Personality Disorders

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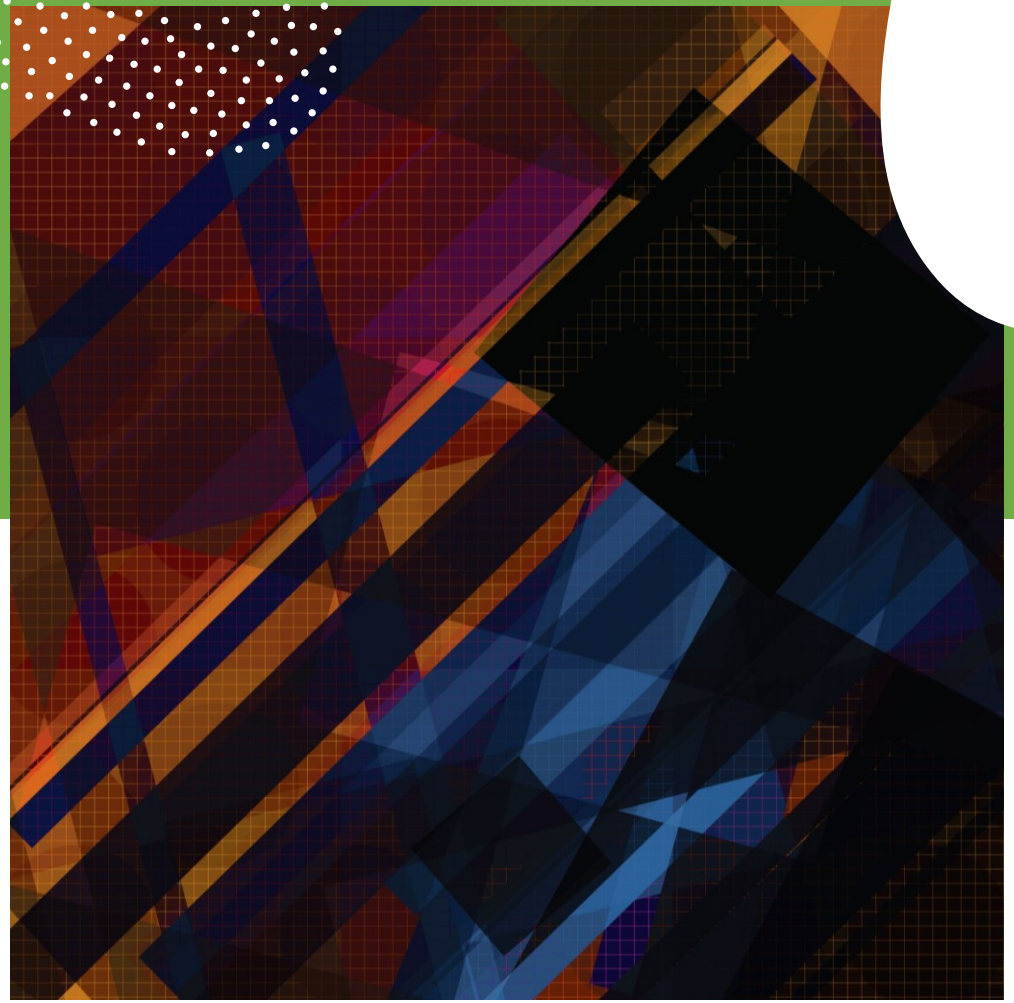

Introduction

- Individuals with PDs represent a significant (often extreme) deviation from how an average individual in the given culture perceives, thinks, feels and particularly relates to others
  - ICD-10: deeply ingrained, enduring patterns of inner experiences & behaviour, manifesting as inflexible responses to a broad range of personal/ social situations
  - DSM-5: enduring pattern (of traits) manifested in (at least 2) the following domains: (a) cognition, (b) affectivity, (c) interpersonal functioning & (d) impulse control
- Varying degrees of subjective distress and problems in social functioning
- Patterns usually evident during late childhood/ adolescence, but the requirement of stability/ persistence usually restricts the use of the term 'disorder' for adults
- ↑ risk: mortality (suicide, homicide, accidents); comorbidity
  - Separation and divorce, unemployment, poor quality of life
  - Rx of comorbidity: complicated/ lengthier (lack of recognition of PD)

History

- Charaka (100 BC): Triguna theory - man's prakriti (nature) defined by the relative accentuation of one of the three gunas: satvik (consciousness), rajsik (energy) or tamsik (inertia)
- Galen (192 AD): linked Hippocratic 4 'humours' to personality: sanguine (hyperthymic), phlegmatic (cluster A), choleric (cluster B) and melancholic (cluster C) types
- Augustin Morel, Philippe Pinel, Julius Koch (late 18th century): PDs were mainly neurodegenerative disorders
- James Cowles Prichard: 'moral insanity' - disorder with no apparent disease but the gross disturbance of behaviours
- Kurt Schneider (1923): first formal classification of PDs, has persisted in somewhat modified forms till DSM-5
- Both ICD-11 and future DSM revisions are likely to adopt dimensional classificatory approaches

