subsample from Part II

Environmental. Genetic and physiological. of the National Comorbidity Survey Replication was 2.3%. The prevalence of paranoid personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions was 4.4%. A review of six epidemiological studies (four in the United States) found a median prevalence of 3.2%. In forensic settings, the estimated prevalence may be as high as 23%. Development and Course Paranoid personality disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, and interpersonal hypersensitivity. Adolescent onset of paranoid personality disorder is associated with a prior history of childhood maltreatment, externalizing symptoms, bullying of peers, and adult appearance of interpersonal aggression. Risk and Prognostic Factors Exposure to social stressors such as socioeconomic inequality, marginalization, and racism is associated with decreased trust, which in some cases is adaptive. The combination of social stress and childhood maltreatment accounts for the increased prevalence of paranoid symptoms in social groups facing racial discrimination. Both longitudinal and cross-sectional studies confirm that childhood trauma is a risk factor for paranoid personality disorder. There is some evidence for an increased prevalence of paranoid personality disorder in relatives of probands with schizophrenia and for a more specific familial relationship with delusional disorder, persecutory type. Culture-Related Diagnostic Issues Some behaviors that are influenced by sociocultural contexts or specific life circumstances may be erroneously labeled paranoid and may even be reinforced by the process of clinical evaluation. Migrants, members of socially oppressed ethnic and racialized populations, and other groups facing social adversity, racism, and discrimination may display guarded or defensive behaviors because of unfamiliarity (e.g., language barriers or lack of knowledge of rules and regulations) or in response to the neglect, hostility, or indifference of the majority society. Some cultural groups develop low generalized trust, especially of outgroup members, which may lead to behaviors that can be misjudged as paranoid. These include guardedness, limited outward emotionality, cognitive rigidity, social distance, and hostility or defensiveness in situations experienced as unfair or discriminatory. These behaviors can, in turn, generate anger and frustration in others, including clinicians, thus setting up a vicious cycle of mutual mistrust, which should not be confused with paranoid traits or paranoid personality disorder. Sex- and Gender-Related Diagnostic Issues While paranoid personality disorder was found to be more common in men than in women in a meta-analysis relying on clinical and community samples, the National Epidemiologic Survey on

Other mental disorders with psychotic symptoms. Personality change due to another medical condition. Substance use disorders. Paranoid traits associated with physical handicaps. Other personality disorders and personality traits. Alcohol and Related Conditions found it to be more common in women. Differential Diagnosis Paranoid personality disorder can be distinguished from delusional disorder, persecutory type; schizophrenia; and a bipolar or depressive disorder with

psychotic features because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). For an additional diagnosis of paranoid personality disorder to be given, the personality disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms are in remission. When an individual has another persistent mental disorder (e.g., schizophrenia) that was preceded by paranoid personality disorder, paranoid personality disorder should also be recorded, followed by “premorbid” in parentheses. Paranoid personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are a direct physiological consequence of another medical condition. Paranoid personality disorder must be distinguished from symptoms that may develop in association with persistent substance use. The disorder must also be distinguished from paranoid traits associated with the development of physical handicaps (e.g., a hearing impairment). Other personality disorders may be confused with paranoid personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to paranoid personality disorder, all can be diagnosed. Paranoid personality disorder and schizotypal personality disorder share the traits of suspiciousness, interpersonal aloofness, and paranoid ideation, but schizotypal personality disorder also includes symptoms such as magical thinking, unusual perceptual experiences, and odd thinking and speech. Individuals with behaviors that meet criteria for schizoid personality disorder are often perceived as strange, eccentric, cold, and aloof, but they do not usually have prominent paranoid ideation. The tendency of individuals with paranoid personality disorder to react to minor stimuli with anger is also seen in borderline and histrionic personality disorders. However, these disorders are not necessarily associated with pervasive suspiciousness, and borderline personality disorder exhibits higher levels of impulsivity and self-destructive behavior. People with avoidant personality disorder may also be reluctant to confide in others, but more from fear of being embarrassed or found inadequate than from fear of others’ malicious intent. Although antisocial behavior may be present in some individuals with paranoid personality disorder, it is not usually motivated by a desire for personal gain or to exploit others as in antisocial personality disorder, but rather is more often attributable to a desire for revenge. Individuals with narcissistic personality disorder may occasionally display suspiciousness, social withdrawal, or alienation, but this derives primarily from fears of having their imperfections or flaws revealed.

F60.1 Paranoid traits may be adaptive, particularly in threatening environments. Paranoid personality disorder should be diagnosed only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress. Comorbidity Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, paranoid personality disorder may appear as the premorbid antecedent of delusional disorder or schizophrenia. Individuals with paranoid personality disorder may develop major depressive disorder and may be at increased risk for agoraphobia and obsessive-compulsive disorder. Alcohol and other substance use disorders frequently occur. The most common co-occurring personality disorders appear to be schizotypal, schizoid, narcissistic, avoidant, and borderline. Schizoid Personality Disorder Diagnostic Criteria A. 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.
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. Note: If criteria are met prior to the onset of schizophrenia, add “premorbid,” i.e., “schizoid personality disorder (premorbid).” Diagnostic Features

The essential feature of schizoid personality disorder is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings. This pattern begins by early adulthood and is present in a variety of contexts. Individuals with schizoid personality disorder appear to lack a desire for intimacy, seem indifferent to opportunities to develop close relationships, and do not seem to derive much satisfaction from being part of a family or other social group (Criterion A1). They prefer spending time by themselves, rather than being with other people. They often appear to be socially isolated or “loners” and almost always choose solitary activities or hobbies that do not include interaction with others (Criterion A2). They prefer mechanical or abstract tasks, such as computer or mathematical games. They may have very little interest in having sexual experiences with another person (Criterion A3) and take pleasure in few, if any, activities (Criterion A4). There is usually a reduced experience of pleasure from sensory, bodily, or interpersonal experiences, such as walking on a beach at sunset or having sex. These individuals have no close friends or confidants, except possibly a first-degree relative (Criterion A5). Individuals with schizoid personality disorder often seem indifferent to the approval or criticism of others and do not appear to be bothered by what others may think of them (Criterion A6). They may be oblivious to the normal subtleties of social interaction and often do not respond appropriately to social cues so that they seem socially inept or superficial and self-absorbed. They usually display a “bland” exterior without visible emotional reactivity and rarely reciprocate gestures or facial expressions, such as smiles or nods (Criterion A7). They claim that they rarely experience strong emotions such as anger and joy. They often display a constricted affect and appear cold and aloof. However, in those very unusual circumstances in which these individuals become at least temporarily comfortable in revealing themselves, they may acknowledge having painful feelings, particularly related to social interactions. Schizoid personality disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of schizophrenia, a bipolar or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder, or if it is attributable to the physiological effects of a neurological (e.g., temporal lobe epilepsy) or another medical condition (Criterion B).

Associated Features Individuals with schizoid personality disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion. Their lives sometimes seem directionless, and they may appear to “drift” in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Because of their lack of social skills and lack of desire for sexual experiences, individuals with this disorder have few friendships, date infrequently, and often do not marry.

Occupational functioning may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation.

Prevalence

Genetic and physiological. Other mental disorders with psychotic symptoms. Autism spectrum disorder. Personality change due to another medical condition. Schizoid personality disorder is uncommon in clinical settings. The estimated prevalence of schizoid personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 4.9%. The prevalence of schizoid personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions was 3.1%. A review of six epidemiological studies (four in the United States) found a median prevalence of 1.3%. Development and Course Schizoid personality disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, and underachievement in school, which mark these children or adolescents as different and make them subject to teasing. Risk and Prognostic Factors Schizoid personality disorder may have increased prevalence in the relatives of individuals with schizophrenia or schizotypal personality disorder. Culture-Related Diagnostic Issues Individuals from a variety of cultural backgrounds sometimes exhibit defensive behaviors and interpersonal styles that may be erroneously labeled as “schizoid.” For example, those who have moved from rural to metropolitan environments may react with “emotional freezing” that may last for several months and manifest as solitary activities, constricted affect, and other deficits in communication. Immigrants from other countries are sometimes mistakenly perceived as cold, hostile, or indifferent, which may be a response to social ostracism from the host society. Sex- and Gender-Related Diagnostic Issues While some research suggests that schizoid personality disorder may be more common in men, other research suggests that there is no gender difference in prevalence. Differential Diagnosis Schizoid personality disorder can be distinguished from delusional disorder, schizophrenia, and a bipolar or depressive disorder with psychotic features because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of schizoid personality disorder, the personality disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms are in remission. When an individual has a persistent psychotic disorder (e.g., schizophrenia) that was preceded by schizoid personality disorder, schizoid personality disorder should also be recorded, followed by “premorbid” in parentheses. There may be great difficulty differentiating individuals with schizoid personality disorder from individuals with autism spectrum disorder, particularly with milder forms of either disorder, as both include a seeming indifference to companionship with others. However, autism spectrum disorder may be differentiated by stereotyped behaviors and interests. Schizoid personality disorder must be

Substance use disorders. Other personality disorders and personality traits. F21 distinguished from personality change due to another medical condition, in which the traits that emerge are a direct physiological consequence of another medical condition. Schizoid personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use. Other personality disorders may be confused with schizoid personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to schizoid personality disorder, all can be diagnosed. Although characteristics of social isolation and restricted affectivity are

common to schizoid, schizotypal, and paranoid personality disorders, schizoid personality disorder can be distinguished from schizotypal personality disorder by the lack of cognitive and perceptual distortions and from paranoid personality disorder by the lack of suspiciousness and paranoid ideation. The social isolation of schizoid personality disorder can be distinguished from that of avoidant personality disorder, which is attributable to fear of being embarrassed or found inadequate and excessive anticipation of rejection. In contrast, people with schizoid personality disorder have a more pervasive detachment and limited desire for social intimacy. Individuals with obsessive-compulsive personality disorder may also show an apparent social detachment stemming from devotion to work and discomfort with emotions, but they do have an underlying capacity for intimacy. Individuals who are "loners" or quite introverted may display personality traits that might be considered schizoid, consistent with the broader conceptualization of schizoid personality disorder as a disorder defined by pathological introversion/detachment. Only when these traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute schizoid personality disorder. Comorbidity Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, schizoid personality disorder may appear as the premorbid antecedent of delusional disorder or schizophrenia. Individuals with this disorder may sometimes develop major depressive disorder. Schizoid personality disorder most often co-occurs with schizotypal, paranoid, and avoidant personality disorders. Schizotypal Personality Disorder Diagnostic Criteria 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, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).
 3. Unusual perceptual experiences, including bodily illusions.
 4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).
 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.
- 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. Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizotypal personality disorder (premorbid)." Diagnostic Features The essential feature of schizotypal personality disorder is 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. This pattern begins by early adulthood and is present in a variety of contexts. Individuals with schizotypal

