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Recognizing Personality Disorders in Patients Presenting to the Primary Care Provider

"Crazy Ex-Girlfriend," a musical comedy-drama series that ran on television from 2015 to 2019, helped propel borderline personality disorder into pop culture. The heroine of the series, immersed in crisis after crisis, sings longingly of her hope for a definitive diagnosis, referencing the trial and error in managing her thoughts and feelings. But when the diagnosis is revealed to be borderline personality disorder, the negative connotation and shame associated with this diagnosis crushes her optimism.[1]

Often not well understood by the medical community and surrounded in stigma, patients with personality disorders frequently are labeled difficult. Notably, the "difficult patient" is not difficult to recognize but is difficult to manage in the medical office. Understanding that the behaviors responsible for this label may be the result of a personality disorder allows the provider to adopt a more nuanced approach to treatment.

Personality disorders, as conceptualized in the *Diagnostic and Statistic Manual of Mental Disorders, 5th Edition* (DSM-5), include 10 distinct disorders bound together by key features of rigid thinking, feeling, and behaving that result in poor functioning and/or " … lead to distress and impairment."[2] At the core of these disorders is difficulty with trust and an inability to build healthy relationships. Challenges in maintaining a functional patient-provider alliance, poor medical outcomes, and the decreased quality of life seen in patients with personality disorders may be linked directly to these traits.[3,4]

Patients with personality disorders rarely see themselves or their behavior as problematic and tend to blame others for any failures or missteps. Thus, it is unusual for a personality disorder to be the stated reason an office visit.[3,4] However, since a personality disorder has significant potential to negatively affect the course of a medical illness, understanding how to identify individuals with such disorders and developing a sense of strategic approaches to patients with specific personality disorders will aid the primary care provider (PCP) in dealing with these challenging patients.

Personality, or a unique mixture of thoughts, feelings, temperament, and behavior, develops from infancy to adulthood and arises from a complex blend of genetics and environment.

In patients with a disorder of personality, this unique blend malfunctions and interferes with multiple aspects of life.[3-5] Interestingly, the prevalence of these disorders varies globally with socio-economic status (being higher in more developed countries) but occurs worldwide, with recent studies measuring overall prevalence rates of 7.8%.[6]

EXECUTIVE SUMMARY

Personality disorders, as conceptualized in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5), include 10 distinct disorders bound together by key features of rigid thinking, feeling, and behaving that result in poor functioning and/or lead to distress and impairment.

- Personality disorders occur in 10% to 15% of the U.S. population. There is an overrepresentation in primary care patients, with prevalence reaching close to 24%.
- Patients with personality disorders rarely see themselves or their behavior as problematic and tend to blame others for any failures or missteps.
- Currently, the DSM-5 groups personality disorders into three general categories or clusters.
- To be more clinically useful, the International Classification of Diseases 11th revision (ICD-11) does not attempt to classify personality disorders into distinct types, but instead asks clinicians to rank the severity of interpersonal (relationships with others) and intrapersonal (self-worth, self-direction, and self-identity) dysfunction. The three-question inventory probably is best suited for identification of Cluster B (erratic/dramatic/emotional) disorders.
- Despite the lack of Food and Drug Administration-approved medications to treat these diagnoses, there may be a narrow role for pharmacotherapy in the treatment of personality disorders targeting symptoms such as anger outbursts and impulsive aggression.
- Personality disorders are associated with an increased risk of suicide and substance abuse.

Estimates are that a personality disorder occurs in 10% to 15% of the U.S. population, with an overrepresentation in primary care patients. An even higher prevalence is seen in patients in psychiatric care, patients with substance use disorders, and in the incarcerated population.

Personality disorders are highly comorbid with other disorders of mental health and substance abuse, and with medical problems, such as sleep disturbance, chronic pain, and obesity. Medical care often is compromised by the association of personality disorder with high rates of psychosocial stressors, such as domestic violence, homelessness, and unemployment.[3-5,7]

Epidemiologic data collection is hindered by the lack of standard diagnostic criteria that transcend cultural bounds. The diagnosis of a personality disorder is dependent partially on societal norms, since persons with personality disorders maintain patterns of thought or behavior that deviate from these norms. In recognition of this and other diagnostic and classification problems, a school of thought introducing an alternate way to conceptualize and diagnose specific personality disorders is emerging.[6,8,9]

This article provides an overview of the history of personality disorders in medicine followed by a brief discussion regarding the current controversy and understanding of personality disorder diagnosis as presented in a new model introduced in the International Classification of Diseases 11th revision (ICD-11) vs. the more traditional nomenclature of the DSM-5. The descriptive criteria and treatment options for the 10 disorders of personality listed in DSM-5 (paranoid, schizoid, schizotypal, antisocial, borderline, narcissistic, histrionic, avoidant, dependent, and obsessive-compulsive) are summarized.

However, the primary focus in this work is slanted toward strategies and techniques for early recognition and structured approaches to optimize outcomes when an individual with a personality disorder presents with a medical problem. Patients with personality disorders often elicit nonproductive emotional responses from providers; a discussion on the management of such responses is included. Patient cases are presented for illustrative purposes.

