Assessment and Management of Personality Disorders

RANDY K. WARD, M.D., *Medical College of Wisconsin, Milwaukee, Wisconsin*

Patients with personality disorders are common in primary care settings; caring for them can be difficult and frustrating. The characteristics of these patients' personalities tend to elicit strong feelings in physicians, lead to the development of problematic physician–patient relationships, and complicate the task of diagnosing and managing medical and psychiatric disorders. These chronic, inflexible styles of perceiving oneself and interacting with others vary widely in presentation. In the *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., these styles are categorized into three clusters based on their prominent characteristics: cluster A, the odd or eccentric (e.g., paranoid, schizoid, schizotypal); cluster B, the dramatic, emotional, or erratic (e.g., antisocial, borderline, histrionic, narcissistic); and cluster C, the anxious or fearful (e.g., avoidant, dependent, obsessive-compulsive). Knowledge of the core characteristics of these disorders allows physicians to recognize, diagnose, and treat affected patients. The goal of management is to develop a working relationship with patients to help them receive the best possible care despite their chronic difficulties in interacting with physicians and the health care system. Effective interpersonal management strategies exist for these patients. These strategies vary depending on the specific diagnosis, and include interventions such as the use of specific communication styles, the establishment of clear boundaries, limit setting on the patients' behavior and use of medical resources, and provision of reassurance when appropriate. Additionally, medications may be useful in treating specific symptoms in some patients. (Am Fam Physician 2004;70:1505-12. Copyright© 2004 American Academy of Family Physicians.)

Personality disorders are psychiatric disorders characterized by chronic patterns of inner experience and behavior that are inflexible and present across a broad range of situations. They have a marked impact on patients' interpersonal relationships, and social and occupational functioning, and can lead to problematic interactions in the medical setting. By definition, the symptoms of personality disorders cannot be caused by a major psychiatric disorder as diagnosed in the *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed. (DSM-IV), axis I,1 a medical disorder, or the effects of a substance. These disorders are coded on *DSM-IV* axis II, which is used to record personality disorders, personality traits, and mental retardation. This separate axis exists to ensure that appropriate attention is paid to these clinically significant disorders when a comprehensive psychiatric assessment is performed *(Table 1)*.[1,2]

Personality disorders are characterized by chronic patterns of inner experience and behaviors that are inflexible.

Personality disorders are heterogeneous in their clinical features and etiology *(Table 2)*.[2] Their symptom complexes are caused by combinations of hereditary temperamental traits, and environmental and developmental events. The relative percentages of genetic and environmental factors vary with each specific disorder.[3]

The lifetime prevalence of personality disorders in the general population is an estimated 10 to 13 percent.[4] Based on structured surveys, the prevalence rates of personality disorders in primary care outpatient settings may be as high as 20 to 30 percent.[5-7] The treatment of medical and psychiatric disorders is more complicated in patients with comorbid personality disorders. Studies have documented poorer treatment outcomes and health status, and higher rates of health care use and costs in patients with comorbid personality disorders.[6,8-14] Many patients with

Downloaded from the *American Family Physician* Web site at www.aafp.org/afp. Copyright© 2004 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the Web site. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.

TABLE 1
DSM-IV–TR General Diagnostic Criteria for a Personality Disorder

The rightsholder did not grant rights to reproduce this item in electronic media. For the missing item, see the original print version of this publication.

whom physicians experience problematic relationships, and who have been referred to in the literature as patients who are "difficult" have personality disorders.[15,16]

Diagnosis

The diagnosis of a personality disorder is based on the patient's behavior over time in a variety of situations. In the primary care setting, many potential sources of diagnostic data are available. Some personality disorders may be readily apparent, while others may be noted only in the course of time, or by elicitation of a formal psychiatric and social history.[2]

In the clinical setting, the patient's style of engagement may be inappropriate to the situation (e.g., distant, hostile, overly intimate, seductive, anxious). The interpersonal behavior of the patient also may elicit strong emotional reactions in the physician. There may be unrealistic expectations for the physician's availability, time, and ability to help the patient. Medical and psychiatric illnesses may present in an atypical fashion, and may not respond as expected to treatment. Reactions to illness may exacerbate and intensify the

