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## In This Issue



This month's issue of the *Residents' Journal* focuses on the topic of **Personality Disorders**. In an editorial, R. Scott Johnson, M.D., J.D., L.L.M., and Miguel Alampay, M.D., J.D., discuss the alternative DSM-5 model for personality disorders as a nosological shift in the diagnosis of these disorders. Veronica Slootsky, M.D., emphasizes the importance of research into the neuroscience behind borderline personality disorder, with examples of findings showing reductions in some brain regions in this patient population. David S. Mathai, B.S., examines evidence suggesting that borderline personality disorder may be a type of trauma-spectrum disorder. Suzanne Monsivais, B.A., investigates the prevalence of personality disorder traits among chronic pain sufferers. R. Scott Johnson, M.D., J.D., L.L.M., and Sunil N. Jani, M.D., M.P.H., describe how psychopathy traits are distinguished from traits found in antisocial personality disorder. Lastly, Connie L. Barko, M.D., presents a case report examining James Masterson's conceptualization of narcissistic personality disorder.



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# A Potential Paradigm Shift in Personality Disorder Assessment

R. Scott Johnson, M.D., J.D., L.L.M.  
Miguel Alampay, M.D., J.D.

From the first edition of the DSM, psychiatry has struggled with how to understand, treat, and view individuals with behavioral patterns so maladaptive and pervasive as to warrant diagnosis. Paradoxically, the diagnosis of such disorders often leads to added stigma and alienation by providers. Originally neutral labels often become clinician short-hand for a caricature that derogatorily bleeds into popular culture. Counterintuitively, many well-intentioned clinicians then avoid diagnosing to “protect” patients.

DSM-5 presents an “alternative DSM-5 model for personality disorders” as an “emerging model” intended “for further study.” This empirically based model is measured with the Personality Inventory for DSM-5 and the Level of Personality Functioning Scale. This alternative model presents a nosological shift in the diagnosis of personality disorders, based on sets of dimensional personality traits. This perspective views disorders as extremes on the same dimensions of personality as traits found in everyone (1, 2).

The purpose of the alternative model is fivefold and involves 1) reducing the considerable overlap among personality disorder diagnoses, 2) reducing heterogeneity among patients who receive the same personality disorder diagnosis, 3) eliminating diagnostic thresholds with insufficient research bases, 4) addressing the overuse of the personality disorder not otherwise specified diagnosis, and 5) providing diagnostic thresholds that are meaningfully related to the level of impairment (3). In so doing, it reduces the number of personality disorders to six (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal). Although this alternative model had been endorsed by the DSM-5 Personality Disorders Workgroup, the APA Board of Trustees voted to place

*Ultimately, it is anyone's guess as to what the future holds for this alternative model.*

it in DSM-5 only as a construct in need of further study. As a result, the official personality disorders diagnostic criteria remain largely unchanged from previous DSM iterations.

Critics of the existing DSM-5 personality disorders framework contend that there are “numerous shortcomings of the current approach to personality disorders” (4). In support of this, recent research has demonstrated the clinical utility of the alternative model (5) and found it to be more useful than personality disorders criteria in five of six comparisons (6). Additionally, a recent study showed that, generally, personality disorders were strongly associated with their alternative model traits (7), suggesting considerable continuity across these diagnostic systems. However, residents should note that the dimensional model used by the alternative model is not the only such model to have been described. Other examples include the five-factor model, the Livesley four-factor model, and the Clark and Watson three-factor model.

Ultimately, it is anyone's guess as to what the future holds for this alternative model. One would hope that ongoing and future research data will guide future DSM workgroups and the APA in reconciling these alternate nosologies. Although it would be naive to think that political considerations would entirely take a backseat in such decisions, compel-

ling research data have a way of changing minds over the long haul. Therefore, let us hope that DSM-5's issuance begets a surge of research into these approaches, and let the chips fall where they may.

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# Neuroimaging in Borderline Personality Disorder

Veronica Slootsky, M.D.

Despite advances in psychiatry, the etiology of personality disorders remains poorly understood (1). Borderline personality disorder is thought to manifest as a result of a combination of hereditary and environmental factors and is frequently associated with adverse experiences in childhood (2). It is associated with a lack of empathy for others, as well as both impulsivity and aggression (1). This disorder is difficult to treat despite current tools available in psychotherapy and psychopharmacology. The neural circuitry involved may help in the understanding of this disorder and guide the development of future treatments.

Borderline personality disorder is frequently associated with impulsivity and aggression (3). One MRI study of eight patients with borderline personality disorder and eight matched control subjects found that patients with borderline personality disorder had a 24% reduction of the left orbitofrontal cortex and a 26% reduction of the right anterior cingulate cortex, as well as significant volume loss in the hippocampus and amygdala (3). Another study noted dysfunction in the dorsolateral prefrontal cortex in individuals with borderline personality disorder (4). Frontolimbic dysfunction may play a role in the disinhibition, impulsivity, and aggression seen in these patients. In fact, this frontal dysfunction and disinhibition may be related to the suicidal behavior often seen in borderline personality disorder. One study compared borderline personality disorder suicide attempters and nonattempters and healthy control subjects to identify brain regions that may be associated with suicidal behavior in borderline personality disorder (5). Borderline personality disorder patients who attempted suicide had diminished gray matter in the left insula compared with patients who did not (5). Additionally, those who had high-lethality attempts had volumetric decreases in the right mid-superior temporal gyrus, right mid-

inferior orbitofrontal gyrus, right insular cortex, left fusiform gyrus, left lingual gyrus, and right parahippocampal gyrus compared with those with low-lethality attempts (6).

Other studies have also shown reductions in hippocampus and amygdala sizes in borderline personality disorder patients that are independent of comorbid depression, posttraumatic stress disorder, and substance use disorders (6).