Historical Perspective

Historical Eastern and Western medical documents show early evidence of interest in the concept of personality. Confucius (551-479 B.C.) in ancient China discussed "blood and vital essence" as affecting temperament, while Hippocrates (460-370 B.C.) and, later, Greek physician Galen (A.D. 129-200) developed a theory of personality or temperament based on a balance of humors or bodily fluids. Hippocrates identified blood, black bile, yellow bile, and phlegm as the four humors. In this theory, an excess of any one humor results in specific personality patterns: phlegmatic, sanguine, melancholic, or choleric. Galen's writings elaborating on this theory, translated into many languages, including Arabic, strongly influenced medical practice and beliefs worldwide until falling out of favor in the late 1700s and early 1800s.[10]

Phrenology, or the study of the size and shape of the skull, to determine personality traits and mental ability next emerged as a way to understand personality type. This flawed theory was based on a new understanding of neuroanatomy and physiology, including the role of the cerebral cortex in directing thoughts, feelings, and behavior.[10,11]

In the late 1800s and 1900s, psychiatry emerged as a recognized medical science. The task of understanding and/or explaining abnormal and dysfunctional behavior in individuals without a deficit in intellect and without acute psychiatric symptoms (such as psychosis or depression) fell to psychologists and psychiatrists. Several conceptual theories with a common thread arose in Europe and Eastern Asia; each disparate theory described personality traits as durable, unchanging over time, and influenced by inborn temperament and early experiences.[10,11]

Arguably, German psychiatrist Emil Kraeplin's (1856-1926) work on pathologic personality set the stage for the approach to personality disorders seen today in the DSM-5, where disorders with similar symptoms are categorized into clusters, such as odd/eccentric in Cluster A, erratic/dramatic/emotional in Cluster B, and fearful/anxious/nervous in Cluster C. It is useful to note that this descriptive approach is in essence an artificial construction, based on observation and statistical correlation. There are no imaging studies, blood tests, markers, or objective data linking the disorders in each cluster. Although recognition of a personality disorder may be aided by questionnaires and screens, diagnosis even in the 21st century relies on the presenting history and behavior.[10-12]

History shows that medical science has long recognized that understanding personality may aid in the treatment of disease in an individual. Controversy regarding how to conceptualize and explain personality has been a hallmark and continues today, with an alternate model of personality disorders (involving a scale or dimensional system) presented in the DSM-5 for research consideration. ICD-11 has taken this concept a step further, focusing on core personality functioning ("impairments in self and/or interpersonal relations") and rating the level of impairment on a spectrum from "personality difficulty" to "severe personality disorder." Specific traits or qualifiers affecting presentation, such as "negative affect" or "disinhibition," may be attached to the diagnosis, but the 10 specific personality disorder classifications currently described in the DSM-5 do not exist in the ICD-11 nomenclature system nor in the alternate model presented in a subsection of the DSM-5.[12,13]

Although investigations into classification continue, it is less relevant for the PCP to diagnose a specific personality disorder than it is to be cognizant of a patient's characteristic manner of thinking and behaving. With this understanding, delivery of medical care can be slanted toward an approach suitable to the individual, with a goal of achieving optimal functional outcomes.

Personality Disorders by Cluster

Currently, personality disorders in the DSM-5 are grouped into three general categories, or clusters A, B, and C, according to unifying symptoms and characteristics.[14] Table 1 lists the 10 personality disorders, clusters, key features, major differential diagnosis, and prevalence rate (according to a 2018 meta-analysis of prevalence in the Western world).

Because personality shifts during developmental stages, a general rule is that a personality disorder is not diagnosed until the age of 18 years. However, traits of specific disorders often are recognized by the time of adolescence.[15]

Although this is the predominant system used to diagnose patients with personality disorders in the United States, it clearly is an imperfect system. Most patients share criteria across several diagnostic categories, rather than fitting neatly into any one slot. Typically, a single patient is not diagnosed with multiple personality disorders; the diagnosis lies with the most impairing or prominent of the symptoms. There is an option to diagnose with "unspecified personality disorder" when there is no clear fit.[14,18]

ICD-11 Dimensional Model

This diagnostic model presented in ICD-11 is dramatically different from the existing DSM-5 classification system and expands the approach of classification of personality disorders documented in the alternative model presented in DSM-5.[8,19]

To be more clinically useful, the ICD-11 does not attempt to classify personality disorders into distinct types, but instead asks clinicians to rank the severity of interpersonal (relationships with others) and intrapersonal (self-worth, self-direction, self-identity) dysfunction on a scale from "personality difficulty" to mild, moderate, or severe. Additionally, there is an option to note prominent traits that may be the focus of treatment (such as negative affect or mood, disinhibition, or detachment).[8,19] There is a likelihood that future editions of the DSM will categorize personality disorders in a manner more like the ICD-11.[20]

For the PCP, it is important to note that diagnosis in both models relies primarily on a comprehensive history, often gathered over time. Relevant factors in a history include an understanding of the quality of the patient's interpersonal relationships, interactions with the provider, the patient's perception of self-worth, and the ability to tolerate difficult emotions or events without resorting to dysfunctional behavior. Obtaining collateral information with permission from the patient, including history from family or others, is useful to understand a full picture.[21]

