Personality Disorders in Primary Care

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Personality Defined

• Historically, American personality psychology defined by two endeavors¹:
  1. The study of individual differences
     • Dimensions along which people differ from one another
     • Quantitative/Nomothetic
  2. The study of individual persons as unique and integrated wholes
     • Functional analysis of individual constructs and contexts
     • Qualitative/Idiographic

¹. Winter & Barenbaum (1999)
Current Definition of Personality

– Characteristic patterns of behavior, thought, and emotion that exhibit relative consistency across time and situation\(^1\)

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Personality Disorders

• Defined\(^1\):
  – 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
    • Leads to distress or impairment
• Proposed changes to DSM 5
  – Dimensional-prototype hybrid

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1. APA (1994)
1. Funder, 2013
Current Classification System

• Axis II
• Ten personality disorders + PD NOS
• Three Clusters
  – A: Odd/Eccentric
    • Paranoid PD, Schizoid PD, Schizotypal PD
  – B: Dramatic/Erratic
    • Antisocial PD, Borderline PD, Histrionic PD, Narcissistic PD
  – C: Anxious/Fearful
    • Avoidant PD, Dependent PD, Obsessive-Compulsive PD

Introduction to the Disorders

• Prevalence
• Clinical features
• Treatment Options
• Strategies to Facilitate Treatment
Personality Disorders in Primary Care

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Cluster A

• Odd and eccentric disorders
Schizoid Personality Disorder

- Prevalence
  - Up to 7.5% of population
  - Ratio of Male to Female is 2:1
  - Increased among relatives of people with schizophrenia

SPD: Clinical Features

- No desire for close relationships with others
- Little pleasure in activities
- Flat affect
- Appears indifferent to praise or criticism of others
- Almost always chooses solitary activities
**SPD: Intervention Strategies**

- Psychopharmacology
  - Low doses of atypical antipsychotics
  - SSRI’s
  - Stimulants

- Psychotherapy
  - Difficult to engage in therapy
  - Rarely seek treatment
  - May do well in insight-oriented therapy

**SPD in the PCP’s Office**

- Potential barriers to primary care treatment
  - May not present to office regularly
  - May be reluctant to engage in conversation
  - May appear aloof and may not desire a relationship

- Short-term strategies in the office
  - Be non-judgmental of patient’s odd behaviors
  - Be supportive of trust from the patient
Schizotypal Personality Disorder

- Prevalence
  - Up to 3% of general population
  - No difference in prevalence between male and female
  - Increased among family members of schizophrenic patients

STPD: Clinical Features

- Cognitive or perceptual distortions
  - Ideas of reference
  - Clairvoyant or telepathic experiences
- Eccentric behaviors
- Social withdrawal
- Inappropriate or constricted affect
- Beliefs and perceptions separate from cultural norms
STPD: Intervention Strategies

- Psychopharmacology
  - Low-dose atypical antipsychotics to treat “positive” symptoms
  - SSRI’s to treat concurrent depression

- Psychotherapy
  - Supportive
  - Cognitive behavioral therapy
  - Psycho-social education groups

STP in the PCP Office

- Potential barriers to primary care treatment
  - Social anxiety
  - Paranoid ideation
  - Difficulty establishing alliance

- Short-term strategies in the office
  - Avoid appearing skeptical or judgmental
  - Encourage appropriate social interaction
### Paranoid Personality Disorder

- **Prevalence**
  - Up to 2.5% of the general population
  - Prevalence higher in minority groups, immigrants, and deaf
  - More common among males than females

### PPD: Clinical Features

- Pervasive, persistent, and inappropriate mistrust of others
- Assume that others will exploit, harm, or deceive them
- See “evidence” of malevolent intent in benign actions
- Guarded: may question the loyalty of friends, family
- React with extreme anger and bear long-term grudges
- Isolated: difficult to participate in relationships due to mistrust
# Paranoid PD: Intervention Strategies

<table>
<thead>
<tr>
<th><strong>Psychopharmacology:</strong></th>
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<tbody>
<tr>
<td>Low-dose atypical antipsychotics:</td>
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<tr>
<td>Seroquel, Risperdal</td>
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<tr>
<td>Anxiolytics if clinically warranted:</td>
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<tr>
<td>Klonopin, Valium</td>
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<tr>
<th><strong>Psychotherapy:</strong></th>
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<tbody>
<tr>
<td>Individual psychotherapy if patient amenable to treatment</td>
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# PPD in the PCP Office

- Potential barriers to primary care treatment
  - Suspicious of motives of the physician
  - Reluctance to share information of a personal nature