personality disorder often have ideas of reference (i.e., incorrect interpretations of casual incidents and external events as having a particular and unusual meaning specifically for the person) (Criterion A1). These should be distinguished from delusions of reference, in which the beliefs are held with delusional conviction. These individuals may be superstitious or preoccupied with paranormal phenomena that are outside the norms of their subculture (Criterion A2). They may feel that they have special powers to sense events before they happen or to read others' thoughts. They may believe that they have magical control over others, which can be implemented directly (e.g., believing that their spouse's taking the dog out for a walk is the direct result of thinking an hour earlier it should be done) or indirectly through compliance with magical rituals (e.g., walking past a specific object three times to avoid a certain harmful outcome). Perceptual alterations may be present (e.g., sensing

that another person is present or hearing a voice murmuring their name) (Criterion A3). Their speech may include unusual or idiosyncratic phrasing and construction. It is often loose, digressive, or vague, but without actual derailment or incoherence (Criterion A4). Responses can be either overly concrete or overly abstract, and words or concepts are sometimes applied in unusual ways (e.g., the individual may state that he or she was not "talkable" at work). Individuals with this disorder are often suspicious and may have paranoid ideation (e.g., believing their colleagues at work are intent on undermining their reputation with the boss) (Criterion A5). They are usually not able to negotiate the full range of affects and interpersonal cuing required for successful relationships and thus often appear to interact with others in an inappropriate, stiff, or constricted fashion (Criterion A6). These individuals are often considered to be odd or eccentric because of unusual mannerisms, an often unkempt manner of dress that does not quite "fit together," and inattention to the usual social conventions (e.g., the individual may avoid eye contact, wear clothes that are ink stained and ill-fitting, and be unable to join in the give-and-take banter of co-workers) (Criterion A7). Individuals with schizotypal personality disorder experience interpersonal relatedness as problematic and are uncomfortable relating to other people. Although they may express unhappiness about their lack of relationships, their behavior suggests a decreased desire for intimate contacts. As a result, they usually have no or few close friends or confidants other than a first-degree relative (Criterion A8). They are anxious in social situations, particularly those involving unfamiliar people (Criterion A9). They will interact with other individuals when they have to but prefer to keep to themselves because they feel that they are different and just do not "fit in." Their social anxiety does not easily abate, even when they spend more time in the setting or become more familiar with the other people, because their anxiety tends to be associated with suspiciousness regarding others' motivations. For example, when attending a dinner party, the individual with schizotypal personality disorder will not become more relaxed as time goes on, but rather may become increasingly tense and suspicious. Schizotypal personality disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of schizophrenia, a bipolar or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder (Criterion B). Associated Features Individuals with schizotypal personality disorder often seek treatment for the associated symptoms of anxiety or depression rather than for the personality disorder features per se. Prevalence The estimated prevalence of schizotypal personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 3.3%. The prevalence of schizotypal personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions data was 3.9%. A review of five

epidemiological studies (three in the United States) found a median prevalence of 0.6%.

Genetic and physiological. Other mental disorders with psychotic symptoms. Development and Course Schizotypal personality disorder has a relatively stable course, with only a small proportion of individuals going on to develop schizophrenia or another psychotic disorder. Schizotypal personality disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language, and bizarre fantasies. These children may appear “odd” or “eccentric” and attract teasing. Risk and Prognostic Factors Schizotypal personality disorder appears to aggregate familiarly and is more prevalent among the first-degree biological relatives of individuals with schizophrenia than among the general population. There may also be a modest increase in schizophrenia and other psychotic disorders in the relatives of probands with schizotypal personality disorder. Twin studies indicate highly stable genetic factors and rather transient environmental factors for an increased risk for the schizotypal syndrome, and genetic risk variants for schizophrenia may be linked to schizotypal personality disorder. Neuroimaging studies detect group-level differences in the size and function of specific brain regions in individuals with schizotypal personality disorder in comparison with healthy persons, individuals with schizophrenia, and individuals with other personality disorders. Culture-Related Diagnostic Issues Cognitive and perceptual distortions must be evaluated in the context of the individual’s cultural milieu. Pervasive culturally determined characteristics, particularly those regarding supernatural and religious beliefs and practices (life beyond death, speaking in tongues, voodoo, shamanism, mind reading, sixth sense, evil eye, magical beliefs related to health and illness), can appear to be schizotypal to the uninformed clinician. Thus, observed cross-national and cross-ethnic variations in the prevalence and expression of schizotypal traits may be a true epidemiological finding or one due to differences in the cultural acceptance of these experiences. Sex- and Gender-Related Diagnostic Issues Schizotypal personality disorder appears to be slightly more common in men than in women. Differential Diagnosis Schizotypal personality disorder can be distinguished from delusional disorder, schizophrenia, and a bipolar or depressive disorder with psychotic features because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of schizotypal personality disorder, the personality disorder must have been present before the onset of psychotic symptoms and persist when the psychotic symptoms are in remission. When an individual has a persistent psychotic disorder (e.g., schizophrenia) that was preceded by schizotypal personality disorder, schizotypal personality disorder should also be recorded,

Neurodevelopmental disorders. Personality change due to another medical condition. Substance use disorders. Other personality disorders and personality traits. followed by “premorbid” in parentheses. There may be great difficulty differentiating children with schizotypal personality disorder from the heterogeneous group of solitary, odd children whose behavior is characterized by marked social isolation, eccentricity, or peculiarities of language and whose diagnoses would probably include milder forms of autism spectrum disorder or language communication disorders. Communication disorders may be differentiated by the primacy and severity of the disorder in language and by the characteristic features of impaired language found in a specialized language assessment. Milder forms of autism spectrum disorder are differentiated by the even greater lack of social awareness and emotional reciprocity and stereotyped behaviors and interests. Schizotypal personality disorder must be distinguished from personality change due to another medical

condition, in which the traits that emerge are a direct physiological consequence of another medical condition. Schizotypal personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use. Other personality disorders may be confused with schizotypal personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to schizotypal personality disorder, all can be diagnosed. Although paranoid and schizoid personality disorders may also be characterized by social detachment and restricted affect, schizotypal personality disorder can be distinguished from these two diagnoses by the presence of cognitive or perceptual distortions and marked eccentricity or oddness. Close relationships are limited in both schizotypal personality disorder and avoidant personality disorder; however, in avoidant personality disorder an active desire for relationships is constrained by a fear of rejection, whereas in schizotypal personality disorder there is a lack of desire for relationships and persistent detachment. Individuals with narcissistic personality disorder may also display suspiciousness, social withdrawal, or alienation, but in narcissistic personality disorder these qualities derive primarily from fears of having imperfections or flaws revealed. Individuals with borderline personality disorder may also have transient, psychotic-like symptoms, but these are usually more closely related to affective shifts in response to stress (e.g., intense anger, anxiety, disappointment) and are usually more dissociative (e.g., derealization, depersonalization). In contrast, individuals with schizotypal personality disorder are more likely to have enduring psychotic-like symptoms that may worsen under stress but are less likely to be invariably associated with pronounced affective symptoms. Although social isolation may occur in borderline personality disorder, it is usually secondary to repeated interpersonal failures due to angry outbursts and frequent mood shifts, rather than a result of a persistent lack of social contacts and desire for intimacy. Furthermore, individuals with schizotypal personality disorder do not usually demonstrate the impulsive or manipulative behaviors of the individual with borderline personality disorder. However, there is a high rate of co-occurrence between the two disorders, so that making such distinctions is not always feasible. Schizotypal features during

F60.2 adolescence may be reflective of transient emotional turmoil rather than an enduring personality disorder. Comorbidity Particularly in response to stress, individuals with this disorder may experience transient psychotic episodes (lasting minutes to hours), although they usually are insufficient in duration to warrant an additional diagnosis such as brief psychotic disorder or schizophreniform disorder. In some cases, clinically significant psychotic symptoms may develop that meet criteria for brief psychotic disorder, schizophreniform disorder, delusional disorder, or schizophrenia. There is considerable co-occurrence with schizoid, paranoid, avoidant, and borderline personality disorders. Cluster B Personality Disorders Antisocial Personality Disorder Diagnostic Criteria A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.

5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another. B. The individual is at least age 18 years. C. There is evidence of conduct disorder with onset before age 15 years. D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder. Diagnostic Features

The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as psychopathy, sociopathy, or dyssocial personality disorder. Because deceit and manipulation are central features of antisocial personality disorder, it may be especially helpful to integrate information acquired from systematic clinical assessment with information collected from collateral sources. For this diagnosis to be given, the individual must be at least age 18 years (Criterion B) and must have had evidence of conduct disorder with onset before age 15 years (Criterion C). Conduct disorder involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The specific behaviors characteristic of conduct disorder fall into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules. The pattern of antisocial behavior continues into adulthood. Individuals with antisocial personality disorder fail to conform to social norms with respect to lawful behavior (Criterion A1). They may repeatedly perform acts that are grounds for arrest (whether they are arrested or not), such as destroying property, harassing others, stealing, or pursuing illegal occupations. Persons with this disorder disregard the wishes, rights, or feelings of others. They are frequently deceitful and manipulative in order to gain personal profit or pleasure (e.g., to obtain money, sex, or power) (Criterion A2). They may repeatedly lie, use an alias, con others, or malingering. A pattern of impulsivity may be manifested by a failure to plan ahead (Criterion A3). Decisions are made on the spur of the moment, without forethought and without consideration for the consequences to self or others; this may lead to sudden changes of jobs, residences, or relationships. Individuals with antisocial personality disorder tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault (including spouse beating or child beating) (Criterion A4). (Aggressive acts that are required to defend oneself or someone else are not considered to be evidence for this item.) These individuals also display a reckless disregard for the safety of themselves or others (Criterion A5). This may be evidenced in their driving behavior (i.e., recurrent speeding, driving while intoxicated, multiple accidents). They may engage in sexual behavior or substance use that has a high risk for harmful consequences. They may neglect or fail to care for a child in a way that puts the child in danger. Individuals with antisocial personality disorder also tend to be consistently and extremely irresponsible (Criterion A6). Irresponsible work behavior may be indicated by significant periods of unemployment despite available job opportunities, or by abandonment of several jobs without a realistic plan for getting another job. There may also be a pattern of repeated absences from work that are not explained by illness either in themselves or in their family. Financial irresponsibility is indicated by acts such as defaulting on debts, failing to provide child support, or failing to support other dependents on a regular basis. Individuals with antisocial personality disorder show little remorse for the consequences of their acts (Criterion A7). They may be indifferent to, or provide a superficial