Link between historic and current PDs

Galen (192 AD)	Schneider (1923)	ICD-6 (1948)	DSM-III (1980)	ICD-10 (1992)	DSM-5 (2013)
Choleric	Emotionally unstable	Emotional instability	Borderline	Emotionally unstable	Borderline
Choleric	Explosive	Antisocial	Antisocial	Dissocial	Antisocial
Choleric	Self-seeking	-	Narcissistic	-	Narcissistic
Choleric	-	Immature	Histrionic	Histrionic	Histrionic
Melancholic	Depressive	Cyclothymic	Depressive	-	-
Melancholic	Asthenic	Passive dependency	Avoidant	Anxious/ avoidant	Avoidant
Melancholic	Weak willed	Inadequate	Dependent	Dependent	Dependent

Link between historic and current PDs

Galen (192 AD)	Schneider (1923)	ICD-6 (1948)	DSM-III (1980)	ICD-10 (1992)	DSM-5 (2013)
Phlegmatic	Affectless	Schizoid	Schizoid	Schizoid	Schizoid
Phlegmatic	-	Asocial	Schizotypal	-	Schizotypal
Not classified	Insecure sensitive	Paranoid	Paranoid	Paranoid	Paranoid
Not classified	Insecure anankastic	Anankastic	Obsessive–compulsive	Anankastic	Obsessive–compulsive
Not classified	-	-	Passive-aggressive	-	-
Not classified	Fanatical	-	-	-	-
Sanguine	Hyperthymic	-	-	-	-

ICD-10

Specific personality disorder categories (F60): 8

- Paranoid PD (F60.0)
- Schizoid PD (F60.1)
- Dissocial PD (F60.2)
- Emotionally unstable PD (F60.3):
  - F60.30—Impulsive type
  - F60.31—Borderline type
- Histrionic PD (F60.4)
- Anankastic PD (F60.5)
- Anxious (avoidant) PD (F60.6)
- Dependent PD (F60.7)

Mixed PDs (F61)

Enduring personality change not attributable to brain damage or diseases (F62)

Schizotypal disorder (F21) under ‘Schizophrenia, …delusional disorders’ (F20-9)

Narcissistic PD under ‘Other specific personality disorders’ (F60.8)

Organic personality disorder (F06.0) under “Organic, including symptomatic, mental disorder” (F00–9)

DSM-5

- Cluster A: paranoid, schizoid, schizotypal
- Cluster B: antisocial, borderline, histrionic, narcissistic
- Cluster C: avoidant, dependent, obsessive–compulsive

Issues in the current classification(s)

- Overlap
- Nor otherwise specified
- Impairments in personality functioning
- Longitudinal stability

Alternative DSM-5 Model for PDs (AMPD)

Section-III; General criteria for personality disorders (PD)

- Criteria A: levels of personality functioning
  - Self - identity, self-direction
  - Interpersonal - empathy, intimacy
- Criteria B: pathological personality traits
  - 5 broad domains - negative affectivity (vs. emotional stability), detachment (vs. extraversion), antagonism (vs. agreeableness), disinhibition (vs. conscientiousness) and psychoticism (vs. lucidity)
  - 25 specific trait facets e.g., negative affectivity: emotional lability, hostility
- Criteria C & D: pervasiveness and stability
- Criteria E, F & G: R/O alternative explanation for personality pathology - Organic PD; personality changes secondary to substance use; primary psychiatric illness

ICD-11

Classification based on dimensions of severity - mild PD, moderate PD & severe PD (also personality difficulties)

Instead of categories, ICD-11 provides for ‘trait domain specifiers’

- Dimensions corresponding to structure of personality
  - Negative affectivity
  - Detachment
  - Dissociality
  - Disinhibition
  - Anankastia

  ⑩Borderline pattern
- Provide as many ‘trait domain specifiers’ as necessary -
- Usually, more prominent trait domains are present in more severe personality disturbance

Clinical Implications

- Higher mortality and morbidity

	Men	Women
All-cause mortality	4.3 X	2.9 X
Unnatural deaths	9.7 X	17.8 X
Life expectancy ↓	18 yrs	19 yrs

  - Suicide and homicide
  - Cardiovascular diseases
  - Poor quality of care - difficulties in building a relationship
  - Comorbid psychiatric disorders
  - SUD

Poor treatment outcome

- Poor adherence
- Difficult doctor–patient relationship(s)
- Less favourable response to Rx for comorbidities

Risk to self and others

- Self - accidents, DSH, high-risk sexual behaviours and unplanned pregnancies
- Others - homicide, physical abuses, marital discord

Cost of care

- Repeated hospitalizations
- Frequent ‘crisis situations’

Usually, more impairments are seen in more severe forms

Epidemiology : Global

- World Mental Health Survey (13 countries)
  - Point prevalence of All PDs: 6.1% (SE = 0.3)
  - Cluster A: 3.6%
  - Cluster C: 2.7%
  - Cluster B: 1.5%
  - Lowest prevalence in Europe; highest prevalence in North and South America
- General population: equal across genders and ethnic groups
- Clinical population: 25% in 1° care, 50% in Psych OP
  - Gender: female (help seeking; repeated self-harm)
- Legal and justice system: up to 75%

Epidemiology: India

- General population: 0 - 2.8% (weighted mean 0.6%)
  - Male gender
- Clinical populations: 0.3 - 1.6%
  - Retrospective chart review (1996–2006): 1.1%
    - Most common: anxious avoidant and borderline PD

- Special populations
  - Legal: 7.3–33.3%
  - SUD: 20–55%
  - Ever attempted suicide: 47.8–62.2%
  - Psychiatric emergencies (ICD-10): 24%