- Short-Term Strategies in the Office:
  - Focus on building trust
  - Be straightforward and unintrusive
  - Avoid being overly-warm and friendly
<table>
<thead>
<tr>
<th>Cluster B</th>
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<tbody>
<tr>
<td>• Dramatic and erratic disorders</td>
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<thead>
<tr>
<th>Borderline Personality Disorder</th>
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<tr>
<td>• Prevalence:</td>
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<tr>
<td>• About 2% of general population (estimates up to 6%)</td>
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<tr>
<td>• 10% of outpatient mental health patients</td>
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<tr>
<td>• 20% of psychiatric inpatients</td>
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</table>
### BPD: Clinical Features

- BPD is a disorder of dysregulation
  - Emotional dysregulation: marked reactivity of mood, anger outbursts
  - Interpersonal dysregulation: frantic efforts to avoid abandonment, unstable relationships
  - Self dysregulation: chronic feelings of emptiness, identity disturbance
  - Cognitive dysregulation: transient paranoia, dissociation, extreme thinking
  - Behavioral dysregulation: NSSI, impulsive behavior, suicide attempts

### BPD: Intervention Strategies

- **Psychopharmacology:**
  - Affective Dysregulation: SSRI’s, Atypical antipsychotics, Mood stabilizers
  - Impulsivity: SSRI’s, Mood Stabilizers
  - Psychotic-like features: Atypical antipsychotics, Mood stabilizer

- **Psychotherapy:**
  - Dialectical Behavior Therapy
### BPD in the PCP Office

- **Potential Barriers to Primary Care Treatment:**
  - Risk of suicide or non-suicidal self-injury
  - High intensity/quickly changing emotion
  - Poor adherence to medical regimen/advice
  - Frequent contact with providers

- **Short-term Strategies in the Office:**
  - Validate experiences
  - Assess imminent risk
  - Collaborate with mental health providers

### Antisocial Personality Disorder

- **Prevalence**
  - General population: Females 1%, Males 3%
  - Prison population: up to 75%
### ASPD: Clinical Features

- Pervasive disregard for and violation of the rights of others
- Failure to conform to social norms (illegal activities)
- Reckless disregard for safety of self or others
- Irritability/aggression with repeated physical fights
- Role failures: parent, employee, spouse, etc.
- Lack of remorse for harm they have caused

### ASPD: Intervention Strategies

- **Psychopharmacology:**
  - Drugs with abuse-potential must be used judiciously
  - Mood stabilizers: Depakote, Tegretol, Trileptal for impulsivity
  - SSRI’s: Zoloft, Prozac may improve underlying depression

- **Psychotherapy:**
  - Very difficult to engage patient
  - Group-therapy in institutional settings (prison)
**ASPD in the PCP Office**

- Potential Barriers to Primary Care Treatment:
  - Withholding of information
  - Endorsing symptoms for non-medical gains

- Short-Term Strategies for the Office:
  - Establish and maintain firm limits early
  - Be vigilant for attempts to garner secondary gains resources

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**Histrionic Personality Disorder**

- Prevalence
  - 2% - 3% of general population
  - Up to 10% - 15% in inpatient and outpatient mental health settings
HPD: Clinical Features

- Pervasive and excessive need for attention
- Unstable emotional presentation, shallow emotions
- Flirtatious, seductive, sexual behavior and appearance
- Impressionistic language
- Highly suggestible
- Mischaracterize relationships as closer than they are

HPD: Intervention Strategies

- Psychopharmacology
  - SSRI’s for depression and somatic complaints
  - Anxiolytics for anxiety symptoms
  - Atypical antipsychotics for derealization and illusions

- Psychotherapy
  - Individual psychotherapy
    - Cognitive Behavioral Treatment
    - Solution Focused Therapy
HPD in the PCP Office

• Potential Barriers to Primary Care Treatment:
  – Dramatic presentation of symptoms
  – Efforts to maintain attention from provider
  – Suggestibility may result in overendorsing symptoms

• Short-Term Strategies in the Office:
  – Limit number of differential diagnoses offered
  – Ask for objective markers of symptoms
  – Observe limits in interpersonal behaviors

Narcissistic Personality Disorder

• Prevalence
  – Less than 1% in general population
  – 2-16% in the clinical population
  – More common among men than women
### NPD: Clinical Features

- Grandiose sense of self-importance
- Preoccupied with fantasies of ultimate success
- Only wants to associate with other “great” people
- Requires excessive admiration
- Has a sense of entitlement
- Takes advantage of others for personal gain
- Shows arrogant behaviors and attitudes

### NPD: Intervention Strategies

- **Psychopharmacology**
  - Mood stabilizers for mood swings
  - SSRI’s for depression

- **Psychotherapy**
  - Individual psychodynamic therapy
  - Pt may be difficult to engage
NPD in the PCP Office

• Potential Barriers to primary care treatment
  – Pts may be easily offended by perceived insults or injuries
  – Pt may believe his or her opinions are superior to physician’s

