INTRODUCTION

Patients with personality disorders can be difficult to manage and can elicit intense reactions in physicians. Through unrecognized interpersonal pressure, a patient with a personality disorder has an unintentional ability to create dysfunctional patient-physician relationships. This covert pressure placed on the physician often affects how the physician evaluates a patient, communicates, organizes a diagnostic workup, orders laboratory tests, recommends a consult, and suggests treatment. This ultimately determines the quality of care that the patient receives. Prevalence rates for personality disorders are reported to be 4% to 13% in the general population. In a primary care population, up to 24% of patients have personality disorders (Gross et al., 2002; Moran et al., 2000). These rates increase dramatically in certain populations—more than 28% of patients with alcohol disorders and 47% of patients with drug use disorders (Grant et al., 2004). Personality disorders often go unrecognized because those affected do not demonstrate typical psychiatric symptoms or complaints. This is despite the fact that they may suffer from many personality failures. Most commonly, a patient with a personality disorder is recognized after an unexpected or unpleasant interpersonal interaction. Personality disorders are secondarily recognized and experienced through the complaints of family, friends, or others who have had extended contact with the patient. Although family physicians are not expected to treat the underlying personality disorder, recognition and effective management of these difficult patients are routinely possible in medical settings in which the goal is to provide optimal medical care for the patient while limiting the stress on the physician.

Definition: Personality Style Versus Personality Disorder

A personality style is the lifelong habitual way that a person thinks, feels, and behaves. Styles are determined by genetics, an aspect called temperament, and upbringing. Temperamental aspects, such as the ability to filter external stimuli or shyness, are often observable at birth. Other personality traits, such as a cognitive style of all or nothing thinking, are probably developed from early parent-child interactions. Each personality has unique, enduring, and slowly evolving characteristics, including the organization of perception, a set of core beliefs, thinking style, fantasy life, hierarchy of emotional needs, value system, ideals, characteristic ways of relating to oneself and others, and adaptation to external reality.

The distinction between personality style and a personality disorder is a matter of degree. Personality styles tend to be stable over a lifetime and can be modified by psychotherapy or needs to adapt to the environment. Personality disorders are also stable, but are more difficult to modify. If they can be modified at all, it is by long-term or special forms of psychotherapy or by life events. Personality styles that become rigid, extreme, maladaptive, damaging to oneself or others, or that lead to social or occupational impairment, are called personality disorders. Although everyone is unique, there seems to be a continuum of personality styles and disorders that are commonly encountered. Some personality disorders can be recognized in the movies. These include the schizotypal personality disorder portrayed by Robert De Niro in Taxi Driver, the narcissistic personality disorder portrayed by Tom Cruise in Top Gun, and the dependent-borderline personality disorder portrayed by Bill Murray in What About Bob?

Classification of Personality Disorders

KEY POINTS

- Inflexible and maladaptive personality style(s) cause distress or social or occupational impairment.
- Problems are in at least two of these areas: cognition, affectivity, interpersonal functioning, and impulse control.
- Pervasive manifestations occur across a range of situations.
- A personality disorder is stable and of long duration, begins in adolescence or early adulthood, and is diagnosed in adulthood.
- Categorical and dimensional classification systems are used.
- DSM-IV, the most well-known classification system, groups personality disorders into three main clusters (see Table 60-1).
- To diagnose, begin by identifying the cluster: cluster A—odd, eccentric; cluster B—dramatic, emotional; cluster C—anxious, fearful.
- Then, identify the specific personality disorder (see Table 60-1).
- A particular patient may have traits from different clusters and may meet criteria for more than one personality disorder.

There are two primary classification approaches to personality disorders, categorical and dimensional. The dimensional approach uses the presence, absence, or degree of specific personality traits or dimensions to describe patients. The categorical approach describes people as having clusters of associated traits, symptoms, or behaviors that form discrete "prototypes" of personality. Categorical approaches have the advantage of colorfully describing and differentiating distinct personality styles. This classification system remains the most popular approach among physicians for this reason. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000), uses a prototypical personality disorder classification as part of a multiaxial system that encourages physicians to consider personality variables in every patient.

The preliminary diagnosis of a personality disorder begins by identifying the appropriate cluster, because it is easiest to recognize the broad traits of a cluster diagnosis first. The three clusters of personality disorders are cluster A, odd and eccentric; cluster B, dramatic, emotional, or erratic; and cluster C, anxious or fearful. These clusters are subdivided into specific personality subtypes with general characteristics, as described in Table 60-1. Because personalities are
complicated, it is not unusual for a patient to meet criteria for two cluster diagnoses and more than one specific personality disorder diagnosis.

**Physician Reactions to Patients With a Personality Disorder**

**KEY POINTS**

- Physician reactions are useful in recognizing and diagnosing patients with personality disorders.
- Reactions stirred by the patient are referred to as patient-generated countertransferences.
- These reactions are mostly shared in common by all physicians seeing the patient, with some idiosyncratic elements peculiar to each physician.
- These patients often generate intense physician feelings.
- There may be fantasies or thoughts about the patient that are characteristic for the physician.
- The physician may engage in behaviors that would normally not be typical for him or her (see Table 60-2).

Although DSM-IV-TR is a useful aid for making a diagnosis, the family physician often will recognize a patient with a personality disorder by his or her own common reactions to the patient. Physicians working with patients who suffer from personality disorders seem to have specific and characteristic reactions to these patients that need to be recognized, understood, and used for the patient's benefit. Patient-generated feelings provoked in the physician are created through the interpersonal interaction between patient and physician. These typical subjective experiences and reactions to a patient should alert the physician to a possible diagnosis of a personality disorder. Typical physician reactions to patients that are provoked by the patient are referred to as patient-generated countertransferences. These include intense feelings, uncharacteristic fantasies, or atypical behaviors by the physician.

**Intense Affects**

Intense physician affect or feelings, elicited through interpersonal interactions with the patient, can be those of hate, fury, or frustration toward a patient. Alternatively, strong feelings of love, sexual arousal, or wishes to rescue the patient or provide exceptionally good care may occur. These may alternate with other wishes to avoid the patient, terminate the relationship, or transfer the patient to another colleague. In extreme cases, intense feelings aroused in a physician can become a focal point for leading the physician into boundary violations with a patient. These are extremely damaging to both parties and violate the tenets of professional behavior.

**Physician Fantasies**

Physicians may recognize that they are interacting with a patient with a personality disorder by their own fantasies. These might include excessive worrying about a patient after normal work hours, dreaming about a patient, or experiencing exaggerated or intrusive, angry, sexual, or curious fantasies about the patient during personal time.

**Physician Atypical Behaviors**

A physician may notice certain behaviors with a specific patient that are atypical for his or her normal customary medical practice. These unusual physician behaviors should trigger self-examination by the physician and consideration of the possibility that the patient may have a personality disorder. Frequently, patients with a personality disorder are capable of arousing unconscious reactions that lead to new and unusual physician behaviors.

Common atypical physician behaviors may include ordering tests to placate a patient, asking for more than the usual number of consults on a patient whose care does not seem medically complicated, suggesting increasingly aggressive diagnostic testing or procedures when the yield of these tests is likely to be low, repeatedly...
Table 60-2  Physician Reactions to Patients With Personality Disorders