Many personality disorders share features of other psychiatric illnesses or present as comorbid conditions. Obtaining an accurate timeline helps with diagnosis, keeping in mind the persistent and chronic nature of personality disorders as opposed to other mental disorders. Be aware of the high comorbidity of substance abuse in patients with personality disorders as well and evaluate for such use.[16]

There are many screens for diagnosis of a personality disorder, but most are not practical for use in a primary care office. Recognizing this, the three-question Inventory of Interpersonal Problems (IIP-3) recently was introduced.[22] Although not perfect, and probably best suited for identification of Cluster B disorders, this brief screen has the potential to aid a clinician's recognition of a personality disorder and may gain traction over time with more widespread use. Items on this screen include a quantitative response to the following statements:[22]

- I am too sensitive to rejection.
- It is hard for me to take instructions from people who have authority over me.
- I argue with other people too much.

Epidemiology

Personality disorders are an important individual and societal health concern. They are highly comorbid with other disorders of mental health, with substance abuse, and with medical conditions, such as obesity, chronic pain, and insomnia. The complexity of

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Table 1. Personality Disorders in the DSM-5

	Cluster[14]	Key Features[14]	Rule Out[14,16]	Prevalence Rate[17]
Paranoid Personality Disorder	A (odd/ eccentric)	Suspiciousness, distrust, wary of relationships, may be prone to violence, believes others out to get them	Schizophrenia or other psychotic disorders (Onset is more acute and with a remitting course in these disorders.)	3.02% (95% CI, 1.443-5.31)
Schizotypal Personality Disorder	A (odd/ eccentric)	Discomfort with others, eccentric, odd beliefs, may have an odd appearance, may have paranoia, excessive social anxiety	Schizophrenia or other psychotic disorders, autism spectrum disorder (Autism begins in early childhood and is associated with characteristic impairments in communication.)	3.04% (95% CI, 1.21-5.64)
Schizoid Personality Disorder	A (odd/ eccentric)	Detached, restricted affect, indifferent to others, aloof and disinterested in relationships	Schizophrenia or other psychotic disorders, autism spectrum disorder	2.82% (95% CI, 0.57-6.62)
Antisocial Personality Disorder	B (erratic/ dramatic/ emotional)	Violation or disregard for the rights of others, lack of remorse, often irresponsible and/or impulsive, deceitful	If antisocial behavior occurs exclusively during the course of a manic episode or a psychotic episode, consider bipolar disorder or schizophrenia.	3.05% (95% CI, 2.10-4.16)
Narcissistic Personality Disorder	B (erratic/ dramatic/ emotional)	Lack of empathy, longstanding pattern of grandiosity, need for admiration and affirmation, sense of entitlement	Manic episode (Grandiosity may occur during mania, but subsides with treatment and remission of the episode.)	1.23% (95% CI, 0.43-2.40)
Borderline Personality Disorder	B (erratic/ dramatic/ emotional)	Marked impulsivity; fluctuating emotions; pervasive pattern of unstable relationships; unstable sense of self; inappropriate, intense anger; may have transient dissociation or paranoia; may engage in self-harm	Bipolar disorder, PTSD (There is a probable overlap between PTSD and borderline personality disorder; a bipolar disorder diagnosis requires clear manic and depressive episodes.)	1.90% (95% CI, 0.85-3.34)
Histrionic Personality Disorder	B (erratic/ dramatic/ emotional)	Attention-seeking behavior and appearance, unstable and changing superficial emotions, may show provocative and/or seductive behaviors	If dramatic presentation occurs only during a manic episode, consider bipolar disorder.	0.83% (95% CI, 0.36-1.48)
Avoidant Personality Disorder	C (fearful/ anxious/ nervous)	Preoccupation with fear of rejection, fear of criticism, social inhibitions, poor self-esteem	Social anxiety disorder, depression (Consider if the symptoms are pervasive and if the patient perceives these as problematic.)	2.78% (95% CI, 1.74-4.06)
Dependent Personality Disorder	C (fearful/ anxious/ nervous)	High need for explanation, reassurance, advice; clingy and overly submissive; feels unable to care for themself	Separation anxiety disorder (Usually begins in childhood, but can present as a young adult; usually linked to a change in environment or situation.)	0.78% (95% CI, 0.37-1.37)
Obsessive-Compulsive Personality Disorder	C (fearful/ anxious/ nervous)	Overly preoccupied with orderliness and control, rigid, may hoard objects, perfectionism that interferes with function/task completion	OCD (OCD patients recognize behaviors as dysfunctional and unwanted.)	4.32% (95% CI, 2.16-7.16)

DSM-5: *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*; CI: confidence interval; PTSD: post-traumatic stress disorder; OCD: obsessive-compulsive disorder

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diagnosis and the scarcity of objective diagnostic tools hamper efforts to measure prevalence rates.[3,5,7]

