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Personality Disorders and Health: Lessons Learned and Future Directions

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This special issue provides a glimpse into the multi-faceted impact of personality and personality disorders on health, behavior, and well-being. Because the literature on personality, and particularly personality disorders (PD) and health is still lagging relative to the literature on major psychopathology (e.g. mood disorders) and health, several of the articles herewith represent pilot investigations and preliminary examinations of associations between personality and a variety of health-related variables in a range of samples. These studies generate hypotheses for further inquiry. Taken together, several themes emerge: (a) the larger constructs of “personality” and particularly “personality disorders” often need to be dissected into specific components to better delineate the relationships between various aspects and personality; (b) moderators and mediators of the relationships between personality and health related variables must be considered; (c) the reliability and validity not only of personality constructs but also the scales used to assess these constructs are myriad, and may be a contributor to the range of findings observed in this research and will have impacts on clinical applications of such work; (d) the ongoing diagnostic conundrum of dimensional vs. categorical conceptualizations of personality is observed in this collection of articles - with a range of definitions employed to capture personality and personality “disorder” including brief screeners, diagnostic interviews, thresholds and continuous measurement.

Research on personality and personality disorders is often plagued by measurement issues. The studies included herewith all used different methods of measurement including EMRs, clinical interview, validated self-report scales such as the MCMI-III, and brief screeners. Finding that “sweet spot” of personality assessment that can be employed and easily interpretable in primary care or other first-line medical settings remains a challenge, as brief screeners may not yield sufficient data and lengthy interviews and scales can be too unwieldy. Heterogeneity of measurement can raise the challenge of comparing findings across studies. Overall this special issue on personality and health reveals the fact that these relationships are never simple. Specific personality disorders do not have uniform impacts on health and behavior. These results suggest that the impacts of personality are typically moderated and mediated by various factors and specific sub-factors of personality patterns are often more salient than the omnibus personality “disorder” (e.g. emotional dysregulation or negative relationships). This may speak to the rather limited utility of larger umbrella terms (e.g “borderline personality disorder”), and the need to focus on specific traits,

behavioral patterns, or symptom sets. The body of research and clinical work on personality disorders has often disproportionately centered on borderline and antisocial personality disorders given that these two personality disorders and their associated symptomatology often result in the greatest distress and disruption for social and occupational functioning. This special issue illustrates that personality patterns that go beyond these two disorders also have relevant for understanding health, disease and behavior.

Risk Behaviors:

Capturing consistent predictors of risk behaviors remains a proverbial “holy grail” in health psychology. Isolation of predictors provides intervention and prevention targets that can be cost-effective and ideally delimit mortality and morbidity. If personality variables or PDs are found to be consistent predictors of risk, it would be a mixed blessing, as the utility of their consistency could be undercut by their resistance to modification and change and the challenges in assessment. There is a clinical “sensibility” to the expectation that personality disorders and dysfunctional personality patterns would be associated with risk behaviors, particularly within interpersonal contexts such as sexual risk. Within this special issue, Mainville et al observed that these relationships between personality disorder symptomatology and risk behaviors are not that straightforward and their results actually revealed no consistent relationship between borderline and antisocial PD symptoms and sexual risk behaviors. However, they did note that gender moderated the relationship between PD symptoms and risk with women with higher numbers of antisocial and borderline PD symptoms reporting a greater likelihood of riskier sex, and also that emotional dysregulation was associated with a greater likelihood of sex without a condom.

The paper by Benotsch et al which examines dependency traits and sexual risk raises complementary findings. Dependency may be associated with risk but also raises consideration of causal directions and larger contextual frameworks. In women receiving services at an STI clinic, higher dependency traits were associated with a variety of riskier behaviors including drug use and lower condom use. However, dependency traits were also associated with greater vulnerability to violence and subsequent risk within intimate relationships. In the absence of a longitudinal design, it is impossible to discern the degree to which the pattern of dependency predated or was significantly augmented by intimate partner violence. Together both the Mainville and Benotsch manuscripts highlight the potential utility of assessing personality characteristics and patterns of sexual risk, particularly in women. However, it also raises the larger issue of whether these trait patterns in women may place them at greater risk by dint of larger societal patterns and extant gender frameworks that place women at greater risk for relational violence.

