American Psychiatric Nurses Association

# ESSENTIALS
## Of Caring For People Who Are Diagnosed With Personality Disorders

**Approved by the APNA Board of Directors**

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# INTRODUCTION

This resource was created to assist nurses in caring for patients whose symptoms and struggles have caused them to meet the criteria for the diagnosis of a personality disorder, as well as to ultimately help nurses avoid judgment and decrease stigma. This resource is intended for use in inpatient and outpatient settings by registered nurses, advanced practice nurses, and nurse educators. It organizes the diagnosis of personality disorder in three parts: Cluster A, Cluster B, and Cluster C.

The essential features sections will help nurses understand the complexities of the disorders, develop an awareness of the prevalence and presentation of each disorder, and gain the ability to better understand, communicate, and form a therapeutic relationship with the patient. An awareness of the influence trauma has on the development of personality disorders is also essential for fully understanding the symptomatology. These sections are not to be confused with the specific symptoms outlined in the DSM-V which assist in establishing a diagnosis. The essential features are meant to guide nurses to a better understanding of the experiences of the patient and to assist them in establishing a therapeutic treatment plan. Patients with diagnoses of personality disorders may not exhibit all of the features listed in this document and may be on a spectrum. The nurse's self-awareness of transference and countertransference when caring for a patient diagnosed with a personality disorder is a critical part of therapeutic care.

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# The Essentials of Caring for People Who Are Diagnosed With Cluster A Personality Disorders

Cluster A personality disorders include symptoms of odd or eccentric thinking patterns or behaviors. Individuals with these personality disorders are often thought of as different and are loners or have lifestyles with very limited social interactions. Disorders in this category include Paranoid Personality Disorder, Schizoid Personality Disorder, and Schizotypal Personality Disorder.

## SPECIFIC DISORDERS

### Paranoid Personality Disorder

Paranoid Personality Disorder (PPD) has several defining features, including inherent mistrust with belief of persecution from family, friends, and other acquaintances.  Additional characteristics for PPD include irritability, sensitivity to criticism, self-absorption, anger, stubbornness, and feelings of being unjustly treated (Fox, 2014).

*Essential features include:* A pervasive distrust and suspiciousness of others,  where their motives are assumed to be malevolent, that begins by early adulthood, and includes four of the following traits:

- Suspecting without sufficient basis, that others are intentionally exploiting, harming, or deceiving them.

- Preoccupation with doubts, that are unjustified, regarding the trustworthiness, and loyalty of friends, family, and associates.

- Reticence to confide in others due to fear information will be used against them.

- Reading hidden meanings into benign remarks or events.

- Holding grudges and being unforgiving of insults, slights, or injuries.

- Perceiving attacks on reputation or character, that are not apparent, and reacting with anger or being quick to retaliate.

- Suspecting the fidelity of significant others, without justification, on an ongoing basis.

(American Psychiatric Association, 2013)

### Schizoid Personality Disorder

Schizoid personality disorder has been described as one in which the individual is lacking in desire for interpersonal relationships. They may have a constricted affect and appear cold, indifferent, uncaring and be seen as a loner (Fox, 2014).  Millon and Davis (1996) identified four subtypes of Schizoid Personality Disorder as

Affectless, Remote, Languid, or Depersonalized, with slightly different associated characteristics. It is considered one of the Schizophrenia Spectrum Disorders and in the past has been described as having many similarities with Asperger's Disorder (now Autism Spectrum Disorder), and this remains an important differential diagnosis.

*Essential features include:*

- Detachment from social relationships beginning by early adulthood.
- Quiet, reserved, and unsociable; chooses solitary activities.
- Has little if any sexual interest in others.
- Emotionally detached, flat affect.
- Extreme sensitivity with a rigid mental set, emotional coldness.
- Lack of close friends or confidants.
- Infrequent participation in activities for fun or pleasure.
- A sense of indifference to praise or criticism.
- Indifference to social norms.
- Difficulty expressing anger or emotions.

## Schizotypal Personality Disorder

Schizotypal personality disorder is defined by the DSM-5 as "a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior" (APA, 2013). Schizotypal Personality Disorder is a serious disorder. Its essential features include a pattern of social and relationship-based challenges that are characterized by acute discomfort and difficulty with being in close interpersonal relationships. In addition, this disorder is also associated with alterations in perceptions and behavioral eccentricities that lead to significant reductions in quality of life and high rates of comorbidity (anxiety, mood, substance use and others) (Pulay, Stinson, Dawson et al., 2009).

*Essential features include:*

- Ideas of reference (though not delusions of reference).
- Odd beliefs or magical thinking that influence behavior.
- Unusual perceptual experiences, including bodily illusions.
- Odd thinking and speech (e.g., vague, circumstantial, metaphorical).
- Inappropriate or constricted affect.
- Behavior or appearance that is odd, eccentric, or peculiar.
- Lack of close friends or confidants other than first-degree relatives.
- Excessive social anxiety that does not diminish with familiarity.
- Paranoid fears about self.