A 2018 meta-analysis looking at prevalence rates in European and North American countries found significant heterogeneity among studies and only 10 investigations since 1994 met inclusion standards. Results of the meta-analysis point to a prevalence rate of 12.6% for any personality disorder, with rates highest for Cluster A (odd/eccentric) at 7.23%, then followed by Cluster C (anxious/fearful) at 6.70%, and, finally, Cluster B (dramatic/emotional) at 5.53%. Obsessive-compulsive personality disorder has the highest individual prevalence rate at 4.32%.[17]

The prevalence of patients with a personality disorder reaches close to 24% in primary care settings and substantially higher in psychiatric clinics. A 2015 meta-analysis looked at the prevalence of patients with a personality disorder associated with a specific medical diagnosis and found:[7]

• Insomnia: In one sample of 87 patients, about 50% of the respondents had a Cluster C (anxious/fearful) personality disorder. In a larger subset of investigations, about 50% of patients with borderline personality disorder and antisocial personality disorder reported a mixture of sleep disturbances.[22,23]

• Obesity: Seventeen large studies included in the meta-analysis point to a co-occurrence between personality disorder and obesity with a likelihood of a higher body mass index (BMI), especially in the Cluster A (odd/eccentric) category.[22,24]

• Chronic pain/headache: Twenty-two studies included in the meta-analysis point to an association between patients with chronic pain and personality disorders and an association with high service use (phone calls, repeat visits). The strongest link with chronic pain was found between patients with either obsessive-compulsive personality disorder or borderline personality disorders, with greater than 25% of patients with chronic pain qualifying for one of these diagnoses.[22,25]

• Chronic health conditions, including cardiovascular disease and arthritis: Seventeen relatively small studies reveal an association between personality disorders (most often Cluster B [dramatic and emotional]) and chronic medical illnesses. These studies were not well controlled for medication, and the use of agents, such as atypical antipsychotics, which predispose a patient to metabolic syndrome, may have affected results.[22,26]

Etiology and Treatment

The etiology of personality disorders remains unclear. Research indicates that personality disorders arise from a complex play of genetic susceptibility combined with environmental triggers.

Inborn temperament may be a factor as well, with children who are "highly reactive" to external stimuli being more likely to develop Cluster C (fearful/anxious/nervous) personality disorders. Environmental stressors may include maltreatment as a child, such as sexual, physical, and/or verbal abuse. Conversely, environmental factors, such as strong, positive relationships (for example, with peers, community, or family members) may be protective.[27,28]

Genetic links have been found between Cluster A disorders (specifically paranoid and schizotypal personality disorders) and schizophrenia. There also is biologic evidence of heritability of antisocial personality traits and less robust evidence regarding heritability of obsessive-compulsive personality disorder.

Borderline personality disorder, one of the more well-studied disorders, is associated with mood disorders in first-degree relatives as well as a high rate of adverse early childhood experiences. This link has led some in the field to conceptualize borderline personality disorder as a type of post-traumatic stress.[28,29]

Traditional psychodynamic theory postulates that the development of personality goes astray as the result of trauma or other insults during any one of the key periods of development and results in a specified disorder of personality.[19,30] Although theories and hypotheses regarding etiology and risk abound, no evidence exists that a person is born with a personality disorder. All agree that these disorders develop over time and are evident by late adolescence or early adulthood.[19,28-30]

Many of the manifestations of personality disorders subside or resolve by the time a patient reaches the age of 60 years. This is not a blanket rule; treatment during young adulthood often is associated with earlier remission and, conversely, some personality disorders persist into older years. The control of comorbid substance abuse may be a key factor in this process.[31,32]

Given what we know about the development of personality disorders, it seems logical that the focus of treatment revolves around specific types of psychotherapy. Dialectic behavior therapy (DBT), an intensive form of cognitive behavior therapy focused on emotional regulation, mindfulness, and tolerance of strong negative emotions, was developed in the 1970s for use in suicidal patients with borderline personality disorder. This therapy currently has widespread use, is recommended for patients with other personality disorders, and has evidence for effectiveness in helping patients lessen the expression of maladaptive personality disordered traits.[33]

Other types of therapy may be helpful in addressing the dysfunctional behavior exhibited by patients with personality disorders. Psychodynamic therapy, exploring unconscious motivations driving unwanted behavior, has shown promise in research trials with patients with borderline personality disorder. Interpersonal therapy, focused on relationships, also has shown promise in studies with patients with specified personality disorders.[4,34]

Despite the lack of Food and Drug Administration-approved medications to treat these diagnoses, there may be a narrow role for pharmacotherapy in the treatment of personality disorders. In many cases, the PCP who has seen the individual over time may be the most appropriate clinician to initiate and monitor psychopharmaceutical treatment. This may be particularly appropriate in settings where psychological resources are scarce and/or in situations when patients refuse to consider psychotherapy.[35]

Research in this field tends to revolve around borderline personality disorder.

