Approach to Personality Disorders in Primary Care

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INTRODUCTION

Primary care physicians are well aware of the frequency of depression in the general population and, therefore, the necessity of diagnosing and treating this disorder. In the United States, 16.2% of the population will meet diagnostic criteria for major depressive disorder at some point in their lifetime,1 and at any given time, approximately 5% to 10% of primary care patients will qualify for this diagnosis.2

Recent studies indicate that nearly 50% of patients with a depressive disorder also meet criteria for a personality disorder (PD).3,4 PDs have an estimated incidence as high as 24% in the primary care setting.5 These disorders may be difficult to assess, pose the greatest threat to the development and maintenance of good physician-patient relationships, and if unrecognized, can lead to significant functional psychosocial impairment in patients. In addition, the presence of a PD can impair the recovery of patients with depression and other Axis I disorders.6 Because the diagnosis of PD requires an evaluation of the patient’s long-term patterns of functioning, the continuity of care provided by primary care physicians places these physicians in an ideal position to make a diagnosis or to recognize the need for referral to a mental health practitioner.

This manual begins with a general description of PDs and an overview of the clinical approach to diagnosis and management of PDs in the primary care setting. This is followed by a review specifically focused on 4 PDs that have the potential to cause significant problems for both physicians and patients: paranoid PD, antisocial PD, borderline PD, and dependent PD. Of the many defined PDs, borderline PD and dependent PD are more likely to be encountered in the primary care setting.7 Paranoid PD and antisocial PD, while perhaps less common, are associated with profound interpersonal difficulties. For each disorder, we describe the condition, review the prevalence data and comorbidities, provide a case example, and discuss treatment/management strategies.

GENERAL CHARACTERISTICS OF PERSONALITY DISORDERS AND PRINCIPLES OF DIAGNOSIS AND MANAGEMENT

DEFINITION AND GENERAL DESCRIPTION

PDs have been described and classified in many ways but commonly are regarded as disorders of psychopathology less severe than the major psychoses but severe enough to impair occupational or interpersonal functioning. Common features in the various definitions of PDs are that the characteristics must be long-standing, persistent, and pervasive and must cause distress to the individual or others. The current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines PDs as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”8 The DSM-IV-TR provides a general set of diagnostic criteria applicable to all PDs (Table 1).8

The DSM-IV-TR classifies PDs as Axis II disorders.8 The intent of placing PDs on a separate axis for diagnosis is to encourage clinicians to diagnose not only the patient’s immediate clinical problem (eg, a depressive episode) but also his or her chronic maladaptive behavior and interpersonal problems. The DSM-IV-TR further categorizes PDs into 3 clusters (A, B, and C). Knowledge of the clinical manifestations within this cluster classification system is critical to diagnosis. In general, individuals with cluster A PDs (paranoid, schizoid, and schizotypal) tend to appear odd or eccentric. Those with cluster B PDs (antisocial, borderline, histrionic, and narcissistic) tend to appear overly emotional, dramatic, erratic, or unstable in their relationships. Individuals with cluster C PDs (avoidant, dependent, and obsessive-compulsive) tend to appear overly anxious, fearful, or needy.

DIAGNOSTIC APPROACH

Diagnosing PDs can be difficult in clinical practice,
particularly when functional or organic illness coexists, but it is important to attempt to recognize these disorders. PDs often must be taken into account when a comorbid Axis I disorder (eg, major depression, generalized anxiety disorder) is treated, because their presence often affects the treatment response and prognosis for the Axis I disorder. The presence of a comorbid Axis I disorder can also complicate the assessment of Axis II traits. The greatest challenge in diagnosing PDs lies in the fact that affected individuals often are oblivious to their dysfunctional personality traits and may instead blame others for their difficulties or even deny that they have problems.

It has been difficult for researchers to develop valid instruments for the assessment of a PD.\textsuperscript{9,10} A number of structured interviews and self-report questionnaires are available, such as the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II)\textsuperscript{11} and the Millon Clinical Multiaxial Inventory-III (MCMI-III).\textsuperscript{12} However, despite demonstrating adequate reliability (eg, test-retest, inter-rater), these instruments have no clearly established validity. In addition, time constraints limit the usefulness of these assessment instruments in a primary care setting. Also, although PD screening tools are available that limit the number of items a patient must respond to, such as the Assessment of DSM-IV Personality Disorders Questionnaire (ADP-IV),\textsuperscript{13} these instruments tend to over-diagnose PD. Thus, the final determination that a PD exists can be made only after the physician or mental health professional determines that a patient meets DSM-IV criteria.