Interestingly, brain imaging has shown changes in 11 patients with borderline personality disorder who have undergone dialectical-behavior therapy, which teaches emotion-regulation skills. In one study, functional MRI (fMRI) was obtained pre- and post-12 months of standard dialectical-behavior therapy in nonmedicated borderline personality disorder patients and in control subjects. During the scans, participants viewed emotionally arousing pictures. Borderline personality disorder patients exhibited decreased amygdala activation during the viewing of the pictures after dialectical-behavior therapy (7). Thus, the frontal deficits observed in borderline personality disorder may lead to the evaluation of other treatment modalities and the risk for suicidal behavior.

Empathy is a complex process that involves both the ability to share and experience the feelings of others, as well as to imagine and understand the motives of others. Patients with borderline personality disorder have deficits with aspects of empathy. Neuroimaging attempts are being made to elucidate crucial regions that may play a role in the dysfunctional empathic process that is observed in these individuals.

One study examined empathy in 51 borderline personality disorder patients and 50 matched control subjects. During assessment of cognitive empathy, the brain responses of the borderline personality disorder patients were reduced compared

with responses in the control subjects in the left superior temporal sulcus and gyrus. During assessment of emotional empathy, borderline personality disorder patients showed greater brain activity on fMRI than the control subjects in the right middle insular cortex (8). Because the insula region is associated with the experience of empathy, these alterations may play a role in the interpersonal deficits seen in borderline personality disorder.

The present findings highlight the importance of further research into the neuroscience behind borderline personality disorder, which is often difficult to treat in the clinical setting with present methods of psychopharmacology and therapy. Understanding the neuroscience behind this disorder may also help destigmatize individuals who suffer from it and lead to further interest in finding improved treatments. It is also important to note that the neuropsychiatric differences may be malleable, as evidenced by the changes seen in borderline personality disorder patients who underwent treatment with dialectical-behavior therapy. Future treatment modalities may be developed and guided by a neuropsychiatric approach.

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*The author thanks Dr. Sam Vaknin and Lidija Rangelovska.*

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# Borderline Personality Disorder and a Spectrum of Trauma

David S. Mathai, B.S.

Section III of the DSM-5 presents an alternative approach to the diagnosis of personality disorders: a new model that combines categorical diagnosis with dimensional ratings to allow for a more thorough evaluation of individual disorder and level of functioning (1). Its addendum reflects the growing concept of behavioral health as a continuum and responds to concerns with current measurements of impairment associated with personality disorders (2). While this paradigm shift affects the workup for all types of personality dysfunction, borderline personality disorder is a diagnosis that may benefit the most from a change in thinking. Borderline personality disorder is highly prevalent, is characterized by significant functional impairment, and is associated with the extensive usage of mental health services (3). It remains, however, a psychiatric classification mired in controversy, some of which is attributed to its obscure etiology (4). The borderline personality disorder literature has identified early traumatic experience as an important factor in our understanding of disease pathogenesis (5). The present article examines evidence suggesting that borderline personality disorder merits acknowledgement as a type of trauma-spectrum disorder and discusses implications for diagnosis and treatment.

## DSM Criterion for Trauma

A systematic review described high rates of childhood sexual abuse (between 16% and 71%) and physical abuse (between 10% and 73%) in borderline personality disorder patients (6). Still, there are patients without conventional histories of trauma, and there are cases of trauma that do not progress to borderline personality disorder. This discrepancy limits the value of trauma consideration in clinical practice, and it is not mentioned within the

DSM-5 criteria for borderline personality disorder. However, this absence may not fully account for the complexity of adverse events implicated in the development of borderline personality disorder. It has been shown that quantity, timing, and severity of traumatic experience can affect the extent of symptoms that develop (7). A contemporary movement to dimensionally assess pathology should then, theoretically, allow for a dimensional assessment of insult as well. There may even be problems with how we define trauma to begin with. DSM-5's criterion A for posttraumatic stress disorder (PTSD) requires "exposure to actual or threatened death, serious injury, or sexual violence," but this widely used definition of trauma fails to address many forms of significant interpersonal trauma such as psychological maltreatment or neglect, especially when these exposures are chronic or sequential (8). These ideas indeed challenge how we approach trauma in the context of borderline personality disorder, but it is still important to distinguish that they do little to establish causality. Other studies have attempted to address this gap. One emergent hypothesis is that emotional dysregulation, a core feature of borderline personality disorder, is the mechanism that links trauma to mature disease (9). More rigorous evaluation of developmental pathology is needed, but if borderline personality disorder is to be understood as the multifactorial product of biological vulnerability, life experience, and reinforced interpersonal behavior (10), then it is important to consider a wide spectrum of trauma as a latent trigger for disease.

## Complex PTSD

It may be useful to look beyond borderline personality disorder criteria for greater insight into patients who present with borderline personality disorder symptoms. Even though the PTSD stan-

dard for trauma falls short when faced with nontraditional stressors, there are related diagnostic concepts that expand the definition of trauma and also contain features of impairment frequently seen in borderline personality disorder patients. Complex PTSD (also labeled disorders of extreme stress, not otherwise specified) was initially proposed as a non-PTSD posttraumatic syndrome that addressed a broader spectrum of underlying adverse experiences, dealt more specifically with emotional dysregulation, and accounted for dissociative symptoms (11). Although complex PTSD was never recognized as a freestanding DSM diagnosis, its associated body of research led to changes in PTSD criteria and its resultant overlap with seven of nine borderline personality disorder criteria (12). The current DSM-5 PTSD definition still hinges on the rigid criterion A designation of a stressor, however, and does not address the two borderline personality disorder criteria dealing with the terror of abandonment or rejection, as well as the alternating idealization and devaluation of others. This disagreement reinforces the idea of two discrete clinical entities, even if PTSD and borderline personality disorder draw several interesting comparisons. So if the concept of complex trauma has advanced our knowledge of PTSD, what has it done for our understanding of borderline personality disorder?

