Comorbidity of syndrome disorders and personality disorders

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1 INTRODUCTION

The question of whether comorbid personality disorders negatively affect the treatment of syndrome disorders (in DSM-IV terms: "axis-I disorders"), is one of the most controversial in the field. Empirical research on the influence of comorbid personality disorders on the treatment of syndrome disorders is also characterized by various methodological issues, which can strongly influence the conclusions. We will come back to this issue later in the chapter. With regard to the comorbidity of syndrome and personality disorders, the following topics are discussed in this chapter: phenomenology, treatment models, assessment, treatment planning, the empirical evidence and lastly, the conclusions.

1.1 Epidemiology

The prevalence of personality disorders in the general population (estimate: 10-12%; Torgersen, 2012) and in clinical populations (estimate: 65%; Torgersen, 2012) is also controversial. Although there are well-conducted studies using semi-structured interviews like the SCID-II in clinical populations, which show a prevalence of around 65% (Torgensen, 2012) and comorbidities of 35-60% in anxiety and mood disorders (Friborg et al., 2013, 2014), there is also some reason to doubt these numbers. For example, negative mood and demoralization, as well as the tendency of patients to overemphasize problems in an attempt to receive good help, lead to an over-reporting of symptoms that match certain personality traits. Although the influence of a condition dominated by a syndrome disorder is clearly stronger in self reporting to assess personality disorders than in a diagnostic interview, the pitfall of overdiagnosis cannot be ruled out, not even in interviews. For example, it is difficult to understand that personality disorders would disappear after a treatment purely focused on syndrome disorders, although this is in fact regularly reported (e.g., Durbin &

Klein, 2006). One explanation for these findings is an overdiagnosis of personality disorders when patients are referred to treatment.

1.2 Phenomenology and accompanying phenomena of personality disorders

Personality disorders are defined as mental problems that originate in childhood. Personality disorders lead to problems and impairments to the person (or their environment) in a multitude of situations (the three Ps: persistent, pervasive and pathological). Thus, they consist of a person's habitual and dysfunctional emotions, thoughts and behaviour. An important characteristic of personality disorders is that this pattern of thinking, feeling and behaviour is egosyntonic: the person regards this as "normal" and finds it hard to imagine other ways of feeling, thinking and behaving. A person with a depression may feel worthless but may also remember that there were times when he/she did feel worthy. In a way, feeling worthless is egodystonic, not consistent with the self-concept. This stands in stark contrast to a person with a personality disorder: if feeling worthless is part of the personality pathology, the person assumes that he or she is actually worthless, and that this has always been the case. Although it has long been thought that personality is shaped in childhood and does not change in adulthood (or only under extreme conditions), empirical research shows that this is in fact not true for both normal personality and personality disorders (Roberts et al., 2000, 2006).

It is striking that in general, personality traits change in the direction of better adaptation. Important role changes (e.g., increased responsibility after having children), and influence of the environment (e.g., criticism about inappropriate behaviour) play a role in this development (Roberts et al, 2006). Systematically using the influence of the environment is done during psychotherapy, which we will get back to later.

Compared to many syndrome disorders, personality disorders are associated with a lower quality of life (Torgersen, 2012; Samuels, 2011; Soeteman et al., 2008a), and an increase in physical health problems and problematic lifestyles (Samuels, 2011). The costs for society are high, much higher than for example depression, because of a high healthcare consumption, dropout from work and school, substance abuse, crime, and costs made by the environment (Soeteman et al., 2008b; van Asselt et al., 2007; Bamelis et al., 2015). The life expectancy is around 18 years shorter compared to the general population, excluding early death by suicide. The greatest risk of premature death is

before the age of 44, which is also the time when an important contribution to society and raising children is expected (Fok et al., 2012). Cardiovascular diseases also play a major role, to which chronically elevated stress levels are probably an important possible cause (Moran et al., 2007).

In personality disorders, comorbidity is more often the rule than an exception. Comorbidity with other personality disorders, personality traits, and syndrome disorders is common. In addition, patients are more likely to seek help for anxiety or mood problems than for a personality disorder (which is, after all, regarded as egosyntonic). Therefore, in many cases help or treatment is primarily aimed at a (presumed) syndrome disorder. However, the question is to what extent that is a good idea.