Studies unequivocally demonstrate that medications are not effective in addressing relationship problems, underlying identity issues, or in remission of the disorder, but may be efficacious in addressing targeted symptoms, such as anger outbursts and impulsive aggression. There are basic principles useful to a PCP when considering prescribing psychotropics to address behavioral manifestations of a personality disorder.[35,36]

- Verify the diagnosis, identify the symptom of concern (such as sleep or anxiety), and target this specifically.
- Be certain the patient is interested in medication and understands the limits of medication efficacy for personality disorders.
- Be aware of comorbidities. Check for another psychiatric diagnosis that may be an appropriate focus for treatment (such as major depressive disorder) or one that needs specialized treatment (such as substance use disorder).
- Avoid polypharmacy. Carefully assess the response of the targeted symptom without trying to broaden the reach of the medication.
- Avoid benzodiazepines, which may be helpful acutely but often lead to disinhibition and further behavioral problems. Keep in mind the chronicity of the symptoms and the limited efficacy of these agents over time.

A structured approach to measure baseline symptom severity and response is helpful. Clinicians can use a commercially available scale, such the Beck Depression Inventory (BDI), or devise a simple rating scale assessing relief of a target symptom (for example, rating quality of sleep or social avoidant behavior on a scale from 1 to 10.) These scales are most effective when used at each follow-up visit.[35-37]

Evaluating Suicidal Risk

Personality disorders are associated with an increased risk of suicide. A 2016 United Kingdom study looking at the suicide risk of patients with personality disorders in a primary care practice found a four-fold increase in suicide risk in patients with personality disorders compared with patients with other mental illnesses. The study also found a 20-fold increase in suicide risk in patients with personality disorder when compared to patients without mental health problems, and a 45-fold increase in suicide risk in patients with a personality disorder and comorbid alcohol abuse.[38] Psychological autopsies show that at least 30% of patients who have completed suicide have been diagnosed with an "abnormal personality."[39] Notably, a 2017 study revealed close to one-half of adults completing suicide had contact with a PCP within a month before death, and 80% had such contact in the year preceding suicide.[40]

Patients may be hesitant to express thoughts about suicide directly, but often will respond to open-ended queries. Although suicide screens may be useful, the clinical interview remains the gold-standard tool for suicide risk evaluation. It is useful to keep in mind that a previous suicide attempt is the singlemost important risk factor for suicide.[40-42]

Refer patients with suicidal intention to a specialist. Regional variation in mental health specialist availability ultimately may determine referral and consultation patterns. There is growing evidence that collaborative care models, with a team led by the PCP and including mental health professionals, such as psychiatry and case management, leads to efficient and effective care for more complex, higher-risk patients. Telemedicine consultation also has shown evidence of efficacy and can assist in bringing specialty care to previously underserved communities. Regardless of the manner of delivery, it is useful for the PCP to have a strong working relationship with professionals in the mental health community. In addition, providing patients with information about local support groups and services, such as suicide hotlines, provides an additional safety net for this population.[40,41]

Substance Abuse

Recent studies confirm the high comorbidity of substance abuse and personality disorder. Estimates are that between 65% and 90% of patients treated for substance abuse have a personality disorder. In general, there is a higher likelihood of alcohol abuse in patients with Cluster C disorders and of illegal substances in patients with Cluster B disorders (perhaps in part caused by prominent impulsivity in Cluster B). Notably, about 66% of patients with borderline personality disorder meet criteria for a substance use disorder.[42,43]

Although research efforts regarding these associations continue, it remains critical to evaluate patients with personality disorders for co-occurring substance use and to refer them to appropriate treatment. Interestingly, many patients with personality disorders report using substances to help with intense and uncomfortable emotions. Tolerating this type of discomfort and identifying healthy coping skills is a key component of DBT. Integrating substance use treatment with DBT or similar therapies often is the most efficient treatment strategy.[42-44]

Approach in the Primary Care Office

Cluster A Personality Disorders: Eccentric/Odd

Cluster A personality disorders include paranoid personality disorder, schizotypal personality disorder, and schizoid personality disorder.

M., the last patient of the day, presents to establish care. He is a 45-year-old divorced male, working nights as a custodian. The PCP is running about 10 minutes late, and the front desk staff pulls the provider aside to note, "This patient seems very anxious, pacing and asking how much longer he will have to wait." He comes into the office, refuses the offer of a chair, looks away, and says, "Are you always this late? Everyone in the waiting area was looking at me." Not waiting for a response, he continues, "I don't need a doctor. I haven't seen one for years and I'm fine. But since my divorce, I'm living with my sister, and she's making me see you."

M. is demonstrating behavior that is pushing the boundaries of accepted social norms, seems excessively anxious, and is hinting at functional impairment (a recent divorce and his sister says he needs to see a medical provider). At this early stage in the provider-patient relationship, there is little merit in worrying about a specific DSM-5 personality diagnosis. However, recognizing

that there is a potential disruption in care and that the disruption could stem from a personality impairment help guide the provider response.

1. Validate/acknowledge. To evaluate the situation further, the first step is to validate the patient's feelings. A simple statement, such as, "I can see that it was difficult for you to wait in the waiting area, especially when you don't really want to be here," may help break down some of the initial defensive barriers and allow M. to feel understood. As mentioned previously, validation of feelings is an important component of DBT, the type of cognitive behavioral therapy that is helpful in the treatment of some of the personality disorders.

