CHAPTER 13
Personality Disorders

SOPHIA F. DZIEGIELEWSKI AND GEORGE A. JACINTO

INTRODUCTION

This chapter provides information about adults who suffer from the mental disorders known as the personality disorders. Several epidemiological studies in the United States and abroad with different populations provide consistent estimations of persons diagnosed with a personality disorder (cited by Lenzenweger, 2008). The mean prevalence rate for any personality disorder is estimated at 10.56% (Lenzenweger, 2008). This figure suggests that 1 in 10 people have a diagnosable personality disorder, but the actual criteria and treatment options remain controversial. These illnesses relate directly to an individual's personality, which defines the basic core of his or her self-identity, and how the world is interpreted, influencing all interactions that result. Our personality creates the basic defining characteristic from which all responses and behaviors result (Barnhill, 2014). When inflexible and pervasive, these enduring patterns of behavior can cause troubled and disturbed relations that touch every aspect of a person's life. Personality functioning affects the development of individual talents and responses, as well as close relationships with others. The link between developing these disorders and how exhibiting these problematic behaviors affect the family system is not well known. As individuals develop, there does appear to be a correlation with early separation and loss, parental neglect, and other types of family dysfunction, although most professionals agree this factor alone could not account for the development of personality disorders (Sherry, Lyddon, & Henson, 2007). There also appears to be a strong correlation between substance use and personality disorders, so much so that some practitioners believe that when a personality disorder is assessed, so should the possibility of a substance-related disorder (McMain & Ellery, 2008).

This chapter has a brief overview of each disorder and a case example that provides specific treatment planning and intervention-related applications. A lack of understanding of the symptoms related to having a loved one who suffers from a personality disorder can disturb family relationships and thereby alienate support systems critical to enhanced functioning. This chapter highlights the guidelines for using the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*; American Psychiatric Association [APA], 2013), to better understand and assess these conditions. The *DSM-5* (2013) dedicates one chapter to the 13 different personality disorders, which are broken down into four areas. Cluster A includes paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder (described in this chapter but also listed as part of the schizophrenia spectrum and the other psychotic disorders); cluster B is antisocial personality disorder (described in this chapter but listed in the chapter on the disruptive, impulse-control, and conduct disorders), borderline personality disorder, narcissistic personality disorder, and histrionic personality disorder; and cluster C is

avoidant personality disorder, dependent personality disorder, and obsessive compulsive personality disorder. In addition, three other types of personality disorders are listed as personality change due to another medical condition, other specified personality disorder, and unspecified personality disorder.

It is beyond the purpose of this chapter to explore in depth all of the diagnoses in the personality disorders and the treatment options specific to each. Rather, this chapter introduces the primary disorders as listed in *DSM-5*. The application section of this chapter provides a case example of an individual suffering from borderline personality disorder. The extent, importance, and early predictors of problem behaviors and symptoms are explored. The various aspects of the disorder are presented with a case application that highlights diagnostic assessment, treatment planning, and evidence-based treatment strategy. In addition, the latest practice methods and newest research and findings are here to further the understanding of these often-devastating illnesses.

The *DSM-5* provides an alternative model in the area for further study that is designed to better understand the traits that characterize the personality disorders. In conceptualizing personality disorders, it focuses on personality functioning and personality traits and is included as an emerging measure for current consideration or future use. The foci of this chapter are to discuss the description of personality disorders listed in the *DSM-5* (2013) and provide an overview of the alternative model to be used for further study in Section III.

TOWARD A BASIC UNDERSTANDING OF THE PERSONALITY DISORDERS

The personality of each individual mediates environmental, cognitive, emotional, spiritual, physical, and interpersonal events. When disturbed, it can negatively affect the individual's way of understanding the self and virtually all interactions in the world in which he or she lives. The notion of personality disorders dates back to the ancient Egyptians; allusion to the disorders is contained in the Ebers Papyrus (Okasha & Okasha, 2000). The ancient Greeks described their god Achilles as antisocial (Walling, 2002); accounts of Alcibiades, a Greek general, describe him as having had the traits of antisocial personality disorder with narcissistic features (Evans, 2006). In addition, whether the condition runs in families is not certain; however, individuals suffering from a personality disorder may also experience a genetic predisposition to developing a disorder similar to that diagnosed previously for a first-degree relative. Research on family members and how best to treat individuals within the family system is gaining interest (Hoffman, Buteau, & Fruzzetti, 2007).

The *DSM-5* (2013) has some minor revisions of the *DSM-IV-TR* (APA, 2000) categories of personality disorders. However, the *DSM-5* also presents an alternative model from which to construe personality disorders, which suggests that an understanding of the disorders is shifting. The APA Board of Trustees decided to include both models to establish continuity between current clinical practice and further study of the alternative approach.