<table>
<thead>
<tr>
<th>DSM-IV-TR Classification</th>
<th>Physician Reactions</th>
<th>Patient Beliefs</th>
<th>Patient Fears</th>
<th>Patient Health Behaviors</th>
<th>Adherence</th>
<th>Use of Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>Fearful, sense of danger; mistrust; feeling accused, blamed, or threatened.</td>
<td>Others are adversaries and to blame; I am being examined; they are out to get me; I can't trust anyone.</td>
<td>Exploitation; slight; betrayal; humiliation; physical intrusions from medical procedures</td>
<td>Wariness, suspicion, mistrust, jealousy, self-sufficiency, counterattacking, anger, violence</td>
<td>Difficult when requested by the physician because patient is suspicious of need for compliance; problematic, but may be easier when patient is seeking relief from symptoms</td>
<td>Limited use or, as a condition for medical service use, patient may seek detailed explanations or reasons for diagnostic testing or needs for other services</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Detached or removed; wish to involve patient with others, to break through the isolation.</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>Withdrawal; seeks isolation and privacy</td>
<td>May be difficult; will need reinforcement and monitoring, may need outreach services</td>
<td>Underuse; outreach needed, if not too frequent, may help foster appropriate use of medical services</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Detached; removed; &quot;weird and alone&quot; feelings; wish to involve or break through the isolation.</td>
<td>Idiosyncratic, magical, or eccentric beliefs; I know what they're thinking, feeling, premonitions.</td>
<td>Emotional contact; warmth, caring, violation of privacy</td>
<td>Withdrawal; odd, autistic, magical behaviors and movements; seeks isolation and privacy</td>
<td>May be difficult; may need outreach, visiting nurse, community resources, or case management</td>
<td>Underuse; may need outreach to gain reasonable and appropriate use of medical services</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Feels used, exploited, or deceived; anger; wish to uncover lies, punish, or imprison</td>
<td>People are there to be used and exploited; I came before all others.</td>
<td>Boredom; loss of prestige, power, or esteem</td>
<td>Lies, deceit, and manipulation; violence; seeks secondary gain</td>
<td>May be resistant; problematic, intolerant of need for ongoing compliance</td>
<td>May misuse medical resources for secondary gain</td>
</tr>
<tr>
<td>Histrionic</td>
<td>Flattered, captivated, seduced or aroused; flooded by emotions; depleted; wish to rescue</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>Dramatics; exhibitionism; expressiveness; impressionistic</td>
<td>Often dependent on others or inconsistent</td>
<td>May misuse or overuse medical resources to gain attention from physician's staff</td>
</tr>
<tr>
<td>Borderline</td>
<td>Feels manipulated, angry, impotent, depleted, self-doubting; wish to rescue or get rid of patient</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>Impulsive behaviors; suicidal actions; cutting; anger, violence; panic; anxiety; poor reality; stormy relationships self-esteem</td>
<td>Inconsistent—adherence easily influenced by emotional storms, interpersonal conflicts, chaotic lifestyles</td>
<td>Misuse or high use for maladaptive behaviors, such as suicidal or disruptive behaviors</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Devalued, overvalued; inferior, superior; fearful of patient's criticism or anger; wish to retaliate, devalue, or get rid of patient</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 self-esteem</td>
<td>Self-aggrandizement; inflated, deflated self-view; entitled; devalue, idealize, viciousness, envy; competitive</td>
<td>Can be problematic; intolerant of need for ongoing compliance requirements</td>
<td>Entitled to use, or may abuse medical services when needed</td>
</tr>
<tr>
<td>DSM-IV-TR Classification</td>
<td>Physician Reactions</td>
<td>Patient Core Beliefs</td>
<td>Patient Fears</td>
<td>Patient Health Behaviors</td>
<td>Adherence</td>
<td>Use of Medical Services</td>
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<tr>
<td>Avoidant</td>
<td>Frustrated because patient often can't articulate fears; annoyed at patient's weakness</td>
<td>I must avoid harm or be cautious, because I may get rejected, exposed, or be humiliated.</td>
<td>Rejection; embarrassment in social situations; humiliation; exposure of inadequacies</td>
<td>Avoidance; withdrawal; social timidity; caution; fear, anxiety</td>
<td>Diverted or delayed by avoidance behavior; guided by wish to avoid disapproval of medical staff</td>
<td>Seeks medical services to secure approval or avoid criticism, not necessarily seeking health benefits</td>
</tr>
<tr>
<td>Dependent</td>
<td>Depleted; annoyed at patient's dependence; may deny patient's reasonable needs</td>
<td>I am helpless without others; I can't make a decision; I need constant reassurance and care.</td>
<td>Fears separation, independence, making decisions, anger</td>
<td>Unusually submissive; clinging, indecisive, childlike, needing to be taken care of</td>
<td>Dependent on others for medical supervision; easily overwhelmed by demands of self-monitoring compliance</td>
<td>Underuse when left to themselves, but may overuse service when physician or medical staff becomes source of needed gratification</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>In battle of control, with negative reactions to patient's stiffness; need for order, and stubbornness; distanced from feelings; bored with details</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>Perfectionism, driven orderliness; logical, compulsions; controlling, critical, stubbornness, stinginess; workaholic; rational</td>
<td>Rigid and inflexibly follows rules; disrupted or anxious if unexpected changes required</td>
<td>Conflicted about use; fears of uncertainty may drive use, increased fears of loss of control may decrease use</td>
</tr>
<tr>
<td>Self-defeating*</td>
<td>Wish to rescue; sadistic fantasies that patient will suffer, die, defeated, self-blame, self-doubt, or hopelessness and helplessness</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>Feels worse with good news; self-defeating, self-destructive</td>
<td>Dependent on others, may be help seeking, then help rejecting</td>
<td>Underuse of medical services because they don't deserve them or they won't help; excessive use when they are treated badly</td>
</tr>
</tbody>
</table>

extending the time spent with a particular patient or family, or both, lowering the customary fee, offering free treatment, or developing a personal (not professional) relationship with a patient. A list of common physician reactions associated with specific personality-disordered patients are reviewed in Table 60-2.

Physicians can use the scope of patient-generated countertransference (their feelings, fantasies, and atypical medical behaviors) as a valuable diagnostic aid, because these tend to provoke the same feelings in most physicians who deal with them. For example, a patient with a borderline personality disorder often leaves many physicians exhausted and worried about the patient's suicidal threats. A physician who recognizes provoked feelings experimentally learns to identify the subtype of personality disorders according to the feelings elicited. More importantly, physicians who can recognize their unusual reactions will be better able to tolerate them and avoid acting out their feelings with a patient. This will improve their medical decision-making and patient care.

**Patient Core Beliefs, Irrational Thoughts, and Fears**

- Patients have identifiable core beliefs, worldviews, and fears.
- These interact and can feed off each other in patients with personality disorders.
- Stress activates these core beliefs and precipitates intense and dysfunctional emotions, fears, and thoughts, which are characteristic for each of the personality disorders.
- Adherence and use of medical services are affected differently by each personality disorder.
- Patients with specific personality disorders tend to behave in characteristic ways (see Table 60-2).

Family physicians can apply principles of cognitive-behavioral therapy (CBT) to facilitate the management of patients with personality disorders. The theory of CBT (Beck and Freeman, 1990; Greenberger and Padesky, 1995) is that patients have core beliefs, a worldview, and personality-specific fears that can be identified and directly influenced by conscious awareness. Core beliefs and fears are exaggerated in their intensity and idiosyncratic in their quality. These core beliefs and fears are rooted in a patient's basic personality organization.

When an environmental stress occurs against the background of a core belief, a reinforcing circular feedback sequence ensues. The core belief is acted on by the stressor, which leads to irrational thinking. This creates irrational fears, negative moods, or emotions that lead to maladaptive behaviors and physical symptoms. Behaviors or symptoms can feed back directly to confirm a core belief and fear. Core beliefs and fears are readily activated during a routine visit to the physician, when a patient feels sick and vulnerable.

For example, patients with a borderline personality disorder fear separation, loss, and emotional abandonment. They have a core belief about themselves that reveals fluctuating levels of self-esteem (poor to grandiose), an unstable identity, and oscillating beliefs that they are very bad or very good. When a borderline patient becomes medically ill, he or she may cling to the physician and react to a separation with anger, manipulative suicide attempts, devaluing attacks, or panic. By understanding the patient's core beliefs and associated fears, it is possible to prevent a worsening of the patient's condition while the physician is away. This can be done by empathizing with the patient, discussing the patient's core beliefs and fears, helping the patient recognize the distorted, irrational, or illogical thoughts, and ultimately interpreting the patient's defenses. The CBT sequence of stress, acting on core beliefs and irrational fears, and subsequent maladaptive behaviors is described for each personality disorder in Table 60-2.

**Patient Behaviors, Compliance, and Use of Medical Services**

Patients with personality disorders often display typical patient behaviors that affect their compliance to medical recommendations and use of medical services. Understanding these behaviors can help the physician manage his or her expectations of these difficult patients and improve the chances for effective interventions geared toward optimizing the patient's medical care. In general, cluster A patients will tend not to adhere to medical recommendations and will underuse medical services. They may require outreach to involve them in their own medical care. Cluster B patients tend to have variable adherence to medical recommendations and may misuse, overuse, or underuse medical care. Cluster C patients tend to be adherent to medical recommendations because of fear of what could happen if they don't. They are ambivalent users of the medical system and tend to use medical services appropriately when others are involved in their care.

