HIGH-YIELD FACTS IN

Personality Disorders

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**DEFINITION**

Personality is one’s set of stable, predictable emotional and behavioral traits. Personality disorders involve deeply ingrained, inflexible patterns of relating to others that are maladaptive and cause significant impairment in social or occupational functioning. The disorders include marked limitations in problem solving and low stress tolerance. Patients with personality disorders lack insight about their problems; their symptoms are either ego-syntonic or viewed as immutable. They have a rigid view of themselves and others and around their fixed patterns have little insight. Patients with personality disorders are vulnerable to developing symptoms of Axis I disorders during stress.

Personality disorders are Axis II diagnoses.

**DIAGNOSIS AND DSM-IV CRITERIA**

1. Pattern of behavior/inner experience that deviates from the person’s culture and is manifested in two or more of the following ways:
   - Cognition
   - Affect
   - Personal relations
   - Impulse control

2. The pattern:
   - Is pervasive and inflexible in a broad range of situations
   - Is stable and has an onset no later than adolescence or early adulthood
   - → significant distress in functioning
   - Is not accounted for by another mental/medical illness or by use of a substance

The international prevalence of personality disorders is 6%. Personality disorders vary by gender. Many patients with personality disorders will meet the criteria for more than one disorder. They should be classified as having all of the disorders for which they qualify.

**CLUSTERS**

Personality disorders are divided into three clusters:

- **Cluster A**—schizoid, schizotypal, and paranoid:
  - Patients seem eccentric, peculiar, or withdrawn.
  - Familial association with psychotic disorders.
- **Cluster B**—antisocial, borderline, histrionic, and narcissistic:
  - Patients seem emotional, dramatic, or inconsistent.
  - Familial association with mood disorders.
- **Cluster C**—avoidant, dependent, and obsessive-compulsive:
  - Patients seem anxious or fearful.
  - Familial association with anxiety disorders.

**Personality disorder not otherwise specified (NOS)** includes disorders that do not fit into cluster A, B, or C (including passive-aggressive personality disorder and depressive personality disorder).
**Etiology**

- Biological, genetic, and psychosocial factors during childhood and adolescence contribute to the development of personality disorders.
- The prevalence of personality disorders in monozygotic twins is several times higher than in dizygotic twins.

**Treatment**

- Personality disorders are generally very difficult to treat, especially since few patients are aware that they need help. The disorders tend to be chronic and lifelong.
- In general, pharmacologic treatment has limited usefulness (see individual exceptions below) except in treating coexisting symptoms of depression, anxiety, and the like.
- Psychotherapy and group therapy are usually the most helpful.

**Cluster A**

These patients are perceived as eccentric or hermetic by others and can have symptoms that meet criteria for psychosis (Table 5-1).

**Paranoid Personality Disorder (PPD)**

Patients with PPD have a pervasive distrust and suspiciousness of others and often interpret motives as malevolent. They tend to blame their own problems on others and seem angry and hostile. They are often characterized as being pathologically jealous, which leads them to think that their sexual partners or spouses are cheating on them.

<table>
<thead>
<tr>
<th>Table 5-1. Cluster A Personality Disorders and Classic Clinical Examples</th>
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</thead>
<tbody>
<tr>
<td><strong>Personality Disorder</strong></td>
</tr>
<tr>
<td>Paranoid personality disorder</td>
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<tr>
<td>Schizoid personality disorder</td>
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<tr>
<td>Schizotypal personality disorder</td>
</tr>
</tbody>
</table>
**Diagnosis and DSM-IV Criteria**

- Diagnosis requires a general distrust of others, beginning by early adulthood and present in a variety of contexts.
- At least four of the following must also be present:
  1. Suspicion (without evidence) that others are exploiting or deceiving him or her.
  2. Preoccupation with doubts of loyalty or trustworthiness of acquaintances.
  3. Reluctance to confide in others.
  4. Interpretation of benign remarks as threatening or demeaning.
  5. Persistence of grudges.
  6. Perception of attacks on his or her character that are not apparent to others; quick to counterattack.
  7. Recurrence of suspicions regarding fidelity of spouse or lover.

