International Clinical and Medical Case Reports Journal
Case Study (ISSN: 2832-5788)

Unlocking the Secrets of Personality: Evidence-Based ICD-11 Guidelines for Diagnosing Common Personality Disorders

Basem Abbas Ahmed Al Ubaidi*

Assistant Professor, Consultant Family Physician, Arabian Gulf University, Bahrain

Citation: *Al Ubaidi BAA. Unlocking the Secrets of Personality: Evidence-Based ICD-11 Guidelines for Diagnosing Common Personality Disorders. Int Clinc Med Case Rep Jour. 2023;2(17):1-8.*

Received Date: 18 November, 2023**; Accepted Date:** 28 November, 2023**; Published Date:** 01 December, 2023

***Corresponding author:** Dr. Basem Abbas Ahmed Al Ubaidi, Assistant Professor, Consultant Family Physician, Arabian Gulf University, Bahrain

ABSTRACT

Personality disorders represent pervasive patterns of behavior, cognition, and inner experience that deviate significantly from societal expectations. They have a profound impact on individuals' lives and interpersonal relationships, underscoring the crucial importance of their recognition and accurate diagnosis in clinical practice. This case series emphasizes the clinical diagnostic application of prevalent personality disorders in daily practice, highlighting their relevance in comprehending and effectively managing patients' mental health. The co-occurrence of personality disorders with other mental health conditions adds complexity to diagnosis and treatment, necessitating the identification of comorbidities for comprehensive patient care. The diagnostic process requires sensitivity and a holistic assessment, considering both the patient's history and current functioning. Engaging patients in the diagnostic process enhances rapport and treatment adherence. Recognizing and diagnosing common personality disorders in daily clinical practice is fundamental for delivering appropriate care and enhancing patients' mental health and quality of life. Knowledge of these disorders equips healthcare professionals with the tools to develop targeted interventions and foster therapeutic relationships.

Keywords: Personality disorders; Diagnosis; Mental health; Clinical practice

INTRODUCTION

Personality disorders (PDs), characterized by pervasive and enduring patterns of behavior and cognition, manifesting as a substantial deviation from societal norms, affect various dimensions of an individual's life, including emotional states, thought processes, behavioral patterns, relationships, and overall well-being[1]. The etiology of PDs is intricate and influenced by a combination of genetic and environmental factors[2,3].

These disorders typically manifest in late adolescence or early adulthood, resulting in substantial functional impairments. They are categorized into three clusters: A, B, and C[1-3].

Cluster A-PDs, classified as Odd or Eccentric, encompass three subtypes: paranoid, schizoid, and schizotypal. Cluster B-PDs, identified as Dramatic-Emotional, includes four PDs: antisocial, borderline, histrionic, and narcissistic. Cluster C- PDs, designated as Anxious-Fearful, consist of three subtypes: dependent, avoidant, and obsessive-compulsive[1-3].

Challenging patient behaviors often encountered in clinical practice include demanding, dependent, aggressive, angry, and manipulative tendencies[2,3]. Notably, the core feature of PDs is the profound difficulty in establishing and maintaining healthy interpersonal relationships[2,3].

Primary care physicians (PCPs) are pivotal in the initial diagnosis and treatment planning for patients presenting with PDs. These individuals require specialized care and unwavering attention due to their heightened susceptibility to physical health issues and increased mortality rates. It is imperative for healthcare practitioners to adopt a patient-centric approach, focusing on assessing functional disturbances rather than adhering strictly to ICD-11 clinical diagnostic criteria[3]. A significant challenge arises from the fact that patients typically seek healthcare for issues unrelated to their PDs, leading to underdiagnosis and undertreatment[4].

The impact of PDs extends to patients and their families, with significant suffering, reduced quality of life, and increased risk of premature mortality. Individuals with PDs often become frequent attendees of healthcare services, imposing substantial costs on both society and the healthcare system[5-7].

In summary, recognizing and diagnosing common PDs in routine clinical practice is imperative for providing appropriate care, thereby enhancing the mental well-being and quality of life for affected individuals. Proficiency in understanding these disorders equips healthcare professionals with the means to devise targeted interventions and nurture therapeutic relationships[8].

