Chapter 6
Personality Disorders

Somma A.[a], Fregna L.[b,*], Martini F.[b,*], Fossati A.[a]

[a]: School of Psychology, Vita-Salute San Raffaele University, Milan

[b]: IRCCS San Raffaele Scientific Institute, Milan

***Corresponding Authors:**

fregna.lorenzo@hsr.it

francesca.martini1@hsr.it

Other authors: somma.antonella@hsr.it, fossati.andrea@hsr.it

Abstract

The present chapter aims at providing an overview of the current state-of-the-art as to the conceptualization, diagnosis, epidemiology, etiological correlates, and treatment of personality disorders (PDs). The two DSM-5 models for PDs (i.e., the traditional categorical model listed in DSM-5 Section II and the Alternative Model of PD proposed in DSM-5 Section III) are reviewed and the scientific rationale for moving from a categorical model to an empirically based dimensional model of PDs are presented. Key aspects and basic principles of PD treatment are summarized. Finally, the chapter offers three clinical vignettes to help the reader familiarizing with the clinical presentation of PDs.

Keywords: Personality Disorders; DSM-5 Section II Personality Disorders Model; DSM-5 Section III Alternative Model of Personality Disorders; Personality Disorders Epidemiology; Personality Disorders Treatment.

6.1. Definitions

Personality disorders (PDs) are very common conditions affecting the interaction between health professionals and patients. Accordingly, they are important to all medical practitioners because of their key role as predictors of treatment outcome, cause of premature mortality, and great cost to society. Therefore, PD should be an important part of every psychiatric assessment, whether done by a qualified expert in PD or a family doctor. However, PD assessment has largely been overlooked in clinical psychiatric practice. For many years (even after the release of the DSM-III in 1980), the PD diagnosis has been used in a pejorative sense, or as a label applied to people who were considered as difficult to treat. Attention to PD in practice has therefore oscillated between attempts to dismiss it as a non-diagnosis, or instead, to regard it as a specialist subject that could be placed outside the realm of "true" psychiatric disorders. The difficulties with the PD diagnosis stem from issues that the scientific and clinical community started to address only in recent years: indeed, nobody doubts the existence of personality, but what constitutes its dysfunctionalities has been difficult to specify. For instance, the DSM-IV-TR and the DSM-5 Section II describe PD general features as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of an individual's culture. This pattern is manifested in two or more of the following areas: cognition, affectivity, interpersonal functioning, impulse control. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations, leads to clinically significant distress or impairment in social, occupational or other important areas of functioning, is stable and of long duration, and its onset can be traced back at least to childhood or early adulthood, and is not better accounted for by other mental disorder or effects of a substance". As it can be easily observed, this statement has three major problems: a) it does not indicate what represents normal personality and its functions; b) consequently, which functions should be perturbed to generate PD; consequently, c) it provides no formal diagnostic criteria for general PD diagnosis. From this poor operationalization of PD diagnosis were likely to originate many of the problems that we will take into considerations in the next sections. As Tyrer and colleagues nicely documented in 2015, the DSM-5 Section II PD diagnoses rely heavily on Schneider's nine pathological personality types. Schneider's nine personality types were based solely on his clinical experience; notwithstanding this fact, they have generally persisted in slightly different forms in all subsequent classifications of personality pathology until DSM-5 Section II. Since the release of DSM-III, operational criteria were used to define ideal or prototypical manifestations that could be considered as exemplars of each PD. Antisocial, borderline, narcissistic, and other qualifying adjectives have proved so enticing to clinicians describing patients that they have often led clinicians to bypass the issue of their scientific foundation. Regrettably, extant research indicates that the DSM-IV/DSM-5 Section II PD categories

are neither valid nor homogeneous types (rather, PDs are better conceptualized as dimensions than as categories), while showing extensive co-occurrence rates with other psychiatric conditions and marked continuities with potentially adaptive personality traits. In an attempt to move the science forward, the DSM-5 Personality and Personality Disorder Work Group proposed the Alternative Model of Personality Disorder (AMPD), which is currently included in the DSM-5 Section III. Consistent with DSM-5 general aim to provide clinicians with trans-theoretical operational criteria for mental disorder diagnoses, which are thought to provide clinicians both maximally inter-rater reliable and valid diagnostic criteria, the DSM-5 AMPD strongly relied on scientific evidence in providing a new approach to PD diagnosis that was largely dimensional in nature (although six diagnostic types are still available). Interestingly, the evidence-based dimensional approach to PD diagnosis, leading to abandoning the typological tradition in PD assessment, informed also the development of PD criteria in the ICD-11. Regrettably, the adoption of a typological model, which received few (if any) empirical supports, in PD research is likely to represent a major reason for the (very) limited advancement of knowledge in aetiology, pathogenesis, and treatment efficacy in personality pathology.

