



## Complete Summary

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### GUIDELINE TITLE

Personality disorders in patients with HIV/AIDS. Mental health care for people with HIV infection.

### BIBLIOGRAPHIC SOURCE(S)

Personality disorders in patients with HIV/AIDS. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2006. p. 1-20. [12 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Working with patients' personalities and styles. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 19-23.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection/acquired immunodeficiency syndrome (AIDS)
- Personality disorder

### GUIDELINE CATEGORY

Diagnosis  
Evaluation

Management  
Treatment

### **CLINICAL SPECIALTY**

Allergy and Immunology  
Family Practice  
Infectious Diseases  
Internal Medicine  
Psychiatry

### **INTENDED USERS**

Advanced Practice Nurses  
Health Care Providers  
Physician Assistants  
Physicians  
Public Health Departments

### **GUIDELINE OBJECTIVE(S)**

- To present an overview of fixed patterns of behavior and interpersonal relationships that characterize personality disorders
- To provide guidelines for management of personality disorders in human immunodeficiency virus (HIV)-infected patients

### **TARGET POPULATION**

Human immunodeficiency virus (HIV)-infected persons with personality disorders

### **INTERVENTIONS AND PRACTICES CONSIDERED**

#### **Evaluation**

1. Patient assessment for any underlying conditions (differential diagnosis)
2. Screening for domestic violence
3. Mental status evaluation including cognitive function

#### **Management/Treatment**

1. Effective communication with patients
2. Using an interdisciplinary team
3. Developing a treatment plan
4. Specific approaches to patients depending on cluster and patient subtype
5. Individual and group psychotherapies
6. Referral to human immunodeficiency virus (HIV)-specific programs
7. Referral to a mental health professional

### **MAJOR OUTCOMES CONSIDERED**

Not stated

## METHODOLOGY

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

Not stated

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus (Committee)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

### **METHODS USED TO ANALYZE THE EVIDENCE**

Review

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

### **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation

to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Not stated

# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

### **Key Point:**

Human immunodeficiency virus (HIV)-infected patients who present with maladaptive personality traits and behaviors may have other causative or co-occurring medical, mental health, and/or social disorders that require intervention.

Please refer to the original guideline document for the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) definition of personality disorders grouped into three "clusters" based on shared descriptive features:

- Cluster A - odd, eccentric
- Cluster B - dramatic, emotional, or erratic
- Cluster C - anxious or fearful

### **Differential Diagnosis for Personality Disorders**

Clinicians should assess patients with maladaptive behaviors for any treatable underlying medical, mental health, or social disorders that may cause or exacerbate these behaviors.

Refer to Table 2 in the original guideline document for medical, psychiatric, and social disorders that may present with maladaptive behavior.

#### *Patients Who Are Victims of Domestic Violence*

Clinicians should screen patients for domestic violence annually and when patients display inhibited, avoidant, excessively emotional, or submissive behavior.

#### *Patients With Low or Borderline Intelligence*

Clinicians should perform a mental status evaluation that includes cognitive function of patients who are suspected of having cognitive deficiencies.

### **Management of Patients with Personality Disorders**

Primary care clinicians should consult a mental health professional when the medical staff is unsuccessful in persuading the patient to replace old, maladaptive patterns of behavior with alternative, more adaptive behaviors.

Clinicians should clearly instruct the medical support staff about how to manage crises caused by patients with personality disorders, such as isolating the patient from other patients or contacting emergency services, when a crisis arises in the waiting area, laboratory, or other patient care areas.

#### **Key Point:**

The diagnosis of a specific personality disorder may not be as important as identifying and focusing on specific personality traits that make treatment planning and provision of health care difficult. The medical staff's principal objective should be to help patients maximize health-oriented behaviors.

#### *General Approach to Patients With Personality Disorders*

##### Effective Communication

Clinicians should help all members of the staff develop and enhance their skills for working with patients with personality disorders.

All staff members who interact with patients who present disruptive behavior should convey the message that the staff's intent is to assist the patient in obtaining necessary medical care and to improve the patient's function.

Clinicians should clarify for the patient the role and responsibility of each staff member, as well as the patient's own responsibility for his/her treatment.

<b>Table. General Guidelines for Effective Communication and Establishing a Therapeutic Provider-Patient Relationship</b>
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- |   |
|---|
| <ul style="list-style-type: none"><li>• Listen carefully to identify the patient's agenda</li><li>• Maintain eye contact</li><li>• Use body language that conveys support and respect; avoid abrupt</li></ul> |
|---|

**Table. General Guidelines for Effective Communication and Establishing a Therapeutic Provider-Patient Relationship**

<p>movements</p> <ul style="list-style-type: none"> <li>• Communicate in an unhurried manner</li> <li>• Avoid the use of humor that may signify disrespect or lack of professionalism</li> <li>• Offer choices and options whenever possible; this will involve the patient and help share responsibilities of care</li> </ul>
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Interdisciplinary Team

Because management of patients with personality disorders can be stressful for all staff members, a team approach that focuses on supportive, effective communication among everyone involved in the patient's treatment should be used when developing a treatment plan.

**Key Point:**

Some patients with severe personality disorders may have styles of interaction that could foster conflict among patients, clinicians, and other staff. A team approach that relies on supportive, effective communication among everyone involved in the patient's treatment is essential.