TABLE 2
Descriptions of Personality Disorders

Cluster A—odd or eccentric	Cluster B—dramatic, emotional, or erratic	Cluster C—anxious or fearful
Paranoid	Antisocial	Avoidant
Pervasive pattern of mistrust and suspiciousness	Disregard for rights of others	Social inhibition
Begins in early adulthood	Violation of rights of others	Feelings of inadequacy
Presents in a variety of contexts	Lack of remorse for wrongdoing	Hypersensitivity to criticism
Schizoid	Lack of empathy	Dependent
Detachment from social relationships	Borderline	Excessive need to be taken care of
Restricted range of emotional expressions	Instability of interpersonal relationships, self-image, and affects	Submissive behavior
Schizotypal	Marked impulsivity	Fear of separation
Social and interpersonal deficits	Histrionic	Obsessive-compulsive
Cognitive or perceptual distortions and eccentricities	Excessive emotionality	Preoccupation with orderliness and perfectionism
	Attention-seeking behavior	Mental and interpersonal control
	Narcissistic	
	Grandiosity	
	Need for admiration	

Information from American Psychiatric Association. Dysfunctional personality traits. In: Diagnostic and statistical manual of mental disorders, 4th ed., primary care version. Washington, D.C.: American Psychiatric Association, 1995:169-74.

TABLE 3
Differential Diagnosis of Personality Disorder Symptoms or Change in Personality*

Adjustment reaction
Axis I psychiatric disorder
Central nervous system disorder
Medical disorder
Medication use
Substance abuse or dependence

**—Listed in alphabetical order.*

Information from American Psychiatric Association. Personality disorders. In: Diagnostic and statistical manual of mental disorders, 4th. ed., text revision. Washington, D.C.: American Psychiatric Association, 2000:685-729.

patient's personality characteristics, further hampering his or her ability to obtain proper care. The patient's insight into the presence of these disorders is usually limited or absent.

The psychosocial functioning of patients with personality disorders can vary widely. These patients' history of interpersonal relationships, educational and work history, psychiatric and substance abuse history, and legal history are important areas to review. Usually, marked impairments exist in significant areas of the patient's life, such as intimate relationships or occupational functioning. Some patients are globally impaired and function marginally overall.

Patients may meet the criteria for more than one personality disorder. Comorbid mood, anxiety, and substance abuse disorders are common, and should be identified and treated. When symptoms that may indicate a personality disorder, such as increased dependency, social isolation, obsessions, or poor impulse control, are identified, it is important to view them within the context of the patient's psychiatric and medical history.

Personality disorders are, by definition, chronic conditions. Patients with these disorders generally exhibit consistent patterns of behavior and coping throughout their adult lives. Axis I psychiatric disorders can present with patterns of symptoms similar to those of a personality disorder, but these symptoms usually have an identifiable onset, and remit or improve with appropriate treatment. A change in personality from baseline at any time, but particularly in adults and elderly persons, may indicate the onset of an axis I psychiatric disorder or a potentially serious underlying organic disorder.

When a personality change occurs, it is crucial to identify the new-onset condition that has precipitated the change *(Table 3)*.[1] This includes conditions such as psychiatric disorders (e.g., depression), substance abuse disorders (e.g., alcohol dependence), medical disorders (e.g., hyperthyroidism), and neurologic disorders (e.g., early dementia).[1] An initial screening evaluation that includes a medical, psychiatric, and social history; mental status examination; and physical examination is necessary to help narrow the diagnostic possibilities. Further laboratory studies, central nervous system imaging, consultation, and treatment decisions are based on these data.

Patients with personality disorders exhibit consistent patterns of behavior and coping throughout their adult lives.

