Sri Lakshmi Narayana Institute of Medical Sciences

Date:2/12/2021

From
DR.V.R Sridhar
Professor and Head,
Department of Psychiatry,
Sri Lakshmi narayana institute of medical sciences,
Bharath Institute of Higher Education and Research,
Chennai.

To
The Dean,
Sri Lakshmi narayana institute of medical sciences,
Bharath Institute of Higher Education and Research,
Chennai.

Sub: Permission to conduct value-added course The Types Of Personality Disorders Along With Assessment And Mangament

Dear Sir,

With reference to the subject mentioned above, the department proposes to conduct a value-added course titled: **The Types Of Personality Disorders Along With Assessment And Mangament** on 2/01/22. We solicit your kind permission for the same.

Kind Regards Dr.V.R. Sridhar

FOR THE USE OF DEANS OFFICE

Names of Committee members for evaluating the course:

The Dean: **Dr. Jayakumar**

The HOD: **Dr. Sridhar.V.R**

The Expert: **Dr. Arun.S**

The committee has discussed about the course and is approved.

Dr. ARUN SEETHARAMAN, MD.,
Reg. No: 91440
Associate Professor, Psychiatry
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502.

Dr. V. R. SRIDHAR, MD.,D.P.M.,
Reg. No: 30995
Professor & HOD, Psychiatry
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502.

Dean	Subject Expert	HOD
(Sign & Seal)	(Sign & Seal)	(Sign & Seal)

Dr. P. JAYAKUMAR, M.S., M.CH.,
DIRECTOR / DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram Post, Pondicherry-605502

OFFICE OF THE DEAN

Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,
PUDUCHERRY - 605 502.

[Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME (P -II) dt. 11/07/2011]
[Affliated to Bharath University, Chennai - TN]

Circular

15.12.2021

Sub: Organizing Value-added Course: Awareness, Identification and Classification of Personality disorders.

With reference to the above mentioned subject, it is to bring to your notice that Sri Lakshmi Narayana Institute of Medical Sciences, **Bharath Institute of Higher Education and Research** is organizing **Awareness, Identification and Classification of Personality disorders**. . The course content and registration form is enclosed below."

The application must reach the institution along with all the necessary documents as mentioned. The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 31 December, 2021. Applications received after the mentioned date shall not be entertained under any circumstances.

Dean

Dr. P. JAYAKUMAR, M.S., M.CH.,
DIRECTOR / DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram Post, Pondicherry-605502

Encl: Copy of Course content

Course Proposal

Course Title: **Awareness, Identification And Classification Of Personality Disorders And Its Management** .

Course Objective:

Awareness on the importance of personality disorders
Awareness On The Contributing Factors To personality Disorders Bio-psychosocial Model Of Approach
Identify diagnostic criteria for personality disorders

Course Outcome:

Course Audience: FINAL YEAR STUDENTS of 2021 Batch
Course Coordinator: Dr.V.R. Sridhar
Course Faculties with Qualification and Designation:
1.Dr.V.R.SRIDHAR, Professor & HOD
2.Dr.Arun, Assistant Professor
Course Curriculum/Topics with schedule (Min of 30 hours)

SlNo	Date	Topic	Resource person	Time	Hours
1.	02.01.2022	• Personality disorders Course and outcome • Prevalence, sociodemographics, and functional impairment	Dr.Arun	4-5p.m	1
2.	04.01.2022	• Theories of personality and personality disorders Manifestations, clinical diagnosis, and comorbidity	Dr.Arun	2-3p.m	1
3.	06.01.2022	• Neurobiology • Developmental issues	Dr.Arun	4-6p.m	2
4.	09.01.2022	• Childhood experiences and development of maladaptive and adaptive personality traits •	Dr.Arun	4-6p.m	2
5.	11.01.2022	Cluster A disorders	Dr.Arun	4-6p.m	2
6.	13.01.2022	Cluster B disorders	Dr.Arun	4-5p.m	2
7.	16.01.2022	Cluster C disorders	Dr.Arun	4-5P.M	1

8.	18.01.2022	Levels of care in treatment	Dr.Arun	4-5p.m	1
9.	20.01.2022	Pharmacological management	Dr. Shridhar	4-6p.m	1
10.	23.01.2022	Non-pharmalogical management	Dr.Arun	4-6p.m	2
11.	25.01.2022		Dr.Arun	4-6p.m	1
12.	27.01.2022	• Substance abuse • Future directions	Dr.Arun	4-6p.m	2
13.	30.01.2022	Pre course and Post Course evaluation, Feedback analysis from Likert scale	Dr.Arun	2-5p.m	3
		Practical Class I	Dr. Shridhar		
13.	01.02.2022	• Psychoanalysis and psychodynamic psychotherapy	Dr. Shridhar	2-3 PM	1
14.	03.02.2022	Dialectical behavior therapy	Dr. Shridhar	2-3 PM	1
15.	06.02.2022	• Hypnotherpy • Mentalization-based treatment of borderline personality disorder	Dr. Shridhar	2-4 PM	2
16.	08.02.2022	• Techniques Group treatment • Cognitive Behaviour Therapy • Somatic treatments	Dr. Shridhar	2-4 PM	2
17.	10.02.2022	• Therapeutic alliance • Assessing and managing suicide risk	Dr. Shridhar	2-4p.m	2
			Total		30 hrs

REFERENCE BOOKS:

- **Comprehensive textbook of psychiatry – Kaplan & Saddock**
- **Oxford Textbook Of Psychiatry**
- **Synopsis - Kaplan & Saddock**
- **Stahl's essential psychopharmacology**

VALUE ADDED COURSE

1. Name of the programme & Code

The Types Of Personality Disorders Along With Assessment And Management

2. Duration & Period

30 hrs -January– 2022

3. Information Brochure and Course Content of Value Added Courses

Enclosed as Annexure- I

4. List of students enrolled

Enclosed as Annexure- II

5. Assessment procedures:

Assessment by multiple choice questions- *Enclosed as Annexure- III*

6. Certificate model

Enclosed as Annexure- IV

7. No. of times offered during the same year:

1 times January– 2022

8. Year of discontinuation: 2022

9. Summary report of each program year-wise

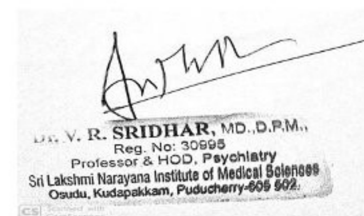
Value Added Course- January– 2022					
Sl. No	**Course Code**	**Course Name**	**Resource Persons**	**Target Students**	**Strength & Year**
1	PSYC04	The Types Of Personality Disorders Along With Assessment And Mangament	Dr.SRIDHAR Dr.ARUN	Final year	(15) January– 2022

10. Course Feed Back

Enclosed as Annexure- V

Resource Person
1. **Dr. V.R. Sridhar**
2. **Dr. C. Arun Seetharaman**

COORDINATOR
V.R. Sridhar



- Exhibits suicidal or self-harming behavior, thoughts, or threats on more than one occasion
- Expresses significant fears of abandonment and exhibits behaviors intended to reduce the possibility of being abandoned

Antisocial Personality Disorder. Traits and behaviors corresponding to antisocial personality disorder (ASPD) have been described using such terms as sociopath, psychopath, deviant, amoral, moral insanity, and dyssocial. The term "antisocial personality disorder" was introduced with the publication of DSM-III (APA, 1980) and represented an attempt to operationalize the much-maligned term of psychopathy. The criteria were derived from empirical research based on Robins' (1966) seminal work.

As defined by DSM-5, ASPD is a pervasive pattern of irresponsible behavior and disregard for the rights of others that begins in childhood or early adolescence. People with this disorder repeatedly engage in unlawful and/or reckless behavior. Frequently victimizing others and blaming their victims for their own fate, they typically lack remorse for having hurt or mistreated another person. "They had it coming" is a common rationalization for victimized others. Alternatively, a person with this disorder might minimize the negative consequences of their actions, or blame others for being weak or foolish. Those with ASPD are prone to impulsiveness, irritability, and aggressiveness that often leads to physical fights or assault, and they have a reckless disregard for the safety of themselves or others. In addition, they might repeatedly fail to honor work or financial obligations, or display other evidence of consistent and extreme irresponsibility. Manipulativeness, deceitfulness, and dishonesty are also central features of this disorder, often making collateral sources of information necessary for accurate diagnosis.

To receive a diagnosis, individuals must both present with evidence of conduct disorder before age 15, as well as three or more of the following criteria as adults:

- Is impulsive in more than one domain
- Shows lack of respect for laws or social customs by repeatedly engaging in illegal activity
- Exhibits irresponsibility by repeated absenteeism or by failing to honor debts, loans, or other obligations
- Is aggressive or irritable to the point of repeatedly engaging in physical fights
- Manipulates others, lies, or is frequently deceitful
- Shows little, if any, consideration of the safety of him or herself or others
- Shows little, if any, remorse or empathy for others he or she may have endangered, injured, slighted, or taken advantage of

Histrionic Personality Disorder. Histrionic personality disorder (HPD) has its early roots in Hippocrates' writings more than 2000 years ago on "hysteria" in women, thought to be caused by a "wandering womb" (Veith, 1977). According to ancient Greek medicine, the uterus would detach from its proper place and wander throughout the body, affecting the brain and causing excessive emotionality.

Hysteria was first officially linked to the term "histrionic personality" in DSM-II (APA, 1968), which listed hysterical personality disorder and mentioned histrionic personality disorder parenthetically thereafter. By DSM-III (APA, 1980), however, hysterical personality disorder had been completely replaced by histrionic personality disorder.

The core components of HPD include excessive emotionality, attention-seeking behavior, egocentricity, flirtatiousness, seductiveness, and denial of anger or. Other characteristics of HPD

are extreme gregariousness, manipulativeness, low frustration tolerance, suggestibility, and somatization. In addition, according to DSM-IV-TR (APA, 2000), histrionic individuals consistently use their physical appearance in order to draw attention to themselves, spending excessive time, attention, and money on clothes and grooming.