1.3 Treatment models (sequential/parallel/integrated) for this comorbidity

Various treatment models are available for the treatment of comorbid syndrome and personality disorders. According to the classical psychodynamic model, every syndrome disorder is the result of underlying personality problems, and treatment should therefore focus on the personality disorder. In contrast to this idea is the 'classical' way of thinking in CBT, which (initially) denied the existence of personality disorders. Treatment had to exclusively focus on the syndrome disorder (or on symptoms that, in DSM terms, belong to a syndrome disorder). Both models thereby deny the necessity or desirability of directing treatment on the disorder that does not fit the model. Nowadays, the most common approach is stepped care, in which syndrome disorders are treated first. This is usually not based on a well-considered choice but is caused by the failure to recognize personality problems and the lack of time spent to assess them. So, the syndrome disorder (or what is presumed to be a syndrome disorder) is treated. If this treatment does not work properly or if there are complications, then (sometimes) the possibility of a personality disorder is considered, and the patient is referred to a specialized treatment program. As a result, patients in treatment programs for personality disorders have usually already received several treatments targeted at syndrome disorders. This is not always the case for borderline personality disorder, as this personality disorder is reasonably easy for clinicians (and patients) to detect without extensive diagnostic assessment. However, even in this group the majority of patients have often received a series of previous treatments before finally joining a personality disorder treatment program. Integrated and parallel treatments for syndrome- and personality disorders are much less common. Developers and practitioners of specialized treatments for personality disorders often believe that their treatments are able to address all psychopathology. Sometimes, parallel treatments are offered at highly specialized institutions for personality disorders, for example for phobias or PTSD,

but this makes up only a small proportion of all available options. However, an important nuance must be made: In pharmacotherapy, parallel treatment is the rule. Most patients with comorbidity receive psychotropic drugs, which (unfortunately) often comes in the form of polypharmacy. If one drug fails to provide sufficient relief, it is not tapered off but instead a new drug is added. In the pharmacotherapeutic treatment of comorbid syndrome- and personality disorders, it is often unclear whether a particular drug is meant to treat the syndrome disorder or certain aspects of the personality disorder. This raises the question if parallel treatment really exists in such cases. To conclude, there is currently no consensus about the specific treatment principles in relation to these comorbidities. In practice, treatment is usually initially directed at a (presumed) syndrome disorder and only when the treatment(s) repeatedly stagnates or does not provide sufficient improvement, patients are offered a treatment for the personality disorder. Only in cases where the personality problems present themself so pronounced that it overshadows any syndrome disorder, treatment is aimed directly at the personality disorder.

2. ASSESSMENT

2.1 Detection

There are no (early) detection instruments for personality disorders with sufficient sensitivity and specificity to be applied individually. In practice, the clinician will have to pay attention to long-lasting dysfunctional patterns of cognitions, emotions and behaviour, that also manifest themselves beyond the bounds of the syndrome disorder(s). Suspicion of personality problems and a request for help related to these problems are indications that specialized diagnostic assessment should be conducted.

2.2 Diagnostic system

The DSM-5 no longer consists of the multi-axis system of the DSM-IV, in which syndrome and personality disorders were categorized and diagnosed on different axes. The personality disorder diagnoses in the DSM-5 remained the same as in the DSM-IV; a new (but very complex) system of diagnosing personality disorders was not included in the new edition. The 10 personality disorders are often grouped into three clusters: cluster A (the strange, bizarre cluster, characterized by the formulation of odd ideas, which can be seen as a psychotic form of personality pathology); cluster B (the dramatic, impulsive and emotional cluster, characterized by excessive expressions of emotions and impulses; which can be considered as an externalizing form of personality pathology); and cluster C (the anxious cluster, characterized by excessive fear and fear-driven coping such as

avoidance, clinging and perfectionism; this cluster can be seen as an internalizing form of personality pathology). Table 1 shows the personality disorders ordered by cluster. In addition, the DSM-5 has a "residual" category: the other specified personality disorder. This diagnosis can be made when there are traits of different personality disorders present which cause significant impairment, warranting a diagnosis, while the criteria for one of the 10 individual diagnoses are not met. This residual category can also be used when the clinician diagnoses a personality disorder on the basis of traits not included in the DSM-5, such as the sadistic personality disorder.

Table 1. Personality disorders according to DSM-5 by cluster.

