

# Personality Disorders: Review and Clinical Application in Daily Practice

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Personality disorders have been documented in approximately 9 percent of the general U.S. population. Psychotherapy, pharmacotherapy, and brief interventions designed for use by family physicians can improve the health of patients with these disorders. Personality disorders are classified into clusters A, B, and C. Cluster A includes schizoid, schizotypal, and paranoid personality disorders. Cluster B includes borderline, histrionic, antisocial, and narcissistic personality disorders. Cluster C disorders are more prevalent and include avoidant, dependent, and obsessive-compulsive personality disorders. Many patients with personality disorders can be treated by family physicians. Patients with borderline personality disorder may benefit from the use of omega-3 fatty acids, second-generation antipsychotics, and mood stabilizers. Patients with antisocial personality disorder may benefit from the use of mood stabilizers, antipsychotics, and antidepressants. Other therapeutic interventions include motivational interviewing and solution-based problem solving. (*Am Fam Physician*. 2011;84(11):1253-1260. Copyright © 2011 American Academy of Family Physicians.)

**T**reatment of primary care patients who have challenging personality traits must be carefully managed by the family physician to ensure patient-centered quality medical care. Commonly encountered provocative patient behaviors include actions that are demanding, dependent, aggressive, angry, and manipulative; these behaviors often leave physicians feeling helpless, frustrated, irritated, or angry. Patients with personality disorders have increased utilization of primary care and mental health services.<sup>1,2</sup>

Personality disorders are an axis II diagnosis, allowing an axis I disorder (e.g., bipolar disorder) and a personality disorder to be listed concurrently for the same patient. Several studies have shown that personality disorders commonly occur with axis I diagnoses, which impact function and clinical prognosis.<sup>3-6</sup> The *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text rev. (DSM-IV-TR), defines personality disorder as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture.”<sup>7</sup> The pattern is inflexible and pervasive across a broad range of personal and social situations; leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning; is stable and

of long duration; and has an onset traceable to at least adolescence or early adulthood.

Studies have reported that 9 to 14.8 percent of patients have at least one personality disorder.<sup>5,8</sup> Many patients have multiple personality disorders or traits that span several types of disorders, and significant comorbidity exists with alcohol and chemical abuse, and with anger traits. Because the traits of personality disorders tend to be stable over time,<sup>9</sup> these disorders have been considered not amenable to treatment; however, multiple treatments are now available, including cognitive behavior therapy, dialectical behavior therapy, mentalization-based therapy, transference-focused psychotherapy, and pharmacotherapy (e.g., typical and atypical antipsychotics, antidepressants, mood stabilizers<sup>10,11</sup>).<sup>12,13</sup> Although these treatments have been studied for use in several personality disorders, most of the medical literature is limited to borderline personality disorder.

## Personality Disorder Types

Personality disorders are classified into clusters A, B, and C. Cluster A, characterized as odd or eccentric personalities, includes paranoid, schizoid, and schizotypal personality disorders. Cluster B, characterized as dramatic, emotional, or erratic personalities,

## SORT: KEY RECOMMENDATIONS FOR PRACTICE

<i>Clinical recommendation</i>	<i>Evidence rating</i>	<i>References</i>
Physicians should carefully articulate constructive criticism to patients with narcissistic personality disorder, because these patients may interpret this as humiliating or degrading and react with disdain, or they may counteract.	C	7, 17
Second-generation antipsychotics, mood stabilizers, and omega-3 fatty acid supplements can be used to treat patients with borderline personality disorder. These treatments may be combined with dialectical behavior therapy or psychodynamic psychotherapy.	B	21
A crisis and safety plan should be developed collaboratively for patients with a personality disorder, particularly those with borderline personality disorder.	C	35
Motivational interviewing and solution-based problem-solving techniques are useful for coping with problematic patient behaviors and attitudes driven by personality traits and personality disorders.	C	29-33

*A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to <http://www.aafp.org/afpsort.xml>.*

includes antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster C disorders, characterized as anxious or fearful, are more prevalent and include avoidant, dependent, and obsessive-compulsive personality disorders.

