Treating Patients with Personality Disorders in Primary Care

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Objectives

- Quickly identify personality disorder traits in patients and stratify related health risks.
- Differentiate common personality disorder presentations from mood, anxiety, psychotic, and substance-related disorders.
- Apply at least three evidence-based communication strategies to improve therapeutic alliance and treatment adherence in patients with personality disorder traits.
- Develop a management plan that incorporates appropriate boundaries, safety considerations, and referral strategies for patients with personality disorder traits.

Approaches to PD Patient Care

Heuristics:

- Model healthy communication, boundaries and empathy.
- Don’t work harder than the patient.
- Practice self-awareness. Recognize the emotional state the patient provokes in you.
- Don’t hesitate to consult mental health professionals.

Targeted Approaches:

- Compassionate confrontation can be therapeutic.
- Safety is #1.
- Set clear boundaries and expectations.
- Use leverage to induce patient to achieve treatment goals.
- Validate emotional experience while being careful not to validate or invalidate irrational thoughts or actions.
- Explicitly define treatment goals.

Personality Disorder Clusters

Cluster A	Cluster B	Cluster C
Odd and Eccentric • Schizoid • Schizotypal • Paranoid	Dramatic, Erratic, Emotional • Borderline • Histrionic • Narcissistic • Antisocial	Anxious, Fearful • Avoidant • Obsessive-Compulsive • Dependent

Descriptions of Personality Disorders

Cluster A—odd or eccentric

Paranoid
- Pervasive pattern of mistrust and suspiciousness
- Begins in early adulthood
- Presents in a variety of contexts

Schizoid
- Detachment from social relationships
- Restricted range of emotional expressions

Schizotypal
- Social and interpersonal deficits
- Cognitive or perceptual distortions and eccentricities

Cluster B—dramatic, emotional, or erratic

Antisocial
- Disregard for rights of others
- Violation of rights of others
- Lack of remorse for wrongdoing
- Lack of empathy

Borderline
- Instability of interpersonal relationships, self-image, and affects
- Marked impulsivity

Histrionic
- Excessive emotionality
- Attention-seeking behavior

Narcissistic
- Grandiosity
- Need for admiration

Cluster C—anxious or fearful

Avoidant
- Social inhibition
- Feelings of inadequacy
- Hypersensitivity to criticism

Dependent
- Excessive need to be taken care of
- Submissive behavior
- Fear of separation

Obsessive-compulsive
- Preoccupation with orderliness and perfectionism
- Mental and interpersonal control

Personality Disorder Epidemiology

- Worldwide prevalence: 5-10%
- Decreases life expectancy by 5-10 years.
- 30% of patients accessing primary care and about 50% accessing outpatient psychiatric care.
- Higher rates of disability
- Higher rates of disease across multiple organ systems…

Parent-Child Outcomes	• Neurodevelopmental disorders. • Anxiety and depressive disorders. • Abuse.
Psychiatric Disorders and Addiction	• Mood disorders (MDD, Bipolar Disorder), PTSD, Substance Use Disorder, Anxiety Disorder, Functional Neurologic Symptom Disorders • Misdiagnoses are common.
Pain Disorders	• Chronic pain • Somatic symptom-related disorders (fibromyalgia, interstitial cystitis, etc.)
Cardiovascular and Metabolic Disease	• 1.5-8x more likely to have CVA or ACS event. • Higher rates of HTN, obesity. • Higher rates of psychotropic prescribing. • Diabetes • POTS
Genitourinary Disease	• STI
Neurologic Disease	• Epilepsy • Migraines
Gastrointestinal Disease	• IBS

Evidence-based Treatment

- Treat underlying mood/anxiety/thought/trauma conditions.
- Borderline PD, Narcissistic PD:
  - DBT, CBT, ACT, Mentalization-based therapy, psychodynamic psychotherapy.
- Antisocial PD:
  - Schema-based therapy, Mentalization-based therapy
- Paranoid PD:
  - CBT
- Dependent PD:
  - CBT
- Obsessive compulsive PD:
  - CBT
- Avoidant PD:
  - CBT, psychodynamic psychotherapy

Case 1

A 23-year-old woman presents to you, her new family medicine physician, due to anxiety and insomnia. She states she has an irritable mood and isn't getting along well with her fiancé, reporting she has been "blowing up" at him more often. She reports a psychiatric history of anxiety, depression and bipolar disorder, with numerous psychiatric hospitalizations as a teen. She states she has tried several SSRIs, short-term benzos, stimulants and an antipsychotic at some point during childhood. She vapes THC daily, usually for anxiety or sleep. She reports she thinks she's "manic" often and reports history of hallucinations and "paranoid" thoughts. In your review of systems, she also reports fatigue, occasional migraines, episodic, stress-induced presyncope events, and diffuse, chronic musculoskeletal pain.