# EXISTING THERAPEUTIC TREATMENT PROTOCOLS

**Paranoid Personality Disorder**
- Individual Psychotherapy:  develop trust, relationships.
- Schema Based Therapy: emotion regulation.
- Object Relations Focused Therapy: childhood abuse or trauma.
- *Group Therapy is contraindicated in persons with a diagnosis of Paranoid Personality Disorder.*

**Schizoid Personality Disorder**
- Individual psychotherapy:  psychodynamic, develop trust.
- Cognitive Behavioral Therapy:  increase interpersonal relationships.
- Social Skills Training:  increase social skills.
- Group Therapy:  challenge false beliefs.

**Schizotypal Personality Disorder**
- Individual Psychotherapy:  anxiety management, treat thought disorders.
- Cognitive Behavioral Therapy:  concrete goals.
- Group Therapy:  build awareness of other's self-criticism.
- **Persons may be treatment rejecting

# CLINICAL PEARLS

**Paranoid Personality Disorder**
- Paranoid Personality Disorder may be viewed as sub-syndromal to schizophrenia spectrum disorders or other psychotic disorders.
- Treatment goals should focus on development of trust and therapeutic relationships.
- Individuals with Paranoid Personality Disorder may be hypervigilant to criticism and judgement and rejection sensitive.
- Clinicians need to assist the patient to develop pattern recognition and to assess incidents on a case-by-case basis, and to avoid generalizations.
- Therapeutic interventions that focus on hostility, and its reciprocal nature, may be helpful in assisting the patient to develop understanding of patterns of avoidance, control, and anticipatory retaliation. Group therapy is contraindicated as it may increase the patient's suspiciousness which may inhibit the group process.
- Focus on your therapeutic relationship to develop trust, decrease suspiciousness and negative affective states.
- Promote the development of positive relationships with other clients.

- Help the patient who shifts rapidly between emotional states or who remains stuck in one maladaptive state through the exploration of various emotional states with games like Charades.

- Role play of a problem or situation can help patient to understand or modulate different emotional states.

- A study by Bamelis et al. (2014) identified that schema therapy was significantly more effective than client centered therapy, in a group of 323 outpatients with diagnoses of AVPD, DPD, HPD, NPD, OCPD or Paranoid Personality Disorder. Patients had a reduction in maladaptive behaviors and were more likely to stay engaged in treatment with schema-based therapy (Bernstein & Clercx, 2018).

## Schizoid Personality Disorder

- Assist with expression of feelings and provide emotional support during crisis or problems even if individual does not request or seek help. Short term counseling can focus on problem solving or crisis management.

- Long-term therapy can focus on improvement of empathy, emotional warmth, motivation, and general level of functioning.

- Countertransference is often a key component of the treatment process as the therapist assists the client in corrective emotional experiences to change internal object relations.  More frequent therapy sessions, i.e., twice weekly are often recommended (Fox, 2014).

- Cognitive Behavioral Therapy (CBT) is usually focused on increasing social skills and interactions. The establishment of a therapeutic relationship with a patient with Schizoid Personality Disorder (PD) may take extra time and/or be a slower process before starting the work. Processes such as negotiation, making lists of pros and cons, and a collaborative approach are needed.  Beck et. al. (2004) found that the use of homework, role playing, and real-life exposure with techniques to reduce anxiety were effective with this population, though a focus on relapse prevention was important.

- There is some evidence that Group Therapy can be an effective modality with this population and that a group can become a safe environment for individuals with Schizoid PD to challenge some of their dysfunctional belief systems (Fox, 2014).

## Schizotypal Personality Disorder

- It takes much longer to develop a therapeutic relationship with an individual with Schizotypal Personality Disorder, but this is essential – and so patience and continued effort is necessary by health care provider for good patient outcomes.

- Individuals with Schizotypal Personality Disorder often are not bothered by their eccentricities and are not aware of their relationship problems that they encounter. Assisting them to develop insight into the

connection of these is an important focus (Fox, 2014).

- Individuals with a thought disorder will benefit from combination of psychotherapy and medication management.

- Use concrete methods such as compiling a list of evidence for and against false beliefs or magical thinking. This is helpful when developed in collaboration with the individual, identifying some of the evidence that are against the belief as well (Beck et. al., 2004).

- Anxiety is an emotion often experienced by an individual with Schizotypal Personality Disorder while in treatment, though it may not be observable or expressed. Work with the individual on anxiety management techniques as this will be an important part of recovery (Fox, 2014).

- Motivational Interviewing can be used to strengthen the desire to change maladaptive patterns and interpersonal interactions and begin steps to develop a relationship.

## ADDITIONAL CONSIDERATIONS

### Paranoid Personality Disorder

- A large Chinese study of psychiatric patients identified the incidence of Paranoid Personality Disorder at over 40% (Yang et al., 2000).

- Additional research is needed regarding this specific personality disorder, as it is not included as one of the personalities in Section III of the DSM 5: Emerging Measures and Models, which is a proposed new hybrid model, called the Alternative Model of Maladaptive Personality.

### Schizoid Personality Disorder

- There are no specific measures to assess this personality disorder specifically. Development of a tool for this would be useful, as it is also not included as one of the personalities in the DSM 5 Alternative Model of Maladaptive Personality.

- Longitudinal studies with children and adolescents are needed, as Karen, et.al., (2001) found that individuals diagnosed with a psychiatric disorder in adolescence were associated with later diagnosis of Schizoid Personality Disorder as well as Paranoid Personality Disorder in early adulthood.

