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THE DOCTOR, THE HATEFUL PATIENT & THE MOVIES

Management of Personality Disorders in a Primary Care Setting

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303 724-7734
<table>
<thead>
<tr>
<th>Cluster A (Odd, Eccentric)</th>
<th>Cluster B (Dramatic, Emotional)</th>
<th>Cluster C (Anxious, Fearful)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Paranoid</strong>&lt;br&gt;Expects exploitation, harm; questions loyalty, fidelity; bears grudges; easily slighted</td>
<td><strong>1. Antisocial</strong>&lt;br&gt;Cruelty; problems with authority, unlawful exploits others behavior; dishonesty; irresponsibility;</td>
<td><strong>1. Dependent</strong>&lt;br&gt;Indecisive; lacks initiative; submissive; helpless; dependent; fears abandonment</td>
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<tr>
<td><strong>2. Schizoid</strong>&lt;br&gt;Loner; aloof; indifferent to praise or criticism; social anxiety; constricted affect</td>
<td><strong>2. Histrionic</strong>&lt;br&gt;Overly emotional; seductive, sexual attention seeking; shallow, superficial</td>
<td><strong>2. Obsessive-compulsive</strong>&lt;br&gt;Perfectionism; inflexibility; detail preoccupation; wishes to control others; stingy; over-conscientiousness; excessive morality or ethics</td>
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<tr>
<td><strong>3. Schizotypal</strong>&lt;br&gt;Odd, eccentric; social anxiety; magical thinking; suspicious, paranoid ideation</td>
<td><strong>3. Borderline</strong>&lt;br&gt;Unstable intense relationships; self-destructive, suicidal; impulsive; affect instability; identity disturbances</td>
<td><strong>3. Avoidant</strong>&lt;br&gt;Easily hurt; timid, fearful; social discomfort; avoids interpersonal interactions</td>
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<td><strong>4. Narcissistic</strong>&lt;br&gt;Grandiose; inflated self-importance; entitled; exploits others; lacks empathy; needs admiration; hypersensitive to criticism</td>
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<tr>
<td><strong>Self-Defeating</strong>†&lt;br&gt;Suffers; self-sacrificing; defeats others; self-destructive; can’t enjoy; easily hurt</td>
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## Movie Analysis

<table>
<thead>
<tr>
<th>Schema</th>
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<td><strong>Patient Fears &amp; Core Beliefs</strong></td>
<td>Review on your own See below</td>
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<td><strong>Interventions</strong></td>
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| Patient Fears & Core Beliefs | Review on your own  
See below |
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See below |
| Medical Utilization     | Review on your own  
See below |
| Coping Styles           | Review on your own  
See below |
| Defenses                |          |                   |
| Interventions           |          |                   |
PERSONALITY DISORDERS-DSM-5 [KEY POINTS 1]

• An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture.
• Problems are in at least two of these areas: cognition, affectivity, interpersonal functioning, and impulse control.
• An enduring pattern is inflexible and pervasive across a broad range of persona and social situations.
• The enduring pattern leads to clinically significant distress or impairment in social, occupational or other areas of functioning.
• The pattern is stable and of long duration and onset can be traced back to adolescence or and is diagnosed in adulthood.
• To diagnose begin with dimensional measures: Cluster A-odd eccentric, Cluster B- dramatic emotional Cluster C-avoidant fearful. ( Table-1)
• Use the categorical classification systems to identify the specific personality disorder
• A particular patient may have traits from different clusters and may meet criteria for more than one personality disorder.

SCHEMA FOR MANAGING PATIENTS SUFFERING WITH A PERSONALITY DISORDER [KEY POINTS 2]

To create therapeutic relationships with personality disordered patients who might otherwise be experienced as difficult, and to offer a management strategy, the following five-step process is useful for family physicians:

• The clinician must first understand patients’ core beliefs, irrational thoughts, and fears;
• Identify the patient’s defense mechanisms and coping style, and use confrontation, clarification, and interpretation to modify these.
• Recognize recurrent patient behaviors and how these will likely affect patient adherence and use of medical services.
• Learn to use the physician’s own reactions to the patient to help identify the diagnosis and management strategy.
• Recognize that specific interventions are helpful for different types of patients. (Table 3)

PATIENT CORE BELIEFS, IRRATIONAL THOUGHTS, AND FEARS [KEY POINTS 3]