Cluster A	Paranoid personality disorder
	Schizotypal personality disorder
	Schizoid personality disorder
Cluster B	Narcissistic personality disorder
	Histrionic personality disorder
	Borderline personality disorder
	Antisocial personality disorder
Cluster C	Avoidant personality disorder
	Dependent personality disorder
	Obsessive-Compulsive personality disorder
Rest	Other specified personality disorder

2.3 Specialized assessment

For a valid diagnostical process, it is necessary to use clinical interviews with which clinicians systematically check the criteria of the diagnoses. These interviews also prevent the clinician to come to a too early judgment and to no longer be open to disconfirmation of the already formed judgement or impression. For the DSM-5 syndrome disorders, the SCID-5-S and the MINI are available and for personality disorders the SCID-5-P is available. The diagnosis of personality disorders should be preceded by thorough assessment of syndrome disorders, because without knowledge of the presence of possible syndrome disorders and their course, the clinician can wrongfully attribute certain problems to personality disorders. For example, it is important to check

whether excessive dependence can be attributed solely to panic disorder with agoraphobia, or whether the dependency is not limited to the panic disorder. Another example are mood swings, which are wrongly attributed to borderline personality disorder when clinicians fail to assess the presence of a bipolar disorder. Similarly, it is wrong to attribute panic attacks to a panic disorder if they only occur in situations/events of (perceived) abandonment, i.e., one of the criteria of borderline personality disorder. In other words, it is of the utmost importance to avoid two types of mistakes in diagnostic assessment: (i) mistaking a syndrome disorder for a personality disorder; and (ii) mistaking a personality disorder for a syndrome disorder.

2.4 Planning the treatment

In the case of comorbid syndrome and personality disorders, it is therefore important to first make a diagnostic assessment with good (semi-)structured clinical interviews. Too often, psychological or pharmacological treatments are aimed at syndrome disorders which actually result from personality disorders because of sloppy diagnostic assessment. In the case of syndrome disorders, it is therefore necessary to consider whether the problem is autonomous (i.e., not caused by personality problems).

Treatment is usually focused on the primary diagnosis. However, from clinical interviews such as the SCID the primary diagnosis (i.e., what should be the focus of treatment) cannot be determined. This problem also arises in the case of comorbidity between syndrome disorders. In order to determine what the primary treatment focus should be, the clinician makes a decision in close consultation with the patient using the following considerations:

1. What request for help does that patent have exactly? In most cases, treatment will focus on the diagnosis related to the problems the patient is requesting help for (It would be strange to start offering help for a problem the patient wishes no treatment for).
2. Which problem was there first?
3. Which problem is (currently) the most serious? Psychotic disorders, anorexia nervosa, addiction, bipolar disorder, and borderline personality disorder are often more severe than other disorders and are therefore often regarded as primary disorders.
4. Which problem is the most urgent or which problem should be dealt with first before the (other) problems the patient requests help for can be addressed? (An example is an addiction, which should first stop before other disorders can be treated, even if the patient initially only wants treatment directed at other problems and he or she does not see the addiction as a problem at all).

Psychoeducation is of great importance during this joint process. The patient may initially have difficulty understanding that a particular disorder is present, like with the above-mentioned addiction or personality disorder as mentioned earlier. The patient often has little knowledge about the different treatment possibilities and, in particular, the treatability of problems (the insight that personality disorders are treatable is quite new). It may therefore be necessary to take some time before deciding what the primary diagnosis is, and whether the treatment should be focused primarily on one diagnosis or whether an integrated or parallel treatment should be offered.

3 TREATMENT

3.1 Pharmacological interventions

There are no pharmacological interventions available to cure personality disorders (Lieb et al., 2010; Care Standard Personality Disorders, 2017). Research, mainly in borderline personality disorder, does give evidence for the effects of such interventions on specific symptoms of the personality disorder. Notably, there is little evidence for the effectiveness of antidepressants on symptoms of borderline personality disorder, while they are often prescribed even in the absence of a depression. The EBRO module of the standard treatment of personality disorders provides a detailed overview (Zorgstandaard Persoonlijkheidsstoornissen, 2017; Dutch). Internationally, there are large differences between guidelines. The British NICE guidelines are the most hesitant in prescribing psychotropic drugs in the case of personality disorders (NICE 2009) and strongly warn against unwarranted use of polypharmacy.

