Personality Disorders in Patients with Intellectual Disability

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EDITOR'S NOTE

The patient cases presented in Psychotherapy Rounds are composite cases written to illustrate certain diagnostic characteristics and to instruct on treatment techniques. The composite cases are not real patients in treatment. Any resemblance to a real patient is purely coincidental.

ABSTRACT

Both individuals with intellectual disability (ID) and individuals with personality disorders represent populations that require unique interactions with healthcare providers and consist of high utilizers of the healthcare system. The intersectionality of these diagnoses poses further considerations in diagnosis and management. This article describes two fictional case studies intended to illustrate, examine, and identify symptomology of individuals with these comorbid diagnoses and establish recommendations for evidence-based management of these individuals. While personality disorders should not be diagnosed in individuals with severe and profound ID, they can and should be diagnosed in patients with mild or moderate ID who have characteristic symptoms and meet diagnostic criteria. Management for these diagnoses focuses on themes of consistency, safety, staff education, and goal-based behavioral objectives. Care must be taken in ruling out confounding factors and overlapping symptomology, but appropriate comorbid diagnoses can aid in apposite treatment, reduce stigma, and improve quality of life.

KEYWORDS: Personality disorder, borderline personality, antisocial personality, intellectual disability, developmental disability, psychotherapy, psychiatric treatment

"...personality disorders are to be conceptualized as impairment in both self-organization and interpersonal relating, caused by pathological (extreme) personality traits. This represents progress in that marked impairment in self organization and interpersonal relating are plausibly characteristic of personality disorder."[1]

INTRODUCTION

Personality refers to individual differences in characteristic patterns of thinking, feeling, and behaving. The study of personality focuses on two broad areas; the first is understanding individual differences in particular personality characteristics, such as sociability or irritability; the second is understanding how the various parts of a person come together as a whole. Regarding personality disorders, critically important aspects also include impulse control, affective modulation, and ability to learn from previous experiences.[2] Individuals with intellectual disability (ID) might be more difficult to assess for personality disorders due to decreased self-report, communication challenges, and problem-solving skills, among other factors. The diagnosis of a personality disorder implies that the individual has or could have the ability to evaluate interpersonal, social, legal, and professional behavior in their self.[3]

The diagnosis of personality disorders in individuals with ID is complicated and controversial for various reasons. The criteria for personality disorders are all potentially altered in persons with ID, and their behavior can be greatly affected by the severity of cognitive deficits. It is now widely accepted that individuals with severe and profound ID should not be diagnosed with personality disorders.[1,4] Both ID and certain personality disorders can be associated with behavioral dysregulation, including self-harm, impulsivity, and intense anger. This adds layers of complication for psychiatrists, providers, and caregivers of persons with ID.

According to the existing diagnostic criteria for the general population, there are three broad categories of personality disorders.[1] Cluster A includes schizoid, schizotypal, and paranoid personality disorders. Cluster A has a general focus on thought processes, including peculiar ideas, magical thinking, and social isolation. In persons with ID, these features can overlap with symptoms of autism spectrum disorder (ASD).[4] Cluster B includes borderline, antisocial, narcissistic, and histrionic personality disorders, with a general theme of poor impulse control and emotional instability. Cluster C includes avoidant, passive, and dependent personality disorders, with a general theme of social or professional withdrawal. Dependent personality disorder is especially complicated in persons with ID, overlapping with realistic dependency needs.[1]

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The *Diagnostic Manual, Intellectual Disability, 2nd edition* (DM-ID)[5] is an internationally recognized resource that recommends adaptations of *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5) criteria for mental health disorders to better fit patients with ID. The DM-ID notes that persons with ID are "not exempt" from development of personality disorders.[5] The DM-ID cautions that all evaluations of persons with ID must consider the developmental and cultural framework of the individual. There is also discussion in the DM-ID regarding the distinction between an individual's real need for support versus fear of abandonment. These are realistic concerns in individuals who have frequently inconsistent support systems and who have experienced multiple losses.