• Short-term strategies in the office
  – Convey empathy for patient’s sensitivity
  – Avoid direct confrontation with patient’s distorted views
  – Deal personally with patient when possible

Cluster C

• Anxious and fearful
Avoidant Personality Disorder

• Prevalence:
  – .5% to 1% of the general population
  – 10% of outpatients in mental health clinics
  – Comorbid in up to 1/3 of anxiety disorder patients

1. Alden et al., 2002

AVPD: Clinical Features

• Extreme avoidance: school, work, relationships

• Rejection sensitivity: fears of criticism, disapproval, rejection

• Inhibited expression: emotion, opinion, preferences

• Restricted interpersonal contacts

• Over-controlled emotions
AVPD: Intervention Strategies

<table>
<thead>
<tr>
<th>Psychopharmacology:</th>
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<tbody>
<tr>
<td>– Serotonergic medications: SSRI’s, MAOI’s</td>
<td></td>
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<tr>
<td>– Beta-Blockers: Propranolol, Atenolol</td>
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<tr>
<td>– Anxiolytics: Klonopin, Ativan for short-term relief</td>
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<th>Psychotherapy:</th>
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<tr>
<td>– Cognitive Therapy</td>
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AVPD in the PCP Office

<table>
<thead>
<tr>
<th>Potential Barriers to Primary Care Treatment:</th>
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<tbody>
<tr>
<td>– Fear related to seeking treatment and/or discussing symptoms</td>
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<tr>
<td>– Avoidance of treatments that are associated with discomfort</td>
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<tr>
<td>– “Freezing” behavior – approach/avoidance conflict</td>
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<th>Short-term Strategies in the Office:</th>
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<tr>
<td>– Provide accepting stance, reduce judgment</td>
<td></td>
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<tr>
<td>– Decrease avoidance of medically necessary behaviors without criticism – provide alternative explanations</td>
<td></td>
</tr>
<tr>
<td>– Identify barriers to medically necessary behaviors</td>
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Obsessive Compulsive Personality Disorder

- Prevalence:
  - 1% in general population
  - 3% to 10% in mental health outpatient clinics
  - Twice as common in males

OCPD: Clinical Features

- Rigid control: overvaluing of rules, lists, procedures, details
- Perfectionism at the cost of progress
- Excessively conscientious, rigid in values/opinions/morals
- Self-critical and judgmental of others
- Controlling: money, delegation
### OCPD: Intervention Strategies

- **Psychopharmacology:**
  - Serotonergic agents: SSRI’s, Tricyclic antidepressants
  - Atypical antipsychotics: Low-dose Seroquel, Risperdal for extreme cases

- **Psychotherapy:**
  - Cognitive Therapy may be less effective than for other d/o
  - Schema-Focused Therapy

### OCPD in the PCP Office

- **Potential Barriers to Primary Care Treatment:**
  - Rigid expectations of provider
  - Reluctance to report “less than perfect” behavior
  - Difficulty asking for help

- **Short-term Strategies in the Office:**
  - Work with symptoms: give rules to follow
  - Provide rationale for medical requests/prescriptions
  - Attempt to keep to schedule and honor the patient’s time
# Dependent Personality Disorder

## Prevalence
- No good estimates of prevalence in general population
- One of the most frequently reported Axis II disorders reported in mental health clinics

## DPD: Clinical Features
- Fears of separation from significant other (e.g., partner, parent, etc.)
- Uncomfortable or feelings of helplessness when alone
- Quick to attach to others
- Difficulty making everyday decisions
- Rely on others to direct life
- Reluctance to express disagreement
- Difficult initiating projects or tasks independently
- Needs/preferences secondary to securing approval
# DPD: Intervention Strategies

- **Psychopharmacology**
  - SSRI’s for depression and anxiety
  - Benzodiazepines for anxiety
  - Stimulants for withdrawal symptoms

- **Psychotherapy**
  - Cognitive behavioral therapy – shorter in length
  - Behavioral experiments surrounding independence

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# DPD in the PCP Office

- **Potential Barriers to Primary Care Treatment:**
  - Reliant on others to provide important information
  - Difficulty making decisions
  - Need support to implement suggested changes

- **Short-term Strategies in the Office:**
  - Incorporate important others in discussions
  - Reduce decision points – provide specific recommendations
  - Assess for ways to incorporate interventions into life
Summary, Part 1

- Personality disorders are:
  - Pervasive patterns of inner experience and behavior:
    - that deviates from the culture
    - that leads to distress or impairment

Summary, Part 2

- Personality d/o may disrupt primary care
  - Affects interactions with patient
  - Affects reporting of symptoms
  - Affects compliance with medications
## Summary, Part 3

- Appropriate treatment and referral for therapy will:
  - Improve adherence to treatments
  - Improve quality of life for the patient
  - Reduce frustration in treatment providers