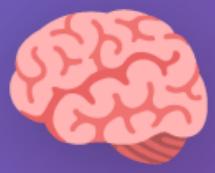
NCLEX RN • 2026 TEST PLAN STANDARD



Personality Disorders

High-Yield Clinical Judgment Review

💊 MENTAL HEALTH / PSYCH

A

ODD / ECCENTRIC

"MAD"
Paranoid • Schizoid • Schizotypal

B

DRAMATIC / ERRATIC

"BAD"
Antisocial • Borderline • Histrionic • Narcissistic

C

ANXIOUS / FEARFUL

"SAD"
Avoidant • Dependent • OCPD

📖 Overview & Pathophysiology

💡 DEFINITION / OVERVIEW

- **Personality Disorder (PD)** = enduring, inflexible pattern of inner experience & behavior that deviates markedly from cultural norms.
- Begins by **late adolescence/early adulthood**, pervasive across situations, and causes **significant distress or impairment**.
- **Ego-syntonic** 🔑 — client sees behavior as normal/acceptable → low insight, low motivation to change. (Contrast: OCD is ego-*dystonic*.)

🔬 PATHOPHYSIOLOGY (SIMPLIFIED)

Genetic vulnerability + Temperament → **Early trauma / attachment disruption / abuse** → **Maladaptive coping patterns solidify**

Dysregulation of serotonin, dopamine, norepinephrine → **Limbic / prefrontal cortex dysfunction** → **Persistent rigid personality pattern**

🚨 **Key point: PDs are not psychotic disorders — reality testing remains intact (except transient stress-induced psychosis in BPD & schizotypal).**

🎯 THE THREE CLUSTERS (DSM-5-TR)

CLUSTER A 🤨

"Odd / Eccentric" — MAD

- Paranoid
- Schizoid
- Schizotypal

↳ **Linked to schizophrenia spectrum**

CLUSTER B 🎭

"Dramatic / Erratic" — BAD

- Antisocial
- Borderline
- Histrionic
- Narcissistic

↳ **Highest NCLEX yield**

CLUSTER C 😨

"Anxious / Fearful" — SAD

- Avoidant
- Dependent
- OCPD

↳ **Linked to anxiety disorders**

🧠 MASTER MNEMONIC — "Weird, Wild, Worried"

Cluster A = Weird (odd, eccentric) • **Cluster B = Wild** (dramatic, emotional) • **Cluster C = Worried** (anxious, fearful)

Also known as: **MAD** / **BAD** / **SAD**

CLUSTER A

"MAD" — Odd, withdrawn, suspicious • Related to schizophrenia spectrum

Paranoid PD

"Everyone is out to get me."

KEY SIGNS	Pervasive distrust, reads hidden meanings, holds grudges, questions loyalty of friends/partners, quick to counterattack.
MANAGEMENT	**Be matter-of-fact & honest** — no surprises. Provide clear explanations. **Avoid excessive friendliness** (triggers suspicion). Same staff daily when possible.
TEACHING	Reality testing, cognitive reframing, stress-management. Encourage journaling of triggers.

Schizoid PD

"I prefer to be alone — always."

KEY SIGNS	Detached from social relationships, restricted/flat affect, no desire for close friends, indifferent to praise or criticism, solitary activities.
MANAGEMENT	**Respect need for solitude**. Don't push group therapy. Use brief, low-key interactions. Build trust slowly. Avoid forcing emotional expression.
TEACHING	Social skills training (voluntary), identify basic emotional states, simple communication scripts for work/daily life.

Schizotypal PD

"I have magical powers and see signs everywhere."

KEY SIGNS	Odd beliefs/magical thinking, ideas of reference, eccentric appearance, odd speech, social anxiety that **does not diminish** with familiarity. RED FLAG may have brief psychotic episodes under stress.
MANAGEMENT	**Reality orientation** without arguing about beliefs. Respectful, structured environment. Low-dose atypical antipsychotics may be used for transient psychosis.
TEACHING	Basic social skills, stress-reduction (these clients decompensate under stress), medication adherence education.

