

HOSPITAL PHYSICIAN®

FAMILY MEDICINE BOARD REVIEW MANUAL

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The *Hospital Physician Family Medicine Board Review Manual* is a study guide for residents and practicing physicians preparing for board examinations in family medicine. Each manual reviews a topic essential to current practice in the specialty of family medicine.

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Approach to Personality Disorders in Primary Care

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Table of Contents

Introduction	2
General Characteristics of Personality Disorders and Principles of Diagnosis and Management . . .	2
Paranoid Personality Disorder	4
Antisocial Personality Disorder	5
Borderline Personality Disorder	6
Dependent Personality Disorder	8
Summary	9
References	10

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Approach to Personality Disorders in Primary Care

John H. Porcerelli, PhD, ABPP, and Steven K. Huprich, PhD

INTRODUCTION

Primary care physicians are well aware of the frequency of depression in the general population and, therefore, the necessity of diagnosing and treating this disorder. In the United States, 16.2% of the population will meet diagnostic criteria for major depressive disorder at some point in their lifetime,¹ and at any given time, approximately 5% to 10% of primary care patients will qualify for this diagnosis.²

Recent studies indicate that nearly 50% of patients with a depressive disorder also meet criteria for a personality disorder (PD).^{3,4} PDs have an estimated incidence as high as 24% in the primary care setting.⁵ These disorders may be difficult to assess, pose the greatest threat to the development and maintenance of good physician-patient relationships, and if unrecognized, can lead to significant functional psychosocial impairment in patients. In addition, the presence of a PD can impair the recovery of patients with depression and other Axis I disorders.⁶ Because the diagnosis of PD requires an evaluation of the patient's long-term patterns of functioning, the continuity of care provided by primary care physicians places these physicians in an ideal position to make a diagnosis or to recognize the need for referral to a mental health practitioner.

This manual begins with a general description of PDs and an overview of the clinical approach to diagnosis and management of PDs in the primary care setting. This is followed by a review specifically focused on 4 PDs that have the potential to cause significant problems for both physicians and patients: paranoid PD, antisocial PD, borderline PD, and dependent PD. Of the many defined PDs, borderline PD and dependent PD are more likely to be encountered in the primary care setting.⁷ Paranoid PD and antisocial PD, while perhaps less common, are associated with profound interpersonal difficulties. For each disorder, we describe the condition, review the prevalence data and comorbidities, provide a case example, and discuss treatment/management strategies.

GENERAL CHARACTERISTICS OF PERSONALITY DISORDERS AND PRINCIPLES OF DIAGNOSIS AND MANAGEMENT

DEFINITION AND GENERAL DESCRIPTION

PDs have been described and classified in many ways but commonly are regarded as disorders of psychopathology less severe than the major psychoses but severe enough to impair occupational or interpersonal functioning. Common features in the various definitions of PDs are that the characteristics must be long-standing, persistent, and pervasive and must cause distress to the individual or others. The current *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* defines PDs as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”⁸ The DSM-IV-TR provides a general set of diagnostic criteria applicable to all PDs (**Table 1**).⁸

The DSM-IV-TR classifies PDs as Axis II disorders.⁸ The intent of placing PDs on a separate axis for diagnosis is to encourage clinicians to diagnose not only the patient's immediate clinical problem (eg, a depressive episode) but also his or her chronic maladaptive behavior and interpersonal problems. The DSM-IV-TR further categorizes PDs into 3 clusters (A, B, and C). Knowledge of the clinical manifestations within this cluster classification system is critical to diagnosis. In general, individuals with cluster A PDs (paranoid, schizoid, and schizotypal) tend to appear odd or eccentric. Those with cluster B PDs (antisocial, borderline, histrionic, and narcissistic) tend to appear overly emotional, dramatic, erratic, or unstable in their relationships. Individuals with cluster C PDs (avoidant, dependent, and obsessive-compulsive) tend to appear overly anxious, fearful, or needy.

DIAGNOSTIC APPROACH

Diagnosing PDs can be difficult in clinical practice,