Aetiology and Risk Factors

Genetics

Twin and adoptive studies

- Schizotypal PD may be linked with schizophrenia/ schizophrenia spectrum
- Paranoid & schizoid PD may be linked with schiz (paranoid > schizoid)
- Antisocial PD, borderline PD and SUD share a common genetic liability

Molecular genetic studies

- Several genetic polymorphisms (dopamine transporter gene [*DAT1*], dopamine D2 receptor [DRD2], DRD3, DRD4, catechol-O-methyltransferase [COMT] and platelet monoamine oxidase A [MAOA]) are associated with various PDs or behaviours related to specific PDs

Gene - environment (childhood maltreatment, poor parental warmth and emotional abuse) interaction may explain several dysfunctional behaviours associated with PDs

Genome-wide association studies (GWAS) has shown some genetic overlap among borderline PD, bipolar disorder, major depressive disorder and schizophrenia

Molecular genetic studies

Study	PD	Findings
Joyce et al. (2003)	Av & OC	*DRD3*
Stefanis et al. (2004)	Schizotypal	*COMT*
Ni et al. (2009)	Borderline	5-HT2A receptor
Nemoda et al. (2010)	Borderline	*DRD2*
Basoglu et al. (2011)	Antisocial	*SNAP25* gene (plasma membrane)
Roussos et al. (2013)	Schizotypal with high paranoia	*CACNA1C* gene (voltage-dependent L-type calcium channel)
Plieger et al. (2014)	Cluster-C	Serotonin transporter gene *5-HTTLPR*
Martín-Blanco et al. (2015)	Borderline with childhood trauma	Dopamine β hydroxylase (*DBH*), enzyme converts dopamine to norepinephrine
Huang et al. (2015)	Borderline with mood D	*DAT1*
Salvatore et al. (2015)	Antisocial with ADS	*ABCB1* gene (ATP-dependent efflux pump of cell membrane)
Kolla et al. (2017)	Cluster B	*MAOA*

Neuroimaging

Schizotypal PD

- ↑ VBR
- ↓ cerebral volume: STG, planum temporale, fusiform gyrus, anterior limb of internal capsule
- fMRI: altered default mode network connectivity (cognitive or emotional regulation)

Antisocial PD

- ↓ Cerebral volume: orbito-frontal, middle-frontal, B/L medial PFC
- Violent offence: ↓ brain volume, hippocampal area (> with SUD)
- fMRI: ↓ activation in B/L DL PFC
- DTI: ↓ white matter fractional anisotropy in the genu of corpus callosum (B/L)

Borderline PD

- fMRI: abnormal structural and functional connectivity – ACC, PCC and precuneus (emotional regulation circuitry)
- DBT enhances functional connectivity between limbic and prefrontal regions

Neuroimaging (Cont.)

Narcissistic PD

- ↓ grey matter volume: right middle frontal gyrus, left anterior insular region
- DTI: ↓ fractional anisotropy in right frontal lobe white matter

Neurochemistry

Schizotypal PD

- ↓ striatal dopaminergic activity

Cluster-B PDs (ASPD & BPD)

- 5-HIAA levels (CSF) and parameters of 5-HT functioning are inversely related to impulsive aggression & negative affect
- COMT and MAO levels are inversely related to sensation seeking & impulsivity
- Abnormalities concerning the regulation of cortisol, catecholamines and glucose occur in antisocial PD

Psychological Factors: Theories Of Personality

Cognitive theory

- Individual's perception and interpretation shape the emotional and behavioural response to situations
- Conceptualizes PDs in terms of pervasive self-perpetuating cognitive–interpersonal cycles that are dysfunctional

Psychodynamics theory

- Personality is codetermined by temperament, character and superego
- Temperament (constitutionally given): intensity, rhythm and threshold of affective responses
- Character: dynamic organization of behavioural patterns of each individual, i.e., behavioural manifestations of ego identity, ego structures and ego functions
- Superego: internalized value system
- The dynamic unconscious (id) constitutes the dominant and potentially conflictive motivational system of personality

Psychological Factors: Theories Of Personality & Trauma

Interpersonal theory (Benjamin, 1996)

- Early childhood experiences of relationship with attachment objects patterns adult personality through the development of an internal working model (internalized representation of important persons [IRIPs]), which resembles the attachment object
- When mixed warm and hostile messages (complex codes) are shown by important others in a major way, the person may be unable to accurately label his/her own affect or know how others see him/her

Childhood maltreatment/ abuse

- Longitudinal studies: association of childhood abuse or neglect with later PDs
  - Johnson et al (1999) observed 639 families in the USA over 18 years: 4X

Clinical Presentation

Patterns of behaviours start manifesting in adolescence and continue till late adulthood

- Frequent mood swings
- Anger outbursts, inappropriate at times
- Difficulty in delaying gratifications
- Need to be the centre of attention
- Unwillingness to get involved unless certain of being liked
- Insensitivity to the concerns and needs of others
- Proneness to overemphasize importance
- Social anxiety sufficient to cause difficulty in making friends
- Feelings of being widely cheated or taken advantage of
- Tendency to bear grudges or unforgiving of insults
- Tendency to externalize and blame the world for one's behaviours and feelings
- Tendency to feel that there is nothing wrong with one's behaviour (ego-syntonic)
- Oversuspiciousness without sufficient basis
- Oversensitivity to negative criticism
- Avoidance behaviour
- Excessive devotion to work and perfectionism