UNDERSTANDING INDIVIDUALS SUFFERING FROM A PERSONALITY DISORDER

Individuals who suffer from a personality disorder often report significant distress or impairment in social functioning (APA, 2013). The personality disorders are placed in three clusters. Each cluster has behavioral symptoms that can impair social functioning, and behaviors can take

many forms, from odd-eccentric to dramatic-emotional to anxious-fearful. Furthermore, these unusual symptoms can affect interactions with family members, functioning at school or work, and other areas of an individual's life situation.

Cluster A personality disorders may appear odd and eccentric. Individuals with schizoid and schizotypal characteristics avoid social contact and find it difficult to place themselves in situations where they need to interact with others. Often they may seem odd and threatening to individuals who do not know them. Individuals who suffer from paranoid and schizotypal personality disorders often present as suspicious and guarded, and when communication is compromised, others may avoid them because of their suspicious and threatening presentation.

In the cluster B grouping, individuals present as dramatic-emotional. Antisocial individuals may violate others' rights and might also have the potential to inflict physical harm on others or lie and steal and otherwise con people. Those with borderline personality traits may appear at first to be close and admiring and then, once a relationship is formed, become angry and critical. Their intense anger may result in arguments and physical fights. This erratic and intense behavior makes it difficult for them to develop lasting associations with others. The histrionic and narcissistic personality disorders share the theme of dramatic attention-seeking behavior that gets in the way of developing friendships or romantic relationships. They often do not understand why others avoid them.

Cluster C individuals have characteristics that focus around anxiety and fear and thereby often exhibit anxious and fearful behaviors. Avoidant individuals shun social interaction because they see themselves as inadequate and fear negative responses from others. Dependent individuals experience fear of separation and cling to others, wanting others to make decisions for them. They can appear burdensome to others even in superficial social settings. Those with obsessive-compulsive disorder focus on control of their environment, and their perfectionism can be offensive to others.

Social interaction on all levels can often lead to emotional and sometimes physical injury to those with a personality disorder. Individuals suffering from a personality disorder often feel isolated and negatively judged because of their problematic social interactions; they may also be difficult to work with because they lack insight into their own conduct as well as subsequent willingness to engage in treatment to address problematic behaviors.

History of the Personality Disorder and the DSM

Over the past 50 years, the number and types of personality disorders listed in the *DSM* have changed with each new edition. The *DSM-I* (APA, 1952) had 17 categories of personality "disturbance," as well as "transient situational personality disorders," four of which were labeled as "adjustment reactions." (See Quick Reference 13.1.)

The *DSM-II* (APA, 1965) is similar to the listing of the disorders in *DSM-I* (1952). Its several modifications include deletion of inadequate personality pattern disturbance, emotionally unstable personality pattern disturbance, and dyssocial reaction under the sociopathic personality disturbance, and it removes the special symptoms reactions from the listing. The term *personality disorder* appears to have replaced personality pattern disturbances, personality trait disturbance, and sociopathic personality disturbance. The *DSM-II* (1965) retained the sexual deviations listing and added a description of specific conditions in this section.

The *DSM-III* (1980) and *DSM-III-R* (1987) removed the sexual deviations and substance-