To receive a diagnosis, individuals must meet five or more of the following criteria:

- Experiences distress if he or she is not the center of attention
- Engages with others in a sexually inappropriate or exaggerated way
- Uses his or her physical appearance in a showy or attention-seeking way
- Speaks in a vague, dramatic, or superficial manner
- Exhibits exaggerated emotions or carries him or herself in a theatrical or dramatic way
- Shows quickly changing or shallow emotions
- Is easily swayed by others opinions or suggestions
- Feels that he or she is closer to others than they feel to him or her

Narcissistic Personality Disorder. According to DSM-5, the central features of narcissistic personality disorder (NPD) are pervasive grandiosity, a constant need for admiration, and a lack of empathy for others. An individual with NPD has a sense of self-importance and an attitude of arrogance that might manifest in boastfulness, pretentiousness, or disdain. An overestimation of one's own abilities and a devaluation of others are characteristic of this disorder. Also common is a preoccupation with fantasies about one's own brilliance, beauty, or expected success.

People suffering from NPD usually require constant attention and admiration and may become furious with others who do not shower them with compliments or accolades. Persons with this disorder are commonly concerned with their own performance and how others evaluate them. They typically have fragile self-esteem, so their self-importance might alternate with

feelings of unworthiness. They frequently either experience feelings of envy of other people or imagine that others are envious of them.

The sense of entitlement that is central to NPD often precludes the recognition of others' abilities, needs, feelings, or concerns. Individuals with this disorder might discuss their own problems or concerns in lengthy detail, yet react with insensitivity or impatience to the problems of others. Inappropriate and hurtful remarks are frequently uttered by people with NPD, although they are typically oblivious to how these remarks affect others. They might also unconsciously exploit others and believe that the needs and feelings of other people are signs of weakness. To others these individuals appear cold, disinterested, disdainful, snobbish, or patronizing.

To receive a diagnosis, individuals must meet five or more of the following criteria:

- Considers his or her own importance to be much greater than others
- Considers only high-status or unique people to be able to understand him or her or to be worth affiliating with
- Frequently fantasizes about being highly successful, wealthy, powerful, or having the perfect romantic relationship
- Exhibits frequent envy of others or frequently considers others to be envious of him or her
- Seeks or demands excessive respect or deference
- Expects specialized treatment or unwavering compliance from others
- Takes advantages of others for personal gain
- Is unable or unwilling to show empathy or concern for others
- Exhibits arrogance in his or her behaviors or attitudes

Cluster C: Anxious-Fearful Personality Disorders

Avoidant Personality Disorder. Avoidant personality disorder (AVPD) was a new category added to the DSM-III based on an evolutionary social-learning theory of PDs (Millon, 1981). According to DSM-5, persons with AVPD are characterized by pervasive social inhibition and discomfort in social situations, feelings of inadequacy and low self-esteem, and hypersensitivity to criticism or rejection. Although they long for close relationships, they avoid activities that involve interpersonal contact and have difficulty joining group activities. Persons with this disorder assume that other people will be critical and disapproving. They act with restraint in social situations and have difficulty sharing intimate feelings for fear of criticism, disapproval, shame, or ridicule. They have a strong need for certainty and security that severely restricts their ability to become close to others, and they typically are not able to establish new friendships or intimate relationships without the assurance of uncritical acceptance.

People with AVPD frequently feel socially incompetent, personally unappealing, or inferior to others. Therefore, they are reluctant to engage in new activities and they tend to be shy, inhibited, and quiet to avoid attracting attention to themselves. In addition, they are hyper-vigilant about detecting subtle cues that suggest the slightest criticism or rejection. Because they expect others to disapprove of them, they quickly detect any indication of such disapproval and typically feel extremely hurt.

To receive a diagnosis, individuals must meet four or more of the following criteria:

- Avoids new activities or ventures for fear of embarrassment
- Fears negative evaluation in occupational settings, which leads to frequent avoidance of occupational activities that involve others

- Fears negative evaluation in social arenas, which leads to frequent avoidance of social interactions with others
- Considers him or herself to be incapable, unattractive, or of less value than others
- Hesitates to form relationships with others unless he or she is certain of being well-liked
- Is shy, restrained, or quiet in interactions with strangers due to feelings of inadequacy.
- Is often unwilling to be open or candid in relationships for fear of being negatively evaluated

Dependent Personality Disorder. The history of dependent personality disorder (DPD) begins with descriptions of oral dependency by Abraham and Freud. The DSM-I (APA, 1952) mentioned what was called "passive-dependent personality," which was virtually synonymous with DSM-5 DPD.

According to the DSM-5, the central characteristic of DPD is a pervasive need to be taken care of that begins by early adulthood. People with this disorder have an exaggerated fear that they are incapable of doing things or taking care of themselves on their own, and therefore, rely on other people (usually one person) to help them. They rely heavily on advice and reassurance from others in making decisions. Because of their lack of self-confidence, it is difficult for people with DPD to begin tasks on their own without being assured that someone is supervising them. They may appear to others to be incompetent because they believe that they are inept and they present themselves as such.

DSM-5 notes that because of their dependency on others, people with DPD often fail to learn basic independent living skills, and frequently find themselves in abusive or otherwise unbalanced relationships. It is not unusual for people with DPD to feel unrealistically fearful of being abandoned. They are typically passive and unwilling to disagree or become appropriately

angry with the person on whom they depend. They will also go to great lengths to secure or maintain the support of another person. People with DPD usually feel highly uncomfortable being alone because of an exaggerated fear of helplessness or the inability to care for themselves. The end of an intimate relationship will often be followed by urgent efforts to replace the person with another source of closeness and support.

To receive a diagnosis, individuals must meet four or more of the following criteria:

- Requires considerable input or advice from others before being able to make everyday decisions
- Is reliant on others for managing finances, living arrangements, and other major areas of responsibility
- Is often unable to begin projects or activities due to a fear of the consequences of his or her own incapacity or ignorance
- Willingly engages in unpleasant tasks or duties to gain support and encouragement from others
- Avoids arguments or disagreements with others for fear of losing their assistance or care
- If a close relationship ends, he or she tries desperately to form a new source of care and assistance
- Is distressed when alone due to feelings of helplessness or an inability to take care of him or herself
- Exhibits excessive fear of being able to manage his or her own affairs or care for him or herself.

DPD is substantially comorbid with mood, anxiety, and non-PD psychotic disorders

Obsessive-Compulsive Personality Disorder. The modern concept of obsessive-compulsive personality disorder has its roots in Freud's description of the anal personality as one who is excessively orderly, obstinate, and parsimonious (Freud, 1906-1908/1959). Synonymous with anankastic personality disorder in Europe, the DSM-5 describes OCPD as a pervasive pattern of perfectionism, orderliness, and inflexibility that begins by early adulthood. People with OCPD have an excessive need for control that interferes with their ability to maintain interpersonal relationships or employment. They are typically preoccupied with rules, lists, schedules, or other minor details (Abraham, 1921). Their rigidity, inflexibility, and stubbornness often prevent them from accepting any new ideas or alternative ways of doing things, creating difficulty in both work and personal relationships.

In addition, the DSM notes that individuals with OCPD often sacrifice personal relationships in favor of work, and become obsessively devoted to productivity. They hold both themselves and others to unrealistic standards of morality, ethics, or values. They are also reluctant to delegate tasks to others because they insist that everything be done their own way. Their excessive attention to trivial details, however, often interferes with their ability to complete a task (Horney, 1950).

Individuals with obsessive-compulsive PD usually have difficulty expressing emotion (Horney, 1950) and subject to dichotomous thinking, magnification, catastrophizing, and displays of anger, frustration, and irritability. The DSM further notes that individuals with OCPD might be reluctant to throw away worthless and unsentimental objects for fear that they might be needed at a later date. Furthermore, people with this disorder might hoard money and tightly control their spending, believing that money should be saved for a future catastrophe.

To receive a diagnosis, individuals must meet four or more of the following criteria:

- Values details, organization, and rules over the main point of activities
- Is so devoted to ensuring tasks are done properly or correctly that they are often not completed
- Avoids working with others or delegating tasks without being sure that his or her own way of doing things will be followed
- Strongly prefers occupational activities over leisure activities or friendships
- Maintains more rigid views of ethics and morality than other members of his or her cultural background
- Exhibits excessive stubbornness and inflexibility
- Avoids spending money on activities or goods that are not considered absolutely necessary
- Hoards useless or broken items even if they have no sentimental value

The Psychodynamic Diagnostic Manual (PDM)

In response to growing dissatisfaction with the DSM approach within the psychodynamic community, a task force was created by the major psychoanalytic organizations that developed a diagnostic manual, the Psychodynamic Diagnostic Manual, that articulated disorders that were more consistent with psychodynamic theory and addressed concerns of psychodynamic clinicians (e.g., integrating descriptions of inferred internal psychological processes such as defense and external manifestations of disorders (PDM Task Force, 2006). Included in the PDM is an axis describing personality patterns and disorders (axis P). The conceptualization is based on an integration of the theoretical and clinical work of Kernberg and Westen and Shedler as well as the empirical research on personality disorders broadly. Similar to the DSM, the PDM differentiates personality disorders as a different class from personality proper, symptom

disorders, psychosis, and the effects of brain trauma, chronic stress, and substances. The PDM points out that one can have an obsessive personality without necessarily having an obsessive personality disorder. Also based on Kernberg (1984), the PDM makes distinctions in the level of personality organization in terms of the severity of the personality disorder with distinctions between healthy personalities (the absence of personality disorder), neurotic-level personality disorders, and borderline level personality disorders and unlike manuals from the DSM system, discusses the implications for level of the severity dimension for psychotherapy.

Dimensional Models

Both the DSM-5 Section II criteria and the ICD-10 classification systems use categorical diagnostic systems that present personality disorders as representing distinct clinical syndromes with specific cut-off points for reaching threshold for a specific personality disorder. While the use of categories implies discontinuity—that is, one either has or does not have the disorder—many researchers have argued that they can be better conceptualized along a continuum or dimension from normality to pathology. Two current systems exist by which dimensional assessment of PDs are possible: the five-factor model and ICD-11 dimensional frameworks.

The five-factor model (FFM) is one of the most widely studied alternatives to the DSM categorical approach with regard to the assessment of personality disorders. In the FFM, PDs are typically assumed to represent extreme or maladaptive variants of normal personality traits. The five higher-order traits and various lower-order facets have been related to DSM personality disorder categories in a number of studies. Given this research on the five-factor model, some authors have suggested that a personality trait approach is sufficient to encapsulate personality disorder constructs. Indeed, a considerable corpus of studies have posited and supported the use of the five-factor model as an alternative to categorical diagnoses for PDs (Trull & Durrett,

2005). For example, the DSM-5 Section III alternative model to the assessment and diagnosis of PDs utilizes a trait-based approach, reflecting a shift towards dimensional PD assessment adopted by many in the field.