- Additional study of the connection between Schizoid Personality Disorder and Asperger's or Autism Spectrum Disorder: Mild (ASD) may be useful. Although the usual differentiation is the individual with ASD will show earlier and more severe problems with social cues and nonverbal communication, as well as some need for routine or rituals not needed with the personality disorder (Fox, 2014).

### Schizotypal Personality Disorder

- Use of the Schizotypal Personality Questionnaire-Brief can be helpful in early identification and intervention.

- It can be helpful to understand the three main factors that underlie the nine signs and symptoms of SPD. These are 1) cognitive-perceptual (magical thinking, unusual perceptual experiences, ideas of reference, paranoid ideation); 2) interpersonal (no close friends, constricted affect, social anxiety, paranoid ideation) and 3) disorganized features (odd/ eccentric behavior, odd speech) (Raine, 2006).

- Incidence is approximately 3%-3.9% of population and studies have shown .6 to 4.6 worldwide.  It is more common among first-degree relatives of people with Schizophrenia, and more common in males. It is noted to have biological factors: deficits in frontal lobe (Walsh, 2017); reduced activation of certain areas of the brain; decreased grey matter volume (associated with negative symptoms) (Boyd, 2019); as well as a genetic component.

- Schizotypal Personality Disorder (SPD) is associated with substantial mental disability in both sexes (Pulay et al., 2009).

- Interestingly, the odds of having SPD are noted to be greater among men, black women, individuals with lower incomes, unmarried people for any reason, and Asian men (Pulay et a., 2009).

- People with SPD have higher rates of comorbidity with other Axis I and II disorders than other disorders. Specific Axis I disorders that were significant in persons with SPD include bipolar 1 and 2 disorders, mood and anxiety disorders, phobias, and PTDS as well as borderline and narcissistic personality disorder (Pulay et al., 2009).

- The presence of drug dependence is also high among persons with Schizotypal Personality Disorder (Pulay et al, 2009)

- Additional research is needed regarding family dynamics as there is also a suggestion of high correlation of emotionally neglectful or barren dynamic as well as abuse.

- Schizotypal Personality Disorder was believed to be an enduring and stable personality disorder for years (Raine, 2006). However, cross-sectional and longitudinal studies have brought new information to light that questions this belief.

- There does appear to be an early-onset form of SPD that is stable, but many other forms develop schizophrenia or other psychotic disorders based on older studies (Raine, 2006; Pulay et al., 2009).

- Some studies have shown reduced schizotypal scores with older ages leading to the interesting conjecture that adult neurodevelopmental growth factors may ameliorate or even provide protective factors against SPD (Raine, 2006).

# The Essentials of Caring for People Who Are Diagnosed With Cluster B Personality Disorders

Cluster B personality disorders include symptoms of dramatic, overly emotional, or unpredictable thinking or behavior. They include Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder and Narcissistic Personality Disorder.

## SPECIFIC DISORDERS

### Antisocial Personality Disorder (ASPD)

Characterized by a pattern of disregard for and violation of others. Individuals with this disorder can be described both in terms of how their overall functioning is affected and how they interact with others. The individual may present as irritable and aggressive and show no empathy to those they have harmed (Mancke & Herpertz, 2018; Turner, Sebastian, & Tüscher, 2017), demonstrate disturbed interpersonal relationships, and be unable to maintain employment (Sperry, 2016; Black & Blum, 2014). Persons with this disorder are described as adhering to the philosophical belief that "the ends justify the means" (Sperry, 2016). To be diagnosed with ASPD, the person must have a history of conduct disorder prior to age 15 years old and be at least 18 years of age (American Psychiatric Association, 2013).

*Essential features include:*

- Failure to conform to social norms with respect to lawful behaviors.
- Initially present as charming then may use deceit to meet personal needs within relationships.
- Inability to perceive the needs of others.
- Demonstrate impulsivity or failure to plan.
- Irritability and aggressiveness (repeated physical fights or assaults).
- Reckless disregard for safety of self or others.
- May present with absence of ability to take responsibility for own actions and for tasks and financial obligations within relationships.
- Lack of remorse for individuals they have harmed.

### Borderline Personality Disorder

Characterized by difficulty with perception of sense of self which leads to a fear of abandonment and feelings of emptiness. Individuals are likely to experience unstable relationships due to splitting, a phenomenon which occurs when a person is unable to merge the positive and negative aspects of the self and projects their feeling onto

another person. Affected individuals also demonstrate labile emotions with sudden eruptions that can range from tearfulness to anger or violence (Chun et al., 2017). Impulsive behaviors might include substance abuse, sexual activity, binge eating, and excessive spending (Turner, Sebastian, & Tüscher, 2017). They may engage in suicidal behaviors or non-suicidal self-injury when feeling abandonment anxiety, a concept used in Object Relations Theory to describe situations in which individuals do not experience a consistent experience of self, due to lack of familiar or comforting objects in situations they currently face (Gunderson, 2014; Kernberg, 1984; Kernberg, 2018.)