🧠 **Mnemonic — Remember the 3 S's of Cluster A**

SUSPICIOUS • SOLITARY • STRANGE

Suspicious = Paranoid (distrusts others) ▸ **Solitary** = Schizoid (prefers alone) ▸ **Strange** = Schizotypal (odd beliefs/behavior)

CLUSTER B

"BAD" — Dramatic, emotional, unpredictable • Highest NCLEX yield ⭐

😈 Antisocial PD

"Rules don't apply to me." (Age ≥18 + conduct Dx before age 15)

KEY SIGNS	Disregard for rights of others, deceitful, manipulative, impulsive, aggressive, **no remorse**, irresponsible. Often charming. RED FLAG aggression/violence risk.
MANAGEMENT	**Set firm, consistent limits** — document & enforce. **All staff on same page** (prevents manipulation). No bargaining. Matter-of-fact tone, no power struggles. Safety first!
TEACHING	Natural consequences of behavior, anger management, problem-solving. (Poor response to insight therapy.)

🌊 Borderline PD ⭐ HIGH YIELD

"Please don't leave me — I hate you, don't leave me!"

KEY SIGNS	**Splitting** (all-good/all-bad), frantic efforts to avoid abandonment, unstable relationships & identity, impulsivity, **self-harm** / suicidal gestures, chronic emptiness. RED FLAG **#1 suicide/self-injury risk among PDs.**
MANAGEMENT	**Safety FIRST** (remove harmful objects, 1:1 as needed). **Consistent limits** — same rules from every nurse. **Don't take splitting personally.** Validate feelings without validating behavior. **DBT is gold standard.**
TEACHING	Dialectical Behavioral Therapy (DBT): distress tolerance, emotion regulation, mindfulness, interpersonal effectiveness. Safety plan.

💃 Histrionic PD

"If I'm not the center of attention, I don't exist."

KEY SIGNS	Attention-seeking, seductive/provocative, shallow shifting emotions, dramatic speech, easily influenced, views relationships as more intimate than they are.
MANAGEMENT	Professional boundaries (seductive behavior common). **Maintain same-gender staff if possible.** Don't reinforce dramatic behaviors with excess attention. Model direct communication.
TEACHING	Identify real feelings vs dramatized ones, assertiveness training, healthy ways to get needs met.

👑 Narcissistic PD

"I'm special. You should feel lucky to care for me."

KEY SIGNS	Grandiosity, needs admiration, sense of entitlement, lacks empathy, exploits others, envious, arrogant. Fragile self-esteem underneath → **narcissistic rage** when challenged.
MANAGEMENT	Matter-of-fact, respectful tone. **Don't argue about grandiosity** — redirect to realistic goals. Set limits without shaming. Acknowledge strengths genuinely.
TEACHING	Empathy building, healthy self-esteem vs grandiosity, realistic self-appraisal, coping with criticism.

CLUSTER C

"SAD" — Fearful, anxious, clingy • Linked to anxiety disorders

😟

🙈 Avoidant PD

"I want closeness but I'm too afraid of rejection."

KEY SIGNS	Socially inhibited, feels inadequate, hypersensitive to criticism/rejection, avoids activities involving contact — but **desires connection** (vs schizoid who doesn't).
MANAGEMENT	**Convey acceptance**. Gradual exposure to social situations. Praise effort, not just outcomes. Group therapy (once trust is built).
TEACHING	Assertiveness training, CBT for negative self-beliefs, graduated social exposure, challenge "I'm inadequate" thinking.

🤦‍♀️ Dependent PD

"I can't survive without someone to take care of me."

KEY SIGNS	Excessive need to be taken care of, submissive & clingy, can't make decisions without reassurance, fears being alone, urgently seeks new relationship when one ends.
MANAGEMENT	**Promote independence** — do NOT do things for them that they can do themselves. Encourage decision-making, one small choice at a time. Avoid fostering dependence on the nurse.
TEACHING	Problem-solving, self-care/autonomy skills, assertiveness, building a support network (not just one caregiver).