**Epidemiology**

- Prevalence: 0.5 to 2.5%.
- Prevalence is higher in men than in women.
- Higher incidence in family members of schizophrenics.
- The disorder is misdiagnosed in minority groups, immigrants, and deaf people.

**Differential Diagnosis**

- **Paranoid schizophrenia:** Unlike patients with schizophrenia, patients with paranoid personality disorder do not have any fixed delusions and are not frankly psychotic, although they may have transient psychosis under stressful situations.
- **Social disenfranchisement and social isolation:** Without a social support system, persons can react with suspicion to others. The differential in favor of the diagnosis can be made by the assessment of others in close contact with the person, who identify what they consider as excess suspicion, etc.

**Course and Prognosis**

- Some patients with PPD may eventually be diagnosed with schizophrenia.
- The disorder usually has a chronic course, causing lifelong marital and job-related problems.

**Treatment**

- Psychotherapy is the treatment of choice.
- Patients may also benefit from antianxiety medications or short course of antipsychotics for transient psychosis.

**Schizoid Personality Disorder**

Patients with schizoid personality disorder have a lifelong pattern of social withdrawal. They are often perceived as eccentric and reclusive. They are quiet and unsociable and have a constricted affect. They have no desire for close relationships and prefer to be alone.
**Diagnosis and DSM-IV Criteria**

- A pattern of voluntary social withdrawal and restricted range of emotional expression, beginning by early adulthood and present in a variety of contexts.
- Four or more of the following must also be present:
  1. Neither enjoying nor desiring close relationships (including family)
  2. Generally choosing solitary activities
  3. Little (if any) interest in sexual activity with another person
  4. Taking pleasure in few activities (if any)
  5. Few close friends or confidants (if any)
  6. Indifference to praise or criticism
  7. Emotional coldness, detachment, or flattened affect

**Epidemiology**

- Prevalence: Approximately 7%.
- Prevalence in men is twice that of women.
- There is no ↑ incidence of schizoid personality disorder in families with history of schizophrenia.

**Differential Diagnosis**

- *Paranoid schizophrenia*: Unlike patients with schizophrenia, patients with schizoid personality disorder do not have any fixed delusions, although these may exist transiently in some patients.
- *Schizotypal personality disorder*: Patients with schizoid personality disorder do not have the same eccentric behavior or magical thinking seen in patients with schizotypal personality disorder. Schizotypal patients are more similar to schizophrenic patients in terms of odd perception, thought, and behavior.

**Course**

Usually chronic course, but not always lifelong.

**Treatment**

Similar to paranoid personality disorder:

- Psychotherapy is the treatment of choice; group therapy is often beneficial.
- Low-dose antipsychotics (short course) if transiently psychotic, or antidepressants if comorbid major depression is diagnosed.

**Schizotypal Personality Disorder**

Patients with schizotypal personality disorder have a pervasive pattern of eccentric behavior and peculiar thought patterns. They are often perceived as strange and eccentric. The disorder was developed out of the observation that certain family traits predominate in first-degree relatives with schizophrenia.

**Diagnosis and DSM-IV Criteria**

- A pattern of social deficits marked by eccentric behavior, cognitive or perceptual distortions, and discomfort with close relationships, beginning by early adulthood and present in a variety of contexts.
- Five or more of the following must be present:
  1. Ideas of reference (excluding delusions of reference)
  2. Odd beliefs or magical thinking, inconsistent with cultural norms
3. Unusual perceptual experiences (such as bodily illusions)
4. Suspiciousness
5. Inappropriate or restricted affect
6. Odd or eccentric appearance or behavior
7. Few close friends or confidants
8. Odd thinking or speech (vague, stereotyped, etc)
9. Excessive social anxiety
   - Magical thinking may include:
   - Belief in clairvoyance or telepathy
   - Bizarre fantasies or preoccupations
   - Belief in superstitions
   - Odd behaviors may include involvement in cults or strange religious practices.