ASSESSMENT

Assessment tools might be difficult or impossible to utilize in individuals with ID, and tests, such as the Minnesota Multiphasic Personality Inventory (MMPI), have not been standardized for use in individuals with cognitive deficits. Many personality tests and inventories require that the individual not only answer hundreds of questions, but also that they utilize recall and memory skills. Although there are tools created specifically for persons with ID, most, if not all, of these assessment instruments have limitations in construct validity and lack of conceptual clarity.[6] As with other categories of psychiatric conditions, there is a complex interplay among behavior, personality, and psychiatric disorders in individuals with ID. When working with individuals with ID, knowledge of their baseline functioning and collateral data are particularly important and specific to evaluating behavior and thought processes. Collateral information further necessitates a reliable source who is very familiar with the individual. While baseline and collateral subjective information is extremely valuable, objective proxy measures, including, but not limited to, behavior, are additional necessities for proper assessment.[5,6]

Because individuals with ID have realistic dependency needs, there are complicating factors in applying the diagnostic criteria for dependent personality disorder to this specialized population. The use of this specific disorder in the ID population would thus be debatable.[5–8] Studies on both schizoid and obsessive compulsive personality disorders suggest that the criteria for these conditions overlap with symptoms of ASD; these diagnoses should thus be avoided or utilized with caution in this population.[9]

BORDERLINE PERSONALITY DISORDER

Borderline personality disorder (BPD) is characterized by the presence of a pattern of unstable interpersonal relationships, disturbances of self-image and affect, and marked impulsivity.[8] In the general population, BPD often coexists with comorbid psychiatric disorders, such as substance use disorders, mood disorders, eating disorders, posttraumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), and other personality disorders.[1,5] Some of the cardinal features of BPD also occur frequently in individuals with ID, including self-injurious behavior, impulsivity, and affective lability.[8] Commonly prevalent mood disorders might present similarly to personality disorders among individuals with ID (i.e., via mood changes, impulsivity, etc.), so collateral data and detailed history-taking are vital to distinguish these conditions.[1,7,8] The DSM-5, DM-ID, and the internationally based Project Air Strategy for Personality Disorders endorse these similarities[1,7,8] and emphasize that the clinician should look for additional features of BPD in persons with ID, including:

- Patterns of idealization and devaluation
- Splitting
- Manipulative behavior
- Subjective perceptions of victimization
- Chronic feelings of emptiness
- Stress-related paranoia
- Impulsive patterns of self-destructive behavior other than self-mutilation[5]

The following vignette illustrates an individual with mild ID and BPD, an intersectional comorbidity that is a high utilizer of both ID and mental health community resources. Layers of complication include chaotic relationships, which can result in recurrent emotional turmoil for the patient with subsequent, recurrent emergency department evaluations. Chronic suicidal threats of the patient create urgency in the direct care staff, whose goal is to ensure patient safety, the consequence being that the patient might consciously or unconsciously seek medical attention as part of their character pathology.

FICTIONAL CASE VIGNETTE 1

"I just want to die! Just leave me alone so I can kill myself!" J, a 27-year-old white woman with mild ID, was seen in the emergency department. J was well-known at the facility because of her frequent visits to the hospital.

Dr. W: What's going on, J?

J begrudgingly admitted that she got into a fist-fight with a member of her home staff when the staff did not drive her to visit her boyfriend.

Dr. W: But I thought she was your favorite staff?
J: Well, not anymore!

Before the fight, J tried to break into her locked medication box, and this was discovered by staff, who heard her yelling about taking all her medications.

J: I was so mad I blacked out. I don't remember what I said. I'm depressed because my boyfriend didn't answer his phone when I called.

J had multiple boyfriends, and she seemed to have constant conflict with each one. She did not have female friends because "I just can't trust them not to steal my boyfriend." J frequently broke up with boyfriends when she suspected them of cheating on her, whether this was verified or not. J also believed that people often talked behind her back and were trying to hurt her. She had been hospitalized eight times for suicidal ideation and auditory hallucinations of "the wind calling my name."