📏 Obsessive-Compulsive PD (OCPD)

"There's only one right way — my way."

KEY SIGNS	Preoccupation with order, perfectionism, control, rigidity, workaholism, miserly, stubborn. **Ego-syntonic** (feels right). **NOT the same as OCD!**
MANAGEMENT	Provide structure & predictable routine. Involve client in plan of care. **Don't engage in power struggles** about rules. Gently challenge rigid thinking.
TEACHING	Flexibility & tolerating imperfection, relaxation techniques, time management, delegating tasks.

🚨 **CRITICAL NCLEX DISTINCTION — OCPD vs OCD: OCPD = personality trait, ego-syntonic, NO true obsessions or compulsions, patient feels their way is correct. OCD = anxiety disorder, ego-dystonic, unwanted intrusive thoughts + ritualistic compulsions cause distress.**

Priority Nursing Care & Pharmacology

PRIORITY NURSING INTERVENTIONS (ABCS • SAFETY • LIMITS)

1 SAFETY FIRST (Always the priority)

- **Assess** for suicidal/self-harm ideation every shift — especially BPD (#1 risk).
- **Remove** sharps, cords, belts, glass when self-harm risk identified.
- **Ensure** safe environment — 1:1 observation if active ideation or plan.
- **Assess** for violence risk in Antisocial PD (de-escalation, security nearby).

2 CONSISTENT LIMITS & BOUNDARIES (team-based)

- **Communicate** the plan of care across all shifts — same rules, same language.
- **Limit-setting** is therapeutic, NOT punishment. State rule + consequence clearly.
- **Don't** accept gifts, favors, or share personal info (manipulation risk).
- **Avoid** power struggles — state the limit once, then disengage.

3 THERAPEUTIC COMMUNICATION

- **Use** matter-of-fact, non-judgmental tone (esp. Antisocial, Narcissistic).
- **Validate** feelings without validating maladaptive behaviors.
- **Avoid** excessive cheerfulness with Paranoid/Schizoid — triggers mistrust.
- **Acknowledge** splitting ("I notice you say I'm great but another nurse is bad…").

4 PROMOTE INSIGHT & SELF-REGULATION

- **Encourage** journaling of triggers, emotions, and coping responses.
- **Refer** to evidence-based therapy: DBT (BPD), CBT (most PDs), group therapy.
- **Reinforce** adaptive behaviors with genuine positive feedback.

PHARMACOLOGY (NO DRUG CURES A PD — TARGET SYMPTOMS)

⚠️ No FDA-approved medication for any personality disorder. Pharmacotherapy targets co-occurring symptoms (depression, anxiety, psychosis, mood instability).

SSRIs (fluoxetine, sertraline)

MECHANISM	↑ serotonin in synapse
USE	Depression, anxiety, impulsivity (BPD)
SE	GI upset, sexual dysfx, ↑ suicidal ideation (esp. <25 yo)
NURSING	Full effect 4–6 wks; assess SI; never stop abruptly

Mood Stabilizers (lamotrigine, valproate)

MECHANISM	Stabilize neuronal firing
USE	BPD mood swings, impulsivity, aggression
SE	Lamotrigine: STEVENS-JOHNSON RASH 🚨; Valproate: liver, thrombocytopenia
NURSING	Teach: report rash IMMEDIATELY; titrate slowly; LFTs

Atypical Antipsychotics (olanzapine, risperidone, quetiapine)

MECHANISM	Block D2 + 5-HT2A receptors
USE	Schizotypal, BPD brief psychosis, anger/aggression
SE	Weight gain, ↑ glucose/lipids (metabolic syndrome), sedation, EPS (low)
NURSING	Monitor BMI, fasting glucose, A1c, lipids q3–6 mo

Benzodiazepines (lorazepam, alprazolam)