QUICK REFERENCE 13.1

PERSONALITY DISORDERS AS LISTED IN EACH EDITION OF THE *DSM*

DSM-I (1952)	*DSM-II* (1965)	*DSM-III* (1980) *DSM-III-R* (1987)	*DSM-IV* (1994) *DSM-IV-TR* (2000)	**DSM-5* (2013)
Personality Pattern Disturbance (PPD) ■ Inadequate PPD ■ Schizoid PPD ■ Cyclothymic PPD ■ Paranoid PPD **Personality Trait Disturbance** (PTD) ■ Emotionally unstable PTD ■ Passive-aggressive PTD ■ Compulsive PTD ■ PTD, Other **Sociopathic Personality Disturbance** ■ Antisocial reaction ■ Dyssocial reaction ■ Sexual deviation: Specify term ■ Addiction Alcoholism Drug addiction **Special Symptoms/ Reactions** ■ Learning disturbance ■ Speech disturbance ■ Enuresis ■ Somnambulism ■ Other	**Personality Disorders** (PD) ■ Paranoid PD Cyclothymic PD Schizoid PD Explosive PD Obsessive compulsive PD ■ Hysterical PD ■ Asthenic PD ■ Antisocial PD ■ Passive-aggressive PD ■ Inadequate PD ■ Other PD NOS ■ Unspecified PD **Sexual Deviations** ■ Homosexuality ■ Fetishism ■ Pedophilia ■ Transvestitism ■ Exhibitionism ■ Voyeurism ■ Sadism ■ Masochism ■ Other sexual deviation ■ Unspecified sexual deviation **Alcoholism** **Drug Dependence**	***Cluster A*** ■ 301.00 Paranoid ■ 301.20 Schizoid ■ 301.22 Schizotypal ***Cluster B*** ■ 301.70 Antisocial ■ 301.83 Borderline ■ 301.50 Histrionic ■ 301.81 Narcissistic ***Cluster C*** ■ 301.82 Avoidant ■ 301.60 Dependent ■ 301.40 Obsessive compulsive ■ 301.84 Passive aggressive ■ 301.90 Personality disorder NOS **Note:** 301.89 Atypical, mixed or other personality disorder was listed in the *DSM-III* and changed in the *DSM-III-R* to 301.90 Personality Disorder NOS	***Cluster A*** (odd-eccentric) 301.0 Paranoid PD 301.20 Schizoid PD 301.22 Schizotypal PD ***Cluster B*** (dramatic-emotional) 301.7 Antisocial 301.83 Borderline 301.50 Histrionic 301.81 Narcissistic ***Cluster C*** (anxious-fearful) 301.82 Avoidant 301.6 Dependent 301.4 Obsessive-compulsive 301.9 Personality disorder NOS **Note:** 301.84 Passive Aggressive Personality Disorder (listed in the *DSM-III-R*) was removed from the Personality Disorders in the *DSM-IV* and placed in the section titled Criteria Sets and Axes Provided for Further Study.	***General Personality Disorder*** ***Cluster A*** (odd-eccentric) 301.0 Paranoid PD 301.20 Schizoid PD 301.22 Schizotypal PD ***Cluster B*** (dramatic-emotional) 301.7 Antisocial 301.83 Borderline 301.50 Histrionic 301.81 Narcissistic ***Cluster C*** (anxious-fearful) 301.82 Avoidant 301.6 Dependent 301.4 Obsessive-compulsive **Note:** NOS was changed to three diagnostic categories. 310.1 Personality change due to another medical condition 301.89 Other specified personality disorder and unspecified PD 301.9 Unspecified Personality Disorder

**DSM-5* lists *ICD-9-CM* codes in this table; *DSM-5* also lists *ICD-10-CM* codes.

related disorders (alcoholism and drug dependence) sections from the listings under personality disorders. In the *DSM-III-R* (1987), the three clusters of disorders were introduced. Cluster A was disorders with odd or eccentric behaviors. Cluster B included disorders that had dramatic, emotional, or erratic behaviors. Cluster C included those disorders characterized by anxiousness and fear.

In the *DSM-IV-TR* (2000), the personality disorders were grouped into three clusters similar to what was previously described in the *DSM-III-R* (1987). The *DSM III-R* cluster C disorder labeled passive-aggressive personality disorder was removed from the list of personality disorders and does not appear in the *DSM-IV-TR* (2000). Because the symptoms can still be problematic, it has been added to the potential list of defense mechanisms outlined in that version.

In the *DSM-5* (2013), the NOS category was deleted and changed to include three diagnostic labels: personality change due to another medical condition, other specified personality disorder, and unspecified personality disorder. In addition, an alternate model for personality disorders was presented in Section III. The APA Board of Trustees included the alternate model for further study (Kreuger & Markon, 2014).

WHAT IS A PERSONALITY DISORDER?

The development and usage of current criteria for a personality disorder in the *DSM* provide a definition with a clear listing of criteria, thereby making an accurate diagnosis of a specific personality disorder. The general personality disorder criteria involve a long-term pattern of inner experience and behavior that differs strikingly from the expectations of the individual's culture. The pattern is demonstrated by two of the following areas outlined in criterion A: (1) cognitive functioning such as ways of observing and understanding self, others, and events: (2) affective response that includes the range, intensity, mood fluctuation, and proper emotional reaction; (3) social functioning, and (4) impulse control.

Criterion B includes an ongoing pattern that is rigid across a range of personal and social circumstances. Criterion C states that the ongoing pattern results in clinically significant distress or damage in social, occupational, or other significant areas of functioning. Criterion D requires that the onset began in adolescence or early adulthood and is a long-term, stable pattern of behavior. Criterion E states that the long-term pattern is not better accounted for as a distinct element or consequence of another mental disorder. Criterion F requires that the long-term pattern not be the result of physiological effects of a substance of abuse or prescription medication or another medical condition, such as traumatic brain injury.

When assessing for symptoms relevant to the diagnosis, the practitioner needs to first review for the presence of minimal levels of the criteria for a personality disorder. Once the symptoms are identified, the predominance of certain symptoms that form clusters of behavior is noted. To facilitate this process, a brief discussion of the personality disorders organized under clusters A, B, and C is presented with the diagnostic criteria outlined by the *DSM-5* (2013) for the disorder. In addition, for each personality disorder, a brief case example clearly identifies how the behavior meets the criteria. Because the behaviors exhibited are often less severe, although enduring, a brief case scenario clearly outlines the occurrence of the problematic behaviors. After the criteria for the personality disorder are described, each case scenario highlights how these behaviors relate to the diagnostic assessment.

