Personality Disorders in Primary Care

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Personality Defined

• Historically, American personality psychology defined by two endeavors: 1:
  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


Current Definition of Personality

—Characteristic patterns of behavior, thought, and emotion that exhibit relative consistency across time and situation

1. Funder, 2013

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

1. APA (1994)
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

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

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**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

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**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

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**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: 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

### 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

### 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

## Paranoid PD: Intervention Strategies

### Psychopharmacology:
- Low-dose atypical antipsychotics: Seroquel, Risperdal
- Anxiolytics if clinically warranted: Klonopin, Valium

### Psychotherapy:
- Individual psychotherapy if patient amenable to treatment

## 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

## 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
Cluster B

<table>
<thead>
<tr>
<th>Dramatic and erratic disorders</th>
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Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Prevalence:</th>
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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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BPD: Clinical Features

<table>
<thead>
<tr>
<th>BPD is a disorder of dysregulation</th>
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<tr>
<td>• Emotional dysregulation: marked reactivity of mood, anger outbursts</td>
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<td>• Interpersonal dysregulation: frantic efforts to avoid abandonment, unstable relationships</td>
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<tr>
<td>• Self dysregulation: chronic feelings of emptiness, identity disturbance</td>
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<td>• Cognitive dysregulation: transient paranoia, dissociation, extreme thinking</td>
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<td>• Behavioral dysregulation: NSSI, impulsive behavior, suicide attempts</td>
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BPD: Intervention Strategies

<table>
<thead>
<tr>
<th>Psychopharmacology:</th>
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<tr>
<td>• Affective Dysregulation: SSRI's, Atypical antipsychotics, Mood stabilizers</td>
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<tr>
<td>• Impulsivity: SSRI's, Mood Stabilizers</td>
</tr>
<tr>
<td>• Psychotic-like features: Atypical antipsychotics, Mood stabilizer</td>
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<tr>
<th>Psychotherapy:</th>
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<tr>
<td>• Dialectical Behavior Therapy</td>
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### 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

### 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

### Antisocial Personality Disorder

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

### 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

### 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 over-endorsing symptoms

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

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

Narcissistic Personality Disorder

- Prevalence
  - Less than 1% in general population
  - 2-16% in the clinical population
  - More common among men than women

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

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

Cluster C

• Anxious and fearful

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

- **Psychopharmacology:**
  - Serotonergic medications: SSRI's, MAOI's
  - Beta-Blockers: Propranolol, Atenolol
  - Anxiolytics: Klonopin, Ativan for short-term relief

- **Psychotherapy:**
  - Cognitive Therapy

### AVPD in the PCP Office

- **Potential Barriers to Primary Care Treatment:**
  - Fear related to seeking treatment and/or discussing symptoms
  - Avoidance of treatments that are associated with discomfort
  - "Freezing" behavior – approach/avoidance conflict

- **Short-term Strategies in the Office:**
  - Provide accepting stance, reduce judgment
  - Decrease avoidance of medically necessary behaviors without criticism – provide alternative explanations
  - Identify barriers to medically necessary behaviors

### 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

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

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

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

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**

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<tr>
<td>• Appropriate treatment and referral for therapy will:</td>
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<tr>
<td>– Improve adherence to treatments</td>
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<tr>
<td>– Improve quality of life for the patient</td>
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<tr>
<td>– Reduce frustration in treatment providers</td>
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