**Patient Defense Mechanisms**

- Defense mechanisms are automatic psychological processes that protect the patient from anxiety and stressors and help with adaptation to the environment.
- Each personality disorder is associated with particular defense mechanisms (see Table 60-3).
- The patient's level of personality organization is another helpful way of looking at these patients.
- Patients with a neurotic level can differentiate what is real from what is not.
- Patients with a borderline level experience breaks in reality with stress.
- Patients with a psychotic level experience persistent difficulty in interpreting reality accurately.
- Each personality disorder is associated with typical levels of personality organization (see Table 60-4).

Using a psychodynamic psychotherapy (PDP) approach, a family physician can attempt to relieve the core problem and symptom interfering with medical care by fostering the patient's insight into his or her problems. In the PDP approach, it is important for the family physician to appreciate the unconscious psychological processes known as defense mechanisms. These are psychological processes used to resolve internal conflicts, manage moods, mediate external dangers, and facilitate adaptations to reality. By understanding the constellation of specific defenses used with each personality disorder, the physician may be able to modify the pathologic functioning of the defense interfering with the patient-physician alliance and necessary medical care by clarification, confrontation, and interpretation (see Table 60-4). For example, a borderline patient may feel hurt and abandoned by the physician's vacation and accuse the physician of not caring. This patient may use a defense mechanism called devaluation (she or he deprecates the physician as uncaring) and acting out (she or he expresses suicidal ideation or intent). With this understanding, the physician can begin to help the patient by not taking the patient's efforts to devalue or manipulate personally. The physician can respond to the patient by empathizing with the patient's feelings of abandonment. The physician may clarify that the patient has a distorted belief and that the vacation is being incorrectly experienced as a personal abandonment of the patient. The physician may further clarify that the vacation does not communicate anything about the physician's future ability or wish to care for the patient. The patient can be reassured of the physician's return, future realistic medical availability, specific limits of
availability, and medical coverage by another physician. In a preventive effort to allay a crisis and help a borderline patient manage separation fears, the physician (before the vacation) could schedule the patient for a meeting with the colleague who will provide coverage while the physician is away. Often, it is also helpful to anticipate issues that may come up for the patient while the physician is away and suggest a specific way of problem solving and coping.

**Psychiatric Level of Functioning**

A particularly useful model in describing the level of personality organization was introduced by Kernberg (1975). Kernberg assessed the psychiatric level of personality organization as functioning on a neurotic, borderline, or psychotic level. These levels of functioning are determined by assessing reality testing, defenses, and identity diffusion (Table 60-3).

**Neurotic Personality Organization**

Patients with a neurotic personality organization (NPO) have the capacity to differentiate what is real from what is not. When reality testing is intact, patients can differentiate their own thoughts from external sensory perceptions, distinguish themselves from others, and realistically evaluate how their own emotions, behaviors, and thoughts are perceived in relation to ordinary social norms. Neurotic patients typically use higher level defense mechanisms centered on repression. These include reaction formation, displacement, suppression, and inhibition. They have stable and slowly evolving views of themselves and others as having a mixture of good and bad qualities.

**Borderline Personality Organization**

Patients with a borderline personality organization (BPO) generally have intact reality testing (i.e., they can differentiate reality from fantasy or ideas from perceptions). However, the stresses of an illness, extreme emotions, or drug abuse may precipitate transient breaks in reality. These may last seconds, minutes, or even hours. Breaks in reality often present as severe distortions of what the physician has said or done to them, transient misperceptions of real events, feelings of unreality, depersonalization, and, in the extreme case, temporary hallucinations or changing delusions. Patients with borderline personality organization use defenses that are centered on splitting (all good or all bad thinking and feeling). Associated defenses include idealization, devaluation, and particular forms of projection. These patients suffer from an unstable identity (identity diffusion) that manifests as radically alternating and exaggerated views of self. For example, at one time a patient may see himself or herself as a kind, caring, giving person who is close to perfection. This oscillates in a brief period of time with a different view as a selfish, demanding, or hateful person. Patients who manifest identity diffusion see themselves and others in extremes of black and white. There is memory for these alternating states but the apparent contradictions seem to have no emotional relevance to them (i.e., splitting).

**Psychotic Personality Organization**

Patients with a psychotic personality organization (PPO) have a gross loss of reality testing that allows differentiation from patients with a borderline personality organization. They may have inappropriate or bizarre affect, behavior, and thought content. They may suffer from hallucinations and delusions. They are frequently unable to empathize or clarify how others see them (Kernberg, 1984). They typically use primitive defenses (e.g., projection, incorporation, denial of reality) and have confused, blurred, or generally chaotic views of themselves and others. For example, they may see themselves as God at one time and the devil the next, or they may think that they have both male and female sexual organs.

**Variability in Personality Organizations**

These levels of personality organization are generally stable for each patient. However, stress may cause each patient to vary within a limited range of personality organizations for each specific DSM-IV-TR personality category. For example, patients with paranoid, schizotypal, and schizoid personality disorder generally function at a psychotic or borderline personality organization. At their best, they function on a borderline level. Alternatively, patients with antisocial, histrionic, borderline, and narcissistic personality disorders typically function on a borderline or neurotic level. With stress (such as the threat of abandonment), they appear more borderline and can briefly lose reality testing and function on a psychotic level. Patients in cluster C (dependent, avoidant, obsessive-compulsive) typically can function at the neurotic or borderline level and only rarely, with extreme stress, do they function at a psychotic level. Refer to Table 60-4 for a summary of personality disorders.

**Office Management and Interventions**

**KEY POINTS**

- Attend to the patient’s emotional needs.
- Modify the patient’s surroundings.
- Improve the patient’s capacity to test reality.
- Empathize with the patient’s worldview.
- Accept the patient’s limitations and strengths.
- Manage unreasonable patient expectations and set limits.
- Question illogical feelings, thoughts, and behaviors.
- Discuss coping style and interpret defense mechanisms.
- Prescribe medication.
- Use specific interventions for each personality disorder as detailed in Table 60-4.

**Attending to a Problematic Alliance**

To establish a good working alliance based on trust, acceptance, and confidence, the family physician should begin each patient encounter...
### Table 6A: Summary of Features of Personality Disorders

<table>
<thead>
<tr>
<th><strong>Personality Disorders</strong></th>
<th><strong>Patient Interventions</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Cluster A</strong></td>
<td><strong>Cluster B</strong></td>
</tr>
<tr>
<td><strong>Paranoid</strong></td>
<td><strong>Antisocial</strong></td>
</tr>
<tr>
<td><strong>Schizoid</strong></td>
<td><strong>Histrionic</strong></td>
</tr>
<tr>
<td><strong>Schizotypal</strong></td>
<td><strong>Borderline</strong></td>
</tr>
</tbody>
</table>

**Patient Interventions:**

1. **Empathy with patients:** Feel their pain, distress, and dejection.
2. **Be available:** They may feel abandoned and need reassurance.
3. **Listen actively:** Acknowledge their feelings and concerns.
4. **Avoid confrontation:** Discourage criticism or blame.
5. **Maintain boundaries:** Establish clear limits and boundaries.
6. **Encourage self-care:** Promote their physical and emotional well-being.
7. **Support relationships:** Foster healthy relationships and connections.
8. **Promote autonomy:** Encourage independence and self-sufficiency.
9. **Reinforce positive behavior:** Recognize and reward healthy coping strategies.
10. **Monitor progress:** Regularly assess their progress and adjust treatment plans accordingly.

**Cluster C**

- **Avoidant:**
  - **Interventions:**
    1. **Empathy with patients:** Understand their fear of rejection and abandonment.
    2. **Safe boundaries:** Maintain a safe and non-intrusive environment.
    3. **Encourage independence:** Help them develop self-reliance.
    4. **Promote socialization:** Encourage participation in social activities.
    5. **Support relationships:** Help them build supportive relationships.

- **Dependent:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of taking personal responsibility.
    4. **Promote decision-making:** Encourage them to make decisions and take responsibility.
    5. **Support relationships:** Help them build healthy, independent relationships.

- **Narcissistic:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for admiration and validation.
    2. **Set limits:** Help them understand the importance of respecting others.
    3. **Encourage empathy:** Help them develop empathy and understanding for others.
    4. **Support relationships:** Help them build healthy, emotionally balanced relationships.

**Cluster D**

- **Depressive:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their suffering and distress.
    2. **Encourage independence:** Help them develop self-reliance.
    3. **Promote socialization:** Encourage participation in social activities.
    4. **Support relationships:** Help them build supportive relationships.