Emotional dependency as well as emotional dysregulation are difficult traits to operationalize and assess. Like many personality traits they are multiply determined via not only macro factors such as culture and community but also individual level variables including temperament, trauma and psychosocial history. These factors are embedded in complicated societal structures and constructs including gender oppression that can reinforce these unhealthy patterns and render risk management all the more challenging. Risk mitigation may be experienced as “out of reach” especially in those with high level of

dependent traits in abusive relationships, and such individuals may face other intersectional oppressions secondary to race, gender, sexual orientation, and social class. In addition, in a sample such as that employed by Mainville, which was comprised of residentially unstable adults also living with severe mental illness, personality issues in women may also place them at risk for greater difficulty for coping with the severe stress of their circumstances, greater dysregulation, and a greater likelihood of engaging in risky behaviors in the fact of economic hardship.

Risk behaviors may be presaged by other psychosocial risks, and D'Avanzo and his colleagues examined the associations between pathologic patterns of personality and psychosocial factors young sexual minority men. They observed higher levels of internalized anti-gay bias and lower connection with the gay community among men with higher levels of personality pathology. The authors highlight that an overly simplified focus on mental health factors such as substance use, mood and anxiety and suicidality within the context of HIV and HIV risk in young sexual minority men has missed the larger tableau of young sexual minority men's health. They maintain that personality factors may provide a framework from which to understand other psychosocial factors which may not only be reciprocally associated with mental health, but overall well-being. D'Avanzo's findings highlight the idea that personality may also serve as a marker variable for psychosocial and other risks. The interpersonal difficulties that personality pathology can heighten may also result in alienation from larger community structures, which for groups like young sexual minority men may inflate a sense of alienation and augment the likelihood of health risks and overall greater psychological and psychosocial vulnerability.

Treatment:

The literature on the treatment of personality disorders in general is variegated, often inconsistent and quite complex. Treating clients with PDs or significant personality pathology within health care settings raises a variety of management issues. It is less likely that the short term and symptom focused interventions being delivered in primary care settings could even begin to address the depth and breadth of personality disorders as a treatment target. However, to the degree that the behavioral and interpersonal patterns associated with personality disorders would impact engagement in health care as well as adherence to treatment, examining the impact of personality factors on health care and management of comorbid psychiatric conditions is essential.

The subtlety of personality disorder often results in very differential impacts on not only psychotherapeutic treatment, but also within health care settings. The impacts of personality disorders, particularly disorders such as narcissistic personality disorder (NPD), were highlighted in a series of case reports by Kacel. These cases highlighted the impact of NPD and associated traits on resistance to change in psychotherapy, challenges in treatment adherence, and difficult relationships with HCPs. The use of a case based approach allows for specifically highlighting 6 key challenges for working with what are often labeled "Cluster B" personality disorders (e.g. narcissistic, borderline, antisocial PD) including problematic boundaries with HCPs, ambivalence about change, cognitive distortions, "split" perceptions of HCPs, poor adherence, and help rejecting behaviors. These are obviously

challenges observed with many psychiatric populations, however, Kacel's article and the use of a case approach allows for further dissection of some of the dynamics that may propel these patterns, and provide not only behavioral targets for change, but also etiological factors that could be addressed in longer term psychotherapy. This paper also highlights an issue that faces all clinicians working with PD - comorbidity. The acute management demands of a medical condition as well as mood, anxiety, substance use, and other syndromal patterns can result in a balancing act that can be particularly challenging in primary care settings.

