See article by Penner-Goeke et al

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Personality Disorders:
A Burden in the Community, Neglected in the Clinic?

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In this issue of the *Journal*, the article "Reductions in Quality of Life Associated With Common Mental Disorders: Results From a Nationally Representative Sample" by Penner-Goeke and colleagues[1] examines losses in quality of life (QoL) years associated with common mental and physical disorders in the large (US) sample of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). The authors were especially interested in assessing the impact of personality disorders on QoL, since personality disorders have rarely been studied in comparison to other disorders in community populations. The NESARC Wave 2 sample is very large (N = 34,533), thus enabling examination of the impact of many variables on QoL simultaneously. All 10 *DSM-IV* personality disorders were diagnosed, as well as a wide range of other mental and physical disorders, and impact on QoL was examined at both individual and population levels. Penner-Goeke and colleagues[1] found that mood disorders were associated with the greatest decreases in health-related QoL, followed by stroke, psychotic disorders, and arthritis. Due to the relative prevalence of the various disorders, however, the greatest annual QoL losses were caused by arthritis, mood disorders, and personality disorders at a population level.

Clinical Significance of Personality Disorders

Personality disorders cause significant problems for those who have them. Persons with personality pathology often suffer, and their relationships with others are typically problematic. They have difficulty responding flexibly and adaptively to the changes and demands of life, and they lack resilience under stress. Instead, their usual ways of responding perpetuate and intensify their difficulties. However, individuals with personality disorders often blame others for their difficulties or deny that they have any problems at all.

Studies that have compared patients who have personality disorders with those who have no personality disorder or who have other mental disorders have found that patients with personality disorders were more likely to be separated, divorced, or never married and to have had more unemployment, frequent job changes, or periods of disability.[2] Studies that have examined quality of functioning have found poorer social functioning or interpersonal relationships and poorer work functioning or occupational achievement and satisfaction.[2] Among the different personality disorders, those with severe types, such as schizotypal and borderline, have been found to have significantly more impairment at work, in social relationships, and at leisure than patients with less severe types, such as obsessive-compulsive personality disorder, or with an impairing Axis I disorder, such as major depressive disorder, in the absence of personality disorder.[3] Even less impaired patients with personality disorders (eg, obsessive-compulsive), however, have moderate to severe impairment in at least 1 area of functioning. Thus, patients with specific personality disorders differ from each other not only in the degree of associated functional impairment but also in the breadth of impairment across functional domains.

Impairment in functioning in patients with personality disorders tends to be persistent even beyond apparent improvement in personality pathology itself.[4,5] The persistence of impairment is understandable because personality pathology has usually been relatively long-standing and, therefore, has disrupted a person's work and social development over a period of time.

Personality disorders also often cause problems for others and are costly to society. They are associated with elevated rates of conflict with family members and romantic partners, child custody proceedings, homelessness, high-risk sexual behavior, and perpetration of child abuse. Individuals with personality disorders also have increased rates of accidents; emergency department visits; medical hospitalization and treatment utilization; police contacts; violence and criminal behavior, including homicide and convictions; self-injurious behavior; and attempted and completed suicide. A high percentage of individuals with alcoholism and drug abuse have a personality disorder.[2]

Personality disorders should be identified also because of their implications for the development of other disorders and for treatment planning. Personality disorders often need to be a focus of treatment or, at the very least, need to be taken into account when other comorbid mental disorders are treated, because their presence often affects another disorder's prognosis and treatment response. For example, patients with depressive disorders, bipolar disorder, panic disorder, obsessive-compulsive disorder, and substance abuse often respond less well to pharmacotherapy when they have a comorbid personality disorder.[2] The presence of a comorbid personality disorder is also associated with poor

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compliance with pharmacotherapy. Furthermore, recent rigorous prospective studies in both clinical and community populations (including the NESARC) have shown that personality disorders predict the development and relapse of major depression, and individuals with personality disorders are less likely to remit from major depression,[6,7] substance use disorders,[8,9] bipolar disorder,[10] and anxiety disorders.[11,12] As a result, the risks for negative long-term prognoses for individuals with comorbid other mental disorders and personality disorders approximates the sum of the risks for the separate disorders or even multiplies those risks.[13] And, as most clinicians are well aware, the characteristics of patients with personality disorders are likely to be manifested in the treatment relationship regardless of whether the personality disorder is the focus of treatment or not. For example, some patients may be overly dependent on the clinician, others may not follow treatment recommendations, others view their therapists with contempt, and still others may experience conflict about getting well. Although individuals with personality disorders use psychiatric services extensively,[14] they are also more likely to be dissatisfied with the treatment they receive.