*Essential features include:*

- Frantic efforts to avoid real or imagined abandonment.
- Pattern of unstable and intense interpersonal relationships.
- Identity disturbance/Unstable self-image or sense of self.
- Impulsivity which is potentially self-damaging.
- Recurrent suicidal thoughts and self-harming behaviors.
- Affective instability due to a marked reactivity of mood.
- Chronic feelings of emptiness.
- Dichotomous (all or none thinking for example: "you are the best nurse ever, the only one who really cares, you are not like that nurse last night." This response is out of proportion to the care the nurse has provided.)
- Idealize/devalue individuals and aspects of life. For example, may excessively praise the nurse in the morning and then recommend the nurse be fired that afternoon. The individual with BPD may go to another staff member about this nurse to complain or ask for a modification to the treatment plan. Staff will describe this as staff splitting. The patient is projecting the negative and positive aspects of themselves on the staff.
- Inappropriate, intense anger or difficulty controlling anger.
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

## Histrionic Personality Disorder

Characterized by difficulty controlling emotions and attention seeking. Attention seeking behaviors may include wearing flashy clothing, needing to be the center of attention in all contexts (at home, at work or in school), or demonstrating sexually suggestive behaviors. Relationships are often shallow. Individuals want to be loved, thus continue to seek relationships.  They often have a history of abuse, and do not let others become close.

*Essential features include:*

- Being uncomfortable in situations where they are not the center of attention.
- Interpersonal interactions that may involve inappropriate sexually seductive or provocative behavior.
- Rapidly shifting and shallow expression of emotions.

- Using physical appearance to draw attention to self.

- Speech that may be excessively impressionistic and lacking in detail.

- Self-dramatization, theatricality, and exaggerated expression of emotion.

- Being suggestible (i.e., easily influenced by others or circumstances).

- Considering relationships to be more intimate than they are.

- HPD associated with higher rates of somatic symptom disorder, conversion disorder, and depression (American Psychiatric Association, 2013).

## Narcissistic Personality Disorder

Characterized by a pervasive behavior pattern of grandiosity, entitlement, and self-centered focus, seeking admiration, but manifesting a lack of empathy. The person is preoccupied with unrealistic or imaginary success and approval by others. The person is personally exploitive of others and arrogant on an interpersonal level.

*Essential features include:*

- Grandiose sense of self-importance.

- Preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love.

- Belief of being "special" and unique and can only be understood by, or should associate with, other special or high-status people.

- Requiring excessive admiration.

- Sense of entitlement.

- Interpersonally exploitative behavior.

- Lacking empathy: unwilling to recognize or identify with the feelings and needs of others.

- Is often envious of others or believes that others are envious of them.

- Showing arrogant, haughty behaviors or attitudes.

# PSYCHOPHARMACOLOGICAL APPROACHES TO TREATMENT

No specific medications have been identified by the Food and Drug Administration (FDA) as effective for treatment of Cluster B Disorders. Each disorder recommendations for psychopharmaceutical treatment include the suggestion to treat comorbid disorders, such as anxiety and depression, and problem symptoms which currently affect patient functioning (Sperry, 2016; Schlesinger and Silk, 2014). Use of benzodiazepines is not recommended.

**Antisocial Personality Disorder** – Some patients have responded to Selective Serotonin Reuptake Inhibitors {SSRIs} (Sperry, 2016)

**Borderline Personality Disorder** – Treatment targets affective instability, interpersonal sensitivity, impulsivity, aggressiveness, self-harm and suicidal thoughts and behavior (Sperry, 2016; Ripoli, 2012; Clarkin, Levy, Lenzenweger, & Kernberg, 2013).

- Antimanic agents (Sperry, 2016) and mood stabilizers (Sperry, Schlesinger, and Silk, 2014, Ripoli,2012) can be used to target affective instability. Gunderson and Choi-Kain (2018) recommend using these agents cautiously.

- Sperry (2016) notes that serotonergic agents are effective with impulsivity and aggression, while Schlesinger and Silk (2014) note that literature supports use of mood stabilizers for symptoms of impulsivity and aggression.

- SSRIs are effective for reducing interpersonal sensitivity.

## Histrionic Personality Disorder

- Medications may be used to help the patient better manage their volatile emotional outbursts (Sperry, 2016). These medications may include antidepressants, mood stabilizers and antipsychotics. Mood stabilizers may also be used to improve impulse control and help patients gain control over their behavior (Sperry, 2016).

## Narcissistic Personality Disorder

- Sperry (2016) suggests consideration of medications for depression, anxiety, and sleep as indicated by patient's condition.

# EXISTING THERAPEUTIC TREATMENT PROTOCOLS

Successful treatment of the individual with a personality disorder begins after an in-depth assessment, and screening for comorbid disorders. Individuals with Personality Disorders often have comorbid substance use disorders. When planning treatment, the nurse next needs to start with understanding the patient's goals for treatment. Motivational Interviewing (MI) can be used to help the patient identify their goals. Understanding the patient's goals for treatment will strengthen the nurse/patient relationship and increase the patient's motivation for change. Multiple psychotherapeutic treatment modalities exist to treat Cluster B diagnoses. Evidence in support of these modalities varies as noted below.

**Antisocial Personality Disorder** – Structured therapies like Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) might be effective; however, success depends on maintaining a therapeutic position in which the patient is made aware of their current antisocial behaviors, not one of neutrality. Behavioral approaches are more successful (Sperry, 2016)

- Obstacles include difficulty developing a collaborative relationship between the therapist and patient due to the patient's tendency to lie and therapist countertransference. Therapists initially focus on helping affected individuals learn to control their behaviors. Once trust has been developed, the therapist can begin to work on addressing problematic cognitions (Sperry, 2016).