• Patients have identifiable core beliefs or worldviews, and fears.
• These interact and can feed off each other in difficult patients.
• Stress activates these core beliefs and precipitates intense and dysfunctional emotions, fears, thoughts, physical symptoms or maladaptive behaviors which are characteristic for each specific personality disorder ( Table-2)
• Adherence to medical recommendations and use of medical services are somewhat predictable based on the particular personality disorders.
DEFENSES AND COPING STYLES [KEY POINTS 4]

- Defense mechanisms are automatic internal psychological processes that protect the patient from anxiety and stress and help with adaptation to the environment.
- Patients with specific personality diagnoses use a known range of particular defense mechanisms (see Table 2).
- Patients with unexplained somatic symptoms tend to use denial, externalization, and somatization, converting psycho-social distress and problematic interpersonal relationships, into unexplained physical complaints.
- Coping styles are typical behavioral ways of dealing with the external world.
- Patients with specific personality diagnoses tend to use a known range of coping styles (see Table 2).
- Patients with severe unexplained somatic symptoms tend to use high/low anxious coping styles or manipulative coping styles (See Table 3).

PATIENT BEHAVIORS, ADHERENCE, AND USE OF MEDICAL SERVICES [KEY POINTS 5]

- Cluster A personality disorders (paranoid, schizoid, and schizotypal) tend not to adhere to medical recommendations and underuse medical services.
- Cluster B patients (antisocial, histrionic, borderline, narcissistic, and self-defeating) tend to have variable adherence to medical recommendations and may misuse, overuse, or underuse medical care.
- Cluster C patients (dependent, obsessive-compulsive, avoidant) tend to adhere to medical recommendations because of fear of the consequences of non-adherence.

PHYSICIAN REACTIONS TO PATIENTS WITH A PERSONALITY DISORDER [KEY POINTS 6]

- Physician reactions are useful in recognizing, diagnosing, and managing difficult patients.
- Reactions stirred by the patient are referred to as patient-generated counter-transferences.
- Physician reactions are often similar or shared in common by all physicians seeing the patient, with some elements peculiar to each individual physician.
- Difficult patients often generate intense physician feelings.
- There may be fantasies or thoughts about the patient that are uncharacteristic for the physician.
- The physician may engage in atypical behaviors that would normally not be typical for him or her (see Table xx-2).

GENERAL MANAGEMENT PRINCIPLES FOR PATIENTS WITH A PERSONALITY DISORDER [KEY TREATMENT BOX 1]

- Attend to the doctor-patient relationship.
- Focus the interview on manageable goals within the time frame available.
• Use psychotherapeutic techniques of confrontation, clarification and interpretation when interviewing the patient (SOR: A)
• Attend to the patient’s emotional needs. SOR: B
• Modify the patient’s surroundings. SOR: C
• Improve the patient’s capacity to test reality. SOR: B
• Empathize with the patient’s worldview. SOR: B
• Accept the patient’s limitations and strengths. SOR: C
• Manage unreasonable patient expectations and set limits. SOR: C
• Question illogical feelings, thoughts, and behaviors. SOR: C
• Discuss defenses and coping style and interpret them. Table xx-3. SOR: C
• Prescribe medications as needed. SOR: B
• Use specific interventions for each kind of difficult patient as detailed in Table xx-3. (SOR: B)

USING MEDICATIONS FOR PATIENT’S WITH PERSONALITY DISORDER; FOCUS ON KEY SYMPTOMS [KEY TREATMENT BOX 2]