CLUSTER A PERSONALITY DISORDERS

The cluster A personality disorders include paranoid personality disorder, schizoid personality

disorder, and schizotypal personality disorder. Each of these personality disorders shares the common theme of odd or eccentric behavior. When diagnosed in this cluster, individuals have trouble relating to others. Others might comment openly or privately that the person with a cluster A personality disorder acts strangely, and people often are uncomfortable around them. Often they appear to others as odd and eccentric, which causes them to be loners, or others avoid them as they say they make them feel uncomfortable.

Paranoid Personality Disorder (PPD) [301.0 (F60.0)]

Paranoid personality disorder (PPD) is characterized by a pattern of distrust and suspiciousness of others, whose motives and intentions are perceived as malicious. These perceptions begin in early adulthood and are present in a number of situations. Those with PPD assume the ill intent of others and believe that others might exploit, harm, or deceive them. At times, they may believe others have seriously injured them when there is no evidence that an injury has taken place (APA, 2013). These individuals and the suspicious nature of their interactions can be so frustrating for others that often they are avoided. It is most often diagnosed in males.

According to the *DSM-5*, there are two primary criteria for the disorder (A-B). Of the seven characteristics of the disorder that constitute criterion A, the individual must have at least four. Generally, individuals suffering from paranoid personality disorder exhibit a pervasive attitude of distrust, and when they interact, they consider others' motivations vindictive or malevolent. This pattern is often so pronounced that the individual avoids others at times because of suspicion of their motives, often questioning their true loyality, trustworthiness, and intent. These patterns of behavior are usually noted as beginning by early adulthood and present in a variety of contexts.

To place the diagnosis, criterion A requires four of the seven characteristic symptoms are required: (A-1) The individual suspects and distrusts others without sufficient basis and believes others are exploiting him or her. He or she may also believe others are trying to cause harm and are deceiving in regard to true intensions. (A-2) The client is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates. (A-3) Often individuals with paranoid personality disorder remain reluctant to confide in others. They do not share because of an unwarranted fear that the information will be maliciously used against them. (A-4) In general conversations, others' remarks are believed to have hidden meanings, even when it is clear no harm was intended. (A-5) Relationships with them are often strained because the client bears a grudge and remains unforgiving, even if the injury or insult was unintended. (A-6) The individual is often on the defensive, feels he or she is under attack, and responds with a counterattack that may appear out of proportion to the event. (A-7) Intimate relationships are strained as the individual is convinced that a partner is having an affair and questions fidelity without cause. In criterion B, other mental disorders that could be causing the characteristic symptoms should be assessed, such as schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder, and it is not attributable to the physiological effects of a general medical condition (APA, 2013). If the criteria are met prior to the onset of schizophrenia, the term *premorbid* should be added and documented as paranoid personality disorder (premorbid). The following case example shows the characteristics of the disorder.

CASE EXAMPLE - CASE OF LEON

Leon has gotten up late this morning and suspects that someone who was meaning him harm interfered with his alarm clock so that he would be late for work (Criterion A1). He thinks it is Morgan at work, who he believes wants to make him look bad before his boss so that he will be fired (A6). When he arrives an hour late at work, he is greeted by the receptionist, Mary, who says, "Good morning, Leon" (A4). She was trying to be friendly, but Leon thinks she is trying to get him in trouble with the boss by making a scene so the boss will know he is late. Morgan, who believes she is a good friend of Leon, greets him. He ignores Morgan and goes to his workstation. He is thinking of how disloyal Morgan has been (A2). Leon notices his boss, Jacob, and Morgan were whispering about something. He believes they are discussing his tardiness this morning and plotting to write him up (A1 and A2). He cannot contain himself any longer and confronts his boss about his conversation with Morgan. The boss tells him they were planning a surprise for a coworker who was celebrating her 50th birthday. Leon does not believe his boss. This incident adds to his grudge against Morgan, whom he cannot forgive for meddling with his alarm clock (A5).

In reviewing this case, Leon meets five of the diagnostic criteria (A1, A2, A4, A5, and A6) for a diagnosis of PPD. People with PPD commonly blame others for their own failures. Cultural considerations in diagnosing this disorder may have to do with immigrant groups who do not understand the dominant culture, may experience language barriers, or may not understand rules and regulations of the new country. Several ethnic groups may also display behaviors that might be incorrectly misinterpreted as paranoia (APA, 2013). Persons with PPD can be very difficult to treat in psychotherapy because of their chronic suspiciousness and perception of attacks on their character (Dobbert, 2007).