**Epidemiology**
Prevalence: 3.0%.

**Differential Diagnosis**
- *Paranoid schizophrenia*: Unlike patients with schizophrenia, patients with schizotypal personality disorder are not frankly psychotic (though they can become transiently so under stress), nor do they have fixed delusions.
- *Schizoid personality disorder*: Patients with schizoid personality disorder do not have the same eccentric behavior seen in patients with schizotypal personality disorder.

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**TABLE 5-2. Cluster B Personality Disorders and Classic Clinical Examples**

<table>
<thead>
<tr>
<th>PERSONALITY DISORDER</th>
<th>CLINICAL EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial personality disorder</td>
<td>A 30-year-old unemployed man has been accused of killing three senior citizens after robbing them. He is surprisingly charming in the interview. In his adolescence, he was arrested several times for stealing cars and assaulting other kids.</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>A 23-year-old medical student attempted to slit her wrist because things did not work out with a man she had been dating over the past 3 weeks. She states that guys are jerks and “not worth her time.” She often feels that she is “alone in this world.”</td>
</tr>
<tr>
<td>Histrionic personality disorder</td>
<td>A 33-year-old scantily clad woman comes to your office complaining that her fever feels like “she is burning in hell.” She vividly describes how the fever has affected her work as a teacher.</td>
</tr>
<tr>
<td>Narcissistic personality disorder</td>
<td>A 48-year-old company CEO is rushed to the ED after an automobile accident. He does not let the residents operate on him and requests the chief of trauma surgery because he is “vital to the company.” He makes several business phone calls in the ED to stay on “top of his game.”</td>
</tr>
</tbody>
</table>
COURSE

- Course is chronic or patients may eventually develop schizophrenia.
- Premorbid personality type for a patient with schizophrenia.

TREATMENT

- Psychotherapy is the treatment of choice to help develop social skills training.
- Short course of low-dose antipsychotics if necessary (for transient psychosis). Antipsychotics may help decrease social anxiety and suspicion in interpersonal relationships.

Cluster B

Includes antisocial, borderline, histrionic, and narcissistic personality disorders. These patients are often emotional, impulsive, and dramatic (Table 5-2).

Mr. Harris is a 35-year-old man with no prior psychiatric history who was arrested for assaulting his pregnant girlfriend. While in jail, he reports feeling depressed, and you are called in for a psychiatric evaluation. Mr. Harris is cooperative during the evaluation and presents as friendly and likeable. He reports that he is innocent of his charges and expresses feeling sad and tearful since his incarceration 2 days ago. He requests that you transfer him to the mental health unit at the correctional facility. However, you perform a thorough evaluation, and you do not find symptoms suggestive of a mood or psychotic disorder. When asked if he has been incarcerated before, he reports a history of multiple arrests and convictions for robbery and gun possession. He reports that he is unemployed because he has been “in and out of jail” during the past 5 years. He provides explanations of his limited involvement in these past crimes and does not appear remorseful.

Mr. Harris reveals a pattern of repeated fights since childhood and says that he quit school while in the ninth grade after being suspended for smoking pot on school grounds. Mr. Harris reports that throughout his childhood he bullied others, and laughs when recounting an episode during which he threw his cat against the wall to see it bounce back. He denies any family history of psychiatric illnesses, but reports that his father is currently incarcerated for drug trafficking.

What is his Axis II diagnosis?

Mr. Harris’s diagnosis is antisocial personality disorder. His history shows a pervasive pattern of disregard for and violation of others since age 15, and there is evidence of conduct disorder with onset before age 15 years. Remember that, although it is common, not all criminals have antisocial personality disorder.