The use of a case approach in understanding the behavioral health impacts of NPD can also infuse some sense of opportunity in what is often a rather pessimistic landscape of managing health behaviors in persons with NPD. If nothing else, the cases presented in Kacel's manuscript highlight that small shifts may be possible, and these small shifts may facilitate adherence or mitigate some of the distress associated with treatment. In addition, provision of these sorts of "small" interventions may provide a greater sense of efficacy for HCPs at all levels who are working with these clients, and are often confounded and frustrated when working with them, resulting in strained HCP-patient relationships.

Personality disorders are often viewed as an impediment to successful outcomes in psychiatric management with comorbid psychiatric disorders. The resistance, defensiveness, and interpersonal and emotional dysregulation can make it difficult to develop rapport, and initiate or maintain cognitive, affective, and behavioral change. Holder et al.'s article addresses this directly in a unique sample of female veterans who have experienced military sexual trauma. Borderline personality disorder (BPD) is often comorbid with PTSD, and Cognitive Processing Therapy (CPT) has been found to be an evidence based treatment for PTSD. However, given the high comorbidity of BPD and PTSD -- they empirically addressed the impact of BPD on PTSD treatment. They noted that in their sample, BPD did not impact treatment completion or treatment response, despite the wide-ranging assumption that BPD could be an impediment to successful treatment of PTSD with CPT.

Holder's findings raise some larger issues around treatment of clients with BPD and PTSD. Holder notes that those with BPD DID evince higher PTSD symptoms compared to those without BPD on the basis of clinician ratings but not subjective ratings -- a finding which raises the possibility of clinicians overpathologizing clients with BPD and maintaining biases about poorer treatment outcomes. In concert with Kacel, Holder's also addresses some of the stereotypes of PD clients being more "difficult" and less adherent to therapy.

While the Holder study represents a pilot investigation -- it is a critical piece of clinical evidence contributing to EBTs that have utility for the comorbid picture of BPD and other psychopathology. Once again, tools that can be successfully employed with persons experiencing comorbid PD and other psychopathology not only provide some relief for clients impacted by the complex emotional regulatory issues associated with BPD and comorbid PTSD, but also provide clinicians with a greater sense of efficacy via data driven treatment frameworks and measurable outcomes.

Comorbid Psychopathology:

Similar to PTSD, emotional dysregulation is observed in binge eating disorder (BED) and bulimia nervosa (BN). Minnick et al provided a preliminary pilot overview of MCMI patterns which were most prevalent in a sample of Latinas with BED and BN. The patterns suggested by this data -- with more “withdrawn” patterns such as those observed in depressive, dependent and avoidant personality -- may potentially represent differential challenges in treatment, assessment, and even identification of these cases. Comorbid clinical issues such as social anxiety, and contextual issues such as traditional roles (which may magnify and reinforce the presence of traits deemed “dependent”) may be risk factors and may also complicated help-seeking behaviors in Latinas with BN and BED. Such findings, given their preliminary nature, highlight the need for far more work in personality disorders with diverse populations, especially Latinas.

While preliminary, Minnick’s investigation bears note as very little investigation in the personality disorder literature examines ethnically diverse samples, and virtually none address Latina women. While cross cultural issues in assessment and differential cross cultural validity of personality disorder assessment remain an issue, the lack of empirical data means that there are few frameworks for researchers and clinicians working with diverse populations. This special issue also highlighted work on PD and personality with other groups with whom personality has been understudied such as D’Avanzo’s manuscript on young sexuality minority men.

Management of Physical Symptoms:

Psychiatric symptomatology complicates primary care management in myriad ways -- negatively impacting adherence to HCP recommendations and medication, substance use, magnification of physical symptoms such as pain, and heightened responsivity to stress, vegetative symptoms including changes in sleep and appetite. Pain is a clinical management issue that cuts across primary and chronic health care management. Because pain is so influenced by psychological, psychiatric, and psychosocial factors, it can greatly impact overall health for persons who are experiencing comorbid mental illness and pain. While Kacel’s article highlights the challenges that narcissistic personality disorder can pose in primary health care settings, Dokyoung et al. focus on borderline personality symptoms, which can raise similar impacts in HCP engagement, and BPD has been associated with increased clinical pain. Using both static and dynamic pain measures in a non-clinical sample, Dokyoung observed that borderline features were associated with pain indices that reflect greater central pain sensitivity. Once again, and similar to other studies reported in this special issue, Dokyoung was able to highlight a specific factor of borderline personality that was associated with pain sensitization, specifically negative relationships. They note that their findings support that greater pain sensitivity in their sample appears to be more associated with chronic interpersonal stressors than acute stressors. From a behavioral medicine perspective, this illustrates that factors that may appear distal to pain management (relationship difficulties) may be key contributors to pain experience and subsequently management.