- **Anxious:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of taking personal responsibility.
    4. **Support relationships:** Help them build healthy, independent relationships.

- **Obsessive-Compulsive:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for order and control.
    2. **Encourage independence:** Help them develop self-reliance.
    3. **Support relationships:** Help them build healthy, emotionally balanced relationships.

**Cluster E**

- **Interpersonal:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of respecting others.
    4. **Promote decision-making:** Encourage them to make decisions and take responsibility.

- **Neurotic:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their emotional distress.
    2. **Encourage independence:** Help them develop self-reliance.
    3. **Support relationships:** Help them build supportive relationships.

**Cluster F**

- **Anxious:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of taking personal responsibility.
    4. **Support relationships:** Help them build healthy, independent relationships.

- **Depressive:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their suffering and distress.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Promote socialization:** Encourage participation in social activities.
    4. **Support relationships:** Help them build supportive relationships.

**Cluster G**

- **Borderline:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of respecting others.
    4. **Support relationships:** Help them build healthy, independent relationships.

- **Histrionic:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Support relationships:** Help them build supportive relationships.

- **Narcissistic:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for admiration and validation.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Support relationships:** Help them build healthy, emotionally balanced relationships.

**Cluster H**

- **Avoidant:**
  - **Interventions:**
    1. **Empathy with patients:** Understand their fear of rejection and abandonment.
    2. **Safe boundaries:** Maintain a safe and non-intrusive environment.
    3. **Encourage independence:** Help them develop self-reliance.
    4. **Promote socialization:** Encourage participation in social activities.
    5. **Support relationships:** Help them build supportive relationships.

- **Dependent:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of taking personal responsibility.
    4. **Support relationships:** Help them build healthy, independent relationships.

- **Narcissistic:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for admiration and validation.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Support relationships:** Help them build healthy, emotionally balanced relationships.

- **Depressive:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their suffering and distress.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Support relationships:** Help them build supportive relationships.

- **Anxious:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of taking personal responsibility.
    4. **Support relationships:** Help them build healthy, independent relationships.

- **Obsessive-Compulsive:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for order and control.
    2. **Encourage independence:** Help them develop self-reliance.
    3. **Support relationships:** Help them build healthy, emotionally balanced relationships.

- **Interpersonal:**
  - **Interventions:**
    1. **Empathy with patients:** Acknowledge their need for emotional support.
    2. **Encourage independence:** Help them develop self-confidence and skills.
    3. **Set limits:** Help patients understand the importance of respecting others.
    4. **Support relationships:** Help them build healthy, independent relationships.
<table>
<thead>
<tr>
<th>DSM-IV-TR Classification</th>
<th>Personality Organization</th>
<th>Patient Coping Style</th>
<th>Patient Defenses</th>
<th>Physician Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline</td>
<td>BPO; with stress, PPO</td>
<td>Hostile dependency; chaotic lifestyle; threatening, intimidating or seeking intimacy, dependency, or pseudo-autonomy</td>
<td>Splitting, projection, projective identification, dissociation, regression, acting out—see above Omnipotence—seeing self, others as all-powerful Idealization, devaluation—vaccillate between seeing self or others as ideal and then deprecating self or others Minispsychotic experiences</td>
<td>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.</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>BPO; with stress, PPO</td>
<td>Superiority and arrogance, self-aggrandizing, self-centered, self-protecting, demeaning, critical</td>
<td>Splitting, projection, projective identification, acting out, denial, regression—see above</td>
<td>1. Empathize with patient's vulnerability and low self-esteem. 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.</td>
</tr>
<tr>
<td>Avoidant</td>
<td>NPO, BPO; rarely, PPO</td>
<td>Withdraw or escape, avoiding criticism</td>
<td>Inhibition—restriction of thoughts, feelings, behaviors to avoid shame, exposure of inadequacies, rejection, humiliation Phobias—fears of objects, people, situations; avoided to prevent anxiety Avoidance, withdrawal, repression, somatization—see above</td>
<td>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.</td>
</tr>
<tr>
<td>Dependent</td>
<td>NPO, BPO; rarely, PPO</td>
<td>Passive, dependent, helpless</td>
<td>Dependent—yearning for care, clinging, needing direction Passive-aggressive—superficial compliance and passivity disguising stubbornness and anger Reaction formation—unacceptable impulses expressed as the opposite Regression, splitting—see above</td>
<td>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.</td>
</tr>
</tbody>
</table>
Table 60-4  Summary of Features of Personality Disorders—Cont'd

<table>
<thead>
<tr>
<th>DSM-IV-TR Classification</th>
<th>Personality Organization</th>
<th>Patient Coping Style</th>
<th>Patient Defenses</th>
<th>Physician Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsessive-compulsive</td>
<td>NPO, BPO, rarely, PPO</td>
<td>Inflexible, constricted, governed by rules, safety, or security concerns</td>
<td>Isolation of affect, intellectualization, reaction formation, undoing—see above</td>
<td>1. Empathize with patient's logic, detailed, perfectionistic style of thinking.</td>
</tr>
<tr>
<td>Self-defeating*</td>
<td>NPO, BPO, rarely, PPO</td>
<td>Self-defeating, self-destructive</td>
<td>Ambivalence—coexistence of opposite feelings; Displacement, denial, projective identification, reaction formation, passive-aggressive, splitting—see above</td>
<td>2. Emphasize that recovery may be a slow steady process.</td>
</tr>
</tbody>
</table>


by listening, asking open-ended questions, and continually striving for empathy. The alliance is also fostered by the physician's own self-awareness, ability to acknowledge mistakes, and efforts to adapt to the patient's wishes or needs that will foster improved health. Problems often occur in developing an alliance with a patient who has a personality disorder. As soon as the physician becomes aware of any tension in the alliance, he or she should first ask for the patient's view of the current problem. If the patient expresses the problem clearly, the physician should join with the patient in solving the problem to deliver effective medical care. If the problem is the physician-patient relationship, nondefensive reflective listening, clarifications, admitting mistakes, and expressing new efforts to make things better are often helpful. If the physician believes that there is a different problem affecting the alliance, the physician may say, "I believe that there is a different problem (identify the problem, e.g., drinking) that is affecting my ability to help you get well and offer you the best medical care available. We need to think about this problem and come up with some solutions."  

Choosing a Focus for the Interview

When delivering medical care to a patient with a personality disorder, it is important to be consistent, reliable, and predictable whenever possible to avoid future problems. Patients with severe personality disorders often experience an inability to verbalize or prioritize their most important medical concerns, or both. For these patients, it is particularly important to strive for a mutual agreement regarding the medical focus for short and long-term treatment. It is often helpful to use a process called informed shared decision-making (Feinstein et al., 1999), in which the physician takes time with the patient to discuss and negotiate the acute focus of medical care, long-term medical goals, strategies to achieve these goals, and specific timelines for accomplishing the prioritized medical plan.

Psychotherapy Techniques

As is often the case with patients with personality disorders, a general medical approach may not be sufficient. After a brief period of immersion in the patient's complaints, the family physician can respond with empathic responses initially acknowledging the patient's fears (see Table 60-2). If this is not helpful, the physician can use general psychotherapeutic techniques, such as confrontations, clarifications, or interpretations directed toward the current problem interfering with medical care.

A confrontation is an observation by the physician offered to a patient for his or her examination. It is usually a comment that draws attention to contradictions in the patient's beliefs, thoughts, feelings, or behaviors.

A clarification adds new information or perspective or elucidates misunderstandings, miscommunications, or other information that seems vague or confusing. The need for repeated clarifications occurs regularly with patients who have severe personality disorders. It is important to use clarifications before suggesting a new plan to correct the problem.
Interpretations are integrating comments that link confrontations and clarifications with the patient's current problem that is interfering with medical care. Interpretations can be made about the immediate medical situation and may address the patient's core beliefs, irrational thoughts, fears, maladaptive behaviors, or defense mechanisms. Interpretations can also be directed at a difficulty in the physician-patient interaction, problems with the patient coping with the disease, patient refusal of a necessary medical workup or treatment, or the patient's life circumstances. For example, an interpretation to a borderline patient who is depressed and refusing to take his or her medication might be the following: "I think you want relief from your depression. However, your refusal to take the antidepressant as I prescribed makes relief from your depression less likely (confrontation). You then get anxious with me and more depressed, which leads you to stay at home and miss your appointment, and then you feel suicidal (clarification). Instead of accepting my help, you feel hopeless and blame me for your depression. Your depression becomes an excuse for why you don't get your life organized (interpretation)." Such interpretations take practice, but can powerfully restore a realistic and helpful physician-patient relationship.