- Research supports use of Psychoanalytic therapy (Sperry, 2016).

- Group therapy is more beneficial than individual therapy. Types of group therapy most often used include psychoeducation, psychotherapy, and

psychosocial support. Content and group management are structured, for example may have two people (two nurses or therapist and nurse) conducting group to decrease chances of members sabotaging message of therapist.

## Borderline Personality Disorder

- Dialectical Behavioral Therapy (DBT) has been researched the most and is noted to be effective in reducing suicidal and non-suicidal self-injurious behaviors in individuals with Borderline Personality Disorder (Clarkin et al., 2013; Sperry, 2016). Full treatment with DBT consists of both individual sessions in which, as applicable, suicidal ideation, avoided emotions, trauma and other underlying factors are addressed and group therapy for skills training (Fowler & Hart 2014). Vickers (2016) noted that delivering a skills-based group intervention led to decreased symptoms and improved functioning.

- Multiple studies support use of CBT, object relations therapy, transference focused psychotherapy, and psychoanalytic therapy (Clarkin et al., 2013; Sperry, 2016, Fowler & Hart, 2014; Yeomans, Clarkin & Levy, 2014; Gunderson & Links, 2014; Kernberg, 1976; Kernberg & American Psychiatric Association Publishing, 2018).

- While group therapy can be effective at reducing suicidal behavior, it should be conducted in combination with individual therapy (Sperry, 2016).

## Historonic Personality Disorder – Research supports use of Psychoanalytic therapy, CBT, and DBT. While group therapy was contraindicated in the past, current clinicians note that two benefits of its use include diverting the patient's focus from the therapist to the group as a whole, thus limiting transference and having other patients challenge the patient's shallow thought processes (Sperry, 2016).

- Research supports use of Psychoanalytic therapy, CBT, and DBT. While group therapy was contraindicated in the past, current clinicians note that two benefits of its use include diverting the patient's focus from the therapist to the group as a whole, thus limiting transference and having other patients challenge the patient's shallow thought processes (Sperry, 2016).

## Narcissistic Personality Disorder – Evidence supports the use of psychoanalytic therapy, CBT, and DBT (Sperry, 2016). Group therapy is also effective for the following reasons:

- May have less transference towards therapist as group members reflect what the patient needs and ask questions about emotions denied by patient.

- Patients may additionally learn to respect others, develop relationships, and empathize with group members

# CLINICAL PEARLS

Psychiatric-mental health nurses can best help patients if they use therapeutic communication to reflect the emotions the patient reports and assist the patient to determine what can be controlled. Nurses need to maintain awareness of the therapeutic relationship and their own countertransference. Ideally, to address countertransference and difficult clinical decisions, the nurse would benefit from reviewing the case through clinical supervision. Limit setting and setting boundaries are important tools in the development of the therapeutic relationship. Use of the therapeutic relationship can help patients maintain self-control, stay engaged in treatment, and promote patient's progress toward their goals and recovery. McMurren et. al. (2013) used Motivational Interviewing (MI) strategies to help involve patients with personality disorders engage in their treatment. MI can also be used to assist patients to focus on their goals. When facing challenging situations with individuals with Cluster B personality disorders, use a team approach. Actively consult with the treatment team or clinical supervisor for patient conflict within the milieu.

**Antisocial Personality Disorder** – Structured therapies like Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) might be effective; however, success depends on maintaining a therapeutic position in which the patient is made aware of their current antisocial behaviors, not one of neutrality. Behavioral approaches are more successful (Sperry, 2016)

- Healthcare providers need to maintain awareness of the fact that countertransference may be high with this population based on the providers fear of the patient's past and present behavior (Florence, 2021; Sperry, 2016).

**Borderline Personality Disorder**

- A major goal is to improve individuals with BPD adaptation to life and reduce their self-destructive responses to interpersonal stressors.

- Treatment assists the patient to identify and address underlying feelings of abandonment.

- Understanding one's own stigma and or countertransference will help the nurse maintain an effective therapeutic environment (Florence, 2021). Seek clinical supervision as necessary.

- Identify personal boundaries to decrease splitting behaviors and promote a consistent treatment program.

- Establish limit setting in the context of a supportive milieu to develop trust and respect, for example:

  » On an inpatient unit the treatment team should discuss and share with staff how to help the patient stay focused on goals and steps staff members can take to recognize and work through potential splitting.

- Promote structure, independence and provide clear expectations for positive behaviors.

- Demonstrate unconditional positive regard by validating underlying emotions.

## Historonic Personality Disorder

- It may be challenging to establish a therapeutic relationship. Clinical supervision and understanding theory to practice can assist with providing patient centered care.

- Patients are focused on seeking admiration and approval. They communicate using exaggerated emotionality and superficial content.

- Use open- ended and closed questions as well as restatement as primary use of open-ended questions may result in the patient becoming sidetracked (Sperry, 2016).

- Use questions which follow a specific theme, for example a problem on the job or within a relationship (Sperry, 2016)

*Conditions for effective therapeutic intervention:*

- Understand that although patients are motivated for treatment, they may find it frustrating to focus on a single issue at a time.

- To decrease dependence, choose approaches which allow patient to participate in therapy; facilitate their exploration of self.