R/O other explanations (mental illness, medical condition or substance use)

Paranoid PD

- Excessive suspiciousness and distrust expressed as a tendency to interpret actions of others as deliberately demeaning, hateful, threatening, exploiting or deceiving
- DSM-5:
  - General population: 0.5–4.4%
  - Psychiatric outpatients: 2–10%
  - Psychiatric inpatients: 10–30%
  - More Dx: males
- Comorbid PDs: Cluster A, NPD, AvPD, BPD
- Complications: ↑ risk of depression, OCD, agoraphobia, SUD, brief reactive psychosis
- Antecedent of delusional disorder

Schizoid PD

- Pervasive pattern of social detachment and a restricted range of expressed emotions in interpersonal settings
- DSM-5
  - General population: 3.1–4.9%
  - More Dx: males
- Comorbid PDs: PaPD, StPD, AvPD
- Complications: brief reactive psychosis
- Antecedent of delusional disorder, schizophrenia, depression

Schizotypal PD

- Social and interpersonal deficits indicated by pervasive discomfort with & reduced capacity for close relationships; cognitive and perceptual distortions; and eccentric behaviour
- DSM-5
  - General population: 3.9–4.6%
- Comorbid PDs: ScPD, PaPD, AvPD, BPD
- Complications: depression, brief reactive psychosis
- ↑ prevalence of schizotypal PD among 1° relatives of probands with schizophrenia

Borderline PD

- Pervasive and excessive instability of affects; self-image; interpersonal relationships; and marked impulsivity
- DSM-5
  - General population: 2%
  - Psychiatric outpatients 10%
  - Psychiatric inpatients 20%
  - More Dx: females, young (improve)
- Comorbid PDs: most PDs, Cluster B
- Complications: depression, SUD, PTSD, ADHD, ED (bulimia), micro-psychotic ep, physical complications, death (early years)
- Course: improves over 2 decades

Antisocial PD

- Pervasive disregard for, and violation of, the rights of others occurring since the age of 15 years and continuing into adulthood (Dx after 18 years, CD before 15 years)
- DSM-5
  - Gen. popln: 3% M; 1% F (LSES, Urban)
  - Clinical: 10-30%
  - Higher rates: Legal, SUD
  - More Dx: males
- Comorbid PDs: Cluster B
- Complications: ICD, SUD, pathological gambling, depression, anxiety, somatization, death
- Course: improves over 3 decades

Narcissistic PD

- Pervasive sense of grandiosity (fantasy; behaviour), need for admiration, lack of empathy and chronic intense envy
- DSM-5
  - Gen. popln: <1%
  - Clinical: 2-16%
  - More Dx: males
- Comorbid PDs: BPD, ASPD, HiPD, PaPD
- Complications: depression, SUD
- Course: diminish after 40 years

Histrionic PD

- Pervasive and excessive self-dramatization, excessive emotionality and attention seeking
- DSM-5
  - General population: 2%
  - Clinical: 10-15%
  - Dx: Equal across genders
- Comorbid PDs: NaPD, BPD, ASPD, DePD
- Complications: depression, somatization, conversion disorder
- Interpersonal: suicidal gestures, shallow/ unstable, marital problems

Obsessive Compulsive PD

- Pervasive preoccupation with orderliness, perfectionism, mental and interpersonal control at the expense of flexibility, openness and efficiency
- DSM-5
  - General population: 2-8%
  - Clinical: 3-10%
  - More Dx: males
- Comorbid PDs: Cluster-C
- Complications: depression, anxiety, ?OCD; ?MI(type A features)

Avoidant PD

- Pervasive and excessive hypersensitivity to negative evaluation, social inhibition and feelings of inadequacy
- DSM-5
  - General population: 0.5-2%
  - Clinical: 10%
  - Dx: equal across genders
- Comorbid PDs: ScPD, StPD, PaPD, DePD, BPD
- Complications: mood, anxiety disorders (esp social phobia, generalized type)
- Course: begins in childhood with shyness

Dependent PD

- Pervasive and excessive need to be taken care of, leading to clinging behaviour, submissiveness, fear of separation and interpersonal dependency
- DSM-5
  - General population: 0.5-0.6%
  - Dx: equal across genders
- Comorbid PDs: HiPD, AvPD, BPD
- Complications: depression, anxiety, adjustment disorder and social phobia

ICD-11

3 steps

All cases

- Essential features of PD
- Severity - mild, moderate, severe

Optional

- Trait domain specifiers
  - Negative affectivity, detachment, dissociality, disinhibition, anankastia
- Borderline pattern
  - ≥5/9 DSM-5 criteria

ICD-11: Essential Features

- Problems in the functioning of
  - Aspects of self (e.g., identity, self-worth, accuracy of self-view, self-direction)
  - Interpersonal dysfunction (e.g., ability to develop & maintain close and mutually satisfying relationships, ability to understand others' perspectives and manage conflicts)
- Persists over an extended period (e.g., ≥2 years)
- Manifests in patterns of cognition, emotional experience/ expression and maladaptive behaviour (e.g., inflexible or poorly regulated)
- Manifests across personal/ social situations (i.e., not limited to specific relationships/ social roles)
- Disturbance are not developmentally appropriate; can't be explained by social/ cultural factors
- Disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning

ICD-11:Severity

Mild personality disorder

- Problems are discrete; affect specific areas of personality functioning
- Can maintain at least some relationships and occupational roles
- Not typically associated with substantial harm to oneself or others

Moderate personality disorder

- Problems are diffuse; affect several areas of personality functioning
- Social roles markedly compromised; Few friendships are maintained; normal work relationships are absent & conflict with others common and persistent
- History and expectation of harm to self/ others (long-term damage or danger to life unlikely)

Severe personality disorder

- Problems in social interaction profound; multiple/ all aspects of personality fn
- Friendships are shallow/ non-existent; Occupational roles are absent or severely compromised; Societal responsibilities are ignored
- History and expectation of harm to self/ others (caused long-term damage or danger to life)

ICD-11: Trait Domain Specifiers

Negative affectivity

- Core feature: tendency to experience a broad range of negative emotions
- Common manifestations
  - Experiencing a range of negative emotions (frequency and intensity out of proportion to the situation)
  - Emotional lability and poor emotion regulation
  - Negativistic attitudes
  - Low self-esteem and self-confidence
  - Mistrustfulness

Detachment

- Core feature: tendency to maintain interpersonal and emotional distance
- Common manifestations
  - Social detachment (avoidance of social interactions, lack of friendships, avoidance of intimacy)
  - Emotional detachment (reserve, aloofness, limited emotional expression & experience)

ICD-11: Trait Domain Specifiers

Dissociality

- Core feature: disregard for the rights and feelings of others, encompassing self-centredness and lack of empathy
- Common manifestations
  - Self-centeredness (e.g., entitlement, expectation of admiration, attention-seeking, concern with one's own needs/ desires/ comfort)
  - Lack of empathy (i.e., indifference to inconvenience or hurt of others – deceptive/ manipulative/ exploitative/ ruthless; mean/ aggressive; callousness to others' suffering)

Disinhibition

- Core feature: tendency to act rashly based on immediate external or internal stimuli (i.e., sensations, emotions, thoughts) without consideration of potential negative consequences
- Common manifestations
  - Impulsivity, distractibility, irresponsibility, recklessness, lack of planning

Anankastia

- Core feature: narrow focus on one's rigid standard of perfection/ right and wrong/ on controlling one's own and other's behaviour and controlling situations to ensure conformity to these standards
- Common manifestations
  - Perfectionism (e.g., concern with social rules/ obligations/ norms of right and wrong; scrupulous attention to detail; rigid/ systematic day-to-day routines; hyper-scheduling and planfulness; emphasis on organization/ orderliness/ neatness)
  - Emotional and behavioural constraint (e.g., rigid control over emotional expression; stubbornness and inflexibility; risk avoidance; perseveration/ deliberativeness)

Borderline pattern

- Pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity
  - Frantic efforts to avoid real or imagined abandonment
  - Pattern of unstable and intense interpersonal relationships
  - Identity disturbance (markedly and persistently unstable self-image or sense of self)
  - Tendency to act rashly in states of high negative affect (potentially self-damaging behaviours)
  - Recurrent episodes of self-harm
  - Emotional instability due to marked reactivity of mood
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger
  - Transient dissociative or psychotic-like features in situations of high affective arousal

Differential diagnoses: Paranoid PD

Differential Dx	Differentiating features	Assessment
Schizophrenia/ psychotic D	When brief reactive psychosis occurs with PaPD - short duration of psychosis; frequent association with stress	Hx & MSE PANSS
Schizotypal PD	Additional features of StPD: magical thinking; unusual perceptual experiences; oddities in speech/ appearance/ thought processes	Hx & MSE IPDE
Avoidant PD	AvPD: avoidance due to fear of embarrassment PaPD: avoidance due to paranoid ideations	Hx & MSE IPDE
Antisocial PD	PaPD rarely demonstrate antisocial behaviour for personal gains	Hx & MSE IPDE
Narcissistic PD	NPD may fear revelation of 'hidden' imperfections and flaws but they do not fear persecution	Hx & MSE IPDE

Differential diagnoses: Schizod PD

Differential Dx	Differentiating features	Assessment
Schizophrenia/ psychotic D	When brief reactive psychosis occurs with ScPD - short duration of psychosis; frequent association with stress	Hx & MSE PANSS
ASD	ASD have more severely impaired social interactions; stereotypic behaviours and interests	Dev Hx & MSE ISAA, IND-ASD
Schizotypal PD	Additional features of StPD: magical thinking; unusual perceptual experiences; oddities in speech/ appearance/ thought processes	Hx & MSE IPDE
Avoidant PD	AvPD: avoidance due to fear of embarrassment ScPD: social detachment, emotional detachment	Hx & MSE IPDE
OC PD	OCPD have adequate capacity for intimacy, despite isolation due to perfectionism and workaholic attitudes	Hx & MSE IPDE
Paranoid PD	Additional features of PaPD: suspiciousness, ideas of reference, guardedness	Hx & MSE IPDE

