Diagnosing a Personality Disorder:

A personality disorder is defined by a set of abnormal or maladaptive behaviors and modes of thought expressed by an individual. Some of the behaviors that make up the criteria for specific Personality Disorders are abnormal whenever they occur, such as suicidal behavior, reckless disregard for safety, etc.

Other behaviors are maladaptive, but within the range of what is considered to be “normal” when the intensity of their expression is moderated and the target of their expression is limited to a few specific situations (e.g., suggestibility, envy of others, excessive social anxiety, suspiciousness). The mere presence of abnormal or maladaptive behavior is not sufficient for the diagnosis of Personality Disorder. Three additional factors must be taken into account for the diagnosis:

1. The pervasiveness of the behavior(s)

   The pervasiveness of an abnormal or maladaptive behavior is a key factor in the diagnosis of Personality Disorder. A pervasive behavior is commonly and frequently exhibited by the individual in many different settings. For example, an isolated suicide attempt that occurs when a patient has Major Depressive Disorder, Single Episode, is not part of the criteria set for any Personality Disorder. However, recurrent suicidal behavior, gestures, or threats are a criterion for the diagnosis of Borderline Personality Disorder.

   Periodic suggestibility, self-dramatization, or fear of criticism, although potentially maladaptive, are not part of the criteria for any Personality Disorder. It is only when the symptoms form an enduring and pervasive part of the patient’s repertoire of behaviors that they fulfill criteria for Personality Disorder.

2. The pattern of behavior(s)

   Personality Disorders also require a pattern or set of different behaviors that present a consistent theme. Rigidity, lack of empathy, suicidal behavior, impulsivity, or similar symptoms, no matter how intense, are not sufficient in isolation to satisfy the criteria for any personality disorder. It is only when a characteristic group of behaviors appear together, and define a syndrome, that the diagnosis can be made (e.g., irritability and aggressiveness, impulsivity, reckless disregard for the safety of self or others in the diagnosis of Antisocial Personality Disorder).

   Specific Personality Disorders also come in different “flavors”. For example, the diagnosis of Borderline Personality Disorder can be made by any combination of five of the nine possible abnormal behaviors or modes of thought listed in the criteria set. Some Borderline Personality Disorder patients may have recurrent suicidal behavior, whereas others may not. This is possible because patients may express the same core problem in several different ways. In Borderline Personality Disorder, the core problem is a pervasive pattern of instability of interpersonal relationships, self-image, affects, and control over
impulses. The expression of this problem may emphasize suicidal behavior or intense and inappropriate anger.

3. The intensity of the behavior(s)

Many people are arrogant, fearful of criticism, afraid of abandonment, aggressive, or suspicious. These behaviors, when expressed in moderation, are not necessarily indicative of Personality Disorder. The intensity of the behavior is one factor that distinguishes Personality Disorder from a variant of normal behavior. For example, a normal person who becomes irritated at a co-worker might make an angry comment or yell. An individual with Antisocial Personality Disorder might hit the co-worker in the face and feel no remorse for the act.

Similarly, a normal individual who is slighted becomes briefly irritated at the person who insults him. An individual with Paranoid Personality Disorder often never forgives someone who slights him. He bears a persistent grudge against the person and always remains suspicious of his subsequent behavior. Therefore, in the diagnosis of Personality Disorder, the assessment of a patient’s behavioral repertoire must include an evaluation of the intensity, as well as the type, pattern, and pervasiveness of the abnormal behaviors.