There is little evidence that the presence of a comorbid personality disorder decreases the effectiveness of pharmacotherapy for syndrome disorders, with one exception: for a comorbid borderline personality disorder, there are serious doubts about the effectiveness of antidepressants in the treatment of a depression (Lieb et al., 2010; Feurino & Silk, 2011; Skodol, 2015). When prescribing psychotropic drugs for comorbid personality disorders, the increased risk of abuse, addiction, and suicide should be carefully considered. Moreover, the reliance on psychotropic drugs may lead to a healthcare dependence in patients with a personality disorder. Paradoxical effects, such as an increase of anxiety instead of a decrease after the use of benzodiazepines during a period of experienced agitation in borderline personality disorder (Cowdry & Gardner, 1988; Gardner& Cowdry, 1985) can also occur. This is probably due to the disinhibiting effects of

benzodiazepines, which impair the patient's ability to inhibit impulses, which (justifiably) makes the patient more anxious. The use of psychotropic drugs in combination with alcohol increases this paradoxical effect.

3.2 Psychosocial interventions

In general, the empirically supported psychosocial treatments can be used when a syndrome disorder is the primary disorder. It is strongly discouraged to deny patients a treatment for a primary syndrome disorder in case of a comorbid personality disorder (see next paragraph). Unfortunately, this often happens in practice. It may be more difficult to build a constructive therapeutic relationship and to motivate patients to commit themselves to the treatment (Dreessen et al., 1999), but therapists generally succeed to do so. If there is still a need for treatment of the personality problems after completion of the treatment for the syndrome disorder, a follow-up treatment can be offered (sequential treatment; perhaps better described as stepped care because it only concerns the subgroup that still has a request for help). However, it is recommended that treatment aimed at the syndrome disorder should not continue for too long. If treatment is unsuccessful, it may be because the problem is not sufficiently independent of the personality disorder: the extent to which the problem has become autonomous may have been misjudged. In such cases, the mechanism that maintains the problems may not have been addressed in the treatment for the syndrome disorder, indicating the need of another focus. That other focus may be on personality problems, and/or past experiences such as childhood trauma and neglect, that underlie both the syndrome disorder and the personality disorder.

When treatment is focused on the personality disorder, specialized psychotherapy should be the treatment of choice (Zorgstandaard Persoonlijkheidsstoornissen, 2017). These psychotherapies are based on specific theories about the development and maintenance personality disorders. These treatments are characterized by a set of specific techniques that intervene in the maintaining mechanisms and a consistent model from which the therapeutic relationship is initiated and from which techniques are used. For borderline personality disorder, these specialized Psychotherapies are: Dialectical Behaviour Therapy (DGT), Schema Therapy (ST), Transference-Focused Psychotherapy (TFP), and Mentalization-Based Treatment (MBT). For the other personality disorders the specialized psychotherapies are ST, and specialized types of CBT and psychodynamic psychotherapy (Zorgstandaard Persoonlijkheidsstoornissen, 2017).

The extent to which these specialized psychotherapies can integrate or combine a treatment for a comorbid syndrome disorder differs. In therapies derived from CBT, such as ST and DBT, this works well. For example, the schema therapy protocol already describes the need to process traumatic experiences, for example with imaginary rescripting and writing exercises; and how CBT techniques such as exposure in vivo exposure and behavioural change can be used. With DBT, treatment will more likely consist of a parallel (or sequential) treatment of the syndrome disorder, rather than an integration of this treatment. This is because the DBT protocol (at least for year 1) is fixed in considerable detail. It is also relatively easy to integrate a CBT treatment aimed at a syndrome disorder in the CBT therapies for cluster C personality disorders. In psychodynamic treatments, such an integration is less obvious because of the difference in the frame of reference of these treatments on the one hand, and that of most evidence-based syndrome treatments on the other hand. Moreover, mindful of the psychodynamic tradition, the syndrome disorder will be primarily seen as a manifestation of underlying personality problems on which the treatment is focused. If necessary, a parallel or serial treatment of a persistent syndrome disorder possible, as is often done for phobic complaints in psychotherapeutic centres.