CASE 1

The mother inquired about the well-being of her 30-year-old son, who recently resigned from his position as a pilot. He exhibited a marked proclivity for social detachment, an aversion to engaging in interpersonal interactions, a notable absence of friendships and intimate relationships. In a private consultation, the patient manifested peculiar ideation and concrete thought processes. There was a profound emotional disconnect in the patient's demeanor, characterized by extreme reserve, a preference for isolation, and a limited expression and experience of emotional intelligence. Additionally, the patient was presented with symptoms of depression, although without any overt suicidal ideation. His sleep-wake cycle was severely disrupted, as he spent his nights engrossed in playing PlayStation and daytime hours in slumber. The patient's eccentric and unconventional personality traits emerged during early adulthood, yet he had refrained from seeking medical guidance.

1.1 What is your assessment or clinical diagnosis?

The case was diagnosed as a schizoid PD and coexisting depression. Subsequently, the patient was referred to a psychiatric facility for comprehensive evaluation and tailored therapeutic interventions.

1.2 What are the steps for reaching a diagnosis and meeting the criteria outlined in ICD-11?

This disorder is characterized by enduring patterns of social detachment and a restricted range of emotional expression in interpersonal contexts. The onset typically occurs in early adulthood and is evident across various life situations[9-11].

To make the diagnosis, a minimum of four of the following criteria must be met[9-11]:

- Demonstrates neither desire for nor enjoyment of close relationships, including familial bonds.
- Consistently prefers solitary activities.
- Displays minimal interest in engaging in sexual experiences with another individual.
- Derives pleasure from only a limited range of activities.
- Lacks close friendships or confidants outside of immediate family members.
- Exhibits apparent indifference to both praise and criticism.
- Presents with emotional coldness, detachment, or flattened affectivity.

CASE 2

A 44-year-old male has elicited avoidance by numerous healthcare providers due to his pronounced deviant and aggressive demeanor, which markedly deviates from accepted behavioral norms. Despite consistently generating complications in his interactions with various healthcare professionals through his idiosyncratic and unpredictable conduct, he remains untroubled by the emotional distress he inflicts on others. Furthermore, he exhibits a persistent and conspicuous pattern of noncompliance with the rules and regulations governing healthcare centers, characterized by a marked and enduring sense of apathy and disregard for societal norms. Consequently, he struggles to maintain normal relationships with family members, relatives, and friends. Moreover, he exhibits a pronounced inability to function effectively under pressure, revealing a notably low threshold for experiencing frustration and a propensity for readily expressing aggression, encompassing both physical and verbal aggression. Upon further exploration of his eccentric personality, it becomes apparent that he does not experience feelings of guilt, regularly deflecting responsibility, and attributing blame to others. Furthermore, he possesses a significant history of police records documenting various incidents, along with an extensive record of conduct-related issues dating back to early adolescence.

2.1 What is your assessment or clinical diagnosis?

The patient was diagnosed with antisocial PD.

2.2 What are the steps for reaching a diagnosis and meeting the criteria outlined in ICD-11?

The disorder is characterized by the presence of pervasive patterns of disregard for the rights of others, deceit, manipulative actions, or impulsivity, beginning in childhood or adolescence and continuing into adulthood.

To make the diagnosis, at least three of the following criteria must be met[10-12]:

- Failure to conform to social norms and lawful behaviors.
- Deceitfulness, lying, or use of aliases for personal profit or pleasure.
- Impulsivity or lack of planning ahead.
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
- Reckless disregard for the safety of self or others.
- Consistent irresponsibility, as indicated by repeated failures to sustain consistent work behavior.

- Lack of remorse, as indicated by indifference to or rationalizing hurting, mistreating, or stealing from another.

CASE 3

A 35-year-old married male, with a recurrent history of marital discord, exhibits a pattern of impulsive and disinhibited behaviors without due consideration of the ensuing consequences. Subsequently, he experiences guilt following these inappropriate, unrestrained, and hurried actions in response to both internal and external stimuli. This impulsivity extends to his work, characterized by a marked propensity for easy distraction and irresponsibility arising from a lack of concentration and planning.

Furthermore, the patient grapples with addiction issues, encompassing gambling, sexual behaviors, and substance abuse, all of which he struggles to restrain. He describes a feeling of being akin to a train on a relentless track, unable to halt, interrupt, or modify his actions, even when such actions are manifestly inappropriate for the given context.