Intuitively, HCPs may believe that assessing acute stressors may help understand pain sensitivity, when rather, it may be more useful to focus on chronic relational stress which is nearly always part of the borderline personality clinical picture. Interestingly, Dokyoung et al. observed no associations between borderline personality features and a measure of static pain and suggest that persons with borderline personality features may be more vulnerable to the chronic and persistent pain patterns associated with somatic syndromes including fibromyalgia. Blunted sympathetic response also appeared to mediate the association between borderline features and dynamic pain response. Interestingly, this pattern of sympathetic response was highlighted as being observed in those who have experienced greater childhood adversity and trauma -- etiological patterns not uncommon in borderline personality disorder. As such, education about borderline features, especially specific symptom sequelae such as relational distress, may provide some relief for clients impacted by the complex emotional regulatory issues associated with borderline features, and may facilitate a more holistic approach to pain management in a variety of chronic pain conditions.

Sleep, like pain, is a key issue in behavioral health, especially when working with populations at risk for comorbid psychiatric issues. In a clinical sample of forensic inpatients all of whom met criteria for either antisocial or borderline PD, Van Veen et al observed that sleep difficulties were recorded in half of their sample, particularly insomnia. Their findings reveal that a specific facet, attentional impulsiveness, was associated with sleep. While causality is difficult to determine, these findings again highlight the reciprocal nature of these specific behavioral and cognitive subsets of PDs and specific outcomes. Whether the impulsiveness is driven by sleep difficulties or vice versa, sleep difficulties can have numerous negative outcomes for well-being and physical health and may also have further effects with regard to amplifying the likelihood of other risk behaviors via impacts on impulsivity. This work highlights sleep as a circumscribed treatment target, and one that may in fact be more manageable than some of the more challenging clinical elements of borderline and antisocial PDs.

Summary:

In total, this set of thoughtful and diverse articles which examine a diversity of samples and settings, employing a variety of measurement tools, and a range of behavioral outcomes raise awareness of the need for addressing personality in research, clinical care, and prevention. Many of these studies are preliminary investigations, pilot studies, or employ non-clinical samples, but all raise fruitful hypotheses for ongoing study. Personality has often been treated as “noise” and individual differences that cannot be systematically addressed at a population or even sample level. However, personality and personality disorders in particular often act as an amplifier, magnifying the impacts of factors such as stress which are such a key element of understanding health, disease and wellness. Specific elements of personality disorders such as dysregulation in all forms -- emotional, behavioral, interpersonal -- can undercut attempts to target adherence, risk mitigation, and also can raise the probability of contexts (e.g. intimate partner violence, residential instability, comorbid mental illness) which can greatly complicate the successful implementation and maintenance of prevention and intervention.

Several articles also raise the critical point that personality -- which is often treated as a “micro-” individual level variable, may actually also reflect “macro-” contextual variables at the level of culture, society, community and family -- with differential reinforcement of certain personality patterns, as well as the fact that societal oppression of marginalized groups including women, racial/ethnic minorities, sexual minorities, immigrants, religious minorities, and low social class may also result in magnification of trait patterns (e.g. dependency) through maintenance of extant structures that place these groups at risk. As such, thinking about personality through both micro- and macro-lenses as we develop the literature on the nexus of personality and personality disorders, psychopathology, disease, behavior, health and wellness represents the next step in better conceptualizing these issues.