What are some associated findings?

Antisocial personality disorder is more prevalent in males, is associated with low socioeconomic background, and has a genetic predisposition. It has been found that the children of parents with antisocial personality disorder have an ↑ risk for this disorder, somatization disorder, and substance-related disorders.
Antisocial Personality Disorder

A 26-year-old man has a history of multiple criminal arrests and is the son of two alcoholic parents. His brother recalls him setting their pet dog on fire as a kid. Think: antisocial personality disorder.

Antisocial personality disorder is a disorder in which a person violates the rights of others without showing guilt. Men, especially those with alcoholic parents, are more likely than women to have this condition.

Patients diagnosed with antisocial personality disorder show superficial conformity to social norms but are exploitive of others and break rules to meet their own needs. Lack empathy and compassion; lack remorse for their actions. They are impulsive, deceitful, and often violate the law. They are skilled at reading social cues and appear charming and normal to others who meet them for the first time and do not know their history.

Diagnosis and DSM-IV Criteria

- Pattern of disregard for others and violation of the rights of others since age 15.
- Patients must be at least 18 years old for this diagnosis; history of behavior as a child/adolescent must be consistent with conduct disorder (see chapter on Psychiatric Disorders in Children).
- Three or more of the following should be present:
  1. Failure to conform to social norms by committing unlawful acts
  2. Deceitfulness/repeated lying/manipulating others for personal gain
  3. Impulsivity/failure to plan ahead
  4. Irritability and aggressiveness/repeated fights or assaults
  5. Recklessness and disregard for safety of self or others
  6. Irresponsibility/failure to sustain work or honor financial obligations
  7. Lack of remorse for actions

Epidemiology

- Prevalence: 3% in men and 1% in women.
- There is a higher incidence in poor urban areas and in prisoners but no racial difference.
- Genetic component: Five times ↑ risk among first-degree relatives.

Differential Diagnosis

Drug abuse: It is necessary to ascertain which came first. Patients who began abusing drugs before their antisocial behavior started may have behavior attributable to the effects of their addiction.

Course

- Usually has a chronic course, but some improvement of symptoms may occur as the patient ages.
- Many patients have multiple somatic complaints, and coexistence of substance abuse and/or major depression is common.
- There is ↑ morbidity from substance abuse, trauma, suicide, or homicide.
Treatment

- Psychotherapy is generally ineffective; dialectical behavior therapy (DBT) and behavioral therapy best choice.
- Pharmacotherapy may be used to treat symptoms of anxiety or depression, but use caution due to high addictive potential of these patients.

Borderline Personality Disorder (BPD)

Patients with BPD have unstable moods, behaviors, and interpersonal relationships. They fear abandonment and have poorly formed identity. Relationships begin with intense attachments and end with the slightest conflict. Aggression is common. They are impulsive and may have a history of repeated suicide attempts/gestures or episodes of self-mutilation. They have higher rates of childhood physical, emotional, and sexual abuse than the general population (25–35% of these patients report no such abuse).

Diagnosis and DSM-IV Criteria

- Pervasive pattern of impulsivity and unstable relationships, affects, self-image, and behaviors, present by early adulthood and in a variety of contexts.
- At least five of the following must be present:
  1. Desperate efforts to avoid real or imagined abandonment
  2. Unstable, intense interpersonal relationships (e.g., extreme love-hate relationships)
  3. Unstable self-image
  4. Impulsivity in at least two potentially harmful ways (spending, sexual activity, substance use, binge eating, etc)
  5. Recurrent suicidal threats or attempts or self-mutilation
  6. Unstable mood/affect
  7. General feeling of emptiness
  8. Difficulty controlling anger
  9. Transient, stress-related paranoid ideation or dissociative symptoms

Epidemiology

- Prevalence: 1–2%.
- Prevalence is twice as high in women than men.
- Suicide rate: 10%.

