Overview of personality disorders

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INTRODUCTION

Personality consists of enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited across numerous social and personal contexts. A personality disorder is diagnosed when personality traits are so inflexible and maladaptive across a wide range of situations that they cause significant distress and impairment of social, occupational, and role functioning. The thinking, displays of emotion, impulsivity, and interpersonal behavior of the individual must deviate markedly from the expectations of the individual's culture in order to qualify as a personality disorder.

Patients with personality disorders can significantly strain the doctor-patient relationship. Clinicians frequently lack training in how to recognize and manage personality disorders.

This topic provides an overview of the personality disorders. Borderline, antisocial, narcissistic, schizotypal personality disorders are reviewed in detail separately. Pharmacotherapy for personality disorders is also reviewed separately. Challenges to maintaining a therapeutic alliance in the treatment of patients with personality disorders and pathological personality traits are also discussed separately.

- (See "Personality disorders: Overview of pharmacotherapy".)
- (See "Approaches to the therapeutic relationship in patients with personality disorders".)
- (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)

- (See "Borderline personality disorder: Treatment overview".)
- (See "Borderline personality disorder: Psychotherapy".)
- (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)
- (See "Narcissistic personality disorder: Treatment overview".)
- (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)
- (See "Antisocial personality disorder: Treatment overview".)
- (See "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)
- (See "Schizotypal personality disorder: Treatment overview".)
- (See "Schizotypal personality disorder: Psychotherapy".)

CLASSIFICATION

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) Section II includes 10 personality disorders grouped into three clusters based upon descriptive similarities [1]:

- Cluster A characteristics – Individuals may appear odd and eccentric
  - Paranoid (see 'Paranoid' below)
  - Schizoid (see 'Schizoid' below)
  - Schizotypal (see "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis")
- Cluster B characteristics – Individuals often appear dramatic, emotional, or erratic
  - Antisocial (see "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis")
  - Borderline (see "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis")
  - Histrionic (see 'Histrionic' below)
  - Narcissistic (see "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis")

- Cluster C characteristics – Individuals often appear anxious or fearful
  - Avoidant (see 'Avoidant' below)
  - Dependent (see 'Dependent' below)
  - Obsessive-compulsive (see 'Obsessive-compulsive' below)

EPIDEMIOLOGY

The estimated mean international prevalence of personality disorders in the community is 11 percent [2]. Personality disorders may be slightly more common in males and the young, and are common among the poorly educated and unemployed, although individual personality disorders differ on gender and age. Obsessive-compulsive personality disorder is associated with higher education and income. These disorders are highly comorbid with each other and with other non-personality mental disorders.

The prevalence of personality disorders in clinical populations has been estimated to be over 64 percent [3]. Personality disorders were diagnosed by structured interview in 45.5 percent of 859 patients presenting for psychiatric outpatient treatment [4].

Mean prevalence rates have been reported for individual personality disorders in community based samples from 13 studies conducted in the United States (7 studies), Germany (3), Norway, Iceland, and the United Kingdom (1 each) between 1989 and 2011 (table 1) [2] and clinical samples from 9 studies conducted in the United States (4 studies), Italy (2), Norway (2), and Sweden (1) between 1985 and 2005 [3]. Avoidant personality disorder and obsessive-compulsive personality disorder are the most common in the community. Borderline personality disorder and avoidant personality disorder are the most common in clinical populations.

CLINICAL MANIFESTATIONS

The consistent presence of certain behaviors and traits, with onset in middle to late adolescence and continuing into adult life is particularly suggestive of a personality disorder [5]:

- Frequent mood swings
- Angry outbursts
- Social anxiety sufficient to cause difficulty making friends
- Need to be the center of attention
- Feeling of being widely cheated or taken advantage of

- Difficulty delaying gratification
- Not feeling there is anything wrong with one's behavior (ego-syntonic symptoms)
- Externalizing and blaming the world for one's behaviors and feelings

Clinical manifestations of individual personality disorders are as follows [1]:

- **Paranoid** – Distrust and suspiciousness of others such that their motives are interpreted as malevolent.

- **Schizoid** – Detachment from social relationships and a restricted range of expression of emotions in interpersonal settings.

- **Schizotypal** – Social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentric behavior. (See "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)

- **Antisocial** – Disregard for and violating the rights of others, lying, stealing, defaulting on debts, neglect of children or other dependents. (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)

- **Borderline** – Instability of interpersonal relationships, self-image, affects, and control over impulses. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)

- **Histrionic** – Excessive emotionality and attention seeking.