In successful psychotherapy for personality problems, often (but not always) recovery of the comorbid syndrome disorders is observed. Therefore, it is not recommended to set up very complex integrated, parallel or serial treatment programs. Simplicity and consistency of working from one model is more appropriate than an overload of treatments that are difficult to integrate for the patient, and also difficult for the clinicians to align. In most cases, the best option is to focus the personality disorder treatment on core themes, and to evaluate whether treatment also has the desired effects on the comorbid syndrome disorders after some time (e.g., after one year). Moreover, improvement often continues after the completion of therapy. For this reason, it is recommended that after a certain dose of therapy (varying from one to two years in the case of outpatient psychotherapy) there should be a break of at least one year before evaluation is carried out and any further treatment decided on (e.g., Bamelis et al., 2014).

3.3 Empirical evidence on the effects of treatment

The treatment indications mentioned above are largely based on current scientific insights. We will now discuss the empirical evidence.

1. There is no (strong) evidence for a negative impact of comorbid personality disorders on the effects of good treatments for syndrome disorders. In short, research shows that patients with this

comorbidity experience more severe problems at the start of treatment, which is also true for the severity of the syndrome disorder. However, on average these patients show either parallel improvement compared with patients without a personality disorder, or very small differences in the degree of improvement (0.5-1% explained variance; Goddard et al., 2015; Porter & Chambless, 2015). This has been studied most in the treatment of depression and anxiety disorders, including OCD and PTSD (Godard et al., 2015; Mulder, 2002; Olatunji et al., 2010; Weertman et al, 2005). However, when the severity of the syndrome disorder after treatment, or recovery of the syndrome disorder is the dependent variable, a negative influence of a comorbid personality disorder is reported more often (e.g., Newton-Howes et al., 2006). Because the group with comorbidity usually has more severe complaints at the start of treatment, this is also to be expected when both groups show (approximately) the same improvement. In other words, the conclusion as to whether or not a comorbid personality disorder has a negative influence on the treatment outcome of a depression or anxiety disorder depends to a large extent on whether one looks at the *degree* of improvement or at *the end point* without considering the starting point.

However, it is not the case that the treatment of anxiety or depression is equally easy in the group with comorbidity. Research shows that therapists report that they have to put in more effort (Dreessen & Arntz, 1999; Steketee et al., 2001). This makes it all the more remarkable that they eventually manage to achieve an effect that on average (or hardly different) has the same size.

Some reviews have noted that the influence of comorbid personality disorders appears to be greater in naturalistic designs than in RCTs. One explanation suggested by Mulder (2002) is that in clinical practice, the more complex comorbid group often receives worse treatment, because they will be written off beforehand. This then becomes a self-fulfilling prophecy. RCTs protect against such a bias because the allocation is random.

There are, however, some nuances to be made to the general pattern that there is little influence of comorbid personality disorders on the effects of treatments targeted at syndrome disorders. Firstly, it is possible that at baseline, the number of diagnosed personality disorders contains many false positives (see the note in section 1.1). Secondly, there are indications that specific beliefs related to personality disorders actually do have a negative influence. This applies to beliefs that are based on distrust, magical thinking, having to control or avoid emotions, dependence and hopelessness (Arntz, 2014; Weertman et al., 2005). Thirdly, in many studies, certain serious personality disorders, such as borderline-, schizotypal- and antisocial- personality disorder are excluded. Fourth, while there are indications that borderline personality disorder in particular is a predictor of dropout (Arntz, 2014), dropout from treatment has been studied much less.

2. The reason why it is advised to treat personality disorders with specialized psychotherapy, and not with general forms of psychotherapy or other psychosocial treatment, becomes clear from the background documentation of the *"Zorgstandaard Persoonlijkheidsstoornissen"* (2017). The specialized psychotherapies for borderline personality disorder systematically outperform treatment of usual and Community Treatment by Experts[1] on the overall severity of the disorder (pooled effect size in terms of the Standardized Mean Difference[2] = .5; Oud et al, 20[1]17). There are no RCTs showing that more generic treatments, such as General Psychiatric Management (GPM) and Structural Clinical Management (SCM), are superior to treatment as usual. However, one study did not show any significant differences between GPM and DBT, but it is statistically wrong to infer equal effectiveness from a non-significant difference between treatments: that is why equivalence trials are necessary, in which a difference that is just about clinically relevant is considered and where very large numbers are necessary to exclude the possibility that there truly are no differences. Also, by means of meta-analyses it is not yet possible to establish equivalence statements, simply because there are too few RCTs comparing the same treatments. For the non-borderline personality disorders, the same pattern can be observed, namely that (some) specialized psychotherapies have been supported with the most evidence, but the number of studies is too small for a meta-analysis.