*Approach to Specific Patient Types*

<b>Recommended Approaches to Personality Types</b>	
<b>Cluster and Patient Subtype</b>	<b>Recommended Approaches</b>
<b>Cluster A -- Odd or Eccentric</b>	
Guarded, suspicious, argumentative patients	Acknowledge the patient's perception of the world, without debate or agreement, and try to focus his/her attention on healthcare treatment. Maintain a respectful, professional distance; the patient may appreciate a clinician who is more formal and "business-like."
Aloof or uninvolved patients	Show that the patient's style is understood and his/her privacy is respected. Explain the need for personal questions but do not push the patient to increase social involvement.
Idiosyncratic or eccentric patients	Provide a consistent approach that addresses the patient's complaints and beliefs; neither challenge the patient's beliefs nor reinforce his/her perspective.
<b>Cluster B -- Dramatic, Emotional, or Erratic</b>	
Dramatic, dependent, and overdemanding patients	Set limits on interactions with the patient to prevent excessive and unrealistic demands from him/her. Refer the patient, if needed, to programs that extend his/her social and healthcare support networks.
Dramatic, emotionally involved, seductive, and captivating patients	Demonstrate a supportive attitude toward the patient. Maintain professional boundaries to prevent the patient from provoking unhelpful responses.
Superior patients	Recognize and support the patient's strengths and

<b>Recommended Approaches to Personality Types</b>	
<b>Cluster and Patient Subtype</b>	<b>Recommended Approaches</b>
	achievements, and show interest in the patient's opinions. Demonstrate competence without challenging the patient's need to feel superior.
Sociopathic patients	Set realistic limits on patient visits; never tolerate aggressive behavior or any other behavior that creates an unsafe environment. Consider a mental health consultation, which may help with development of an appropriate treatment plan.
<b>Cluster C - Anxious, Fearful</b>	
Orderly, controlled, and controlling patients	Clearly state the treatment approach and give the fullest details possible, with a discussion about treatment rationale and other treatment options. Always avoid a struggle over who is in charge.
Anxiously avoidant patients	Show patience and availability and express empathy toward the patient's fears.
Anxiously dependent and clinging patients	Consider providing more frequent but briefer appointments; scheduling interactions with the patient may help minimize his/her excessive demands at inconvenient times. Forewarn him/her of change, such as vacations and other absences.
Controlling, avoidant, and dependent patients	Directly address concerns about the patient's behavior, suggesting that it may indicate underlying feelings about his/her illness and treatment. Encourage medical staff to avoid feeling resentful toward a patient who "acts out" his/her frustration.

### *Treatment of Personality Disorders*

Clinicians should refer patients to mental healthcare professionals when complex mental status evaluations become necessary or when the patient's behavior leads to instability or jeopardizes effective treatment.

Clinicians should develop treatment plans that focus on helping patients with personality disorders change their behavior and style of interacting with others in the healthcare setting and, if possible, in other settings as well.

Clinicians should be aware of symptoms in these patients that suggest a comorbid psychotic disorder.

### **Key Point:**

Although long-term intensive, individual psychotherapy is necessary for fundamental, lasting change in patients' personalities, briefer psychotherapies may help patients modify their maladaptive behaviors.

### **CLINICAL ALGORITHM(S)**

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Patients with personality disorders often present challenging therapeutic situations. Clinicians can interact with these patients effectively with a plan that focuses on support between the patient and the care team.

### POTENTIAL HARMS

Not stated

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening, or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (*HIV clinical practice guidelines*, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience.
- Define target audience (providers, consumers, support service providers).
  - Are there groups within this audience that need to be identified and approached with different strategies (e.g., human immunodeficiency virus (HIV) specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.
  - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
- Determine appropriate implementation processes.
  - What steps need to be taken to make these activities happen?

- What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
- What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
- Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
  - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
  - Did the processes and strategies work?
  - Were the guidelines implemented?
  - What could be improved in future endeavors?

## **IMPLEMENTATION TOOLS**

Personal Digital Assistant (PDA) Downloads  
 Quick Reference Guides/Physician Guides  
 Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Living with Illness

### **IOM DOMAIN**

Effectiveness  
 Patient-centeredness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

Personality disorders in patients with HIV/AIDS. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2006. p. 1-20. [12 references]

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

### **DATE RELEASED**

2001 Mar (revised 2006 May)

## **GUIDELINE DEVELOPER(S)**

New York State Department of Health - State/Local Government Agency [U.S.]

## **SOURCE(S) OF FUNDING**

New York State Department of Health

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Mental Health Guidelines Committee

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## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

## **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Working with patients' personalities and styles. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 19-23.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 90 Church Street, New York, NY 10007-2919; Telephone: (212) 268-6108

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- HIV clinical practice guidelines. New York (NY): New York State Department of Health; 2003. 36 p. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Mental health screening: a quick reference guide for HIV primary care clinicians. New York (NY): New York State Department of Health, 2006. 1 p. Electronic copies: [Available from the New York State Department of Health AIDS Institute Web site](#).
- Appendix I: interactions between HIV-related medications and psychotropic medications: indications and contraindications. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix II: HIV-related causes of psychiatric symptoms: differential diagnosis. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix III: rating scales. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix IV: mental health care resources in New York State. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

- Appendix V: syringe access resources in New York State. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix VI: permanency planning and transitional services. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 90 Church Street, New York, NY 10007-2919; Telephone: (212) 268-6108

This guideline is available as a Personal Digital Assistant (PDA) download from the [New York State Department of Health AIDS Institute Web site](#).

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This NGC summary was completed by ECRI on May 4, 2005. This NGC summary was updated by ECRI on June 13, 2006.

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