- Set limits which are clear while also rewarding assertive requests that fall within these limits. Patients who define themselves by their sexuality, through excessive touching will need the nurse to assist them to find alternative methods of expression such as music and/or art.

## Narcissistic Personality Disorder

- Use a team approach. Actively consult with the treatment team or clinical supervisor for patient conflict within the milieu.

- Maintain clear, unambiguous communication with the patient and the treatment team.

- Explore treatment options in an atmosphere of hope and optimism.

- Work in an open, engaging, and non-judgmental manner to build a trusting relationship.

- Remember that people with cluster B diagnoses usually come from a life history of trauma, rejection, abuse, and neglect, so that they are especially sensitive to slights and stigmatization (Yalch & Levendosky, 2020).

- Expect emotional volatility and examine underlying thoughts and feelings. Utilize therapeutic communication to assist with problem solving.

- Recognize that intense, dramatic praise or harsh criticism are symptoms of the defense mechanism of splitting (Kernberg, 1984; Kernberg; 2018).

- Support the patient in problem solving identified life problems, by giving them primary responsibility for problem resolution.

- Encourage the patient to identify manageable short-term goals.

# ADDITIONAL CONSIDERATIONS

- Significant stigma exists towards individuals with Cluster B disorders. Sheehan et al (2016) noted that measures of stigma against individuals with BPD traits are higher than rates against individuals with schizophrenia. They added that this stigma can arise from community members and health care providers, or be of a structural nature, for example when practices within an institution discriminate against or do not provide equal access to care to those with personality disorders. Sheehan et al. noted that providing education about personality disorders led to decreased stigma. In both the clinical and academic setting psychiatric nurses can role model identifying stigmatizing language and behaviors and explaining how the personality disorder has uniquely affected the individual.

- Recognize the importance of obtaining a history of past trauma and deliver trauma informed care. A high incidence of past trauma has been recognized in BPD (Van Der Kolk, 2014).

- Importance of self-care.

  » Develop a regular sleep routine- (sleep hygiene).

  » Take your lunch break – this will help with refueling your energy and providing a mental break.

  » Ask for help and accept it when offered.

  » Take 5 to 10 minutes to stretch in the break room.

  » Listen to alpha waves or relaxing instrumental music.

  » Take 5 full deep breaths.

  » Engage in self-affirmation-positive thinking.

  » Organize your day and don't take on more than you can handle.

  » It's okay to say "no" or "this is not a good time"- Learn to set boundaries for yourself.

  » Unplug from work – once you walk away, leave work at work.

  » Be mindful of ongoing research into the biological influence of trauma and its applications to care (Van Der Kolk, 2014).

## Video Resource
In the following video patients and renowned treatment providers discuss Borderline Personality Disorder:

https://youtu.be/967Ckat7f98

# The Essentials of Caring for People Who Are Diagnosed With Cluster C Personality Disorders

Cluster C personality disorders include symptoms characterized by anxiety, fearful thinking or behavior. Disorders in this category include Avoidant Personality Disorder, Dependent Personality Disorder and Obsessive-Compulsive Personality Disorder.

## SPECIFIC DISORDERS

### Dependent Personality Disorder

Characterized by a lifelong style of interpersonal submissiveness in relating to others, rooted in poor self-esteem and feelings of inadequacy and resulting in a lack of trust in themselves to make the right decisions (Weissman, 2019; Osburn, 2018).

*Essential features include:*

- Lacking confidence to care for self or to make small decisions.

- Feeling the need to be taken care of.

- Having frequent fears of being alone.

- Being submissive to others.

- Having trouble disagreeing with others.

- Tolerating unhealthy relationships or abusive treatment.

- Feeling overly upset when relationships end or desperate to start a new relationship right away.

- Believing that one is unable to handle everyday responsibility without considerable help from others (such as taking care of oneself, solving daily problems, exercising good judgement, tackling new tasks, making good decisions). Often presents as helplessness (Young, 2012).

- Fearing abandonment, one suppresses anger or displeasure because the expression might jeopardize the relationship (Weissman, 2019).

### Avoidant Personality Disorder

Characterized by a persistent behavioral pattern of introversion and anxiety, leading to a restricted lifestyle (Weissman 2019).  There is "extensive avoidance of social interaction driven by fears of rejection and feelings of personal inadequacy" (Lampe & Malhi, 2018, p.55).

*Essential features include:*

- Avoids occupational or social activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
- Is unwilling to get involved with people unless certain of being liked.
- Shows restraint with intimate relationships because of the fear of being shamed or ridiculed.
- Is preoccupied with the belief or fear of being criticized or rejected in social situations.
- Feels inadequate and inhibited in new interpersonal relationships.
- Views self as socially inept, personally unappealing, or inferior to others.
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing (APA, 2013).
- May interpret innocuous personal questions as criticisms.
- Tends to assume a passive or submissive role in relationships to avoid standing out (Weissman, 2019).

## Obsessive Compulsive Personality Disorder

Characterized by "a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency beginning by early adulthood and present in a variety of contexts" (DSM-V, 2013, pp. 678-679).