Additionally, it is noted that the patient earned a reputation for recklessness and hastiness during his adolescence and early adulthood. Consequently, the patient and his partner have been referred for couple therapy at a psychiatric hospital, with a concomitant reassessment of a potential PD and the presence of multiple addictive behaviors.

3.1 What is your assessment or clinical diagnosis?

The case was diagnosed as disinhibited PD[10,11,13].

3.2 What are the steps for reaching a diagnosis and meeting the criteria outlined in ICD-11?

Pervasive patterns of disregard for social norms and personal boundaries, impulsivity, and irresponsibility, beginning in childhood or adolescence and continuing into adulthood.

To make the diagnosis, at least presence three of the following criteria must be met[10,11,13]:

- Failure to conform to social norms and lawful behaviors.
- Deceitfulness, lying, or use of aliases for personal profit or pleasure.
- Impulsivity or lack of planning ahead.
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
- Reckless disregard for the safety of self or others.
- Consistent irresponsibility, as indicated by repeated failures to sustain consistent work behavior.
- Lack of remorse, as indicated by indifference to or rationalizing hurting, mistreating, or stealing from another.

CASE 4

A 35-year-old married woman has been experiencing marital issues stemming from her authoritarian, controlling parental style. She exhibits a notable preoccupation with orderliness, perfectionism, and rigid adherence to

concepts of right and wrong. Despite self-identifying as a "Type A" personality, striving for excellence in all aspects of her life, she exerts her dominant behaviors to maintain control over her family.

Additionally, her sister and mother have expressed concerns about apparent symptoms of obsessive-compulsive disorder (OCD), although both have declined mental health treatment. Her husband characterizes her as highly obstinate and inflexible, highlighting her pervasive attempts to regulate even the household environment according to her precise standards. She allocates substantial time to activities in the bathroom, dressing, and tasks, marked by repetitive behaviors and persistent delays. Her diligence is reflected in an over-conscientious approach to her work and presentations, leading to disrupted sleep patterns. She consistently avoids risk, perseveres excessively, maintains an unwavering commitment to social rules and obligations, and exhibits an obsession with details. Furthermore, her daily routines are exceptionally systematic, emphasizing overall organization, orderliness, and neatness, which are accompanied by notable constraints on her emotional expression and behaviors.

4.1 What is your assessment or clinical diagnosis?

The diagnosis of her condition was anankastic (Obsessive-compulsive PD), and she was encouraged to seek mental health help from a psychiatrist experienced in treating OCD[14].

4.2 What are the steps for reaching a diagnosis and meeting the criteria outlined in ICD-11?

The presence of pervasive patterns of preoccupation with orderliness, perfectionism, and control, to the extent that the major point of an activity is lost, beginning in early adulthood and present in various contexts.

To make diagnosis, at least four of the following criteria must be met[10,11,14]:

- Preoccupation with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
- Perfectionism that interferes with task completion (e.g., is unable to complete a project because their own overly strict standards are not met).
- Excessive devotion to work and productivity to the exclusion of leisure activities and friendships.
- Over-conscientiousness, scrupulousness, and inflexibility about matters of morality, ethics, or values.
- Is unable to discard worn-out or worthless objects even when they have no sentimental value.
- Reluctance to delegate tasks or to work with others unless they submit to exactly their way of doing things.
- Adopt a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.

CASE 5

A 15-year-old male adolescent with a history of immature personality presented at the healthcare center accompanied by his concerned mother. Notably, the adolescent exhibited multiple scar wounds on his forearms, suggesting a history of self-harming behaviors. His mother voiced concerns about his intense and inappropriate anger, which had emerged in the context of her divorce and ongoing conflicts with her former husband.

Further mental screening of the adolescent revealed a complex emotional landscape. He experienced feelings of worthlessness, low self-esteem, emotional emptiness, and pronounced mood fluctuations. He also grappled with identity issues and harbored a deep-seated fear of abandonment by his mother. Additionally, the adolescent

displayed a low threshold for stress-induced paranoid ideation, and a history of one prior suicide attempt was identified, involving the ingestion of multiple medications, which necessitated his admission to an emergency department for medical intervention.

5.1 What is your assessment or clinical diagnosis?

The adolescent was referred to a psychiatrist as a case of border line PD. It's important to note that a diagnosis of borderline PD should be made by a qualified mental health professional based on a thorough clinical assessment that considers the presence of these criteria, their impact on the individual's life, and any co-occurring conditions[15].