Differential diagnoses: Schizotypal PD

Differential Dx	Differentiating features	Assessment
Schizophrenia/ psychotic disorder(s)	When brief reactive psychosis occurs with ScPD - short duration of psychosis; frequent association with stress	Hx & MSE PANSS
Communication disorders	Primacy and the severity of the language disorder & compensatory efforts to communicate by other means	Dev Hx & MSE Specific scales
ASD	ASD have more severely impaired social interactions; stereotypic behaviours and interests	Dev Hx & MSE ISAA, IND-ASD
Schizoid PD Paranoid PD	Additional features of StPD: magical thinking; unusual perceptual experiences; oddities in speech/ appearance/ thought processes	Hx & MSE IPDE
Avoidant PD	AvPD: avoidance due to fear of embarrassment ScPD: social & emotional detachment; oddities in speech/ behaviour	Hx & MSE IPDE
Borderline PD	Affective instability; stormy relationships; impulsive & manipulative behaviour	Hx & MSE IPDE
Narcissistic PD	Sense of grandiosity, fragile self-esteem and fear of having their 'hidden' imperfections or flaws revealed are usually not seen in schizotypal PD	Hx & MSE IPDE

Differential diagnoses: Antisocial PD

Differential Dx	Differentiating features	Assessment
Bipolar disorder, manic	Both conditions: anger outbursts, impulsivity, substance use Bipolar D: episodic, sustained elated mood	Hx & MSE YMRS
Narcissistic PD	NaPD: excessive need for admiration and envy of others, but rarely serious criminality, aggression and deceit	Hx & MSE IPDE
Histrionic PD	HiPD: seductiveness, attention seeking, superficiality, but rarely serious criminality and aggressiveness	Hx & MSE IPDE
Borderline PD	BPD: manipulativeness to gain nurturance; affective instability, but rarely serious criminality	Hx & MSE IPDE
Paranoid PD	PaPD: suspiciousness, and guardedness, but rarely serious antisocial behaviours	Hx & MSE IPDE

Differential diagnoses: Narcissistic PD

Differential Dx	Differentiating features	Assessment
Bipolar disorder, manic	Both conditions: grandiosity Bipolar disorder: episodic, sustained elated mood	Hx & MSE YMRS
Antisocial PD	NaPD: exploit due to desire for dominance rather than material gains ASPD: history of conduct disorder	Hx & MSE IPDE
Histrionic PD	HiPD: capacity for empathy and emotional display, rarely unscrupulousness and exploitation of others	Hx & MSE IPDE
Borderline PD	BPD: unstable self-concept, chaotic behaviours, self-destructive gestures; chronic anxiety	Hx & MSE IPDE
OCPD	OCPD: excessive emphasis on details and perfectionism	Hx & MSE IPDE

Differential diagnoses: Histrionic PD

Differential Dx	Differentiating features	Assessment
Antisocial PD	ASPD: history of conduct disorder; antisocial behaviours and crime to gain profit, power or material gratification; lack of excessive self-dramatization or exaggerated emotional expression	Hx & MSE IPDE
Borderline PD	BPD: unstable self-concept, chaotic behaviours, self-destructive gestures; chronic anxiety, identity disturbance	Hx & MSE IPDE
Narcissistic PD	NaPD: fear of having their 'hidden' imperfections and flaws revealed; sense of grandiosity and specialness	Hx & MSE IPDE

Differential diagnoses: Avoidant PD

Differential Dx	Differentiating features	Assessment
Social phobia	Social phobia: avoidance of social contacts in specific situations rather than avoidance of nearly all interpersonal contact	Hx & MSE Leibowitz Social Anxiety Scale
Panic disorder with agoraphobia	PDA: Avoidance of situations where help may not be available rather than avoidance of interpersonal relationships	Hx & MSE HAMA
Schizotypal PD Schizoid PD	AvPD: desire social relations	Hx & MSE IPDE
Paranoid PD	PaPD: guardedness, preoccupation with hidden meanings and conspiratorial explanations of events	Hx & MSE IPDE
Dependent PD	DePD: focused on being taken care of by others rather than fear of negative evaluation by others	Hx & MSE IPDE

Differential diagnoses: Dependent PD

Differential Dx	Differentiating features	Assessment
Borderline PD	BPD: unstable, stormy relationships; anger in reaction to rejection; demandingness as opposed to submissiveness	Hx & MSE IPDE
Histrionic PD	HiPD: clinginess as part of attention seeking Gregarious flamboyance with active demands for attention	Hx & MSE IPDE
Avoidant PD	AvPD: avoidance of interpersonal contact because of the fear of negative evaluation as opposed to clinging and submissive behaviour	Hx & MSE IPDE

Differential diagnoses: Obsessive Compulsive PD

Differential Dx	Differentiating features	Assessment
OCD	OCD: obsessions and compulsions are egodystonic	Hx & MSE YBOCS
Schizoid PD	ScPD: lack of capacity for intimacy; social isolation due to emotional detachment as opposed to devotion to work	Hx & MSE IPDE
Narcissistic PD	NaPD: sense of grandiosity, self-aggrandizement, exhibitionism, and fear of having their 'hidden' imperfections and flaws revealed	Hx & MSE IPDE

Management: Assessment

Clinical work-up: description of incidents/ events with associated cognition, emotion, behaviours and interpersonal functioning to assess traits

Description in the classificatory systems (DSM-5, ICD-10 or ICD-11) may be used to guide the exploration

Self-reported screening instruments

- Structured Clinical Interview for DSM-5 Screening Personality Questionnaire (SCID-5-SPQ)
- Millon's Clinical Multiaxial Inventory (MCMI)-IV
- International Personality Disorder Examination - Screening Questionnaire (IPDE-SQ)