6.2. Diagnosis

The *DSM-5* Section II PD criteria provide ten PD categories, which are assumed to represent independent conditions; as we observed in the introduction, the *DSM-5* Section II provides also a general PD description, which is not required to be met for individual PD diagnoses. In other terms, no formal assessment of the general PD criteria is required to carry out one or more specific PD diagnoses. Rather, the *DSM-5* Section II approach assumes that if the criteria for one or more of the individual PD diagnoses are met, then also the general criteria are satisfied. The *DSM-5* Section II proposes that the 10 PD diagnoses may be grouped in three clusters:

1. Cluster A, which includes Paranoid, Schizoid, and Schizotypal PDs and is defined as the "Odd-Suspicious Cluster";
2. Cluster B, which includes Antisocial, Borderline, Histrionic, and Narcissistic PDs and is defined as the "Dramatic-Emotional-Erratic Cluster";
3. Cluster C, which includes Avoidant, Dependent, and Obsessive-Compulsive PDs and is defined as the "Anxious-Fearful Cluster."

It should be observed that the *DSM-5* Section II 10 PD diagnoses rely on a polythetic format, i.e., only a limited number of criteria should be met to receive the PD diagnosis. For instance, although a total of 9 criteria are provided in *DSM-5* Section II for Schizotypal PD, only five (or more) criteria

are needed for Schizotypal PD diagnosis. Table 1 lists the 10 *DSM-5* Section II PDs, their alleged main presentation, and diagnostic thresholds (i.e., number of criteria that should be met for PD diagnosis). Of course, these conditions should not be the consequence of the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma), and should not be better explained as a manifestation or consequence of another mental disorder. However, the presence of a given PD diagnosis does not exclude the possibility to diagnose one or more other *DSM-5* PDs if diagnostic thresholds are met, as well as of other *DSM-5* Section II psychiatric conditions (e.g., major depression) that may co-occur.

Table 1. The *DSM-5* Section II Personality Disorders: Alleged Main Presentations, Diagnostic Thresholds, and Number of Criteria.

Personality Disorders	Main Presentation	N. of Criteria	Diagnostic Threshold
Paranoid	A pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent	7	4
Schizoid	A pattern of detachment from social relationships and a restricted range of emotional expression	7	4
Schizotypal	A pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour	9	5
Antisocial	A pattern of disregard for, and violation of, the rights of others	7 (+ 15 for Conduct Disorder)	3 (+3)
Borderline	A pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity	9	5
Histrionic	A pattern of excessive emotionality and attention seeking	8	5
Narcissistic	A pattern of grandiosity, need for admiration, and lack of empathy	9	5
Avoidant	A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation	7	4

Dependent	A pattern of submissive and clinging behaviour related to an excessive need to be taken care of	8	5
Obsessive-Compulsive	A pattern of preoccupation with orderliness, perfectionism, and control	8	4
Residual Categories			
Personality change due to another medical condition	A persistent personality disturbance that is judged to be due to the direct physiological effects of a medical condition (e.g., frontal lobe lesion).	--	--
Other specified personality disorder	The individual's personality pattern meets the general criteria for a PD, but the individual is considered to have a PD that is not included in the *DSM-5* classification	Variable	Variable
Unspecified personality disorder	The individual's PD meets the general criteria for a PD, and traits of several different PDs are present, but the criteria for any specific PD are not met	76 (+ 15 for Conduct Disorder)	Variable

As we stated in the Introduction, the *DSM-5* Section II PD criteria represent the "cut-and-paste" of the *DSM-IV/-TR* axis II PD criteria, which in turn were highly similar to those that were reported in the *DSM-III-R* axis II. Thus, more than one generation of clinicians has been trained to PD assessment and treatment based on these criteria. Notwithstanding this traditional appeal, extant research indicates that the *DSM-5* Section II criteria are likely to lack scientific support and to provide PD diagnoses of very limited clinical usefulness. Differential diagnosis among *DSM-5* Section II PDs is often problematic, and high PD covariation rates are the rule rather than the exception. Mostly, a number of studies documented that PD tend to co-vary rather than to co-occur (i.e., they show systematic patterns of association). Indeed, arbitrarily splitting maladaptive personality dimensions into fuzzy categories based on mixtures of trait-like features and symptom-like features rather than on sound definition of core features of personality functioning and their impairment may represent a pathway leading to PD diagnoses that are provided with few (if any) clinical usefulness. Additionally, the results of the Collaborative Longitudinal Personality Disorders Study suggest that PD criteria are likely to represent an admixture trait-like criteria and symptom-like criteria that are likely to capture behaviours that represent attempts to cope with internal or external demands (e.g., subject's self-harm to reduce affective tension in response to end of a relationship). Even *DSM-5* Section II PD clusters seems to be provided with validity problems, as evidenced by studies showing poor empirical evidence for the hypothesized three-cluster structure. As a whole, research stemming from clinical perspectives on *DSM-IV* PDs consistently stressed the inadequacy of relying on 10 categories for diagnosing and treating PDs. The unspecified PD diagnosis, which was defined as Mixed PD diagnosis in *DSM-IV/-TR*, represents a major issue in the clinical assessment of PDs. Indeed, it is likely to represent one of the most frequently observed PD diagnoses in clinical populations; however, it lacks any specific clinical meaning and does not allow to tailor treatment to a specific (personality) pathology.

