Personality Disorders in in Primary Care

Jennifer S. Cheavens, Ph.D
Assistant Professor
Department of Psychology
The Ohio State University Wexner Medical Center

Current Definition of Personality

– Characteristic patterns of behavior, thought, and emotion that exhibit relative consistency across time and situation[1]

1. Funder, 2013

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

1. Winter & Barenbaum (1999)

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

Personality Disorders in in Primary Care

Andrew Savageau, MD
Assistant Professor-Clinical
Department of Psychiatry
The Ohio State University Wexner Medical Center

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

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: 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 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

- Dramatic and erratic disorders

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

Borderline Personality Disorder

- Prevalence:
  - About 2% of general population (estimates up to 6%)
  - 10% of outpatient mental health patients
  - 20% of psychiatric inpatients

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

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

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

Histrionic Personality Disorder

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

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]

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

Obsessive Compulsive Personality Disorder

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

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 conflic
- 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

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

Summary, Part 1

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

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 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