rationalization for, having hurt, mistreated, or stolen from someone (e.g., “life’s unfair,” “losers deserve to lose”). These individuals may blame the victims for being foolish, helpless, or deserving their fate (e.g., “he had it coming anyway”); they may minimize the harmful consequences of their actions; or they may simply indicate complete

indifference. They generally fail to compensate or make amends for their behavior. They may believe that everyone is out to “help number one” and that one should stop at nothing to avoid being pushed around. The antisocial behavior must not occur exclusively during the course of schizophrenia or bipolar disorder (Criterion D). Associated Features Individuals with antisocial personality disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. Some antisocial individuals may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy that may be particularly distinguishing of the disorder and more predictive of recidivism in prison or forensic settings, where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships. They may have a history of many sexual partners and may never have sustained a monogamous relationship. They may be irresponsible as parents, as evidenced by malnutrition of a child, an illness in the child resulting from a lack of minimal hygiene, a child’s dependence on neighbors or nonresident relatives for food or shelter, a failure to arrange for a caretaker for a young child when the individual is away from home, or repeated squandering of money required for household necessities. These individuals may receive dishonorable discharges from the armed services, may fail to be self-supporting, may become impoverished or even homeless, or may spend many years in penal institutions. Individuals with antisocial personality disorder are more likely than individuals in the general population to die prematurely from natural causes and suicide. Prevalence The estimated prevalence of antisocial personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 0.6%. The prevalence of antisocial personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions data was 3.6%. A review of seven epidemiological studies (six in the United States) found a median prevalence of 3.6%. The highest prevalence of antisocial personality disorder (greater than 70%) is among samples of men with the most severe alcohol use disorders and from substance abuse clinics, prisons, or other forensic settings. Lifetime prevalence appears to be similar across non-Latinx White and Black individuals and lower in Latinx and Asian Americans. Prevalence may be higher in samples affected by adverse socioeconomic (i.e., poverty) or sociocultural (i.e., migration) factors.

Environmental. Genetic and physiological. Development and Course Antisocial personality disorder has a chronic course but may become less evident or remit as the individual grows older, often by age 40. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a decrease in the full spectrum of antisocial behaviors and substance use. By definition, antisocial personality cannot be diagnosed before age 18 years. Risk and Prognostic Factors Child abuse or neglect, unstable or erratic parenting, or inconsistent parental discipline may increase the likelihood that conduct disorder will evolve into antisocial

personality disorder. Antisocial personality disorder is more common among the first-degree biological relatives of those with the disorder than in the general population. Biological relatives of individuals with this disorder are also at increased risk for somatization disorder (a diagnosis that was replaced in DSM-5 with somatic symptom disorder) and substance use disorders. Within a family that has a member with antisocial personality disorder, males more often have antisocial personality disorder and substance use disorders, whereas females more often have somatization disorder. Culture-Related Diagnostic Issues Antisocial personality disorder has been associated with low socioeconomic status and urban settings. The diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy (e.g., formation of youth gangs in urban areas with high rates of violence and discrimination). Sociocultural contexts with high rates of child maltreatment or exposure to violence also tend to have elevated prevalence of antisocial behaviors, suggesting either a potential risk factor for the development of antisocial personality disorder or an adverse environment that evokes reactive and contextual antisocial behaviors that do not represent pervasive and enduring traits consistent with a personality disorder. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur. In the National Epidemiologic Survey on Alcohol and Related Conditions, prevalence appears to vary across U.S. ethnic and racialized groups, possibly because of a combination of true prevalence differences, measurement artifacts, and the impact of adverse environments that generate behaviors that resemble those of antisocial personality disorder but are instead reactive and contextual. Individuals from some socially oppressed groups may be at higher risk for misdiagnosis or overdiagnosis of antisocial personality disorder because they are more likely to be misdiagnosed with conduct disorder in adolescence, which is a requirement for a diagnosis of antisocial personality disorder. Sex- and Gender-Related Diagnostic Issues Antisocial personality disorder is three times as common in men than in women. Women with

Substance use disorders. Schizophrenia and bipolar disorders. Other personality disorders. antisocial personality disorder are more likely to have experienced childhood and adult adverse experiences such as sexual abuse compared with men. Clinical presentation may vary, with men more often presenting with irritability/aggression and reckless disregard for the safety of others compared with women. Comorbid substance use disorders are more common in men, while comorbid mood and anxiety disorders are more common in women. There has been some concern that antisocial personality disorder may be underdiagnosed in females, particularly because of the emphasis on aggressive items in the definition of conduct disorder. Differential Diagnosis The diagnosis of antisocial personality disorder is not given to individuals younger than 18 years and is given only if there is evidence of conduct disorder before age 15 years. For individuals older than 18 years, a diagnosis of conduct disorder is given only if the criteria for antisocial personality disorder are not met. When antisocial behavior in an adult is associated with a substance use disorder, the diagnosis of antisocial personality disorder is not made unless the signs of antisocial personality disorder were also present in childhood and have continued into adulthood. When substance use and antisocial behavior both began in childhood and continued into adulthood, both a substance use disorder and antisocial personality disorder should be diagnosed if the criteria for both are met, even though some antisocial acts may be a consequence of the substance use disorder (e.g., illegal selling of drugs, thefts to obtain money for drugs). Antisocial behavior that occurs exclusively during the course of schizophrenia or a bipolar disorder should not be diagnosed as antisocial personality disorder. Other personality disorders may be confused with antisocial

personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to antisocial personality disorder, all can be diagnosed. Individuals with antisocial personality disorder and narcissistic personality disorder share a tendency to be tough-minded, glib, superficial, exploitative, and lack empathy. However, narcissistic personality disorder does not include characteristics of impulsivity, aggression, and deceit. In addition, individuals with antisocial personality disorder may not be as needy of the admiration and envy of others, and persons with narcissistic personality disorder usually lack the history of conduct disorder in childhood or criminal behavior in adulthood. Individuals with antisocial personality disorder and histrionic personality disorder share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with histrionic personality disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with histrionic and borderline personality disorders are manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification. Individuals with antisocial personality disorder tend to be less emotionally unstable and more aggressive than those with borderline personality disorder. Although antisocial behavior may be

Criminal behavior not associated with a mental disorder. F60.3 present in some individuals with paranoid personality disorder, it is not usually motivated by a desire for personal gain or to exploit others as in antisocial personality disorder, but rather is more often attributable to a desire for revenge. Antisocial personality disorder must be distinguished from antisocial behavior not due to a mental disorder, for example, criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. In these cases, the condition adult antisocial behavior may be coded (see "Other Conditions That May Be a Focus of Clinical Attention").

Comorbidity Individuals with antisocial personality disorder may also experience dysphoria, including complaints of tension, inability to tolerate boredom, and depressed mood. They may have associated anxiety disorders, mood disorders, substance use disorders, somatic symptom disorder, and gambling disorder. Individuals with antisocial personality disorder also often have personality features that meet criteria for other personality disorders, particularly borderline, histrionic, and narcissistic personality disorders. The likelihood of developing antisocial personality disorder in adult life is increased if the individual experienced childhood onset of conduct disorder (before age 10 years) and accompanying attention-deficit/hyperactivity disorder.

Borderline Personality Disorder Diagnostic Criteria A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more

than a few days). 7. Chronic feelings of emptiness. 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights). 9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Diagnostic Features

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts. Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors, which are described separately in Criterion 5 (see also "Association With Suicidal Thoughts or Behavior"). Individuals with borderline personality disorder have a pattern of unstable and intense relationships (Criterion 2). They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, or is not "there" enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will "be there" in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternatively be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected. There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). There are sudden and dramatic shifts in self-image (e.g., suddenly changing from the role of a needy supplicant for help to that of a righteous avenger of past mistreatment). Although they usually have a self-image that is based on the feeling of being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. This can be both painful and frightening to those with this disorder. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support. These individuals may show worse performance in unstructured work or school situations. This lack of a full and enduring identity makes it difficult for the individual with borderline personality disorder to identify maladaptive patterns of behavior and can lead to repetitive patterns of troubled relationships.

Individuals with borderline personality disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly. Individuals with this disorder display

recurrent suicidal behavior, gestures, or threats, or selfmutilating behavior (Criterion 5). Recurrent suicidal thoughts or behavior are often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that the individual assume increased responsibility. Self-mutilative acts (e.g., cutting or burning) are very common and may occur during periods in which the individual is experiencing dissociative symptoms. These acts often bring relief by reaffirming the individual's ability to feel or by expiating the individual's sense of being evil. Individuals with borderline personality disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). The basic dysphoric mood of those with borderline personality disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to interpersonal stresses. Individuals with borderline personality disorder may be troubled by chronic feelings of emptiness, which can co-occur with painful feelings of aloneness (Criterion 7). Easily bored, they may frequently seek excitement to avoid their feelings of emptiness. Individuals with this disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms. Associated Features Individuals with borderline personality disorder may have a pattern of undermining themselves at the moment a goal is about to be realized (e.g., dropping out of school just before graduation; regressing severely after a discussion of how well therapy is going; destroying a good relationship just when it is clear that the relationship could last). Some individuals develop psychotic-like symptoms (e.g., hallucinations, body-image distortions, ideas of reference, hypnagogic phenomena) during times of stress. Individuals with this disorder may feel more secure with transitional objects (i.e., a pet or inanimate possession) than in interpersonal relationships. Premature death from suicide may occur in individuals with borderline personality disorder, especially in those with co-occurring depressive disorders or substance use disorders.