J was admitted, stabilized, and discharged within two days. At her check-up with her outpatient psychiatrist, J reported that she did not even know why she "made a fuss," but she was terrified that her boyfriend was cheating on her. She was tearful and sobbing throughout much of the exam. Her case manager, who was sitting in on the appointment, asked if getting a soda after the appointment would help. J stopped crying and beamed, "That would be great!"

J had a difficult childhood. Raised by her mother, J never knew her father but allegedly suffered abuse by her mother's boyfriends. J had diagnoses of PTSD and major depressive disorder (MDD). She was treated with sertraline for her

comorbid diagnoses of MDD and PTSD, as well as buspirone for anxiety.

Care was taken by the psychiatrist to rule out bipolar disorder, which can easily be confused for BPD. Some hallmarks of borderline personality were J's affective instability, which is associated with external stimuli, such as thinking her boyfriend was cheating, causing intense anxiety and sadness versus her happiness for a soda with her case manager. J also slept well, which is less consistent with bipolar disorder.

J had an involved treatment team, consisting of a therapist, behavioral support specialist, case management, and habilitation specialists. She attended weekly group therapy for anger management, as well as a separate women's group therapy for relationship issues. She was slowly making progress and did well at her supported employment placement.

The primary goal for J's treatment was for J to talk about her feelings rather than act on them. To accomplish this, her therapist met with her weekly to practice anger management techniques and work on recognizing feeling states.

As illustrated in Clinical Vignette 1, individuals with ID can display a characteristic pattern of BPD symptoms, which include the following:

- Unstable and potentially volatile interpersonal relationships, often characterized by over-reaction toward and verbal abuse of caretakers
- Impulsivity, as marked by global efforts at environmental disruption rather than the goal-directed patterns seen in the nondisabled population
- Labile affect, characterized by sudden shifts in feeling and expression of feeling
- Difficulties in controlling anger, along with excessive reactions to stimuli
- Self-injurious behavior, likely geared to gain attention rather than to complete suicide[1,5]

Psychiatrists are encouraged to use caution, as the above signs in persons with ID are sometimes misunderstood by clinicians and often interpreted as cognitive deficits, emotional immaturity, and neurodysregulation.[1,5,7]

It must be emphasized that staff cohesiveness is essential; if direct caregivers are untrained and/or inconsistent, the outcome will likely include disruptive emotional reactions within the staff, leading to obstacles in creating a therapeutic environment. The goals of treatment must include staff training and the development of existing resources to provide consistent and effective interventions that promote positive therapeutic outcomes.[7,9]

While BPD commonly co-occurs with mood and anxiety disorders, substance use disorders, and additional personality disorders,[10,11] in general, BPD can be associated with any person with neurocognitive dysfunction.[10] Although incidence of self-injurious behavior associated with BPD in the general population is relatively common, it has been shown that neurocognitive abnormalities further contribute to negative outcomes when vulnerable individuals are exposed to abuse or other forms of trauma during the developmental years.[10–12] This results in insecure self-image, disorganized relationships, and impaired ability to process situations and form secure attachments. Finding and maintaining healthy relationships can be especially difficult for individuals coming from dysfunctional backgrounds, as well as those with acute complex circumstances or limited coping strategies. Fear of abandonment is one of the most pronounced symptoms of an underlying personality disorder; in addition to addressing fear of abandonment, however, learning to manage intense anger, unstable moods, and self-harming behavior are of the utmost importance in terms of treatment goals.

Linehan[13] succinctly stated that children with disabilities enter the world with barriers that might correlate to the "poorness of fit" implicated as a vulnerability to developing BPD. Hollins and Sinason[14] added that parents of children with ID frequently struggle with their own grief and issues of loss, making attachments complicated and potentially dysfunctional. Parents prone to potentially being unable to adequately validate the child's experiences thus further contribute to the vulnerability to psychopathology. These factors all play critical roles in the development of a personality disorder in an individual with ID.