Characteristics and Management Strategies

Personality disorders are chronic conditions that require specific management strategies. In the primary care setting, most efforts focus on maintaining and supporting the physician-patient relationship and establishing a working alliance. The goal is to ensure that the patient is able to receive appropriate medical care despite the difficulty he or she may have in interacting with the physician and the health care system. Most primary care interventions are interpersonal, with specific management strategies depending on the disorder. In some cases, psychiatric consultation, formal psychotherapy, or pharmacologic treatment may be indicated *(Table 4)*.[17]

CLUSTER A—THE ODD OR ECCENTRIC

Patients in this cluster—the paranoid, schizoid, and schizotypal—are uncomfortable in interpersonal situations, emotionally distant,

Many of the strategies commonly used to establish a therapeutic alliance can be ineffective and counterproductive in patients who have a cluster A personality disorder.

difficult to engage, and isolative *(Table 5)*.[18] In addition, the paranoid patient exhibits marked distrust and suspicion, and the schizotypal patient exhibits strange or quasi-delusional beliefs. Collectively, this cluster often is referred to as the "schizophrenic spectrum cluster" because of similarities to patients with schizophrenia in terms of clinical presentation, management strategies, and response to pharmacotherapy. These patients do not respond appropriately to affective cues from the physician, and are unable to form connections on a basic emotional level. When dealing with these patients, many of the strategies commonly used to establish a therapeutic alliance are ineffective or counterproductive.

In the clinical setting, these patients may be reluctant to seek care because of the necessary personal contact, they may interact in a manner that is distant and odd, and they may have bizarre ideas regarding their illness. Attempts by the physician to become emotionally close or to delve into their personal issues are seen as intrusive and tend to distance them further. When interacting with these patients, physicians should respect their need for interpersonal distance and adopt a respectful, somewhat distant professional stance. Medical information should be conveyed in a clear, straightforward fashion. Additionally, with paranoid and schizotypal patients who exhibit distrust or strange ideas, it is important not to directly challenge these ideas or become distracted by them.

TABLE 4
Personality Disorder Clusters, Target Symptoms, and Medication Recommendations

The rightsholder did not grant rights to reproduce this item in electronic media. For the missing item, see the original print version of this publication.

CLUSTER B—THE DRAMATIC, EMOTIONAL, OR ERRATIC

Patients in this cluster can be among the most challenging patients encountered in clinical settings *(Table 6)*.[18] They can be excessively demanding, manipulative, emotionally unstable, and interpersonally inappropriate. They may attempt to create relationships that cross professional boundaries and to place physicians in difficult or compromising positions. Physicians often experience strong emotional reactions to these patients. When dealing with such patients, physicians must be keenly aware of the issues of manipulative behavior, professional boundaries, limit setting, and monitoring their own emotional state.

The antisocial patient, with a persistent pattern of deceitfulness, impulsivity, and disregard for the rights of others, may present in the context of medicolegal issues, such as disability evaluation, seeking controlled substances, or in situations involving aggressive or violent behavior. Clinical scenarios involving possible malingering or substance abuse issues may raise "red flags" for this type of behavior. There also may be inconsistencies in the patient's presentation,

TABLE 5
Cluster A Personality Disorders: Manifestations and Management Strategies

Personality disorder	*Prominent features of disorder*	*Experience of illness*	*Problematic behaviors in medical setting*	*Management strategies*
Paranoid	Distrust, suspicion	Heightened sense of fear and vulnerability	Fear physician may harm, arguments, conflict	Adopt a professional stance, provide clear explanations, be empathetic to fears, avoid direct challenge to paranoid ideation.
Schizoid	Social detachment, emotional restriction	Anxiety because of forced contact with others	Delay seeking care, appear unappreciative	Adopt a professional stance, provide clear explanations, avoid overinvolvement in personal and social issues.
Schizotypal	Odd beliefs, socially isolative	Odd interpretations of illness, anxiety because of forced contact with others	Delay seeking care, odd beliefs, odd behavior	Adopt a professional stance, provide clear explanations, tolerate odd beliefs and behaviors, avoid overinvolvement in personal and social issues.

Adapted with permission from Feder A, Robbins SW, Ostermeyer B. Personality disorders. In: Feldman MD, Christensen JF. Behavioral medicine in primary care. 2d ed. New York: Lange Medical Books/McGraw-Hill Medical, 2003:231-52.