### CLUSTER A

Table 1 lists the DSM-IV-TR criteria for the cluster A personality disorders: schizoid (detachment from social relationships), schizotypal (acute discomfort with and reduced capacity for close relationships, as well as cognitive or perceptual distortions and behavioral eccentricities), and paranoid (pervasive distrust and suspiciousness of others).<sup>7</sup>

The prevalence of schizoid personality disorder ranges from 0.5 to 7 percent in the general population to as high as 14 percent in the homeless population.<sup>5,14,15</sup> Physicians may have difficulty establishing and maintaining a relationship with these patients, who may not respond to stimuli in a typical way.<sup>16</sup> Because persons with schizotypal personality disorder have intense anxiety in social situations with unfamiliar people, it is important to establish a therapeutic relationship.<sup>16</sup> The physician should adopt a professional stance, provide clear explanations, tolerate odd beliefs and behaviors, and avoid overinvolvement in the patient's personal or social issues.<sup>17</sup>

Approximately 3 percent of the U.S. population has schizotypal personality disorder.<sup>5</sup> This disorder may have a genetic component and may be a clinical precursor to schizophrenia. Numerous pharmacotherapies have been suggested for certain subtypes of this disorder, whereas patients with other subtypes may be more responsive to psychosocial intervention.<sup>18</sup>

Paranoid personality disorder has a prevalence of 0.5 to 2.5 percent in the general population, 2 to 10 percent among persons in outpatient settings, and 10 to 30 percent among persons in inpatient psychiatric settings.<sup>7</sup>

These patients are difficult to engage in a therapeutic relationship for medical or mental health issues. Physicians should provide a formal, honest, and professional discussion without being too friendly, too warm, or too humorous. Physicians should expect belittling comments, accusations, and potentially litigious threats from these patients, yet they should allow these patients to express grievances without confirming or confronting the paranoid beliefs.<sup>17,19</sup>

### CLUSTER B

There are four cluster B personality disorders: borderline (instability of interpersonal relationships and self-image, with marked impulsivity), histrionic (excessive emotionality and attention-seeking behavior), antisocial (disregard for and violation of the rights of others), and narcissistic (grandiosity, need for admiration, and lack of empathy). The diagnostic criteria from DSM-IV-TR are listed in Table 2.<sup>7</sup>

Borderline personality disorder has a prevalence of 1.6 percent in the general population.<sup>5</sup> It is the most studied and has the most detailed treatment recommendations,<sup>20</sup> usually involving a multimodal approach and numerous components of psychotherapy.<sup>12</sup> A recent Cochrane review found that second-generation antipsychotics, mood stabilizers, and dietary supplementation with omega-3 fatty acids have some beneficial effects in patients with borderline personality disorder. Treatment with antidepressants is not widely supported for patients with this disorder, but it may be helpful in those with comorbid conditions.<sup>21</sup> Physicians should avoid excessive familiarity with these patients because it can lead to mistrust. In addition, physicians should understand that although angry outbursts may occur, limits must be set, a venue for frequent follow-up (e.g., telephone or office visits) must be created, and clear explanations without technical jargon must be provided.<sup>17</sup>

**Table 1. Cluster A Personality Disorders**

**Diagnostic Criteria for 301.0 Paranoid Personality Disorder**

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
- (2) Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
- (3) Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
- (4) Reads hidden demeaning or threatening meanings into benign remarks or events
- (5) Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights)
- (6) Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
- (7) Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiological effects of a general medical condition.

NOTE: *If criteria are met prior to the onset of schizophrenia, add "premorbid" (e.g., "paranoid personality disorder [premorbid]").*

**Diagnostic Criteria for 301.20 Schizoid Personality Disorder**

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) Neither desires nor enjoys close relationships, including being part of a family
- (2) Almost always chooses solitary activities
- (3) Has little, if any, interest in having sexual experiences with another person
- (4) Takes pleasure in few, if any, activities
- (5) Lacks close friends or confidants other than first-degree relatives
- (6) Appears indifferent to the praise or criticism of others
- (7) Shows emotional coldness, detachment, or flattened affectivity

B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder and is not due to the direct physiological effects of a general medical condition.

NOTE: *If criteria are met prior to the onset of schizophrenia, add "premorbid" (e.g., "schizoid personality disorder [premorbid]").*

**Diagnostic Criteria for 301.22 Schizotypal Personality Disorder**

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Ideas of reference (excluding delusions of reference)
- (2) Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness; belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
- (3) Unusual perceptual experiences, including bodily illusions
- (4) Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
- (5) Suspiciousness or paranoid ideation
- (6) Inappropriate or constricted affect
- (7) Behavior or appearance that is odd, eccentric, or peculiar
- (8) Lack of close friends or confidants other than first-degree relatives
- (9) Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder.