ANTISOCIAL PERSONALITY DISORDER

Although aggression is quite common in individuals with ID, and numerous factors that make an individual vulnerable to developing antisocial personality disorder commonly occur in this population, the diagnosis of antisocial personality disorder is not frequently used.[15,16] For example, presence of ADHD, abuse history, impoverished developmental upbringing, emotional and behavioral problems, minority race, poor family management and child-rearing practices, and family conflict due to antisocial parents are all common in both ID and antisocial personality disorder.[15,16] In addition, other characteristics related to ID, including impulsivity, acquiescence, and social desirability, might further put these individuals at risk.

There is little research regarding antisocial personality disorder in the ID population. It appears that clinicians hesitate to use this diagnosis, potentially due to concerns about the limited cognitive abilities of the patients or seemingly transparent defense mechanisms, as interpreted by staff. Douma et al[16] studied antisocial and delinquent behaviors in youths who had either borderline intellectual functioning or mild ID. In a sample of 1,556 subjects, 10 to 20 percent of individuals with ID exhibited antisocial or delinquent behavior that persisted over five years. The prevalence was higher in younger male individuals who likely had a comorbid conduct disorder, which appeared to be a consistent risk factor. Several studies have shown that individuals with mild ID have a higher prevalence of offending behaviors, compared to the general population and persons with more severe forms of ID.[15–18] In addition, inmates of penal institutions tended to have lower intelligence quotients compared to the general population.[19]

FICTIONAL CASE VIGNETTE 2

B was a 25-year-old European-American woman with mild ID. She presented to the mental health clinic with her adoptive mother, S, for continuation of mental healthcare when they moved to the area. S reported that "B has problems with stealing and anger. The more I try to regulate her, the more she acts up."

During the examination, B smiled and said, "Yeah, my mom is right. But I'm not doing that anymore, so you don't have to worry about me."

B had been prescribed risperidone 4mg by her previous psychiatrist, and both B and her mother agreed that it had not been effective in helping deal with B's presenting symptoms. S reported that, when left to her own devices, B would spend time with "shady characters" in her apartment

complex and community, which concerned her mother. B again smiled and said, "It's okay. They won't hurt me." B did not currently live with her mother, but rather lived in her own apartment, receiving 10 hours of direct care weekly.

B's parents adopted her from a large orphanage in Europe when she was five years old. Upon taking custody of her, they noticed that B had bruises and some unusual scars. After returning to the United States (US), they took her to the pediatrician, who confirmed their suspicions that B had been abused at her orphanage. S said that B was always a very friendly child who was very affectionate with everyone and that she especially took to her dad, who died four years ago. S reported, "She just seemed to do better with him. She and I have always been a little more distant."

B was diagnosed with ID in school and was well-liked, but always struggled with following rules. B was also working as part of a janitorial crew, contracted out to local businesses through the sheltered workshop. Since her father's death, her mother had remarried. B had been arrested for fighting several times since. Her mother believed that B was involved with the "wrong crowd."

B was given a provisional diagnosis of impulse control disorder, unspecified. Plans were made to begin decreasing the dose of her risperidone because of the adverse effect of weight gain. B also started weekly therapy to address the stress of relocating to the new area, now that her mother had remarried and the family had moved.

B's mother had a long-standing reward/punishment plan that allowed B to receive DVDs for good behavior and restricted her allowed carbohydrate intake with bad behavior. Weight control had been a long-standing issue, likely contributed to by the risperidone. Now that risperidone had been discontinued, B was on a strict, 1,500-calorie diet, as recommended by her family doctor. Despite this diet, B continued to gain weight—20 pounds over three months.

B was caught stealing several times. She was caught taking money and soda from peers at her workshop. Things also were discovered to be missing from the local businesses when B was out on her janitorial jobs. S found these missing items in B's house. When asked, B said that she took the items because people let her get away with it "because I have a disability." She said that her peers were "too stupid to have money, anyway." B stole her staff person's credit card and bought items from McDonald's and the local grocery store. She also had several different boyfriends, and when asked, she laughed and proudly explained, "They all give me the things that I want, but they don't know I don't care about any of them."