• Medications can target anger/impulsive aggression, suicidal ideation, psychotic symptoms, mood instability, interpersonal problems, anxiety and depression (see Table -4). (SOR:: A)
• Doses for symptoms prescribing are the same as doses used for major psychiatric conditions. (SOR:: B)
• Anger/impulsive aggression, psychotic symptoms, and anxiety in Borderline Personality Disorder can be treated with aripiprazole and olanzapine. (SOR:: A)
• Anger/impulsive aggression, disturbed interpersonal relationships, and anxiety of BPD can be treated with the mood stabilizer topirimate. (SOR: A Evidence)
• Treatment of suicidal behaviors is best targeted with flupentixol or fluphenazine decanoate, paroxetine, or olanzapine. (SOR: B B Evidence)
• Irritability, anger, and mood symptoms in patients with personality disorders are not generally responsive to Selective Serotonin Reuptake Inhibitors (SSRI’s) as previously reported (SOR: A)
• Psychotic symptoms can be treated with low doses of typical or atypical antipsychotic medications. (SOR: B Grade B Evidence)
<table>
<thead>
<tr>
<th>DSM-5</th>
<th>PATIENT CORE BELIEFS</th>
<th>PATIENT FEARS</th>
<th>DEFENSES</th>
<th>COPING STYLES</th>
<th>PATIENT HEALTH BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>Others are adversaries and are to blame; I am being examined; They are out to get me; I can’t trust anyone.</td>
<td>Exploitation; slights; Betrayal; humiliation; physical intrusions from medical procedures.</td>
<td>Projection: ascribe one’s impulses to others Projective identification: project one’s impulse plus control of others as way to control one’s own impulses Denial: refusal to admit painful realities Splitting: self and others seen as all good or all bad.</td>
<td>Guarded and Suspicious protective of their autonomy, often with arrogant belief in their own superiority</td>
<td>Wariness, suspicion, mistrusts, jealousy, self-sufficiency, counter-attacking, anger, and violence.</td>
</tr>
<tr>
<td>Schizoid</td>
<td>I need space; I need to be alone; People are replaceable or unimportant.</td>
<td>Emotional contact; warmth; intimacy; caring; intrusions or violation of privacy.</td>
<td>Isolation of affect: thoughts stored without emotion Intellectualization: replace feelings with fact Denial and splitting: see above Regression; revert to childlike thoughts, feelings, behaviors</td>
<td>Inner world insulated from others</td>
<td>Withdrawal; seeking isolation and privacy.</td>
</tr>
<tr>
<td>Antisocial</td>
<td>People are there to be used and exploited; I come before all others.</td>
<td>Boredom; loss of prestige, power, or esteem.</td>
<td>Acting out: expression in action or behavior rather than in words or emotions. Splitting (see above)</td>
<td>Seeks autonomy, freedom; seeks advantage or secondary gain</td>
<td>Lies, deceit and manipulation; violence; seeks secondary gain.</td>
</tr>
<tr>
<td>Histrionic</td>
<td>I need to impress, be admired/loved; I need to be taken care of, or helped.</td>
<td>Loss of love, admiration, attention, or dependent care.</td>
<td>Sexualization; functions or objects changed into sexual symbols to avoid anxieties. Regression, acting out, splitting (see above) Dissociation: disrupted perceptions or sensations, consciousness, memory, or personal identity Somatization: physical symptoms caused by mental processes Repression: involuntary forgetting of painful memories, feelings, experiences</td>
<td>Self-centered, emotion-driven, flirtatious and flighty</td>
<td>Dramatics; exhibitionism; expressiveness; impressionistic.</td>
</tr>
<tr>
<td>Borderline</td>
<td>I am very bad or very good. Who am I? I can’t be alone.</td>
<td>Separations, loss; emotional abandonment; not being loved and cared for; fluctuating self-esteem.</td>
<td>Splitting, projection, projective identification, dissociation, regression, acting out (see above) Omnipotence: seeing self, others as all-powerful Idealization/devaluation: vacillate between seeing self or others as ideal and then deprecating self or others Mini-psychotic experiences</td>
<td>Hostile dependency; chaotic lifestyle; threatening, intimidating or seeking intimacy, dependency, or pseudo-autonomy</td>
<td>Impulsive behaviors; suicidal actions; cutting; anger/violence; panic; anxiety; poor reality; stormy relationships.</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>I am special; I am important; I come first; The world should revolve around me.</td>
<td>Loss of prestige, image, power, or esteem.</td>
<td>Splitting, projection, projective identification, acting out, denial, regression (see above)</td>
<td>Superiority and arrogance, self-aggrandizing, self-centered, self/protecting, demeaning, demanding, critical</td>
<td>Self aggrandizement; inflated/deflated self view; entitled; devalue/idealize; viciousness; envy; competitive.</td>
</tr>
<tr>
<td>Avoidant</td>
<td>I must avoid harm or be cautious, as I may</td>
<td>Rejection; embarrassment in</td>
<td>Inhibition—restriction of thoughts, feelings, behaviors to avoid shame, Withdraw or escape, avoiding criticism</td>
<td></td>
<td>Avoidance; withdrawal; social</td>
</tr>
<tr>
<td>Phobias</td>
<td>Fears of objects, people, situations; avoided to prevent anxiety</td>
<td>Avoidance, withdrawal, regression, somatization—see above</td>
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<tr>
<td>Dependent</td>
<td>I am helpless without others; I can’t make a decision; I need constant reassurance and care.</td>
<td>Passive, dependent, helpless</td>
<td>Unusually submissive; clinging, indecisive, child-like, needing to be taken care of.</td>
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</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>People should do better; try harder; I must be perfect; make no errors or mistakes; details, not feelings, rule.</td>
<td>Disorder, mistakes, imperfection; fears feelings, especially rage/anger, anxiety, self-doubt, dependency.</td>
<td>Inflexible, constricted, governed by rules, safety, or security concerns</td>
<td>Perfectionism, driven orderliness; logical, compulsions; controlling, critical; stubbornness/stinginess; workaholic; rational.</td>
<td></td>
</tr>
<tr>
<td>DMV III-R†</td>
<td>I must suffer and sacrifice; I am a martyr; I should be punished.</td>
<td>Loss of love; fears pleasure; fears recovery.</td>
<td>Self-defeating, self-destructive</td>
<td>Feels worse with good news; self-defeating/ self-destructive.</td>
<td></td>
</tr>
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</table>