Environmental. Genetic and physiological. However, deaths from other causes, such as accidents or illness, are more than twice as common as deaths by suicide in individuals with borderline personality disorder. Physical handicaps may result from self-inflicted abuse behaviors or failed suicide attempts. Recurrent job losses, interrupted education, and separation or divorce are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss are more common in the childhood histories of those with borderline personality disorder. Prevalence The estimated prevalence of borderline personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 1.4%. The prevalence of borderline personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions data was 5.9%. A review of seven epidemiological studies (six in the United States) found a median prevalence of 2.7%. The prevalence of borderline personality disorder is about 6% in primary care settings, about 10% among individuals seen in outpatient mental health clinics, and about 20%

among psychiatric inpatients. Development and Course Borderline personality disorder has typically been thought of as an adult-onset disorder. However, it has been found in treatment settings that symptoms in adolescents as young as age 12 or 13 years can meet full criteria for the disorder. It is not yet known what percentage of adults first entering treatment actually have such an early onset of borderline personality disorder. Borderline personality disorder has long been thought of as a disorder with a poor symptomatic course, which tended to lessen in severity as those with borderline personality disorder entered their 30s and 40s. However, prospective follow-up studies have found that stable remissions of 1–8 years are very common. Impulsive symptoms of borderline personality disorder remit the most rapidly, while affective symptoms remit at a substantially slower rate. In contrast, recovery from borderline personality disorder (i.e., concurrent symptomatic remission and good psychosocial functioning) is more difficult to achieve and less stable over time. Lack of recovery is associated with supporting oneself on disability benefits and suffering from poor physical health. Risk and Prognostic Factors Borderline personality disorder has also been found to be associated with high rates of various forms of reported childhood abuse and emotional neglect. However, reported rates of sexual abuse are higher in inpatients than in outpatients with this disorder, suggesting that a history of sexual abuse is as much a risk factor for severity of borderline psychopathology as it is for the disorder itself. In addition, an empirically based consensus has arisen that suggests that a childhood history of reported sexual abuse is neither necessary nor sufficient for the development of borderline personality disorder. Borderline personality disorder is about five times more common

Depressive and bipolar disorders. among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for substance use disorders, anxiety disorders, antisocial personality disorder, and depressive or bipolar disorders. Culture-Related Diagnostic Issues The pattern of behavior seen in borderline personality disorder has been identified in many settings around the world. Sociocultural contexts characterized by social demands that evoke attempts at self-affirmation and acceptance by others, ambiguous or conflictual relationships with authority figures, or marked uncertainties in adaptation can foster impulsivity, emotional instability, explosive or aggressive behaviors, and dissociative experiences that are associated with borderline personality disorder or with transient and contextual reactions to those environments that can be confused with borderline personality disorder. Given that psychodynamic, cognitive, behavioral, and mindfulness aspects of models of mind and self vary cross-culturally, symptoms or traits that suggest the presence of borderline personality disorder (e.g., number of sexual partners, shifting between relationships, substance use) must be evaluated in light of cultural norms to make a valid diagnosis. Sex- and Gender-Related Diagnostic Issues While borderline personality disorder is more common among women than men in clinical samples, community samples demonstrate no difference in prevalence between men and women. This discrepancy may reflect a higher degree of help-seeking among women, leading them to clinical settings. Clinical characteristics of men and women with borderline personality disorder appear to be similar, with potentially a higher degree of externalizing behaviors in boys and men and internalizing behaviors in girls and women. Association With Suicidal Thoughts or Behavior In a longitudinal study, impulsive and antisocial behaviors of individuals with borderline personality disorder were associated with increased suicide risk. In a sample of hospitalized patients with borderline personality disorder followed prospectively for 24 years, around 6% died by suicide, compared with 1.4% in a comparison sample of individuals with personality disorders other than borderline personality disorder. A study of individuals with borderline personality disorder followed

for 10 years found that recurrent suicidal behavior was a defining characteristic of borderline personality disorder, associated with declining rates of suicide attempts from 79% to 13% over time. Differential Diagnosis Borderline personality disorder often co-occurs with depressive or bipolar disorders, and when criteria for both are met, both should be diagnosed. Because the cross-sectional presentation of borderline personality disorder can be mimicked by an episode of depressive or bipolar disorder, the clinician should avoid giving an additional diagnosis of

Separation anxiety disorder in adults. Other personality disorders. Personality change due to another medical condition. Substance use disorders. Identity problems. borderline personality disorder based only on cross-sectional presentation without having documented that the pattern of behavior had an early onset and a long-standing course. Separation anxiety disorder and borderline personality disorder are characterized by fear of abandonment by loved ones, but problems in identity, self-direction, interpersonal functioning, and impulsivity are additionally central to borderline personality disorder. Other personality disorders may be confused with borderline personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to borderline personality disorder, all can be diagnosed. Although histrionic personality disorder can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, borderline personality disorder is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness. Paranoid ideas or illusions may be present in both borderline personality disorder and schizotypal personality disorder, but these symptoms are more transient, interpersonally reactive, and responsive to external structuring in borderline personality disorder. Although paranoid personality disorder and narcissistic personality disorder may also be characterized by an angry reaction to minor stimuli, the relative stability of self-image, as well as the relative lack of physical self-destructiveness, repetitive impulsivity, and profound abandonment concerns, distinguishes these disorders from borderline personality disorder. Although antisocial personality disorder and borderline personality disorder are both characterized by manipulative behavior, individuals with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification, whereas the goal in borderline personality disorder is directed more toward gaining the concern of caretakers. Both dependent personality disorder and borderline personality disorder are characterized by fear of abandonment; however, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline personality disorder can further be distinguished from dependent personality disorder by the typical pattern of unstable and intense relationships. Borderline personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are a direct physiological consequence of another medical condition. Borderline personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use. Borderline personality disorder should be distinguished from an identity problem, which is reserved for identity concerns related to a developmental phase (e.g., adolescence) and does not qualify as a mental disorder. Adolescents and young adults with identity problems (especially when accompanied by substance use) may transiently display

F60.4 behaviors that misleadingly give the impression of borderline personality disorder. Such situations are characterized by emotional instability, existential dilemmas, uncertainty, anxiety-provoking choices, conflicts about sexual orientation, and competing social pressures to decide on careers. Comorbidity Common co-occurring disorders include depressive and bipolar disorders, substance use disorders, anxiety disorders (particularly panic disorder and social anxiety disorder), eating disorders (notably bulimia nervosa and binge-eating disorder), posttraumatic stress disorder, and attention-deficit/hyperactivity disorder. Borderline personality disorder also frequently co-occurs with the other personality disorders. Histrionic Personality Disorder Diagnostic Criteria A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the center of attention.
 2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
 3. Displays rapidly shifting and shallow expression of emotions.
 4. Consistently uses physical appearance to draw attention to self.
 5. Has a style of speech that is excessively impressionistic and lacking in detail.
 6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.
 7. Is suggestible (i.e., easily influenced by others or circumstances).
 8. Considers relationships to be more intimate than they actually are.
- Diagnostic Features
The essential feature of histrionic personality disorder is pervasive and excessive emotionality and attention-seeking behavior. This pattern begins by early adulthood and is present in a variety of contexts. Individuals with histrionic personality disorder are uncomfortable or feel unappreciated when they are not the center of attention (Criterion 1). Often lively and dramatic, they tend to draw attention to themselves and may initially charm new acquaintances by their enthusiasm, apparent openness, or flirtatiousness. These qualities wear thin, however, as these individuals continually demand to be the center of attention. They commandeer the role of “the life of the party.” If they are not the center of attention, they may do something

dramatic (e.g., make up stories, create a scene) to draw the focus of attention to themselves. This need is often apparent in their behavior with a clinician (e.g., being flattering, bringing gifts, providing dramatic descriptions of physical and psychological symptoms that are replaced by new symptoms each visit). The appearance and behavior of individuals with this disorder are often inappropriately sexually provocative or seductive (Criterion 2). This behavior not only is directed toward persons in whom the individual has a sexual or romantic interest but also occurs in a wide variety of social, occupational, and professional relationships beyond what is appropriate for the social context. Emotional expression may be shallow and rapidly shifting (Criterion 3). Individuals with this disorder consistently use physical appearance to draw attention to themselves (Criterion 4). They are overly concerned with impressing others by their appearance and expend an excessive amount of time, energy, and money on clothes and grooming. They may “fish for compliments” regarding appearance and may be easily and excessively upset by a critical comment about how they look or by a photograph that they regard as unflattering. These individuals have a style of speech that is excessively impressionistic and lacking in detail (Criterion 5). Strong opinions are expressed with dramatic flair, but underlying rationales are usually vague and diffuse, without supporting facts and details. For example, an individual with histrionic

personality disorder may comment that a certain individual is a wonderful human being, yet be unable to provide any specific examples of good qualities to support this opinion. Individuals with this disorder are characterized by self-dramatization, theatricality, and an exaggerated expression of emotion (Criterion 6). They may embarrass friends and acquaintances by an excessive public display of emotions (e.g., embracing casual acquaintances with excessive ardor, sobbing uncontrollably on minor sentimental occasions, having temper tantrums). However, their emotions often seem to be turned on and off too quickly to be deeply felt, which may lead others to accuse the individual of faking these feelings. Individuals with histrionic personality disorder have a high degree of suggestibility (Criterion 7). Their opinions and feelings are easily influenced by others and by current fads. They may be overly trusting, especially of strong authority figures whom they see as magically solving their problems. They have a tendency to play hunches and to adopt convictions quickly. Individuals with this disorder often consider relationships more intimate than they actually are, describing almost every acquaintance as “my dear, dear friend” or referring to physicians met only once or twice under professional circumstances by their first names (Criterion 8). Associated Features Impairment in general tends to be lower in histrionic personality disorder than in many other personality disorders. However, the impairment most associated with histrionic personality disorder appears to be interpersonal in nature. Individuals with histrionic personality disorder have an interpersonal style characterized by social dominance, which can span a spectrum of behaviors that include a “warmer dominance” that can be intrusive in nature (e.g., need to be center of attention; exhibitionistic) to a “colder dominance” that can include arrogant, controlling, and aggressive behaviors. Romantic relationships appear to be particularly impaired, with evidence suggesting that individuals with histrionic personality disorder symptoms are more likely to get divorced or never get married. Individuals with histrionic personality disorder may have difficulty achieving emotional intimacy in romantic or sexual relationships. Individuals

with this disorder often have impaired relationships with same-sex friends because their sexually provocative interpersonal style may seem a threat to their friends’ relationships. These individuals may also alienate friends with demands for constant attention. They often become depressed and upset when they are not the center of attention. They may crave novelty, stimulation, and excitement and have a tendency to become bored with their usual routine. These individuals are often intolerant of, or frustrated by, situations that involve delayed gratification, and their actions are often directed at obtaining immediate satisfaction. Although they often initiate a job or project with great enthusiasm, their interest may lag quickly. Longer-term relationships may be neglected to make way for the excitement of new relationships. Prevalence The estimated prevalence of histrionic personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 0.0%. The prevalence of histrionic personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions data was 1.8%. A review of five epidemiological studies (four in the United States) found a median prevalence of 0.9%. Culture-Related Diagnostic Issues Norms for interpersonal behavior, personal appearance, and emotional expressiveness vary widely across cultures, genders, and age groups. Before considering the various traits (e.g., emotionality, seductiveness, dramatic interpersonal style, novelty seeking, sociability, charm, impressionability, a tendency to somatization) to be evidence of histrionic personality disorder, it is important to evaluate whether they cause clinically significant impairment or distress. The presence of histrionic personality disorder should be distinguished from reactive and contextual expression of these traits, arising in response to socialization pressures in competitive peer groups, including the “need to be liked,” that do not represent pervasive and

enduring traits consistent with a personality disorder. Sex- and Gender-Related Diagnostic Issues In clinical settings, this disorder has been diagnosed more frequently in females; however, the gender ratio is not significantly different from the gender ratio of females within the respective clinical setting. In contrast, some studies using structured assessments report similar prevalence rates among males and females. Association With Suicidal Thoughts or Behavior The actual risk of suicide is not known, but clinical experience suggests that individuals with this disorder may be at increased risk for suicidal gestures and threats. Differential Diagnosis