5.2 What are the steps for reaching a diagnosis and meeting the criteria outlined in ICD-11?

Borderline PD (BPD) is a complex and challenging mental health condition characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and emotions. It typically begins in early adulthood and is present in various contexts.

To make diagnoses at least three of the following criteria must be met[10,11,15]:

- Marked efforts to avoid abandonment: The individual may engage in frantic efforts to avoid real or imagined abandonment. This can include extreme emotional reactions to actual or perceived separations from loved ones.
- Pattern of unstable and intense interpersonal relationships: Individuals with BPD often have tumultuous relationships marked by extreme idealization and devaluation of others. They may oscillate between deep admiration and profound disdain for the same person.
- Identity disturbance: There is a pronounced instability in self-image, leading to a lack of clear understanding of one's identity, values, and goals. This instability often results in frequent shifts in career aspirations, friendships, and life plans.
- Impulsivity in at least two areas that are potentially self-damaging: This includes reckless behavior in areas such as spending, substance abuse, reckless driving, binge eating, and self-harming behaviors.
- Recurrent self-harming behaviors or threats: Individuals with BPD may engage in recurrent self-harming behaviors, such as cutting or burning, or they may make threats of self-harm or suicide.
- Affective instability: Marked mood swings, which can include intense episodic dysphoria, irritability, and anxiety, typically lasting a few hours to a few days.
- Chronic feelings of emptiness: Individuals with BPD often report pervasive feelings of emptiness and loneliness, which may contribute to their impulsive behaviors and intense relationships.
- Inappropriate, intense anger or difficulty controlling anger: Frequent episodes of intense, uncontrollable anger may be directed toward others, themselves, or both.
- Transient, stress-related paranoid ideation or severe dissociative symptoms: Brief episodes of paranoia or dissociation may occur, particularly when the individual is under stress.

Effective treatment often involves psychotherapy, such as dialectical behavior therapy (DBT) or cognitive-behavioral therapy (CBT), and sometimes medications to manage specific symptoms or co-occurring disorders. Early intervention and a supportive therapeutic relationship are critical for individuals with BPD to work toward recovery and increased stability in their lives[10,11,15].

CASE 6

A 55-year-old female with a recurring history of frequent healthcare center visits has exhibited a pattern of hostility, aggression, and a persistently negative attitude towards a significant number of healthcare providers (HCPs). Her interactions with others are marked by unprovoked attacks and verbal hostility, often lacking apparent reasons. She frequently becomes outraged and resorts to derogatory language and insults.

Additionally, the patient engages in exaggerated symptom presentation, marked by excessive emotional displays and dramatic behaviors, primarily for the purpose of seeking attention. She frequently employs threats to healthcare providers, indicating her intent to lodge complaints with higher authorities. Beneath these behaviors lies a pronounced fear of abandonment and loneliness, which further complicates her interactions with healthcare providers.

6.1 What is your assessment or clinical diagnosis?

She was diagnosed with antisocial and histrionic PD (cluster B PD), she was referred to a psychiatrist and started on medication, but still, she came with lessen dramatic emotional presentatio[16]. This case appears to include features of both Antisocial and Histrionic PDs, characterized by disregard for the rights of others, manipulative behaviors, seductive behavior, and a pattern of dramatic emotionality and attention-seeking. Further assessment would be needed to confirm the specific diagnosis[16].

6.2 What are the steps for reaching a diagnosis of histrionic PD and meeting the criteria outlined in ICD-11?

Presence of the pervasive pattern of excessive emotionality and attention-seeking, beginning by early adulthood and present in a variety of contexts[16].

To make diagnoses at least five (or more) of the following criteria must be met[10,11,16]:

- Uncomfortable when not the center of attention.
- Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
- Rapidly shifting and shallow expression of emotions.
- Consistently uses physical appearance to draw attention to oneself.
- Speech is excessively impressionistic and lacking in detail.
- Self-dramatization, theatricality, and exaggerated expression of emotion.
- Suggestible, i.e., easily influenced by others or circumstances.
- Considers relationships to be more intimate than they actually are.

