

Personality Disorders: Clinical Application in Daily Practice

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- Discuss unique characteristics of main PDs
- Describe how PDs impact patient presentations
- Identify appropriate responses to PD patients concerns and symptoms.
- Through case discussion discuss collaborative and psychotherapy care.

What is a Personality Disorder?

DSM 5 Personality Disorder General Criteria

- A. An enduring pattern of inner experience & behavior that deviates markedly from expectations of the individual's culture in 2 or more of the following areas...
- cognition
 - affect
 - interpersonal functioning
 - impulse control

DSM 5 Personality Disorders General Criteria

- B. The pattern is **inflexible** and **pervasive** across a broad range of personal and social situations.
- C. Clinically significant distress or impairment (occupational, social).
- D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
- **Ego syntonic.** Part of who they are, and they often have no desire to change those symptoms
- E. Not something else, drugs or medical condition

Personality Disorders: Facts and Statistics

Prevalence

About 15% of the general population
Rates are higher in primary care settings.
Much higher in psychiatric settings.

Origins and Course of Personality Disorders

Predispositions in form of temperament
Affected by experience
Run a chronic course
Comorbidity rates are high

*National Epidemiologic Survey (NESARC).
Journal of Clinical Psychiatry, 2004*

Why is it important to assess for Personality Disorders?

- Consequences of under-diagnosis
- Consequences of over-diagnosis

Consequences of under-diagnosis

PD Associated with

- Increased suicide risk
- Increased violence/criminality risk
- Increased social /occupational difficulties
- Misdiagnosis of other clinical conditions
- Poorer response to treatment for clinical conditions
- Many are manipulative
- Impact on clinical care

Consequences of over-diagnosis

- STIGMA, STIGMA, STIGMA
 - Permanent record
 - Influences future diagnoses
 - Influences how mental health provider interacts with patient

DSM-5 Personality Disorders

- A. Odd/Eccentric
 - A. Schizoid
 - B. Schizotypal
 - C. Paranoid
- B. Dramatic, Emotional, or Erratic
 - A. Borderline
 - B. Narcissistic
 - C. Antisocial
 - D. Histrionic
- C. Anxious or Fearful
 - A. Avoidant
 - B. Obsessive-compulsive
 - C. Dependent

DSM-5 Changes

- No longer an Axis 1/Axis 2 distinction.
- Proposes an *Alternative Model*
 - Disturbances in **self** and **interpersonal** functioning
 - Pathological Personality Traits related to:
 - Negative Affectivity -- Emotional Stability
 - Antagonism -- Agreeableness
 - Detachment – Extroversion
 - Disinhibition--Conscientiousness
- Six existing personality disorders expected to continue

Specific DSM-5 Personality Disorders

- A. Odd/Eccentric
 - A. Schizoid
 - B. Schizotypal**
 - C. Paranoid
- B. Dramatic, Emotional, or Erratic
 - A. Borderline**
 - B. Narcissistic**
 - C. Antisocial**
 - D. Histrionic
- C. Anxious or Fearful
 - A. Avoidant**
 - B. Obsessive-compulsive**
 - C. Dependent

PD Case 1—HF

- 45 y/o single female.
- Lives alone in the former family home supported by parents.
- Followed by our PCPs since November 2015.

HF-Active Problems

- Allergic rhinitis
- Anxiety
- Asymmetric SNHL (Sensorineural hearing loss)
- Bacterial vaginosis
- Cough
- Dizziness
- Dysuria
- Earache
- Obesity
- Skin rash
- Sore throat
- Tinnitus, right
- Urinary frequency
- Vaginal pain

HF – Active Meds

- BuPROPion HCl ER (XL) 300 MG
- Claritin 10 MG
- Fluconazole 150 MG
- Fluticasone Propionate 50 MCG/ACT
- MetroNIDAZOLE 500 MG
- Triamcinolone Acetonide 0.1% External Cream
- Venlafaxine HCl ER 37.5 MG

HF Physician Note A

Chief Complaint

- The patient presents to the office today with/for f/u anxiety.

History of Present Illness

- Anxiety - Switched off Lexapro as had been gaining weight and making her tired. Doing well with Effexor now for the last month. Gets a little groggy if takes too late with Wellbutrin and now separates it and is doing well. Stress and anxiety much more stable.
- Not nearly as "reacting."
- Things are stable. Feels like Effexor is working really well. Thinks more laid back and mom also notices it. Upset about gaining weight. Stressed out a little bit. Upset about that guy.