Prominent scholars proposed to dismiss issues of differential diagnosis/PD overlap in favour of identifying core personality functions and assessing the severity of their impairment. Indeed, the severity of impairment in personality functioning, rather than specific PD diagnoses, seems to represent the most relevant factor for clinical decision making in PD treatment; however, it should be stressed that no specific criterion for PD severity is provided in *DSM-IV*/*DSM-5* Section II. Moreover, consensus emerged among scholars on relying on dysfunctional personality dimensions mapping onto the empirically and cross-culturally validated adaptive personality dimensions to describe the defining characteristics of the subject's personality pathology.

The *DSM-5* AMPD

These considerations led to the development of the *DSM-5* AMPD, which was designed to provide clinicians with PD diagnoses that would be both scientifically valid and clinically useful. In this respect, the *DSM-5* AMPD was thought to provide sound criteria for clinical PD assessment, thus overcoming the massive reliance of the *DSM-5* Section II PD diagnoses on time consuming psychometric measures (on average, semi-structured *DSM-5* Section II PD interviews take 1-2 hours to be administered), while providing sound measures for assessing both Criterion A and Criterion B features when formal PD assessment is required (e.g., certification, forensic assessment, research diagnoses, etc.). One of the major aims of *DSM-5* AMPD was to provide a clear distinction between personality dysfunction (i.e., problems in the core personality functions), and disability (i.e., functional impairments consequent to personality dysfunction). Thus, *DSM-5* AMPD provides a clear definition of core personality functions whose impairment should be identified in PD assessment. In developing the *DSM-5* AMPD, core personality functions were based on personality functioning features that were considered relevant by the majority of personality models.

In summary, the *DSM-5* AMPD asks clinicians to identify impairments in personality functioning and pathological personality traits to make PD diagnoses. Disturbances in *self* and *interpersonal functioning* constitute the core of personality psychopathology and they are evaluated on a continuum ranging from little or no impairment (i.e., healthy, adaptive functioning; Level 0) to extreme (Level 4) impairment. At least moderate (i.e., Level 2) impairment is required for PD diagnosis. Self-functioning involves identity and self-direction; interpersonal functioning involves empathy and intimacy. The *DSM-5* AMPD provides a measure (i.e., the Levels of Personality Functioning Scale) for helping clinicians in assessing Criterion A even using a limited amount of clinical work with the client. Table 2 lists elements of personality functioning.

Table 2. Elements of personality functioning.

Self	Interpersonal
Identity. Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.	**Empathy**. Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of one's own behaviour on others.
Self-direction. Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behaviour; ability to self-reflect productively.	**Intimacy**. Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behaviour.

The system of the five dysfunctional personality domains and 25 dysfunctional personality traits that were included in the *DSM-5* AMPD Criterion B is listed in Table 3 and Table 4, respectively. This system of dysfunctional personality features has three attractive characteristics: a) it may be easily observed during routine clinical assessment; b) it does not require sophisticated psychology/psychotherapy training (i.e., it can be easily used also by physicians); c) it avoids the potentially stigmatizing jargon of the *DSM-5* Section II PD diagnoses. Ideally, observing behaviours suggestive of dysfunctional personality traits and/or capturing indicators of poor self- and/or interpersonal functioning during first examination may be useful in targeting specialized assessment even in non-psychiatric context, such as general practitioner consultation. Indeed, PD subjects are known to have far higher morbidity and mortality than do those without. In 2015, Tyrer and colleagues reported that in the UK the life expectancy at birth for people suffering from personality dysfunctions is shorter by 19 years for women and 18 years for men than it is in the general population. Increased mortality can be explained partly by increased incidence of suicide and homicide in people with personality disorder; however, increased mortality from cardio- vascular and respiratory diseases suggests that other factors are also important, e.g., high prevalence of smoking, alcohol, and drug misuse in people with PDs.

Table 3. *DSM-5* AMPD Dysfunctional Personality Domains.

Negative Affectivity	Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/ shame, worry, anger) and their behavioural (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.
Detachment	Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions (ranging from casual, daily interactions to friendships to intimate relationships) and restricted affective experience and expression, particularly limited hedonic capacity.
Antagonism	Behaviours that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both an unawareness of others' needs and feelings and a readiness to use others in the service of self-enhancement.

Disinhibition	Orientation toward immediate gratification, leading to impulsive behaviour driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.
Psychoticism	Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviours and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs).

Table 4. *DSM-5* AMPD Dysfunctional Personality Traits.

Emotional lability	Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
Anxiousness	Feelings of nervousness, tenseness, or panic in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen.
Separation insecurity	Fears of being alone due to rejection by—and/or separation from—significant others, based in a lack of confidence in one's ability to care for oneself, both physically and emotionally.
Submissiveness	Adaptation of one's behaviour to the actual or perceived interests and desires of others even when doing so is antithetical to one's own interests, needs, or desires.
Hostility	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behaviour.
Perseveration	Persistence at tasks or in a particular way of doing things long after the behaviour has ceased to be functional or effective; continuance of the same behaviour despite repeated failures or clear reasons for stopping.
Withdrawal	Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
Intimacy avoidance	Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.
Anhedonia	Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure and take interest in things.
Depressivity	Feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; thoughts of suicide and suicidal behaviour.
Restricted affectivity	Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations.