## Developmental Trauma Disorder

Developmental trauma disorder is an emerging diagnosis that revisits both complex trauma and maladaptive personality in a pediatric context. In a proposal to include developmental trauma disorder in DSM-5, van der Kolk et al. (13) established a non-PTSD diagnosis for dysregulated children and adolescents exposed to chronic interpersonal trauma.

The authors argued that developmental trauma disorder is sufficiently distinct from personality disorder because the latter 1) presupposes a fully formed personality, which is not consistent with ongoing personality development throughout childhood and 2) separates symptoms that are addressed in an integrated manner in developmental trauma disorder into several different personality disorders. To address these points, borderline personality disorder is generally not a diagnosis given to children or young adolescents, and one basis for such practice is that traits that appear in childhood can change as an individual reaches adulthood (14). Furthermore, while developmental trauma disorder reasonably stands as a more comprehensive diagnosis than any single, isolated personality disorder, we still cannot rule out borderline personality disorder as a potential subtype or variant of developmental trauma disorder, as proposed. Confirmation of this area of overlap would serve as a strong indication for complex trauma as an underlying mechanism in borderline personality disorder pathogenesis. Developmental trauma disorder may even offer a more integrated clinical approach to borderline personality disorder that could not only increase diagnostic accuracy and efficiency but also replace the scattered assessment that is often required by multiple comorbid diagnoses (15). This relationship between borderline personality disorder and developmental trauma disorder represents a future area of study that may valuably influence the way in which we identify and manage youths with unique trauma histories.

## Treatment Implications

The DSM diagnostic system was designed with an emphasis on utility: a treatment-directed framework concerned more with clear and functional descriptions of symptoms than the etiology of mental disorders (16). This tenet of clinical psychiatry poses a challenge for the introduction of a developmental trauma disorder-type diagnosis, or even for the consideration of borderline personality disorder as a trauma-spectrum disorder. Of greatest importance, could we actually be failing patients by deemphasizing dis-

ease origins? Some have called to redefine borderline personality disorder as a type of complex PTSD in order to minimize the stigma attached to borderline personality disorder patients and reduce rejection by the mental health system, by viewing these patients as victims of adverse events rather than as possessing fundamental character flaws (17). For those who would restructure borderline personality disorder as a disorder of trauma, however, it is important to review previous research that suggests differences in management preference: the gold standard treatment for PTSD is short-term cognitive-behavioral therapy (18), whereas the treatment of choice for borderline personality disorder is generally long-term psychotherapy (19). Alternatively, it could be argued that classic PTSD lies at the far edge of the trauma spectrum with its own unique set of treatment guidelines. As far as the focus of therapy, increasing evidence indicates that a trauma history should be considered in borderline personality disorder patient care, despite it having not always been standard clinical practice (20). Current data also point to significant flexibility and malleability of borderline personality disorder traits in youths (14), proving a key developmental period for targeting earlier interventions. In the process of determining what is clinically useful, we cannot neglect etiology if it directs how we understand and treat a notable patient population.

## Conclusions

Borderline personality disorder patients often challenge clinicians, but it is important to consider that their symptoms may be rooted in complex trauma and subsequent psychosocial dysregulation. Treatment planning should take the diversity of clinical presentation into account, and for some patients, it might be beneficial to explore histories of maltreatment or neglect. Developmental trauma disorder deserves further study as a unique diagnostic methodology for such histories and may allow for a more integrated approach to patients who satisfy borderline personality disorder criteria. The climate for mental illness is shifting; we are able to look beyond artificially constructed boundaries for classification

and assess health with unprecedented genetic and neurobiological rigor. There is ample latitude for ongoing research into the origins of personality dysfunction, but it may well be time for us to start thinking of borderline personality disorder as a trauma-spectrum disorder.

*David S. Mathai is a second-year medical student at Baylor College of Medicine, Houston, Tex.*

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# Recognizing and Addressing Personality Disorder Traits in Chronic Pain Patients

Suzanne Monsivais, B.A.

Personality is a conceptualization of the ways in which a person views oneself and others, and how a person responds to those views, as a result of individual trait and state characteristics. Personality disorders can therefore be considered trait and state characteristics that result in dysfunctional perceptions and relationships within an individual's social context (per DSM-5). In fact, DSM-5 defines a general personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture," manifested in at least two of the following areas: 1) cognition, 2) affectivity, 3) interpersonal functioning, and 4) impulse control. In general, personality disorders severely and negatively affect an individual's ability to function socially.

The present review article aims to summarize a selection of research papers delving into the following questions: What is the prevalence of personality disorders and personality disorder traits among chronic pain sufferers? How can personality disorders/personality disorder traits be systematically identified? How can clinicians constructively approach chronic pain patients with personality disorder traits?

## Prevalence of Personality Disorders in the Chronic Pain Population

Profiles of chronic pain patient populations have tended to suggest a higher prevalence of personality disorders in this population than among the general population. Weisburg (1), for example, characterized the chronic pain sufferer as demonstrating hypochondriasis and hysteria at far greater rates than nonpain sufferers. It has even been suggested that the prevalence of personality disorders is greater in the population of patients with

chronic pain than in any other medical or psychiatric category of patients (2). This information is useful to be aware of because deconstructing the traits and characteristics that comprise a personality disorder diagnosis may be helpful in tailoring treatment strategies for chronic pain patients.

## Temperament and Character Index

Recently, a body of research has emerged that utilizes Robert Cloninger's 1993 Temperament and Character Index (3), a neurobiological categorization of personality, with respect to deconstructing personality disorders (4–10). The Temperament and Character Index defines personality according to the facets of one's temperament and character. There are four categorizations of temperament, and three categorizations of character.