CASE 7

A 42-year-old female, with a longstanding history dating back to her early twenties, has experienced pervasive feelings of being targeted by external conspiracies aimed at causing her harm. She holds strong beliefs that the majority of individuals are untrustworthy and disloyal, resulting in a profound sense of deception by those around her. These suspicions have fueled episodes of intense outrage in response to perceived deception. She exhibits an overly controlling demeanor, particularly concerning her interactions with relatives, and generally maintains negative views of others.

The patient is highly susceptible to even minor criticism and consistently overreacts to comments or feedback from others. Her mental state is characterized by the development of false and delusional beliefs pertaining to unusual incidents that lack grounding in reality. Additionally, she reports experiencing auditory and visual hallucinations, which do not align with objective reality. Her speech patterns are disorganized, manifesting as "salat speech," and her thought processes are disorganized as well.

In the social realm, the patient has undergone a process of withdrawing from social contact, often leading others to avoid her, and she exhibits a marked preference for isolation and loneliness. Furthermore, she reports a history of childhood trauma, notably marked by severe emotional and physical abuse.

The patient's behavioral history also includes numerous instances of hostility and aggressive actions, often resulting in legal involvement, with various police reports and court cases filed against her. She has even experienced periods of incarceration following violent altercations with others.

7.1 What is your assessment or clinical diagnosis?

This case displays features indicative of both borderline PD, characterized by relational and self-identity instability, and paranoid schizophrenia, marked by paranoid delusions and disorganized thinking. Given the complexity of this presentation, a thorough psychiatric evaluation is essential for the establishment of a precise and definitive diagnosis. Consequently, the patient has been referred to a psychiatric hospital for reevaluation and admission[17].

7.2 What are the steps for reaching a diagnosis of paranoid PD and meeting the criteria outlined in ICD-11?

It is pervasive pattern of distrust and suspiciousness of others, such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts[17].

To make diagnoses at least four (or more) of the following criteria must be met[10,11,17]:

- Suspects, without sufficient basis, that others are exploiting, harming, or deceiving them.
- Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
- Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against them.
- Reads hidden demeaning or threatening meanings into benign remarks or events.
- Persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights.
- Perceives attacks on their character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
- Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

CASE 8

A 58-year-old female patient attended a healthcare center for the first time, accompanied by her husband. She presented with a tendency to attribute her illness to her husband quickly, implying that he was the cause of her health problems. Her behavior exhibited signs of an overinflated sense of self-importance, as she regarded her marriage to him as a significant favor and consistently elevated her family's reputation over his. Additionally, she held an inflated perception of her own importance, viewing herself as a renowned artist and writer. She proudly showcased her successful studio, art galleries, and numerous interpersonal relationships.

The patient's self-perception included the belief that she was more intelligent, superior, and more charming than her husband. She expressed disappointment with him, primarily due to his perceived lack of admiration and their recent conflicts.

In a private consultation with the husband, he revealed that she neglected her responsibilities at home, including raising their single son. She heavily relied on a housemaid and leveraged others to achieve her objectives. He

assumed full responsibility for household tasks and even enlisted the assistance of a housemaid. According to him, she displayed a lack of empathy for the feelings and needs of those around her. Her behavior was characterized by arrogance and a snobbish attitude toward others.

The husband's coping mechanisms included the nightly consumption of sleep pills and alcohol to address his sleep issues. He reported that their relatives and friends had begun to distance themselves from her due to her haughty and arrogant demeanor.

8.1 What is your assessment or clinical diagnosis?

It appears that the patient was presented with characteristics narcissistic PD. Consequently, the physician was considering referring her for a psychiatric assessment. Additionally, planning to recommend couple therapy for both individuals[16].

8.2 What are the steps for reaching a diagnosis of narcissistic PD and meeting the criteria outlined in ICD-11?

It is Pervasive patterns of grandiosity, need for admiration, and a lack of empathy, beginning by early adulthood and present in various contexts.

To make diagnoses at least five of the following criteria must be met[10,11,16]:

- Has a grandiose sense of self-importance.
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
- Believes that they are "special" and unique and can only be understood by or should associate with other special or high-status people.
- Requires excessive admiration.
- Has a sense of entitlement.
- Is interpersonally exploitative.
- Lacks empathy.
- Is often envious of others or believes that others are envious of them.
- Shows arrogant, haughty behaviors or attitudes.