Schizoid Personality Disorder (SPD) [301.20 (F60.1)]

Schizoid personality disorder (SPD) is characterized by detachment from social contact and a limited range of emotional expression in settings that require interpersonal exchange. Individuals with SPD do not seek or want to develop intimate relationships and do not seek romantic sexual relationships with others. They do not desire to be part of a social group and prefer to be alone. They prefer to work with mechanical or abstract tasks and find little pleasure in hobbies or the activities of life. When others socialize, these individuals prefer to be alone. They do not connect well with others and avoid social contact whenever possible.

According to the *DSM-5*, seven characteristics of the disorder in criterion A, require that an individual must have a minimum of four. People diagnosed with this disorder are characterized by disconnection from social relationships and constrained emotional expression in social settings. They shun human interaction and are loners who prefer solitude and activities that do not include associating with others. Often those diagnosed with this disorder do not have close friends, except possibly a close relative (*DSM-5*).

To fit the diagnostic picture, criterion A requires four of the seven characteristic symptoms: (A-1) The client does not seek close relationships, including association with members of the family of origin. (A-2) The client prefers solitary activities to the exclusion of time spent with others. (A-3) The client lacks interest in experiencing sexual activity with another person. (A-4) The client has few, if any, activities that bring him or her pleasure. (A-5) The client does not develop close friendships to confide in, other than close relatives. (A-6) The client does

CASE EXAMPLE - CASE OF SAL

Sal has just gotten off work as a night watchman at a warehouse, where he is the only employee during the graveyard shift. Sal meets his brother for breakfast and tells him that he chose this job because it allows him to spend a good amount of time alone (Criterion A2). He has never dated and has lived alone in a one-bedroom apartment for 28 years. He is not interested in a sexual relationship, even though his brother has attempted to set him up with dates over the years (A3). He goes from home to work and, on rare occasion, to his brother's home for dinner. He does not desire any acquaintances or friends; he just does not like being around other people (A1). He simply prefers to be alone. He has told his brother on several occasions that he does not like people. Since he entered school, he has never sought to have friends, and he contacts his brother only when he needs something and cannot figure out how to meet his need on his own (A5). Three weeks ago, he was honored for 15 years' service to his company. His boss showered him with praise for keeping the company free of break-ins and stated he was one of the finest employees any employer would want to have as part of the team. After the ceremony, Sal told his boss that he did not know what the ruckus was about and that he did not desire or deserve the recognition (A6). Sal made it clear to his boss he was just doing his job and nothing more and would prefer not to be subjected to another ceremony of this type again in the future.

Sal meets five of the diagnostic criteria (A1, A2, A3, A5, and A6) for a diagnosis of SPD. Persons with SPD do not see themselves as having a problem and are happy with being left alone. Some individuals who come from a variety of cultural backgrounds may display defensive behaviors, avoid social contact, and be misinterpreted as schizoid. For example, a person moving from a rural environment to New York City may react with shock at the different, stressfully charged milieu of the city. An individual may appear to be cold, hostile, and distant, preferring to stay to himself or herself (APA, 2013). When the patterned behavior is related to the disorder, it would not occur to them that they might benefit from psychotherapy. If a person with SPD were to see a therapist, it would be due to a referral from a health professional or relative. Psychotherapy is generally contraindicated for people with SPD because of their intense resistance to change their way of life.

not respond to praise or criticism from others. (A–7) The client presents with cold affect, indifference, and flattened affect. In criterion B, other mental disorders that could be causing the characteristic symptoms should be assessed, such as schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder or autism spectrum disorder, and it is not attributable to the physiological effects of a general medical condition (APA, 2013). If the criteria are met prior to the onset of schizophrenia, the term *premorbid* should be added and documented as schizoid personality disorder (premorbid). The case example of Sal shows the characteristics of the disorder.

Schizotypal Personality Disorder (STPD) [301.22 (F21)]

Schizotypal personality disorder (STPD) is characterized by significant discomfort with social interaction and close personal relationships and a lack of interest in developing enduring friendships. Additionally, the person with schizotypal personality disorder has cognitive misrepresentations and eccentric behavior. These experiences begin in

early adulthood and are present in a number of situations. This personality disorder, although not equivalent to schizophrenia, is sometimes referred to as the most similar to schizophrenia. One reason is the experience of ideas of reference versus delusions. Those diagnosed with STPD often experience ideas of reference that result from attaching meaning to casual events specific to the individual. The person focuses on the paranormal or entertains superstitions that are not within the norms of his or her cultural milieu. This is similar to schizophrenia, where individuals have a more pronounced form of delusional thinking called delusions of reference. In the personality disorder, the ideas of reference are not as pronounced and usually are related to a specific idea or item as opposed to a general theme that pervades every aspect of a person's life. In assessing for this disorder, the cultural context, including beliefs and practices, need to be considered. Many religious rituals, beliefs, and practices may appear to meet criteria for STPD. For instance, shamanism, speaking and singing in tongues, magical beliefs, voodoo ritual, seeing and talking with dead relatives, and the evil eye related to mental health and physical illness are experiences that are common in many cultures. With regard to etiology of the disorder, when compared with the general population, there appears to be a familial predisposition for development of STPD when first-degree biological relatives are diagnosed with schizophrenia. The child may observe the behaviors of a relative with schizophrenia and copy the behaviors (APA, 2013; Dobbert, 2007).