- **Narcissistic** – Grandiosity (in fantasy or behavior), need for admiration, and lack of empathy. (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis", section on 'Clinical manifestations'.)

- **Avoidant** – Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

- **Dependent** – Feelings of inadequacy, inability to make own decisions, submissiveness, avoidance of confrontation for fear of losing source of support.

- **Obsessive-compulsive** – Preoccupation with perfectionism, mental and interpersonal control, and orderliness, at the expense of flexibility, openness, and efficiency.

Manifestations in clinical care — Individuals with a personality disorder can pose challenges for clinicians, and manifestations of the disorder may compromise care. Barriers to developing

an effective doctor-patient alliance may arise related to patient distrust, irritability, poor communication skills, dependency, or excessive demands [6]. Patients run the risk of alienating health care providers with late night phone calls, angry outbursts, repeated visits or admissions, signing out against medical advice, or being otherwise noncompliant with recommended treatment.

The clinician's reactions to the patient's affect or interpersonal behavior (particularly a negative reaction in the clinician) can further challenge all aspects of the treatment, though this frustration, annoyance, and negative perception of the patient can also be useful diagnostically or at least point in the direction that one might be dealing with a patient who has a personality disorder. The clinician needs to be aware of and manage these feelings (often referred to as countertransference), perhaps through a discussion with a colleague, since it is very difficult to effectively treat a patient one does not like.

Dysfunctional behaviors related to medication issues that typify some types of personality disorder include (see "Personality disorders: Overview of pharmacotherapy"):

- Discontinuing prescribed medication in the personal belief that herbal therapy is more effective (narcissistic personality).
- Lying about compliance with treatment (antisocial personality).
- Misinterpretation of delay in the clinician returning a phone call, leading to feeling of rejection and acting out by stopping or overdosing on a medication (borderline personality).
- Worry about unusual side effects from a prescribed medication, such as blocking the body from absorbing essential nutrients or vitamins, or belief that one is being tricked by a generic substitution into taking something harmful (schizotypal personality).
- Becoming angry when not told of an infrequent or minor drug side effect one had looked up while researching his medications (obsessive-compulsive personality).

Patients with personality disorders often lack insight regarding the connection between their behaviors and interpersonal difficulties. Patients commonly externalize their difficulties, seeing the problem as how people react to them rather than themselves as the problem, and argue that their behavior was appropriate given the provocation by another. In therapy, the patient may similarly interpret the interpersonal difficulties as being generated by the therapist and not as a result or consequence of their own behavior.

The clinician's awareness of their affective reactions and interpersonal experiences with the patient can be useful in the recognition and management of patients with personality disorders. The clinician may feel angry, threatened, defensive, or incompetent, or may find it difficult to feel any emotional connection with the patient. Alternatively, the clinician may find themself preoccupied with the patient without any specific event or attribute that would reasonably induce such involvement. (See "Overview of the therapeutic relationship in psychiatric practice" and "Approaches to the therapeutic relationship in patients with personality disorders".)

IMPACT OF DISORDER

Personality disorders are important risk factors for a variety of medical and other psychiatric difficulties. Adverse outcomes for patients with personality disorders include:

- Physical injury from fights and accidents due to impulsive and reckless behavior [7-9]
- Suicide attempts [10,11]
- Unplanned pregnancy and high risk sexual behavior [12,13]
- Comorbid anxiety, mood, and/or substance use disorder [14,15]
- Less favorable response to treatment for depression, anxiety disorder, or substance use disorder [16-20]
- Comorbid physical disorders, including cardiovascular disease, arthritis, diabetes, and gastrointestinal conditions [21,22]
- Functional impairment (eg, self-care, work, and interpersonal functioning) [15,23]
- Premature death by accidents, natural causes, or suicide [24,25]; reduced life expectancy [26]

DIAGNOSIS

Two sets of criteria are used to diagnose a personality disorder in DSM-5-TR (below) [1]. The first describes general characteristics of a personality disorder. The second describes features specific to individual personality disorders. It is assumed that a patient's condition that meets the criteria for a specific personality disorder also meets the general criteria, but this is not made explicit in DSM-5-TR. DSM-5-TR also includes an Alternative Model for Personality

Disorders in Section III based on impairments in personality functioning and the presence of pathological personality traits [27]. (See "Dimensional-categorical approach to assessing personality disorder pathology".)

Personality disorder — The general diagnostic criteria for personality disorder are found in the table (table 2).

DSM-5-TR diagnostic criteria for individual personality disorders are described below.