Suspiciousness	Expectations of—and sensitivity to—signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others.
Manipulativeness	Use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends.
Deceitfulness	Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
Grandiosity	Believing that one is superior to others and deserves special treatment; self-centeredness; feelings of entitlement; condescension toward others.
Attention seeking	Engaging in behaviour designed to attract notice and to make oneself the focus of others' attention and admiration.
Callousness	Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others.
Irresponsibility	Disregard for—and failure to honour—financial and other obligations or commitments; lack of respect for—and lack of follow-through on—agreements and promises; carelessness with others' property.
Impulsivity	Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behaviour under emotional distress.
Distractibility	Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behaviour, including both planning and completing tasks.
Risk taking	Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger; reckless pursuit of goals regardless of the level of risk involved.
Rigid perfectionism (lack of)	Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order.

Unusual beliefs and experiences	Belief that one has unusual abilities, such as mind reading, telekinesis, thought-action fusion, unusual experiences of reality, including hallucination-like experiences.
Eccentricity	Odd, unusual, or bizarre behaviour, appearance, and/or speech; having strange and unpredictable thoughts; saying unusual or inappropriate things.
Cognitive and perceptual dysregulation	Odd or unusual thought processes and experiences, including depersonalization, derealisation, and dissociative experiences; mixed sleep-wake state experiences; thought-control experiences.

To meet PD criteria, impairments in personality functioning and pathological personality traits should be relatively pervasive across a range of personal and social contexts (i.e., Criterion C), relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood (i.e., Criterion D); moreover, they should not be better explained by another mental disorder (i.e., Criterion E), should not be solely attributable to the physiological effects of a substance or another medical condition (i.e., Criterion F), and should not be better understood as normal for an individual's developmental stage or sociocultural environment (i.e., Criterion G).

The *DSM-5* AMPD provides criteria for PD-Trait Specified (PD-TS) diagnosis, which can be diagnosed when specific criteria for PD prototypes are not met, and six PD diagnoses, namely, Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal PDs. To diagnose PD-TS, moderate or greater impairment in personality functioning manifested by difficulties in two or more areas (i.e., identity, self-direction, empathy and intimacy), as well as one or more pathological personality domains or specific trait within domains are required. Rather, the typical impairments in personality functioning (Criterion A) and characteristic pathological personality traits (Criterion B) for the six *DSM-5* AMPD specific PD are listed in Table 5.

Table 5. Typical features of the *DSM-5* Alternative Model of Personality Disorders Specific Personality Disorder Diagnoses.

	Typical Features
Antisocial	Failure to conform to lawful and ethical behaviour, and an egocentric, callous lack of concern for others, accompanied by deceitfulness, irresponsibility, manipulativeness, and/or risk taking
Avoidant	Avoidance of social situations and inhibition in interpersonal relationships related to feelings of ineptitude and inadequacy, anxious preoccupation with negative evaluation and rejection, and fears of ridicule or embarrassment
Borderline	Instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility.
Narcissistic	Variable and vulnerable self-esteem, with attempts at regulation through attention and approval seeking, and either overt or covert grandiosity.
Obsessive-Compulsive	Difficulties in establishing and sustaining close relationships, associated with rigid perfectionism, inflexibility, and restricted emotional expression.
Schizotypal	Impairments in the capacity for social and close relationships, and eccentricities in cognition, perception, and behaviour that are associated with

	distorted self-image and incoherent personal goals and accompanied by suspiciousness and restricted emotional expression.

6.3. Epidemiology

The epidemiology of personality disorders is poorly described compared with that of other mental disorders; a natural result of accurate personality assessments being more difficult to obtain for personality disorders than other mental disorders in national surveys. Cross-sectional epidemiological studies carried out on community-dwelling participants in North America and Western Europe report a PD point prevalence between 4% and 15%, with a mean prevalence rate of roughly 11%. Differences in prevalence across studies could be attributable to sampling methods, study instruments, and poor diagnostic reliability, especially when based on one interview. Interestingly, epidemiological studies report higher PD prevalence in urban areas than in rural settings. In epidemiological studies based on community samples PD prevalence is usually not affected by participant's gender and ethnicity, although selected PD (e.g., Antisocial PD) may be more frequently observed among men.

In clinical practice, PDs are seldom diagnosed and account for less than 5% of all hospital admissions, with Borderline PD, Antisocial PD, and Unspecified PD being the most frequently used PD categories. However, studies involving systematic PD assessment seem to provide a different picture of PD prevalence in clinical populations. Indeed, 25% of patients in primary care and 50% in psychiatric outpatient settings was reported to meet PD criteria. Several reason may account for these differences, ranging from the cumbersome nature of the *DSM-IV* axis II/*DSM-5* Section II PD diagnosis, resulting in few clinicians assessing all PD components, to clinician's stereotyped thinking (e.g., giving Borderline PD diagnosis to repeatedly self-harming clients, irrespective of the complexity of their issues). In particular, it should be observed that PD subjects rarely seek contact with the healthcare system because of their PD-related problems; rather, they are more likely to ask for treatment because a) co-occurring conditions (e.g., major depressive episode, etc.); b) acute symptoms which are likely to represent extreme reactions to life events rather than manifestations of a non-PD psychiatric disorder (e.g., panic attacks, anger, sleep problems, binge-eating episodes, etc.); c) self-harming/suicidal behaviour and/or aggression; d) alcohol/drug misuse problems; and e) general health problems due to problem lifestyle (e.g., obesity, etc.). All these possible presentations require treatment in and by themselves and may mask the underlying personality dysfunctions. Indeed, successful treatment of PD-related problems (even general health problems) definitively benefits from clinician's ability to capture the personality pathology laying behind the client's clinical presentation.