Temperament is described as the aspects of personality that are notable early in life, are considered heritable, and determine one's unconscious biases and associative reactions. Categorizations of temperament styles include novelty seeking, harm avoidance, reward dependence, and persistence.

In contrast, character is the aspect of personality honed in adulthood and constitutes one's ability to exercise insight learning. Ultimately, insight learning defines one's personal and social efficacy. According to Cloninger (3), the parameters by which character can be evaluated include self-directedness, cooperativeness, and self-transcendence.

Two facets of personality in particular, as defined by the Temperament and Character Index, have been shown to be prevalent in all individuals with any of the personality disorder diagnoses: low cooperativeness and low self-directedness. Interestingly, low self-directedness has

also been shown to predispose to the experience of chronic pain (as has high harm avoidance) (9).

The above findings may provide useful guidance to clinicians regarding how best to approach and treat chronic pain patients. Treatment should optimally address patients' perception of pain and the personality traits that may predispose them to experience pain in a debilitating and chronic manner.

## Applying the Temperament and Character Index to the Pain Experience and Personality Disorders

Two components of personality have been persistently identified in chronic pain patients: high harm avoidance (temperament trait) and low self-directedness (character trait) (9). Harm avoidance is the tendency to employ avoidant coping strategies as a result of habitual interpretation of environmental stimuli as damaging or dangerous (regardless of the objective nature of the stimuli). Self-directedness is defined by Cloninger (3) as the ability to first initiate, and ultimately to integrate, multiple steps to achieve goals consistent with one's values.

The Temperament and Character Index has also proven relevant in the discussion of how to identify and treat personality disorders. Most notably, low self-directedness (and low cooperativeness) has been shown to most strongly predict the presence of personality disorders, irrespective of type (9).

Examination of these two concepts carries implications for why an individual might be predisposed to suffer from chronic pain. Consider that low self-directedness essentially translates to a perception of incompetency on the part of the patient. That is, individuals who possess low self-

directedness do not perceive themselves as being capable of overcoming an undesirable situation, as they are not able to organize their resources in an attempt to do so.

Moreover, high harm avoidance results in the employment of avoidant rather than proactive coping strategies, as well as an excessively negative interpretation of stimuli. The implications of these temperament and character styles are that therapeutic endeavors will either be impeded or never seriously attempted. When compounded by the tonic high levels of stress that a harm-avoidant mentality inflicts, the tendency of low self-directedness to result in the chronic persistence of pain becomes more apparent (9).

The increased prevalence of personality disorders among chronic pain sufferers is marked. Among the general population, as many as 14% of people are estimated to have at least one diagnosable personality disorder (11), but more recent and more conservative estimates have placed the figure around 10% (12). In contrast, studies of patients with chronic pain suggest that the figures among this population may be markedly higher. Polatin et al. (13) applied DSM-III criteria to investigate chronic patient personality profiles and found that there was a 51% incidence of patients who met the criteria for one personality disorder and a 30% incidence for more than one personality disorder. Moreover, specific personality disorders have been associated with specific types of pain. Chronic temporomandibular joint dysfunction sufferers, for example, have been shown to demonstrate higher than average rates of paranoid personality disorder (18%), obsessive-compulsive personality disorder (10%), and borderline personality disorder (10%) (9).

## Applying the Temperament and Character Index Framework to Treatment Strategies

The major utility in deconstructing personality according to the Temperament and Character Index or other tools may lie in determining treatment strategies.

Cloninger and Svrakic (10) offer three general rules for treating those with personality disorders or traits suggestive of personality disorders.

Firstly, precautions must be taken to avoid exercising countertransference, and thereafter developing either very negative or very positive feelings toward a patient, since patients with personality disorders tend to elicit very strong emotions from others. It is crucial to avoid this pitfall, since lack of objectivity hinders treatment progress.

Secondly, Cloninger and Svrakic (10) strongly caution against assuming that treatment of those with personality disorders is fruitless. They point to evidence suggesting that even those with potentially very dysfunctional personality disorders, such as borderline and antisocial patients, benefit from therapy if the therapy is executed in an appropriate fashion.

Lastly, practitioners are cautioned against giving direct advice to patients. This is seen as counterproductive in the effort to get patients to achieve insight into their behaviors and attitudes. If patients are directly told how to modify their behavior, they will never have a chance to recognize the inappropriateness of their current habits.

Pharmacotherapy may also play an important role in modifying character and, ideally, the chronic pain experience. Specifically, individuals displaying high harm avoidance have been shown to respond well to antidepressant pharmacotherapy, including selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, and tricyclic antidepressants (9), which allows them to obtain greater gains through psychotherapy.

## Conclusions

The importance of considering the psychological disposition of chronic pain patients is paramount in the effort to deliver effective treatment. Cloninger and Svrakic (10) emphasize that very specific precautions must be made when treating patients who exhibit characteristics of personality disorders. Most commonly, these characteristics will tend to be low

cooperativeness and low self-directedness. Since evidence presented by Conrad et al. (9) strongly suggests the prevalence of low self-directedness among chronic pain patients, as well as a high prevalence of diagnosable personality disorders, these same precautions seem prudent to exercise when treating chronic pain patients. Certainly, even if a patient does not in fact have a diagnosable personality disorder, he or she could benefit from impartial, nonpaternalistic treatment that is not administered with the presumption of futility on the part of the clinician.

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# Psychopathy in Forensic Populations: A Breed Apart From Antisocial Personality Disorder

R. Scott Johnson, M.D., J.D., L.L.M.  
Sunil N. Jani, M.D., M.P.H.

*"The world is a dangerous place to live, not because of the people who are evil, but because of the people who don't do anything about it."*  
—Albert Einstein

In recent years, movies such as *No Country for Old Men* and *Gone Girl* have fostered a public debate about what it means to be an individual with psychopathy and what the prevalence of this condition might be. Unlike antisocial personality disorder, which has long been defined in the DSM, psychopathy has historically lacked an official DSM definition. Psychopathy was first introduced as a "psychopathy specifier" for antisocial personality disorder in DSM-5's section III alternative model for antisocial personality disorder, although this remains a proposal for future study. The present article seeks to clarify for residents the evolution behind the diagnosis of psychopathy, elucidate how it differs from antisocial personality disorder, and bring to light clinically relevant research in the field.