HF Physician Note A *continued*

Assessment

- Anxiety
- Obesity

Discussion/Summary

- Anxiety – improved
- Continue Effexor XR 37.5 MG daily
- Continue Wellbutrin XL 300 mg daily
- Refer to behavioral health for CBT – recommended remaking that appointment

HF Integrated Behavioral Health - Phone call

- Patient was advised in phone call about cycle of abuse when she reported what sounded like sexual exploitation and aggressive interactions from two men. She had discussed this with her mother who asked her to call us.
- Not in crisis.
- Patient to keep appointment.

HF – IBH Visit

- Patient has begun to recognize this pattern and has been wary although she went out with one of these men last night.
- Patient lacks insight into their effect on her emotionally and inappropriate coping and poor boundaries on her part. Worries frequently about this but not disengaging.
- Gets excited by their overtures.
- Denies depression, substance use and suicidal ideation and rage.
- Discussed limit setting and patient to return with plan.

HF Physician Notes Visit B

HPI

- 45 y/o female presenting with a 2-3 day h/o vaginal redness, foul smell, milky white discharge, frequency and dysuria.
- She states she had a new sex partner one week ago and used protection but intercourse was painful. Then a few days later, she used a vibrator and endorsed significant pain with use.
- States she has had pain with sex for the past 4-5 years.
- In addition, she states she has frequent yeast infections with past intercourse.
- Denies previous h/o STDs and has been tested previously. Her last PAP smear was 1-2 years ago.

HF - IBH Visit

- Patient presented back to the clinic after being dismissed from care because of three missed appointments. It was apparent that patient needed clinical care, therefore I saw the patient again and advocated for her reentry back into clinic care.
- Patient very focused on telling story. Frequently states "I don't know why I am doing this" then gives some explanations like I don't feel good enough about myself since I've put on weight.
- Strokes hair frequently. Very short, tight shorts.
- In session, patient discussed her pattern of dating abusive partners. Patient spoke about her feelings when her partner treats her poorly and described that she feels "dirty and disgusting" when her partner tells her to take explicit pictures of herself.
- Continued to explore how boyfriend's controlling behavior and sex acts make her feel. Patient struggled at first giving thoughts. After clarification, patient described as feeling "down, sad, and alone" when her boyfriend controls her behavior.
- Patient kept asking "Why am I doing this?" and was seeking clarification from therapist. Interpreted how important attention is for patient and the difference between short term and long term feelings.
- Plan includes for patient to write letter to clinic for reentry and therapist clarified importance of this letter. The plan also includes helping patient identify feelings and assisting the patient with getting more power and control back into her life.

Histrionic

A pattern of excessive emotionality and attention seeking.

Associated Features:

- This patient will get you in trouble
- Attempts to control other persons while establishing dependent relationship
- Often overly trusting
- Comorbidity with somatization



https://www.youtube.com/watch?v=7NErj_tot9Y

Video from 2:39 to 3:51

Mnemonic for Histrionic PD (5/8)

- P - provocative (or seductive) behavior
- R - relationships, considered more intimate than they are
- A - attention, must be at center of
- I - influenced easily
- S - speech (style) - wants to impress, lacks detail
- E - emotional lability, shallowness
- M - made-up (physical appearance get attention)
- E - exaggerated emotions (theatrical)

Clinical Application in Daily Practice Histrionic PD

PATIENT PERSPECTIVE

- Illness results in feeling unattractive or presents an opportunity to receive attention.

PROBLEM BEHAVIORS

- Overly dramatic, attention-seeking.
- Excessively familiar relationship.
- Not objective - overemphasis on feeling states.

HELPFUL PROVIDER BEHAVIORS

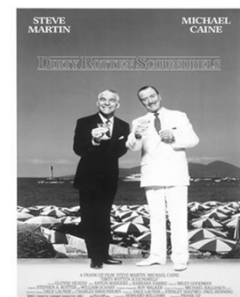
- Avoid frustration with patient vagueness.
- Show respectful and professional concern for feelings, with emphasis on objective issues.
- Avoid excessive familiarity.

