Chapter 22: Personality Disorders

Janine Stevenson

Specialty of Psychiatry, The University of Sydney, Australia.

and

Lisa Lampe

School of Medicine and Public Health, The University of Newcastle, Australia.

Introduction

Patients with personality disorders present for treatment in all medical settings, and every medical practitioner will encounter such patients frequently. People with personality disorders have problems with interpersonal relationships that can affect their interactions with health professionals. Having a comorbid personality disorder is a strong predictor of poor treatment outcome, a cause of premature mortality and a great cost to society.

What is a Personality Disorder?

Personality disorders are generally described as a pervasive and consistent pattern of maladaptive traits, cognition, inner experience and behaviours evident by adolescence or early adult life, leading to substantial personal distress or social dysfunction or both, and disruption to others. The individual thinks about himself/herself, others and their relationships, and acts in interpersonal situations in ways that cause distress and impairment.

To make a diagnosis of personality disorder the maladaptive patterns must be life-long or of many years duration and must be consistent across time and situations. The maladaptive thinking or behaviour must not be limited to times where the individual is unwell with some other illness, such as depression, or experiencing severe stress. We all can display difficult personality traits when

stressed. It only becomes a disorder if it is persistent and affects the individual in a negative way or affects others who encounter the individual.

Diagnostic Criteria for Personality Disorder

An enduring pattern of inner experience and behaviour 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.

Classification

There is disagreement among experts regarding whether personality disorders are best classified categorically or dimensionally. In categorical systems of classification (such as in DSM-5), people are described as having clusters of traits that form a recognizable pattern, for example, a dependent personality, a schizoid personality or a borderline personality. When the person's symptoms meet criterion level on a minimum number of criteria they are diagnosed as having that personality disorder. However, there is considerable overlap between these categories, so that severe personality disorder seems to be manifest as multiple pathologies. An alternative way of classifying personality disorders is a dimensional system utilising trait-based personality theory. The five-factor model (FFM) is arguably the best-supported dimensional system and classifies people on five traits each on a continuum: extraversion, openness to experience, conscientiousness, agreeableness, and neuroticism, each person being somewhere on the continuum for each of these traits.

The DSM-5 categorical classification identifies general features of a personality disorder (see box above) and then distinguishes 10 categories of

personality disorder divided into 3 clusters: Cluster A (paranoid, schizoid and schizotypal), Cluster B (antisocial, borderline, histrionic and narcissistic), and Cluster C (avoidant, dependent, and obsessive-compulsive). The evidence informing the categories and clusters is limited, and decisions are based more on consensus and opinion. The available evidence supports some aspects of these clusters but fails to support the validity of other aspects. DSM-5 also includes an 'alternative model for personality disorders' which sees personality disorders in terms of impairment in personality functioning – deficiencies in self-functioning (self-awareness and self-directedness); or interpersonal functioning (empathy, intimacy, and mutual understanding), or both; essential elements in the capacity of an individual to form good relationships. This model acknowledges the severity of the disorder (the best predictor of outcome) and the form or style of personality pathology, which are represented as traits that lie on dimensions from normality to frank disorder.

The ICD-11 classification abolishes all type-specific categories of personality disorder, identifying simply the presence or absence of personality disorder itself. Different degrees of severity are defined (this can fluctuate over time), and this can be qualified by a description of domain traits (negative affective features, dissocial features, disinhibition, anankastic features, and detachment). Four dimensions have been suggested in ICD-11 to cover the range of personality disorder: emotional dysregulation (vs stability), extraversion (vs introversion), antagonism (vs compliance), and constraint (vs impulsivity).

Epidemiology

Prevalence and Demographics

Community-based surveys in western countries report a prevalence rate of individuals with personality disorders of 12.16% (95% CI 8.01 – 17.02%) (Volkert et al., 2018). A quarter of patients in primary care have been reported to have personality disorder, 50% of psychiatric outpatients, and an even greater proportion of psychiatric inpatients (Stevenson et al., 2011b). There are some gender and cultural differences. Antisocial personality disorder (ASPD) is more prevalent in males while borderline personality disorder is more prevalent in females. There are higher rates in urban areas for all personality disorders than rural areas and two-thirds of prisoners have a personality disorder (predominantly antisocial and borderline). Narcissistic personality disorder is reportedly more prevalent in Western than Eastern countries.

Age at Onset

The manifestations of a personality disorder are usually evident by adolescence or early adulthood, and generally become manifest under stress, depending on current supports and pressures. Complexity and severity usually diminish in older adults, who display less neuroticism (negative affectivity) generally. Although personality disorder is considered to be a lifelong diagnosis, the severity and form of the disorder typically fluctuate over time, depending on many factors. Recognition of the fluctuating nature of the disorder should help de-stigmatisation of the diagnosis.

Implications of Personality Disorder/ Burden of Disease

Personality disorder is associated with both higher morbidity and mortality. Life expectancy is shorter by 13.3 years for women and 15.5 years for men (suicide and homicide, but also increased cardiovascular and respiratory diseases, poor relationships with health professionals, smoking, alcohol and drug abuse) (Chan et al., 2023).