## Definitions and Evolution of Diagnosis

Psychopathy has traditionally been characterized as a disorder of affective and interpersonal traits. The American psychiatrist Hervey Cleckley provided an early description of psychopathy in his classic 1941 text, *The Mask of Sanity*, articulating 16 traits of the condition (1). Subsequently, the Hare Psychopathy Checklist and its subsequent revision (Hare Psychopathy Checklist-Revised) have provided the most commonly used definition of psychopathy, and they have been staples in forensic and correctional settings since the introduction of Hare's first Psychopathy Checklist in 1980. The Psychopathy Checklist-Revised assesses 20 particular traits deemed to be characteristic of psychopathy, with an

individual receiving a score of 0, 1, or 2 depending on that trait's applicability to the individual's presentation and history. The maximum attainable score on the Psychopathy Checklist-Revised is 40, and individuals are diagnosed with psychopathy if they score 30 or more points. Examples of some of these 20 psychopathy traits are superficial charm, grandiosity, pathological lying, need for stimulation, manipulativeness, lack of remorse, lack of empathy, parasitic lifestyle, sexual promiscuity, multiple short-term marital relationships, and impulsivity (2).

Although psychopathy and antisocial personality disorder are often used interchangeably, the diagnostic construct of antisocial personality disorder is distinct, with its focus resting on behaviors, such as irritability/aggression, failure to conform to social norms, and disregard for others' safety, as well as history of conduct disorder. Psychopathy's focus contrasts with these behaviors by resting on affective and interpersonal traits, such as fearlessness (3), boldness (4), and invulnerability (5). Furthermore, with regard to the DSM, psychopathy lacked a definition until DSM-5, while antisocial personality disorder appeared as early as the 1960s in DSM-II as "personality disorder, antisocial type." With psychiatry residents commonly relying on the DSM as their primary diagnostic guide, the lack of DSM diagnostic criteria for psychopathy, until recently, has resulted in it being rather ill-defined in the minds of residents.

While not as broad as the 20 criteria of the Psychopathy Checklist-Revised, the alternative antisocial personality disorder model expands on and slightly modifies DSM-5's current antisocial personality disorder diagnostic criteria (6). The alternative antisocial personality disorder model lists 10 traits, with the following four not shared with the current antisocial

personality disorder criteria: egocentrism, incapacity for intimacy, manipulativeness, and proneness to risk taking. The alternative antisocial personality disorder model's "psychopathy specifier" defines psychopathy as a "distinct variant" of antisocial personality disorder marked by 1) lack of anxiety or fear; 2) bold interpersonal style, possibly masking fraudulent or other maladaptive behavior; and 3) attention-seeking (7).

## Triarchic Model of Psychopathy

At its core, the triarchic model posits that psychopathy consists of three key components: disinhibition, boldness, and meanness (4). Thus, two of its three core elements overlap with two of the three aforementioned alternative antisocial personality disorder model "psychopathy specifier" elements. The Hare Psychopathy Checklist: Screening Version factor 1 measures incorporate the triarchic model in order to enable a more accurate assessment of psychopathy in addition to its violence measure (7). Therefore, the triarchic model has continued utility by dint of its partial incorporation within the Psychopathy Checklist: Screening Version and DSM-5.

## Relationship Between Antisocial Personality Disorder and Other Personality Traits

Antisocial personality disorder is categorized as a cluster B personality disorder, a cluster that also includes histrionic, borderline, and narcissistic personality disorders. The unifying theme of cluster B personality traits is that they inhibit meaningful or functional social interaction with others due to limited impulse

control and emotional regulation. Antisocial personality disorder shares features with cluster B histrionic, borderline, and narcissistic personality traits through the reckless disregard for others, engagement in dangerous or risky situations, and acting on impulsive urges without considering their consequences. Antisocial personality disorder is distinguished from the other cluster B personality disorders because of its central features of deceit, lack of remorse, and emotional manipulation (8).

## Research Findings

### Antisocial Personality Disorder vs. Psychopathy

One particularly helpful study for elucidating the distinctions between antisocial personality disorder and psychopathy was conducted by Coid and Ullrich (9) in the United Kingdom in a population of 496 prisoners to whom both the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) and the Psychopathy Checklist-Revised were administered. Among those 18 years of age or older, 45% received a diagnosis of antisocial personality disorder using SCID-II, of whom 32% were classified as having psychopathy using the Psychopathy Checklist-Revised. Those diagnosed with both antisocial personality disorder and psychopathy demonstrated comorbid schizoid and narcissistic personality disorder, more severe conduct disorder and adult antisocial symptoms, and more violent convictions (9).

Further examining the link between antisocial personality disorder and psychopathy, a 2011 study of 159 male and female undergraduate students found that heavy episodic drinking was associated with psychopathy, irrespective of any antisocial personality disorder diagnosis (10). In a separate study, approximately 300 adult males in a correctional setting were screened for antisocial personality disorder using DSM-IV criteria and were also administered the Psychopathy Checklist-Revised for psychopathy. In that study, boldness was found to be a central feature of psychopathy that distinguished it from antisocial personality disorder (11).

### Differential Diagnosis

The prudent resident must keep a broad differential with regard to behaviors characteristic of psychopathy, since there can be other causes. For example, certain brain injuries, particularly to the frontal lobes, can lead to behaviors similar to psychopathy, such as lack of empathy, impulsivity, aggression, and irresponsible behavior in individuals who were previously healthy (12). This symptomatology has been termed pseudopsychopathy by certain researchers in this field (13). Individuals with pseudopsychopathy can be differentiated from those with psychopathy on the Psychopathy Checklist-Revised by scores less than 30 and that are higher on interpersonal and affective traits than on behavioral ones (14).