Differential Diagnosis

- Schizophrenia: Unlike patients with schizophrenia, patients with BPD do not have frank psychosis (may have transient psychosis, however, if decompensate under stress).
- Bipolar II: Mood swings experienced in BPD are moment-to-moment reactions to perceived environmental triggers. They also are not characterized by spending excess amounts of money or heightened sexual activity.

Course

- Usually has a stable, chronic course.
- High incidence of coexisting major depression and/or substance abuse.
- ↑ risk of suicide (often because patients will make suicide gestures and kill themselves by accident).
TREATMENT

- Psychotherapy (DBT) is the treatment of choice—behavior therapy, cognitive therapy, social skills training, etc.
- Pharmacotherapy to treat psychotic or depressive symptoms as necessary.

HISTRIONIC PERSONALITY DISORDER (HPD)

Patients with HPD exhibit attention-seeking behavior and excessive emotionality. They are dramatic, flamboyant, and extroverted but are unable to form long-lasting, meaningful relationships. They are often sexually inappropriate and provocative.

DIAGNOSIS AND DSM-IV CRITERIA

- Pattern of excessive emotionality and attention seeking, present by early adulthood and in a variety of contexts.
- At least five of the following must be present:
  1. Uncomfortable when not the center of attention
  2. Inappropriately seductive or provocative behavior
  3. Uses physical appearance to draw attention to self
  4. Has speech that is impressionistic and lacking in detail
  5. Theatrical and exaggerated expression of emotion
  6. Easily influenced by others or situation
  7. Perceives relationships as more intimate than they actually are

EPIDEMIOLOGY

- Prevalence: 2–3%.
- Women are more likely to have HPD than men.

DIFFERENTIAL DIAGNOSIS

Borderline personality disorder: Patients with BPD are more likely to suffer from depression, brief psychotic episodes, and to attempt suicide. HPD patients are generally more functional.

COURSE

Usually has a chronic course, with some improvement of symptoms with age.

TREATMENT

- Psychotherapy is the treatment of choice.
- Pharmacotherapy to treat associated depressive or anxious symptoms as necessary.

NARCISSISTIC PERSONALITY DISORDER (NPD)

Patients with NPD have a sense of superiority, a need for admiration, and a lack of empathy. They consider themselves “special” and will exploit others for their own gain. Despite their grandiosity, however, these patients often have fragile self-esteem.

DIAGNOSIS AND DSM-IV CRITERIA

- Pattern of grandiosity, need for admiration, and lack of empathy beginning by early adulthood and present in a variety of contexts.
Five or more of the following must be present:
1. Exaggerated sense of self-importance
2. Preoccupation with fantasies of unlimited money, success, brilliance, etc.
3. Believes that he or she is “special” or unique and can associate only with other high-status individuals
4. Needs excessive admiration
5. Has sense of entitlement
6. Takes advantage of others for self-gain
7. Lacks empathy
8. Envious of others or believes others are envious of him or her
9. Arrogant or haughty

**Epidemiology**
Prevalence: < 1%.

**Diagnosis**

Antisocial personality disorder: Both types of patients exploit others, but NPD patients want status and recognition, while antisocial patients want material gain or simply the subjugation of others. Narcissistic patients become depressed when they don’t get the recognition they think they deserve.

**Course**
Usually has a chronic course; higher incidence of depression and midlife crises since these patients put such a high value on youth and power.

**Treatment**
- Psychotherapy is the treatment of choice. Group therapy may help these patients learn empathy.
- Antidepressants or lithium may be used as needed (for mood swings if a comorbid mood disorder is diagnosed).

**Cluster C**
Includes avoidant, dependent, and obsessive-compulsive personality disorders. These patients appear anxious and fearful (Table 5-3).

**Avoidant Personality Disorder**
Patients with avoidant personality disorder have a pervasive pattern of social inhibition and an intense fear of rejection. They will avoid situations in which they may be rejected. Their fear of rejection is so overwhelming that it affects all aspects of their lives. They avoid social interactions and seek jobs in which there is little interpersonal contact. These patients desire companionship but are extremely shy and easily injured.