CASE 9

A 55-year-old male clerk employed at the health center has a history marked by hostility and aggressive behavior, particularly directed at patients and others. His speech is consistently offensive, causing discomfort and resentment among those he interacts with. Additionally, he exhibits an oppositional attitude, particularly in response to the requests or directives of authority figures. His resistance to cooperating within the clinic environment is notable, and he often engages in deliberate actions designed to create problems and undermine the authority of others. The individual's demeanor is characterized by cynicism and a pervasive toxicity, with a consistently sour mood. Negative body language is frequently employed in response to clinic demands. Moreover, he is an extensive complainer, regularly attributing blame to others and actively seeking out practice shortcomings to fault others for perceived issues.

9.1 What is your assessment or clinical diagnosis?

The patient was diagnosed with characteristic (passive–aggressive PD (negativistic PD)[16].

9.2 What are the steps for reaching a diagnosis of passive–aggressive PD and meeting the criteria outlined in ICD-11?

It is pervasive patterns of negativistic attitudes and passive resistance to demands for adequate performance, beginning by early adulthood and present in various contexts.

To make diagnoses at least four of the following criteria must be met[10,11,16]:

- Acts in a sulking, argumentative, or resentful manner.
- Refuses to comply with routine social and occupational tasks.
- Expresses envy or reluctance to see the success of others.
- Shows a low threshold for discomfort or criticism.
- Has an excessive tendency to complain of personal misfortune.
- Demonstrates excessive irritability and annoyance.
- Shows sullen or argumentative behavior when unresponsive to external constraints.
- Does not live up to social, occupational, or other expectations.

CASE 10

A 35-year-old woman with a recurring history of healthcare visits, primarily due to hypertension, presents with notable psychological and emotional traits. She experiences high stress levels and anxiety, often accompanied by a strong need for explanations, reassurance, and advice to alleviate her anxieties. She frequently feels helpless and struggles to care for herself independently. Her emotional responses tend to be overly passive, and she often relies on others for her emotional and physical needs. This dependence on others is primarily driven by a lack of self-confidence and difficulties in making everyday decisions autonomously.

10.1 What is your assessment or clinical diagnosis?

The patient has received a diagnosis of Dependent PD. To address this, the physician has adopted a therapeutic approach involving problem-solving techniques through the Socratic interviewing method and self-control strategies. This intervention is aimed at promoting the patient's autonomy while concurrently mitigating the adoption of dogmatic and didactic communication styles often observed in healthcare services[18,19].

10.2 What are the steps for reaching a diagnosis of dependent PD and meeting the criteria outlined in ICD-11[10,11,18,19]?

It is pervasive patterns of submissiveness and dependence on others for emotional or physical needs, beginning by early adulthood and present in various contexts.

At least five of the following criteria must be met:

- Difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
- Needs others to assume responsibility for most major areas of their life.
- Has difficulty expressing disagreement with others due to fear of losing their support or approval.
- Has difficulty initiating projects or doing things on their own.
- Goes to excessive lengths to obtain nurturance and support from others, even to the point of volunteering for unpleasant tasks.
- Feels uncomfortable or helpless when alone, due to fear of being unable to care for themselves.
- Urgently seek another relationship as a source of care and support when a close relationship ends.
- Is unrealistically preoccupied with fears of being left to take care of themselves.

CASE 11

A 20-year-old student attending an interior design college has been grappling with various challenges. She experiences numerous absences and struggles to cope with the stressors associated with college life. Her emotional distress has reached a point where she has sought help, expressing, "I am not normal."

The patient presents with social phobia, avoiding social gatherings and expressing a strong aversion to group teamwork presentations. When she eventually responds, she characterizes herself as a "social cripple" who is unable to collaborate effectively with others. Her demeanor is marked by timidity, loneliness, and a preference for isolation, as she attempts to remain inconspicuous. She tends to be quiet, uncommunicative, and unfriendly, often plagued by anxiety.

In addition, she exhibits a pronounced aversion to risk, resistance to adjustment, reluctance to engage in new experiences, and a tendency to restrict herself. She is also inhibited, chronic feelings of inadequacy are a recurring theme, and she is acutely sensitive to negative judgments or evaluations from others.

11.1 What is your assessment or clinical diagnosis?

She was diagnosed as a case of social phobia and avoidant PD[18-20].