In forensic populations, roughly two-thirds of inmates were reported to meet PD diagnostic criteria. By contrast with community-dwelling samples, PD point prevalence in clinical services has been reported to be higher in women than in men, probably a result of higher rates of help seeking in women than in men.

It should be observed that data on PD epidemiology were based on the *DSM-IV* axis II/*DSM-5* Section II PD criteria, whereas epidemiological data based on the *DSM-5* AMPD criteria are still lacking. However, preliminary findings on adult consecutively admitted psychotherapy participants showed that the point prevalence of *DSM-5* Section II and *DSM-5* AMPD PD diagnoses were pretty similar (76.2% vs. 71.4%) albeit non-redundant (Cohen's $\kappa = .69$).

6.4. Clinical Presentation

As we have previously observed, the clinical presentation of PD clients may vary substantially. We will try to give some examples of different clinical presentations of PD clients.

Gordon

Referral.

Gordon is 52 and is a physics graduate. He always worked as an executive in the human resources office of top-ranking Italian companies; however, he lost his job several times because of severe conflicts and fights with his senior executives. Gordon's chief complaint is depressed mood and suicidal ideation.

Presenting symptoms.

Although Gordon describes himself as depressed, during the interview Gordon appears angry rather than sad; Gordon reports difficulty falling asleep, but he denies any modification in his energy level, pleasure level or appetite. His speech is fluent, and the tone of voice is appropriate. Indeed, Gordon complains to be the victim of other people's envy. According to Gordon, his innovative ideas could not be understood by "those ignorant clerks (i.e., the company CEO) who were obviously frightened by me and envious of my smart ideas". Despite his wife's recriminations, Gordon does not see himself as an arrogant man; rather he says, "I am a giant in a land of dwarves; should I lower myself to their level?" According to Gordon, his suicidal ideation derives from the lack of consideration that his wife and the people at works had for his "unconventional way of living". Gordon denied any problems with his peers at work, provided that they do not contradict him; when he gets contradicted, Gordon says that he becomes angry and vengeful (e.g., blackmailing or harassing co-workers). Gordon reports a number of extra-marital relationships with several employees; according to Gordon, these were not

romantic relationships, but "simply a mean to get a preferential line of communication with the company control room". Gordon says that he is facing a marital crisis, since his wife is considering the possibility to divorce. Gordon says that three major factors are making his wife to consider divorce, namely, Gordon's economic instability, his anger outbursts and inability to share affects with his family. Considering the third point, Gordon said that when he is at home and he is all right he likes to read and listen to music alone "without the annoying presence of my wife and my son".

Additional background information.

Gordon asked for a psychiatric consultation five years ago when he became severely depressed after having being fired for the fourth time. At that time, he was sad, had no energy, lost more than 10 kg in less than a month, and attempted to suicide by poison.

DSM-5 Section II PD diagnosis: Narcissistic PD

DSM-5 AMPD Profile

Level of Personality Functioning Scale: Moderate (2). Personality Disorder Domains: Negative Affectivity (+); Detachment (++); Antagonism (+++); Disinhibition (-); Psychoticism (-)

DSM-5 AMPD PD Diagnosis: Narcissistic PD

Elisabeth

Referral.

Elisabeth is 22 years old woman who was attending a residential program for opiate addiction treatment. Elisabeth has been referred because of her problems with rules; Elisabeth induced another young woman attending the rehabilitation program to have a sexual intercourse with her while a third patient was taking pictures, "just to rock the boat".

Presenting symptoms.

During the interview, Elisabeth complains that rules have always been a problem for her; she started to be frequently truant during junior high school; truancy was so frequent that she failed her first year. Elisabeth says that her "love for freedom" started soon afterwards; although Elisabeth comes from a wealthy family, she is currently homeless. Elisabeth says that she ran away from home for the first time when she was 12; Elisabeth says that she definitively left home when she was 16 living in homeless shelters or on trains. Elisabeth denies suicidal ideation; rather, she says "I do not think about killing myself; I simply do it!". Indeed, Elisabeth tried to kill herself four times by injecting heroin overdose; all four times intensive care treatment was necessary to save Elisabeth's life. Elisabeth says that her mood changes abruptly for depression to anger or anxiety during a typical day since she was a teen-ager; Elisabeth says, "When I get mad burning my harms or my breasts with cigarettes usually works, it calms me down". According to Elisabeth drug abuse is closely related to her mood swings.