According to the *DSM-5*, of the nine characteristics for Criterion A, an individual must have a minimum of five. Individuals diagnosed with this disorder are characterized by strong anxiety and limited ability to develop close relationships. They also experience cognitive misinterpretation of reality and peculiar behavior. Often those diagnosed with this disorder demonstrate ideas of reference, which should be distinguished from delusions of reference. In addition, they may be preoccupied with the paranormal or superstitious beliefs that are not commonly held by others of their cultural background. To fit the diagnostic picture, five of the nine characteristic symptoms are required: (A-1) The individual reports ideas of reference, not including delusions of reference. (A-2) The client is preoccupied with odd thinking or magical beliefs that affect behavior and do not fit within the individual's cultural context. (A-3) The client experiences physical illusions or odd perceptions. (A-4) The client's peculiar speech and thought process may include metaphorical thinking and expression. (A-5) The individual is suspicious of others or may experience paranoid thoughts. (A-6) There is unsuitable or constrained emotional impact on the individual's reality perception. (A-7) The client presents with eccentric behavior or as strange. (A-8) The client does not develop intimate friendships with others to confide in, other than close relatives. (A-9) The client experiences high levels of social anxiety that is not reduced by familiarity and is related to mistrustful fears instead of negative beliefs about self. In criterion B, other mental disorders that could be causing the symptoms should be assessed, such as schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder or autism spectrum disorder (APA, 2013). If the criteria are met prior to the onset of schizophrenia, the term *premorbid* should be added and documented as schizotypal personality disorder (premorbid). The case example of Marge shows the characteristics of the disorder.

CLUSTER B PERSONALITY DISORDERS

The cluster B personality disorders are antisocial, borderline, histrionic, and narcissistic personality disorders. The majority of people who suffer

CASE EXAMPLE - CASE OF MARGE

Marge has lived alone during her adult life. She wears clothes that would have been popular in the 1920s, and her makeup causes her to stand out when she is in public (Criterion A7). She is currently suspicious of her neighbor, who she thinks is watching her (A5). The neighbor has left his apartment the same time Marge has for the past 2 weeks, and she thinks he is plotting to take advantage of her (A1). Marge has no friends and says she fears people, even those she has known casually for a long time (A8). She thinks acquaintances may one day snap and take advantage of her (A9). She has three large dogs in her backyard that she says are there for protection and to keep people away from her. Marge has been known to hold odd beliefs as reported by her acquaintances (A2). She believes she is clairvoyant and makes predictions about the future that are not accurate, according to her coworkers. She recently went to a priest to discuss her psychic gifts but was vague and circumstantial when the priest pressed her for a clear explanation of how her psychic abilities work (A2). She was unsatisfied with her consult with the parish priest. She states openly that she does not date and does not want to have any children as she is not sure she could love a child.

Marge meets six of the diagnostic criteria (A1, A2, A4, A5, A7, and A9) for a diagnosis of STPD. Marge is uncomfortable with interpersonal relationships, entertains perceptual distortions, and appears eccentric to those around her. Treatment options for Marge depend on what she is willing to tolerate. Psychotherapy, especially if resistive, is not always considered the treatment of choice and can be contraindicated for individuals who are diagnosed with STPD (Dobbert, 2007).

from a personality disorder fall in the cluster B group (Caligar, 2006). Each of these personality disorders shares the common theme of dramatic and emotional behavior. Often individuals have intense relationships with family and friends that quickly become strained. This frustrates those in their support system, and it is not uncommon for family and friends to say that they simply cannot take the intensity and drama that typically surround relationships with a person with this type of personality disorder. Caregivers in particular may find these behavioral traits extremely frustrating (Scheirs & Bok, 2007).