The ICD-11 (proposed to be released in 2017), in contrast to the dimensional models discussed above that are based on dimensional ratings of traits and personality constructs, has adopted a dimensional model based on the notion of severity of dysfunction (Gunderson, Links, & Reich, 1991; Tyrer & Johnson, 1996; Tyrer, 1999). This model is consistent with the approach taken by the DSM-5 workgroup's conceptualization of severity of functional impairment particularly around self and other functioning (APA, 2013; Tyrer, 2013). This approach is also consistent with other clinical writers such as Kernberg (Kernberg & Caligor, 2005) who have stressed severity as an important diagnostic indicator.

The ICD-11 dimensional scale ranges from 0 to 4, with 0 indicating no personality disorder, 1 some personality difficulty as indicated by being sub-threshold for one or more personality disorders, 2 indicating the presence of a simple personality disorders, that is, meeting criteria for one or more disorders within the same cluster, 3 as a complex or diffuse personality disorders, as indicated by meeting criteria for one or more PDs across more than one cluster, and 4, a severe PD as indicated by meeting criteria for severe disruption to both individual and to others.

Prototype Models

In contrast to classical categories used in the DSM systems, some have proposed the use of prototypes Academic psychology has shown that humans tend to use prototype models when storing or retrieving information about categories (Rosch, 1983). In this vein, Westen and Shedler (2007; Shedler & Westen, 2007) have proposed a prototype-based model of personality

disorder assessment, the Shedler-Westen Assessment Procedure, in which patients are rated against detailed descriptions of personality pathology on a scale assessing similarity/dissimilarity. These authors provide initial data from 496 psychiatrists and psychologists who report on their caseload using individual descriptive items such as "Tends to feel unhappy, depressed, or despondent" (Westen & Shedler, 1999).

Factor analysis of these data resulted in only some factors resembling DSM diagnostic categories. Other factors, such as what Westen and Shedler labeled "dysphoric personality disorder," accounted for large portions of the variance in items, but were distinct from DSM nosology. Several advantages of the SWAP prototype measure are that it is empirically derived, reduces diagnostic overlap and artifactual comorbidity due to orthogonal rotation of factors in the factor analysis, and assesses severity of personality pathology through dimensional ratings.

Incidence and Comorbidity

Epidemiology

Epidemiological data in the United States indicate that PDs have a high overall lifetime prevalence ranging between 5.9% and 21.5% in the community (Crawford et al.., 2005; Lenzenweger et al., 2007; Trull et al., 2010) with most estimates between 9-11%. International epidemiological studies find similar rates ranging from 4.4% to 13.4% depending on whether PDNOS was included or not (Coid, Yang Tyrer, Roberts, & Ulrich, 2006).

Using DSM-IV PD criteria, 9.1% of an epidemiological sample from the National Comorbidity Survey Replication study met criteria for a personality disorder (Lenzenweger, Lane, Loranger, & Kessler, 2007). In 2001 and 2002, prevalence data of seven of the ten personality disorders assessed through the National Epidemiological Survey on Alcohol and

Related Conditions (NESARC) suggested that 14.79% of adult Americans—or 30.8 million—had at least one personality disorder (Grant et al., 2004).

Among countries other than the United States, PD prevalence rates tend to vary. In Norway, PDs are prevalent at 13.4% (Torgersen, Kringlen, and Cramer, 2001), and in Germany, around 10% (Maier et al., 1992). In Great Britain, the estimate is lower, at 4.4% (Coid, 2006). If assessed based on ICD-10 criteria, the general prevalence rate of PDs is estimated to be 6.5% in Australia (Jackson & Burgess, 2004; Maier et al., 1992). There are almost no community data on PDs from countries other than the United States, the United Kingdom, Germany, Norway, and Australia.

In primary care settings, about a third of people attending general practitioners had a personality disorder (Casey & Tyrer, 1990). The vast majority of patients were not presenting for personality difficulties but presented as problematic medical patients (Emerson et al, 1994). Patients with Cluster C PDs are the most common PDs to be encountered in primary care settings (Moran et al, 2000).

Rates of PDs are generally much higher in clinical populations. Studies using structured diagnostic assessments have found that 20–40% of psychiatric outpatients and about 50% of psychiatric inpatients meet criteria for a personality disorder (de Girolamo & Reich, 1993; Dowson & Grounds, 1995; Moran, 1999). A similar rate of 46% has been found in a rural university-based community mental health clinic (Levy & Johnson, 2015).

Studies on the prevalence of specific PDs in the general community have found rates for paranoid PD ranging from 0.4% to 3.3%; schizoid, 0.5% to 0.9%; schizotypal, 0.6% to 5.6%; histrionic, 1.3% to 3.0%; narcissistic, 0% to 6.2%; antisocial 0.2% to 3.7%, avoidant, 0% to 1.3%, dependent, 1.6% to 6.7%; and obsessive compulsive, 1.7% to 6.4% (Baron, Gruen, Asnis,

& Lord, 1985; Coryell & Zimmerman, 1989; Drake & Vaillant, 1985). Wave 2 data from the NESARC study has found rates of 5.9% for BPD (Grant, Chou, et al., 2008), 6.2% for NPD (Stinson et al., 2008), and 3.9 for schizotypal PD (Pulay et al., 2009). The most consistently studied personality disorder in community studies has been antisocial PD, which has a lifetime prevalence of between 2% and 3% and is especially common in those living in urban areas (Moran, 1999).

Research has generally shown that individuals diagnosed with PDs are likely to be single (e.g., Stinson et al., 2008). These studies have also found that PDs are generally more common in younger age groups (particularly the 25-44 year age group). Many PDs are equally distributed between men and women in representative population samples, although most studies have found increased rates in men of NPD, STPD, and ASPD, and increased rates in women of AVPD and DPD.

Comorbidity

At a community level, personality disordered individuals are more likely to suffer from alcohol and drug problems. In addition, they are also more likely to experience adverse life events, such as relationship difficulties, housing problems, and long-term unemployment (Moran 1999).

Reasons for comorbidity include discrete disorders sharing risk factors, or overlap between risk factors, or that one disorder creates increased risk for the other disorder. For example, substance abuse and PDs may share temperamental aspects of impulsivity and negative affect as a shared risk factor (Szerman & Peris, 2015; Verheul et al., 2009) or PTSD and PDs may share traumatic experiences as a shared risk factor. Additionally, substance abuse may impair identity formation and lead to personality disorders such as antisocial and borderline

personality disorder. Conversely, borderline and antisocial personality disorders may impair one's capacity to regulate themselves and lead to the use of substances. Thus, rates and patterns of comorbidity could represent the natural order or nature of psychopathology—that is, it could represent true or valid levels of comorbidity. Different disorders may share a common etiology and be different phenotypic expressions of a common causal factor or factors.

Some estimates suggest that 75% of personality disordered patients meet criteria for another mental disorder (Clarkin & Kendell, 1992; Dolan-Sewell, Krueger, & Shea, 2001; Fyer et al., 1988). For instance, most patients who meet criteria for a personality disorder also meet criteria for at least one other personality disorder. In fact, the average patient meeting criteria for a personality disorder is diagnosed with 2.8 to 4.6 personality disorders (Widiger & Frances, 1994) and it is not uncommon for patients to meet criteria for as many as 5, 6, 7, or even more DSM personality disorders (Plutchik et al., 1994). This level of comorbidity has been considered a serious problem within one or more of the following domains: 1) the validity of the concept of personality disorders; 2) the DSM system as a whole; 3) the interviews developed to assess personality disorders and disorders in general (see Identification and Assessment section below).

Compounding the problem is that personality disorders are also highly comorbid with more the episodic syndromal disorders, originally referred to as Axis I disorders in DSM-III and DSM-IV. For instance, current mood disorders are comorbid with PDs between 15% and 50% (Grant et al., 2008; Grant, Mooney, & Kushner, 2012; Pulay et al., 2009) and anxiety disorders around 30% to 60% (Grant et al., 2012; Lenzenweger et al., 2007; Newton-Howes et al., 2010), with these estimates being even higher for lifetime comorbidity of these disorders. Furthermore, substance abuse and impulse control disorders are commonly comorbid with PDs (Zanarini, Frankenburg, Dubo et al., 1998). PDs are also frequently comorbid with paraphilias (Raymond,

Coleman, Ohlerking, Christenson, & Miner, 1999), dissociative disorders (Ono & Okonogi, 1988), and factious disorders (Zubenko, George, Soloff, & Schulz, 1987). In fact, although sexual function disorders are relatively rare, around half of individuals with a PD also display some form of lifetime psychosexual dysfunction (Zimmerman & Coreyell, 1989). Zanarini refers to the pattern of comorbidity observed in PDs as "complex comorbidity" because of the high number of comorbid diagnoses and the co-occurrence of both internalizing (e.g, depression) and externalizing disorders (e.g. substance use disorders).

Among Cluster A PDs, about two-thirds of patients with PPD meet criteria for another PD, most frequently schizotypal, narcissistic, borderline, and avoidant PDs (Bernstein, Useda, & Siever, 1995). SPD is consistently comorbid with schizotypal and avoidant PDs (Bernstein et al., 1995). STPD appears highly comorbid with other PDs, especially Cluster B PDs (Pulay et al., 2009), and it is often comorbid with dysthymia and anxiety disorders (Alnaes & Torgersen, 1988).

In Cluster B, ASPD is frequently comorbid with borderline (Becker, Grilo, Edell & McGlashan, 2000), narcissistic (Oldham et al., 1992), histrionic (Lilienfeld, VanValkenburg, Larntz, & Akiskal, 1986), and schizotypal PDs (Marinangeli, Butti, Scinto & Di Cicco, 2000). Research has also demonstrated that ASPD has a particularly strong association with substance use disorders (Kessler et al., 1997). HPD is consistently comorbid with borderline and narcissistic PDs (Becker et al., 2000; Marinangeli et al., 2000; Oldham et al., 1992). Some studies have also found HPD to co-occur substantially with antisocial (Lilienfeld et al., 1986; Marinangeli et al., 2000; Oldham et al., 1992) and dependent (Oldham et al., 1992) PDs and with psychoactive substance use (Oldham et al., 1995). NPD is often comorbid with borderline, schizotypal, and obsessive-compulsive PDs (Stinson et al., 2008; Zimmerman, Rothschild &

Chelminski, 2005). Some evidence suggests that antisocial and histrionic PDs may also be highly comorbid with NPD (Oldham et al., 1992; Zimmerman et al., 2005). Epidemiological data suggests that alcohol use disorders are significantly comorbid in NPD, although these and other substance use problems are relatively less frequent compared to those diagnosed in other PDs (Stinson et al., 2008; Trull et al., 2010). The comorbidity of BPD is especially complex as BPD has been conceptualized as both an internalizing and an externalizing disorder (Blatt & Levy, 2003, Levy & Blatt, 1999), contributing to rates of over 80% comorbidity with at least one current non-PD disorder and an average of 3.2 comorbid non-PD disorders per patient (Lenzenweger et al., 2007).