The presence of a personality disorder is a risk factor for developing another psychiatric disorder such as major depression, anxiety and substance use disorders, and typically has a negative effect on treatment outcome. The presence of more than one personality disorder confers more burden. Some personality disorders show a genetic relationship to other psychiatric illnesses, for example, increased rates of schizophrenia have been reported in the first-degree relatives of persons with schizotypal and paranoid personality disorders (Kendler et al., 1993). Comorbid anxiety disorders are common in Cluster C personality disorders, and comorbid depression in avoidant personality disorder.

The overriding issues for people with a personality disorder are relationship problems. The person with the personality disorder is usually unable to recognise a problem in themself and so projects the blame onto others, leading to problems with intimacy, difficulties relating to professionals, inability to function well at work and social isolation. Repeated self-harm is frequent in borderline personality disorder, and impulsive risk-taking in borderline and antisocial personality disorders, contributing to the burden of disease. This propensity for risk taking and substance use increases the likelihood that people with these personality disorders will come in contact with health professionals.

Be aware that personality disorder cannot be diagnosed in the absence of distress or significant impairment. For example, a person with a schizoid personality might be quite comfortable working as a computer programmer at home alone but

could become acutely distressed at having to work in an office among other people, in which case they would be described as having a personality disorder.

Coping Strategies

An Australian study of 240 psychiatric inpatients aged from 18-100 demonstrated that patients with personality disorder used more dysfunctional coping strategies (denial, drug and alcohol abuse, projection, avoidance etc) than patients without personality disorder. The latter used more active and effective coping strategies (facing the problem to do something about it) and seeking support from others (Stevenson et al., 2012).

Risk/Vulnerability Factors (Aetiology)

Biological

There is a large genetic component predisposing a person to develop a personality disorder (probably up to about 50%; (Kendler et al., 2008; Reichborn-Kjennerud, 2010; Torgersen, 2009) but environment, particularly early attachment relationships, plays an important but variable role, depending if it is nurturing and supportive or disruptive and traumatic.

There have been some neurobiological theories postulated. Individual differences in the regulation and organization of cognitive processes, affective reactivity, impulse / action patterns, and anxiety may, in the extreme, provide susceptibility to personality disorders such as borderline and schizotypal personality disorder. A low threshold for impulsive aggression, as observed in borderline and antisocial personality disorders, may be related to excessive amygdala reactivity, reduced prefrontal inhibition, and diminished serotonergic facilitation of prefrontal controls. Affective instability may be mediated by excessive limbic reactivity in GABAergic/glutaminergic/cholinergic circuits, resulting in an increased sensitivity or reactivity to environmental emotional stimuli as in borderline personality disorder and other Cluster B personality disorders.

Disturbances in cognitive organization and information processing may contribute to the detachment, desynchrony with the environment, and cognitive/perceptual distortions of Cluster A or schizophrenia spectrum personality disorders. Epigenetic remodelling of glucocorticoid receptor genes in response to stress has also been proposed as a mechanism for how the environment can interact with the genome contributing to long term changes in behaviour (Bagot and Meaney, 2010). Brain trauma, pre or postnatally can result in personality dysfunction.

Culture/Social Processes

Personality can also be shaped by culture, such that someone who fits well in their own culture might be considered aberrant in another (e.g. Zulu versus Amish societies; the withdrawn and restrained Asian versus the outgoing, exuberant Australian). Social processes, our cognitive/perceptual organisation, and heritable temperamental traits such as affective instability and proneness to impulsivity/aggression all influence personality.

Psychological

Childhood abuse or neglect increased the risk of developing a personality disorder by four times in one study (Johnson et al, 1999). People with borderline personality disorder frequently have a history of emotional, physical or sexual abuse or neglect. A major life crisis, such as suddenly becoming disabled can also result in personality change.

Attachment

Attachment represents another intensive area of study in personality disorder and forms the basis of some treatment approaches. A disorder of attachment to the carer is common. The infant/child looks to the carer for caring and protection, but a carer who is unreliable, erratic, devaluing or frankly abusive can disrupt attachment (see Chapter 13). Attachment style forms an important basis for future relationships. Children require security in their early caregiver relationships, and sufficient emotional attunement and nurturing to develop their capacity to self-soothe when distressed. Without security, consistency, validation and affection it is likely that individuals will struggle to develop a positive sense of self and adaptive strategies for coping with loss and distress (see Chapter 13).

Presentation

Individuals with personality disorders may present due to the distress experienced directly from their maladaptive thoughts or emotional disturbance (e.g., depressed mood or anxiety, suicidal ideation), because of associated behaviours (e.g. self-harming) or the responses of others (criticism or rejection), or because of complications arising from their attempts to manage their problems (e.g. substance misuse). They often present with mental disorders, especially with depressive or anxiety disorders, eating disorders, but they can also present with relationship issues, marital problems, difficulties at work or attempted suicide or deliberate self-harm.

Assessment

The assessment of a patient's personality functioning requires a detailed personal and developmental history. It is critical in establishing that the symptoms with which the person presents, although possibly more severe and acute than usual, are typical of their long-term functioning. But note that some personality disorders can manifest late if they have previously been compensated; for example, a dependent woman who copes until her husband dies and then her neediness manifests itself. Also be wary of diagnosing a personality disorder in the presence of another psychiatric disorder; for example, if the woman with dependent traits was experiencing a major depressive illness, we would need consider whether some of her apparent dependent behaviours are not in fact due to the loss of confidence, concentration and clarity of thinking associated with her depression. More than one assessment may be needed, as well as collaborative history from a relative or friend.