STRATEGIC INTERVENTIONS

Attending to the Patient's Emotional Needs

Patients with personality disorders are often excessively sensitive and distressed by intolerable internal emotional states and desires. At a basic level, this often means attending to hunger, sleep deprivation, intoxication and withdrawal, necessary medical care, and basic creature comforts. Medication is often an essential part of the management strategy for stabilizing the patient's anxious, depressed, or agitated state.

Modifying the Patient's Surroundings

Patients suffering with severe personality disorders will show fewer symptoms and a dramatic improvement in their acute emotional and behavioral functioning when the physician obtains additional support from the environment. This may mean bringing a helpful spouse, friend, or other personal support into the medical care of the patient. Other approaches to stabilizing the patient's external environment may include allowing the nurse or office staff to spend more time with the patient, allowing a few additional telephone calls, and adding the support of social services, self-help support groups, or psychiatric care. In extreme situations, calling the police and using the psychiatric or medical emergency services can be helpful interventions.

Improving the Capacity to Test Reality

Patients with severe personality disorders can function at a psychotic, borderline, or neurotic personality level. Stressed patients with cluster A and B personality disorders may transiently hear voices, hallucinate, have brief episodes of delusional thinking, or have other severe distortions in perception of reality (e.g., paranoia). This is not uncommon with paranoid, schizotypal, and borderline personality disorders. If psychotic disturbances in reality are present, assess and treat them first before providing the requested medical care. Mobilizing external supports, using medications, or placing the patient in a safe and calm environment is often all that is required.

A stressed patient from within any personality cluster can also present with a tenous or disturbed relationship to reality. These states may include a distorted sense of time, disturbances in the sense of reality, such as derealization (watching your life as if it was a movie), depersonalization (not feeling a part of your own life), dramatic distortions of what has been said, transient misperceptions of real events interpreted according to core beliefs or irrational thoughts, or misunderstanding the physician's or the patient's role. Such reality distortions are not usually dangerous, but can lead to severe problems in the physician-patient relationship if they are not recognized and treated. Verbal techniques include uncovering and clarifying the patient's irrational thoughts or core beliefs and the use of confrontation, clarification, and interpretation, which can be conjointly used to improve the patient's reality testing.

Empathizing With the Patient's Core Beliefs

All psychological interventions depend on the patient feeling understood by the physician. Listening and reflecting back the problems identified by the patient while empathizing with his or her world-view can be extremely helpful in management. For example, an avoidant patient may refuse a prostate examination while having complaints of urinary hesitancy and dribbling. The physician could say, "I understand your wish to avoid dealing with this problem. The testing—a blood test, the prostate-specific antigen (PSA) test, and a rectal examination—take only a few minutes and are not terribly uncomfortable. I am not trying to criticize you. I just think it is in your interest to get these examinations. Could we do this today? Then we can plan a way to relieve your symptoms."

Patient's Limitations and Strengths

By definition, patients with personality disorders are rigid in their approach to the world and limited in their capacity for social and occupational functioning. They do not or may not make changes quickly. However, because they often seem reasonable at first impression, there can be a temptation to try to change the patient. This typically leads to frustration for all concerned. It is more effective to accept the patient's limited functioning, focus on his or her strengths, and address how other issues or circumstances can be modified to help the patient cope.

Managing Unreasonable Expectations and Setting Reasonable Limits

Patients with personality disorders often have unreasonable expectations. They may expect an unrealistic cure, constant availability of the medical team, special treatment, a disability diagnosis when they simply don't want to work, excessive pain medication, or many consultations. The physician must set limits on unreasonable expectations by the patient. Effective limit setting involves exploiting why the patient believes that his or her particular expectation can or should be met. This then involves a reasonable physician response about what can or cannot be done. Ultimately, limit setting is about agreeing to a reasonable approximation of the patient's request and tactfully saying "no" to requests that are not appropriate.

Questioning Illogical Feelings, Thoughts, and Behaviors

Patients often have irrational thoughts about their illness and the care that they will receive. They may also misunderstand the physician's efforts to communicate. For example, patients may think that a prescription medicine will make them sick, magnetic resonance imaging (MRI) will give them cancer, or a flu vaccine will give them the flu. These thoughts can be explored with the patient, unless they are part of a delusional system or the patient has a psychotic personality organization. This process is typically clarifying and anxiety-reducing for most patients.

Maladaptive Coping Styles and Defense Mechanisms

Patients may benefit from discussing their maladaptive coping styles and suggesting ways of effectively coping with their situation. For example, and is called: laborator.

Mood 6:

- Medic or imp
- This is
- Mood antipsychotic
- Psychiatric
- Intotab dose a

Prescribin similar to typical or psychotic:

- Mended
- Unstable a full dose (MAC), anxious p.
- The anxiety

Table 1:

<table>
<thead>
<tr>
<th>Mood 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs</td>
</tr>
<tr>
<td>Fluoxetine-</td>
</tr>
<tr>
<td>Sertraline</td>
</tr>
<tr>
<td>Venlafaxi</td>
</tr>
<tr>
<td>Other at Antimypti</td>
</tr>
<tr>
<td>Amantypi</td>
</tr>
<tr>
<td>Low-dos (see color)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mood 6</th>
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<tbody>
<tr>
<td>Divalproei</td>
</tr>
<tr>
<td>Omega-3</td>
</tr>
<tr>
<td>Note: All d</td>
</tr>
<tr>
<td>SSB, 5&amp;6</td>
</tr>
</tbody>
</table>
example, an obsessive-compulsive patient has a high cholesterol level and is calling the physician's office to get more details about the other laboratory tests. The results of the lipid profile are given to the patient, who now wants to know whether a lifestyle change or a statin medication would work better. With a recommendation for an initial lifestyle plan of more exercise and nutritional counseling, the patient becomes concerned about how to pay for this. Repeated efforts to help the patient with additional information are not making the patient feel any better. In fact, more information just raises more questions for additional information. The patient is asked to come for another visit. At this visit, the physician might say, "I can continue to give you more information, but it seems that anxiety is driving your questions. What are you worried about?" In essence, this says, "Your coping style of seeking information and details is not helping you. If you can recognize your anxiety about this subject, you may feel calmer." Review Table 60-4 for specific coping styles. Interpreting defenses requires the ability to recognize the defense and then to implement the preparatory confrontations and clarifications before interpreting the defense.

### Prescribing Medication

**KEY POINTS**

- Medications can target mood, psychotic symptoms, and irritability or impulsiveness (see Table 60-5).
- This is similar to prescribing for major psychiatric conditions.
- Mood symptoms can be treated with an SSRI, mood stabilizer, or antipsychotic medication.
- Psychotic symptoms can be treated with low doses of typical or atypical antipsychotic medications.
- Irritability or impulsive behaviors can be treated with an SSRI, low-dose antipsychotic, or mood stabilizer.

Prescribing medication for patients with personality disorders is similar to prescribing for the major psychiatric disorders. Low-dose typical or newer antipsychotics can be tried if the patient appears psychotic. A full dose of the newer antidepressants is often recommended if the patient has depressive symptoms. Patients with an unstable mood who may be irritable or impulsive may be treated with full doses of a newer antidepressant, monoamine oxidase inhibitor (MAOI), lithium, or other anticonvulsant or mood stabilizer. An anxious patient can be treated with benzodiazepines, as needed. If the anxiety is persistent or chronic, the patient can be treated with low- and full-dose antidepressants, selective serotonin reuptake inhibitors (SSRIs), or MAOIs. Using medication for acute and long-term management can be part of a long-term treatment approach for the management of personality disorders.

The psychopharmacology of personality disorders can be geared in the categorical direction toward specific personality disorders. There is evidence for the effectiveness of pharmacotherapy for borderline personality disorder (Soloff, 2000). These studies are generally at a strength of recommendation taxonomy (SORT) recommendation level B (recommendation based on inconsistent or limited quality of patient-oriented evidence). Some studies of schizotypal personality disorder (Markovitz, 2004) also have a SORT recommendation level B. The pharmacology for other personality disorders has trended toward SORT recommendation C (recommended based on clinical practice, consensus guidelines, or case series).