The comorbidity of Cluster C PDs is often less clear. Although AVPD has been conceptualized as linked to schizoid PD and has been found to be comorbid with schizoid PD (Oldham et al., 1992), multidimensional scaling has found AVPD can be discriminated from schizoid PD but not dependent PD (Widiger, Trull, Hurt, Clarkin & Frances, 1987). AVPD is often comorbid with dependent PDs (Oldham et al., 1992) and mood, anxiety, and eating disorders (Oldham et al., 1995), and especially social phobia (Alnaes & Torgersen, 1988). DPD is substantially comorbid with mood, anxiety, and non-PD psychotic disorders (Oldham et al., 1995) and borderline and avoidant PDs (Marinangeli et al., 2000; Oldham et al., 1992). DPD is also frequently comorbid with paranoid PD (Marinangelli et al., 2000) and obsessive-compulsive PD (Oldham et al., 1992). The results of studies on OCPD comorbidity are inconsistent. While some evidence suggests OCPD co-occurs significantly with several other PDs, including borderline, narcissistic, histrionic, paranoid, and schizotypal PDs (Marinangelli et al., 2000), other data find significant comorbidity with dependent PD among the PDs (Oldham et al., 1992). Investigations of the relationship between OCPD and obsessive-compulsive disorder (OCD)

have also yielded mixed results, with some researchers finding significant co-occurrence (AuBuchon & Malatesta, 1994; Baer et al., 1992; Skodol et al., 1995), and others failing to find a strong relationship between these disorders (Black, Noyes, Pfohl, Goldstein, & Blum, 1993; Joffe, Swinson, & Regan, 1988). On the whole, the literature on OCD and OCPD suggests that the majority of patients with OCD do not meet criteria for OCPD (Pfohl & Blum, 1991). Further, for those with OCD with concurrent PD diagnosis, OCPD occurs no more frequently than any other PD. The authors concluded that there was not enough information to support a meaningful relationship between OCD and OCPD.

The bulk of the evidence indicates that PDs, while frequently comorbid with these disorders, appear to be a distinct, independent problem that provide important information to the clinician in terms of the impact on course and treatment (Fournier et al., 2008; Grilo et al., 2010; Zanarini, Frankenburg, Hennen, & Silk, 2006). With regard to PTSD, researchers have found high rates of childhood abuse in BPD populations (Ogata et al., 1990), and some have argued that trauma may be a potential trigger of posttraumatic BPD symptoms (Soloff, Lynch, & Kelly, 2002). However, while it is accurate that many BPD patients have suffered traumatic physical or sexual abuse, not all have. In fact, data suggests that 30%-70% have not. Thus, the idea that BPD is really a complex PTSD can only explain between 30%-70% of BPD cases, whereas the diagnosis of BPD can explain all cases, including those with complex traumas.

In addition to mental disorders, PDs often present with comorbidity among medical and physical conditions as well. For example, data from the NESARC suggest that a diagnosis of BPD may be related to a number of physical health conditions such as hypertension, cardiovascular disease, and gastro-intestinal diseases (El-Gabalawy et al., 2010). This study further found that comorbid medical conditions may in fact increase the risk of suicide attempts

in BPD, highlighting that paying attention to comorbidity is vital. In sum, PDs are both highly prevalent and highly comorbid with a range of psychiatric and medical disorders.

Effects of PD Comorbidity on Other Disorders

Although it has been common to view comorbid PDs as being a variant of the disorder it is comorbid with, the evidence suggests the opposite. For instance, when comorbid, PDs negatively affect the course of other disorders and the outcome of otherwise efficacious treatments. Bipolar patients with comorbid PDs are less employed, use more medications, have increased rates of alcohol and substance use disorders, show poorer treatment response, and have significantly worse inter-episode functioning than bipolar patients not afflicted with PDs (Bieling, Green, & Macqueen, 2007). Interestingly, the reverse is not true: A comorbid bipolar disorder does not affect the course or outcome for PD patients (Gunderson et al., 2006). Similarly, a number of studies have found that improvements in BPD were often followed by improvements in depression but that improvements in depression were not followed by improvements in BPD (Gunderson et al., 2004; Klein & Schwartz, 2002; Links, Heslegrave, Mitton, Reekum, & Patrick, 1995). BPD also adversely affects treatment for substance abusers, but substance abuse (highly comorbid with BPD) does not appear to alter the course of treatment for BPD (Lee, Bagge, Schumacher, & Coffey, 2010). Finally, a number of studies have shown that the efficacy of treatment of PTSD is significantly reduced when the patient has comorbid BPD (Cloitre & Koenen, 2001; Feeny, Zoellner, & Foa, 2002).

Identification and Diagnosis

Identification and Assessment

Most psychologists in clinical practice rely on unstructured clinical interviews for diagnosing patients presenting for treatment (Zimmerman, 2003). However, unstructured

clinical interviews can be idiosyncratic and unreliable and are vulnerable to a number of biases such as failure to consider all of the necessary diagnostic criteria (and failure to consider additional symptoms and diagnoses beyond the chief complaints once a disorder has been identified), among other biases. A number of studies comparing clinical diagnoses made by unstructured interviews with diagnoses made using structured and semi-structured interviews have shown poor correspondence between the two and that unstructured clinical interviews miss many diagnoses (e.g., Barbato & Hafner, 1998; Basco et al., 2000).

This problem appears to be particularly pronounced for personality disorders. For example, clinicians in university-based outpatient clinics left to their own judgments based on unstructured clinical interviews diagnosed BPD in 0.4% of almost 500 patients seen compared to 14.4% by structured interview (Zimmerman & Mattia, 1999). This means that 97% of those patients diagnosed by structured interviews with BPD were missed by unstructured clinical interviews. The research evidence is clear that without a formal assessment most cases of personality disorders will be missed (Levy, 2013; Magnavita et al., 2010). This may be especially true of NPD and ASPD where manifestations of pathology can be relatively nuanced, distress is denied and externalized, self-monitoring is high, and the criteria for these disorders have both high face validity and a negative connotation.

Beyond the unstructured clinical interview, clinicians and researchers can draw from an array of sources when assessing personality disorders. These sources include self-report paper-and-pencil/computer administered inventories, clinician rating scales and checklists, structured and semi-structured clinical interviews, projective techniques, and data from informants. Many of these assessment instruments assess personality disorders based on the prevailing taxonomy in DSM-IV-TR and DSM-5, which articulates the ten personality disorders described earlier.

However, a number of instruments exist that are based on other conceptualizations of personality disorders and pathology.

Semi-Structured Interviews

Semi-structured interviews provide specific, carefully selected questions for each diagnostic criterion to be assessed, with the purpose of increasing the consistency between interviewers through the use of systematic, replicable, and objective methods. Semi-structured interviews are meant to be "semi" structured rather than fully structured because they include many open-ended and indirect questions, allow for interviewers to follow-up, seek elaboration, and clarification of the information provided as well as observation of the patient's manner of responding and relating to the interviewer. Thus in order to conduct a semi-structured interview, the interviewer needs to have training and experience in order to utilize the clinical judgement required to know when to follow-up and how to rate the criteria.

There are a number of semi-structured and structured interviews for the full range of DSM personality disorders. These include the Structured Interview for DSM Personality Disorders-Revised (SIDP-R; Pfohl et al., 1997), Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First et al., 1995), International Personality Disorders Examination (IPDE; Loranger, 1999), Personality Disorder Interview-IV (PDI-IV; Widiger, 1995), and the Diagnostic Interview for Personality Disorders (DIPD-IV; Zanarini et al, 1987; 2000). They differ from one another in their wording of questions, inclusion of follow-up, suggestions for inquiry and organization. For instance, the SCID-II is organized by disorder whereas the IPDE is organized by domains of functioning (e.g., work, relationships, self, affects). Although these interviews have varying levels of psychometric data, the evidence

suggests that they are promising measures with good reliability and initial validity data. There are no data suggesting that one structured interview is more valid than another.

There are also a number of semi-structured and structured interviews that assess for specific DSM personality disorders. These include the Revised Diagnostic Interview for Borderlines (DIB-R; Zanarini et al., 1989) and Borderline Personality Disorder Severity Index (BPDSI; Arntz et al., 2003), the Diagnostic Interview for Narcissism (Gunderson, Ronningstam, & Bodkin, 1990), and the Hare Psychopathy Checklist-Revised (Hare, 1991). In addition, ASPD can be assessed using the National Institute of Mental Health Diagnostic Interview Schedule, Antisocial Section (Robins, Helzer, Croughan, & Ratcliff, 1981).

There are a number of semi-structured interviews that utilize other conceptions of PDs. These include (1) the Structured Interview for the Five-Factor Model of Personality (Trull & Widiger, 1997), which assesses the five domains of the five-factor model (FFM) and is the only semi-structured interview that assesses general personality; (2) the Personality Assessment Schedule (PAS; Tyrer, 1988), which assess 24 traits (e.g., aggression, impulsivity, conscientiousness) and generates dimensional ratings of five personality styles (normal, passive-dependent, sociopathic, anankastic, and schizoid; (3) the Structured Interview of Personality Organization (STIPO; Clarkin et al., 2004), which allows for dimensional assessment of identity, defenses, and reality testing based on Kernberg's structural interview (1981). This interview is conceptually concordant with DSM-5 Section III conceptualization of personality disorders.

Clinician Rating Scales

There are a number of clinician rating scales such as the Personality Assessment Form (PAF; Shea, Glass, Pilkonis, Watkins, & Docherty, 1987), the Shedler-Westen Assessment Procedure (Westen & Shedler, 1999), and scales for the PDM. The PAF presents a brief

paragraph that describes important features of each personality disorder, and the individual's similarity to the description is rated by an evaluator using a six-point scale. The SWAP is a 200-item Q-set of personality-descriptive statements designed to quantify clinical judgment based on the rater's knowledge of clinical data about the patient. Clinicians are directed to arrange the 200 items (presented on separate index cards) into eight categories with a fixed distribution ranging from those that are not descriptive of the patient to those that are highly descriptive of the patient. SWAP ratings have been shown to be reliable and have concordance with independently carried out semi-structured interviews. The SWAP has demonstrated a reduction in comorbidity with other personality disorders, especially Cluster B personality disorders. This reduction is important because a lack of discreteness of personality disorders has been a frequent critique of their construct validity.