Paranoid — DSM-5-TR diagnostic criteria for paranoid personality disorder are as follows [1]:

- 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 them.
  - 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 them.
  - 4. Reads hidden demeaning or threatening meanings into benign remarks or events.
  - 5. Persistently bears grudges (ie, is unforgiving of insults, injuries, or slights).
  - 6. Perceives attacks on their 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 bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," ie, "paranoid personality disorder (premorbid)."

Schizoid — DSM-5-TR diagnostic criteria for schizoid personality disorder are as follows [1]:

- 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 bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," ie, "schizoid personality disorder (premorbid)."

Schizotypal — DSM-5-TR diagnostic criteria for schizotypal personality disorder are described separately. (See "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)

Antisocial — DSM-5-TR diagnostic criteria for antisocial personality disorder are described separately. (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)

Borderline — DSM-5-TR diagnostic criteria for borderline personality disorder are described separately. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)

Histrionic — DSM-5-TR diagnostic criteria for histrionic personality disorder are as follows [1]:

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 they are 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 (ie, easily influenced by others or circumstances).
- 8. Considers relationships to be more intimate than they actually are.

Narcissistic — DSM-5-TR diagnostic criteria for narcissistic personality disorder are described separately. (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

Avoidant — DSM-5-TR diagnostic criteria for avoidant personality disorder are as follows [1]:

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.

Dependent — DSM-5-TR diagnostic criteria for dependent personality disorder are as follows [1]:

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 their 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 their 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 themself.
- 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 themself.

Obsessive-compulsive — DSM-5-TR diagnostic criteria for obsessive-compulsive personality disorder are as follows [1]:

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 (eg, is unable to complete a project because their 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 their 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.

APPROACH TO MANAGEMENT

A treatment plan should be developed, discussed and modified over time with input from the patient and others involved in their support. This treatment plan for personality pathology may include individual and group therapy, medication, self-education, specialized substance use disorder treatment, partial hospitalization, or brief hospitalization during times of crises. Medications are generally used only as adjuncts to psychotherapy in patients with personality disorders.

Referral to a mental health professional — Patients significantly impaired by a personality disorder will most often benefit from early referral to a mental health professional. Such patients often require much time and often particular skills are needed in dealing with these complicated patients, and the primary care clinician may not have the expertise or available time to address their needs. Additionally, mental health professionals vary in their level of comfort and experience treating patients with personality disorders.

New approaches to the treatment of individuals with personality disorders have been developed to address the shortage of mental health resources in some areas. One approach, “good psychiatric management” has been developed for use by “general practice” clinicians without specific expertise to address borderline personality disorder [28]. (See "Borderline personality disorder: Psychotherapy", section on '"Good psychiatric management"'.)

Discussing the diagnosis — To have a frank and open discussion about treatment options with a patient, the diagnosis should be discussed with him/her in most cases. Many mental health professionals are reluctant to discuss the diagnosis of a personality disorder, for a number of reasons including:

- The clinician's fear that the patient will get angry at them, especially when the patient is emotionally labile, paranoid, or quick to anger.
- The diagnosis is often felt to be less than clear, having been impacted by the patient's cognitions, affect, and interpersonal behavior, compounded by countertransference, and further affected by other difficult feelings that arise in both the patient and therapist during the course of the treatment.
- The clinician may feel guilty about applying a diagnosis of personality disorder to a patient due to perceptions of negative connotations and stigma.

The only way to confront the negative impressions and stigma is to educate the patient as to what we know about the diagnosis. Among the personality disorders, only guidance for borderline personality disorder about how to discuss the diagnosis with the patient is available [26].

The therapist might begin the discussion with the patient by labeling it (eg, "I would like to have a frank discussion and interchange about your diagnosis"). The clinician should explain why the therapist thinks the patient does have a personality disorder, while constantly being sensitive to the fact that the patient probably automatically attaches stigma, if not denigration, to the diagnosis.

The discussion should take place when there is enough time for a full and frank interchange. The patient should be encouraged to ask questions, to disagree, and to express whatever concerns they might have about being labeled with the diagnosis. The patient should be encouraged to make note of any thoughts or concerns about the discussion that should come to mind during the session or between sessions. The responses from the therapist should be both empathic as well as framed in the spirit of educating the patient about the diagnosis and empathizing with the idea that there are many misconceptions that would lead one to not want to be labeled with the diagnosis.