She started to drink alcohol when she was 13; since then, she tried a number of different psychotropic drugs, including MDMA, LSD, and heroin. Elisabeth says that she developed an opiate (heroin) addiction when she was 17. Elisabeth reports to be highly irritable and aggressive; Elisabeth says that she has been involved in a number of fights, and that she has been arrested two times for having tried to stab with a knife "disrespectful people". Elisabeth complains to feel frequently bored or empty, "but I have my way to deal with these feelings. I borrow (i.e., steal) a car and a drive like a mad driver, the faster the better. Elisabeth had four car accidents in the last year, two of which required hospitalization.

Additional background information.

Elisabeth intelligent quotient (IQ) was 110, but she was unable to complete high school; she occasionally resorted to prostitution both to obtain money and to "feel powerful, strong, and desired".

DSM-5 Section II PD Diagnoses: Antisocial PD, Borderline PD, Histrionic PD.

DSM-5 AMPD Profile

Level of Personality Functioning Scale: Severe (3). Personality Disorder Domains: Negative Affectivity (+++); Detachment (++); Antagonism (+++); Disinhibition (+++); Psychoticism (-).

DSM-5 AMPD Diagnosis: Antisocial PD

Gregory

Referral.

Gregory is a tall, markedly overweight 35-year-old unemployed man who lives in a small town. He asked for psychiatric treatment on a voluntary basis 10 years before the psychological consultation. At that time, Gregory complained of being unable to work, as well as to being unable to engage in any leisure activities since he spent all his time controlling repeatedly, the disposition of objects within his room, washing himself repeatedly because of fears of contamination and trying to drive intrusive sexual images away. Recently, he also started to be preoccupied with doubts concerning almost everything (for instance, he was constantly preoccupied with the doubt of not telling all he meant to say when he talked to someone), had to look persistently at people in order to be sure to maintain their images in his memory. He was diagnosed with obsessive-compulsive disorder (OCD), but several interpersonal difficulties that could not be ascribed to the OCD symptoms emerged and that led to Gregory's referral to the psychotherapy unit.

Presenting symptoms.

During the consultation, Gregory looked grim and aloof; however, his affect was not blunted. Although he rarely smiled during the interview, he seemed anxious or manifested anger at times. His mood was neutral. He did not display any sign of mental confusion and did not display any indications

of delusions or hallucinations. His speech was circumstantial and included a lot of irrelevant details. Sometimes, the meaning of his words was somewhat vague and obscure; for instance, he said that he was frightened by a supernatural being that he called 'the entity'. Indeed, Gregory was afraid that the 'entity' could reach him also in the hospital where none of his family could protect him. When the interviewer asked him if this 'entity' was something like a ghost or a devil, he said, 'You are completely wrong. The entity is neither a ghost nor a devil, and this is the reason why it frightens me. You can exorcise evil spirits, but what can be done in the case of the entity?' Gregory said that that he never saw or heard the 'entity'; rather, he felt it as an impending, threatening presence that was moving towards him, "The entity is something that I cannot see; I can only feel it when it comes near to me … I can only ask my mother to stay near the door of my room to protect me". This 'entity' was frightening Gregory from his early childhood; since then, Gregory's mother had to stand guard—particularly when Gregory took his daily shower— to avoid having the 'entity' come too close to him. Although they caused marked anxiety, these episodes did not represent persistent ideas, thoughts or images that are perceived as intrusive (i.e., obsessions); rather, they seemed to represent frequent unusual perceptual experiences (i.e., illusions).

Gregory said that he was not superstitious at all; rather, he has been deeply involved since late childhood in what he called 'the study of ancient sciences', that is, magic and paranormal activities

Gregory describes himself as a loner, "…someone who prefers to stay on his own, on guard …You know, doctor, all you say can be used against you… The less people know of you the less they can damage you. I do prefer that other people mind their own business and not my own business". Gregory complained also to be unable to confide his feelings and thoughts to anybody—with the partial exception of his mother and his older brother—because of the 'fear of being cheated and betrayed'. Gregory said that "I can trust only my family… all other people at a first glance may look nice and polite, but they are there only to take advantage of you or to cheat you".

Additional background information.

In a sense, Gregory lived with his family. However, he always lived alone in a separate room, spending the majority of his time there. At best, he stayed with his parents and his brother only for lunch and dinner. When Gregory was asked if there is something wrong with his family he said, "No, I love them! They have always done their utmost for me. Simply, after a while I am uncomfortable to have them near me. …I told you, I have always preferred to stay on my own. I prefer calling them when I need something; you know my mother lives downstairs, and my older brother lives within reach…"

DSM-5 Section II PD Diagnoses: Avoidant PD, Paranoid PD, Schizotypal PD

DSM-5 AMPD Profile

Level of Personality Functioning Scale: Extreme (4). Personality Disorder Domains: Negative Affectivity (++); Detachment (+++); Antagonism (+); Disinhibition (-); Psychoticism (+++).
DSM-5 AMPD PD Diagnosis: Schizotypal PD.

Far from giving an exhaustive overview of all possible PD presentations, these clinical vignettes aim at helping the reader to appreciate the importance of appropriate assessment of dysfunctional personality features that may lay behind the acute clinical symptoms, which frequently trigger clinical consultation.