Self-Report Instruments

A number of self-report instruments assess for personality disorders; the most widely used ones are the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, Millon, and Davis, 1994), the Personality Diagnostic Questionnaire–4th Edition (PDQ-4; Hyler et al., 1992), the Personality Assessment Inventory (PAI; Morey, 1992), and the Dimensional Assessment of Personality Pathology–Basic Questionnaire (Schroeder, Wormworth, & Livesley, 1992). Other personality disorder measures include the Schedule of Nonadaptive and Adaptive Personality (SNAP; Clark, 1993), the OMNI Personality Inventory (OMNI; Loranger, 2001), the Personality Inventory Questionnaire (PIQ-II; Widiger, 1987), the Wisconsin Personality Disorder Inventory (WIPSI-IV; Klein et al., 1993), and the Minnesota Multiphasic Personality Inventory 2-Personality Disorder Scales (MMPI 2-PD; Morey et al., 1985).

A number of self-report scales assess specific personality disorders. The most commonly used include the Psychopathic Personality Inventory (PPI; Lilienfled & Windows, 2005), Pathological Narcissism Inventory (PNI; Pincus et al., 2009) and Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979) for narcissism, and the Borderline Symptom Index (BSI; Bohus et al., 2007), Borderline Personality Inventory (BPI, Leichsenring,1999), and the Inventory of Personality Organization (IPO; Clarkin, Foelsch, & Kernberg, 1995).

Because self-report measures tend result in higher diagnostic base rates than interviews and there is poor concordance between them and interview measures, they are not recommended for the purpose of diagnosis (McDermut, & Zimmerman, 2005). However, a number of researchers have used and recommend a two-stage or step procedure for identifying those with personality disorders. Self-report measures are administered as a screener as an alert to the probability of a personality disorder, and then a semi-structured interview is administered to those who scored positive for a PD to verify its presence and type.

A number of screening instruments to assess for personality disorders broadly and specific personality disorders have been developed. The most commonly used measures include the Standardized Assessment of Personality Disorders–Abbreviated Scale (SAPAS; Moran et al), Iowa Personality Disorder Screen (IPDS; Langbehn et al., 1999), Inventory of Interpersonal Problems–Personality Disorders-25 (IIP-PD-25; Stern, Kim, Trull, Scarpa, & Pilkonis, 2000), and International Personality Disorders Examination–Screening Questionnaire; IPDE-SQ; Loranger, 1999).

The IPDE-SQ screens for the ten DSM-IV personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive. The IPDE-SQ personality disorder scales are scored based on the sum of endorsed

items. According to the scoring system, the endorsement of three or more items is suggestive of the presence of that disorder. As noted above, previous research (Lenzenweger et al., 1997) has shown that the screener is highly sensitive for identifying those with personality disorder diagnoses.

Use of informant information is important when assessing personality disorders. Sole reliance on an individual's personal report, which is the most common practice both clinically and in research (Klonsky et al., 2002), can prove problematic. Although research shows that agreement between self- and peer-reported personality traits in normal samples can be good to excellent (McCrae & John, 1998), within clinical samples, findings between patient reported data from interviews and measures with informants' report tends to range from poor to adequate (Klonsky et al., 2002). Informants can be aware of and have a better sense of behaviors, traits, and symptoms that the patient may be defensive about or consciously motivated to not share with assessors. Informants are more willing to report on negative aspects of the patient such as arrogance, dishonesty, suspiciousness, hostility and dependence (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997).

Depending on the age, life situation, suspected diagnoses, and reason for referral of an individual, informants can include friends, spouses, parents, children, colleagues, law enforcement/parole officers and court records/judges, and previous and current treaters. For example, when a patient comes into treatment due to an ultimatum from their spouse or significant other, it is important to gather information from that person. Likewise, if a patient comes in for treatment because the boss at work has made it a condition of employment, it would be important to gather information from the boss. It is particularly important to meet with and gather data from informants when ASPD might be present. Additionally, it is important to

gather informant information for any patient presenting to treatment with legal difficulties or through a court mandate.

The recommendation to gather data from the patient through self-report, interviews, observation, and from informants is accordance with the "longitudinal, expert, all-data (LEAD) standard" (Pilkonis, Heape, Ruddy, & Serrao, 1991), which recommends that optimal diagnostic practice requires the consideration of all available data to derive a "best estimate" diagnosis or set of diagnoses. This method has been shown to be more valid and reliable than diagnostic interviews alone (Pilkonis et al., 1991) and result in fewer comorbid diagnoses (Levy et al., 1998).

Differential Diagnosis

Another consideration in PD assessment is differential diagnosis, which consists of choosing from among two or more similar diagnostic criteria which diagnosis best fits the presenting features. The differential diagnosis for personality disorders commonly includes mood disorders such as bipolar, major depression, and dysthymia, anxiety disorders, posttraumatic stress disorder, and substance abuse disorders. Personality disorders are frequently comorbid with all these disorders, which complicates the diagnostic and clinical decision making process. For example, it is often unclear whether symptoms of depression or anxiety reflect a comorbid diagnosis or are primarily an expression of personality pathology.

Even when not comorbid with other disorders, PDs can present in ways that resemble other disorders, particularly Cluster A disorders with psychotic spectrum disorders, Cluster B disorders with mood disorders, and Cluster C disorders with anxiety disorders. These similarities in presentation make it important for practicing clinicians to be able to determine differential diagnoses or if a disorder is comorbid. Studies have shown that it takes between 6-

10 years after first psychiatric contact for those with BPD to be diagnosed properly (Meyerson, 2009; Zanarini, Frankenburg, Dubo et al., 1998). During this gap, patients are not usually treated.

Differential diagnosis of PDs may be categorized into three types: 1) differential from the effects of substances; 2) differential from other similar disorders (including more episodic syndromal disorders (e.g., major depression, bipolar II, generalized anxiety disorder, panic disorder, formerly called Axis I) and other personality disorders (formerly Axis II); and 3) differentiating clinical levels of personality pathology from subclinical or healthy personality functioning.

Unipolar depression. One of the most common differential diagnoses of PDs is with various mood disorders such as major depressive disorder, depressive disorder NOS, and persistent depressive disorder (formally called dysthymia). Those with PDs, particularly BPD and NPD often experience depression, and the patient's phenomenological experience is often that they are "depressed." In fact, research shows that BPD patients typically score as high or higher on measures of depression than those with major depressive disorder (Levy et al., 2007).

Making this differential requires an extensive evaluation of the symptoms and quality of the depression experienced. In BPD, the depression is often experienced as chronic dysphoria and emptiness (Zanarini, Frankenburg, Deluca et al., 1998). In NPD, the depression tends to occur more sporadically and after failures of one sort or another or when individuals are in a vulnerable state (Caligor, Levy, & Yeomans, 2015). In addition, those with BPD and NPD often report chronic suicidality and periodic self-injury and suicidal attempts, typically after interpersonal discord. Without careful assessment, the suicidality, suicide attempts, and self-

injury can easily but mistakenly be interpreted as part of a depression rather than a response to interpersonal discord.

In contrast to MDD where the depressed mood is episodic, in BPD the depressed mood is often chronic and tends to vacillate with anger and irritability (as opposed to normal mood or expansive mood in bipolar disorder). Also, in contrast to those with MDD, borderline patients often show more mood reactivity than is typical of those in a depressive episode. It is not unusual for a suicidal and otherwise seemingly depressed patient with BPD to quickly become quite relieved, cavalier, and even very social with the other patients upon admission to an inpatient hospital unit. BPD patients also often do not present with the neurovegetative signs that are frequently typical of those with major depression and are more likely to report atypical symptoms (e.g., increased appetitive and excessive sleeping). Symptoms related to poor appetite are not accompanied by weight loss, belaying the report of decreased appetite.

Probably the most important issue for differentiating BPD from MDD concerns identity disturbance. People with MDD do not suffer from identity disturbance whereas identity disturbance is typically present in BPD. Given the chronic nature of the BPD patient's depressed mood, it can often be difficult to differentiate BPD from dysthymia (now called "persistent depressive disorder" in DSM-5). Once again mood reactivity, lack of neurovegetative signs, the chronic irritability, suicidiality and parasuicidality are characteristic of BPD.

Bipolar disorders. Another common and challenging differential diagnosis for those with PDs, particularly those with BPD, NPD, and antisocial PD, is with bipolar disorder, particularly bipolar II. The comorbidity between PDs and bipolar I and II tends to be around 28% to 48% (e.g., George et al., 2003; Kay, Altshuler, Ventura, & Mintz, 1999).

There is now a large amount of data suggesting that those with BPD are often misdiagnosed with bipolar disorder. Even when bipolar disorder is present, it is important to determine whether a PD is present because evidence suggests that a comorbid PD diagnosis negatively impacts the course and outcome for bipolar disorder, whereas comorbid bipolar disorder does not impact the course and outcome for PDs (e.g., Bieling, Green, & Macqueen, 2007; Gunderson et al., 2006; Kay, Altshuler, Ventrura, & Mitntz, 2002).

At a practical level, probably the most important point of confusion in differentiating PDs from bipolar disorder concerns affective instability or emotional lability. Because affective instability is a core symptom of bipolar disorder, when it occurs in personality disorders it is often mistaken as an indicator of bipolar disorder. However, research shows that affective instability in BPD is qualitatively different than what is proposed in the criteria for bipolar disorder. Affective instability in bipolar disorder occurs spontaneously and evolves over a period of days and weeks and tends to be longstanding (APA, 2013).

Additionally, the mood swings seen in bipolar disorder are typically between depression and elation, expansiveness, and grandiosity. On the other hand, in BPD and other PDs, the affective instability is reactive (i.e., environmentally driven) usually in response to interpersonal events or internal thought processes, and tends to be of short duration and display frequent vacillations. These vacillations are not between depression and elation or grandiosity, but between depression and anger, hostility, and irritability (Reisch, Ebner-Priemer, Tschacher, Bohus, & Linehan, 2008). BPD patients report significantly more frequent and intense affective shifts than those with bipolar disorder (Reisch, Thommen, Tschacher, & Hirsbrunner, 2014). Interestingly, the affective instability in BPD patients, compared to bipolar patients, tends to be

more intense and frequent and shift between depression and anxiety on the one hand and euthymia and anger on the other (Henry et al., 2001; Reisch et al., 2014).