Antisocial Personality Disorder (APD) [301.7 (60.2)]

Antisocial personality disorder (APD) is characterized by a history of disregarding others and violating others' rights, beginning in childhood or early adolescence and continuing into adulthood (APA, 2013). Key elements of APD include deceit, manipulation of others, and failure to adhere to social norms. To be given a diagnosis of APD, a person has to have a history of conduct disorder symptoms prior to age 15 (APA, 2000). Somatic marker and social cognition models explain APD. Both models include the cortical (prefrontal cortex) and limbic (amygdalae) structures of the brain as integral to the underlying process in the development of APD (Sinclair & Gansler, 2006). Environmental factors may also contribute to the development of APD. Growing up in a home where parents demonstrate antisocial behavior, including domestic violence, separation, divorce, and living in foster care, can deprive children of an emotional bond that may contribute to APD (Black, 2006). Confusing discipline regimens, child abuse, and inadequate supervision have been associated with development of APD (Black, 2006). There is a potential for association

with others who are also aggressive, and they may become gang members (Black, 2006). There may also be intense relationship problems and domestic violence related to and complicated by substance abuse, extreme jealousy, and violent responses (Costa & Babcock, 2008). The key to understanding the individual who suffers from APD (the old term is *psychopath*) is watching for evidence of behavioral deviations from the norm (Federman, Holmes, & Jacob, 2009). The diagnosis of APD is more common in males than in females.

According to the *DSM-5*, of the seven characteristics of the disorder for criterion A, an individual must have a minimum of three. Individuals diagnosed with this disorder are characterized by a pattern of violating the rights of others that begins in childhood or adolescence and persists into adulthood. These individuals are often diagnosed with conduct disorder. Principal features of the diagnosis are deceit and manipulation of others. Those diagnosed with antisocial personality disorder must be at least 18 years old and have a history of some of the symptoms of conduct disorder prior to age 15.

To fit the diagnostic picture, three of the seven characteristic symptoms are required to meet criterion A: (A–1) The client repeatedly has difficulties with the law and engages in risky behaviors without regard for the legal consequences; (A–2) The client has little regard to the feelings or rights of others and often puts his/her wishes first, conning the individual into doing what the client wants regardless of the benefit to the other individual; (A–3) The client is impulsive and often acts before any thought is given to the consequences that result; (A–4) The client wants his or her own way and thinks

CASE EXAMPLE - CASE OF DAVID

David is 14 years old and has had lifelong problems conforming to societal rules and has had repeated incidents involving the legal system (criterion A1). As an adolescent, he regularly stole from parents and stores (A1). When confronted about stealing, he lied and blamed someone else (A2). He cut the family dog with a knife when he was 14 years old; shortly thereafter, he was diagnosed with conduct disorder, which is usually a precursor to the diagnosis of antisocial personality disorder. David has little control over his impulses; for instance, when he wants something, if he does not have the money, he just steals it (A3). When caught, he said he just focused on what he wanted and not on the consequences of his stealing and breaking the law. Because of his low impulse control, he had a history of starting fights in school until he was finally expelled (A4). When he stole a car, he raced the vehicle over 100 mph, placing himself and others in danger (A5). When confronted with his law violations, he never showed remorse for the harm he brought to others (A7). He simply dismissed his wrongdoings as someone else's fault.

David meets six of the diagnostic criteria (A1, A2, A3, A4, A5, and A7) for antisocial personality disorder. Persons diagnosed with APD do not learn from experience. This coincides with the social cognition and somatic marker models that try to explain the development of APD. It appears to be related to urban settings and low socioeconomic status. Practitioners should be careful not to diagnose APD if a person lives in a hostile environment and antisocial behavior is seen as a protective survival tactic. Often persons with APD are arrested for the same crime many times. Due to their lack of insight, individuals with APD may respond best to specific goal-directed treatments with clear goals and objectives that are linked directly to behavioral consequences.

little of hurting others resulting in fights or assaultive behavior to secure what he or she wants from others; (A-5) The client has a wanton disregard for the safety or security of others; (A-6) The client is consistently self-rewarding and often does maintain financial or occupations responsibilities; (A-7) The client presents with a clear lack of remorse and often rationalizes his or her behavior as necessary to obtain what is needed. Consequences for such intrusive behavior are often seen as an inconvenience rather than a problematic consequence. In criterion B, the individual must be 18 years old. Criterion C requires that onset of conduct disorder be prior to the age of 15. Criterion D requires that the occurrence of antisocial behavior in not entirely during incidence of schizophrenia or bipolar disorder (APA, 2013).

Borderline Personality Disorder (BPD) [301.83(F60.3)]

Borderline personality disorder (BPD) is characterized as "an instability of interpersonal relationships, self-image, and affects, and marked by impulsivity that begins by early adulthood and is present in a variety of contexts" (APA, 2013, p. 663). It is diagnosed more frequently in females (75%) than in males. It begins in early adulthood and manifests with symptoms of instability in interpersonal relationships, problems with self-image, unstable affect, and notable impulsivity (APA, 2013, p. 666). It is present in the many person-in-environment circumstances in which a person participates. Circumstances in which BPD symptoms are exacerbated include emotional instability, existential dilemmas, uncertainty, anxiety-provoking choices, conflicts about sexual orientation, and competing social pressures to decide on careers (APA, 2013, pp. 665–666). Difficulties are often noted in setting and establishing boundaries. Crisis situations may be generated to avoid boundaries, and these types of behavior can be very frustrating to family and friends.