Other personality disorders and personality traits. Personality change due to another medical condition. Substance use disorders. Other personality disorders may be confused with histrionic personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to histrionic personality disorder, all can be diagnosed. Although borderline personality disorder can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, it is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and identity disturbance. Individuals with antisocial personality disorder and histrionic personality disorder share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with histrionic personality disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with histrionic personality disorder are manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification. Although individuals with narcissistic personality disorder also crave attention from others, they usually want praise for their "superiority," whereas individuals with histrionic personality disorder are willing to be viewed as fragile or dependent if this is instrumental in getting attention. Individuals with narcissistic personality disorder may exaggerate the intimacy of their relationships with other people, but they are more apt to emphasize the "VIP" status or wealth of their friends. In dependent personality disorder, the individual is excessively dependent on others for praise and guidance, but is without the flamboyant, exaggerated, emotional features of individuals with histrionic personality disorder. Many individuals may display histrionic personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute histrionic personality disorder. Histrionic personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are a direct physiological consequence of another medical condition. The disorder must also be distinguished from symptoms that may develop in association with persistent substance use. Comorbidity Histrionic personality disorder has been associated with higher rates of borderline, narcissistic, paranoid, dependent, and antisocial personality disorders; alcohol and other substance use and misuse; as well as aggression and violence. Histrionic personality disorder is also thought to be related to somatic symptom disorder, functional neurological symptom disorder (conversion disorder), and major depressive disorder. Narcissistic Personality Disorder

F60.81 Diagnostic Criteria A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
 2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
 3. Believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
 4. Requires excessive admiration.
 5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).
 6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
 7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
 8. Is often envious of others or believes that others are envious of him or her.
 9. Shows arrogant, haughty behaviors or attitudes.
- Diagnostic Features The essential feature of narcissistic personality disorder is a pervasive pattern of grandiosity, need for admiration, and lack of empathy that begins by early adulthood and is present in a variety of contexts. Individuals with this disorder have a grandiose sense of self-importance, which may be manifest as an exaggerated or unrealistic sense of superiority, value, or capability (Criterion 1). They tend to overestimate their abilities and amplify their accomplishments, often appearing boastful and pretentious. They may blithely assume that others attribute the same value to their efforts and may be surprised when the praise they expect and feel they deserve is not forthcoming. Often implicit in the inflated judgments of their own accomplishments is an underestimation or devaluation of the contributions of others. Individuals with narcissistic personality disorder are often preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love (Criterion 2). They may ruminate about “long overdue” admiration and privilege and compare themselves favorably with famous or privileged people. Individuals with narcissistic personality disorder believe that they are special or unique and expect others to recognize them as such (Criterion 3). They can be surprised or even devastated when the recognition of acclaim they expect and feel they deserve from others is not forthcoming. They may feel that they can only be understood by, and should only associate with, people of high status and may attribute “unique,” “perfect,” or “gifted” qualities to those with

whom they associate. Individuals with this disorder believe that their needs are special and beyond the ken of ordinary people. Their own self-esteem is enhanced (i.e., “mirrored”) by the idealized value that they assign to those with whom they associate. They are likely to insist on having only the “top” person (doctor, lawyer, hairdresser, instructor) or being affiliated with the “best” institutions but may devalue the credentials of those who disappoint them. Individuals with this disorder generally require excessive admiration (Criterion 4). Their self-esteem is almost invariably very fragile, and their struggle with severe internal self-doubt, self-criticism, and emptiness results in their need to actively seek others’ admiration. They may be preoccupied with how well they are doing and how favorably they are regarded by others. They may expect their arrival to be greeted with great fanfare and are astonished if others do not covet their possessions. They may constantly fish for compliments, often with great charm. A sense of entitlement, which is rooted in their distorted sense of self-worth, is evident in these individuals’ unreasonable expectation of especially favorable treatment (Criterion 5). They expect to be catered to and are puzzled or furious when this

does not happen. For example, they may assume that they do not have to wait in line and that their priorities are so important that others should defer to them, and then get irritated when others fail to assist “in their very important work.” They expect to be given whatever they want or feel they need, no matter what it might mean to others. For example, these individuals may expect great dedication from others and may overwork them without regard for the impact on their lives. This sense of entitlement, combined with a lack of understanding and sensitivity to the wants and needs of others, may result in the conscious or unwitting exploitation of others (Criterion 6). They tend to form friendships or romantic relationships only if the other person seems likely to advance their purposes or otherwise enhance their self-esteem. They often usurp special privileges and extra resources that they believe they deserve. Some individuals with narcissistic personality disorder intentionally and purposefully take advantage of others emotionally, socially, intellectually, or financially for their own purposes and gains. Individuals with narcissistic personality disorder generally have a lack of empathy and are unwilling to recognize or identify with the desires, subjective experiences, and feelings of others (Criterion 7). They tend to have some degree of cognitive empathy (understanding another person’s perspective on an intellectual level) but lack emotional empathy (directly feeling the emotions that another person is feeling). These individuals may be oblivious to the hurt their remarks may inflict (e.g., exuberantly telling a former lover that “I am now in the relationship of a lifetime!”; boasting of health in front of someone who is sick). When recognized, the needs, desires, or feelings of others are likely to be viewed disparagingly as signs of weakness or vulnerability. Those who relate to individuals with narcissistic personality disorder typically find an emotional coldness and lack of reciprocal interest. These individuals are often envious of others or believe that others are envious of them (Criterion 8). They may begrudge others their successes or possessions, feeling that they better deserve those achievements, admiration, or privileges. They may harshly devalue the contributions of others, particularly when those individuals have received acknowledgment or praise for their accomplishments. Arrogant, haughty behaviors characterize these individuals; they often display snobbish, disdainful, or patronizing attitudes (Criterion 9).

Associated Features Vulnerability in self-esteem makes individuals with narcissistic personality disorder very sensitive to criticism or defeat. Although they may not show it outwardly, such experiences may leave them feeling ashamed, humiliated, degraded, hollow, and empty. They may react with disdain, rage, or defiant counterattack. However, such experiences can also lead to social withdrawal or an appearance of humility that may mask and protect the grandiosity. Interpersonal relations are typically impaired because of problems related to self-preoccupation, entitlement, need for admiration, and relative disregard for the sensitivities of others. Individuals with narcissistic personality disorder can be competent and high functioning with professional and social success, while others can have various levels of functional impairment. Professional capability combined with self-control, stoicism, and interpersonal distancing with minimal self-disclosure can support sustained life engagement and even enable marriage and social affiliations. Sometimes ambition and temporary confidence lead to high achievements, but performance can be disrupted because of fluctuating self-confidence and intolerance of criticism or defeat. Some individuals with narcissistic personality disorder have very low vocational functioning, reflecting an unwillingness to take a risk in competitive or other situations in which failure or defeat can be possible. Low self-esteem with inferiority, vulnerability, and sustained feelings of shame, envy, and humiliation accompanied by self-criticism and insecurity can make individuals with narcissistic personality disorder susceptible to social withdrawal, emptiness, and depressed mood. High

perfectionist standards are often associated with significant fear of exposure to imperfection, failure, and overwhelming emotions. **Prevalence** The estimated prevalence of narcissistic personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 0.0%. The prevalence of narcissistic personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions data was 6.2%. A review of five epidemiological studies (four in the United States) found a median prevalence of 1.6%. **Development and Course** Narcissistic traits may be particularly common in adolescents but do not necessarily indicate that the individual will develop narcissistic personality disorder in adulthood. Predominant narcissistic traits or manifestations of the full disorder may first come to clinical attention or be exacerbated in the context of unexpected or extremely challenging life experiences or crises, such as bankruptcies, demotions or loss of work, or divorces. In addition, individuals with narcissistic personality disorder may have specific difficulties adjusting to the onset of physical and occupational limitations that are inherent in the aging process. However, life experiences, such as new durable relationships, real successful achievements, and tolerable disappointments and setbacks, can all be corrective and contribute to changes and improvements in individuals with this disorder.

Other personality disorders and personality traits. **Culture-Related Diagnostic Issues** Narcissistic traits may be elevated in sociocultural contexts that emphasize individualism and personal autonomy over collectivistic goals. Compared with collectivistic contexts, in individualistic contexts, narcissistic traits may warrant less clinical attention or less frequently lead to social impairment. **Sex- and Gender-Related Diagnostic Issues** Among adults age 18 and older diagnosed with narcissistic personality disorder, 50%–75% are men. Gender differences in adults with this disorder include stronger reactivity in response to stress and compromised empathic processing in men as opposed to self-focus and withdrawal in women. Culturally based gender patterns and expectations may also contribute to gender differences in narcissistic personality disorder traits and patterns. **Association With Suicidal Thoughts or Behavior** In the context of severe stress, and given the perfectionism often associated with narcissistic personality disorder, exposure to imperfection, failure, and overwhelming emotions can evoke suicidal ideation. Suicide attempts in individuals with narcissistic personality disorder tend to be less impulsive and are characterized by higher lethality compared with suicide attempts by individuals with other personality disorders. **Differential Diagnosis** Other personality disorders may be confused with narcissistic personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to narcissistic personality disorder, all can be diagnosed. The most useful feature in discriminating narcissistic personality disorder from histrionic, antisocial, and borderline personality disorders, in which the interactive styles are coquettish, callous, and needy, respectively, is the grandiosity characteristic of narcissistic personality disorder. The relative stability of self-image and self-control as well as the relative lack of self-destructiveness, impulsivity, separation insecurity, and emotional hyperreactivity also help distinguish narcissistic personality disorder from borderline personality disorder. Excessive pride in achievements, a relative lack of emotional display, and ignorance of or disdain for others' sensitivities help distinguish narcissistic personality disorder from histrionic personality disorder. Although individuals with borderline, histrionic, and narcissistic personality disorders may require much attention, those with narcissistic personality disorder specifically need that attention to be admiring. Individuals with antisocial and narcissistic

personality disorders share a tendency to be tough-minded, glib, superficial, exploitative, and unempathic. However, narcissistic personality disorder does not necessarily include characteristics of impulsive aggressivity and deceitfulness. In addition, individuals with antisocial personality disorder may be more indifferent and less sensitive to others' reactions or criticism, and individuals with narcissistic personality disorder usually lack the history of conduct disorder in childhood or criminal behavior in adulthood.