Substance abusers suffering from severe posttraumatic stress disorder (PTSD) are potentially at increased risk for committing acts of extreme violence (15). Such behavior could be mistaken for psychopathy when combined with the irritability and emotional detachment seen in PTSD patients. Lastly, some have suggested that some of the symptoms of borderline personality disorder and histrionic personality disorder, both of which are diagnosed primarily in women, may actually be the female equivalent of male psychopathy symptoms (16).

### Prevalence of Psychopathy

No epidemiological data exist regarding psychopathy's prevalence rate in the community. However, regarding traits of psychopathy, forensic and clinical samples have been used to estimate that perhaps as much as 0.75%–1% of the general population may possess these traits. There are more males than females who present with these traits, although the exact ratio of males to females is unclear (17). Additionally, some contend that it is premature to diagnose adolescents as having psychopathy, given the stigma of psychopathy and the considerable changes these young minds will yet undergo (18).

## Treatment Implications

Thus far, there is little evidence that conventional therapeutic approaches or pharmacologic agents are effective with

individuals with psychopathic traits. Wong and Hare (19) developed treatment guidelines for the institutional treatment of individuals with psychopathy that focuses on behavior change and control rather than on conventional empathy training and social skills development. Furthermore, including individuals with psychopathy in conventional treatment groups may detrimentally affect group dynamics; therefore, individuals with psychopathy should generally not be mixed in with other individuals in treatment groups (1). Additionally, caution must be exercised when relying on a clinician's assessment of whether an individual with psychopathic traits has improved in treatment. Seto and Barbaree (20) studied reoffense rates among sex offenders with psychopathy and found that of patients with high Psychopathy Checklist-Revised scores, those who clinicians felt had made "good" improvement in treatment had a reoffense rate that was actually higher than those who clinicians felt had demonstrated "poor" improvement.

## Conclusions

Psychiatry residents should be aware that psychopathy is predominantly a disorder of affective and interpersonal traits. In contrast, the diagnostic construct of antisocial personality disorder is fundamentally behavioral. Therefore, these two conditions are built upon fundamentally different constructs yet share some overlapping traits. It may be that the alternative antisocial personality disorder model's "psychopathy specifier" language is a helpful step toward integrating both the triarchic model and the latest research on psychopathy into the existing criteria for antisocial personality disorder by stressing the features of 1) lack of fear, 2) boldness, and 3) attention-seeking. Clearly, much research is yet needed to better understand and diagnose this little understood and clinically important patient population.

*Dr. Johnson is a fourth-year resident in the Department of Psychiatry at Baylor College of Medicine, Houston, Tex. Dr. Jani is a third-year resident in the Department of Psychiatry at Baylor College of Medicine, Houston, Tex.*

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# Closet Narcissist: A Case Report Examining James Masterson's Conceptualization of the Narcissistic Personality Disorder

Connie L. Barko, M.D.

The diagnosis of closet narcissist is often overlooked in clinical practice because it is not included in the DSM. However, the presentation of a closet narcissist can often mimic other personality disorders. Misdiagnosis can yield years of ineffective treatment and frustration for both clinicians and patients. The present case describes a patient who projected onto his estranged father, assuming his father's role as support and ally in order to please his mother and thereby denied his own grandiose wishes for independence.

## Case

"Michael" is a 21-year-old married, Caucasian male marine who presented to outpatient care for evaluation of nightmares in which the same perpetrator choked him. He endorsed that he had always been anxious and could recall as a child being worried about harm falling upon his mother or himself.

Exploration of his developmental history revealed that his parents divorced when he was 2 years old, after which time he lived with his mother. He idealized his mother, who looked to him as the "man of the house," a source of support, and ally against his father. The patient "hated" his father, describing him as a "sociopath," "alcoholic," and "womanizer." The idea that he might resemble his father was repugnant to him, and any similarities that he perceived evoked shame and anxiety.

As he matured, he developed extreme sensitivity to criticism, ingratiating behavior, and angry outbursts accompanied by destruction of property instigated by small slights or disapproval. However, he characterized his anger as decreased since getting married 1 year prior and attributed this change to his desire to not

resemble his father, who physically assaulted his mother in domestic disputes.

The patient initially presented as self-deprecating and lacking confidence. He blamed himself for his persisting marital problems. Preoccupied with physical fitness, he indicated that he envied other marines and felt inadequate in comparison, despite spending significant time working out. Although his job requires high aptitude test scores, he described himself as "not too smart." This portrayal contrasted with the extensive vocabulary and fund of knowledge he displayed. He described working constantly to gain the approval of his coworkers.

A few weeks after the evaluation, he was escorted to the emergency department after he threatened suicide after bingeing on hard liquor and then tried to grab a pistol from his wife. He recounted an exacerbation of marital strain after he admitted to his wife that he had rekindled feelings for an ex-girlfriend, who he had always admired. He conveyed that he was gratified to have received confirmation that his ex-girlfriend "wanted" him.

## Discussion

Clinicians commonly reference the description of narcissistic personality disorder found in DSM-5, which is characterized by a pervasive pattern of grandiosity, need for admiration, and lack of empathy. Unlike DSM, the Psychodynamic Diagnostic Manual describes two subtypes of narcissism (1). The arrogant/entitled subtype most closely resembles DSM's conceptualization of narcissism and is recognized by an overt sense of entitlement, devaluation of others, and appearing vain, manipulative, charismatic, or commanding. In contrast, the less familiar depressed/depleted subtype

describes individuals who act ingratiating, seek people to idealize, are easily wounded, and feel chronic envy of others seen as in a superior position. Several psychologists have attempted to further define this subtype, using names such as "covert narcissist," "hypervigilant narcissist," or "hypersensitive narcissist."