3. Are the effects of treatment for personality disorders influenced by comorbid syndrome disorders? Most attention has been paid to comorbid depression, perhaps because there is often discussion in clinical practice as to whether the depression must be treated first, and because of the assumption that the demoralizing effects of depression are disastrous for psychotherapy for other problems. However, the only controlled study known to us is the study by Renner et al, based on the RCT by Bamelis et al (2014) with an *N* of 320. Because the type of treatment in an RCT does not depend on patient characteristics, the results are much more reliable than naturalistic studies, which do not control for treatment type. The findings of Renner et al. show the same pattern as the influence of personality disorders on the effects of treatment of syndrome disorders: comorbid depression was already associated with a greater severity of outcome measures at baseline, and the improvement was parallel. The initial negative impact of comorbid depression on the likelihood of recovery from a personality disorder diagnosis disappeared when general severity at the start of treatment was controlled for. The authors conclude that not depression, but general

[1] *This refers to psychotherapy conducted by therapists in the area where the research was conducted, who consider themselves experts in the treatment of the personality disorder in question.*

[2] *This measure expresses the difference between two treatments at the final assessment (i.e., after treatment) in terms of the spread (the standard deviation) of the scores (i.e., the differences between participants).*

severity is the predictor of the diagnostic status after therapy. Another possible complicating comorbid syndrome disorder is PTSD. Although there is no clear evidence that PTSD negatively influences the treatment of personality disorders, the clinical observation is that PTSD leads to suboptimal treatment results in the absence of trauma-focused treatment. For this reason, sequential or integrated treatment models are currently being developed, for example DBT combined with exposure therapy (e.g., Harned et al., 2014; Steil et al., 2011). As already mentioned, this is less relevant for ST, provided that the therapist adheres to the protocol and integrates trauma treatment into the therapy.

4. Do syndrome disorders improve with treatment directed at a personality disorder? The answer is yes: problems related to syndrome disorders usually decrease parallel to the decrease in personality problems (Arntz, 2014; Skodol, 2015). And also, some specialized psychotherapies, such as ST, are particularly effective for mood disorders (Bamelis et al., 2014).

4 CONCLUSIONS

For the time being, the treatment of comorbid syndrome- and personality disorders will remain a controversial issue. This is also related to the sometimes-contradictory research results and the influence of methodological factors on the results. This chapter has tried to convey a nuanced picture. To summarize, if there is a clear syndrome disorder which is the primary diagnosis, it is reasonable to consider focussing treatment on that problem first. This treatment must be state of the art and the comorbidity should not hinder access to such treatment. If there remain personality problems after successful treatment and should the patient wish to receive help for these problems, then specialized psychotherapy for the personality disorder is appropriate. Conversely, when the personality disorder is the primary diagnosis, and there are no exclusions such as untreated bipolar disorder, psychosis, or addiction, then a psychotherapy for the personality disorder is indicated. Although the expectation is that the syndrome disorders will diminish with successful treatment of the personality disorder, it is recommended to monitor it and, if appropriate, to treat it or to supplement or follow it up with therapy specifically aimed at the persistent syndrome disorder. Finally, some notes can be made to this general guideline. Strong beliefs of mistrust, magical thinking, need to control or avoid emotions, dependence, and/or hopelessness, are an indication that treatment of the syndrome disorder has less chance of success. In such cases, it is advisable to first consider focusing treatment on these personality factors, although this consideration is based on clinical experience rather than on direct empirical evidence. Secondly, in the most severe personality disorders, such as borderline and the schizotypal personality disorders, treatment should

initially focus on personality if the patient agrees with this. Thirdly, care should always be taken with the use of pharmacotherapy in patients with comorbid personality disorders, for example because of risks of addiction, abuse and suicide. In particular in the case of borderline personality disorder there is evidence that benzodiazepines can have adverse effects and that antidepressants can have no or unclear effects, even in the presence of a depressive disorder. Finally, the primary treatment of personality disorders should be psychological, whereby any pharmacotherapy should play a supporting role.

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