The clinician-patient relationship — For any patient, how a treatment plan is presented, including discussion of medication side effects, the usual time course to response, possible postoperative complications, anticipated pain, etc influences compliance with the plan. Guidelines about when and how to contact the treating clinician are helpful. This

communication takes on even greater importance for patients with personality disorder. Compared to the general population, patients with personality disorder have greater sensitivity to side effects, tend to take more of a drug than prescribed and more alternative medications (herbals and other natural treatments), and are at increased risk for concurrent use of illicit drugs and alcohol. A family member, spouse, or friend can be recruited to help the patient, if they agree, to maintain adherence to prescribed medication or rehabilitation regimen. This can be particularly helpful during a crisis, when heightened emotions, eg, impulsiveness or hopelessness may lead them to suddenly interrupt a work-up or treatment.

Problems that may arise in the clinical management of the care of patients with a personality disorder are best managed by fostering a relationship in which the patient is comfortable talking about concerns, although direct communication often does not come easily to people with personality disorder. It is sometimes most efficient to tell a patient to call the office or the nurse if they should have a worry about a treatment plan. In the case of medication, one might say something such as "I certainly do not want you to take a medication that is making you feel worse, but I would also hate to have you stop a medication because you thought you have a reaction. Often the body takes a few days to adjust to the medication so please let us know if you have concerns." (See 'Manifestations in clinical care' above and "Approaches to the therapeutic relationship in patients with personality disorders".)

Psychotherapy — Psychotherapy is generally regarded as first-line for patients with personality disorders [29-32]. Medication may be used as an adjunctive treatment. (See "Borderline personality disorder: Psychotherapy" and "Narcissistic personality disorder: Treatment overview" and "Schizotypal personality disorder: Psychotherapy" and "Personality disorders: Overview of pharmacotherapy" and "Overview of the therapeutic relationship in psychiatric practice" and "Approaches to the therapeutic relationship in patients with personality disorders".)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Personality disorders".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, “The Basics” and “Beyond the Basics.” The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading

level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Borderline personality disorder (The Basics)" and "Patient education: Antisocial personality disorder (The Basics)")

SUMMARY AND RECOMMENDATIONS

- **Personality disorder** – A personality disorder is diagnosed when personality traits are so inflexible and maladaptive across a wide range of situations that they cause significant distress and impairment of social, occupational, and role functioning. Symptoms must deviate markedly from the expectations of the individual's culture in order to qualify as a personality disorder. (See 'Introduction' above.)

- **Classification** – Personality disorders are grouped into three clusters in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (see 'Diagnosis' above and 'Classification' above):

  - **Cluster A characteristics** – Individuals may appear odd and eccentric; the disorders include paranoid, schizoid, and schizotypal personality disorders. (See 'Paranoid' above and 'Schizoid' above and "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)

  - **Cluster B characteristics** – Individuals often appear dramatic, emotional, or erratic; the disorders include antisocial, borderline, histrionic, and narcissistic personality disorders. (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis" and "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis" and 'Histrionic' above and "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

- **Cluster C characteristics** – Individuals often appear anxious or fearful; the disorders include avoidant, dependent, and obsessive-compulsive personality disorders. (See 'Avoidant' above and 'Dependent' above and 'Obsessive-compulsive' above.)

- **Clinical manifestations** – The predominant clinical manifestations of personality disorders vary by the specific disorder. Individuals with a personality disorder may pose challenges for clinicians and some manifestations of the disorder may compromise care. Barriers to developing an effective doctor-patient alliance may arise related to patient distrust, irritability, poor communication skills, dependency, or excessive demands. (See 'Manifestations in clinical care' above.)

  Individuals with personality disorders often lack insight regarding the connection between their behaviors and interpersonal difficulties and often externalize their difficulties, seeing the problem as how people react to them rather than stemming from themselves. (See 'Clinical manifestations' above.)

- **Impact of disorder** – Individuals with a personality disorder are at increased risk for adverse outcomes related to physical trauma, suicide, substance use disorders, and concurrent other mental and physical disorders. Patients often have difficulty understanding their conditions and establishing rapport with their clinicians. (See 'Impact of disorder' above.)

- **Approach to management** – We generally regard psychotherapy as the first-line treatment for patients with personality disorders. We often use medications as adjunctive treatment along with psychotherapy. (See 'Approach to management' above.)

  We refer individuals impaired by a personality disorder for treatment with a mental health profession early in the treatment. (See 'Referral to a mental health professional' above.)

  We typically have an open discussion about treatment options and diagnosis with the patient. We believe it is essential to confront the negative impressions and stigma by educating the patient about the diagnosis. (See 'Discussing the diagnosis' above.)

  Problems that may arise in the clinical management of the care of patients with a personality disorder are best managed by fostering a relationship in which the patient is comfortable talking about concerns, although direct communication often does not come easily to people with personality disorder.

  The clinician's awareness of their affective reactions and interpersonal experiences with the patient can be useful in the recognition and management of patients with personality

disorders.

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