Semi structured interview-based instruments

- Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD)
- Quick Personality Assessment Schedule (PAS-Q)
- Standardized Assessment of Personality: Abbreviated Scale (SAPAS)
- Standardized Assessment of Personality - Abbreviated Scale for Informants (SAPAS-INF)
- International Personality Disorder Examination (IPDE): available in Hindi

Management: Assessment

ICD-11

- Standardized Assessment of Severity of Personality Disorder (SASPD)
- Personality Inventory for ICD-11 (PiCD)
- Informant-Personality Inventory for ICD-11 (IPiC)

DSM-5

- Level of Personality Functioning Scale - Self Report (LPFS-SR-DSM-5)
- Structured Clinical Interview for the DSM-5 Alternative Model of Personality Disorders (SCID-AMPD)

OTHER MODELS

- Quick Personality Assessment Schedule (PAS-Q)
- Dimensional Assessment of Personality Pathology (DAPP)
- Neuroticism, Extraversion and Openness - Personality Inventory (NEO-PI-3)
- Big Five Inventory (BFI)
- Temperament and Character Inventory (TCI)

Assessment of psychiatric comorbidities

Comorbidity	Common clinical instruments	Commonly associated PDs
Depressive disorder	HDRS	PaPD, StPD, ASPD, NPD, HiPD, BPD, DePD
GAD	GAD-7	ASPD, NPD, AvPD, DePD, OCPD
Social phobia	Liebowitz Social Anxiety Scale	AvPD, DePD
OCD	YBOCS	PaPD, OCPD
Somatic symptom disorder	PHQ-15	ASPD, HiPD
Dissociative disorders	DES	BPD, HiPD
Impulse control disorder	MIDI	ASPD, BPD
SUD	ASSIST	PaPD, ASPD, NPD, BPD
Gambling disorder	SOGS	ASPD, NPD, BPD
Psychosis	BPRS	ScPD, StPD

Treatment: Psychotherapy

- Nonpharmacological interventions are the first-line treatment option for PDs (high-quality evidence, strong recommendation)
- Several types of psychotherapies are efficacious
- Bateman and Fonagy recommend that psychotherapy for PD should be:
  - (a) long term, (b) integrated with other services, (c) theoretically coherent and (d) focused on compliance (moderate-quality evidence, strong recommendation)
- Psychotherapy for PDs in developing countries would be largely supportive, with simple cognitive–behavioural approaches and lifestyle management, as required (low-quality evidence, strong recommendation)

Psychotherapies

Type	Purpose	Level of evidence	Strength of recommendations
Psychodynamic therapy	To increase reflective capacity; and emotional & interpersonal understanding	Level I	Strong
CBT	To alter dysfunctional core beliefs	Level I	Strong
DBT	Initially, to reduce self-harm; eventually, to achieve transcendence	Level I	Strong
Therapeutic community	To effect attitudinal and behavioural change	Level II	Strong
Cognitive analytic therapy	To achieve greater self-understanding	Level III	Weak
Behaviour therapy	To improve maladaptive behaviour	Level III	Strong
Nidotherapy	To achieve better environmental adjustment, thus minimizing impact of disorder	Level IV	Weak

Dialectical Behavioral Therapy (DBT)

- Philosophy: incorporates dialectics and validation into a treatment focused on skills acquisition and behavioral shaping
- Formulation: BPD is a result of the transaction between individuals born with high emotional sensitivity and 'invalidating environments' (i.e., families, schools, treatment settings, workplaces) that cannot perceive, understand, and respond effectively to their vulnerabilities
- Proposal: individuals can become more effective in managing their sensitivities and interactions with others through acquisition of skills that enhance mindfulness and enable them to better tolerate distress, regulate their emotions, and manage relationships
- Validated package: 1 hour of weekly individual therapy, 2-hour group skills training session, out-of-session paging, and consultation team for the therapist

Mentalization-Based Treatment (MBT)

- Mentalization refers to the complex capacity human beings develop to imagine the thoughts and feelings in one's own and other's minds to understand interpersonal interactions
- Formulation: PD symptoms arise when a patient stops mentalizing, leading patients to operate from pathologically certainty about other's motives, the disconnection from grounding influence of reality, and a desperate need for proof of feelings through action
  - Attachment interactions become hyperactivated, feeding into distress and difficulty coping, rather than providing safety and security, rendering the therapeutic process with BPD difficult
- Proposal: aims to stabilize the problems of BPD by strengthening the patient's capacity to mentalize under the stress of attachment activation
- Validated package: 50 min of weekly individual therapy, 75 min of group therapy, and a reflecting team meeting to support clinical team members' mentalization

Transference-Focused Psychotherapy (TFP)

- Formulation: identity diffusion, primitive defense mechanisms (e.g., splitting), unstable reality testing, internally and externally expressed aggression, and conflicted internal working models of relationships are key features of PDs at borderline level of organization
- Proposal: focus on the problematic interpersonal dynamics in the patient's life and their resultant intense emotional states
  - The patient's inherent interpersonal dynamic emerge in interactions with the therapist in the transference, and are jointly examined to resolve the splits between good and bad that drive instabilities in affect and relationships
  - Helping patients achieve more balanced, integrated, and coherent ways of thinking about oneself and others
- Package: 2 weekly individual therapy sessions, without group therapy; clinicians are encouraged to receive supervision

Schema-Focused Therapy (SFT)