NOTE: *If criteria are met prior to the onset of schizophrenia, add "premorbid" (e.g., "schizotypal personality disorder [premorbid]").*

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Histrionic personality disorder has a prevalence that ranges from less than 1 percent to 3 percent.<sup>5,22</sup> Patients with this disorder can present multiple challenges; they require empathy with boundary setting to limit potentially manipulative behaviors, such as suicidal gestures.<sup>22</sup>

Emphasizing objective data while maintaining a professional concern for the patient's feelings and emotions may be helpful.<sup>17</sup>

Antisocial personality disorder has a prevalence of 1 percent in the general population.<sup>5</sup> It is associated with

**Table 2. Cluster B Personality Disorders**

**Diagnostic Criteria for 301.7 Antisocial Personality Disorder**

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
- (1) Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  - (2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - (3) Impulsivity or failure to plan ahead
  - (4) Irritability and aggressiveness, as indicated by repeated physical fights or assaults
  - (5) Reckless disregard for safety of self or others
  - (6) Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  - (7) Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- B. The individual is at least age 18 years.
- C. There is evidence of conduct disorder with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.

**Diagnostic Criteria for 301.83 Borderline Personality Disorder**

- A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
- (1) Frantic efforts to avoid real or imagined abandonment. *NOTE:* Do not include suicidal or self-mutilating behavior covered in criterion 5.
  - (2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  - (3) Identity disturbance; markedly and persistently unstable self-image or sense of self
  - (4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). *NOTE:* Do not include suicidal or self-mutilating behavior covered in criterion 5.
  - (5) Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior
  - (6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
  - (7) Chronic feelings of emptiness
  - (8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
  - (9) Transient, stress-related paranoid ideation or severe dissociative symptoms

**Diagnostic Criteria for 301.50 Histrionic Personality Disorder**

- A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
- (1) Is uncomfortable in situations in which he or she is not the center of attention
  - (2) Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
  - (3) Displays rapidly shifting and shallow expression of emotions
  - (4) Consistently uses physical appearance to draw attention to self
  - (5) Has a style of speech that is excessively impressionistic and lacking in detail
  - (6) Shows self-dramatization, theatricality, and exaggerated expression of emotion
  - (7) Is suggestible (i.e., easily influenced by others or circumstances)
  - (8) Considers relationships to be more intimate than they actually are

*continued*

substance abuse, acute anxiety, delusional states, and factitious disorders.<sup>22</sup> Medications such as mood stabilizers, atypical antipsychotics, and antidepressants may have some effect on the anxiety, impulsivity, and anger components of this disorder.<sup>10</sup> However, a recent Cochrane review did not definitively show that pharmacologic treatment is effective.<sup>23</sup> This disorder may have social, legal, and financial implications; therefore, multiple treatment options must be considered. Because of the risk of manipulative behaviors by the patient, the physician should use caution

(especially in dealing with new, ill-defined illnesses), be fair and consistent, and set clear limits.<sup>17</sup>

Although only 1 percent of patients in the general population meet the full diagnostic criteria for narcissistic personality disorder, it is present in 2 to 16 percent of the clinical population.<sup>5</sup> These patients can be demanding, with an attitude of entitlement and “specialness,” but the physician should focus on concrete points and attempt to channel patient traits into improving their health.<sup>17</sup> Several medications are helpful in treating components

**Table 2. Cluster B Personality Disorders** (continued)

**Diagnostic Criteria for 301.81 Narcissistic Personality Disorder**

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- (2) Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- (3) Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
- (4) Requires excessive admiration
- (5) Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations)
- (6) Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends)
- (7) Lacks empathy; is unwilling to recognize or identify with the feelings and needs of others
- (8) Is often envious of others or believes that others are envious of him or her
- (9) Shows arrogant, haughty behaviors or attitudes

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of this disorder, such as anger and mood lability.<sup>10</sup> When diagnosing and treating patients with narcissistic personality disorder, physicians must acknowledge that the patient's behavior is protective of his or her sense of internal control and self-esteem.<sup>24</sup> Narcissistic functioning has two components: external and internal. External functioning serves as a protective armor (e.g., self-enhanced and self-preoccupied, controlling, insensitive, critical, aggressive, condescending, provocative), whereas internal functioning indicates vulnerability, dysregulation, and compromised abilities (e.g., low self-esteem, self-criticism, insecurity, inferiority, loneliness, isolation, hypersensitivity, fear, rage, shame). As such, constructive criticism to patients with narcissistic personality disorder should be carefully worded, because these patients may interpret this as humiliating or degrading and react with disdain, or they may counteract.<sup>7,17</sup>