Antisocial PD

A pattern of disregard for, and violation of, the rights of others.

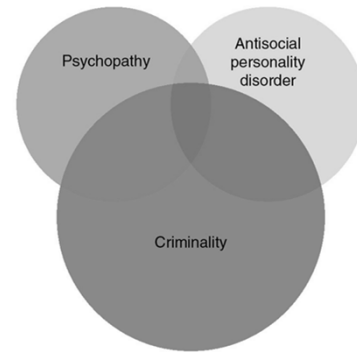
Associated Features:

- Diminishes in midlife
- Substance abuse
- Early sexual experiences
- High levels of criminality



Mnemonic for Antisocial PD (3/7)

- C - cannot follow law
- O - obligations ignored
- R - remorselessness
- R – reckless disregard for safety
- U – underhanded (deceitful)
- P - planning deficit (impulsive)
- T - temper (irritable, aggressive)
- + Childhood conduct disorder



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Clinical Application in Daily Practice Antisocial PD

PATIENT PERSPECTIVE

- Threatened if unable to feel "on top."
- Illness presents opportunity for crime.

PROBLEM BEHAVIORS

- Acts out to gain control; malingering; uses staff and physicians.
- Superficially charming.
- Drug seeking.

HELPFUL PROVIDER BEHAVIORS

- Do not succumb to patient's anger and manipulation.
- Avoid punitive reactions to patients.
- Motivate by addressing patient's self-interest.
- Set clear limits that interventions must be medically indicated.

Narcissistic PD

A pattern of grandiosity, need for admiration, and lack of empathy.

• **Associated Features:**

- May attain significant achievement, but they rarely accept it as "enough" or derive pleasure from it
- Self-esteem, outwardly high, is actually quite fragile with a need for constant attention and admiration
- Other PD are common
- Adjustment Disorders common



<https://www.youtube.com/watch?v=Bmlu26h9H8M>

Mnemonic for Narcissistic PD (5/9)

- S – Special (believes they are)
- P – Preoccupied with fantasies of success, etc.
- E³ – Envious (of others), Entitled, Excessive admiration needed
- C -- Conceited
- I -- Interpersonally Exploitive
- A -- Arrogant
- L -- Lacks Empathy

Clinical Application in Daily Practice Narcissistic PD

PATIENT PERSPECTIVE

- Illness results in feeling inadequate or is an opportunity to receive admiration.

PROBLEM BEHAVIORS

- Demanding and entitled attitude
- Will overly praise or devalue care providers to maintain sense of superiority.

HELPFUL PROVIDER BEHAVIORS

- Avoid rejecting the patient for being too demanding.
- Avoid seeking patient's approval.
- Do not treat emotional reactions.
- Generously validate patient's concerns, with attentive but factual response to questions.
- Protect self esteem of patients by giving them a role in their care.

PD Case 2--BLF

- 28 y/o female, single, never married, lives alone.
- UK professional official, masters degree.

BLF – Active Problems

- Contraceptive surveillance
- Counseling for travel
- Generalized anxiety disorder
- Irritable bowel syndrome (IBS)
- Possible exposure to STD
- Well female exam with routine gynecological exam

BLF– Active Meds

- Ciprofloxacin HCl – 500 MG
- Ondansetron 8 MG 3 x daily

BLF – Physician Notes

Chief Complaint - **Psych disturbances**

History of Present Illness

- Dx with oppositional defiant disorder in teenage years, was placed on medication for a while, but d/c and has been on therapy which helped.
- No hospitalizations, SI/HI in past or current. Patient was on retreat for work and was excessively worried about her dog, to the point she was not interacting with co-workers, did not participate in activities.
- Family member and friend in the last couple of weeks are concerned she is bipolar.

BLF – Physician Notes *continued*

Chief Complaint - **Psych disturbances** *continued*

History of Present Illness

- No changes in appetite or weight.
- Throughout week patient has days with depressed mood, generalized anxiousness, anhedonia, lack motivation, upset at people around her.
- These are followed by few days when she is normal functioning, productive at work, at home, as well as socializes with friends.

Case 2 – Physician Notes *continued*

Chief Complaint - **Insomnia**

History of Present Illness

- Since patient started graduate school 3 years ago and has been improved with OTC sleeping medications.
- Has tried sleep hygiene techniques in the past, however, never for extended period of time.
- She has reduced caffeine intake. No caffeine after noon.