There are similar confusions when differentiating impulsivity and irritability in BPD and bipolar disorder. Impulsivity and irritability in BPD is chronic, whereas in bipolar disorders these characteristics must represent a distinct occurrence and occur as part of a manic or hypomanic episode in order to be counted toward those disorders.

Trauma disorders. Distinguishing between personality disorders and PTSD can be clear-cut when the PTSD is an acute symptomatic reaction to a discrete traumatic event accompanied by psychophysiological correlates. With regard to acute traumas, chronic impulsivity, irritability, and identity disturbance will distinguish BPD and PTSD. This is especially easy to determine when the symptoms of BPD predate the traumatic event. The premorbid functioning in those with PTSD is usually good.

However, it is much more difficult to disentangle these disorders in the context of the enduring effects that early and chronic trauma can have on personality development. A number of clinical researchers and theorists have suggested that BPD can be reconceptualized as a form of complex PTSD (e.g., Herman, 1993; Kroll, 1993, Hodges, 2003). Studies show that 30-70% of BPD patients have broadly experienced traumatic events (e.g., Zanarini & Frankenburg, 1997), conversely, 30-70% of those with BPD do not. Additionally, studies of consecutive admissions find that between 30-45% of BPD have a history of abuse, which is often not significantly different that other mental disorders (e.g., Chapman et al., 2004; Paris, Zweig-Frank, & Guzder, 1994).

In a study of women with PTSD who experienced early childhood abuse, a comorbid BPD diagnosis did not impact traditional symptoms of PTSD such as the frequency and severity

of intrusions, avoidance, and arousal (Heffernan & Cloitre, 2000). However, a comorbid BPD diagnosis did result in elevations in the newly proposed DSM-5 symptoms of PTSD that are historically thought to be part of the BPD symptom picture: anger, anxiety, dissociation and interpersonal problems (Heffernan & Cloitre, 2000). These findings suggest that BPD and traditional PTSD can be distinguished by their symptom picture and cast doubts on the concept of complex PTSD as a substitute for BPD. Thus, anger and interpersonal problems as well as anxiety and dissociation would suggest the possible comorbidity of BPD and the need to assess for it in the context of trauma and PTSD.

Anxiety disorders. Other important differential diagnoses include anxiety disorders, particularly generalized anxiety disorder (GAD) and panic disorder. Those with PDs, particularly BPD, often report diffuse anxiety that may at times resemble GAD. However, the PD patient tends to vacillate between feeling anxious over a range of situations and being remarkably unconcerned and cavalier about situations in which anxiety would be appropriate.

Additionally, whereas in GAD the anxieties are often discordant to the situation (e.g., the student with a high GPA who worries excessively about his or her grades), the worry in PDs tends to be about current crises that have arisen and dissipates once the crises are resolved. For example, a supervisee reports that she believes the patient may have GAD due to the patient's excessive worry about whether or not her disability benefits will be renewed. The patient is concerned because she has been talking in therapy about her off-the-books job and she is afraid that the review agency will discover she is working. The anxiety interferes with her sleep and eating, as well as making her irritable. However, once her benefits are renewed, her anxiety quickly resolves, indicative more of a PD (or even healthy functioning) than GAD.

Substance Use Disorders (SUDs). It is often the case that PD patients who abuse substances do so as a function of their personality disorder. However, sometimes problems associated with substance abuse can create many of the symptoms of a personality disorder. That is, patients who abuse substances can behave in ways consistent with PDs as a function of substance use. For example, it is not unusual for those with SUDs to act in antisocial ways, such as lying or stealing in order to obtain drugs or alcohol. Such a person while on drugs or in the pursuit of drugs may show a callous, remorseless attitude. However, the patient may not have engaged in these behaviors or shown such an attitude either prior to the development of the substance use disorder or after becoming sober, suggesting the absence of antisocial PD.

In a retrospective chart review study, 137 inpatient borderline patients, over two-thirds met DSM-III criteria for substance use disorders (Dulit et al., 1990). Interestingly, when substance use was not used as a criterion for BPD, 35% of patients no longer met DSM-III criteria for BPD. This subgroup was marked by lower severity of symptoms and less chronicity of course. Thus, there may be a subgroup with PD patients who may "appear" personality disordered because of behaviors associated with comorbid substance use and that they would likely lose the PD diagnosis after achieving abstinence.

It is relatively easy to rule out a PD for patients whose personality disorder behavior begins after substance use, particularly when in adulthood or whose PD behavior quickly remits after refraining from substance use. It is much more difficult when substance use begins early or when the patient is in the throes of substance use. In these cases it is useful to rely on the hallmark indicators of PDs that are independent of the consequences of substance abuse, such as identity disturbance in BPD.

Treatment

Personality disorders are considered a major treatment challenge. Historically, PDs have been thought to be difficult to treat, with patients frequently not adhering to treatment recommendations, using services chaotically, and repeatedly dropping out of treatment. Many clinicians are intimidated by the prospect of treating BPD patients and are pessimistic about the outcome of treatment (Lewis & Appley, 1988; Lequesne & Hersh, 2004; McDonald-Scott et al., 1992). Therapists treating patients with BPD have displayed high levels of burnout and have been known to be prone to enactments and even engagement in iatrogenic behaviors (Fonagy & Bateman, 2006; Linehan et al., 2000).

However, in recent years there has been a number of randomized controlled trials that have found PDs can be treated successfully. Beginning with Linehan's (1991) seminal randomized controlled trial (RCT) of Dialectical Behavior Therapy (DBT), there is now a range of treatments—deriving from both the cognitive-behavioral (CBT) and psychodynamic (PDT) traditions—that have shown efficacy in RCTs and are now available for use to clinicians. In addition to DBT, efficacious treatments include Schema-Focused Therapy (SFT) and Systems Training for Emotional Predictability and Problem Solving (STEPPS) from a CBT perspective and Mentalization-Based Treatment (MBT), Dynamic Deconstructive Psychotherapy (DDP), and Transference-Focused Psychotherapy (TFP) from a psychodynamic perspective. Several other treatments appear promising, such as Meares's Interpersonal Treatment (Stevenson & Meares, 1992), Ryle's Cognitive Analytic Therapy (CAT; Ryle, Poynton, & Brockman, 1990), and Beck's CBT (Beck, Freeman, & Davis, 2004) and have received support through RCT designs. All treatments with demonstrated efficacy or effectiveness share some commonalities: they tend to be long-term, integrative, structured, and modified from standard treatments.

Meta-Analyses of Treatment for PDs

Several meta-analyses of psychotherapy for personality disorders provide encouraging findings (Budge et al., 2013; Leichsenring & Leibing, 2003; Perry et al., 1999). One meta-analysis (Perry et al., 1999) identified 15 studies, including six RCTs, and found pre-post effect sizes ranging from 1.1 to 1.3. A second meta-analysis (Leichsenring & Leibing, 2003) examined the efficacy of both PDT (14 studies) and CBT (11 studies) in the treatment of patients with personality disorders; eleven of the studies were RCTs. The authors reported pre-treatment to post-treatment effect sizes using the longest term follow-up data reported in the studies. For psychodynamic psychotherapy (mean length of treatment was 37 weeks), the mean follow-up period was 1.5 years after treatment end and the pre-treatment to post-treatment effect size was 1.46, indicating that psychodynamic treatment benefits endure over time. For CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the pretreatment to posttreatment effect size was 1.0. The authors concluded that both PDT and CBT demonstrated effectiveness for patients with personality disorders, but that current evidence for long-term effectiveness is stronger for psychodynamic psychotherapy. The most recent and comprehensive meta-analysis on PDs (Budge et al., 2013) analyzed 30 studies that compared an active psychotherapeutic treatment with treatment as usual, finding that active psychotherapeutic treatments were more efficient than treatment as usual comparisons, with medium effect size (d = .40). In addition, the effectiveness of PDT for individuals with personality disorders is supported by two more recent meta-analytic studies for short-term PDT (Town et al., 2010) and for the treatment of depression with comorbid personality disorders (Abbass et al., 2011).

Findings from these meta-analyses, suggest that psychodynamic and CBT treatments for PDs are far more effective than no treatment, modestly more effective than treatments as usual,

and appear to be equally effective for personality disorders. Additionally, longer term treatments might yield better outcomes.

At the same time, findings from these meta-analyses of personality disorders are difficult to interpret due to the mixing of different disorders both within studies included in meta-analyses and within and between meta-analyses. These different PDs vary quite a bit in terms of severity. Further complicating the interpretation are the different controls used across studies and within meta-analyses. Research on specific personality disorders would be more informative particularly when the control group is better accounted for.

Pharmacotherapy

A systematic review of 40 RCTs for the PDs (most of which focused on BPD) found some limited effect of psychotropic medication for specific PD symptoms, such as the mood stabilizer lithium for aggression in ASPD, and monoamine oxidase inhibitors for social anxiety in AVPD (Triebwasser & Siever, 2007). A 2010 review of 21 pharmacological treatment studies of BPD and STPD suggested that antipsychotics were moderately effect for cognitive or perceptual symptoms, as well as for reducing anger (Ingenhoven, Lafay, Rinne, Passchier, & Duivenvoorden, 2010). Antidepressants had a small effect on anxiety symptoms, but were not effective for depression among these patients, or for treating core PD symptomatology. Further systematic review evidence suggests antipsychotic medication may especially help to reduce psychotic features of both BPD and STPD, while lithium may be effective for aggressive features among PDs such as ASPD (Hori, 1998). Another recent review posited that antipsychotics may help reduce psychotic features and behavioral symptoms among the PDs (Öyekçin & Yıldız, 2012). This review suggested that psychotherapy for BPD might be enhanced with concurrent pharmacological treatment when mood, cognitive, or behavioral

symptoms are severe, AVPD may be treated with the serotonin-norepinephrine reuptake inhibitor venlafaxine, or with SSRIs, STPD may respond to antipsychotics, but ASPD is not responsive to medication, contradicting earlier findings of the efficacy of lithium in this disorder (Hori, 1998).