**CLUSTER C**

Table 3 lists the DSM-IV-TR diagnostic criteria for the three cluster C personality disorders: avoidant (social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation), obsessive-compulsive (preoccupation with orderliness, perfectionism, and mental and interpersonal control), and dependent (submissive and clinging behavior, and fears of separation).<sup>7</sup>

Avoidant personality disorder occurs in 5.2 percent of the general population<sup>5</sup> and is common in persons with social phobia.<sup>22</sup> Pharmacotherapy and psychotherapy may provide some benefit.<sup>25</sup> Patients with avoidant personality disorder routinely respond to direct questions with "I'm not sure," and may seem evasive. Encouraging the patient in a nonjudgmental manner to report symptoms and validating the patient's concerns are helpful.<sup>17</sup>

Obsessive-compulsive personality disorder is present in approximately 2.4 percent of the general population<sup>5</sup> and is often confused with obsessive-compulsive disorder, which is an axis I diagnosis. Patients with this personality disorder generally exhibit traits that are somewhat adaptive and supportive of the ego and are seldom distressing, whereas patients with obsessive-compulsive disorder tend to have recurrent unpleasant thoughts and ritualized behaviors. Patients with obsessive-compulsive personality disorder tend to fear losing control and have increased attention to detail, to the point of missing the bigger picture. Physicians should be thorough with examinations and explanations, but should not focus on variables or uncertainties.<sup>17</sup> Psychotherapeutic therapies, including short-term inpatient therapy, have been successful for patients with obsessive-compulsive personality disorder.<sup>26</sup> Treatment with selective serotonin reuptake inhibitors may be helpful, especially if anxiety is present.<sup>27</sup>

Dependent personality disorder is the least prevalent of the cluster C disorders; it occurs in 0.6 percent of the general population<sup>5</sup> and is more common in victims of spousal abuse.<sup>28</sup> Physicians should provide reassurance and schedule routine follow-up (e.g., telephone or office visits) with the understanding that the patient may feel that urgent evaluations are necessary based on his or her sense of need, rather than on the medical necessity of the situation.<sup>17</sup>

**Problem-Focused Office Management Tools**

Family physicians may be more effective and optimistic when armed with concrete problem-focused tools that can be used in the 15-minute clinical visit. These tools are designed to avoid being drawn into the patient's

**Table 3. Cluster C Personality Disorders**

**Diagnostic Criteria for 301.82 Avoidant Personality Disorder**

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
- (2) Is unwilling to get involved with people unless certain of being liked
- (3) Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- (4) Is preoccupied with being criticized or rejected in social situations
- (5) Is inhibited in new interpersonal situations because of feelings of inadequacy
- (6) Views self as socially inept, personally unappealing, or inferior to others
- (7) Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

**Diagnostic Criteria for 301.6 Dependent Personality Disorder**

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- (2) Needs others to assume responsibility for most major areas of his or her life
- (3) Has difficulty expressing disagreement with others because of fear of loss of support or approval. NOTE: Do not include realistic fears of retribution.
- (4) Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
- (5) Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
- (6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
- (7) Urgently seeks another relationship as a source of care and support when a close relationship ends
- (8) Is unrealistically preoccupied with fears of being left to take care of himself or herself

**Diagnostic Criteria for 301.4 Obsessive-Compulsive Personality Disorder**

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- (2) Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
- (3) Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
- (4) Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
- (5) Is unable to discard worn-out or worthless objects even when they have no sentimental value
- (6) Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
- (7) Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
- (8) Shows rigidity and stubbornness

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pathologic personality traits, which often results in conflict. The techniques should be user-friendly, nonconfrontational, practical for use in a single patient visit or longitudinal continuity of care, and effective in primary care.

One tool is a modified version of motivational interviewing, which has been proven effective in adults<sup>29</sup> and children<sup>30</sup> (Table 4). The hypothetical patient is an example of a help-rejecter who exemplifies a cluster B mixture of the borderline and histrionic personality disorder types. The second tool is the problem-solving technique<sup>31</sup> (Table 5). For illustrative purposes, the step-by-step

presentation uses a dependent, clinging patient who displays a combination of symptoms of dependent and avoidant personality disorders. The motivational interviewing and problem-solving techniques are useful for coping with problematic patient behaviors and attitudes driven by personality traits and personality disorders.<sup>32,33</sup>

A core strategy for family physicians is an intervention based on active listening, mindfulness, and strengthening the connection to the patient's most cherished values. This intervention was designed for family physicians and addresses the concerns of emotional endurance and job satisfaction while caring for patients with