TABLE 6
Cluster B Personality Disorders: Manifestations and Management Strategies

Personality disorder	*Prominent features of disorder*	*Experience of illness*	*Problematic behaviors in medical setting*	*Management strategies*
Antisocial	Disregards rights of others	Anger, entitlement masking fear	Anger, impulsive behavior, deceit, manipulative behavior	Carefully investigate concerns and motives, communicate in a clear and nonpunitive manner, set clear limits.
Borderline	Instability in interpersonal relationships, self image, and affects; marked impulsivity	Terrifying fantasies about illness	Fear of rejection and abandonment, self-destructive acts, idealization and devaluation of physician	Avoid excessive familiarity; schedule regular visits; provide clear, nontechnical explanations; tolerate angry outbursts, but set limits; maintain awareness of personal feelings; consult psychiatrist.
Histrionic	Excessive attention-seeking behavior, emotionality	Threatened sense of attractiveness and self-esteem	Overly dramatic, attention-seeking behavior, inability to focus on facts and details, somatization	Avoid excessive familiarity, show professional concern for feelings, emphasize objective issues.
Narcissistic	Grandiosity, need for admiration, lack of empathy	Anxiety caused by doubts of personal adequacy	Demanding, attitude of entitlement, denial of illness, alternating praise and devaluation of physician	Validate concerns, give attentive and factual responses to questions, channel patient's skills into dealing with illness.

Adapted with permission from Feder A, Robbins SW, Ostermeyer B. Personality disorders. In: Feldman MD, Christensen JF. Behavioral medicine in primary care. 2d ed. New York: Lange Medical Books/McGraw-Hill Medical, 2003:231-52.

history, and physical examination. If the clinical picture indicates possible antisocial behavior, a thorough review of the patient's history, objective examination and testing, and possible consultation are necessary. Findings, assessments, recommendations, and limits must be clearly and firmly communicated to the patient. In some circumstances, it may be appropriate to obtain psychiatric or legal consultation.

Antisocial patients disregard the rights of others, and are deceitful and impulsive.

Managing borderline personality disorder can be difficult and confusing. Because of their instability in the multiple areas of interpersonal relationships, self image, affects, and impulsivity, these patients can present with a wide range of symptoms, including depression, anger, paranoia, extreme dependency, self mutilation, and alternating idealization and devaluation of the physician. Their lives tend to be chaotic. They transfer many of their dysfunctional feelings and conflicts to the physician and the medical encounter. A somewhat detached professional stance and clear limit setting in terms of availability, appointment frequency, appropriate behavior, and medication use are necessary to manage these patients successfully. It is crucial to monitor one's own feelings, and to refrain from responding inappropriately to verbal attacks and manipulation. The development of a formal behavioral treatment plan and insistence on participation in psychiatric care may be necessary to establish an effective working relationship.

Histrionic patients are uncomfortable if they are not the center of attention. They tend to be emotionally demonstrative and seductive, and use their appearance to attract the attention of others. As a result, the implications of illness and aging may have a profound impact on their psychologic functioning. The physician should maintain an awareness of these patients' interpersonal style, and be empathetic to their issues, while at the same time avoid responding inappropriately to emotional or seductive overtures. Additionally, the cognitive processes of these patients are overly emotional and impressionistic, leading to difficulties in dealing with facts, details, and decision making. As a result, they may require extra assistance in processing medical information.

Narcissistic patients, with their grandiose sense of self-importance, tend to be demanding and insist on special status and treatment in the physician-patient relationship. They can appear haughty and self-absorbed, exhibit denial of illness, and become easily enraged by perceived slights. The physician should try not to directly challenge their sense of entitlement, or to be put off by their anger and demands. Their concerns should be acknowledged, and they should be provided reassurance that they are receiving the best care available. Strategies that help patients to take an active role in dealing with their illnesses are helpful. Tactful negotiation and limit setting around patient demands for testing, treatment, and referrals may be necessary.

CLUSTER C—THE ANXIOUS OR FEARFUL

All patients in this cluster exhibit anxiety in some form *(Table 7)*.[18] Whether it is caused by fears of evaluation by others, abandonment, or loss of order, these patients experience uncomfortable ideas and sensations that cause distress and interfere with their functioning within the physician-patient relationship. The physician must use appropriate strategies to help allay this anxiety and establish an effective working relationship with these patients.