James Masterson's "closet narcissist" was premised on the depressed/depleted subtype described in the Psychodynamic Diagnostic Manual. Although the closet narcissist often presents as unassuming or anxious, the fantasy of the grandiose self and its desire for mirroring and idealization are unmasked when defenses against grandiosity are stripped away (2). In the above case, the patient appeared self-deprecating and described chronic anxiety of being overpowered; however, he would become aggressively angry at small slights and pursued an idealized ex-girlfriend, who gratified his need for grandiose mirroring unlike his wife.

In accordance with object relations theory, the developmental history of narcissistic patients shows an arrest in the separation-individuation phase, similar to borderline personality disorder (2). Narcissistic pathology is attributed to a failure to develop a sense of self secondary to a maladaptive nurturing environment from the primary attachment figure. The caregiver often criticizes or humiliates the child for expressing infantile narcissistic desires, resulting in the child hiding the "real self" and its associated emotional needs in order to gain approval (3-4). Attunement to a "false self" (5), a learned defense to cope with maltreatment and loss, occurs due to the child serving as a "reverse self-object" (6), whose function is to meet the caregiver's own narcissistic needs.

For the closet type, the individual's false self is centered on vigilant attempts to prevent the care giver's anger and retaliation by mirroring her and denying his or her own grandiose desires (7). In the above case, the patient assumed his father's role as support and ally in order to please his mother and thereby denied his own grandiose wishes for independence.

Because separation and individuation are not encouraged, the closet type views the caregiver as an extension of him- or herself, with self-representations and object-representations appearing "fused" (3). Furthermore, the intrapsychic structure contains two parts separated by a splitting defense. The defensive libidinal part consists of the omnipotent object representation that contains complete power and perfection, a grandiose self-representation, and an affect of feeling superior and esteemed. The patient projects the omnipotent object onto others, hoping to share in its perfection and thereby regulate the grandiosity of the self (8). For example, the patient in the above case longed for union with an idealized ex-girlfriend, who "wanted" him and gratified his desire for mirroring.

The aggressive part of the intrapsychic structure is composed of a punitive, attacking object representation, with a self-representation of being humiliated or empty. It is often associated with an affect of abandonment depression, which is experienced as a self-fragmentation and triggers an idealizing defense (3). The patient projects the angry, punitive object onto others. Feeling attacked and vulnerable, the patient either retaliates or withdraws, losing a sense of self. Similarly, the patient in the above case projected the aggressive object onto his estranged father, who he feels manipulated and abandoned him.

Borderline personality disorder is often confused with the closet narcissist because it also presents with low self-esteem, affect of abandonment depression, and clinging behaviors. However, they can be distinguished by motivation; the borderline individual desires unconditional acceptance and the narcissist individual seeks fusion with the idealized object (3-4).

Because the closet narcissist shares in the perfection of the idealized object, fusion with the object is pursued to maintain the individual's self-esteem and prevent an affect associated with abandonment depression. If the fusion is broken by criticism of the idealized object or interactions involving vulnerability, the closet narcissist demonstrates the "disorders of the self triad," which is characterized by self-activation by seeking real self-needs, instigating abandonment depression and producing further defense (3-4).

A close relationship may expose the patient's impaired, vulnerable self (9). Consequently, relationships are built around defense: detachment, having few relationships, or being attracted to people who are unavailable. These individuals may rapidly "fall in love" based on narcissistic supplies such as money, power, or beauty but later become disillusioned when these qualities do not fulfill their unspoken wishes (10).

The treatment of choice for narcissistic disorders is long-term intensive psychotherapy to promote structural intrapsychic change (2). The narcissistic patient begins treatment centered on defense rather than focusing on internal conflict or painful affect. Confrontation is not usually successful, unlike in borderline personality disorder. Instead, the therapeutic focus is to minimize narcissistic vulnerability and strengthen the real self. Empathetic mirroring is often employed, which consists of acknowledging the painful affect, emphasizing the impact on the patient's self, addressing how the defense contributes to the painful affect, and interpreting the need for the patient to focus on the object (7).

## Conclusions

This case report provided an example of a closet narcissist in the hopes that clinicians will be more alert to identifying this patient population and selecting appropriate treatment. Although not currently a diagnosis in DSM, awareness of the closet narcissist is still important for clinicians. It requires a thorough understanding of developmental, self, and object relations and defense mechanisms,

while highlighting challenges in establishing psychiatric nosology.

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*The author thanks Robert M. Perito, Staff Psychiatrist at Walter Reed National Military Medical Center.*

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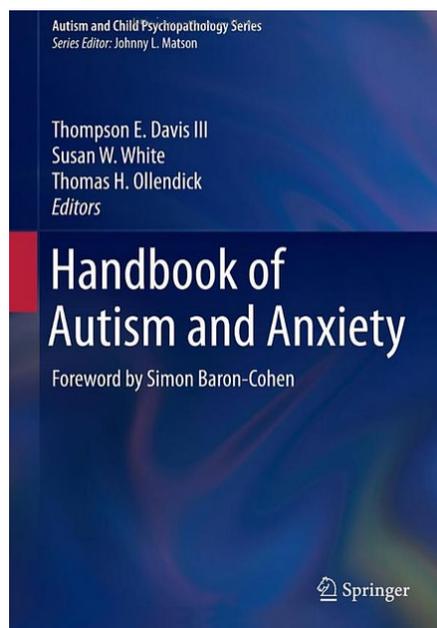
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# Handbook of Autism and Anxiety

Edited by Thompson E. Davis III, Susan W. White, and Thomas H. Ollendick.  
New York, Springer, 2014, 264 pp., \$179.00.