**Table 4. Step-by-Step Implementation of Motivational Interviewing**

<i>Step</i>	<i>Example</i>
1. Ask for permission to discuss the problem. Intent is to increase awareness of a problem that the patient is avoiding or denying.	"I'm concerned about our working relationship because it seems that you often dismiss my medical advice, but continue to ask for recommendations. Would it be okay for us to talk about this now?"
2. Elicit talk about change. Intent is to evoke thoughts about the disadvantages of the status quo, the advantages of change, specific change possibilities, and taking the first step toward change.	"What do you think will happen if the pattern of dismissing medical advice does not change?" "What could work for you if you decided to change?" "What might be some good things about changing?" "What would you be willing to try as a first step?"
3. Importance check. Intent is to have the patient rate his or her readiness and motivation to embrace behavior change, and to reinforce talk about change.	"On a scale of 1 to 10, with 1 being the lowest and 10 being the highest, how important is it for you to change the pattern that we have been discussing and to try the new approach?"
4. Ability check. Intent is to assess the patient's confidence in his or her ability to change and to overcome barriers to change.	"On a scale of 1 to 10, how confident are you that you will succeed in making a behavior change?" "What do you see as barriers to becoming more self-confident and to independently making informed choices, and how might you overcome these obstacles?"
5. Statement to terminate the motivational interview for today. Intent is to summarize the main discussion points, the patient's commitment to change, and the follow-up plan. It is important to state what the patient has agreed to, but also what he or she has not agreed to.	"If I may summarize our discussion, the problem in our working relationship appears to be the pattern of dismissing medical advice. You are motivated to make changes with my encouragement, and you are specifically going to work on _____." "Let's talk about this again in a couple of weeks to check on your progress, to talk about how you are coping with barriers to change, and to modify the solution a bit, if necessary."

**Table 5. Step-by-Step Implementation of Problem Solving**

<i>Step</i>	<i>Example</i>
1. Problem identification. Intent is to identify a specific problem that the physician perceives as interfering with good medical care.	"What is the problem here?" "What needs to be fixed?"
2. Consider multiple potential solutions. Intent is to collaboratively consider and brainstorm alternative solutions to the agreed-on problem.	"What might you do differently so that less care or support from others will not prevent you from following medical advice?" "What are the possible consequences of each option that was identified in our brainstorming discussion?"
3. Seek patient commitment. Intent is to get a commitment from the patient to try a new and preferred solution and to set a starting time.	"Which of these solutions are you willing to try?" "Please state exactly what you are going to do and when." "When are you willing to start?"
4. Summary statement. Intent is to summarize the main points of the discussion and schedule follow-up to assess outcomes so that the patient is not put off if the first solution does not work; to address new barriers that may arise; to encourage the patient to apply the solution consistently; and to model positive self-reinforcement for small initial success.	"If I may summarize our discussion, the problem seems to be a lack of self-confidence and, perhaps, a fear of disapproval when you need to make decisions about your medical care. These lead to being too dependent on others for making choices. You are willing to try a new solution or plan with my encouragement, and you are specifically going to do _____ starting _____. Does this summarize the plan fairly?" "Let's talk about this again in a couple of weeks to check on your progress, to talk about how you are coping with barriers to change, and to modify the solution a bit, if necessary."

personality disorders.<sup>34</sup> When treating patients with a personality disorder, physicians should consider a collaboratively developed crisis and safety plan, particularly for those with borderline personality disorder.<sup>35</sup>

Because of the longitudinal nature of the expression of personality disorders and the continuity of primary care,

family physicians should understand the frequency and characteristics of these disorders and their implications on the interpersonal relationship between the physician and patient. As effective treatments for personality disorders continue to emerge, family physicians can direct treatment and improve long-term patient care.

# Personality Disorders

**Data Sources:** PubMed and Google Scholar were searched using the keywords personality disorders and the individual personality disorders: cluster A, cluster B, cluster C, paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive. For each disorder, the search included treatments, guidelines, reviews, and psychotherapies. The search was not restricted to a particular timeline; however, the most recent peer-reviewed articles were identified from among the search results. Diagnostic criteria from the DSM-IV-TR and suggested diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., were also reviewed. Data sources included peer-reviewed manuscripts, published books, and Cochrane reviews. Search period: September and October 2010.

The authors thank the Mayo Clinic's Section of Scientific Publications for assistance in editing and proofreading the manuscript, and for reference verification.

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Author disclosure: No relevant financial affiliations to disclose.

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