Another approach to the pharmacology of personality disorders is to target symptoms. Using this approach with patients with borderline personality disorder has also been offered (Yehudi, 2004). The evidence for the symptom approach to treating a borderline patient has a SORT level B recommendation. Borderline patients suffer from three main symptom clusters: cognitive perceptual symptoms (e.g., suspiciousness, referential thinking, paranoid ideation, or hallucinations); affective dysregulation (e.g., irritability, unstable moods, anger or temper outbursts, hypomania, or depression); and impulse control symptoms (e.g., suicide attempts, cutting, binge eating, substance abuse, reckless spending, gambling, or promiscuity). Table 60-5 lists medications that have been used with some efficacy in treating symptoms associated with borderline personality disorder.

### SPECIFIC INTERVENTIONS

To intervene with specific interventions for each subtype of personality disorders is the art of medicine. A basic specific approach is outlined for each disorder in Tables 60-2 and 60-4. This schema includes choosing the correct DSM-IV-TR cluster, identifying the specific personality diagnosis, recognizing common physician reactions to each type of personality disorder, and understanding the patient's core beliefs, irrational thoughts, specific fears, level of personality organization, and main defense mechanisms. Tailored interventions using this knowledge are described for each disorder in Table 60-4. This conceptual framework may make it possible to formulate some helpful interventions for the primary care management of specific personality disorders.

#### Table 60-5: Medication Dosages (in mg) for Symptom Clusters in Personality Disorders

<table>
<thead>
<tr>
<th>Mood Symptoms</th>
<th>Psychotic Symptoms</th>
<th>Irritability and Impulsivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs</td>
<td>Typical antipsychotics</td>
<td>SSRI</td>
</tr>
<tr>
<td>Fluoxetine, 20-80</td>
<td>Olanzapine, 2.5-10</td>
<td>Fluoxetine, 20-80 (right eye)</td>
</tr>
<tr>
<td>Sertraline, 100-200</td>
<td>Risperidone, 1-4</td>
<td>Sertraline, 100-200 (right eye)</td>
</tr>
<tr>
<td>Venlafaxine, 75-225</td>
<td>Clozapine, 75-550</td>
<td>Venlafaxine, 75-225</td>
</tr>
<tr>
<td>Other antidepressants</td>
<td>Typical antipsychotics</td>
<td>Low-dose antipsychotic</td>
</tr>
<tr>
<td>Amoxapine, 100-400</td>
<td>Haloperidol, 1-4</td>
<td>[see column 2]</td>
</tr>
<tr>
<td>Amoxapine, 200-250</td>
<td>Perphenazine, 12-16</td>
<td></td>
</tr>
<tr>
<td>Low-dose antipsychotic for anger</td>
<td>Trifluoperazine, 2-6</td>
<td>Mood stabilizers</td>
</tr>
<tr>
<td>[see column 2]</td>
<td>Thiothixene, 2-40</td>
<td>Divalproex, 1000-2000</td>
</tr>
<tr>
<td>Mood stabilizers</td>
<td>洛xapine, 13.5-14.5</td>
<td>Lithium, 1000</td>
</tr>
<tr>
<td>Divalproex, 1000-2000</td>
<td>Chlorpromazine, 105-120</td>
<td></td>
</tr>
<tr>
<td>Omega-3 fatty acid, 1000</td>
<td>Note: All doses are daily milligram dosage recommendations. SSRIs, Selective serotonin reuptake inhibitors.</td>
<td></td>
</tr>
</tbody>
</table>

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Paranoid Personality Disorder

When interacting with a paranoid patient, the physician commonly reacts with fear, mistrust, and a sense of danger. The physician may also feel blamed or accused. The patients may have a similar fear of being hurt, exploited, or invaded. They often react to suggestions for medical care with mistrust, excessive fault finding, sensitivity to criticism, or hypervigilance. They may fail to take other people’s prophecies or beliefs as proof of the world’s injustices. When invasive medical procedures are performed, the paranoid patient may react with full-blown panic and anxiety. This may occur because many paranoid patients unconsciously experience a body invasion as a homosexual assault. Patients with paranoid personality disorder typically function at the level of a psychotic personality organization, as evidenced by severe and unwarranted suspiciousness of others. They rely most heavily on projection as their main defense. Using projection, they accuse the physician of having or neglecting their own aggressive or hostile feelings. A physician working with such a patient needs to empathize with the patient’s mistrust and hypersensitivity. The physician should avoid arguing or attempting to reason the patient out of the paranoid worldview. It is extremely important to use confrontations and clarifications to help correct the patient’s distorted perceptions about the physician’s and their medical care. Unfortunately, direct confrontation of a delusion or hallucination (the most disturbing deficit in reality testing) often has the paradoxical effect of making these patients more suspicious of the physician.

Acknowledging that the patient’s suspicion has an emotional reality can be helpful. Rather than confronting mistrust or suspicions directly, the physician can acknowledge responsibility for any actions that the patient might have perceived as mistakes. For example, the physician could say, “I did not appreciate the importance you attached to my action; I ordered that lab test.” It may also help to openly express understanding and concern for the patient’s rights. If there is a medical need for special testing of which the patient is suspicious, acknowledge the patient’s fears, describe openly and honestly the details of the procedure, potential for pain, and likely risks and benefits. If the patient still refuses to comply, do not use direct persuasion. Ask the patient, “Is it all right with you if we have different opinions?” With the patient’s consent to hearing a different opinion, openly discuss the medical necessity of the testing without trying to resolve the problem. At future office visits, attempt new and ongoing discussions of the patient’s fears of complying with the request for specialized testing. It may take months for the paranoid patient to trust enough to consent to the appropriate treatment. Counterprojection statements of the physician can diffuse the projections and distortions directed at the physician. The physician can use counterprojection remarks to help the patient access his or her feelings while focusing on angry or suspicious feelings away from the physician toward others who are not present. For example, a physician harassed by an angry, suspicious, or blaming patient could use a counterprojection statement such as “You felt angry and hurt when the lab technician drew your blood. You must be fearful of the result of these tests.”

Schizotypal Personality Disorder

Schizotypal patients often have a tendency to form common reactions to social delusions and paranoia. Schizotypal patients often have a feeling that the patient is alone and weird or strange. Superficially, patients with either diagnosis fear personal contact, emotional involvement, and invasion of their privacy. At the deepest level, they long for emotional contact that is not overwhelming. They may react to suggestions for medical care with avoidance, withdrawal, apparent emotional detachment, or denial of the medical problem. Schizotypal patients function at a psychotic level, with impaired reality testing manifested by magical, odd, or psychotic modes of thinking. Schizotypal patients use regression to schizoid fantasy and, to a lesser extent, denial as their main defenses. They appear increasingly idiosyncratic and withdrawn when stressed. Schizotypal personality disorder appears to be a significant risk factor for the future development of schizophrenia, although most patients do not go on to develop overt schizophrenia.

Schizoid patients do not appear psychotic or idiosyncratic in their behavior. They are disinterested in intimate contacts with others, appear detached and unemotional, and wish to be left alone. They often can function at a borderline level of personality organization. Infrequently, the schizoid personality will also be associated with the future development of schizophrenia. When stressed by a medical problem, schizoid patients will use isolation and intellectualization to hide their emotions. If necessary, they will regress to childhood functioning or use psychotic denial of their illness as their main defenses.

Efforts to reach schizotypal and schizoid patients are often felt as intrusions into their privacy and may drive them away from their physician. They are relieved when the physician is not present and prefer fewer medical appointments and contacts. It is generally helpful to accept their lack of sociability at a level that does not demand involvement or permit total withdrawal. Neutral or unemotional expressions of medical information are most likely to be heard and used.

Antisocial Personality Disorder

Common physician reactions to a patient with antisocial personality disorder are feelings of being used, exploited, or deceived. This can lead to physician anger and wishes to be free of the patient, uncover lies, or punish or imprison the patient. These patients fear that they will become vulnerable, lose respect or admiration from others, and become easy prey to manipulation when they become ill. They expect to be exploited, demeaned, or humiliated. Like the narcissistic patient, they often have low self-esteem, excessive self-love, compensatory feelings of superiority, grandiosity, recklessness, and emotional shallowness, and a lack of concern for others. They often react to medical care with entitled demands for special treatment. When caught in dishonesty, they may angrily attack or devalue the physician. They may resort to other psychopathic manipulations of deception, lying, cheating, or stealing. They typically function at the borderline level of personality organization and their reality testing appears intact. In fact, their friendly, facile, slick, superficial charm, and intelligent appearance is often beguiling for the physician. They can lose reality testing when stressed by the potential of gaining their trust and keeping them in the pattern of behavior and thought patterns for a long time. They engage in other manipulative actions that reveal severely impaired or even psychotic judgments. When they are receiving medical care for a legitimate illness, they typically function at the same level and often appear to have the same characteristic issues as for the narcissistic personality disorder (Kernberg, 1992). They can be managed similarly (see “Narcissistic Personality Disorder”).