It is currently an exciting time for assessing, treating, and researching autism spectrum disorder (ASD). The prevalence of autism has increased for the past several decades, with rates of 1 in 1,000 children in 1980 to 1 in 88 children in 2008 (1). As our clinical understanding of this spectrum of disorders has grown, there is increasing recognition that ASD does not occur in isolation. An estimated 41% of ASD patients are diagnosed with two or more comorbid disorders (2), which contribute to poor outcomes. Some of the most common comorbid conditions are those related to anxiety, including social phobias, obsessive-compulsive disorder (OCD), social anxiety/agoraphobia, generalized anxiety disorder, separation anxiety disorder, and panic disorder. The *Handbook of Autism and Anxiety*, edited by Thompson E. Davis III, Susan W. White, and Thomas H. Ollendick, synthesizes our current understanding of ASD and anxiety, with international experts across interrelated disciplines highlighting the fundamental similarities and differences, examining the existing clinical challenges, and discussing future research directions for ASD and comorbid anxiety disorders.

The book targets a wide audience, including researchers, clinicians/professionals, students, and patients and families. To this end, it is divided into four parts that each appeal to audiences of varying levels of expertise and perspectives. Part I focuses on the fundamental relationship between ASD and anxiety, by which ASD patients have a higher rate of comorbid anxiety disorders and vice versa. Starting with an historical review of autism, subsequent sections are devoted to the variability in ASD presentation. The authors argue that ASD as defined in



DSM-5 is likely a heterogeneous collection of disorders with different biological mechanisms that converge in a similar phenotypic presentation. Anxiety disorders with and without ASD are also discussed, with emphasis on the amygdala as a potential convergence of biological malfunctions. Part I concludes with a chapter on the future of ASD and anxiety research, emphasizing the etiologic and transdiagnostic complexities involved in the interplay of these conditions. Part II of the book introduces specific anxiety diagnoses for consideration alongside ASD symptoms, including OCD, social anxiety, and specific phobias. Part III tackles common issues that clinicians face in assessing and treating ASD and anxiety, including the use of group cognitive-behavioral therapy for youths and recommendations for addressing challenges of treatment implementation in a school setting. Part III emerges as a

Reviewed by Jie Xu, M.D., Ph.D.

valuable resource for researchers and clinicians alike, addressing the nuances of complex diagnosing and optimizing current treatment strategies. Lastly, Part IV discusses the new DSM-5 criteria, as well as Research Domain Criteria recommendations for future practice and research.

The *Handbook of Autism and Anxiety* is a well-referenced scholarly book that summarizes our current understanding of the overlap between ASD and anxiety. The book uses simple language to dissect the similarities and differences between these disorders, making it a worthwhile reference for medical students, psychology students, residents, and fellows who are interested in this area of clinical practice and research. However, it is most useful as a scholarly reference for clinicians, researchers, and behavioral therapists who take care of pertinent patients and their families. Use of this book can help guide clinicians and behavioral therapists in taking care of their patients and is also beneficial to researchers, as it summarizes the latest research findings to help guide their future work.

*Dr. Xu is a first-year resident in the Department of Psychiatry, University of Texas Southwestern Medical Center, Dallas.*

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*Room 202 C-D, Level 200, North Building, Toronto Convention Centre*

3:30 p.m. to 5:00 p.m.

**A Resident's Guide to Borderline Personality Disorder: From the Experts (Part 2 of 2)**  
*Room 202 C-D, Level 200, North Building, Toronto Convention Centre*

## Tuesday, May 19th

11:00 a.m.-12:30 p.m.

**High Anxiety in the Resident Clinic: Challenges for Therapists in Training**  
*Room 204 (Summit), Level 200, North Building, Toronto Convention Centre*

11:00 a.m.-12:30 p.m.

**I Wish I Learned That in Residency: Preparing Future Psychiatrists for the Future of Psychiatry**  
*Room 802 A-B, Level 800, South Building, Toronto Convention Centre*

5:15 p.m.-6:15 p.m.

**MindGames (APA's national residency team competition)**  
*Toronto Convention Centre*

## Wednesday, May 20th

9:00 a.m.-10:30 a.m.

**Interactive Session: A Conversation With Resident Fellow Members and Paul Summergrad, M.D., APA President**  
*Room 802 A-B, Level 800, South Building, Toronto Convention Centre*

3:00 p.m.-5:00 p.m.

**Resident Wellness Today: Current Challenges, Programs, and Recommendations for Tomorrow's Trainees**  
*Room 204 (Summit), Level 200, North Building, Toronto Convention Centre*

# Author Information for *The Residents' Journal* Submissions

## Editor-in-Chief

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(Yale)

## Deputy Editor

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(Yale)

*The Residents' Journal* accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted. To submit a manuscript, please visit <http://mc.manuscriptcentral.com/appi-ajp>, and select "Residents" in the manuscript type field.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
- 3. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
- 4. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
- 5. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
- 6. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 7. Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

## Upcoming Themes

*Please note that we will consider articles outside of the theme.*

### Biological Psychiatry

If you have a submission related to this theme, contact the Section Editor, Adarsh S. Reddy, M.D., Ph.D. ([redhya@psychiatry.wustl.edu](mailto:redhya@psychiatry.wustl.edu))

### Pediatric Neuropsychiatry

If you have a submission related to this theme, contact the Section Editor, Aaron J. Hauptman, M.D. ([AJHauptman@seton.org](mailto:AJHauptman@seton.org))

### Medicine for Psychiatrists

If you have a submission related to this theme, contact the Section Editor, Venkata Kolli, M.B.B.S., M.R.C.Psych. ([venkatakolli@creighton.edu](mailto:venkatakolli@creighton.edu))

\*If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Misty Richards, M.D., M.S., Editor-in-Chief ([mcrichards@mednet.ucla.edu](mailto:mcrichards@mednet.ucla.edu)).