*Essential features include:*

- Disinterested in affective quality of relationships, describing their life in an intellectualized manner with muted emotional tone (Weissman, 2019).
- May have occupational relational problems if they refuse to work with others or if others see them as annoying.
- Preoccupied with details, rules, lists, order, organization, or schedules.
- Demonstrates perfectionism.
- Excessively devoted to work.
- Overconscientious, scrupulous, and inflexible about matters of morality, ethics or values.
- Unable to discard worn-out or worthless objects.
- Reluctant to delegate tasks or work with others.
- Adopts a miserly spending style.
- Shows rigidity and stubbornness.
- Attempts to maintain a sense of control which may or may not interfere with their quality of life.
- Excessively careful and prone to repetition, paying extraordinary

attention to detail and repeatedly checking for mistakes.

- Time is poorly allocated.
- Self-imposed high standards of performance cause dysfunction and distress.
- Play becomes a structured task.
- Mercilessly self-critical about own mistakes.
- "Correct way" may limit standard of living and negatively affect relationships.
- The individual expresses affection in controlled or stilted fashion.
- Some individuals may become preoccupied with logic and intellect.
- Decision-making may become time-consuming with difficulty determining priority.
- The individual may struggle with flexibility and compromise.

## PSYCHOPHARMACOLOGICAL APPROACHES TO TREATMENT

**Dependent Personality Disorder** – There is no FDA approved psychopharmacological treatment for Dependent Personality Disorder. However, co-morbid associated disorders may be treated such as depression, anxiety, sleep problems, etc. Fatigue, malaise, or vague anxiety may respond to SSRIs or tricyclic antidepressant medication. Attempts at autonomy can exacerbate fear of abandonment/separation; anxiolytic medications may be useful but should be targeted and time limited (Weissman, 2019). Medications are generally used as adjunct to psychotherapy and skills training. Troubling symptoms often respond to medication sooner than psychological interventions and may be prescribed at the onset of treatment (Sperry 2016).

**Avoidant Personality Disorder** – No drug treatment has been identified as an effective treatment for Avoidant Personality Disorder. However, Avoidant Personality Disorder symptoms overlap with those of multiple disorders, including social anxiety or social phobia disorder, schizoid personality disorder, and seasonal affective disorder. Based on these overlaps, recommendations exist for the use of SSRIs and SNRIs with Seasonal Affective Disorder (Herpetz et al., 2007). Some literature support exists for the use of SSRIs, SNRIs, MAO-Is, and beta blockers for the symptoms of Social Phobia and Social Anxiety Disorder (Lampe & Malhi, 2018; Weissman, 2019). Controlled studies are still needed. Other anxiolytic medications may be useful when patients are making efforts at social risk taking, but risk for abuse or addiction should be monitored (Weissman, 2019). Psychopharmacotherapy is likely to be of value for co-morbid disorders, such as depression, anxiety, etc.

**Obsessive Compulsive Personality Disorder** – Mood stabilizers and antipsychotics have been tried to relieve some symptoms of the disorder. SSRIs have not been shown to have a similar effect to that when used for Obsessive Compulsive Disorder. However, they may be of some help in decreasing the perfectionism and ritualizing of Obsessive Compulsive Personality Disorder. SSRIs may be useful during crisis states characterized by depression and anxiety. Overall, psychopharmacotherapy has not been shown to be effective in treating Obsessive Compulsive Personality Disorder (Weissman, 2019).

# EXISTING THERAPEUTIC TREATMENT PROTOCOLS

## Dependent Personality Disorder

- Cognitive Behavioral Therapy including Social Skills Training (SST), Schema Therapy (ST), Mindfulness, etc.
- Group, Family and Couples Therapy. Family Therapy should proceed with caution as dependence may be important to maintaining family equilibrium.
- Psychodynamic Psychotherapy encouraging self-expression, assertiveness and self-decision making.
- Adjunctive therapies and Self-help Strategies. Stress management may include arts, yoga, music; relaxation and mindfulness; sleep management; and psychoeducation.

## Avoidant Personality Disorder

- Cognitive Behavioral Therapy (CBT) including Social Skills Training (SST), Graded Exposure Therapy and Schema Therapy.
- Group, Family and Couples Therapy
- Supportive, expressive psychotherapy
- Psychodynamic psychotherapy

## Obsessive Compulsive Personality Disorder

- Cognitive Behavioral Therapy (CBT)
- Group, Family and Couples Therapy - although difficulties may be presented by symptoms of intellectualizing and a desire to control others.
- Psychodynamic Psychotherapy
- Interpersonal Therapy

# CLINICAL PEARLS

## Dependent Personality Disorder

- Patients can become reliant and dependent upon the therapist/staff member. Maintaining boundaries and teaching assertive behavior to patients is evidenced-based.
- Nurses should use positive reinforcement to encourage independent behaviors.
- Provide opportunities for independent decision making. Help the individual tolerate being alone. Support the person to take responsibility for facilitating personal wellbeing.

- Because of transference and countertransference related to dependency conflicts, be aware of the therapist/staff resentment to dependency of the client.

- Encourage goal development based on client current needs.

- Move slowly with client to avoid increasing client's anxiety about achievement and independence while being supportive of all client's individual achievements.

- For individuals with a personality disorder, many dysfunctional behaviors were established in childhood.  Longer term counseling can help to examine the person's belief system that underlie these problematic behaviors.  It is useful for the nurse to remain supportive through the change process.

- An ability for the nurse to stay aware that the person's behavior makes sense to them because of their past experiences can help to promote an empathetic response.