- Integrative cognitive therapy focused on generating structural changes to a patient's personality
- Proposal: variety of behavioral, cognitive, & experiential techniques that focus on the therapeutic relationship, daily life outside therapy, and past traumatic experiences
  - Unlike the neutral stances of other therapies, SFT encourages an attachment between therapist and client, a process described as "limited re-parenting"
  - Therapy focuses on four schema modes of BPD: detached protector, punitive parent, abandoned/ abused child, and angry/ impulsive child
- Package: 2 weekly individual therapy sessions

General Psychiatric Management (GPM)

- Issue of significant training and clinic resources
- Proposal: case management model (focus: patient's life outside Rx; common sense interventions)
  - Prioritizes attainment of stable vocational functioning over romantic relationships; and improvement in social functioning over specific symptom improvement
  - Diagnostic disclosure and psychoeducation for patients and their families (positive prognosis)
  - Multimodal (psychotropics, coordinated provision of group and family therapy)
  - Facilitate the natural course of the disorder with specific attention to functioning
  - Focus on interpersonal hypersensitivity (symptoms cascade from interpersonal stressor e.g., separation, criticism) - therapist hypothesizes that emotion dysregulation, impulsive or self-harming behavior, or hospitalization result from interpersonal problems, and works with the patient to understand his/ her sensitivities and responses
- Package: one weekly individual appointment

Pharmacotherapy

- Not routinely advised for PDs: Role
  - Targeting specific symptoms/ symptom clusters (high-quality evidence, strong recommendation)
  - Crisis management - short-term prescription (moderate-quality evidence, strong recommendation)
  - Management of coexisting psychiatric disorders (moderate-quality evidence, strong recommendation)
- Psychotropics: limited evidence
  - Antidepressants: comorbid depression, anxiety, phobias; mood swings, impulsive behaviours, suicidality
  - Mood stabilizers: mood swings, substance use, aggression (lithium for suicidality)
  - Antipsychotics: psychotic symptoms, mood swings, aggression, sleep disturbances
  - Anxiolytics: anxiety and panic attacks (caution: risk of habit formation and paradoxical increase in impulsivity)

Psychotropic medications

Drugs	Doses (mg/day)	Indications	Level of evidence	Strength of recommendations
Escitalopram	5–20	Impulsivity, anger, affective instability, depression, self-harm and anxiety symptoms	Level II	Strong
Sertraline	50–200	Same as escitalopram *(may be better tolerated by some individuals)*	Level II	Strong
Mirtazapine	7.5–45	Depression, anxiety and somatic symptoms	Level IV	Weak
Lamotrigine	25–275	Affective instability, impulsivity, anger and aggression	Level II	Weak
Topiramate	100–250	Aggression and somatic symptoms (e.g., headache)	Level II	Weak

Psychotropic medications

Drugs	Doses (mg/day)	Indications	Level of evidence	Strength of recommendations
Divalproex	250–1500	Impulsivity, anger, aggression and substance use	Level II	Weak
Olanzapine	2.5–20	Inappropriate anger, impulsivity, paranoid ideation and dissociative symptoms *(side effects may lead to poor adherence to treatment in higher doses)*	Level I	Strong
Aripiprazole	5–30	Anger, depression, anxiety and self-harm	Level II	Weak
Risperidone	0.5–8	Anger, cognitive inflexibility, paranoid ideation and affective instability	Level II	Weak
Quetiapine	25–600	Sleep disturbance, cognitive inflexibility, paranoid ideation and affective instability	Level II	Weak

Tips for using Psychotropic Medications

Medications should not be the only Rx - adjunct to psychological interventions

Collaborative decision involving the patient (families)

Risk-benefit analysis: limited benefit of medications vs. harmful side effects

Monitor closely for SEs

Consider lowest possible doses

Avoid polypharmacy: withdraw previous medication before prescribing a new one

Beware of the risk of prescription medication overdose (self-harm/ suicidal behaviours)

Be aware of the local medico-legal atmosphere

Conclusions

PDs are associated with high mortality and morbidities
Various Rx approaches significantly improve QOL
Managing psychiatric comorbidities (e.g., depression) is important
Psychological interventions are the first-line Rx option for all PDs
DBT has shown the best response in BPD
Focus on Rx adherence and lifestyle modification may be beneficial
Pharmacotherapies address specific symptoms (e.g., mood swings, aggression)

Thanks

Guideline links

Title	Society	Year	Links
Principles of care for people with a PD	NICE	2020	http://pathways.nice.org.uk/pathways/personality-disorders
Practice guideline for the treatment of patients with BPD	APA	2001	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bpd.pdf
WFSBP guidelines for biological treatment of PDs	WFSBP	2007	https://www.wfsbp.org/fileadmin/user_upload/Treatment_Guidelines/Guidelines_Personality_Disorders.pdf
CPG for the management of BPD	NHMRC, Australia	2013	https://bpdfoundation.org.au/images/mh25_borderline_personality_guideline.pdf

GRADE criteria

Level of evidence	
High	Very confident that the true effect lies close to that of the estimate of the effect
Moderate	The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low	The true effect may be substantially different from the estimate of the effect
Very low	The true effect is likely to be substantially different from the estimate of effect
Strength of recommendation	
Strong	Indicates confidence that the benefits of the intervention clearly outweigh the harm
Weak	Indicates uncertainty (difficult to judge balance of benefits and harm/ unclear benefits or harm)