**Step-by-Step Method of Diagnosing a Personality Disorder:**

- What is the patient’s predominant clinical appearance or presentation?
  - Identify one or more unusual behaviors or modes of thought that are characteristic of the patient’s behavioral repertoire. The behavior should be unusual due to its
    - Nature
    - Intensity
  - Elicit evidence of the additional features needed to fulfill the criteria. The early identification of these behaviors will help narrow the diagnostic choice to one of the three clusters
    - If the patient’s most prominent and pervasive behavior is odd, eccentric, isolative, or suspicious, consider the diagnoses in Cluster A (Paranoid Personality Disorder, Schizoid Personality Disorder, and Schizotypal Personality Disorder).
    - If the patient’s most prominent and pervasive behavior is dramatic, emotional, erratic, or impulsive, or if the patient appears to have a reduced capacity for empathy, consider the diagnoses in Cluster B (Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder, and Narcissistic Personality Disorder).
    - If the patient’s most prominent and pervasive behavior is anxious, fearful, or perfectionistic, consider the diagnoses in Cluster C (Avoidant Personality Disorder, Dependent Personality Disorder, and Obsessive-Compulsive Personality Disorder).
Is the patient’s most prominent and pervasive behavior odd, eccentric, isolative, or suspicious (Cluster A)?

- If the most prominent symptom is strikingly odd behavior or strange modes of thought (for example, unusual dress, ideas of reference, magical thinking, paranoid ideation, belief in clairvoyance, unusual speech or mannerisms) that are inconsistent with the norms of any specific subculture, consider the diagnosis of **Schizotypal Personality Disorder**. Although Schizoid patients have a disturbance of thinking and communication, they are not overtly psychotic. Schizotypal patients have no close friends and appear anxious, eccentric, or bizarre in most social situations. If psychotic symptoms appear, they are brief and not as severe as in Schizophrenia.

- If the most prominent symptom is social withdrawal, isolation, or aloofness associated with a restricted range of emotional expression, and little or no desire to have intimate relationships with other people, consider the diagnosis of **Schizoid Personality Disorder**. Schizoid patients generally do not experience their isolation and lack of intimate relationships as dysphoric or depressing. They are not paranoid or suspicious, which distinguishes them from patients with Paranoid Personality Disorder. Schizoid patients may seem mildly eccentric, but they do not have severe oddities of behavior, thinking, perception, or speech that are present in most Schizotypal patients.

- If the most prominent symptom is suspiciousness, lack of trust, and the continual unwarranted perception of being attacked, consider the diagnosis of **Paranoid Personality Disorder**. Paranoid patients generally avoid intimacy, are isolative, and try to be self-sufficient. They are often jealous, argumentative, easily slighted, hypervigilant, and question the loyalty or motivations of others with little cause. Paranoid patients are also generally cold, lacking warmth, tender feelings, and pride themselves on being rational, objective and unemotional. To other people they usually appear hostile, uncompromising, stubborn, and defensive. Schizoid patients may be seen as aloof, cold, and somewhat eccentric, but they do not have the prominent paranoid ideation of patients with Paranoid Personality Disorder.

Is the patient’s most prominent and pervasive behavior dramatic, emotional, erratic, impulsive, or a reduced capacity for empathy (Cluster B)?

- If the patient’s most prominent symptom is a pervasive disregard for and violation of the rights of others often associated with lack of remorse, consider the diagnosis of **Antisocial Personality Disorder**. These patients’ erratic or emotional behavior is frequently demonstrated by deceitfulness, impulsivity, and repeated outbursts of anger, accompanied by physical fights. Antisocial patients have a previous history of Conduct Disorder occurring before the age of 15.

- If the patient’s most prominent symptoms are erratic and unstable interpersonal relationships, affect, self-image, and control over impulses, consider the diagnosis of **Borderline Personality Disorder**. These patients generally have chronic feelings of emptiness and may have periods of intense anger and dysphoria that are associated with suicidal behavior, gestures, or threats. They also may have transient psychotic or dissociative episodes that usually resolve within 1-2 days. The patient’s erratic behavior is further demonstrated by repeated self-damaging, impulsive acts, such as
multiple sexual partners, excessive spending, substance abuse, and reckless driving. It may be difficult to distinguish patients with Borderline Personality Disorder from patients with Antisocial or Histrionic Personality Disorders. Key differentiating features include the Borderline Personality Disorder patient’s excessive emotional demands in close relationships, chronic feelings of emptiness, and manipulative suicidal or self-mutilating behavior. Borderline Personality Disorder patients are differentiated from Paranoid Personality Disorder patients because they do not display the extreme suspiciousness of the latter. They can be distinguished from Schizotypal Personality Disorder patients because they do not have marked odd or bizarre behavior, thoughts, thinking, and speech.