Diagnosis?

A. MDD
B. Bipolar Disorder
C. Schizoaffective Disorder
D. Borderline Personality Disorder
E. Schizotypal Personality Disorder
F. Post-traumatic Stress Disorder
G. Generalized Anxiety Disorder
H. Substance-induced Mood/Anxiety/Psychotic Disorder
I. Neurocognitive Disorder w/ behavioral disturbance 2/2 TBI
J. ADHD
K. Secondary Gain

Bipolar?

Rapid mood swings (“highs and lows”) throughout the day brought on by stress. Denies distinct episodes of lack of need for sleep lasting 4+ consecutive days w/ simultaneous elated mood and elevated energy.

Psychotic ?

When stressed or depressed she sees “shadows” in her periphery (not central) and has heard “a man” who wasn’t there call her name; and she gets “paranoid” exclusively during the night when she is alone, reporting an irrational thought that someone is going to come into her home and attack her.

Case 1, continued

- BP 149/92, HR 90, BMI 42.3
- Tachycardic, otherwise normal heart and lung sounds, well-appearing.
- Presently denies SI/HI/AVH. No delusions or internal preoccupations. Insight and judgement fair
- CBC, CMP, iron studies, UA, UPT, TSH all within normal limits.
- A1c 6.8, microalbumin elevated.

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Case 1, continued

She takes up a large proportion of the visit discussing history of broken therapeutic alliances with multiple clinicians in the past “because they didn’t listen” and was discharged from the practice of her previous PCP. She states she really likes you “because you seem listen” and she has a “great feeling” about this practice.

Behaviors associated with Borderline PD

- Trauma dumping/monopolizing visit time discussing clinically irrelevant topics.
- Difficult to redirect.
- Loosely following treatment recommendations.
- Missed follow up.
- More crisis appointments/situations.
- Frequently showing up late.
- Medication sensitivities/treatment resistance.
- Splitting clinician-clinician and clinician-office staff relationships.
- Poor communication/judgmental statements.

➢Projective identification.

Approaches to Borderline PD Behaviors

- Recognize the red flags early.
- Take your own pulse.
- Validate feelings to build therapeutic alliance with empathic statements.
- Clearly and explicitly state your expectations.
  - Hold the line! Stick firmly to your clinical boundaries.
- Practice shared decision-making.
- Avoid prescribing controlled substances when possible.

Case 2

A 43-year-old man presents for post-hospital follow up at your clinic. You see him via telehealth which has always been the case since he came to your practice during the COVID-19 pandemic. He rarely follows through on getting recommended tests and lab work and often goes off his medications, sometimes for a month or more; his recent hospitalization was at least partially related to non-adherence.

Diagnosis?

A. Generalized Anxiety Disorder
B. Agoraphobia
C. Illness Anxiety Disorder
D. Obsessive Compulsive Disorder
E. Avoidant Personality Disorder
F. Obsessive Compulsive Personality Disorder
G. Social Anxiety Disorder

Avoidant Personality Disorder-associated Behaviors

- Avoiding self-advocacy.
- Will agree to anything you say but will often not follow through.
- Will often not seek care unless it’s an emergency.
- Self-isolate, which creates additional barriers to care.

Approaches to Avoidant PD Behaviors

- *Avoid* prescribing controlled substances when possible.
- Ask about barriers to care and strategize to overcome them.
- Validation, positive reinforcement.
- Gentle paternalism.

Case 3

A 39-year-old man with history of Type 1 Diabetes presents to his primary care physician for establishment of care. He declines to complete intake forms fully and self-pays. During the clinical interview he is a somewhat reliable historian and reports ongoing symptoms of fatigue and chronic lower back pain. His speech is coherent, behavior goal-directed, and there is no evidence of hallucinations or fixed delusions.

Case 3, Continued

At subsequent follow up visit, he has not completed maintenance lab work. When the physician greets him, he voices that he's upset the physician is running 15 minutes late. After you ask how you can help, he tells you that his wife urged him to come see you because he has been having "dizziness" and she thinks it's because he stopped taking his insulin. When you ask if he would like to get back on insulin as prescribed, he tells you he stopped insulin and started taking a supplement sold by his favorite comedian-podcaster to "treat" his condition" more holistically. You explain to him (again) the difference between his condition, Type 1 Diabetes, and type 2. In spite of your extensive counseling, he declines your recommendations and is lost to follow up.

Diagnosis?

A. Delusional Disorder
B. Schizophrenia
C. Schizoaffective Disorder
D. Paranoid Personality Disorder
E. Schizoid Personality Disorder

Paranoid Personality Disorder-associated Behaviors

- Resistance to following treatment recommendations.
- Aversion toward biopharmaceuticals or accessing traditional Western medical care.