Semi-structured interviews typically take 1h-2h to complete and even self-rating instruments take a long time. Semi-structured instruments administered by a clinician are the most reliable, but all such instruments tend to over diagnose, and clinical assessment tends to under diagnose.

Obtaining a collateral history is important. Comorbidities must be explored as well as the burden of symptoms, for example, has there been a likely adverse impact on social and occupational functioning? There are no essential medical investigations for personality disorder but there may be for any comorbidity such as an eating disorder, or for any impacts of self-harm or risk-taking behaviour (e.g., drug use, unprotected sex).

Factors to elicit from history

- History of abuse (physical, sexual, psychological) or neglect
- Difficulties with interpersonal relationships
- Problems maintaining employment
- Dysfunctional coping strategies
- History of self-harm/ suicidality
- Lack of a sense of identity
- Emotional dysregulation
- Impulsivity
- Lack of empathy

Diagnosis

People with personality disorders do not usually present for treatment of their personality disorder but with symptoms such as depression, anxiety, or in the case of borderline personality disorder, often with recurrent self-harm. Therefore, it is important to have your mind open to the possibility of an underlying personality disorder. Ask yourself the questions: does this person have a treatment-resistant disorder? Consider especially the person's long-term functioning. Does this person have relationship problems? Difficulty working? Is this simply a cultural difference? Is this person displaying personality traits but no impairment in functioning? A narrative approach to history taking (get the person to tell their life story) is often helpful.

Threshold for diagnosis varies with the particular personality disorder, but it is the extent of interference with intrapersonal and interpersonal function that determines whether the patterns of thinking and behaviour represent traits or disorder. Keep in mind the difficulty of diagnosing personality disorder in the context of acute psychiatric illness, for example psychosis, major depression, substance dependence/intoxication/withdrawal. Be aware that behaviours could also be due to some other cause, for example cognitive impairment, intellectual disability, stage of development, cultural difference, or acute stress.

Clues to a diagnosis of personality disorder

- Multiple emergency presentations
- Conflicted opinions about the patient (splitting)
- Chaos in the patient's life
- Negative counter-transference reactions
- Negative self-image
- Inappropriate anger
- History of dysfunction in occupational settings
- History of unhappy or failed relationships

As stated above, DSM-5 describes 10 subtypes (see Table 22.1): antisocial, avoidant, borderline, dependent, histrionic, narcissistic, obsessive-compulsive, paranoid, schizoid, schizotypal; and a group of 'other personality disorders' which includes personality change due to a general medical condition, and 'other specified personality disorder' and 'unspecified personality disorder' (where symptoms characteristic of one or more personality disorders are present, together with

distress and impairment, but criteria are not met for any specific personality disorder).

Significant problems with the categorical approach to personality disorder diagnosis, including arbitrary diagnostic thresholds, extensive overlap among categories, lack of evidence for 10 distinct categories, and insufficient clinical utility have led the 11th edition of the International Classification of Diseases (ICD-11) to adopt a dimensional approach to the classification of personality disorders.

Table 22.1 Personality disorder subtypes in DSM-5

Personality Type	Description
Cluster A	
Paranoid personality	Distrusting, suspicious, malevolent perception of others
Schizoid personality	Social detachment, restricted emotional range
Schizotypal personality	Eccentric, odd beliefs, discomfort with intimacy
Cluster B	
Narcissistic personality	Grandiosity, exhibitionism, lacking empathy
Antisocial personality	Disregard for and violation of others' rights, lack of guilt, narcissism
Borderline personality	Unstable interpersonal relationships, self-image and affect, emotional dysregulation, impulsivity
Histrionic personality	Attention-seeking, excessive emotionality
Cluster C	
Avoidant personality	Excessive sensitivity to negative evaluation, feelings of inadequacy, social inhibition and avoidance
Dependent personality	Submissive, clingy, needy, avoids decisions
Obsessional personality	Preoccupied with rules, likes to be in control, perfectionism

The lack of clear boundaries between types of personality disorder, state vs trait factors (temporary versus lifelong) and poor agreement among clinicians is leading towards a general diagnosis of "personality disorder" based on the problems and disabilities characteristic of personality disorders, with some description of traits. They refer to a diathesis or vulnerability model (rather than a disorder model) conferring a tendency to develop other psychiatric disorders or abnormal behaviours. Exacerbation occurring in response to a stressful event is consistent with

the stress diathesis model. Social dysfunction persists and persistent maladaptation is seen as the core of the condition.

The ICD-11 classification of personality disorders focuses on core personality dysfunction, while allowing the practitioner to classify three levels of severity (Mild Personality Disorder, Moderate Personality Disorder, and Severe Personality Disorder) and the option of specifying one or more prominent trait domain qualifiers (Negative Affectivity, Detachment, Dissociality, Disinhibition, and Anankastia). Additionally, the practitioner is also allowed to specify a Borderline Pattern qualifier.