- If the patient’s most prominent symptoms include an exaggerated, overly dramatic expression of emotions that are in reality shallow and rapidly shifting, and a pervasive need to be the center of attention, consider the diagnosis of **Histrionic Personality Disorder**. These patients are frequently sexually seductive and provocative, and they dress or act in a dramatic fashion to gather attention. They are further characterized by superficial thinking, superficial interpersonal relationships, and a tenuous sense of their own ideas and beliefs they make them very suggestible. Histrionic Personality Disorder patients may also fulfill the criteria for the diagnosis of Borderline Personality Disorder patients who are more likely to have repeated suicide attempts, difficulty with an unstable self-image, and transient psychotic episodes.

- If the patient’s most prominent symptoms are grandiosity, a sense of entitlement, a need for excessive admiration, exploitation of others, and a lack of empathy, consider the diagnosis of **Narcissistic Personality Disorder**. These patients are erratic in the sense that their self-esteem is often fragile, and simple criticism may provoke rage or depression. In other circumstances, their affect may fluctuate from a grandiose sense of well-being to shame and humiliation if they fail in a task or feel ignored. The distinction between patients with Narcissistic Personality Disorder and patients with Borderline, Antisocial, or Histrionic Personality Disorders can be difficult because patients may display attributes of all four personality disorders. Patients with Narcissistic Personality Disorder generally have more stable lives, a more cohesive identity, and less impulsivity than patients with Borderline Personality Disorder. Narcissistic Personality Disorder patients also are less impulsive than patients with Antisocial Personality Disorder and their exploitation of others is more likely to focus on power and control rather than outright theft and fraud to gain material wealth. They generally display less emotional exaggeration and are less dependent on others than patients with Histrionic Personality Disorder.

- Is the patient’s most prominent and pervasive behavior anxious, fearful, or perfectionistic (Cluster C)?
  - If the patient’s most prominent symptoms are fear of criticism and feelings of inadequacy that are associated with social inhibition, consider the diagnosis of **Avoidant Personality Disorder**. These patients want human companionship, but are afraid of rejection or criticism. They require an unusually strong guarantee of uncritical acceptance before they will enter into a relationship. They differ from patients with Schizoid Personality Disorder who genuinely desire to be isolated and feel uncomfortable in a close intimate relationship. The differential diagnosis
between Avoidant Personality Disorder and Dependent Personality Disorder may be difficult because Avoidant Personality Disorder patients are often dependent once they form a relationship. However, Dependent Personality Disorder patients are often seen as more fearful of being abandoned than Avoidant Personality Disorder patients.

- If the patient’s most prominent symptoms are dependent and submissive behavior associated with a pervasive need to be cared for, exaggerated anxieties about separation and abandonment, and fears of not being able to care for himself or herself, consider the diagnosis of Dependent Personality Disorder. These patients often establish a long-term relationship with one person on whom they are excessively dependent. If that relationship ends, they immediately seek another relationship. They rely on other people to make important decisions for them or require excessive reassurance and advice before making everyday decisions themselves. Dependency is common in patients with Borderline Personality Disorder and Histrionic Personality Disorder. However, these patients have more unstable interpersonal relationships than patients with a diagnosis of Dependent Personality Disorder.

- If the patient’s most prominent symptoms are a rigid preoccupation with orderliness, perfectionism, money, and control of themselves and others in response to anxiety, consider the diagnosis of Obsessive-Compulsive Personality Disorder. Frequently, these patients’ excessive attempts at control make it difficult for the individual to finish a task or work closely with colleagues. These individuals are often seen as rigid and stubborn in their work, ethics, and values. They differ from patients with Obsessive-Compulsive Disorder who have true obsessions and compulsions.