As Clinical Vignette 2 illustrates, while B's disorder might be rooted in a childhood diagnosis of an attachment disorder, she now meets the criteria for antisocial personality disorder. Her criminal behavior and lack of empathy for her victims are the most striking symptoms. While there remain mixed views on the effectiveness of treating antisocial personality disorder, B's therapist continued working with her and her team to reduce the harm that could come to B, as well as limit the harm that she could bring to others. Medication might be helpful on a symptomatic basis for depression, irritability, anxiety, or aggression, but is unlikely to bring about a significant change in her overall behavior or personality disorder.

PRINCIPLES OF TREATMENT FOR PERSONALITY DISORDERS

The gold standard of treatment for personality disorders remains psychotherapy, with the success of the therapy being dependent on the patient's diagnoses, motivation, insight, cognitive functioning, and willingness to change interpersonal patterns and interactions.[20] The studies reviewed all agree that the need for support and utilization of resources for individuals with comorbid ID and personality disorders distinguish them from persons with ID without personality disorders.[5] Overall, psychological and behavioral interventions are preferable to medications, unless there are co-occurring symptoms or conditions that could benefit from pharmacologic management. Any pharmacologic intervention should focus on the targeted symptoms of mood lability, depression, and psychosis, and must be used in combination with psychotherapeutic and behavioral strategies.[20] Patients presenting with Cluster A pathology might benefit from antipsychotic medications; those with Cluster B symptoms, including emotional lability and impulse control, might benefit from mood stabilizers. In the general population, individuals with personality disorders often have co-occurring substance use, depressive, and anxiety disorders; it is important that the clinician screen for these and treat appropriately.

Dialectical behavior therapy (DBT) was originally developed by Linehan for the treatment of BPD in the outpatient treatment setting.[13,20] DBT has been found to be effective in reducing self-injurious behavior and number of days hospitalized in patients with BPD. There is evidence that this form of treatment would benefit individuals with ID as well. First, DBT is a skills-based model consistent with the habilitative approach, already frequently utilized in other interventions for patients with ID. DBT recognizes that the individual in treatment has likely experienced or is currently experiencing an "invalidating" environment, where thoughts, feelings, and needs might not have been adequately recognized for numerous reasons. Furthermore, the promotion of self-advocacy of the individual would be beneficial for persons with ID.[20] This is consistent with traits of assertiveness, independence, and empowerment commended in persons with ID.

Multiple authors have outlined clinical pearls for the management and treatment of personality disorders in the ID population, which include the following:

- Focus on reducing risk of damage to self and others
- Establish a safe environment
- Educate staff
- Conceptualize the personality disorder in a therapeutic framework
- Debrief staff
- Encourage consistency, cohesiveness, and reliability
- Remain consistent in all aspects of treatment
- Provide a consistent daily schedule and clear behavioral goals
- Reduce staff turnover and provide reliable care and consistent work from physicians and therapists
- Give the patient concrete and easily understood rules of behavior, with the goal of eliminating specific negative behaviors
- Create rules that make clear the consequences of behavior and must be followed consistently across staff and across environments
- Give the patient a means of self-control (e.g., relaxation techniques, etc.)[5,7,10,13,20]

CONCLUSION

Morbidity and mortality are greatly increased in individuals with personality disorders. There are many potential consequences of personality disorders, including the loss of important relationships. A greater number of individuals with ID alone (i.e., with no personality disorder) lived with family versus persons diagnosed with concurrent ID and personality disorder. Personality disorders have a significant effect on rehabilitation and integration of persons with ID from hospitals to community settings; the presence of a personality disorder might thus result in a more restrictive environment, lower quality of life, and increased use of community resources. Although diagnosing personality disorders in individuals with ID is clinically significant for several reasons, many clinicians find there is a lack of diagnostic clarity and difficulty in applying standardized diagnostic instruments to individuals with ID. There is a clear need for consensus in diagnostic criteria that use objective measures specific to the developmental framework of the individual. Accurate diagnoses would have significant implications in reducing stigma, improving treatment options, increasing acceptance into community resources, and identifying and meeting specific care needs of individuals with ID. Finally, the presence or absence of a personality disorder would directly and significantly impact an individual's quality of life.