11.2 What are the steps for reaching a diagnosis of avoident PD and meeting the criteria outlined in ICD-11[10,11,18-20]?

It is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in various contexts.

At least four of the following criteria must be met:

- Avoids occupational activities that involve significant interpersonal contact due to fears of criticism, disapproval, or rejection.
- Unwilling to get involved with people unless certain of being liked.
- Shows restraint in intimate relationships due to the fear of being shamed or ridiculed.
- Is preoccupied with being criticized or rejected in social situations.
- Is inhibited in new interpersonal situations because of feelings of inadequacy.
- Views self as socially inept, personally unappealing, or inferior to others.
- Is unusually reluctant to take personal risks or engage in any new activities because they may prove embarrassing.

CASE 12

A concerned mother has made multiple appointments for her 15-year-old son but has repeatedly failed to bring him to the clinic. She characterizes her son as an odd adolescent. The boy resides with his divorced mother and aunt in a flat. He has been refusing to attend school, especially after a prolonged period of corona lockdown. He expresses a strong preference for distance learning over in-person attendance.

Upon contacting the boy to discuss his preference for distance learning, he attended the appointment with his mother. He presented with an eccentric and unkempt appearance, actively avoiding eye contact. Notably, he exhibited talent in social media and spent several hours daily on the Internet, engaging in online gaming and participating in chat rooms to connect with others. His social circle was limited to only one friend, and he habitually avoided social gatherings, citing heightened restlessness and displaying significant social detachment. Academic performance was a concern, with his grades consistently ranking among the lowest in his school.

In terms of family history, the mother had a history of treatment for chronic depression and anxiety. Additionally, one of the boy's uncles had been treated for schizophrenia. In his early childhood, the boy exhibited peculiar beliefs related to the presence of the devil and ghosts in his surroundings. He displayed an intense interest in paranormal incidents and notions surrounding "negative energy." During the consultation, he exhibited inappropriate smiling, vague speech, fixation on trivial details, and displayed abnormal thinking patterns.

12.1 What is your assessment or clinical diagnosis?

He was referred to a mental school health assessment as a case of schizotypal PD with a high risk of developing psychosis.

12.2 What are the steps for reaching a diagnosis of schizotypal PD and meeting the criteria outlined in ICD-11[9-11,18,19]?

It is pervasive patterns of interpersonal deficits, eccentricities of behavior, and cognitive or perceptual distortions, beginning by early adulthood and present in various contexts.

At least four of the following criteria must be met:

- Ideas of reference.
- Odd beliefs or magical thinking.
- Unusual perceptual experiences, including bodily illusions.
- Odd thinking and speech.
- Suspiciousness or paranoid ideation.
- 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 tends to be associated with paranoid fears rather than negative judgments about self.

Here is a checklist of 10 recommendations for primary care physicians when dealing with patients diagnosed with PDs[18,19,21]:

1. Prioritize clear, authentic, and non-judgmental communication with both the patient and your therapeutic team to foster a trusting relationship. Encourage open exchanges of views and experiences among the team members.

2. Establish a consistent schedule for regular patient visits within designated time slots, irrespective of whether the patient is currently experiencing a crisis or somatic symptoms.

3. If you suspect that emotions such as fear of abandonment, anger, or shame underlie challenging behaviors, acknowledge these emotions and inquire if they are indeed the driving factors.

4. Be aware that patients with PDs may initially meet you with skepticism, scrutiny, or heightened sensitivity, often stemming from past experiences of rejection, abuse, or neglect.

5. Set clear boundaries at the outset of the therapeutic relationship and resist responding to boundary violations unless there is a genuine emergency.

6. If multiple healthcare professionals are involved in the patient's treatment, prioritize open and honest communication within the team and with the patient as an essential requirement for effective care.

7. Exercise caution in prescribing multiple medications (polypharmacy) and avoid extensive use of potentially toxic or addictive drugs, such as tricyclic antidepressants and tranquilizers. Inform patients about this approach early in the treatment process.

8. Assist patients in identifying solutions to their problems while offering guidance and assigning primary responsibility for setting manageable short-term goals. Encourage active patient participation in this process.

9. In the case of frequent crises, collaborate with the patient to develop a crisis management plan, involving other relevant parties if necessary. Maintain flexibility in the approach and refrain from rigid rule enforcement.