BLF – IBH Intake

History of present illness

- Referred by MD.
- Symptoms of up and down reactive mood, extreme homesickness (moved to KY one year ago to take professional job).
- Loves job, but gets anxious and mood changes across multiple work situations.
- Feels disconnected from people at times.
- Very attached to mother and pets.
- Reports intense, quickly formed heterosexual relationships.
- Endorses fearing abandonment.
- Denies suicide attempt. Has had ideation when low mood but not now.
- Sometimes uncertain of who she is.
- Denies manic symptoms, substance abuse and micropsychotic symptoms. Does not recall any medications for this.
- Denies history of molestation/trauma.

BLF – Physician notes: health maintenance evaluation

History of present illness

- Social history: patient lives alone. She is not ready to quit drinking.
- Dental, vision, hearing: She has regular dental visits. She denies vision problems. She denies hearing loss.
- Lifestyle: She consumes a diverse and healthy diet. She does not have any weight concerns. She does not exercise regularly. Exercise includes walking. She uses tobacco.

BLF – Physician notes: health maintenance evaluation

continued

- Tobacco use duration: 10 pack year(s) of cigarette use.
- She consumes alcohol. She reports frequent alcohol use and does not want to discuss further today.
- Reproductive health: She reports regular menses. She uses no contraception. She is not sexually active. She denies prior pregnancies.
- Additional history: OB/GYN – last pap at UK Dec 2015. No h/o abnormal pap smears. GPO. Pt currently not taking BC. Periods are regular.

BLF – IBH Visit-@ 1 year in tx

Counseling

- Patient drinking less alcohol
- Took week off after semester started for sudden trip home.
- Feeling very angry towards work and father.
- Intervention:
 - We practiced mindfulness to manage anger
 - Discussed impact of first of semester and time away on work load
 - Identified helplessness and frustration she feels with father to develop insight into the projective identification she is experiencing.

Borderline PD

A pattern of instability in, self-image, interpersonal relationships, and affect, and marked impulsivity.

Associated Features:

- Up to 10% of persons with BPD eventually die by their own hand
- High co-morbidity with Mood Disorders
- Marked mood shifts, unpredictable
- Undermining one's own success
- Some symptoms may improve by midlife
- Over 50% report childhood maltreatment

<https://www.youtube.com/watch?v=9DQ7wLbuXAM>



Mnemonic for Borderline PD (5/9)

- A - Abandonment fears
- M - Mood instability
- S - Suicidal / self-injurious behavior
- U - Unstable, intense relationships
- I - Impulsivity
- C - Control of anger poor
- I - Identity disturbance
- D - Dissociative / paranoid symptoms
- E - Emptiness

Borderline PD Description

PATIENT PERSPECTIVE

- Fears abandonment.
- Overreacts to symptoms and situation.

PROBLEM BEHAVIORS

- Idealizes, then devalues care;
- Self-destructive acts.
- Splits staff.

HELPFUL PROVIDER BEHAVIORS

- Manage feeling of hopelessness about patient.
- Avoid getting too close emotionally.
- Schedule frequent periodic checkups.
- Tolerate periodic angry out-bursts, but set limits.
- Monitor for self destructive behaviors.
- Discuss feelings with coworkers.

Borderline defenses

- Splitting (DSM-IV, pg. 757). The individual deals with emotional conflict or internal or external stressors by compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of the self or others into cohesive images. Because ambivalent affects cannot be experienced simultaneously, more balanced views and expectations of self or others are excluded from emotional awareness. Self and object images tend to alternate between polar opposites: exclusively loving, powerful, worthy, nurturant, and kind--or exclusively bad, hateful, angry, destructive, rejecting, or worthless.
- Projective identification (DSM-IV, pg. 756). The individual deals with emotional conflict or internal or external stressors by falsely attributing to another his or her own unacceptable feelings, impulses, or thoughts. Unlike simple projection, the individual does not fully disavow what is projected. Instead, the individual remains aware of his or her own affects or impulses but misattributes them as justifiable reactions to the other person. Not infrequently, the individual induces the very feelings in others that were first mistakenly believed to be there, making it difficult to clarify who did what to whom first.