Differential Diagnosis

At times, a person with a psychiatric disorder can behave in a manner which may suggest personality disorder because of dysfunctional interpersonal interactions, but which fully resolves when the acute disorder is treated. This is referred to as "state dependent personality dysfunction". It does not mean the person has an enduring disturbance of personality, but that they have decompensated under stress or the effects of the primary mental disorder. There may be diagnostic uncertainty around schizotypal personality and schizophrenia. The presence of delusions rather than overvalued ideas, and hallucinations should point to a diagnosis of schizophrenia, and longitudinally there would usually be evidence of functional decline, and deficit symptoms such as apathy and amotivation.

Social phobia and avoidant personality look similar and may in fact represent variations of the same spectrum. Anxiety symptoms are generally more prominent in social phobia, and the sense of inferiority more pervasive in avoidant personality disorder. DSM-5 allows both diagnoses to be given. A mood disorder with low mood, self-harm, and social withdrawal can appear similar to borderline personality disorder. Mood symptoms are common in a borderline personality disorder, but the depressive states tend to be more transient, reactive and angry.

PTSD with depressed mood, anger, relationship problems, substance abuse and inability to work can look like borderline personality disorder. The history should usually identify a traumatic stress. Diagnostic difficulties can arise with 'complex PTSD', where an individual experienced sustained abuse over a period of time. Some patients will have symptoms of both disorders.

Personality change can be linked to brain pathology caused by medical conditions such as systemic lupus erythematosus (SLE), encephalitis, and acquired immunodeficiency syndrome (AIDS). Substance abuse can affect personality, both

acutely and with chronic use. Substance abuse is also common in personality disorders characterised by impulsivity.

State Dependent Personality Dysfunction

People who show evidence of personality pathology only when suffering a symptom disorder, which disappears when the symptom disorder is treated are considered to have a state dependent personality disorder only, for example someone who displays self- harming behaviour, impulsive acts, angry mood and relationship problems while suffering from major depression and not when well. They could also be considered to lie along the spectrum from "normal" to "severe personality disorder" or be said to have a personality diathesis (Tyrer and Tyrer, 2015).

Borderline Personality Disorder

This personality disorder is dealt with in more detail as it is likely to be the most commonly encountered and most problematic personality problem in medical practice.

Symptoms include:

- **impulsivity** (self-harming, drug abuse, reckless driving, eating disorders).
- **mood instability (emotional dysregulation)** with frequent fluctuations from depression, anger, anxiety, and temporary euphoria. This can at times look like bipolar disorder and is often misdiagnosed as such (though both can occur together).
- **black and white** thinking (someone is all good (idealized) or all bad (devalued) which can lead to
- **splitting**, especially in the inpatient situation where staff develop very different opinions and behaviour towards a patient which can cause clashes between staff if not recognized.
- frequent changes regarding **relationships** with one person being a friend this week and rejected the next because of some perceived injustice.
- **identity** issues are common, for example feeling empty, unsure of sexual orientation, future plans, often a noxious sense of self,
- **intolerance of being alone/ severe separation anxiety**; frequent **altercations** –arguments, fights, recurrent accidents.
- chronic **anger** and angry outbursts out of proportion to the trigger**.**

Patients with borderline personality disorder have frequent presentations to emergency departments with self- harm or serious suicide attempts. They present for surgery after ingesting sharp objects; they present to their general practitioner with multiple somatic complaints. Because of difficulty with trust, they can anticipate rejection and easily interpret responses as critical or rejecting which can lead them to be aggressive and abusive to medical staff, often complaining and uncooperative with care. Counter-transference reactions (emotional reactions to the patient and/or their behaviour) of staff are often negative and can be neglectful. It is important to react with empathy, realising that these patients are not deliberately difficult, as their traumatic childhood experiences, lacking nurturing and support, have communicated a hostile world where there is no-one to trust. Listening to their concerns, understanding their pain is the better approach. There is also the danger of a positive countertransference to an idealizing (or "seductive") patient who then becomes "special". Appropriate, consistent boundaries should be set, never wavering from the patient/doctor relationship. Apparent kindness can be misinterpreted as a special friendship, and there are cases where patients have intruded into health care workers' lives, a situation, which ends badly for both.

The intrinsic symptoms of borderline personality disorder – chronic angry dysphoria, self-harm, relationship difficulties – often prompt help-seeking. Whatever area of medicine you enter you will encounter these patients. Failure to recognize the problem can result in poor rapport, non-compliance, either idealization or vexatious complaints and a difficult relationship. As a result, the individual will receive less than optimal medical care and be at risk of reduced quality of life and life expectancy.

Evidence Based Treatments

Outcome Studies

Psychotherapy has a long tradition dating from Freud and Jung. The publication of DSM-III in 1980 provided a stimulus for the development of psychotherapies to treat personality disorders, particularly borderline personality disorder, given its prominence in acute psychiatric presentations. Subsequently, most studies examining the effectiveness of psychotherapy in personality disorder have focused on the treatment of borderline personality disorder

Marsha Linehan in the USA introduced dialectical behaviour therapy (DBT). Bateman and Fonagy in the UK introduced mentalization-based therapy. Interpersonal psychotherapy was developed by Klerman and Weissman, and in Australia the Conversational model of psychodynamic psychotherapy was developed by Russell Meares (Meares, 2004; Stevenson and Meares, 1992). Schema-focussed

therapy was developed by Jeffery Young. Acceptance and Commitment Therapy by Hayes, Strosahl and Wilson. All these forms of therapy have been shown to have efficacy in treating borderline personality disorder in clinical trials.