Table 3: Personality Disordered Patients: Adherence, Utilization, Physician Reactions, and Interventions DSM-5

<table>
<thead>
<tr>
<th>DSM IV-TR</th>
<th>ADHERENCE</th>
<th>UTILIZATION</th>
<th>PHYSICIAN REACTIONS</th>
<th>INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>Difficult when requested by the physician since the patient is suspicious of the need for compliance. Problematic, but may be easier when the patient is seeking relief from symptoms.</td>
<td>Limited utilization; or as a condition for medical service utilization, the patient may seek detailed explanations or reasons for the diagnostic testing or needs for other services.</td>
<td>Fearful; sense of danger; mistrust; feeling accused, blamed, or threatened.</td>
<td>1. Empathize with patient’s fear of being hurt; acknowledge complaints without arguing or ignoring. 2. Openly and honestly explain medical illness. 3. Correct reality distortions and unreasonable patient expectations. 4. Gently question irrational thoughts and suggest more rational ones. 5. Don’t confront delusions. 6. If the patient refuses care out of mistrust, rather than insist, ask if it’s OK if you can disagree about the need for the test. 7. Interpret projection (blame) and other defenses.</td>
</tr>
<tr>
<td>Schizoid</td>
<td>May be difficult. Will need reinforcement and monitoring, may need outreach services.</td>
<td>Under utilization. Outreach, if not too frequent, may help foster appropriate use of medical services.</td>
<td>Detached or removed; wish to involve patient with others; to break through the isolation.</td>
<td>1. Empathize with patient’s need for privacy and contact. 2. Accept the patient’s unsociability. 3. Reduce the patient’s isolation as tolerated. 4. Neutrally impart medical information. 5. Don’t demand involvement nor permit total withdrawal. 6. Correct reality distortions and unreasonable patient expectations. 7. Gently question irrational thoughts and suggest more rational ones. 8. Interpret isolation and other defenses.</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>May be difficult. May need outreach, visiting nurse, community resources, or case management.</td>
<td>Under-utilization. May need outreach to gain reasonable and appropriate utilization of medical services.</td>
<td>Detached; removed; &quot;weird and alone&quot; feelings; wish to involve; or to break through the isolation.</td>
<td>1. Empathize with patient’s idiosyncratic style, magical thinking, and perceptions without directly confronting them. 2. Recognize the need for privacy and contact. 3. Accept the patient’s unsociability; reduce the patient’s isolation, as tolerated. 4. Neutrally impart information. 5. Don’t demand involvement or permit total withdrawal. 6. Correct reality distortions and unreasonable patient expectations. 7. Gently question irrational thoughts and suggest more rational ones. 8. Interpret regression and other defenses.</td>
</tr>
<tr>
<td>Antisocial</td>
<td>May be resistant, problematic, and intolerant of the need for ongoing compliance.</td>
<td>May misuse medical resources for secondary gain.</td>
<td>Used, exploited or deceived; anger, and a wish to uncover lies, punish, or imprison.</td>
<td>1. Empathize with patient’s fear of exploitation and low self-esteem. 2. Determine if you are being used for secondary gain. Should you suspect dishonesty, verify symptoms and illness progression with others. 3. Don’t moralize. Explain that deception results in your giving the patient poor care. 4. Correct reality distortions and unreasonable patient expectations. 5. Gently question irrational thoughts and suggest more rational ones. 6. Interpret defenses. 7. Medications as adjunctive treatment (See table xx-4).</td>
</tr>
<tr>
<td>Personality Type</td>
<td>Description</td>
<td>Symptoms</td>
<td>Recommended Approach</td>
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| **Histrionic**   | Often dependent on others or inconsistent | May misuse or overuse medical resources to gain attention from the physician or staff. | 1. Empathize with patient’s fear of losing love or care.  
2. Interact in a friendly way, not too reserved or too warm.  
3. Discuss patient’s fears; reassure when possible.  
4. Use logic to counteract an emotional style of thinking.  
5. Set limits if patient regresses.  
6. Correct reality distortions and unreasonable patient expectations.  
7. Gently question irrational thoughts and suggest more rational ones.  
8. Interpret sexualization, regression, and other specific defenses. |
| **Borderline**   | Inconsistent as adherence is easily influenced by emotional storms, interpersonal conflicts, or chaotic lifestyles | Misuse or high use for maladaptive behaviors such as suicidal or disruptive behaviors | Feeling manipulated, angry, impotent, depleted, self-doubting; wish to rescue or get rid of the patient; guilty.  
1. Empathize with patient’s fear of abandonment and separation and plan for absences by arranging coverage.  
2. Express a wish to help and satisfy reasonable needs.  
3. Ask the patient to monitor impulsive behaviors with a diary or log.  
4. Set firm limits and do not punish.  