The patient with avoidant personality is essentially a shy, inhibited person who has feelings of inadequacy and low self-esteem.

The Author

RANDY K. WARD, M.D., is an assistant professor of family and community medicine, and psychiatry and behavioral medicine, and director of the combined family medicine/psychiatry residency program at the Medical College of Wisconsin in Milwaukee. He received his medical degree from Northwestern University Medical School, Chicago, where he also completed a residency and fellowship in psychiatry. Dr. Ward subsequently completed a residency in family practice at MacNeal Hospital, Berwyn, Ill., and the primary care faculty development fellowship at Michigan State University, East Lansing.

Address correspondence to Randy K. Ward, M.D., Medical College of Wisconsin, Family Medicine/Psychiatry Program, 1121 E. North Ave., Milwaukee, WI 53212 (e-mail: rward@mcw.edu). Reprints are not available from the author.

These patients are hypersensitive to perceived criticism, but have the capacity to develop appropriate relationships if they feel safe and accepted. These patients appear shy and withdrawn, may withhold information that they feel is potentially embarrassing, and may be reluctant to question or disagree with their physician. In the medical encounter, the physician should approach these patients with an accepting and attentive attitude, provide ample reassurance, and encourage them to report and discuss their symptoms and concerns.

The dependent patient struggles with the self-perception that he or she is unable to function adequately without the help of others. This leads to difficulties in decision making, motivation, assumption of responsibility, and in fears of being abandoned by significant others. Dependent patients go to excessive lengths to maintain their relationships and sense of safety. In the medical setting, particularly during times of illness, these patients rely heavily on their physician for guidance and support. Physicians can provide assistance, but must monitor their level of involvement, acknowledge their limitations, and resist making major decisions for the patient. Limits on the need for time and resources should be set empathetically and openly. Alternate sources of assistance, such as a family member, member of the clergy, or a therapist can be enlisted to help manage the patient in times of increased need.

Obsessive-compulsive patients are preoccupied with orderliness and control. They tend to "miss the forest for the trees" in their concern for details, rules, and organization. In the medical setting, they expect similar characteristics in their physician. These patients need to maintain a sense of control and become particularly anxious when dealing with uncertainty and "gray areas." The physician must be aware of the patient's style of information processing, and present medical issues in an appropriately organized format. However, caution should be exercised to prevent discussions from being derailed by the patient's obses-

Persons with obsessive-compulsive disorder are preoccupied with orderliness and control.

TABLE 7

Cluster C Personality Disorders: Manifestations and Management Strategies

Personality disorder	*Prominent features of disorder*	*Experience of illness*	*Problematic behaviors in medical setting*	*Management strategies*
Avoidant	Social inhibition due to fears of rejection or humiliation	Heightened sense of inadequacy, low self-esteem	Withholds information, avoids questioning or disagreeing with physician	Provide reassurance, validate concerns, encourage reporting of symptoms and concerns.
Dependent	Excessive need to be taken care of, submissive and clinging behavior	Fear of abandonment, helplessness	Urgent demands for attention, prolongation of illness behavior to obtain attention and care	Provide reassurance, schedule regular check-ups, set realistic limits on availability, enlist others to support patient, avoid rejection of patient.
Obsessive-compulsive	Preoccupation with orderliness, perfection, control	Fear of losing control of bodily functions and emotions	Fear of relinquishing control, excessive questioning and attention to details, anger about disruption of routines	Complete thorough history and examinations, provide thorough explanations, do not overemphasize uncertainty, encourage patient participation in treatment.

Adapted with permission from Feder A, Robbins SW, Ostermeyer B. Personality disorders. In: Feldman MD, Christensen JF. Behavioral medicine in primary care. 2d ed. New York: Lange Medical Books/McGraw-Hill Medical, 2003:231-52.

sional style. An effective tactic is to provide patients with assignments such as monitoring symptoms and reading on their condition, thus increasing their participation and sense of control. Offering reassurance and setting limits on time may be necessary.