Dialectical Behaviour Therapy

Marsha Linehan developed a treatment program for young, suicidal, self-harming women (Linehan et al., 1991). An offshoot of cognitive behaviour therapy, the approach is a highly structured, directive, individual and group therapy format that seeks to teach patients general problem-solving skills, emotional regulation strategies, interpersonal skills, and distress tolerance. The strategies and techniques are outlined in manual form.

The group treatment is organised didactically, divided into 16 weekly modules with an emphasis on experiential learning through formal instruction, modelling, behavioural and cognitive rehearsal, cognitive restructuring, interpersonal feedback, reinforcement, and homework assignments. The therapy is aimed at teaching the individual new coping and problem-solving skills and helping them tolerate and find meaning as it currently exists in their life. It has the best evidence base for its effectiveness (Stoffers-Winterling et al., 2022).

Schema-Focused Therapy

Schema-focused therapy can be done individually or in a group (Clarkin et al., 2006). It can help to identify unmet needs that have led to negative life patterns, which at one time may have been helpful for survival, but as an adult are hurtful in many areas of their life. Therapy focuses on helping the person get their needs met in a healthy manner to promote positive life patterns. It integrates elements of cognitive therapy, behaviour therapy, object relations, and gestalt therapy into one unified systematic approach that focuses on maladaptive schemas. Schema therapy is easily applicable to Cluster C personality disorders as well as borderline personality disorder and is noted to be effective across a number of personality disorders (Zhang et al., 2023).

Mentalization-Based Psychotherapy

Mentalization-Based Psychotherapy (MBT) aims to increase mentalization capacity, leading to better affect regulation and interpersonal relationships (Bateman and Fonagy, 1999). Mentalization refers to the capacity to represent feelings in the mind, and to connect behaviours, events, feelings and thoughts. Often patients with personality damage lack the capacity to imagine what is in the mind of another person, what they might be feeling. Mentalization is a process by which patients

learn to think about others and themselves before acting. The aims of MBT are to improve behavioural control and affect regulation as well as to foster better relationships. It serves to stabilize the patient's sense of self and to enhance stability in emotions and relationships.

Transference-Focused Psychotherapy

There are many transference-focused psychotherapies that are based upon a psychodynamic approach to treatment. It is presumed that there has been an arrest in development at an early stage of life due to emotionally traumatic events during childhood (Clarkin et al., 2006). The approach is maturational, resulting in the development of a more mature, realistic, and flexible sense of self and others, and more coherent sense of self-identity. The therapist helps the patient build a positive sense of self, and well-being involving validation of their experience. This is then followed by dealing with the trauma and integrating it into the person's narrative. Although these treatments are known by a confusing range of terms and acronyms and have seldom been subjected to a randomised controlled trial there is an evidence base that supports their use as another possible treatment approach to borderline personality disorder (Setkowski et al., 2023).

General Psychiatric Management

Developed by Gunderson who views personality disorders in terms of disturbed attachment, symptoms are taken to indicate maladaptive ways of coping with emotional distress. Gunderson developed General Psychiatric Management after noting that less intensive and easier-to-learn therapies could be nearly as effective as more intensive psychotherapies and more accessible to more patients. General Psychiatric Management includes case management, encouragement of emotional processing, and relational management (Smith et al., 2001). Gunderson describes this therapy as a once-weekly, generalist model that medicalizes borderline personality disorder, emphasizes psychoeducation, and focuses on social adaptation (Gunderson et al., 2018).

Systems Training for Emotional Predictability and Problem-Solving (STEPPS)

STEPPS was developed with an assumption that personality disorder reflects dysfunctional ways of dealing with emotions. It is a group intervention that helps patients develop better ways of dealing with emotions (Black et al., 2013; Stoffers-Winterling et al., 2022).

Common Features

All these treatments include a clear, detailed and mutually agreed upon treatment framework in terms of appointment times, fees, cancellation policy, and termination policy. Secondly, all treatments pay close attention to the emotional experiences of patients. All therapies focus on the quality of the treatment relationship and assign an active role to the therapist who is encouraged to be mentally and emotionally engaged with the patient. They encourage exploratory interventions and change-oriented interventions. Use of interpretations in a strict psychoanalytic sense is not encouraged, nor is advice giving. All encourage support for the therapist (e.g., supervision with an experienced peer).

Partial Hospitalisation and Step-Down Treatments

This allows more containment during crises without the patient developing emotional dependence on the hospital environment. The patient attends during the day and goes home at night. The program involves psychoeducation, learning and practising better coping strategies, individual therapy and support. The next step down is to less frequent outpatient care, group programs and social support, followed by weekly individual therapy, which may last one year or more.

Medication

Medication is not indicated as a first line treatment for personality disorder, but may be needed for comorbid symptom disorders (Bohus et al., 2021). Antidepressants may be useful for comorbid major depression and sometimes for the dysthymia commonly comorbid with personality disorders, perhaps especially borderline personality disorder and avoidant personality disorder.