5. Correct reality distortions and unreasonable patient expectations.  
6. Gently question irrational thoughts and suggest more rational ones.  
7. Interpret splitting and other defenses.  
8. Negotiate emergency procedures in advance. If suicidal, the patient must go to the emergency room, if not safe. If the patient refuses emergency help when you offer, let the patient know in advance that this therapeutic breach may end the relationship.  
9. Medications as adjunctive treatment (See table xx–4) |
| **Narcissistic** | Can be problematic. Intolerant of the need for ongoing compliance requirements | Entitled to use, or may abuse medical services when needed | Devalued/overvalued; Inferior/superior; fearful of patient’s criticism or anger; wish to retaliate, devalue, or get rid of the patient.  
2. Don’t mistake patient’s superior attitude for real confidence and don’t confront entitlement.  
3. When devalued or attacked, acknowledge the patient’s hurt, your mistakes, and express your continued wish to help.  
4. If devaluing continues, offer a referral as an option, not as punishment.  
5. Correct reality distortions and unreasonable patient expectations.  
6. Gently question irrational thoughts and suggest more rational ones.  
7. Interpret splitting and other defenses.  
8. Medications as adjunctive treatment (See table xx–4) |
| **Avoidant**     | Diverted or delayed by avoidant behavior. Guided by a wish to avoid disapproval of medical staff. | Seeks medical services to secure approval or avoid criticism, not necessarily seeking the health benefits. | Frustrated because the patient often can not articulate fears; annoyed at the patient’s weakness.  
1. Empathize with patient’s social fears, shame, shyness, and fears of revealing inadequacies, rejection, embarrassment, humiliation, and anger.  
2. Help the patient describe in detail the feared situation(s).  
3. Encourage and support the need for the patient to gradually face the fears and the tendency to avoid. If this seems overwhelming, choose smaller fears to confront or refer.  
4. If frustrated or unclear about the nature of the fears, ask for detailed descriptions of the problem.  
5. Gently elicit irrational thoughts and suggest more rational ones.  
6. Correct reality distortions.  
7. Interpret avoidance, phobias, and other defenses.  
8. Medications as adjunctive treatment (table 4) |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
<th>Treatment</th>
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</thead>
</table>
| Dependent                  | Dependent on others for medical supervision and easily overwhelmed by the demands of self monitoring compliance. | 1. Empathize with the patient’s need for care.  
2. Frustrate total dependence.  
3. Be careful to avoid telling the patient what to do.  
4. Encourage independent thinking and action.  
5. Realize that what the patient says that he or she wants (caretaking) is not necessarily what he or she needs.  
6. Ask the patient what it is about independence that is so frightening.  
7. Don’t abandon or threaten termination, because some very dependent patients need regular physician contact for life.  
8. Correct reality distortions and unreasonable patient expectations.  
9. Gently elicit irrational thoughts and suggest more rational ones.  
10. Interpret regression and other specific defenses.  
11. Medications as adjunctive treatment (See table xx-4). |
| Obsessive-compulsive       | Rigid and inflexibly follows the rules; disrupted or anxious if unexpected changes are required. | Conflicted about utilization. Fears of uncertainty may drive increased use, while fears of loss of control may decrease use.  
In a battle of control with negative reactions to patient stinginess, need for order, and stubbornness; distanced from feelings; bored with details.  
1. Empathize with patient’s logical, detailed, unemotional style of thinking.  
2. If obsessive thoughts are interfering with medical care, ask about the patient’s feelings.  
3. Don’t struggle with the patient over control or critical judgments.  
4. Avoid abandoning the patient.  
5. Correct reality distortions and unreasonable patient expectations.  
6. Gently elicit irrational thoughts and suggest more rational ones.  
7. Interpret specific defenses. |
| Self-defeating†            | Dependent on other, may be help seeking then help rejecting. | Under use of medical services because they don’t deserve them or they won’t help, or excessive use when they are treated badly.  
Wish to rescue; sadistic fantasies that the patient will suffer/die; defeated; self-blame; self-doubt, or hopelessness and helplessness.  
1. Empathize with patient’s suffering. Acknowledge and appreciate the difficulty of the illness and treatment.  
2. Emphasize that recovery may be a slow steady process.  
3. The need for recovery can be presented as necessary to benefit others.  
4. Inquire about obviously self-destructive or self-defeating behaviors.  
5. Don’t abandon.  
6. Correct reality distortions and unreasonable patient expectations.  
7. Gently elicit irrational thoughts and suggest more rational ones.  
8. Interpret specific defenses. |