The assessment of PDs in actual clinical practice differs substantially from the assessment of Axis I disorders. For depressive and anxiety disorders, clinicians tend to ask questions about specific symptoms and their frequency, intensity, and duration. However, direct questioning is only marginally useful in the assessment for PDs.\textsuperscript{9} For example, directly asking a patient with antisocial PD if he repeatedly lies or a patient with paranoid PD if he reads hidden, threatening meanings into benign remarks is not likely to elicit useful diagnostic information. However, catching a patient with antisocial PD in a lie (eg, by discovering the true reasons the patient is seeking pain medication) or being accused of being untrustworthy by a patient with paranoid PD (eg, who refuses to take a prescribed medication because of mistrust) would be more useful in diagnosing PD.

Thus, clinicians should assess PDs through close attention to the patient’s description of past and present interpersonal interactions (eg, with family, friends, coworkers), through observing the patient’s behavior during the clinical interview, and through repeated encounters with the patient. Special attention should be paid to the quality of the patient’s relationships (ie, the capacity for love, warmth, trust, and mutuality) as well as the quality of the physician-patient relationship over time.

The physician’s self-awareness regarding potential negative reactions to patients becomes an important clinical tool in assessing for PDs.\textsuperscript{14} For example, subtly hostile remarks of a patient with a cluster B PD during the clinical encounter may not initially indicate a PD to the physician but rather may leave the physician feeling irritated after the encounter. A moment of self-reflection can often help to identify the source of the hostility and can result in a more careful assessment of the patient’s aggression during the next visit. If the physician is alerted to the patient’s repetitive patterns of pathological personality characteristics, traits, and/or interpersonal behaviors during the clinical encounter, more specific questions can be asked to assess for the 5 general diagnostic criteria for a PD (Table 1).

<table>
<thead>
<tr>
<th>Table 1. DSM-IV-TR General Diagnostic Criteria for a Personality Disorder</th>
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<tr>
<td><strong>A.</strong> An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. This pattern must be manifested in 2 (or more) of the following areas:</td>
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<tr>
<td>1) Cognition (ie, ways of perceiving and interpreting self, other people, and events)</td>
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<tr>
<td>2) Affectivity (ie, the range, intensity, lability, and appropriateness of emotional response)</td>
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<td>3) Interpersonal functioning</td>
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<td>4) Impulse control</td>
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<td><strong>B.</strong> The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.</td>
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<tr>
<td><strong>C.</strong> The enduring pattern leads to clinically significant distress or impairment of social, occupational, or other important areas of functioning.</td>
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<tr>
<td><strong>D.</strong> The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.</td>
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<tr>
<td><strong>E.</strong> The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.</td>
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<tr>
<td><strong>F.</strong> The enduring pattern is not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, head trauma).</td>
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Table 2. DSM-IV-TR Diagnostic Criteria for Paranoid Personality Disorder

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by 4 (or more) of the following:

1) Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
2) Is preoccupied with unjust doubts about the loyalty or trustworthiness of friends or associates
3) Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
4) Reads hidden demeaning or threatening meanings into benign remarks or events
5) Persistently bears grudges (ie, is unforgiving of insults, injuries, or slights)
6) Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7) Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiological effects of a general medical condition.


The physician fails to discuss these fears, the physician-patient relationship can be negatively affected. For patients with PDs who struggle with overt hostility and aggression, it may be necessary to establish clear limits and boundaries for behavior at the time of the visit. For example, a patient who yells at the physician should be told that complaints or disagreements must be voiced in a normal tone in order for the patient to remain in the practice.

Before recommending psychiatric and/or psycho-social treatments, the physician should assess the patient’s awareness of his/her problems and readiness for change. Patients with PDs tend to externalize blame for their problems or distress to others and therefore may not be open to mental health referrals. Once a physician feels that the patient is open to a discussion about a referral for mental health treatment, the physician can acknowledge the patient’s strengths (eg, the patient’s ability to verbalize concerns) and explain specific coping skills for the patient to learn (eg, a patient with borderline PD can learn how to lessen the frequency and intensity of negative emotions). Once the patient acknowledges his/her difficulties, a referral to a mental health practitioner is recommended in order for the patient to learn how to manage these difficulties. Note that PD patients with comorbid Axis I disorders may need more preparation before being open to a mental health referral.

Finally, physicians should get to know the mental health practitioners in their community who treat patients with PDs and collaborate with them in the care of these challenging patients. In general, cognitive behavioral and psychodynamic therapies are effective treatments for many PDs. Pharmacotherapy may also be used to lessen the effects of certain symptoms that often coexist with many of the PDs, especially cluster B PDs (depression, anxiety, and aggression). Additional treatment (eg, day hospitalization) may be necessary when patients with PDs have comorbid substance abuse disorders, poor impulse control, or suicidal behavior.