6.5. Etiopathogenesis

Notwithstanding the impressive number of studies that were carried out on PDs since 1980, no established etiological factor has been reported in the literature for any PD. Moreover, it should be observed that the large majority of studies were carried out on Schizotypal PD, Antisocial PD, and Borderline PD, with few (if any) studies investigating other PD manifestations, with the possible exception of psychopathy. Psychopathy should not be considered synonymous of Antisocial PD and is not included in the *DSM-5* Section II, although a psychopathic specifier was provided for *DSM-5* AMPD Antisocial PD profile.

The most consistent etiological research findings are related to the genetic connection of Schizotypal PD to schizophrenia. Indeed, a large body of literature suggested that schizotypal PD is moderately heritable, and genetically associated with schizophrenia. For example, adoption data have demonstrated that Schizotypal PD is overrepresented in the first-degree biological relatives, but not first-degree adoptive relatives, of probands with schizophrenia. Moreover, individuals with schizophrenia and individuals with Schizotypal PD manifest deficits in working memory and executive functioning, high rates of smooth-pursuit eye movement dysfunction, and diminished frontal lobe grey matter volume, although these abnormalities are less pronounced in Schizotypal PD than in schizophrenia.

Twin and adoption studies have demonstrated that antisocial personality disorder, and chronic antisocial behaviour more generally, are moderately heritable by a marked shared environmental component, meaning that it is influenced by environmental factors shared within families. Although data are still controversial, studies of monozygotic twins discordant for a history of early maltreatment have pointed to higher rates of antisocial behaviour in abused twins, lending credibility to the possibility that such maltreatment is directly causal.

Although a biosocial model of Borderline PD has been proposed (which postulates a complex set of developmental transactions between genetic vulnerabilities to emotional dysregulation and psychosocial factors, particularly an invalidating environment provided by parents and others), it received inconsistent support from empirical literature and the aetiology of Borderline PD remains unknown. Indeed, twin studies have indicated that Borderline PD is at least moderately genetically influenced; however, the magnitude of heritability varies substantially across studies, perhaps reflecting the heterogeneity of this condition. Molecular genetic studies suggested that genetic factors may contribute to the development of Borderline PD; however, no specific genes have yet been clearly identified as causative.

Early brain imaging studies suggested that people with Borderline PD exhibit amygdala overactivity when judging others' emotions. Although reduced volume in the amygdala has been reported in some studies with structural magnetic resonance imaging, evidence about the specificity of reductions in amygdala volume in patients with Borderline PD seems to be inconsistent. Recent positron emission tomography and functional magnetic resonance studies suggested that Borderline PD may be characterized by a dysfunctional fronto-limbic network; however, studies on the specificity of these findings for Borderline PD are still lacking; thus, further studies are needed before considering these preliminary reports, particularly studies including healthy controls, participants with other psychiatric disorders or participants with other PDs.

Research data suggest that Borderline PD subjects report elevated rates of childhood sexual and physical abuse. However, data from studies of monozygotic identical twins discordant for Borderline PD, a design that allows investigators to control for genetic influences, found little or no evidence for a direct causal effect of trauma, including early emotional, sexual, or physical abuse, on later Borderline PD traits. Indeed, participants with Borderline PD report many negative psychosocial factors during childhood and substantially more adverse events than do subjects with other PDs; however, no close association between these experiences and the development of psychopathological changes in adulthood has been documented.

In summary, findings from twin studies, molecular genetics and epidemiological research suggests that joint consideration of multiple genetic and environmental factors has greater explanatory power than separate studies of genetic or environmental causation. Thus, multi-factorial gene-environment interactions are likely to be a generic mechanism involved in the majority of cases of mental illness, which is only partially tapped by existing gene-environment studies.

6.6. Treatment

Up to now, the evidence base for the effective treatment of PDs is insufficient with the large majority of the available literature on PDs focusing on the treatment of Borderline PD. Psychotherapy treatment is considered the treatment of choice for PDs, although firm evidence for its efficacy is still missing. Indeed, the average duration of treatment was short, follow-up were scares, and poor control of coexisting psychopathology was performed; rather, the number of outcome measures was very large, particularly in relation to the small number of participants. The psychobiological model of PD remains untested despite researchers reasonably suppose that behavioural traits associated with PD could respond to drugs. Accordingly, pharmacotherapy should only be used when integrated into psychotherapy treatments, should be time limited to manage specific symptoms, and withdrawn when these are resolved. Moreover, most clinical trials investigating the effect of drugs on PD were poorly designed, and focused almost exclusively on Borderline PD, with most of trials being underpowered in terms of sample size.

Psychotherapy treatment of PDs

No data are currently available as to the efficacy of psychotherapy treatment for subjects suffering from *DSM-5* Section II Cluster A disorders, with the partial exception of Schizotypal PD which has been suggested to benefit from cognitive therapy. No randomized controlled trials on the efficacy of drugs for subjects with Schizoid or Paranoid PD are currently available; individuals with Schizotypal PD have been studied in a few small, usually open-label studies using typical and atypical antipsychotics. Although Schizotypal PD subjects showed some improvement in overall symptom severity, the risk to benefit ratio is still unclear.