### Table 4: Pharmacotherapy for Symptomatic Treatment of Personality Traits and Disorders*

<table>
<thead>
<tr>
<th>Anger Impulsive Aggression</th>
<th>Suicidal Ideation</th>
<th>Psychotic Symptoms</th>
<th>Mood Instability Interpersonal problems</th>
<th>Anxiety</th>
<th>Depression</th>
</tr>
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<tbody>
<tr>
<td><strong>Borderline Personality Disorder - Grade B Level of Evidence</strong></td>
<td></td>
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<tr>
<td>Haloperidol</td>
<td>Aripiprazole</td>
<td>Olanzapine</td>
<td>Lamotrigine</td>
<td>Topiramate</td>
<td>Aripiprazole</td>
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<tr>
<td></td>
<td>Flupentixol deconoate</td>
<td>Olanzapine</td>
<td>Fluphenazine decanoate</td>
<td>Paroxetine</td>
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<tr>
<td><strong>Antisocial Personality Disorder - Grade C Level of Evidence</strong></td>
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<tr>
<td>Lithium</td>
<td>Phenytoin</td>
<td>Citalopram</td>
<td>Sertraline</td>
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<tr>
<td><strong>Schizotypal Personality Disorder - Grade B Level of Evidence</strong></td>
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<tr>
<td>Olanzapine</td>
<td>Resperidone</td>
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<tr>
<td><strong>Avoidant Personality Disorder/Dependent Traits - Grade C Level of Evidence</strong></td>
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<tr>
<td>Brofaromine</td>
<td>Citalopram</td>
<td>Sertraline</td>
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</table>

References


43. Smith GR, Rost K, Kashner TM. A trial of the effect of a standardized psychiatric consultation on health outcomes and costs in somatizing patients. *Arch Gen Psychiatry.* 1995;52:238-243.


**Web Resources**

National Center for Biotechnology Information
Reviews of the major personality disorders and treatments

www.nmha.org/go/information/get-info/personality-disorders
Mental Health America
Consumer information about personality disorders

www.nice.org.uk/search/guidancesearchresults.jsp?keywords=Personailty+Disorders&newSearch=true&searchType=Guidance
National Institute for Health and Clinical Excellence (NICE)
Practice guidelines for personality disorders

National Guideline Clearinghouse
Practice guidelines for borderline and antisocial personality disorders

www.nlm.nih.gov
National Institute of Mental Health on Somatization and Personality Disorders

www.psych.org
American Psychiatric Association
Information on somatic and personality disorders

*Tables/boxes*