**Diagnosis and DSM-IV Criteria**
- A pattern of social inhibition, hypesensitivity, and feelings of inadequacy since early adulthood.
- At least four of the following must be present:
  1. Avoids occupation that involves interpersonal contact due to a fear of criticism and rejection
  2. Unwilling to interact unless certain of being liked

Narcissism is characterized by an inflated sense of entitlement. People with narcissistic personality are often “fishing for compliments” and become irritated and anxious when they are not at the center of attention.

Social phobia is the most common phobia in avoidant personality disorder.
3. Cautious of interpersonal relationships
4. Preoccupied with being criticized or rejected in social situations
5. Inhibited in new social situations because he or she feels inadequate
6. Believes he or she is socially inept and inferior
7. Reluctant to engage in new activities for fear of embarrassment

**Epidemiology**
- Prevalence: 1–10%.
- Sex ratio is not known.

**Differential Diagnosis**
- **Schizoid personality disorder**: Patients with avoidant personality disorder desire companionship but are extremely shy, whereas patients with schizoid personality disorder have no desire for companionship.
- **Social phobia (social anxiety disorder)**: See chapter on Anxiety and Adjustment Disorders. Both disorders involve fear and avoidance of social situations. If the symptoms are an integral part of the patient’s personality and have been evident since before adulthood, personality disorder is the more likely diagnosis. Social phobia involves a fear of embarrassment in a particular setting (speaking in public, urinating in public, etc), whereas avoidant personality disorder is an overall fear of rejection and a sense of inadequacy. However, a patient can have both disorders concurrently and should carry both diagnoses if criteria for each are met.
- **Dependent personality disorder**: Avoidant personality disorder patients cling to relationships, similar to dependent personality disorder patients; however, avoidant patients are slow to get involved, whereas dependents actively and aggressively seek relationships.

**Course**
- Course is usually chronic.
- Particularly difficult during adolescence, when attractiveness and socialization are important.
HIGH-YIELD FACTS

PERSONALITY DISORDERS

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\[ \text{↑ incidence of associated anxiety and depressive disorders.} \]
\[ \text{If support system fails, patient is left very susceptible to depression, anxiety, and anger.} \]

**TREATMENT**

- Psychotherapy, including assertiveness training, is most effective.
- Beta blockers may be used to control autonomic symptoms of anxiety, and selective serotonin reuptake inhibitors (SSRIs) may be prescribed for major depression.

**DEPENDENT PERSONALITY DISORDER (DPD)**

Patients with DPD have poor self-confidence and fear separation. They have an excessive need to be taken care of and allow others to make decisions for them. They feel helpless when left alone.

**DIAGNOSIS AND DSM-IV CRITERIA**

- A pattern of submissive and clinging behavior due to excessive need to be taken care of.
- At least five of the following must be present:
  1. Difficulty making everyday decisions without reassurance from others
  2. Needs others to assume responsibilities for most areas of his or her life
  3. Cannot express disagreement because of fear of loss of approval
  4. Difficulty initiating projects because of lack of self-confidence
  5. Goes to excessive lengths to obtain support from others
  6. Feels helpless when alone
  7. Urgently seeks another relationship when one ends
  8. Preoccupied with fears of being left to take care of self

**EPIDEMIOLOGY**

- Prevalence: Approximately 1%.
- Women are more likely to have DPD than men.

**DIFFERENTIAL DIAGNOSIS**

- Avoidant personality disorder: See discussion above.
- Borderline and histrionic personality disorders: Patients with DPD usually have a long-lasting relationship with one person on whom they are dependent. Patients with borderline and histrionic personality disorders are often dependent on other people, but they are unable to maintain a long-lasting relationship.