Notably, relatively more studies have been conducted on *DSM-5* Section II Cluster B PDs than on other PDs, although findings are still controversial. There is very limited evidence available on psychological interventions for adults with Antisocial PD; specifically, only three studies showed some evidence that contingency management, schema therapy, and dialectical behaviour therapy may be more effective than the control condition in addressing aggression, reconviction, global state/functioning, social functioning and adverse events as main target variables; however, no intervention reported compelling evidence of change in antisocial behaviour.

Over the last decades, a variety of psychological interventions for Borderline PD have been developed. Although dialectical behaviour therapy and mentalization-based treatment were the most studied psychotherapies, other treatment are available, including schema focused therapy, transference focused psychotherapy, and systems training emotional predictability problem solving. Recent meta-analytic data showed that psychotherapy reduced the severity of Borderline PD symptoms and suicidality and may reduce self-harm and depression while improving psychological

functioning compared to usual treatment. However, it should be observed that all available findings were based on low-quality evidence; moreover, most trials did not report adverse effects. No controlled psychological or pharmacological intervention studies on Histrionic PD and Narcissistic PD are currently available.

Meta-analytic data suggested that cognitive and psychodynamic treatment resulted in medium to large positive effect size for Cluster C disorders, although it was unclear which of the personality disorders benefited most from treatment. Preliminary controlled studies have suggested that cognitive–behavioural treatments may be efficacious for Avoidant PD; moreover, group treatments seemed to be beneficial. Currently, there are no controlled psychological or pharmacological intervention studies on dependent personality disorder, whereas one controlled study suggested superior outcomes for interpersonal therapy as opposed to cognitive therapy among depressed patients meeting criteria for Obsessive-Compulsive PD.

Pharmacological treatment of PDs

Few small sample studies, usually based on open label design were carried out to evaluate the efficacy of typical and atypical antipsychotics on Schizotypal PD; although Schizotypal PD participants showed some improvement in overall symptom severity, the risk-to-benefit ratio remains unclear. No randomized controlled trials have been carried out for pharmacological treatment of Schizoid or Paranoid PDs; thus, no robust evidence for drug efficacy in these PDs is available at present.

There is a dearth of studies of drug treatment of Histrionic PD and Narcissistic PD, with most of the evidence focusing primarily on Borderline PD and to a lesser extent on Antisocial PD. Cochrane review gave no evidence for the efficacy of SSRIs, while showing that mood stabilizers (in particular, topiramate, lamotrigine, and valproate) could diminish affective dysregulation and impulsive–aggressive symptoms in Borderline PD. Moreover, antipsychotic drugs (in particular, aripiprazole and olanzapine) showed some efficacy in improving cognitive–perceptual symptoms and affective dysregulation. However, concerns were raised as to the fact that the trials showing positive outcome provided unreliable data. Mostly, risk-to-benefit ratio should be taken into account in drug treatment of Borderline PD.

Drugs have substantial long-term risks whereas other treatments such as psychosocial interventions do not have these risks should not be overlooked.

Based on these considerations, the following recommendations for the use of drugs in the treatment of Borderline PD clients were proposed: a) Drugs should not be used as the primary treatment choice for Borderline PD; b) the time-limited use of drugs that showed evidence for efficacy in randomized clinical trials can be considered as an adjunct to psychosocial treatment, to manage specific

symptoms; c) clinicians should be extremely cautious in prescribing drugs that could be lethal in overdose or associated with substance misuse; d) the use of drugs can be considered in acute crisis situations but should be withdrawn once the crisis is resolved; e) drug treatment should be considered when a client with Borderline PD has active comorbid psychiatric disorders; f) at the opposite, if Borderline PD clients have no comorbid illness, efforts should be made to reduce or stop the drug.

A recent meta-analysis on pharmacological interventions for Antisocial PD, based on 11 studies involving 416 participants indicated that many participants who received an Antisocial PD diagnosis in the original studies presented primarily with substance abuse problems. Although 11 different drugs were compared with placebo, data for Antisocial PD participants were available only for phenytoin, desipramine, nortriptyline, bromocriptine, and amantadine. Thus, available evidence is insufficient to draw any conclusion about the use of pharmacological interventions in the treatment of Antisocial PD; moreover, data on pharmacological treatment of Antisocial PD came from single, non-replicated studies, which suffered from severe methodological issues. In other terms, available evidence indicates that pharmacological interventions should not be routinely used in treating of Antisocial PD or its associated behaviours.

Finally, no data from randomized controlled trials of pharmacological treatment of participants satisfying the full criteria of any cluster C PD have been reported in the scientific literature. However, suggestions have been published that studies in patients with social phobia, which consistently reported that antidepressants are better than placebo, could be thought of as evidence that these drugs might be effective in participants with Avoidant PD. It should be observed that although social phobia and Avoidant PD may share a common genetic liability, some studies documented that Avoidant PD captured a broader constellation of symptoms and personality features pointing toward more severe personality dysfunction when compared to social phobia. These considerations suggest caution in extending social phobia data to pharmacological treatment of Avoidant PD.

Hopefully, new, evidence-based approaches to PD diagnosis (e.g., *DSM-5* AMPD), as well as better understanding about the underlying biological and psycho-social developmental processes that lead to the manifestation of dysfunctional personality will result in developing specific psychotherapies and drugs in the future for specific dimensions of personality dysfunction.

Suggested Readings

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