2. Be self-aware. Unfortunately, in a busy office, many providers may not have the time to think about validation and may react in a defensive manner. This can be understood as a type of countertransference, or strong emotional reaction, in a provider elicited by the patient. The provider is wise to be aware that patients with personality disorders may stir up nonproductive emotions in the provider. Learning to recognize and manage these responses makes caring for these patients less challenging and more productive.[4,45]

Examples of countertransference range from sympathy to frustration to hostility. In many cases, the extreme emotional state of the patient can derail the visit and clinical focus is lost. Guarding against emotional decisions in the office (including ordering unnecessary tests or prescriptions) allows the patient and provider to concentrate on medical problems and logical decision making.[4,45,46]

M. responds to a validating statement and takes a seat in the office. Remembering that he said his sister sent him in for the appointment, the PCP asks, "I wonder why your sister thought you should see me?" He replies, "You don't know? I figured my sister called you or your nurse. She thinks that something is wrong with me because I got lightheaded at work last month, and my boss sent me home for the day. It hasn't happened since — just that one hot day. I think it was because I don't have a wife to pack me meals anymore and I can't eat or drink at work, so I got dizzy."

3. Evaluate. *A review of the medical history form that M. completed reveals he is on no medications and has no documented medical illnesses. His vital signs in the office are pulse, 101 bpm; blood pressure, 145/90 mmHg; and weight, 218 lbs. The PCP considers discussing hypertension management, weight control, and a cardiovascular workup, but feels a need for further history. Picking up where M. left off, the PCP says, "That must be tough not being able to eat or drink at work. Is that a standard rule?"*

M. looks up and shakes his head. "No," he says, "I don't trust the food or water there — I never have and I have been working there for 14 years." His foot starts tapping and he looks increasingly uncomfortable. "So, what do I have to do to let my sister know that I am OK? I don't want to answer a bunch of questions, especially if you are going to put my answers into that computer. I don't want to do any tests and I don't have much time today."

What do we know at this point? There appears to be an element of paranoia that sounds chronic in nature (he hasn't trusted the food for 14 years), and M. clearly is in the office with a narrow goal: to satisfy his sister. Based on this limited information and his behavior in the office, consideration of a personality disorder, probably Cluster A, is further warranted. Having more history and understanding a timeline certainly would help diagnostically, but it is unlikely that M. will allow much more information gathering today.

M. demonstrates a typical pattern for patients with Cluster A personality disorders in healthcare systems — coming in when there is an acute precipitant (in this case, the precipitant was his sister's insistence).

Knowing that patients with Cluster A personality disorders often are uncomfortable interacting with others and recognizing there is a degree of paranoia steers the PCP toward:[47]

- keeping the visit time as brief as possible;
- providing clear written information recommending follow-up tests and a preliminary plan, and reviewing this succinctly in the office with the patient;
- suggesting accommodations that may allow a more comfortable visit experience for M. at the next appointment, such as offering a video visit, asking M. to invite his sister to accompany him, and/or offering a private area for waiting should he choose to return to the office.

The PCP also may want to make a note to rule out comorbid conditions, including substance abuse. Asking about substance use may be accomplished in this first meeting, but M.'s responses may be more accurate during future appointments after a basic level of trust is established or if his sister is able to provide collateral information.

Cluster B Personality Disorders: Erratic/Dramatic/Emotional

Cluster B personality disorders include antisocial, borderline, narcissistic, and histrionic personality disorders.

P., a 32-year-old single woman with type 1 diabetes (T1D), is transferring care. She states she was dissatisfied with her former provider because, "He didn't like me … he never gave me enough time in the office and had the nerve to tell me I should see a shrink, which I hardly think would help my diabetes." She laughs: "My mom says I treat my doctors and boyfriends like shoes — move on to new ones when the old ones are worn out!" She mentions that her glucose usually is stable, but she sometimes uses insulin to control her weight. "Not too much … I know that can be dangerous, but I am in the public eye and have to look good," she says.

Today, she requests a change in antidepressants ("It stopped working after I discovered my ex was cheating with my sister," she adds), a refill of low-dose benzodiazepine for anxiety, and a refill of gabapentin, which she states she uses for pain control. A physical exam is remarkable for diffuse back and neck pain with even light palpitation. "It always is worse when I am anxious," she states. "Even though every blood test, magnetic resonance imaging, and computed tomography scan says I am perfectly healthy, the pain always comes back." She adds, "Maybe you can figure out what really is wrong with me."

P.'s presentation and the limited history elicited so far may lead providers to label her as a "difficult patient." Although this may be valid, viewing her behavior through the lens of a personality disorder may be more

helpful in moving toward a successful encounter.

Breaking down the interaction, note that her comments about feeling rejected by her former provider and her remark about changing medical caregivers (and boyfriends) frequently hints at unstable relationships. Manipulation of insulin for weight control and the finding of chronic pain without a clear etiology are factors alerting a provider to consider the presence of an underlying personality disorder.

1. Validate/acknowledge. P.'s statement about her pain worsening when she is anxious gives the provider an opening. A statement such as, "It could be difficult to switch providers, especially if you feel like your last provider did not connect with you" or "Being examined by a new provider can be anxiety-provoking" can serve to convey empathy without judgment.

