Personality Disorders: Comprehensive Psychoeducation (Clusters A, B, and C)

Introduction & Scope

Personality disorders (PDs) are enduring patterns of inner experience and behavior that deviate markedly from cultural expectations, are pervasive and inflexible, have onset in adolescence or early adulthood, are stable over time, and lead to distress or impairment. DSM-5-TR classifies PDs into three clusters (A, B, C) based on descriptive similarities. This document summarizes DSM-5-TR diagnostic features, etiology, clinical presentation, assessment, treatment, and prognosis across the PD clusters.

Cluster A: Odd/Eccentric Disorders

Includes Paranoid PD, Schizoid PD, Schizotypal PD. Common features: social withdrawal, suspiciousness, eccentricity.

Paranoid PD

- Pervasive distrust and suspiciousness; interprets motives of others as malevolent.
- Preoccupied with doubts of loyalty/trustworthiness.
- Reluctant to confide in others; reads hidden demeaning threats into benign remarks.

Schizoid PD

- Detachment from social relationships; restricted range of emotions.
- Lacks desire for close relationships, prefers solitary activities.
- Appears indifferent to praise/criticism; emotionally cold or flattened affect.

Schizotypal PD

- Acute discomfort with close relationships, cognitive/perceptual distortions, eccentric behavior.
- Ideas of reference, odd beliefs/magical thinking, unusual perceptual experiences.
- Suspiciousness, constricted affect, eccentric speech/dress.

Cluster B: Dramatic, Emotional, Erratic Disorders

Includes Antisocial PD, Borderline PD, Histrionic PD, Narcissistic PD. Features: impulsivity, emotional dysregulation, dramatic behavior.

Antisocial PD

- Disregard/violation of rights of others since age 15; deceitfulness, impulsivity, aggressiveness.
- Consistent irresponsibility, reckless disregard for safety, lack of remorse.
- Requires age ≥18 with history of conduct disorder before age 15.

Borderline PD

- Instability in interpersonal relationships, self-image, and affect; marked impulsivity.
- Frantic efforts to avoid abandonment; recurrent suicidal behavior or self-mutilation.
- Chronic feelings of emptiness; intense anger; stress-related paranoia/dissociation.

Histrionic PD

- Excessive emotionality, attention seeking.
- Uncomfortable not being center of attention; inappropriate seductive behavior.
- Rapidly shifting emotions; impressionistic speech; considers relationships more intimate than they are.

Narcissistic PD

- Grandiosity, need for admiration, lack of empathy.
- Preoccupied with fantasies of unlimited success, beauty, power.
- Interpersonally exploitative, arrogant behaviors/attitudes.

Cluster C: Anxious/Fearful Disorders

Includes Avoidant PD, Dependent PD, Obsessive-Compulsive PD. Features: anxiety, fearfulness, need for control/reassurance.

Avoidant PD

- Social inhibition, feelings of inadequacy, hypersensitivity to criticism.
- Avoids occupational activities due to fear of rejection; reluctant to take risks.
- Desires relationships but fears embarrassment/shame.

Dependent PD

- Excessive need to be taken care of → submissive/clinging behavior, fears of separation.
- Difficulty making everyday decisions without reassurance; needs others to assume responsibility.
- Difficulty expressing disagreement; urgently seeks new relationship when one ends.

Obsessive-Compulsive PD (OCPD)

- Preoccupation with orderliness, perfectionism, and control.
- Perfectionism interferes with task completion; excessive devotion to work at expense of leisure/relationships.

- Rigid, stubborn, overly conscientious about morality; reluctant to delegate unless others follow their way.

Assessment & Differential

Assessment includes detailed psychiatric interview, collateral history, and use of structured tools (e.g., SCID-5-PD). Differentiate PDs from other mental disorders, cultural/trauma influences, and neurodevelopmental conditions. Comorbidity with mood, anxiety, substance use, and PTSD is high.

Treatment Approaches

Psychotherapy

- Primary modality: evidence-based psychotherapy.
- Borderline PD: Dialectical Behavior Therapy (DBT), Mentalization-Based Therapy (MBT), Schema Therapy.
- Cluster A: Supportive therapy, social skills, CBT; low-dose antipsychotics for cognitive-perceptual symptoms.
- Cluster B: DBT, Schema-focused, transference-focused, group therapy (with caution).
- Cluster C: CBT, exposure, assertiveness training.

Pharmacotherapy

- No FDA-approved meds for PDs; used adjunctively for symptom clusters.
- SSRIs/SNRIs for mood/anxiety; low-dose antipsychotics for cognitive-perceptual disturbance; mood stabilizers for impulsivity/affective lability.

Prognosis & Course

PDs are enduring but not fixed; longitudinal studies show symptom improvement and recovery possible, especially with sustained psychotherapy and support. Early intervention and addressing comorbidities improve prognosis. Borderline PD shows high remission rates with treatment over time.

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