Medications are also commonly used to alleviate specific symptoms experienced in personality disorders, although there is no evidence that they improve overall outcome. SSRIs may be useful to treat anxiety. Anticonvulsants, such as sodium valproate and carbamazepine may help control the anger felt by people with borderline and antisocial personality disorder. Antipsychotics help manage aggression and psychotic symptoms.

Benzodiazepines are not recommended because of the risk of disinhibition (especially in antisocial personality disorder), misuse and dependence. In practice it is common to see patients with personality disorder who are already taking an antidepressant, an antipsychotic, a mood stabilizer, and one or more benzodiazepines – the polypharmacy attesting to the fact that medications have not helped, yet trials of medication are repeated relentlessly.

Crisis Management

Patients present in crisis when their usual defences fail, resulting in suicide attempts, self- harm, failure to cope. Deliberate self-harming (cutting, burning, overdosing) may occur without suicidal intent, driven by painful emotions and memories. Physical pain may relieve emotional pain albeit temporarily. Individuals may also attempt (and often succeed) suicide when feeling hopeless and overwhelmed by emotional pain, failed relationships and other social stressors. Patients with borderline personality disorder are the most likely to present to an emergency department after an overdose, cutting, burning or mutilating themselves in some other way. They act impulsively and are often also involved in car accidents or other reckless behaviour. Drug abuse and misuse and dependence is also common.

It is vitally important to be empathic, not condemning or critical of their behaviour, for that compounds their already high levels of distress and intensely negative self-concept. Unfortunately, critical and rejecting responses are common from emergency staff, who may see the same person come in again and again with self-harming. It is likely that staff feel frustrated at the apparent inability of the person to learn better coping strategies, and perhaps at their own seeming impotence to make a difference.

Be mindful that this is most likely a person who experienced significant adversity in childhood and on into adult life. This behaviour may be the only strategy they know to manage their symptoms, the physical pain masking the emotional pain for a short time, sometimes to prove to themselves that they are alive, that they actually exist (feelings of emptiness are common in borderline personality disorder), and sometimes to punish themselves, consistent with a view of worthlessness or feelings of guilt. It is important to listen, and hear their story so that they feel heard, and to validate their feelings. Treat them with respect, give them time, help them deescalate, treat their physical needs gently and carefully and seek psychiatric review. The person should also receive a follow-up appointment with a member of the mental health team within a couple of days. This is ideally followed by an arrangement for more long-term therapy to treat the underlying personality disorder. Treatment of comorbidities such as substance abuse and dependence, anorexia, mood disorders, and anxiety must also be considered.

Outcome/Prognosis

Stability of Diagnosis and Impairment

Longitudinal work suggests that people diagnosed with antisocial, avoidant, borderline, histrionic, and schizotypal personality disorders are likely to continue to meet these diagnoses for many years. However, research has also underscored the

potential for ongoing personality change and maturation (Nestadt et al., 2010). Maturity and life experience, good relationships, and therapy enables some people to develop more mature coping strategies and discard the maladaptive ones. Arguably this may be most prominent for borderline personality disorder and antisocial personality disorder where survivors may show significantly better function over time. However, symptoms can recur in old age when supports are lost and coping strategies are fewer.

Comorbidity

Any comorbid symptom disorder such as schizophrenia, bipolar disorder, anxiety disorder worsens prognosis, and vice versa. Comorbid drug abuse also hampers progress in therapy, because either they are impaired during therapy sessions, because sessions are not remembered or because the individual continues to avoid directly dealing with problems or learning to tolerate emotional distress, instead escaping into intoxication. Persons who abuse drugs also have an increased mortality.

Age at Treatment/Diagnosis

Treatment beginning in adolescence or early adulthood takes less time and is more likely to be successful than therapy started, say in middle age, when maladaptive traits are well-developed and entrenched. On the other hand, young people may be less willing to engage in therapy, and less convinced that interpersonal problems originate from their own thinking and behaviour, or that their problems may be enduring and unlikely to resolve spontaneously.

Interpersonal Relationships

A stable long-term relationship such as an intimate partnership (or therapy) confers a better prognosis, either because the disorder is less severe, allowing enough trust to develop a relationship or because the relationship itself is healing.

Social Supports

Developing other social supports, such as a stable job, which provides a sense of achievement, and good friendships also seem to help.

Severity of Disorder

More severe disorders usually have features of more than one personality disorder indicating more pathology. This usually means a worse prognosis for recovery.

The Older Patient with a Personality Disorder

It was thought until recently that personality disorders "burn out" in old age. We now know differently. The trend is for personality disorders to ameliorate in middle age, but with the stresses encountered as a person ages (loss of spouse, loss of health, eyesight, hearing, occupation etc) coping strategies may no longer be available, and the personality disorder can again become a problem. Nevertheless, personality disorders in older adults are less severe and of lower prevalence than in young people (Abrams and Horowitz, 1999).

Prevalence

Overall prevalence in older adults (over 65s) is approximately 10%. In the community it ranges from 2.8%-13%, from 5%-33% among psychiatric outpatients and from 7%- 61.5% among inpatients. In an Australian inpatient survey, the prevalence was 59% (Engels et al., 2003; Stevenson et al., 2011b). The most common personality disorders were obsessive-compulsive, dependent and paranoid. Older patients with a personality disorder are more likely to be single, separated or divorced. Men were more likely to have antisocial or schizoid personality disorder than women. Never married people were more likely to have obsessive-compulsive or paranoid personality disorder. Obsessive-compulsive personality disorder was also associated with a higher level of income and education.