REFERENCES

1. American Psychiatric Association. *The Diagnostic and Statistical Manual of Mental Disorders, 5th edition*. American Psychiatric Association; 2013.
2. American Psychological Association. What causes personality disorders? 2010. https://www.apa.org/topics/personality-disorders/causes. Accessed 5 May 2022.
3. Putnam C. *Guidelines for Understanding and Serving People with Intellectual Disabilities and Mental, Emotional, and Behavioral Disorders*. Florida Developmental Disabilities Council, Inc; 2020.
4. Alexander R, Green F, O'Mahony B, et al. Personality disorders in offenders with intellectual disability: a comparison of clinical, forensic and outcome variables and implications for service provision. *J Intellect Disabil Res*. 2010;54(7):650–658.
5. Fletcher R, Barnhill J, Cooper S. *DM-ID-2: Diagnostic Manual, Intellectual Disability : A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability*. NADD Press; 2018.
6. Talia T, Coleman J, Riley K, et al. Standardized assessment accommodations for individuals with intellectual disability. *Contemp Sch Psychol*. 2018;22(4):443–457.
7. Project Air: A Personality Disorders Strategy. Intellectual disability and personality disorder. https://documents.uow.edu.au/content/groups/public/@web/@ihmri/documents/doc/uow184577.pdf. Accessed 5 May 2022.
8. Grenyer, BFS. An integrative relational step-down model of care: The Project Air Strategy for Personality Disorders. *ACPARIAN*. 2014;9:8–13.
9. Yuhas D. Untangling ties between autism and obsessive-compulsive disorder. *Scientific American*. 28 Feb 2019. https://www.scientificamerican.com/article/untangling-the-ties-between-autism-and-obsessive-compulsive-disorder1/. Accessed 1 May 2022.
10. Wink L, Erickson C, Chambers J, McDougle C. Co-morbid intellectual disability and borderline personality disorder: a case series. *Psychiatry*. 2010;73(3):277–287.
11. Grant B, Chou S, Goldstein R, et al. Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *J Clin Psychiatry*. 2008;69(4):533–545.
12. Dudas R, Lovejoy C, Cassidy S, et al. The overlap between autistic spectrum conditions and borderline personality disorder. *PLoS One*. 2017;12(9):e0184447.
13. Linehan M. *DBT Training Manual*. Guilford Press; 2014.
14. Hollins S, Sinason V. Psychotherapy, learning disabliies and trauma: new perspectives. *Br J Psychiatry*. 2000;176(1):32–36.
15. Webb Z. Personality disorder and individuals with intellectual disabilities. In: *Intellectual Disabilities and Personality Disorder: An Integrated Approach*. Pavilion Publishing; 2014.
16. Douma J, Dekker M, de Ruiter K, et al. Antisocial and delinquent behaviors in youths with mild or borderline disabilities. *Am J Ment Retard*. 2007;112(3):202–220.
17. Centers for Disease Control and Prevention. Safety and children with disabilities: aggression and violence. Updated 22 Jun 2018. https://www.cdc.gov/ncbddd/disabilityandsafety/aggression.html. Accessed 22 Apr 2022.
18. Gentile J, Cowan A, Dixon D. *Guide to Intellectual Disabilities. A Clinical Handbook*. Springer Publishing; 2019.
19. Garcia-Largo LM, Marti Agusti G, Martin-Fumado C, et al. Intellectual Disability Rates Among Male Prison Inmates. Int J Law Psychiatry. Review. 2020 May-Jun;70:101566
20. Lew M, Matta C, Watts D. DBT for individuals with intellectual disabilities: a program description. *Ment Health Aspects Dev Disabil*. 2006;9(1):1–9. ICNS