Mania or hypomania. Substance use disorders. Persistent depressive disorder. F60.6 In both narcissistic personality disorder and obsessive-compulsive personality disorder, the individual may profess a commitment to perfectionism and believe that others cannot do things as well. However, while those with obsessive-compulsive personality disorder tend to be more immersed in perfectionism related to order and rigidity, individuals with narcissistic personality disorder tend to set high perfectionistic standards, especially for appearance and performance, and to be critically concerned if they are not measuring up. Suspiciousness and social withdrawal usually distinguish those with schizotypal, avoidant, or paranoid personality disorder from those with narcissistic personality disorder. When these qualities are present in individuals with narcissistic personality disorder, they derive primarily from shame and fear of failure, or fear of having imperfections or flaws revealed. Many highly successful individuals display personality traits that might be considered narcissistic. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute narcissistic personality disorder. Grandiosity may emerge as part of manic or hypomanic episodes, but the association with mood change or functional impairments helps distinguish these episodes from narcissistic personality disorder. Narcissistic personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use. Experiences that threaten self-esteem can evoke a deep sense of inferiority and sustained feelings of shame, envy, self-criticism, and insecurity in individuals with narcissistic personality disorder that can result in persistent negative feelings resembling those seen in persistent depressive disorder. If criteria are also met for persistent depressive disorder, both conditions can be diagnosed. Comorbidity Narcissistic personality disorder is associated with depressive disorders (persistent depressive disorder and major depressive disorder), anorexia nervosa, and substance use disorders (especially related to cocaine). Histrionic, borderline, antisocial, and paranoid personality disorders may also be associated with narcissistic personality disorder. Cluster C Personality Disorders Avoidant Personality Disorder Diagnostic Criteria A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity

to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.

7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing. Diagnostic Features The essential feature of avoidant personality disorder is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts. Individuals with avoidant personality disorder avoid work activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection (Criterion 1). Offers of job promotions may be declined because failure to manage the new responsibilities might result in criticism from coworkers. These individuals avoid making new friends unless they are certain they will be liked and accepted without criticism (Criterion 2). Until they pass stringent tests proving the contrary, other people are assumed to be critical and disapproving. Individuals with this disorder are highly avoidant of group activities. Interpersonal intimacy is often difficult for these individuals, although they are able to establish intimate relationships when there is assurance of uncritical acceptance. They may act with restraint, be reluctant to talk about themselves, and withhold intimate feelings for fear of being exposed, ridiculed, or shamed (Criterion 3). Because individuals with this disorder are preoccupied with being criticized or rejected in social situations, they may have a markedly low threshold for detecting such reactions (Criterion 4). If someone is even slightly disapproving or critical, they may feel extremely hurt. They tend to be shy, quiet, inhibited, and “invisible” because of the fear that any attention would be critical or rejecting. They expect that no matter what they say, others will see it as “wrong,” and so they may say nothing at all. They react strongly to subtle cues that are suggestive of mockery or derision, and may misinterpret a neutral gesture or statement as critical or rejecting. Despite their longing to be active participants in social life, they fear placing their psychological welfare in the hands of others. Individuals with avoidant personality disorder are inhibited in new interpersonal situations because they feel inadequate and have low self-esteem (Criterion 5). These individuals believe themselves to be socially inept, personally unappealing, or inferior to others (Criterion 6). Doubts concerning social competence and personal appeal may be most intense for some individuals in settings involving interactions with strangers. But many others report more

difficulties with repeated interaction, when sharing of personal information would normally occur, thus, in the individual’s perception, increasing the chances that their inferiority would be revealed and that they would be rejected. When commencing a new ongoing social or occupational commitment requiring repeated interpersonal interaction, individuals may over weeks or months develop a growing conviction that others or colleagues view them as inferior or lacking worth, resulting in intolerable distress or anxiety that prompts resignation. Thus, a history of repeated job changes may be present. Individuals with this disorder are unusually reluctant to take personal risks or to engage in any new activities because these may prove embarrassing (Criterion 7). They are prone to exaggerate the potential dangers of ordinary situations, and a restricted lifestyle may result from their need for certainty and security. Associated Features Individuals with avoidant personality disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. They are likely to misinterpret social responses as critical, which in turn confirms their self-doubts. They are described by others as being “shy,” “timid,” “lonely,” and “isolated.” The major problems associated with this disorder occur in social and occupational functioning. The low self-esteem and hypersensitivity to rejection are associated with restricted

interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network that can help them weather crises. They desire affection and acceptance and may fantasize about idealized relationships with others. Avoidant behaviors can also adversely affect occupational functioning because these individuals try to avoid the types of social situations that may be important for meeting the basic demands of the job or for advancement. Individuals with avoidant personality disorder have been reported as having insecure attachment styles characterized by a desire for emotional attachment (which may include a preoccupation with previous and current relationships), but their fears that others may not value them or may hurt them may lead them to respond with passivity, anger, or fear. These attachment patterns have been referred to variously as “preoccupied” or “fearful” depending on the model employed by researchers.

Prevalence The estimated prevalence of avoidant personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 5.2%. The prevalence of avoidant personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions was 2.4%. A review of six epidemiological studies (four in the United States) found a median prevalence of 2.1%.

Development and Course The avoidant behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Although shyness in childhood is a common precursor of avoidant personality disorder, in most individuals it tends to gradually dissipate as they get older. In

Social anxiety disorder. Agoraphobia. Other personality disorders and personality traits. contrast, individuals who go on to develop avoidant personality disorder may become increasingly shy and avoidant during adolescence and early adulthood, when social relationships with new people become especially important. There is some evidence that in adults, avoidant personality disorder tends to become less evident or to remit with age; the prevalence in adults older than 65 years has been estimated at 0.8%. This diagnosis should be used with great caution in children and adolescents, for whom shy and avoidant behavior may be developmentally appropriate.

Culture-Related Diagnostic Issues There may be variation in the degree to which different cultural and ethnic groups regard diffidence and avoidance as appropriate. Moreover, avoidant behavior may be the result of problems in acculturation following migration. In some sociocultural contexts, marked avoidance might occur following social embarrassment (“loss of face”) or failure to meet major life goals rather than temperamental shyness. In these settings, the goal of avoidance includes deliberate minimization of social interactions in order to preserve social harmony or prevent public offense.

Sex- and Gender-Related Diagnostic Issues Avoidant personality disorder appears to be more common in women than in men in community surveys. This gender difference in prevalence is small but consistently found in large populationbased samples.

Differential Diagnosis There appears to be a great deal of overlap between avoidant personality disorder and social anxiety disorder. It has been suggested that they may represent different manifestations of similar underlying problems, or avoidant personality disorder may be a more severe form of social anxiety disorder. However, differences have also been described, especially in relation to self-concept (such as self-esteem and the sense of inferiority in avoidant personality disorder); the latter is indirect evidence as it shows that negative self-concept in social anxiety disorder may be unstable and thus less pervasive and entrenched than in avoidant personality disorder. Additionally, studies have shown that avoidant personality disorder frequently occurs in the absence of social anxiety disorder, and some separate risk factors have been identified, providing support for retaining two separate diagnostic categories. Avoidance characterizes both avoidant personality disorder and agoraphobia, and they often co-occur. They can be distinguished by the motivation for the

avoidance (e.g., fear of panic or physical harm in agoraphobia). Other personality disorders may be confused with avoidant personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to avoidant personality disorder, all can be diagnosed. Both avoidant personality disorder and dependent personality disorder are characterized by feelings of

Personality change due to another medical condition. Substance use disorders. F60.7 inadequacy, hypersensitivity to criticism, and a need for reassurance. Similar behaviors (e.g., unassertiveness) and attributes (e.g., low self-esteem and low self-confidence) may be observed in both dependent personality disorder and avoidant personality disorder, although other behaviors are notably divergent, such as avoidance of social proximity in avoidant personality disorder but proximity-seeking in dependent personality disorder. The motivations behind similar behaviors may be quite different. For example, the unassertiveness in avoidant personality disorder is described as more closely related to fears of being rejected or humiliated, whereas in dependent personality disorder it is motivated by the desire to avoid being left to fend for oneself. However, avoidant personality disorder and dependent personality disorder may be particularly likely to co-occur. Like avoidant personality disorder, schizoid personality disorder and schizotypal personality disorder are characterized by social isolation. However, individuals with avoidant personality disorder want to have relationships with others and feel their loneliness deeply, whereas those with schizoid or schizotypal personality disorder may be content with and even prefer their social isolation. Paranoid personality disorder and avoidant personality disorder are both characterized by a reluctance to confide in others. However, in avoidant personality disorder, this reluctance is attributable more to a fear of humiliation or being found inadequate than to a fear of others' malicious intent. Many individuals display avoidant personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute avoidant personality disorder. Avoidant personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are a direct physiological consequence of another medical condition. Avoidant personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use. Comorbidity Other disorders that are commonly diagnosed with avoidant personality disorder include depressive disorders and anxiety disorders, especially social anxiety disorder. Avoidant personality disorder also tends to be diagnosed with schizoid personality disorder. Avoidant personality disorder is associated with increased rates of substance use disorders at a similar rate to the generalized form of social anxiety disorder. Dependent Personality Disorder Diagnostic Criteria A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution.)

4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Diagnostic Features The essential feature of dependent personality disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation. This pattern begins by early adulthood and is present in a variety of contexts. The dependent and submissive behaviors are designed to elicit caregiving and arise from a self-perception of being unable to function adequately without the help of others. Individuals with dependent personality disorder have great difficulty making everyday decisions (e.g., what color shirt to wear to work or whether to carry an umbrella) without an excessive amount of advice and reassurance from others (Criterion 1). These individuals tend to be passive and to allow other people (often a single other person) to take the initiative and assume responsibility for most major areas of their lives (Criterion 2). Adults with this disorder typically depend on a parent or spouse to decide where they should live, what kind of job they should have, and which neighbors to befriend. Adolescents with this disorder may allow their parent(s) to decide what they should wear, with whom they should associate, how they should spend their free time, and what school or college they should attend. This need for others to assume responsibility goes beyond age-appropriate and situation-appropriate requests for assistance from others (e.g., the specific needs of children, elderly persons, and handicapped persons). Dependent personality disorder may occur in an individual who has a serious medical condition or disability, but in such cases the difficulty in taking responsibility must go beyond what would normally be associated with that condition or disability. Because they fear losing support or approval, individuals with dependent personality disorder often have difficulty expressing disagreement with other individuals, especially those on whom they are dependent (Criterion 3). These individuals feel so unable to function alone that they will agree with things that they feel are wrong rather than risk losing the help of those to whom they