Although each personality disorder is known to be comorbid with other personality disorders and with psychiatric syndromes over the lifetime, in older people single personality disorders are more common, meaning overall they have less personality pathology. The hypothesis is that personality disorders are not qualitatively distinct syndromes but rather maladaptive variants of personality functioning. Vaillant and Milofsky described a process of maturation and a reduction in the detrimental effects of dysfunctional personality from age 18 to 65. A decline in neuroticism (negative affectivity) up to the age of 70 has been described (Vaillant and Vaillant, 1990).

Personality disorders that caused impairment in the young adult, but which ameliorated in mid-life, can again become a problem in older adults as coping strategies that were available earlier are lost. Increased social isolation, loss of supports and less effective coping, as well as inflexibility of reactions all combine leading to exacerbation of personality disorder symptoms.

Aetiology

Personality disorders generally develop early in life – adolescence or early adulthood – due to a combination of genetic predisposition and environmental trauma. Change in personality can also be caused by brain disease such as dementia, tumour, infection, chronic illness and major life trauma.

Presentation

Personality disorder features may present differently across the life span because of maturational processes and context changes. The outward expression of personality can change although the internal structure of the underlying personality remains stable. For example, impulsivity and reckless behaviour occurs less in older adults with borderline personality disorder, but underlying dysphoria and identity conflicts still exist. The changes of aging further complicate assessment – increased introspection, slowing of thought and motor function, physical disability, hearing and visual impairments.

When faced with a treatment-resistant psychiatric disorder such as chronic depression, be mindful of the possibility of an underlying personality disorder that needs to be addressed as well.

Assessment

Information from those who know the patient well is necessary in addition to that from the patient. Look for patterns, interpersonal difficulties, blaming others, trouble keeping jobs, relationships. If you see any of this, ask specific questions.

Lifetime Psychiatric Comorbidities

All personality disorders have been shown to be significantly correlated with each other except for antisocial personality disorder. The strongest association was between paranoid and schizoid (Zimmerman et al., 2012). The presence of a personality disorder also confers susceptibility to mental disorders, such as major depression, schizophrenia, anxiety disorders as well as physical disorders such as cardiovascular disease (Grilo et al., 2010).

As at other ages, people with personality disorders tend to use dysfunctional coping strategies such as denial, use of alcohol or drugs. They also have fewer or no social supports and less satisfaction with social supports to rely on (Stevenson et al., 2012). Late life personality disorders are associated with impaired

general, social and psychological functioning, interpersonal relationships and quality of life.

Treatment

When mental disorders and personality disorders coexist, treatment efforts are generally directed first at the mental disorder. However, in those with coexisting personality disorders symptoms of the mental disorder are usually more severe, take longer to treat, result in more functional impairment and often cannot be completely resolved.

Treatment of the mental disorder is often pharmacological, but the personality disorder is better treated with psychological approaches, such as dialectical behaviour therapy, interpersonal therapy, cognitive behavioural therapy or problem-solving therapy. Simply teaching more adaptive coping strategies and providing extra social supports can help (De Leo et al., 1999).

Prognosis

The presence of a personality disorder makes treatment of the mental disorder more complicated and may see it take longer and be less successful. The older adult with a personality disorder often has a poorer prognosis because they lack the social supports and the coping skills to aid recovery. They tend to be isolated; family is often estranged and when entering a residential facility, they tend not to "fit in". Medical morbidity is higher, lifespan often decreased, and suicide is more common (Stevenson et al., 2011a).

Strategies to Sustain Care

We cannot cure the personality disorder quickly, but we can manage the deficits caused by the disorder.

Firstly, treat as any mental health disorder:

1. Establish an empathic understanding of the patient's situation
2. Do not blame
3. Provide social supports, physical supports
4. Teach coping strategies

Further Reading

The Harvard Study of Adult Development: **www.adultdevelopmentstudy.org/**

Tyrer, P., Mulder, R., Kim, Y. R., & Crawford, M. J. (2019). The development of the ICD-11 classification of personality disorders: An amalgam of science, pragmatism, and politics. *Annual Review of Clinical Psychology*, *15*(1), 481-502.

Vaillant, G. E. (1998). *Adaptation to Life*. Harvard University Press.

Cite as:

Stevenson, J., Lampe, L. (2024). Personality disorders. In Boyce, P., Harris, A., and Malhi, G.S. (Eds.), *The Sydney textbook of psychiatry* (pp. 286–306). The University of Sydney.

References

Abrams RC and Horowitz SV (1999) Personality disorders after age 50: meta-analytic review of the literature. In: Rosowsky E, Abrams RC, Zweig RA, et al. (eds) *Personality disorders in older adults: emerging issues in diagnosis and treatment.*: Lawrence Earlbaum Associates, 55-68.

Bagot RC and Meaney MJ (2010) Epigenetics and the biological basis of gene x environment interactions. *Journal of the American Academy of Child & Adolescent Psychiatry* 49(8): 752-771.