**COURSE**

- Usually has a chronic course.
- Often, symptoms ↓ with age and/or therapy.
- Patients are prone to depression, particularly after loss of person on whom they are dependent.
- Difficulties with employment since they cannot act independently or without close supervision.

Regression is often seen in people with DPD. This is defined as going back to a younger age of maturity.

Symptoms of dependent personality disorder—
**OBEYING**
Obsessive about approval
Bound by others decisions
Enterprises are rarely initiated due to their lack of self-confidence
Difficult to make own decisions
Invalid feelings while alone
Engrossed with fears of self-reliance
Needs to be in a relationship
Tentative about decisions

Many people with debilitating illnesses can develop dependent traits. However, to be diagnosed with DPD, the features must manifest in early adulthood.
TREATMENT
- Psychotherapy, particularly groups and social skills training, is the treatment of choice.
- Pharmacotherapy may be used to treat associated symptoms of anxiety or depression.

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER (OCPD)
Patients with OCPD have a pervasive pattern of perfectionism, inflexibility, and orderliness. They get so preoccupied with unimportant details that they are often unable to complete simple tasks in a timely fashion. They appear stiff, serious, and formal, with constricted affect. They are often successful professionally but have poor interpersonal skills.

DIAGNOSIS AND DSM-IV CRITERIA
- Pattern of preoccupation with orderliness, control, and perfectionism at the expense of efficiency, present by early adulthood and in a variety of contexts.
- At least four of the following must be present:
  1. Preoccupation with details, rules, lists, and organization such that the major point of the activity is lost
  2. Perfectionism that is detrimental to completion of task
  3. Excessive devotion to work
  4. Excessive conscientiousness and scrupulousness about morals and ethics
  5. Will not delegate tasks
  6. Unable to discard worthless objects
  7. Miserly
  8. Rigid and stubborn

EPIDEMIOLOGY
- Prevalence is unknown.
- Men are more likely to have OCPD than women.
- Occurs most often in the oldest child.
- ↑ incidence in first-degree relatives.

DIFFERENTIAL DIAGNOSIS
- Obsessive-compulsive disorder (OCD): Patients with OCPD do not have the recurrent obsessions or compulsions that are present in obsessive-compulsive disorder. In addition, the symptoms of OCPD are ego-syntonic rather than ego-dystonic (as in OCD). That is, OCD patients are aware that they have a problem and wish that their thoughts and behaviors would go away.
- Narcissistic personality disorder: Both personalities involve assertiveness and achievement, but NPD patients are motivated by status, whereas OCD patients are motivated by the work itself.

COURSE
- Unpredictable course.
- Some patients later develop obsessions or compulsions (OCD), some develop schizophrenia or major depressive disorder, and others may improve or remain stable.
Treatment

- Psychotherapy is the treatment of choice. Group therapy and behavior therapy may be useful.
- Pharmacotherapy may be used to treat associated symptoms as necessary.

Personality Disorder Not Otherwise Specified (NOS)

This diagnosis is reserved for personality disorders that do not fit into cluster A, B, or C. It includes passive-aggressive personality disorder, depressive personality disorder, sadomasochistic personality disorder, and sadistic personality disorder. Only passive-aggressive personality disorder and depressive personality disorder will be discussed below.

Passive-Aggressive Personality Disorder

Passive-aggressive personality disorder was once a separate personality disorder like those listed above but was relegated to the NOS category when DSM-IV was published. Patients with this disorder are stubborn, inefficient procrastinators. They alternate between compliance and defiance and passively resist fulfillment of tasks. They frequently make excuses for themselves and lack assertiveness. They attempt to manipulate others to do their chores, errands, and the like, and frequently complain about their own misfortunes. Psychotherapy is the treatment of choice.

Depressive Personality Disorder (DPD)

Persons with this disorder are characterized by lifelong traits of depressed-like state. These people are pessimistic, self-doubting, chronically unhappy, and distressed.