PD Case--DF

- 58 y/o female.
- Part time school teacher
- Divorced. 3 children.
 - Son in and out of the house.

DF – Active Problems

- Anxiety
- Benign paroxysmal positional vertigo
- Closed fracture of base of metatarsal bone
- Distal radius fracture
- Forearm fracture
- Forearm fractures, both bones, closed
- Headache
- Insomnia
- Left foot pain
- Sleep apnea

DF – Active Meds

- Clonazepam 1 MG; 2 tabs po tid for anxiety
- Trazodone HCl – 150 mg 1x daily
- Butalbital-Aspirin-Caffeine 50-325-40 MG;
- Amitriptyline HCl – 25 MG oral tablet; take 1-2 pills per day

DF – MD Visit

Chief Complaint - **Anxiety**

HPI

- She is not sleeping well and her anxiety is not controlled and it is "off the chart." The clonazepam is not working.
- The trazodone is also not working. She is taking 100 of Trazodone about 7:30 pm which again is not helping sleep.
- She is on a waiting list for UK Harris Center for her anxiety which they have a therapist and a psychiatrist.
- She is having trouble with living life.
- She is agoraphobic. She is having issues with her son who is now out of her house.
- She spends a lot of time crying and she is having nightmares.

DF – MD Visit *continued*

- She can fall asleep without any problem but she wakes up early.
- She is not having SI. She has a new grand baby in Ohio and she wants to live for her.
- She has no support system here. She has a neighbor which checks on her.
- She keeps saying it will take too long to explain things to me about the situation about her son.
- She wants anxiolytics and she took her last dose pf clonazepam this am.

DF – IBH Intake

Counseling

- Patient referred by MD for severe anxiety. PT reports many years of anxiolytic medications (17 years with Xanax).
- Reports significant anxiety when d/c'd but not seizures.
- Has had SSRI's and mirtazapine.
- Receiving clonazepam 2 mg (but taking 1-1.5mg) TID and Elavil now.
- Focused on getting benzodiazepines.
- Tried other treatments including aroma therapy and homeopathy.

DF – IBH Intake *continued*

- Previous tx at Harris Center but not compliant. Expects psychiatrist there will prescribe benzo's
- Describes dysfunctional relationship with her son.
- Affect varies animated to tearful. Very talkative. Goes on about problems after point made. Requires redirection.
- Low cut blouse. When animated sits with side to me and feet on couch. Strokes her thigh.
- Several comments suggesting fear of not being taken care of properly or abandonment.

DF – IBH Intake Diagnosis and Plan

- Was counseled regarding confidentiality, risks and benefits of treatment options, importance of compliance with treatment.
- Impression: not of imminent harm to self-others with anxiety worsened by long term benzo use.
- Diagnoses: Dependent Personality Disorder; Benzodiazepine Dependence (Quasi therapeutic treatment)
- Has not been compliant with treatment.
- Has not had adequate trial of psychotherapy.
- Patient will return to discuss treatment but told that she will have to wean off anxiolytic to treat this correctly.
- Build trust. Manage manipulations. Coordinate with medical providers.

DF – IBH 4th Visit

Counseling

- Patient introduced to CBT model to identify situation, thoughts, feelings and behaviors.
- Able to identify patterns, and using recent event with daughter, we noted catastrophic thoughts, belief that situation was unfair, and regression to anxious/helpless state.
- Patient is making good progress and understands how her anxiety has become conditioned and how this approach should help.

Case 3 – IBH 4th Visit *continued*

- Patient knows we will also train her to be able to use her mind-body connection positively to manage anxiety and pain.
- After a bit more progress, she should be able to benefit from support group for families of substance users which will help her to deal with her enmeshment and anxious role in the family. Will introduce that as adjunct soon.

DF – MD Visit

Anxiety

- She got to see her granddaughter who is about 7 weeks old which really helped.
- She is overall the same, but the day she saw her grand baby made her very happy.
- She is eating more while she was around the baby.
- She has a subbing job tomorrow at (school). The last time she worked was around April and she knows this will be good for her.
- She is seeing Dr. Elder. She has homework from him and she is trying really hard.

DF – MD Visit *continued*

- She is cleaning daily, and going to doctor appointments but she is in the bed a lot still.
- She feels about the same as last time but her mind is telling her she can get better.
- She is about to cut down about 5 pills over the last month of the clonazepam.