2. Be self-aware. P. may come across both as demanding and demeaning. She is almost certain to elicit a host of negative counter transferential responses from a provider. Remaining focused on clinical issues rather than an emotional response allows the provider to calmly note that to develop an effective care plan, a comprehensive history and past records are necessary.

P. begins to cry. "No one is willing to help me. It will take forever to get records and then I have to wait for another appointment for you just to refill some medicines," she says. "You are as bad as the others — just in it for the money."

The PCP may recognize that the feeling of helplessness ("What am I supposed to do with this patient?") and frustration within the provider most likely echoes P.'s own emotional state.

Reframing the situation may be helpful. For example, the PCP may note,"You do not feel like the medical system has been helpful to you. Let's have a goal that after I understand more of your medical history, we work together to develop a plan that makes sense to both of us."

3. Evaluate. *P. stops crying and says she likes the idea of being included in developing a treatment plan. She agrees to sign releases for past records, stating, "You are the only provider who ever included me." The PCP notes that checking the state database in the office today will provide up-to-date information about recent dispenses and refills of the benzodiazepine and gabapentin. P. replies, "I can wait to refill them because I don't think either are helping, but I think a new antidepressant is important." The PCP agrees to hold off on refills and use the remainder of this visit to focus on evaluating the need for an antidepressant, including identifying target symptoms and understanding past responses.*

P.'s emotional lability, dramatic mood swings, and tendency to overvalue or devalue others help the provider feel more confident that she may have a personality disorder, most likely in Cluster B.

Patients with these personality disorders often are very difficult to manage. Knowing that the manipulative and demanding behaviors seen in patients with Cluster B personality disorders often reflect deep insecurities and fear of rejection helps the PCP to:[48]

- set and follow clear and unambiguous boundaries regarding appointments, including frequency, length, and goal (followup, review of results, etc.) of each appointment;
- set and follow clear limits regarding contact between visits and emergencies;
- give factual and objective responses without emotional overlay;
- obtain psychiatric consultation if necessary.

The PCP should do the following:

- Remember to evaluate for substance abuse. Use medication contracts and set clear limits for prescribing. If a controlled substance is indicated, identify a narrow goal for use and evaluate efficacy often. If it is not effective, do not prescribe.
- Target the antidepressant toward objective symptoms (for example, hours of sleep or days missed at work) and re-evaluate the status of these symptoms at follow-up appointments. Remind the patient that an antidepressant will have a limited role in overall treatment.

Cluster C Personality Disorders: Fearful/Anxious

Cluster C personality disorders include avoidant, dependent, and obsessive-compulsive personality disorders.

L. is a 50-year-old, mildly obese, married accountant, well known to you for treatment of mild to moderate hypertension and acid reflux. He was diagnosed with hypertension at age 46 and had some difficulties bringing his blood pressure down initially. With a diet change and mild weight loss, he has shown reasonable control for more than two years on lisinopril 20 mg daily. Despite the stable readings, he comes to appointments every three months with lengthy and meticulous notes documenting three-times daily blood pressure measurements, specifics of his daily diet, and time spent exercising. He visits his PCP today for an urgent appointment, stating, "I went to the emergency room over the weekend." He explains that his "sphygmomanometer" broke last week, and he decided to wait for a few days to order a replacement. He notes, "I woke up Saturday morning at 7:42 a.m. with chest pain. I had palpitations Saturday night off and on from 6:03 p.m. until 11:17 p.m., and I was short of breath on Sunday morning at 7 a.m. I could not check my blood pressure. The emergency room provider said I needed a bunch of tests, but she wouldn't answer my questions, so I left and made this appointment."

Does this patient demonstrate characteristics of a personality disorder? His previous style of interacting with the PCP may be viewed as rigid and obsessive but not necessarily dysfunctional. The recent encounter in the emergency room gives more evidence of personality traits negatively affecting medical care and raises the likelihood of an underlying personality disorder.

1. Validate/acknowledge. A simple validating statement, such as, "It must have been frightening having those symptoms and not being able to check your pressure" can help L. feel understood and, hopefully, tolerate the appointment.

2. Be self-aware. Prior frustration with L.'s rigid approach to blood pressure management may drive the provider to focus on anxiety rather than the new symptoms. It may be useful to focus on clinical issues and inquire if L. has experienced such symptoms prior to this episode.

L. notes that, in fact, he has had several episodes of chest pain over the last

two weeks, but "my blood pressure always was fine, so I never worried." When the provider starts to ask him more about the chest pain, he appears increasingly uncomfortable and begins telling the provider about his internet research. He pulls out several pages printed from a discussion board and begins to read a list of recommendations, from trying a new antihypertensive medication to relaxation therapy to adding supplements.

3. Evaluate. *L.'s blood pressure in the office today is 135/87 mmHg — a bit higher than normal. His pulse is 106 bpm, his temperature is 99.5°F, and his respirations are 18 breaths per minute and shallow. Wheezes are heard faintly over the left lower lobe.*

Knowing L.'s characteristic manner of processing medical information and recognizing his need for control and organization helps the provider develop an effective treatment plan. A good first step is to provide clear information regarding the clinical findings and to recommend a course of treatment (verbally and in writing). Be aware that presenting too much information or speculating out loud may add to the patient's anxiety. Be as concrete and definitive as possible.