Bateman A and Fonagy P (1999) Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomised controlled trial. *The American Journal of Psychiatry* 158: 36-42.

Black DW, Blum N, McCormick B, et al. (2013) Systems Training for Emotional Predictability and Problem Solving (STEPPS) group treatment for offenders with borderline personality disorder. *Journal of Nervous & Mental Disease* 201(2): 124-129.

Bohus M, Stoffers-Winterling J, Sharp C, et al. (2021) Borderline personality disorder. *The Lancet* 398(10310): 1528-1540.

Chan JKN, Correll CU, Wong CSM, et al. (2023) Life expectancy and years of potential life lost in people with mental disorders: a systematic review and meta-analysis. *EClinicalMedicine* 65: 102294.

Clarkin J, Yeomans F and Kernberg O (2006) *Psychotherapy of Borderline Personality Disorder, Focusing on Object Relations.* Washington, DC.: American Psychiatric Publishing.

De Leo D, Scocco P and Meneghel G (1999) Pharmacological and psychotherapeutic treatment of personality disorders in the elderly. *International Psychogeriatrics* 11(2): 191-206.

Engels GI, Duijsens IJ, Haringsma R, et al. (2003) Personality disorders in the elderly compared to four younger age groups: a cross-sectional study of community residents and mental health patients. *Journal of Personality Disorders* 17(5): 447-459.

Grilo CM, Stout RL, Markowitz JC, et al. (2010) Personality disorders predict relapse after remission from an episode of major depressive disorder: a 6-year prospective study. *Journal of Clinical Psychiatry* 71(12): 1629-1635.

Gunderson J, Masland S and Choi-Kain L (2018) Good psychiatric management: a review. *Curr Opin Psychol* 21: 127-131.

Kendler KS, Gardner CO, Annas P, et al. (2008) A longitudinal twin study of fears from middle childhood to early adulthood: evidence for a developmentally dynamic genome. *Archives of general psychiatry* 65(4): 421-429.

Kendler KS, McGuire M, Gruenberg AM, et al. (1993) The Roscommon Family Study. III. Schizophrenia-related personality disorders in relatives. *Archives of general psychiatry* 50(10): 781-788.

Linehan MM, Armstrong HE, Suarez A, et al. (1991) Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of general psychiatry* 48(12): 1060-1064.

Meares R (2004) The conversational model: an outline. *American Journal of Psychotherapy* 58(1): 51-66.

Nestadt G, Di C, Samuels JF, et al. (2010) The stability of DSM personality disorders over twelve to eighteen years. *J Psychiatr Res* 44(1): 1-7.

Reichborn-Kjennerud T (2010) Genetics of personality disorders. *Clinics in Laboratory Medicine* 30(4): 893-910.

Setkowski K, Palantza C, van Ballegooijen W, et al. (2023) Which psychotherapy is most effective and acceptable in the treatment of adults with a (sub)clinical borderline personality disorder? A systematic review and network meta-analysis. *Psychol Med* 53(8): 3261-3280.

Smith GW, Ruiz-Sancho A and Gunderson JG (2001) An intensive outpatient program for patients with borderline personality disorder. *Psychiatric Services* 52(4): 532-533.

Stevenson J, Brodaty H, Boyce P, et al. (2011a) Personality disorder comorbidity and outcome: Comparison of three age groups. *Australian and New Zealand Journal of Psychiatry* 45(9): 771-779.

Stevenson J, Brodaty H, Boyce P, et al. (2012) Does age moderate the effect of personality disorder on coping style in psychiatric inpatients? *Journal of Psychiatric Practice* 18(3): 187-198.

Stevenson J, Datyner A, Boyce P, et al. (2011b) The effect of age on prevalence, type and diagnosis of personality disorder in psychiatric inpatients. *International Journal of Geriatric Psychiatry* 26(9): 981-987.

Stevenson J and Meares R (1992) An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry* 149(3): 358-362.

Stoffers-Winterling JM, Storebø OJ, Kongerslev MT, et al. (2022) Psychotherapies for borderline personality disorder: a focused systematic review and meta-analysis. *The British Journal of Psychiatry* 221(3): 538-552.

Torgersen S (2009) The nature (and nurture) of personality disorders. *Scandinavian Journal of Psychology* 50(6): 624-632.

Tyrer P and Tyrer H (2015) Nidotherapy: The expansion of environmental treatment. *Australian & New Zealand Journal of Psychiatry* 49(10): 934.

Vaillant GE and Vaillant CO (1990) Natural history of male psychological health, XII: a 45-year study of predictors of successful aging at age 65. *American Journal of Psychiatry* 147(1): 31-37.

Volkert J, Gablonski T-C and Rabung S (2018) Prevalence of personality disorders in the general adult population in Western countries: systematic review and meta-analysis. *The British Journal of Psychiatry* 213(6): 709-715.

Zhang K, Hu X, Ma L, et al. (2023) The efficacy of schema therapy for personality disorders: a systematic review and meta-analysis. *Nordic Journal of Psychiatry* 77(7): 641-650.

Zimmerman M, Galione JN, Chelminski I, et al. (2012) Does the diagnosis of multiple Axis II disorders have clinical significance? *Annals of Clinical Psychiatry* 24(3): 195-201.