Numerous future areas of inquiry are suggested on the basis of this collection of articles include:

- (a) Utilization of samples that are more diverse with regard to ethnicity, sexual orientation, cultural background, more international work on these constructs,
- (b) Continuing to challenge research that solely relies on traditional diagnostic constructs of PD. Many of the studies within this special issue teased out the subsets within personality disorders and patterns (e.g. emotional dysregulation, relationship conflict) as well as moderators (e.g. gender) and mediators (e.g. sympathetic reactivity). It is quite likely that PD does not behave as a uniform construct in its impacts on health and behavior, and understanding of the component parts may better inform targeted interventions designed to address personality variables in health care settings
- (c) Addressing measurement of PDs. The 8 articles in this issue relied on 8 different modalities of assessment, and generation of reliable and valid streamlined tools for personality and PD assessment for use in health care settings may allow for better elucidation of the impacts of personality on health and health care delivery.
- (d) Ongoing work with larger samples that allow investigators to better examine multivariate associations between personality, health and the myriad other factors highlighted in this issue including risk behaviors, comorbid psychopathology, and various other elements of personality.
- (e) Further idiographic and qualitative approaches in this research is critical as the subtlety of these patterns often requires going beyond nomothetic and quantitative approaches to understanding the diversity of personality patterns captured under the rubric of “personality disorder.”
- (f) Consideration of etiological factors in personality disorders and psychological development, especially trauma as trauma may be an independent factor impacting health and health behaviors but may also be mediated through personality.

- (g) While some of the work included in this special issue consisted of work with international samples, there is a need for ongoing cross-cultural and cross-national work examining these relationships between personality and health, particularly given the differential reinforcements of specific personality patterns in various contexts and how this may impact health behaviors and perceptions.
- (h) Further work on the impact of patients' personality traits and personality disorders on health care provider -- patient relationships, as well as training of HCPs in understanding and managing the nuances raised by PD in health care settings.
- (i) Attempting to better understand HCP and mental health practitioner attitudes about personality pathology and PD. Biases about treatment outcomes with these clients need to be better understood to facilitate training and supervision.
- (j) This special issue is meant to promote further research, and encourage consideration of a wider array of health outcomes and behaviors (e.g. diet, exercise, substance use, tobacco use, post-surgical recommendations, dialysis) to be examined in conjunction with personality across the continuum. In addition, to broaden this work across disease treatment and prevention to include a wide variety of chronic and acute illnesses (e.g. cancer, cardiovascular disease, diabetes, cerebrovascular disease, infectious disease).
- (k) Much of the work on PD, and this is also observed in the papers comprising this special issue, disproportionately focuses on antisocial and borderline PD. Expanding beyond these disorders and considering other dysfunctional personality patterns can broaden our understanding of the impacts of personality across the continuum on health and with a wider array of patient populations and comorbid disorders.

Taken together, the articles comprising this special issue advance the conversation about a complex but essential issue in behavioral medicine -- understanding the role of personality on health in a range of populations, across health and disease models, employing a variety of assessment methods, and examining a range of outcomes. The authors and their manuscripts address critical questions in the field and open up numerous future areas of inquiry. Further understanding of personality and health can have multiple impacts within the field of behavioral medicine including enhancement of clinical management and assessment in primary and chronic health care settings, better understanding of psychiatric comorbidities in research and clinical management, enhancement of patient-provider relationships, conceptualizations of risk, adherence and other health behaviors, and optimized targeting of prevention and intervention programs in a manner that accounts for long standing patterns of personality and acute psychiatric comorbidities. In addition, personality development and expression is embedded within larger contexts of culture, society, community and family. All of these contexts are also associated with health and health behaviors -- as such, the moderating role of these contexts on relationships between personality and health requires further exploration. In addition, the validity and reliability of personality constructs including personality disorders in cross-cultural and transnational research must also be considered. The investigations comprising this special issue, taken together, also raise

awareness of the need for provider training across all health care settings about the impacts of personality on health with a goal of providing more responsive health care across populations.

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