For BPD specifically, a systematic review and meta-analysis of 27 RCTs conducted by the Cochrane Collaboration determined that mood stabilizers, such as lamotrigine, showed some efficacy in treating both core and accessory features of the disorder (Lieb, Völlm, Rücker, Timmer, & Stoffers, 2010). The second-generation antipsychotic aripiprazole also showed some effect in reducing BPD symptoms. Antidepressant medications (e.g., SSRIs) were not found to be effective as a BPD treatment option. These findings partially confirmed an earlier review (Nosé, Cipriani, Biancosino, Grassi, & Barbui, 2006) that found that mood stabilizers reduced affective instability and anger in BPD, and antipsychotics were effective in reducing impulsivity and aggression, as well as improving interpersonal functioning. However, as the authors of these studies point out, pharmacotherapy for the PDs tends to have only limited effect and focus on specific core or secondary symptoms of specific disorders, rather than on global change, and, if used, should be considered adjunctive treatment to psychotherapy, the gold standard of care for PDs.

Self-Help Resources

A number of self-help resources are available for those with personality disorders, particularly borderline personality disorder. These resources include (1) books written by professionals and/or patients or family members geared towards patients, families and professionals; (2) Internet resource centers that provide information through text, videos, and additional links; (3) Self-help and family organizations that in addition to website and written information provide lectures, education, and trainings and support to people with personality

disorders and their families. Many of these resources provide mechanisms for referrals, advocacy, and bring current research findings to individuals and families suffering from personality disorders.

In the United States the main self-help and family organizations include the, the BPD Resource Center (www.bpdresourcecenter.org), Treatment and Research Advancements for Borderline Personality Disorder (TARA4BPD; www.tara4bpd.org), National Education Alliance for BPD (NEA-BPD; www.borderlinepersonalitydisorder.com), and RethinkBPD. Other online resources include: www.BPDCentral.com, www.borderlinepersonalitydisorder.com, www.bpdworld.org, www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml, & www.bpdfamily.com. The BPD Resource Center contains a number of videos with prominent BPD researchers and clinicians as well as patients discussing aspects of the disorder, the experience of BPD, and the kind of changes that can occur with treatment. In addition to producing a documentary called “Back from the Edge” that weaves patient accounts, family commentary, and expert advice, they have also provided local lectures and outreach and importantly provide a referral service. RethinkBPD has provided lectures and developed a documentary called “The Fight Within Us.”

The two largest and most far reaching organizations are TARA and NEA-BPD. These organizations not only provide current research information to patients and families but also provide educational trainings and support groups to families. NEA-BPD has sponsored family education workshops throughout the United States, as well as a periodic call-in series to speak with experts in the field. Additionally, these two organizations have carried out research relevant to families as well as the outcome of their family education programs. Using retrospective self-reports, TARA examined the outcome for 74 graduates of its family education program. They

found significant decreases in a number of problem areas such as violent arguments, financial bailouts, suicide threats, hospitalizations, as well as significant improvements in family relationships (Porr, Mandelbaum, & Freilich, get date). In two published studies (Hoffman, Fruzzetti, & Buteau, 2007; Hoffman et al., 2005), NEA-BPD has examined the outcome of its Family Connections program, a 12-week program, for 55 and 45 family members, respectively. Across the two studies, they found significant decreases in grief, burden and depression and significant increases in mastery. However, these studies only examined treatment completers and none of these studies employed control groups, making the results difficult to interpret. One randomized controlled trial examined 12-weeks of psychoeducation for patients with BPD (Zanarini & Frankenberg, 2008). Although psychoeducation resulted in significant decreases in impulsivity and storminess in relationships, there was no effect on psychosocial functioning.

Self-help books for BPD include "Stop Walking on Eggshells", "I Hate You, Don't Leave Me: Understanding Borderline Personality Disorder," "Self-Help for Managing the Symptoms of Borderline Personality Disorder," "The Borderline Personality Disorder Survival Guide," "Borderline Personality Disorder Demystified," and "Get Me Out of Here: My Recovery From Borderline Personality Disorder."

Books geared toward families with a member who has been diagnosed with a personality disorder include "Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families," Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change," "Remnants of a Life on Paper," "Loving Someone with Borderline Personality Disorder, and "The Essential Family Guide to Borderline Personality Disorder." However, as can be seen from this review, while BPD has received much attention in the domain of self-help and psychoeducation, such resources for other PDs are lacking.

Major Accomplishments

A key achievement in the field of PD research has been the establishment of diagnostic cut-offs and consensual diagnostic criteria for personality disorders. The reliability of various PD diagnoses have been shown to be as reliable as other accepted disorders (e.g. generalized anxiety disorder and bipolar disorder; Brown, Di Nardo, Lehman, & Campbell, 2001). Another achievement consists of increased validity and clinical utility of the PD concept, such that many of the individual PDs are now well-established (Pilkonis, Heape, Ruddy, & Serrao, 1991). Various PD diagnoses been shown to be stable over time, particularly when compared to episodic disorders like major depression. Moreover, PDs have been differentiated from near-neighbor disorders and been determined to have clinical utility in predicting course and outcome when comorbid with the acute syndromal disorders.

Another key achievement has been the established efficacy of a number of treatments for PDs in randomized controlled trials. Now there are number of useful manualized treatments for treating personality disorder from both CBT and PDT traditions that have been tested in more than 40 RCTs combined. Much of this work has focused on BPD and to a lesser extent ASPD and mixed personality disorders, particularly cluster C disorders. In contrast to dismal prognosis in the past, individuals with PDs now have access to a range of structured and empirically supported treatments that are likely to provide at least moderate decrease in symptoms and improvement in functioning.

Finally, the field has also generated improvements in both research and training surrounding the PDs and their treatment. Published treatment manuals for evidence-based therapies allow for training in efficient and standardized ways across training programs that may help avoid conceptual drift or miscommunication. Research has now documented prevalence of

PDs, their comorbidity, etiology, differential diagnosis, and efficacy of treatments, providing a solid foundation for future research in this area. Research has begun to explore and elaborate on theoretical conceptualizations of PD development in the hopes of one day delineating the progression of PD features and providing early intervention and prevention for such serious mental disorders.

Future Directions

Radical shifts in practice have evolved since the early 20th century. From the 1930s through the 1990s, practice with personality disordered individuals was primarily carried out from a psychodynamic orientation and often involved intermittent short- and long-term hospitalizations. Diagnosis became increasingly based on signs and symptoms that were articulated by a few clinical theorists and integrated into the various versions of the DSM. The 1990s and early part of the 21st century saw the dominance of dialectical behavior therapy rapidly emerge based on a combination of empirical assessment and aggressive dissemination and outreach. In the beginning of the 21st century, other treatments slowly began to be examined. At present, there are a number of empirically supported treatments for personality disorders, particularly BPD that have derived from both CBT and PDT traditions. These treatments tend to be quite integrative. Although few direct comparisons exist, the ones that do exist, as well as a host of meta-analytic reviews strongly suggests that no one current treatment is better than any other. Moreover the effects of these treatments tend to be smaller than hoped.

As the equivalence among treatments has emerged, the similarities between treatments, rather than the differences, have been stressed. As we move forward, an emphasis on empirical support continues. However, there is also an acknowledgment that these different approaches need further study and that clinicians may need to be trained in multiple approaches to best serve

their patients. It is unclear at this point whether or not one treatment might be better than another for a particular patient or type of patient or whether a better approach might be to combine aspects of treatments in order to develop more powerful interventions. Clinical practice is thus moving toward becoming more integrative.

Training in personality disorders is becoming more concrete and explicit. Prior to the rise of DBT, training in personality disorders tended to occur through supervision by experts typically through clinical training experiences at a handful of internship and residency training programs that had specialized programs in personality disorders, such as Cornell Medical College or McLean Hospital. Training in personality disorders was even less common in clinical psychology training programs (Magnavita et al., 2010). Among the many innovations ushered in by Linehan with DBT was the explication and standardization of training procedures that allowed them to be transported widely into the community independent of one to one supervision. This model has been taken up by developers of various other empirically supported treatments such as mentalization-based treatment, schema focused psychotherapy, and transference focused psychotherapy. Given the success of these methods of training clinicians, the future of training will most likely include the broad dissemination of training in psychotherapy techniques for those with personality disorders. As we learn more about the similarities and differences in the various treatments and make gains in their integration, we should also see more principle-based training, instead of training in treatment packages.

With regard to research there are a number of important directions for the field. Research is moving toward better understanding the relationship between genotype, endophenotype and phynotypes, especially as they relate to diagnostic and etiological issues. A number of diagnostic issues need be resolved over the coming decade with regard to personality disorders.

This includes better defining, or even redefining, the phenotypes underlying personality disorders. Debates about reliance on categories, prototypes, or dimensions—or some combination of these—remain unresolved. There has been some attempt to incorporate developments from a breadth of theoretical domains; for example, the Research Domain Criteria (RDoC; Insel et al., 2010) initiative begun by the National Institute of Mental Health (NIMH) is designed to address this issue. However, the RDoCs, with their exclusive focus on neurobiologically based markers of psychopathology may not effectively capture all the necessary areas of PD research (Lilienfeld, 2014) and thus is also a call to better integrate other conceptual models such as dimensional trait models into the diagnostic system.

Another important direction for personality disorders is a fuller understanding of the etiology and development of personality disorders. Over the last few decades, conceptions of PD development have evolved from being primarily focused on psychosocial contributions (e.g., parenting, trauma) to broader conceptions that include a wide array of biological, psychosocial, and cultural factors often in interaction with each other. The data suggest that each of these contribute a relatively small effect and none appear necessary or sufficient to cause a PD. Future research will focus on explicating the relative parameters and contributing factors, as well as the interaction between genetic and environmental contributions to the development of PDs.

In terms of treatment, we foresee developing and examining treatments for personality disorders beyond BPD, specifically narcissistic personality disorder, given its prevalence, distress caused, and toll on society. Only a small portion of the treatments developed and tested thus far have been widely disseminated. Given that even effective treatments tend to show only about 60% of patients improve, broader dissemination and establishment of the various empirically supported treatments is needed in order to better serve our patients. Consistent with

the goals of research funding agencies and NIMHs focus on mechanisms, in the future, the field will move beyond the horse race mentality toward studying underlying change mechanisms. Those who study personality disorders have been interested in mechanisms that include not only processes elucidated by neuroscience, but also those involving social cognition and therapy technique.

In sum, the field has come a long way with regards to training, research, and practice in the area of personality disorders; nonetheless, the cliché that "more research is needed" is clearly true in the case of PDs. However, the field has defined important domains for further investigation. The answers to these questions and those that arise in the course of research hold promise in helping psychologists understand and treat the relatively large segment of the population suffering from personality disorders.