To intervene with an antisocial patient, the family physician needs to be alert and anticipate the possibility that the patient may be requesting unnecessary medical care. He or she may be seeking the secondary gain of illegal benefits or money, excuses for work absenteeism, or avoidance of legal problems. It is important not to collude with the patient’s plan for secondary gain inadvertently. For example, if the physician thinks that a patient’s request for disability is fraudulent or unwarranted, the patient should not be referred for additional evaluations. If deception is suspected, the physician can ask for verification of symptoms from other reliable sources. There is often dishonesty in a patient’s communication in the form of partial truths or outright lying, cheating, or stealing. If this occurs, avoid the common reaction of moralizing. Instead, grant the patient the reality that he or she has the ability to fool all the physicians if he or she chooses to. The patient can be told that the result of the
necrotic in acts with left alone, ty organ-associated need by a intellectu-regress to as their 

often felt from their resent and generally does not or uncommonly be heard 

Personality. This can be uncovered that they theirs, and they expect narcissistic, comp, and emo-often reacting. When the phas listeners, on testing the person, and they appear person-ly similarly physicians may seek for appro priate to this test. For insufficiency, a physician can be. There is a form of his occur. The patient vosics from suit of the 

decision is that the physician may make poorly informed medical decisions. This will ultimately result in the patient receiving inade-quate or poor medical care. The physician can explore with the patient why he or she needs to act self-destructively. Patients may need to be reminded that the physician's role is to help with medical problems and not to pass judgment or help the patient obtain unfair medical benefits.

**Histrionic Personality Disorder**

Patients with histrionic personality disorder have an emotionally expressive style, seek excessive attention, and are often dramatic. Physicians may feel flattered, captivated, seduced, or sexually aroused by these patients. Alternatively, the physician may feel overwhelmed by the patient's exaggerated or excessive emotions, embarrassed by the sexual overtures, or deserted. These patients may use their sexuality to recruit others to satisfy their needs to be romantically pursued and dependently taken care of. They fear that they are not desired and will lose the care or admiration of others.

There are two different levels of functioning with this personality disorder (Kernberg, 1984, 1992). Kernberg describes a neuritically functioning "hysteric" who shows intact reality testing, defenses centered on repression, and stable and mature relations with others. The female hysteric has a flirtatious, clinging, childlike dependence on intimate relationships but can function at mature levels of work and social situations (Kernberg, 1992). Male hysteric has similar psychological conflicts, but may appear as "macho" or "effeminate" (Kernberg, 1992). The hysteric of either sex often reacts to medical care with regression to a childlike, sexualized, dependent, and clinging position. They seek to gratify their wishes for dependent care by seducing or flattering others. Outside the office, they usually function well.

By contrast, the "histrionic patient" who functions with a borderline personality organization (Kernberg, 1984, 1992) can display transient losses of reality testing, defenses centered on splitting, and chaotic sexualized relations with others. This patient is more self-centered and self-indulgent, with a pervasive childlike dependence that extends from intimate relationships into all aspects of social and occupational functioning. Female histrionics typically act flirtatiously but may become indignant when a man shows sexual interest. Male histrionics also show the self-centered and dependent pattern, but may also be severely hypochondriacal or have antisocial features (Kernberg, 1992). Histrionics of both genders may react to medical care with regression but, unlike the hysteric, use defenses centered on splitting. They may see the doctor as all good or all bad and are extremely devaluing. They may appear severely self-centered, attention seeking, diffuse sexual, hypochondriacal, somatic, and exploitative. All this may be coupled with an exhaust-ing dependency on the physician.

In working with hystereics and histrionics, a physician needs to be friendly, not overly warm or reserved. Hystereics often benefit from some gratification of their dependent wishes and a free discussion of their fears and emotions. They can often be reassured by an educational and informational approach to their medical illness and are capable of expressing gratitude to the physician. In contrast, the intense dependency of histrionics is often made worse by gratifying the patient's needs. Offering excessive emotional care may make them greedy or demanding for satisfaction of their needs. Histrionics benefit from firm, kind limit setting (especially to their sexual overtures), with neutral acknowledgment and gratification of their reasonable needs. They may be further helped by focusing on their distortions in reality perception and through interpretation of their splitting mechanisms.

**Borderline Personality Disorder**

Borderline patients frequently become dependent on their physicians in an extremely demanding, clinging, helpless, or self-destructive manner. Physicians typically feel manipulated, angry, depleted, exhausted, or self-doubting. They may wish to get rid of the patient or rescue the patient from himself or herself. These patients fear separation or abandonment and may react to potential losses with panic, emotional instability, anger, or impulsive (suicidal or self-destructive) actions. They often react to medical care with an aggressive and dependent caregiving to their physician and other caretakers. They may angrily devalue others and make entitled demands for special treatment when they become frustrated. They tend to relate to others as all good or all bad, which significantly contributes to their poor life functioning.

They function on the borderline level of personality organization, in which reality testing is typically intact. However, under stress, they may temporarily lose reality testing and manifest severe distortions in perceptions or sense of reality. They may misunderstand the physician's intentions or instructions. They may also experience episodes of derealization, depersonalization, or brief psychotic episodes. Borderline patients have identity diffusion—extreme fluctuations in self-perception from a grandiose to an excessively harshly underestimate of their abilities. They also suffer from stormy and chaotic relationships with others. They rely heavily on splitting, projection, identification, projection, and devaluing.

Office management of these patients involves an empathic understanding of their fears. These fears revolve around the threat to their security or fears of separation or abandonment and, secondar-ily, sensitivity to rejection or fears of humiliation. They require firm limit setting (e.g., what the physician can realistically offer). When the physician attempts to satisfy these patients' intense needs, it often results in an exhausted or angry physician. This can be avoided by setting realistic limits while offering the patient several different ideas or options for more adaptive behaviors. Initial interventions should attempt to establish reality testing or correct reality distortions. If reality testing is intact, the most helpful interventions can be aimed at decreasing the pathologic splitting defenses by using confrontation, clarification, and interpretations of the problematic situation.

The primary treatment for borderline personality disorder is psychotherapy complemented by symptom-targeted pharmacotherapy. Certain types of psychotherapy and medications are effective in the treatment of borderline personality disorder. Most patients with borderline personality disorder will need extended psychotherapy to attain and maintain lasting improvement in their personality, interpersonal problems, and overall functioning. Pharmacotherapy often has an important adjunctive role, especially for diminution of symptoms such as affective instability, impulsivity, psychotic-like symptoms, and self-destructive behavior (source: American Psychiatric Association, 2001).

**Narcissistic Personality Disorder**

The family physician's reactions to the narcissistic patient are often difficult to manage. The superior, entitled, self-loving, arrogant attitude of these patients can be intimidating. They may elicit feelings of being devalued and inferior or fears of the patient's anger and criticism in the physician. Alternatively, the lack of empathy and interpersonal exploitation of these patients can readily provoke the physician to anger, a wish to retaliate with harsh criticism, or a wish to get rid of the patient.

The core fears of these patients are the result of a fragile self-esteem and their need for constant approval and praise from others. They fear loss of admiration, potency, power, and fear of being exploited when vulnerable. Any perceived insult to their "grandiose self" (Kernberg, 1984, 1992) makes them feel rejected, deflated, and criticized and frequently results in feelings of rage, shame, or humiliation.

The narcissistic patients who are most difficult to manage func-tion at the level of borderline personality organization. Their reality
testing is usually intact, yet can undergo severe distortions when they perceive slights, rejection, or competition from others with talent. Those narcissistic patients who have paranoid and antisocial features (Kernberg, 1992) have a worse prognosis. They often have a fragile identity that can swing from the grandiose to the worthless. They rely heavily on splitting mechanisms to regulate their self-esteem. They portray themselves as grandiose and superior. This helps defend against feelings of extreme inadequacy and vulnerability. They can devalue, viciously attack, or degrade those around them when they act in a self-important way. Alternatively, as splitting operates, they may idealize or envy others who are, for the moment, seen as more powerful or successful. In this position, their self-esteem plummets, as evidenced by their sense of worthlessness and their reports of deprecating and degrading self-attacks.