Finally, it also may help to acknowledge that L. seems to appreciate being involved in his own care (as evidenced by his vigorous embracing of monitoring blood pressure and dedicated internet research). Finding a role for him to play in the treatment of this new medical condition can help shift his attention to a more meaningful self-assessment.

L. demonstrates a Cluster C personality disorder with prominent traits of rigidity of thinking and excessive adherence to routine; often these patients "miss the forest for the trees." It appears as if he can function well (as best as can be determined from his history) until his routine is disrupted. Eliciting the strengths of this patient can be helpful in providing treatment. In this case, his need for information and willingness to comply with follow-up can be used to advance his treatment. Acknowledging his underlying anxiety when his routine is broken is equally important. Psychotropic medication could be considered if L. perceives his anxiety as problematic.

Knowing that the adherence to routine and structure in some patients with Cluster C personality disorder may reflect a defense against powerlessness and fear of losing control steers the provider toward:[49]

- considering slightly longer appointments to respond to questions;
- encouraging participation in treatment;
- providing concrete information and explanations.

Summary

Take-Home Points

- About 24% of primary care patients have personality disorders.
- The diagnosis of personality disorders is shifting gradually from a descriptive model to a focus on the degree of functional impairment.
- A personality disorder rarely is the reason for a primary care encounter, but often it negatively affects the presentation of a medical problem, disease course, and treatment.
- The goal for the PCP is to optimize medical outcomes for these "difficult" patients by recognizing their behaviors as a manifestation of a personality disorder and applying targeted management strategies appropriate to the individual patient.
- The PCP should be aware of and control countertransference to fully focus on clinical issues.
- These disorders have high comorbidities. The PCP should look for and consider the treatment of other disorders of mental health and/or substance abuse.
- The PCP should consider psychotropic medication for targeted and narrow symptoms (sleep, aggression) and follow the response in a structured manner.
- The PCP should keep in mind the higher risk of suicide associated with patients with personality disorders, especially when there is comorbid substance abuse.

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CME Questions

1. Which of the following statements about personality disorders is correct?
   a. Personality disorders are manifestations of other mental health disorders, such as depression, anxiety, or psychosis.
   b. Personality disorders are different from other disorders of mental health, in part because of the persistent and chronic nature of personality disorders rather than a waxing and waning pattern.
   c. Personality disorders are different from other disorders of mental health as a result of the extreme severity of personality disorders.
   d. Personality disorders strictly are manifestations of poor parenting and/or early trauma.
2. The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) classifies personality disorders according to:
   a. the severity of dysfunction and prominent traits.
   b. genetic links.
   c. descriptive criteria.
   d. prevalence.
3. The International Classification of Diseases 11th Revision (ICD-11) classifies personality disorders according to:
   a. the severity of dysfunction and prominent traits.
   b. genetic links.
   c. descriptive criteria.
   d. prevalence.
4. In general, recognizing a personality disorder:
   a. requires a mental health provider and psychometric testing.
   b. may be done in the primary care provider (PCP) office, but requires specialized screening and testing.
   c. may be done in the PCP office with a comprehensive history, collateral information, and ruling out other diagnoses.
   d. requires a mental health provider who has worked with the patient over time.

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5. Which of the following statements about psychotropic medication is correct?
   a. It rarely is appropriate when a patient has a personality disorder because of concerns of medication abuse.
   b. It may have a limited role in patients with personality disorders for specific and targeted symptoms.
   c. It is almost always required for patients with personality disorders, especially if suicidal thoughts are present.
   d. It is effective only in the treatment of patients with personality disorders if there are comorbidities.
6. Which of the following are common comorbidities in patients with personality disorders?
   a. Substance abuse, other disorders of mental health, insomnia, obesity, and chronic pain
   b. Substance abuse, inflammatory disease, bipolar disorder, and insomnia
   c. Intellectual disabilities, other disorders of mental health, chronic pain, and asthma
   d. Schizophrenia, learning disorders, asthma, and obesity
7. Management of "difficult" patients in the PCP office includes which of the following?
   a. Performing a psychiatric consultation before establishing as a patient
   b. Collecting collateral information and having a second provider (such as a nurse) in the office when the patient is seen
   c. Validating the concerns of the patient to help establish trust, being self-aware/managing nonproductive emotional response to the patient, setting appropriate limits
   d. Referring these patients to specialists, since they typically are not able to be managed in the PCP office
8. Which of the following statements about the risk of suicide in patients with personality disorders is correct?
   a. It is about 20% less than the risk of suicide in patients with other disorders of mental health.
   b. It is 45% higher in patients with personality disorders and alcohol abuse than in patients without mental health problems (20% higher in patients with personality disorders without comorbid substance abuse and four times higher than patients with other disorders of mental health).
   c. It is unknown because of the difficulty with accurate epidemiologic data, but probably lower than in patients with other mental health disorders, unless there is comorbid substance abuse.
   d. It is higher when patients are asked about suicidal intention or thoughts; the provider never should ask about suicidal thoughts but should wait for the patient to initiate this topic.

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