Approaches to Paranoid PD

- Validate emotional experience. Be careful not to validate or invalidate irrational thoughts or actions.
- Practice shared decision-making.
- Showing interest is giving care. The goal is building trust.

Case 4

A 38-year-old woman presents to a primary care clinic for evaluation of intermittent fatigue and poor concentration. Upon learning that her appointment today is with a nurse practitioner rather than a physician, she asks to be rescheduled. When she is told by the staff member that the next appointment with the physician is in 6 months, she agrees to attend her scheduled appointment for the day. Throughout the visit, she repeatedly references difficulty having to “deal with all of these stupid people around” her. Mental status examination reveals no evidence of depression, psychosis or mania.

Diagnosis?

A. Bipolar Disorder
B. Cyclothymic Disorder
C. Narcissistic Personality Disorder
D. Antisocial Personality Disorder

Narcissistic Personality Disorder-associated Behaviors

- Litigious
- Entitled
- Perseverative on clinician's credentials and training.
- Can dysregulate if ego is challenged.
- Resistant to accessing mental health resources.
- Almost delusional sense of expertise.

Approaches to Narcissistic PD

- Mentalization
  - Be curious about the patient's emotional experiences.
  - Encourage therapeutic alliance with 'we' rather than 'me' language.
  - Thought experiments exploring the emotions and motivations of others.
- Practice shared decision-making.
- Redirect focus back to problem at hand.

Case 5

A 34-year-old man presents to a primary care clinic requesting medication for chronic back pain and anxiety. He states he was previously treated with “a medication with a name like, ‘ata-something’.”

The clinician replies, “Do you mean ‘Atarax’?

“No,” says the patient. “I tried Atarax before and it just put me to sleep…I tried one of my sister’s Klonopin and I never felt better, it really helped.”

The clinician replies, “I just have a few questions for you, and I’d like to do an exam, so I can come up with a more definitive, or solid, diagnosis to inform an appropriate treatment.”

“You’re all alike!” exclaims the patient. “You won’t give me the treatment I need. You don’t care about me.” The patient abruptly jumps to his feet and heads for the exam room door.

The clinician quickly reaches the door and opens it before the patient, exiting room for both parties to safely leave. The patient exits the building safely and without incident and security is notified.

Diagnosis?

A. Intermittent Explosive Disorder
B. Schizophrenia
C. Traumatic Brain Injury
D. Antisocial Personality Disorder
E. Narcissistic Personality Disorder

Antisocial Personality Disorder-associated Behaviors

- Appears eerily charming, confident, calm.
- Often seeks care for secondary gain.
- Big adult-tantrum in the middle of the waiting room.
- Assaulting or making inappropriate comments to staff.

Approaches to Antisocial PD Behaviors

- Situational awareness.
- Have an office safety plan in place.
- Present as a united front with staff.
- Clearly and directly communicate expectations and consequences of both violating and adhering within boundaries.

Case 6

A 29-year-old woman presents to her primary care provider for evaluation of abdominal discomfort and dysuria. She is well-known to the front office staff as someone whom staff describe as, ‘a lot.’ As she gets her vitals checked in the triage area, she can be heard all the way down the hall through closed doors crying and talking loudly to the medical assistant about how she’s so happy she finally found ‘the love of [her] life.’ When the physician assistant arrives in the exam room the patient smiles big and compliments the PA’s appearance before he is able to introduce himself. She is dressed in bulky jewelry and what appears to be a loose-fitting camisole that is not appropriate to situation. When asked about her complaints she redirects the conversation to talk about specific sexual acts she has been exploring with her new boyfriend in explicit detail. She also reports intermittent anxiety and irritability, and requests STI testing.

Diagnosis?

A. Borderline Personality Disorder
B. Exhibitionistic Disorder
C. Acute Intoxication
D. Sexual Sadism Disorder
E. Schizotypal Personality Disorder
F. Histrionic Personality Disorder

Histrionic Personality Disorder-associated Behaviors

- Provocatively dressed.
- Overtly flirtatious.
- Drama, drama, *drama*!

Approaches to Histrionic PD Behaviors

- Bring a chaperone into the exam room.
- Do not respond to flirtatious or salacious or provocative comments and redirect focus to clinically relevant conversation.
- Maintain strict professional boundaries.

Takeaways

- Presence of personality disorders can come with specific health risks, and complicate diagnosis and treatment.
- Check your pulse. Be mindful of countertransference.
- Modeling healthy behaviors is therapeutic.
- Identify PD behaviors and apply your newly developed behavioral approaches.
- Facilitate access to mental health services when appropriate.
- Patient and staff safety is a priority. Have plans in place.

Patient Resources

- BPD Alliance: Borderline Personality Disorder: Symptoms, Treatment & Family Support | BPD Alliance - BPD Alliance
- New England Personality Disorder Association: NEPDA
- Stop Walking On Eggshells | Dealing With High-Conflict People

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Questions?