look for guidance. They do not express anger toward others whose support and nurturance they need for fear of alienating them. If the individual's concerns regarding the consequences of expressing disagreement are realistic (e.g., realistic fears of retribution from an abusive spouse), the behavior should not be considered to be evidence of dependent personality disorder. Individuals with this disorder have difficulty initiating projects or doing things independently (Criterion 4). They lack self-confidence and believe that they need help to begin and carry through tasks. They will wait for others to start things because they believe that as a rule others can do them better. These individuals are convinced that they are incapable of functioning independently and present themselves as inept and requiring constant assistance. They are, however, likely to function adequately if given the assurance that someone else is supervising and approving. There may be a fear of becoming or appearing to be more competent, because they may believe that this

will lead to loss of support. Because they rely on others to handle their problems, they often do not learn the skills of independent living, thus perpetuating dependency. Individuals with dependent personality disorder may go to excessive lengths to obtain nurturance and support from others, even to the point of volunteering for unpleasant tasks if such behavior will bring the care they need (Criterion 5). They are willing to submit to what others want, even if the demands are unreasonable. Their need to maintain an important bond will often result in imbalanced or distorted relationships. They may make extraordinary self-sacrifices or tolerate verbal, physical, or sexual abuse. (It should be noted that this behavior should be considered evidence of dependent personality disorder only when it can clearly be established that other options are available to the individual.) Individuals with this disorder feel uncomfortable or helpless when alone because of their exaggerated fears of being unable to care for themselves (Criterion 6). When a close relationship ends (e.g., a breakup with a lover; the death of a caregiver), individuals with dependent personality disorder may urgently seek another relationship to provide the care and support they need (Criterion 7). Their belief that they are unable to function in the absence of a close relationship motivates these individuals to become quickly and indiscriminately attached to another individual. Individuals with this disorder are often preoccupied with fears of being left to care for themselves (Criterion 8). They see themselves as so totally dependent on the advice and help of an important other person that they worry about losing the support of that person when there are no grounds to justify such fears. To be considered as evidence of this criterion, the fears must be excessive and unrealistic. For example, an elderly man with cancer who moves into his son's household for care is exhibiting dependent behavior that is appropriate given this person's life circumstances. Associated Features Individuals with dependent personality disorder are often characterized by pessimism and selfdoubt and tend to belittle their abilities and assets. They take criticism and disapproval as proof of their worthlessness and lose faith in themselves. They may seek overprotection and dominance from others. Occupational functioning may be impaired if independent initiative is required. They may avoid positions of responsibility and become anxious when faced with decisions. Prevalence

Separation anxiety disorder in adults. Other mental disorders and medical conditions. Other personality disorders and personality traits. The estimated prevalence of dependent personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 0.6%. The prevalence of dependent personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions was 0.5%. A review of six epidemiological studies (four in the United States) found a median prevalence of 0.4%. Development and Course This diagnosis should be used with great caution, if at all, in children and adolescents, for whom dependent behavior may be developmentally appropriate. Culture-Related Diagnostic Issues The degree to which dependent behaviors are considered to be appropriate varies substantially across different age and sociocultural groups. Age and cultural factors need to be considered in evaluating the diagnostic threshold of each criterion. Dependent behavior should be considered characteristic of the disorder only when it is clearly in excess of the individual's cultural norms or reflects unrealistic concerns. An emphasis on passivity, politeness, and deferential treatment is characteristic of some societies and may be misinterpreted as traits of dependent personality disorder. Similarly, societies may differentially foster and discourage dependent behavior in males and females. Individuals with dependent personality disorder exhibit a pervasive inability to make decisions, continuous feelings of subjugation, lack of initiative, silence, and social distancing that are far in excess of usual cultural norms of politeness and purposeful passivity. Sex- and Gender-

Related Diagnostic Issues In clinical and community settings, dependent personality disorder has been diagnosed more frequently in women compared with men. **Differential Diagnosis** Adults with separation anxiety disorder are typically overconcerned about their offspring, spouses, parents, and pets, and experience marked discomfort when separated from them. In contrast, individuals with dependent personality disorder feel uncomfortable or helpless when alone because of exaggerated fears of being unable to take care of themselves. Dependent personality disorder must be distinguished from dependency arising as a consequence of other mental disorders (e.g., depressive disorders, panic disorder, agoraphobia) and as a result of other medical conditions. Other personality disorders may be confused with dependent personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to dependent personality disorder, all can be diagnosed.

Personality change due to another medical condition. Substance use disorders. Although many personality disorders are characterized by dependent features, dependent personality disorder can be distinguished by its predominantly submissive and clinging behavior and by the person's self-perception of not being able to function adequately without the help and support of others. Both dependent personality disorder and borderline personality disorder are characterized by fear of abandonment; however, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline personality disorder can further be distinguished from dependent personality disorder by a typical pattern of unstable and intense relationships. Individuals with histrionic personality disorder, like those with dependent personality disorder, have a strong need for reassurance and approval and may appear childlike and clinging. However, unlike dependent personality disorder, which is characterized by self-effacing and docile behavior, histrionic personality disorder is characterized by gregarious flamboyance with active demands for attention. Moreover, individuals with histrionic personality disorder typically have less insight regarding their underlying dependency needs than do people with dependent personality disorder. Both dependent personality disorder and avoidant personality disorder are characterized by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance; however, individuals with avoidant personality disorder have such a strong fear of humiliation and rejection that they withdraw until they are certain they will be accepted. In contrast, individuals with dependent personality disorder have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships. Many individuals display dependent personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute dependent personality disorder. Dependent personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are a direct physiological consequence of another medical condition. Dependent personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use. **Comorbidity** There may be an increased risk of depressive disorders, anxiety disorders, and adjustment disorders. Dependent personality disorder often co-occurs with other personality disorders, especially borderline, avoidant, and histrionic personality disorders. Chronic physical illness or persistent separation anxiety disorder in childhood or adolescence may

predispose the individual to the development of this disorder. Obsessive-Compulsive Personality Disorder

F60.5 Diagnostic Criteria A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met).
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
4. Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.

8. Shows rigidity and stubbornness. Diagnostic Features The essential feature of obsessive-compulsive personality disorder is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency. This pattern begins by early adulthood and is present in a variety of contexts. Individuals with obsessive-compulsive personality disorder attempt to maintain a sense of control through painstaking attention to rules, trivial details, procedures, lists, schedules, or form to the extent that the major point of the activity is lost (Criterion 1). They are excessively careful and prone to repetition, paying extraordinary attention to detail and repeatedly checking for possible mistakes, losing track of time in the process. For example, when such individuals misplace a list of things to be done, they will spend an inordinate amount of time looking for the list rather than spending a few moments trying their best to recreate it from memory and proceeding to accomplish the tasks. They dismiss the fact that other people tend to become very annoyed at the delays and inconveniences that result from this behavior because they preferentially respond to either their anxiety about making a mistake or their insistence on how things should be done. Time is poorly allocated, and the most important tasks are left to the last moment. The perfectionism and self-imposed high standards of performance cause significant dysfunction and distress in these individuals. They may become so involved in making every

detail of a project absolutely perfect that the project is never finished (Criterion 2). For example, the completion of a written report is delayed by numerous time-consuming rewrites that all come up short of "perfection." Deadlines are routinely missed or the individual has a pattern of exerting extraordinary effort (e.g., working through the night, skipping meals) in order to make the deadline at the last moment, and aspects of the individual's life that are not the current focus of activity

may fall into disarray. Individuals with obsessive-compulsive personality disorder display excessive devotion to work and productivity to the exclusion or devaluing of leisure activities and friendships (Criterion 3). This behavior is not accounted for by economic necessity. They often feel that they do not have time to take an evening or a weekend day off to go on an outing or to just relax. They may keep postponing a pleasurable activity, such as a vacation, so that it may never occur. When they reluctantly take time for leisure activities or vacations, they are very uncomfortable unless they have taken along something to work on so they do not “waste time.” There may be a great concentration on household chores (e.g., repeated excessive cleaning so that “one could eat off the floor”). If they spend time with friends, it is likely to be in some kind of formally organized activity (e.g., sports). Hobbies or recreational activities are approached as serious tasks or with methodical intensity, requiring careful organization and hard work to master. The emphasis is on perfect performance. These individuals turn play into a structured work-like task (e.g., correcting an infant for not putting rings on the post in the right order; telling a toddler to ride their tricycle in a straight line; turning a baseball game into a harsh “lesson”). Individuals with obsessive-compulsive personality disorder may be excessively conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (Criterion 4). They may force themselves and others to follow rigid moral principles and very strict standards of performance. They may also be mercilessly self-critical about their own mistakes or harshly judgmental of others’ moral or ethical missteps. Individuals with this disorder are rigidly deferential to authority and rules and insist on quite literal compliance, with no rule bending for extenuating circumstances. For example, the individual will not lend a dollar to a friend who is short of the fare needed to get on a bus because “neither a borrower nor a lender be” or because it would be “bad” for the friend’s character. These qualities should not be accounted for by the individual’s cultural or religious identification. Individuals with this disorder may be unable to discard worn-out or worthless objects, even when they have no sentimental value (Criterion 5). Often these individuals will admit to being “pack rats.” They regard discarding objects as wasteful because “you never know when you might need something.” The clutter may also result from an accumulation of partially read learning material or unfinished projects that the individual intends to get to someday but that have been sidelined because of procrastination and/or a meticulous yet slow work style. These individuals will become upset if someone tries to get rid of the things they have saved. Their spouses or roommates may complain about the amount of space taken up by old parts, piles of reading material, broken appliances, and so on. Individuals with obsessive-compulsive personality disorder are reluctant to delegate tasks or to work with others (Criterion 6). They stubbornly and unreasonably insist that everything be done their way and that people conform to their way of doing things. They often give very

detailed instructions about how things should be done (e.g., there is one and only one way to mow the lawn, wash the dishes, load the dishwasher, build a doghouse), even to the point of micromanaging others, and are surprised and irritated if others suggest creative alternatives. At other times they may reject offers of help even when behind schedule because they believe no one else can do it right. Individuals with this disorder may be miserly and stingy (having difficulty spending money on both themselves and others) and maintain a standard of living far below what they can afford, believing that spending must be tightly controlled to provide for future catastrophes (Criterion 7). Obsessive-compulsive personality disorder is characterized by rigidity and stubbornness (Criterion 8). Individuals with this disorder are so concerned about having things done the one “correct” way that they have trouble going along with anyone else’s ideas. These individuals plan ahead in meticulous detail and are unwilling to consider changes to these plans or

their usual routines. Totally wrapped up in their own perspective, they have difficulty acknowledging the viewpoints of others. Friends and colleagues may become frustrated by this constant rigidity. Even when individuals with obsessive-compulsive personality disorder recognize that it may be in their interest to compromise, they may stubbornly refuse to do so, arguing that it is “the principle of the thing.”