Office management of the narcissistic patient requires that the physician not mistake the patient's superior and entitled manner for genuine confidence. When being assaulted by a devaluing attack, it may help the physician to see the attacking patient as a wounded child having a disruptive outburst. This may prevent retaliation from the physician that would only escalate a worsening situation. Interventing in the face of a devaluing attack involves acknowledging that the patient feels hurt and that the patient also has a right to his or her opinions. If this patient can discuss these hurt feelings with a nonjudgmental and empathic physician, the problems generally resolve and a good physician-patient alliance is restored. If this is not possible, offer the patient the right to seek another expert for consultation without malice, defensiveness, or apology. This may help the patient calm down and reconsider his or her position.

In a long-term relationship with a narcissistic patient, the current splitting can be interpreted. This can be done by reminding patients that they previously praised the skill and abilities of the physician. Patients can be asked why they are so critical and angry now. When this is effective, it will allow patients to discuss their perception of insults to their self-esteem.

Avoidant Personality Disorder

Patients with avoidant personality disorder are characterized by feelings of inadequacy and fear of criticism. They have low self-esteem and believe that others are critical and disapproving until proven otherwise. Although these patients crave human relationships and affection, their fear of being criticized, rejected, embarrassed, or hurt causes them to avoid social situations or meeting new people. This shyness and avoidance protects them from their fears of being rejected or humiliated. In medical encounters, they fear revealing any aspects of themselves that may leave them vulnerable. Their timidity, hypersensitivity, and caution can generate feelings of frustration or annoyance in the physician. Patients with avoidant personality disorder tend to function at a neurotic level of personality organization. Most commonly used defense mechanisms are based on repression and include inhibition, phobia, and isolation.

Managing these patients is more effective when the physician can recognize and empathize with the patient's social fears, including the fear of the physician. Patients may minimize symptoms or delay seeking help because of fear of the physician or the feeling that they are unworthy or not important. The physician should help the patient identify any specific fears revolving around the diagnostic or therapeutic plan. Irrational fears and thoughts can be gently corrected and alternative interpretations can be offered to the patient. Patients should be encouraged, with appropriate support, to face their fears as the best way of mastering them. If the physician feels frustration or annoyance, it is often helpful to encourage the patient to describe what he or she is finding most difficult in the medical care or proposed medical plan.

Dependent Personality Disorder

Patients with dependent personality disorder may be characterized by an exaggerated need for care or need for direction from someone else, or both. They feel helpless and inadequate when it comes to making even minor decisions (such as what to wear or who to be friends with). They have a core belief that they cannot function alone, are completely incapable of taking care of themselves, and must have someone else to provide care and make decisions for them. Their major fear is of independence. Although both borderline and dependent personality disorder patients are extremely dependent on others, they react very differently to the threat of loss of a significant other. The borderline patient becomes angry or enraged, whereas the dependent patient becomes submissive and obsequious. Dependent personality disorder patients usually function at the neurotic or borderline level of personality organization, using defenses that include regression, passive-aggression, and reaction formation.

Patients with dependent personality disorder are submissive and clinging with their caretakers because of fear of losing them. The dependence of these patients can make physicians feel annoyed, drained, or depleted. There may be a tendency to deny reasonable needs of the patient. The secondary gains that dependent personality patients receive from illness also create extra challenges for the physician. The physician must understand and empathize with the patient's need for being taken care of while at the same time encouraging and fostering independent thinking and action by the patient. Because these patients often use medication, alcohol, food, and other means to satisfy their dependency needs, the physician must exercise caution in how these are used in the therapeutic plan. Unreasonable expectations for being taken care of should be gently modified by the physician.

Obsessive-Compulsive Personality Disorder

Patients with obsessive-compulsive personality disorder (OCPD) are preoccupied with details, order, and control. Although their labels are similar, these patients differ in substantial ways from patients with obsessive-compulsive disorder (OCD). OCD patients have recurrent disturbing thoughts or obsessions that create marked subjective distress. They may also be driven to ritualistic or compulsive behaviors, such as hand washing or checking rituals. These behaviors help them manage, control, and distract them from intense anxiety.

The core adaptive traits of patients with OCD are orderliness, attention to detail, and an emphasis on rational thinking and logic. These traits are lifelong patterns that many patients use successfully in their professional life. Patients with OCPD often view these traits as a personal strength. However, often their attention to detail leads them to a perfectionistic belief or worry that they must not make mistakes or be imperfect. They can interpret rules, regulations, and values rigidly and stubbornly. Patients with OCPD are often uncomfortable with feelings and emotions. They may fear disorderliness and dirt. The compulsive, critical, controlling, self-righteous side of their personalities often creates difficulty in relationships with co-workers, friends, and family. They can be stingy, orderly, and obstinate. Physicians, who often have obsessive-compulsive personality traits themselves, may feel irritated and competitive with these patients about who controls the diagnostic workup or treatment plan.

Patients with obsessive-compulsive personality disorder usually function at the neurotic or borderline level of personality organization. Commonly used defense mechanisms include intellectualization, isolation, displacement, doing and undoing, and reaction formation. Using reaction formation, they may behave in a superfluous deferential or obsessive manner to repress from themselves and hide from others their critical and self-righteous feelings. These defenses are used against their anger and dependency needs, which are often consciously denied.
Illness often represents a dangerous threat to the sense of self-control in patients with obsessive-compulsive personality disorder. The physician should understand and empathize with this loss of self-control while at the same time helping the patient regain control in the management of the problem. Struggle or conflict with the patient over control should be avoided. Reality distortions including excessive perfectionism, idealization of logic, and avoidance of feeling can be gently elicited, explored, and worked through with the patient.

Self-Defeating Personality Disorder

Self-defeating patients are often depressed, suffering, and self-sacrificing. They repeatedly make bad choices that lead to failure or pain. This diagnostic category was eliminated from DSM-IV-TR because of a gender bias (female) and an inability to reach a general agreement for the diagnostic features. However, it is included in this chapter because patients who are self-defeating are commonly seen and present difficult clinical problems for many physicians that still need to be addressed. A common physician reaction to self-defeating patients is a wish to rescue them from their own self-destructiveness. Trying too vigorously to help these patients frequently results in a worsening of the patient's complaints and symptoms, such as hypochondria or somatic complaints. This often leaves the physician frustrated, angry, defeated, self-doubting, self-blaming, or hopeless. Alternatively, these patients can arouse sadistic fantasies in the physician, such as a wish that the patient would suffer or die. Patients in this group are excessively dependent on love, support, and acceptance from others. They cannot directly express their anger and may be harshly self-judgmental. They fear recovery, which to them means losing love and care. Improvement of their medical condition often leads to the development of new complaints that have no somatic basis.

Within this group, patients may function on the neurotic or borderline level of personality organization. Neurotically functioning masochistic patients can make the physician feel mildly guilty that he or she is causing pain or suffering or not helping enough. The patient and the physician both suffer. However, these patients usually can be helped and can express genuine gratitude toward the physician. Borderline functioning masochistic patients often passively-aggressively reject the help of their physicians and make them feel helpless and responsible for the patients’ severe suffering or self-destructiveness.

Physicians can manage these patients by empathizing with the patient’s realistic medical suffering, symptoms, or complaints from the illness. It should not be suggested that the patient’s symptoms are psychological or that they will improve or be cured quickly. These optimistic predictions by the physician may paradoxically increase the patient’s symptoms, complaints, telephone calls, and office visits. Potential recovery can be presented as a likely but distant reality. If patients cannot permit or admit relief of the symptoms or suffering, they can be asked to speak less about their symptoms for the benefit of other family members.

CONCLUSIONS

Patients suffering with personality disorders contribute significantly to physician dissatisfaction with medical practice. The result is often poor quality of medical care for this difficult but all too common patient population. This chapter has described diagnostic, management, and intervention strategies for working with those with personality disorders in the family medicine setting. The schema outlined combines DSM-IV-TR diagnosis and cognitive-behavioral and psychodynamic viewpoints with the following elements: common physician reactions, patient's core beliefs and irrational thoughts, patient's fears, patient's defenses, general strategies for physician interventions, and specific physician interventions for each subtype of personality disorder.

REFERENCES


BEST EVIDENCE SOURCES