MECHANISM	↑ GABA → CNS depression
USE	Short-term anxiety ONLY
SE	Sedation, falls, DEPENDENCE & ABUSE 🚨
⚠️ AVOID	**In BPD & Antisocial PD (high addiction risk, disinhibition)**

⚠️ NCLEX TEST TRAPS — WHERE STUDENTS LOSE POINTS

⚠️ TRAP: **Setting limits is "mean" or "punishing" the client.**
✅ **Limit-setting is therapeutic — it provides structure, safety, and models healthy boundaries.**

⚠️ TRAP: **Picking "be friendly and warm" with a paranoid client.**
✅ **Use a matter-of-fact, neutral, honest approach. Excess warmth triggers suspicion.**

⚠️ TRAP: **Confusing OCPD with OCD.**
✅ **OCPD = ego-syntonic personality (no true rituals, feels "right"). OCD = ego-dystonic anxiety disorder (intrusive thoughts + distressing rituals).**

⚠️ TRAP: **Engaging with a BPD client's "splitting" (nurse A is great, nurse B is terrible).**
✅ **Team huddles + consistent rules across all staff. Never bad-mouth coworkers. State "the team agreed on this plan."**

⚠️ TRAP: **Assuming self-harm in BPD = suicidal intent.**
✅ **Self-injury often serves emotional regulation — but ALWAYS assess suicide risk and take every threat seriously.**

⚠️ TRAP: **Giving a benzo to a BPD or Antisocial PD client for anxiety.**
✅ **AVOID benzos — high abuse potential, disinhibition can worsen impulsivity & aggression.**

⚠️ TRAP: **Forcing a schizoid client into group therapy to "help them socialize."**
✅ **Respect their preference for solitude. Low-key, brief individual interactions are more effective.**

⚠️ TRAP: **Trying to argue a paranoid or schizotypal client out of their beliefs.**
✅ **Don't argue. Acknowledge the feeling, present reality calmly, redirect to concrete tasks.**

📘 PATIENT & FAMILY EDUCATION

- **DBT** = gold standard for BPD (distress tolerance, emotion regulation, mindfulness, interpersonal skills).
- **CBT** helps challenge rigid or distorted thinking in most PDs.
- Teach family: limit-setting at home, avoiding "rescuing," recognizing splitting & manipulation.
- Medication education: exact symptom target, 4–6 wk onset for SSRIs, **never stop abruptly**.
- Crisis/safety plan: warning signs, coping strategies, emergency contacts, crisis line 988.
- Encourage support groups, consistent follow-up, and avoiding substance use (↑ relapse of symptoms).
- Sleep hygiene, nutrition, exercise — stable routines reduce symptom flare-ups.

🧠 QUICK MEMORY BOOSTERS

🔹 **Cluster patterns:**
A = **MAD** (weird) ▸ B = **BAD** (wild) ▸ C = **SAD** (worried)

🔹 **PRAISE ME — Histrionic:**
Provocative • **R**elationships seem intimate • **A**ttention-seeking • **I**nfluenced easily • **S**peech impressionistic • **E**motional lability • **M**ake-up (theatrical) • **E**xaggerated

🔹 **SUSPECT — Paranoid:**
Spouse suspected • **U**nforgiving • **S**uspicious • **P**erceives attacks • **E**nemy/friend • **C**onfides in no one • **T**hreats perceived

🔹 **Avoidant vs Schizoid trick:**
Avoidant **wants** closeness but fears rejection 😟
Schizoid **doesn't want** closeness at all 🧊

🔹 **OCPD vs OCD:**
OCPD = "**P**ersonality, **P**roud of it" (ego-syntonic)
OCD = Distressing, unwanted (ego-dystonic)

⭐ FINAL NCLEX PEARL — Priority Ranking

When in doubt, prioritize in this order: **1) Safety (self-harm/violence) → 2) ABCs → 3) Consistent limits → 4) Therapeutic communication → 5) Insight/teaching.**
Remember: PDs are **ego-syntonic** — the client rarely seeks change. Your role is **structure, safety, and consistency** — not a cure.