Quality of Life in Earlier Epidemiologic Studies

The findings of Penner-Goeke and colleagues[1] corroborate and extend earlier findings on individual personality disorders from other general population-based studies.[15] In an earlier study on the NESARC Wave 1 sample, Grant and colleagues[16] found that respondents with dependent personality disorder had the poorest QoL, followed by those with avoidant, paranoid, schizoid, or antisocial personality disorders. Those with histrionic personality disorder had no reduction in QoL, and limited reduction was found for those with obsessive-compulsive personality disorder. However, only 7 of 10 personality disorders were included in Wave 1, personality disorders were not compared to other mental or physical disorders, and population-level reduction in QoL was not considered.

In a Norwegian general population sample (N = 2,000+), QoL including subjective well-being, self-realization, relation to friends, social support, negative life events, relation to family of origin, and neighborhood quality was assessed.[17] Personality disorders were more strongly related to reductions in QoL than Axis I mental disorders, somatic health, or any other socioeconomic, demographic, or life situation variable. Among the specific personality disorders, avoidant personality disorder was most strongly related to reduced QoL, controlling for all other variables, followed by schizotypal, paranoid, schizoid, borderline, dependent, and antisocial personality disorders. Histrionic, obsessive-compulsive, and passive-aggressive personality disorders were unrelated to QoL.[17]

These "burden of disease" findings demonstrate the importance of personality pathology in the general population, among individuals unselected for seeking treatment. Treatment-seeking can be assumed to be associated with distress or functional impairment, so the impact of personality disorders on QoL in community samples strengthens conclusions that can be drawn about the associations, but also underscores the need for personality disorder assessment in clinical populations.

Personality Disorders in Clinical Practice

Personality disorders were placed on a separate Axis II of the *DSM-III*'s multiaxial system in 1980 in order to focus clinical attention on them, especially when a patient presented with a co-occurring Axis I disorder. Unfortunately, as a consequence of the myriad of problems with the *DSM*'s traditional categorical approach to personality disorders, clinicians have often not used these diagnoses as intended. For example, they have often indicated "diagnosis deferred on Axis II," made the diagnosis of personality disorder not otherwise specified more frequently than any other, or made personality disorder diagnoses on the basis of too few of the required criteria. This has become the case despite the accumulating evidence described above in both clinical and epidemiologic studies of the tremendous burden and costs of personality pathology on affected individuals, their social networks, and society at large.

Now, the criteria for personality disorders in Section II of *DSM-5* have not changed from those in *DSM-IV*, and the multiaxial system has been abandoned. Whether the placement of personality disorders at the same level of classification as all other mental disorders will override their inherent problems and increase their use in clinical settings remains to be seen. Meanwhile, an Alternative *DSM-5* Model for Personality Disorders has been placed in Section III—Emerging Measures and Models—of the manual. The Alternative Model has been shown to represent *DSM-IV* personality disorders well[18] and to capture all of their predictive validity with respect to clinical judgments concerning current psychosocial functioning; risk for self-harm, violence, and criminality; optimal level of treatment intensity; and prognosis.[19] In a recent study of the perceived clinical utility of the Alternative Model compared to *DSM-IV* personality disorder criteria (now *DSM-5* Section II criteria), the *DSM-5* trait model was judged to be *more useful* with respect to ease of use, communication with patients, comprehensive description of personality pathology, formulation of effective treatment interventions, and description of an individual's global personality—by both psychiatrists and psychologists.[20]

Regardless of the model for assessing and diagnosing personality pathology, no more compelling mental disorders exist in terms of their impact—as primary or comorbid disorders. Since, both cognitive-behavioral and psychodynamic psychotherapies have been shown to be effective for personality disorders,[21] clinicians would do well to attend to them if they want to provide the best care to their patients.

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