PSYCHOPHARMACOLOGY

Psychotropic medications generally are viewed as an adjunctive treatment in the management of personality disorders. They can be helpful for some symptoms in some patients. Large studies are lacking, but an emerging body of data includes some small controlled studies. Three of the disorders, the schizotypal, borderline, and avoidant personalities, have received the most attention. Medication recommendations are based on extrapolations from these three disorders to the others in their respective clusters.

Specific medication-responsive target symptoms have been identified for each cluster. If these target symptoms are identified, a carefully monitored medication trial may be considered. *Table 4*[17] describes the basic target symptoms and medications for each of the three personality disorder clusters. Clusters A and C have fairly straightforward and limited target symptoms and medication options. Cluster B has multiple groupings of target symptoms and more complicated medication regimens. Psychiatric consultation should be considered for patients in whom the diagnosis is unclear, for complex treatment regimens, or for refractory symptoms.[17]

The author indicates that he does not have any conflicts of interest. Sources of funding: none reported.

REFERENCES

1. American Psychiatric Association. Personality disorders. In: Diagnostic and statistical manual of mental disorders, 4th ed., text revision. Washington, D.C.: American Psychiatric Association, 2000:685-729.
2. American Psychiatric Association. Dysfunctional personality traits. In: Diagnostic and statistical manual of mental disorders, 4th ed., primary care version. Washington, D.C.: American Psychiatric Association, 1995:169-74.
3. Oldham JM. Personality disorders. Current perspectives. JAMA 1994;272:1770-6.
4. Weissman MM. The epidemiology of personality disorders: A 1990 update. J Pers Disord 1993;7(suppl 1):44-62.
5. Moran P, Jenkins R, Tylee A, Blizard R, Mann A. The prevalence of personality disorders among UK primary care attenders. Acta Psychiatr Scand 2000;102:52-7.
6. Hueston WJ, Werth J, Mainous AG 3d. Personality disorder traits: prevalence and effects on health status in primary care patients. Int J Psychiatry Med 1999;29:63-74.
7. Casey PR, Tyrer P. Personality disorder and psychiatric illness in general practice. Br J Psychiatry 1990;156:261-5.
8. Hueston WJ, Mainous AG 3d, Schilling R. Patients with personality disorders: functional status, health care utilization, and satisfaction with care. J Fam Pract 1996;42:54-60.
9. Gross R, Olfson M, Gameroff M, Shea S, Feder A, Fuentes M, et al. Borderline personality disorder in primary care. Arch Intern Med 2002;162:53-60.
10. Rendu A, Moran P, Patel A, Knapp M, Mann A. Economic impact of personality disorders in UK primary care attenders. Br J Psychiatry 2002;181:62-6.
11. Moran P, Rendu A, Jenkins R, Tylee A, Mann A. The impact of personality disorder in UK primary care: a 1-year follow-up of attenders. Psychol Med 2001;31:1447-54.
12. Reich JH, Vasile RG. Effect of personality disorders on the treatment outcome of axis I conditions: an update. J Nerv Ment Dis 1993;181:475-84.
13. Reich J, Boerstler H, Yates W, Nduaguba M. Utilization of medical resources in persons with DSM-III personality disorders in a community sample. Int J Psychiatry Med 1989;19:1-9.
14. Patience DA, McGuire RJ, Scott AI, Freeman CP. The Edinburgh Primary Care Depression Study: personality disorder and outcome. Br J Psychiatry 1995;167:324-30.
15. Schafer S, Nowlis DP. Personality disorders among difficult patients. Arch Fam Med 1998;7:126-9.
16. Steinmetz D, Tabenkin H. The 'difficult patient' as perceived by family physicians. Fam Pract 2001;18:495-500.
17. Simeon D, Hollander E. Treatment of personality disorders. In: Schatzberg AF, Nemeroff CB. The American Psychiatric Publishing textbook of psychopharmacology. 3d ed. Washington, D.C.: American Psychiatric Publishing, 2004:1049-66.
18. Feder A, Robbins SW, Ostermeyer B. Personality disorders. In: Feldman MD, Christensen JF. Behavioral medicine in primary care. 2d ed. New York: Lange Medical Books/McGraw-Hill Medical, 2003:231-52.