## Avoidant Personality Disorder

- This diagnosis should be used with great caution in children and adolescents, for whom shy and avoidant behavior may be developmentally appropriate (APA, 2013, p. 674).

- Affective lability can be seen in these patients, similar to borderline personality (Snir et al., 2017).

- Therapeutic alliance can be achieved through gentle, nonjudgmental approach so as not to cause further withdrawal; compassion-focused therapy has been successful in case studies (Maillard & Kramer, 2019)

- Because of transference and countertransference related to interpersonal expectations, be aware of the potential therapist/staff resentment to avoidance and lack of self-disclosure by the client.

- Therapy should target self-concept, experiential avoidance, and maladaptive schemas (Lampe & Malhi, 2018).

- For individuals with a personality disorder, many dysfunctional behaviors were established in childhood. Longer term counseling can help to examine the person's belief system that underlie these problematic behaviors. It is useful for the nurse to understand that behavior change usually happens slowly over time.  It is critical for the nurse to remain supportive through the change process.

- An ability for the nurse to stay aware that the person's behavior makes sense to them because of their past experiences can help to promote an empathetic response.

## Obsessive Compulsive Personality Disorder

- Individuals with OCPD often struggle with compromise because of an excessive need to control a situation.

- For individuals with this disorder, disagreements or criticism may be perceived as an attack. They tend to have a low threshold for being hurt (Rowland, Jainer, & Panchal, 2017). This hypersensitivity can lead to feelings of resistance, frustration, and anger when challenged. Decision-making can be impaired because the individual is trying to avoid a critical reaction from others.

- Individuals with this disorder, who are treated in an inpatient setting, may need additional time to respond to requests made by staff. The individual may perceive a benign comment or request as a criticism. Nursing staff members should make efforts to avoid a power struggle by being patient and implementing facilitative communication strategies.

- It is very important to understand what a person with OCPD's challenges are, so staff can plan effective care. Usually clients with OCPD seek mental health services when they have attacks of anxiety, concerns of immobilization, sexual impotence, and or fatigue that is excessive. Nurses need to assess the client's physical symptoms such as sleep, eating, sexual concerns, as well as interpersonal relationships and social problems.

- Clients with OCPD may want to improve their quality of life, but anxiety concerns may impair their ability to make important changes. Psychotherapy is needed to change compulsive patterns.

- To encourage clients to have enough confidence to try new behaviors, nurses are encouraged to provide supportive nurse-patient relationships while accepting the client's needs to have order and rigidity.

- Because of transference and countertransference related to interpersonal expectations, be aware of the potential therapist/staff resentment to perfectionism and rigid controlling nature by the client.

- For individuals with a personality disorder, many dysfunctional behaviors were established in childhood. Longer term counseling can help to examine the person's belief system that underlie these problematic behaviors. It is useful for the nurse to understand that behavior change usually happens slowly over time. It is critical for the nurse to remain supportive through the change process.

- An ability for the nurse to stay aware that the person's behavior makes sense to them because of their past experiences can help to promote an empathetic response.

## ADDITIONAL CONSIDERATIONS

**Dependent Personality Disorder** – The therapist must maintain an awareness of the impact cultural, ethnicity, religious or geographical backgrounds may have on how patients present themselves for treatment. For example, uncontrollable crying and headaches may be a sign of panic attacks in one culture, where in other cultures, heavy breathing may be a sign. Understanding cultural expressions will assist in diagnosing behaviors (APA, 2013). Behaviors that may appear problematic may be culturally appropriate within that person's value system.  The impact of cultural differences can (1) make accurate diagnosis difficult and (2) provide insight into mutually agreed upon goals for the most effective treatment options.

**Avoidant  Personality Disorder** – Affect lability can be present (as high as 9%) and efforts to regulate emotional lability "may in fact be the driving force behind may additional behaviors, such as substance use, self-injury and even suicidal behavior" (Snir et al., 2017, p. 363).  Future research is needed in the areas of pharmacological and non-pharmacological treatments. The impact of cultural differences can provide insight into treatment choices.

**Obsessive Compulsive Personality Disorder**  – Salzman (1989) makes the case for a combined integrated approach to care. He states that a true understanding of a person with an obsessive-compulsive personality disorder requires an "integration of psychodynamic, pharmacologic and behavior therapies, because the resolution of the disabling disorder demands cognitive clarity plus behavioral and physiologic alterations. Each modality alone deals with only a piece of the puzzle.  A therapist who can combine all these approaches will be the most effective" (Salzman, 1989, p. 2782).

Individuals that present with symptoms of one personality disorder frequently have symptoms of an additional personality disorder.  Individuals diagnosed with a personality disorder are at higher risk of developing co-morbid depressive disorders, anxiety disorders, substance use disorders, self-injury and suicidal behaviors.  Although pharmacotherapy does not directly treat most personality disorders, medication can be helpful for symptom management and to treat co-morbid conditions.

Dialectical and Behavioral Therapy (DBT) is an evidence-based treatment for patients diagnosed with Borderline Personality Disorder.  Many of the skills taught as part of DBT can be helpful to lessen the distress of symptoms of other personality disorders including Dependent, Avoidant, and Obsessive Compulsive Personality Disorders.

Future research is needed in the areas of pharmacological and non-pharmacological treatments for many of the personality disorders.

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