DF – MD Visit *continued*

Headaches

- She has them about 4 times a week. She gets relief from Fioricet.
- The pain is brought on by stress. These are not migraines. The pain will go away within 20 minutes.
- The headaches have not changed in character.
- Her headaches have been consisted the whole time.

Insomnia

- She is doing well on her Amitriptyline. She is taking one-two tabs at bedtime.

Dependent PD

A pattern of submissive and clinging behavior related to an excessive need to be taken care of.

DPD Mnemonic (5/8)

- **D** – Difficulty making everyday decisions
- **E** – Excessive lengths to obtain nurturance and support from others
- **P** – Preoccupied with fears of being left to take care of self
- **E** – Exaggerated fears of being unable to care for himself or herself
- **N** – Needs others to assume responsibility for his or her life
- **D** – Difficulty expressing disagreement with others
- **E** – End of a close relationship = beginning of another relationship
- **N** – Noticeable difficulties in initiating / doing things on their own
- **(T)** – “Take care of me” is his or her motto



Dependent PD Description

PATIENT PERSPECTIVE

- Fears abandonment. Intensifies feelings of helplessness.

PROBLEM BEHAVIORS

- Dramatic and urgent demands for medical attention; may contribute to or prolong illness to get attention.

HELPFUL PROVIDER BEHAVIORS

- When exhausted by patient needs, avoid hostile rejection of patient.
- Give reassurance and consistency.
- Set limits to availability - schedule regular visits.
- Help patient obtain outside support.

Working with patients w/ BPD in medical settings

1. Recognize the characteristics. The patient fears abandonment and increase demands on the physician. May be noncompliant, manipulative, somaticize, or “split” the healthcare team.
2. Behavior is need-driven. Demands may be overt or covert. Identify needs and motivations. Patient has little insight into problems. Externalization is symptomatic.

Working with patients w/ BPD in medical settings *continued*

3. Tolerate patient’s behaviors. Speaking “harshly or strictly” will activate abandonment fears and worsen the situation. Use a non-confrontational but an educational approach.
4. A long-term plan provides stability for the patient. Follow continuity of care principles. This may be curative for the patient.

Working with patients w/ BPD in medical settings *continued*

5. Titrate closeness and visit frequency. Avoid extremes of constant availability.
6. Set limits. Make clear agreements about call and office visits. Point out to patients that you are almost always involved in solving some type of problem and are unable to give full attention to their problems without an appointment. Suggest that patients schedule fairly frequent visits so that a regular time is available to discuss the problems they are experiencing.

Working with patients w/ BPD in medical settings *continued*

7. Foresee problems related to abandonment fears such as when the social situation is disturbed, when the patient is referred, or when there are changes in physician or staff.
8. Use a multidisciplinary approach. Involve a highly skilled clinical psychologist or clinical social worker in the care. Encourage communication and cooperation among the care team.

Working with patients w/ BPD in medical settings *continued*

9. Monitor your and the staff’s reactions. Frustration and anger may be expected. Discuss the situation. Help the staff to recognize that the etiology of the frustration might originate in the patient’s personality, not in the crisis of the moment. Coordinate responses to patients.
10. Set personal limits for the number of these challenging patients that you accept into your practice.

Schizotypal PD

A pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.

Associated Features:

- Interpersonal relatedness impaired w/rare reciprocation of the expressions or gestures of others
- Few close friends
- Features of Borderline Personality often present.
- History of MDD common (> 50%)



Mnemonic for Schizotypal PD (5/9)

- M - magical thinking
- E - eccentric behavior or appearance

- P - paranoid ideation
- E - experiences unusual perceptions
- C - constricted (or inappropriate) affect
- U - unusual thinking & speech
- L - lacks friends
- I - ideas of reference
- A - anxiety (socially)
- R - rule out psychosis

Clinical Application in Daily Practice Schizotypal PD

PATIENT PERSPECTIVE

- Understanding of care may be odd or near delusional.

PROBLEM BEHAVIORS

- Odd health beliefs and behaviors.
- Poor hygiene.
- Avoids care.

HELPFUL PROVIDER BEHAVIORS

- Communicate directly.
- Avoid misinterpreting patient as intentionally noncompliant; do not reject patient for oddness
- Honor patient's beliefs.