Table 1

Comparison of the ICD-10, PDM, Millon, and Westen and Shedler Personality Disorder Classification Systems to DSM-5

DSM-5 Personality Disorder	ICD-10	PDM	Millon	Westen and Shedler
*Cluster A**				
Paranoid	Paranoid	Paranoid	Paranoid	Paranoid
Schizoid	Schizoid	Schizoid	Schizoid	Schizoid
Schizotypal			Schizotypal	
Cluster B				
Histrionic	Histrionic	Hysterical	Histrionic	Histrionic
Antisocial	Dissocial	Psychopathic	Antisocial	Antisocial-psychopathic
Borderline	Emotionally unstable – borderline type		Borderline	Dysphoric: emotionally dysregulated
Narcissistic		Narcissistic	Narcissistic	Narcissistic
Cluster C				
Obsessive-compulsive	Anankastic	Obsessive-compulsive	Compulsive	Obsessional
Avoidant	Anxious	Phobic	Avoidant	Dysphoric: avoidant
Dependent		Dependent	Dependent	Dysphoric: dependent-masochistic
		Sadistic and Sadomasochistic	Sadistic	
		Masochistic	Masochistic	Dysphoric: dependent-masochistic

		Depressive	Melancholic	
		Somatizing		
		Anxious		
		Dissociative		
			Negativistic	Dysphoric: hostile-externalizing
			Hypomanic	
				Dysphoric: high-functioning neurotic
Other specified personality disorder	Other specified personality disorders; mixed personality disorder	Mixed/other		
Unspecified personality disorder	Personality disorder, unspecified			
	Emotionally unstable – impulsive type			

Note: ICD-10 = International Statistical Classification of Diseases and Related Health Problems, 10th Revision; PDM = Psychodynamic Diagnostic Manual; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Millon's classification system drawn from Millon (1977). Westen and Shedler's classification system drawn from Westen and Shedler (1999).

* "Cluster" terminology and categorization utilized only by DSM-5.

Table 2

DSM-5 General Personality Disorder Criteria

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

    1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
    2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
    3. Interpersonal functioning.
    4. Impulse control.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a

drug of abuse, a medication) or another medical condition (e.g., head trauma).

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

    1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
    2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
    3. Interpersonal functioning.

Note. From the DSM-5 (APA, 2013, p. 645). DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCE

VALUE ADDED COURSE STUDENT DETAILS

CLASSIFICATION OF PERSONALITY AND ITS TREATMENT METHODS- 2ND YEAR STUDENTS

S.No	Register No	Students List	Department	SIGNATURE
1	U14MB316	SIKKANDAR. A	Psychiatry	A. Sikkandar
2	U14MB317	SINDHU. M	Psychiatry	Sindhu. M
3	U14MB318	SIVARAJ. S	Psychiatry	Raj. S.
4	U14MB319	SOUNDARYA. S	Psychiatry	Soundharya
5	U14MB320	SOWMYA DEVI. N	Psychiatry	N. Sowmya Devi
6	U14MB321	SOWWMYA. S	Psychiatry	S. Sowmya
7	U14MB322	SOWMYAMANJA MADHA.I	Psychiatry	Madha. I
8	U14MB323	SREEDEVI. B	Psychiatry	B. Sreedevi
9	U14MB324	SREEPADMA PURUJITH. S.S.	Psychiatry	S. S. Sreepadma Puruj.
10	U14MB325	SRI JAYALAKSHMI. A	Psychiatry	A. Srijayalakshmi
11	U14MB326	SRITATA. S	Psychiatry	Sritata. S.

12	U14MB327	SRRUTHII. N.M.	Psychiatry	
13	U14MB328	SUBRAMANI. B	Psychiatry	
14	U14MB329	SUDARSHNA. K	Psychiatry	
15	U14MB330	SUKIRTHA. K	Psychiatry	

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

The Types Of Personality Disorders Along With Assessment And Mangament

MULTIPLE CHOICE QUESTIONS

Candidate Name		Assessor Name	
Date of Assessment		Assessor Position	

Course Code: PSYC04

I. ANSWER ALL THE QUESTIONS

1) Personality disorders (PD) consist of a loosely-bound cluster of sub-types. Which of the following common features are evident in PD?

a) they are characterized by an enduring pattern of behaviour that deviates markedly from expectations within that culture

b) they are associated with unusual ways of interpreting events, unpredictable mood swings, or impulsive behaviour

c) they result in impairments in social and occupational functioning

d) All of the above

Check your answer

2) Which of the following is the most well-known of the Personality disorders ?

a) Borderline Personality Disorder

b) Melancholic Personality Disorder

c) Associative Personality Disorder

d) Dissociative Personality Disorder

Check your answer

3) Which of the following is NOT a characteristic of individuals with paranoid personality disorder

- a) avoidance of close relationships
- b) avoidance of public places
- c) are often spontaneously aggressive to others
- d) often feel that they have been deeply and irreversibly betrayed by others

Check your answer

4) An Individual with a schizotypal personality disorder will usually exhibit which of the following characteristics?

- a) eccentric' behaviour marked by odd patterns of thinking and communication
- b) discomfort with close personal relationships
- c) often exhibit unusual ideas of reference
- d) All of the above

Check your answer

5) Which of the following is a subtype of Dramatic/Emotional Personality Disorders (Cluster B)

- a) Paranoid Personality Disorder
- b) Schizotypical Personality Disorder
- c) Histrionic Personality Disorder
- d) Schizoid Personality Disorder

XI. Check your answer

6) The term 'sociopath' or 'psychopath' is sometimes used to describe which type of personality disorder

- a) Histrionic Personality Disorder
- b) Antisocial Personality Disorder APD
- c) Paranoid Personality Disorder
- d) Schizotypal Personality Disorder

Check your answer

7) An individual with narcissistic personality disorder will routinely overestimate their abilities and inflate their accomplishments, and this is characterized by which of the following?

- a) a pervasive need for admiration
- b) An inability to monitor reality
- c) impulsive behaviour such as drug abuse
- d) unusual ideas of reference

Check your answer

8) The apparent lack of empathy and the tendency to exploit others for self-benefit, has lead psychologists to compare narcissistic personality disorder with which one of the following?

- a) Histrionic Personality Disorder
- b) Antisocial personality Disorder

c) Paranoid Personality Disorder

d) Schizotypal Personality Disorder

9) Which of the following are considered to be the main features of avoidant personality disorder?

a) persistent social inhibition

b) feelings of inadequacy

c) hypersensitivity to negative evaluation

d) All of the above

Check your answer

10) Some clinicians have come to believe that antisocial personality disorder and social phobia are both components of a broader spectrum called:

a) Social identity spectrum

b) Broad spectrum disorder

c) social anxiety spectrum

d) generalised anxiety disorder

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

The Types Of Personality Disorders Along With Assessment And Mangament

MULTIPLE CHOICE QUESTIONS

Candidate Name	SOWMYA MANJA MADH	Assessor Name	DR. ARUN
Date of Assessment	15.5.2022	Assessor Position	ASSISTANT PROFESSOR

UNIVERSITY REG NO:- U14 MB322

Course Code: PSYC04

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The Types Of Personality Disorders Along With Assessment And Mangament

MULTIPLE CHOICE QUESTIONS

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Date of Assessment	15.5.2022	Assessor Position	ASSISTANT PROFESSOR

UNIVERSITY REG NO:- U14MB321

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Check your answer

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Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research
(Deemed to be University under section 3 of the UGC Act 1956)

CERTIFICATE OF MERIT

This is to certify that SUDARSHNA. K has actively participated in the Value Added Course on **The Types Of Personality Disorders Along With Assessment And Management** held January - 2022 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

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Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research
(Deemed to be University under section 3 of the UGC Act 1956)

CERTIFICATE OF MERIT

This is to certify that SUKIRTHA. K has actively participated in the Value Added Course on **The Types Of Personality Disorders Along With Assessment And Management** held January - 2022 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

Dr. ARUN SEETHARAMAN
RESOURCE PERSON
Dr. ARUN SEETHARAMAN, MD.,
Reg. No: 91440
Associate Professor, Psychiatry
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502.

Dr. V.R.SRIDHAR
COORDINATOR
Dr. V. R. SRIDHAR, MD.,D.P.M.,
Reg. No: 30995
Professor & HOD, Psychiatry
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502.

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Student Feedback Form

Course Name: **PERSONALITY DISORDERS**
Subject Code: **PSYC04**

Name of Student: ____ Roll No.: ______________

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					
2	Course contents met with your expectations					
3	Lecturer sequence was well planned					
4	Lectures were clear and easy to understand					
5	Teaching aids were effective					
6	Instructors encourage interaction and were helpful					
7	The level of the course					
8	Overall rating of the course	1	2	3	4	5

* *Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Student Feedback Form

Course Name: **PERSONALITY DISORDERS**

Subject Code: **PSYC04**

Name of Student: SOWMYA DEVI - N Roll No.: U14MB320

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					✓
2	Course contents met with your expectations				✓	
3	Lecturer sequence was well planned				✓	
4	Lectures were clear and easy to understand					✓
5	Teaching aids were effective				✓	
6	Instructors encourage interaction and were helpful					✓
7	The level of the course					✓
8	Overall rating of the course	1	2	3 ✓	4	5

Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory

Suggestions if any:

Sowmya.devi

Signature

Date:

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Student Feedback Form

Course Name: **PERSONALITY DISORDERS**

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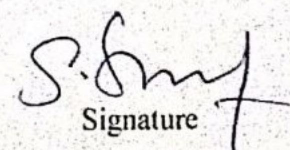
Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear			✓		
2	Course contents met with your expectations				✓	
3	Lecturer sequence was well planned					✓
4	Lectures were clear and easy to understand				✓	
5	Teaching aids were effective			✓		
6	Instructors encourage interaction and were helpful				✓	
7	The level of the course					✓
8	Overall rating of the course	1	2	3	4	5 ✓

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:



Signature

Date:

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Date: 30-6-2022

From

Dr.V.R.Sridhar
Professor and Head,
Department of Psychiatry,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research,
Chennai.

Through Proper Channel

To
The Dean,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research,
Chennai.

Sub: Completion of value-added course: Identification and Classification of Personality Disorders and Its Management

Dear Sir,

With reference to the subject mentioned above, the department has conducted the value-added course titled: **Awareness, Identification and Classification Of personality Disorders and Its Management**. We solicit your kind action to send certificates for the participants that is attached with this letter. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards,

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Dr. Sridhar

PSYC04- The Types Of Personality Disorders Along With Assessment And Mangament – JAN 2022 TO JUNE 2022

Encl: Certificates

Photographs

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