Associated Features When rules and established procedures do not dictate the correct answer, decision-making may become a time-consuming, often painful process (e.g., exhaustively researching options before making a purchase). Individuals with obsessive-compulsive personality disorder may have such difficulty deciding which tasks take priority or what is the best way of doing some particular task that they may never get started on anything. They are prone to become upset or angry in situations in which they are not able to maintain control of their physical or interpersonal environment, although the anger is typically not expressed directly. For example, an individual may be angry when service in a restaurant is poor, but instead of complaining to the management, the individual ruminates about how much to leave as a tip. On other occasions, anger may be expressed with righteous indignation over a seemingly minor matter. Individuals with this disorder may be especially attentive to their relative status in dominance-submission relationships and may display excessive deference to an authority they respect and excessive resistance to authority they do not respect. Individuals with this disorder have difficulty relating to and sharing emotions. For example, they may express affection in a highly controlled or stilted fashion and may be very uncomfortable in the presence of others who are emotionally expressive. Their everyday relationships have a formal and serious quality, and they may be stiff in situations in which others would smile and be happy (e.g., greeting a lover at the airport). They carefully hold themselves back until they are sure that whatever they say will be perfect. They may be preoccupied with logic and intellect and intolerant of displays of emotion in others. They often have difficulty expressing tender feelings, rarely paying compliments. Individuals with this disorder may experience occupational difficulties and distress, particularly when confronted with

Obsessive-compulsive disorder (OCD). Hoarding disorder. Other personality disorders and personality traits. new situations that demand flexibility and compromise.

Prevalence The estimated prevalence of obsessive-compulsive personality disorder based on a probability subsample from Part II of the National Comorbidity Survey Replication was 2.4%. The prevalence of obsessive-compulsive personality disorder in the National Epidemiologic Survey on Alcohol and Related Conditions was 7.9%. A review of five epidemiological studies (three in the United States) found a median prevalence of 4.7%.

Culture-Related Diagnostic Issues In assessing an individual for obsessive-compulsive personality disorder, the clinician should not include those behaviors that reflect habits, customs, or interpersonal styles that are culturally sanctioned by the individual’s reference group. Certain cultural communities place substantial emphasis on work and productivity, and some members of sociocultural groups (e.g., certain religious groups, professions, migrants) may at times rigidly embrace codes of conduct; work demands; restrictive social environments; rules of behavior; or standards that emphasize overconscientiousness, moral scrupulosity, and striving for perfectionism that may be reinforced by norms of the cultural group. Such behaviors should not on their own be considered indications of obsessive-compulsive personality disorder.

Sex- and Gender-Related Diagnostic Issues In large population-based studies, obsessive-compulsive personality disorder appears to be equally prevalent in men and women.

Differential Diagnosis Despite the similarity in names, OCD is usually easily distinguished from obsessive-compulsive personality disorder by the presence of true obsessions and compulsions in

OCD. When criteria for both obsessive-compulsive personality disorder and OCD are met, both diagnoses should be recorded. A diagnosis of hoarding disorder should be considered especially when hoarding is extreme (e.g., accumulated stacks of worthless objects present a fire hazard and make it difficult for others to walk through the house). When criteria for both obsessive-compulsive personality disorder and hoarding disorder are met, both diagnoses should be recorded. Other personality disorders may be confused with obsessive-compulsive personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to obsessive-compulsive personality disorder, all can be diagnosed. Individuals with narcissistic personality disorder may also profess a commitment to perfectionism and believe that others cannot do

Personality change due to another medical condition. Substance use disorders. F07.0 things as well, but these individuals are more likely to believe that they have achieved perfection, whereas those with obsessive-compulsive personality disorder are usually self-critical. Individuals with narcissistic or antisocial personality disorder lack generosity but will indulge themselves, whereas those with obsessive-compulsive personality disorder adopt a miserly spending style toward both self and others. Both schizoid personality disorder and obsessive-compulsive personality disorder may be characterized by an apparent formality and social detachment. In obsessive-compulsive personality disorder, this stems from discomfort with emotions and excessive devotion to work, whereas in schizoid personality disorder there is a fundamental lack of capacity for intimacy. Obsessive-compulsive personality traits in moderation may be especially adaptive, particularly in situations that reward high performance. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute obsessive-compulsive personality disorder. Obsessive-compulsive personality disorder must be distinguished from personality change due to another medical condition, in which the traits are a direct physiological consequence of another medical condition. Obsessive-compulsive personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use. Comorbidity Individuals with anxiety disorders (e.g., generalized anxiety disorder, separation anxiety disorder, social anxiety disorder, specific phobias) and OCD have an increased likelihood of having a personality disturbance that meets criteria for obsessive-compulsive personality disorder. Even so, it appears that the majority of individuals with OCD do not have a pattern of behavior that meets criteria for this personality disorder. Many of the features of obsessive-compulsive personality disorder overlap with "type A" personality characteristics (e.g., preoccupation with work, competitiveness, time urgency), and these features may be present in individuals at risk for myocardial infarction. There may be an association between obsessive-compulsive personality disorder and depressive and bipolar disorders and eating disorders. Other Personality Disorders Personality Change Due to Another Medical Condition Diagnostic Criteria A. A persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern. Note: In children, the disturbance involves a marked deviation from normal development or a significant change in the child's usual behavior patterns, lasting

at least 1 year. B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition. C.

The disturbance is not better explained by another mental disorder (including another mental disorder due to another medical condition). D. The disturbance does not occur exclusively during the course of a delirium. E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify whether: Labile type: If the predominant feature is affective lability. Disinhibited type: If the predominant feature is poor impulse control as evidenced by sexual indiscretions, etc. Aggressive type: If the predominant feature is aggressive behavior. Apathetic type: If the predominant feature is marked apathy and indifference. Paranoid type: If the predominant feature is suspiciousness or paranoid ideation. Other type: If the presentation is not characterized by any of the above subtypes. Combined type: If more than one feature predominates in the clinical picture. Unspecified type Coding note: Include the name of the other medical condition (e.g., F07.0 personality change due to temporal lobe epilepsy). The other medical condition should be coded and listed separately immediately before the personality change due to another medical condition (e.g., G40.209 temporal lobe epilepsy; F07.0 personality change due to temporal lobe epilepsy). Subtypes The particular personality change can be specified by indicating the symptom presentation that predominates in the clinical presentation. Diagnostic Features The essential feature of a personality change due to another medical condition is a persistent personality disturbance that is judged to be a physiological consequence of another medical condition. The personality disturbance represents a change from the individual's previous characteristic personality pattern. In children, this condition may be manifested as a marked deviation from normal development rather than as a change in a stable personality pattern (Criterion A). There must be evidence from the history, physical examination, or laboratory

Chronic medical conditions associated with pain and disability. Delirium or major neurocognitive disorder. findings that the personality change is the direct physiological consequence of another medical condition (Criterion B). The diagnosis is not given if the disturbance is better explained by another mental disorder (Criterion C). The diagnosis is not given if the disturbance occurs exclusively during the course of a delirium (Criterion D). The disturbance must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E). Common manifestations of the personality change include affective instability, poor impulse control, outbursts of aggression or rage grossly out of proportion to any precipitating psychosocial stressor, marked apathy, suspiciousness, or paranoid ideation. The phenomenology of the change is indicated using the subtypes listed in the criteria set. An individual with the disorder is often characterized by others as "not himself [or herself]." Although it shares the term "personality" with the other personality disorders, this diagnosis is distinct by virtue of its specific etiology, different phenomenology, and more variable onset and course. The clinical presentation in a given individual may depend on the nature and localization of the pathological process. For example, injury to the frontal lobes may yield symptoms such as lack of judgment or foresight, facetiousness, disinhibition, and euphoria. In this example, the diagnosis of personality change due to frontal lobe injury would be made if a persistent personality disturbance is a deviation from the individual's previous characteristic personality pattern prior to the injury (Criterion A). Right hemisphere strokes have often been shown to evoke personality changes in association with unilateral spatial neglect, anosognosia (i.e., inability of the individual to recognize a bodily or functional deficit, such as the existence of hemiparesis), motor impersistence, and other neurological deficits. Associated Features A variety of neurological and other medical conditions may cause personality changes, including central nervous system neoplasms, head trauma,

cerebrovascular disease, Huntington's disease, epilepsy, infectious conditions with central nervous system involvement (e.g., HIV), endocrine conditions (e.g., hypothyroidism, hypo- and hyperadrenocorticism), and autoimmune conditions with central nervous system involvement (e.g., systemic lupus erythematosus). The associated physical examination findings, laboratory findings, and patterns of prevalence and onset reflect those of the neurological or other medical condition involved. Differential Diagnosis Chronic medical conditions associated with pain and disability can also be associated with changes in personality. The diagnosis of personality change due to another medical condition is given only if a direct pathophysiological mechanism can be established. This diagnosis is not given if the change is due to a behavioral or psychological adjustment or response to another medical condition (e.g., dependent behaviors that result from a need for the assistance of others following a severe head trauma, cardiovascular disease, or dementia). Personality change is a frequently associated feature of a

Another mental disorder due to another medical condition. Substance use disorders. Other mental disorders. Other personality disorders. delirium or major neurocognitive disorder. A separate diagnosis of personality change due to another medical condition is not given if the change occurs exclusively during the course of a delirium. However, the diagnosis of personality change due to another medical condition may be given in addition to the diagnosis of major neurocognitive disorder if the personality change is judged to be a physiological consequence of the pathological process causing the neurocognitive disorder and if the personality change is a prominent part of the clinical presentation. The diagnosis of personality change due to another medical condition is not given if the disturbance is better explained by another mental disorder due to another medical condition (e.g., depressive disorder due to brain tumor). Personality changes may also occur in the context of substance use disorders, especially if the disorder is long-standing. The clinician should inquire carefully about the nature and extent of substance use. If the clinician wishes to indicate an etiological relationship between the personality change and substance use, the other specified category for the specific substance can be used (e.g., other specified stimulant-related disorder with personality change). Marked personality changes may also be an associated feature of other mental disorders (e.g., schizophrenia; delusional disorder; depressive and bipolar disorders; other specified and unspecified disruptive behavior, impulse-control, and conduct disorders; panic disorder). However, in these disorders, no specific physiological factor is judged to be etiologically related to the personality change. Personality change due to another medical condition can be distinguished from a personality disorder by the requirement for a clinically significant change from baseline personality functioning and the presence of a specific etiological medical condition. Other Specified Personality Disorder F60.89 This category applies to presentations in which symptoms characteristic of a personality disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the personality disorders diagnostic class. The other specified personality disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific personality disorder. This is done by recording "other specified personality disorder" followed by the specific reason (e.g., "mixed personality features").

Unspecified Personality Disorder F60.9 This category applies to presentations in which symptoms characteristic of a personality disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the personality disorders diagnostic class. The unspecified

personality disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific personality disorder and includes presentations in which there is insufficient information to make a more specific diagnosis.

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