10. Maintain a balanced perspective, neither overly swayed by excessive praise nor disheartened by harsh criticism. Maintain professionalism and consistency in your care approach.

CONCLUSION

The predominant PD worldwide is cluster C. Availability of skillful mental health care workers and well-trained family physicians on diagnosing common PDs. Besides, accessibility of psychiatric drugs (e.g., antipsychotics, mood stabilizers, and antidepressants) in the health center is essential for treating common PDs in primary care.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

REFERENCES

1. Winsper C, Bilgin A, Thompson A, et al. The prevalence of PDs in the community: a global systematic review and meta-analysis. Br J Psychiatry. 2020;216(2):69-78.
2. Angstman KB, Rasmussen NH. PDs: review and clinical application in daily practice. Am Fam Physician. 2011;84(11):1253-1260.
3. Ekselius L. PD: a disease in disguise. Upsala J Med Sci. 2008;123(4):194-204.
4. Sulzer SH. Does "difficult patient" status contribute to de facto demedicalization? The case of borderline PD. Soc Sci Med. 2015;142:82-89.
5. Huang IC, Lee JL, Ketheeswaran P, Jones CM, Revicki DA, Wu AW. Does personality affect health-related quality of life? A systematic review. PLoS One. 2017;12(3):e0173806.
6. Bjorkenstam C, Bjorkenstam E, Gerdin B, Ekselius L. Excess cause-specific mortality in out-patients with a PD. BJPsych Open. 2015;1(1):54-55.
7. Bjorkenstam E, Bjorkenstam C, Holm H, Gerdin B, Ekselius L. Excess cause-specific mortality in in-patient-treated individuals with PD: 25-year nationwide population-based study. Br J Psychiatry. 2015;207(4):339-345.
8. Herpertz SC, Schneider I, Renneberg B, Schneider A. Patients with PDs in Everyday Clinical Practice-Implications of the ICD-11. Dtsch Arztebl Int. 2022;119:1-7.
9. Zoghbi AW, Bernanke JA, Gleichman J, et al. Schizotypal PD in individuals with the Attenuated Psychosis Syndrome: frequent co-occurrence without an increased risk for conversion to threshold psychosis. J Psychiatric Res. 2019;114:88-92.

10. World Health Organization. International Classification of Diseases 11th Revision. 2018.
11. Reed GM, First MB, Kogan CS, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. World Psychiatry. 2019;18(1):3-19.
12. McCabe GA, Smith MM, Widiger TA. Psychopathy and antisocial personality disorder in the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: An attempted replication of Wygant et al. (2016). Personal Disord. 2023;14(6):636-648.
13. Allen TA, Hallquist MN. Disinhibition and Detachment in adolescence: A developmental cognitive neuroscience perspective on the Alternative Model for PDs. Psychopathology. 2020;53(4):205.
14. Reddy MS, Vijay MS, Reddy S. Obsessive-compulsive (Anankastic) PD: A Poorly Researched Landscape with Significant Clinical Relevance. Ind J Psychol Med. 2016;38(1):1-5.
15. Guilé JM, Boissel L, Alaux-Cantin S, de La Rivière SG. PD in adolescents: prevalence, diagnosis, and treatment strategies. Adolesc Health Med Ther. 2018;9:199-210.
16. Bach B, Kramer U, Doering S, et al. The ICD-11 classification of PDs: a European perspective on challenges and opportunities. Borderline PD and Emotion Dysregulation.2022;9(1):1-11.
17. Kingdon DG, Ashcroft K, Bhandari B, et al. Schizophrenia, and borderline PD: similarities and differences in the experience of auditory hallucinations, paranoia, and childhood trauma. J Nerv Ment Dis. 2010;198(6):399-403.
18. Feldman E, Gitu AC. Recognizing PDs in Patients Presenting to the Primary Care Provider. Primary Care Reports. 2021;27(9).
19. Huprich SK. PDs in the ICD-11: opportunities and challenges for advancing the diagnosis of personality pathology. Current Psychiatry Reports. 2020;22:1-7.
20. Lampe L, Malhi GS. Avoidant PD: current insights. Psychol Res Behav Manag. 2018;11:55-66.
21. Dubovsky AN, Kiefer MM. Borderline PD in the primary care setting. Med Clin North Am. 2014;98(5):1049-1064.