According to the *DSM-5*, the criteria for this personality disorder differs from the others in that the criteria are not divided into similar lettered steps. This disorder simply lists the criterion in numerical order. When using the assessment scheme outlined individuals must have nine characteristics of the disorder, clearly experiencing a minimum of five. Individuals diagnosed with this disorder are characterized by a persistent pattern of unstable social relationships, self-image, emotion, and impulsive behavior, the onset of which is during early adulthood. The disorder exists in a number of contexts. Often those diagnosed with this disorder fear abandonment and make every effort to avoid such a situation. In addition, they have intense and unstable social relationships.

To fit the diagnostic picture, five of the nine characteristic symptoms are required: (1) extreme efforts to avoid abandonment that is either real or envisioned; (2) history of unstable and intense interpersonal relationships that alternate between idealization and devaluation of the other person; (3) persistent unstable identity disturbance that manifests with one's self-image or sense of the self; (4) two specific situations need to be identified where self-damaging situations and impulsive behaviors can result, such as reckless driving, excessive spending, substance abuse, binge eating, and unsafe sexual activity; (5) continual self-injury, gestures and threats, or suicidal behavior; (6) emotional instability resulting from a noticeable reactive mood response to life circumstances; (7) persistent feelings of emptiness; (8) difficulty in controlling anger or experiencing unacceptable intense rage; and (9) extreme dissociative symptoms or temporary, stress-related paranoid thoughts with possible separation (through disassociation) from the event (APA, 2013).

CASE STUDY - CASE OF SARAH

Sarah was chronically unemployed because of her difficulty in controlling her anger (criterion 8) and her development of intense and unstable relationships at work (2). She has been seeing a psychotherapist for 10 years. In therapy, she is working on her feelings of emptiness (7), abandonment issues (1), and unstable pattern of relationships, both romantic and nonromantic (2). While in therapy, she has attempted suicide four times (5) and states her partner is to blame for her insecurity. She deliberately planned to be unavailable and not respond to requests by her therapist. She refused to answer the phone when her therapist tried to contact her to check on her well-being. She cut her wrist (self-mutilating behavior), and when she saw the psychotherapist at her next appointment, she said she felt such intense emotional pain she wanted to feel it physically on her body as well (5). She had numerous surface cuts to her arm from previous attempts at suicide. To hide these marks, she would often wear a long-sleeve shirt. When she met with her therapist, however, she often folded up her sleeves to expose the scarring on her arms. She often demonstrates her unstable relationship patterns with her therapist. At times, she reports that she idealizes the therapist and, on other days, devalues her contributions (2). She has been addicted to prescription medication for several years. She doctor-shops so she will always have a sufficient supply of medications, and she smokes marijuana (4).

Sarah meets six of the diagnostic criteria (1, 2, 4, 5,7, and 8) for BPD, which is five times more common among first-degree relatives diagnosed with the disorder than in the general population. The research about the genetic association of families and BPD is mixed in its results. Dobbert (2007) reports that there appears to be an inverse relationship between the neurochemical serotonin and impulsivity. Additional research suggests that it is possible that exposure to abuse as a child suppresses the level of serotonin, and life situations such as this can play an important role in developing BPD (Dobbert, 2007). Symptoms are reported to decline with advancing age, appropriate medication, and psychotherapy. Although BPD is chronic in nature, most people with BPD successfully emerge from psychotherapy and experience a remission of symptoms (Dobbert, 2007).

Histrionic Personality Disorder (HPD) [301.50 (F60.4)]

Histrionic personality disorder (HPD) is characterized by "excessive expression of conditions and attention-seeking behavior. This pattern begins by early adulthood and is present in a variety of contexts" (APA, 2013, p. 667). Often persons diagnosed with HPD have a dramatic flair in their self-presentation to others. They are happy being the center of attention and become uneasy and feel unappreciated when they are not the focus of their environment. While they command the position of life of the party, they are often inappropriately attired in sexually provocative dress and behave in a seductive manner. Although they may present in a dramatic manner, they are often vague about details and extremely impressionistic. Persons with HPD are exceedingly trusting of authority figures and can be highly suggestible.

According to the *DSM-5*, of the eight characteristics of the disorder, an individual must have a minimum of five. Similar to several other personality disorders listed in this section, this disorder also does not use the traditional alphabetical coding. Individuals diagnosed with this disorder are characterized by extreme emotional responses to life events, with a significant focus on attention-seeking behavior. When not the