PARANOID PERSONALITY DISORDER

DEFINING CHARACTERISTICS

Paranoid PD is one of the more problematic PDs because of the pervasiveness of a mistrust of others, suspiciousness, hostility, and a need for control, as well as the level of dysfunction associated with the disorder. Patients with paranoid PD often have challenging relationships and significant difficulties with close
relationships. These patients may express their mistrust and suspiciousness through argumentativeness, through excessive complaining, or through hostile aloofness. It is useful to understand that patients with paranoid PD are hypervigilant (ie, “paranoid”) because of ever-present issues of being harmed by others. Addressing these issues early in an encounter may help to ease the patient’s fears and aid in the building of a “safe-enough” physician–patient relationship. Physicians should be aware that members of minority groups, immigrants, political and economic refugees, and patients from different ethnic backgrounds may exhibit behaviors consistent with paranoid PD (guardedness, suspiciousness, or anger) because of cultural or language barriers or in response to feelings of indifference or neglect from the dominant society. DSM-IV-TR criteria for the diagnosis of paranoid PD are listed in Table 2.

PREVALENCE AND COMORBIDITY

The prevalence of paranoid PD ranges between 0.5% and 2.5% in the general population, between 10% and 30% in hospitalized psychiatric cohorts, and between 2% and 10% in outpatient psychiatric cohorts. Paranoid PD has a high degree of overlap with other PDs, especially schizotypal PD (sharing traits of suspiciousness, paranoia, and aloofness), schizoid PD (sharing strange, eccentric, odd, and aloof behavior), and borderline and histrionic PDs (sharing anger over minor accurate or inaccurate slights). Paranoid PD can be differentiated from psychotic disorders (delusional disorder, persecutory type; schizophrenia, paranoid type; and mood disorder with psychotic features) by the absence of persistent psychotic symptoms such as delusions and hallucinations.

CASE ILLUSTRATION

A divorced 37-year-old man presents for the first time to the clinic with a complaint about “high blood pressure” that he says his “last doctor didn’t seem to know what to give” to control. With slight agitation, he says that he found a lot of information on the internet and cannot understand why his previous physician did not help him. When asked about this point, the patient replies, “I don’t know if some doctors just have it out for you.” When asked for further clarification, he answers angrily, “I’ll never go back there! I could barely understand his accent—I don’t even know if he got to this country legally!”

The patient lives alone and has no children. He appears annoyed when asked about his sexual history and refuses to answer questions about it but spontaneously offers, “You can’t trust women these days with all the diseases out there!” The patient works in the information technology department for a large company but says he would like to find another job because he has difficulty “working with idiots.” He has a younger sibling who he has not talked to in several years.

The physician notes the patient’s concern that doctors are not helping him with his hypertension. She then tells the patient, “It must be frustrating for you not to have received the care you were hoping for to get your blood pressure under control. We’ll work together on this problem and get you started on medication. You can help us by monitoring your blood pressure at home. Then, we’ll see you each week until we get your blood pressure where it should be. How does this plan sound to you?”

TREATMENT

Most treatment information for paranoid PD comes from clinical observation—very little is known empirically. To maintain an optimal primary care relationship with such patients, the physician should address the patient’s concerns as they arise in the clinical encounter. Encouraging the patient to voice concerns will usually prevent the magnification of the patient’s distrust. In this case, the physician empathized with the patient’s frustration over the care he recently received and reassured him that they would work together to find the right treatment for controlling his blood pressure. The patient was also asked if he agreed with the physician’s plan in order to foster a collaborative relationship and bolster the patient’s sense of control. The physician was direct, nonjudgmental, and empathic and offered a collaborative approach to care.

ANTISOCIAL PERSONALITY DISORDER

Throughout recorded history, individuals have been described whose behavior showed a persistent disregard for and violation of social rules and the rights of others. Unlike patients with other PDs, patients with a diagnosis of antisocial PD must be at least 18 years of age and have a history of childhood conduct disorder symptoms (aggression toward people or animals, damage to property, deceitfulness or stealing, or serious rule violations) since age 15 years. Patients with antisocial PD show a pattern of unlawful behavior; disregard feelings and rights of others; are manipulative and deceitful for purposes of personal gain, power, or pleasure; are dishonest, impulsive, and irresponsible; and may lack remorse for wrong-doing. DSM-IV-TR criteria for the diagnosis of antisocial PD are listed in Table 3.
Table 3. DSM-IV-TR Diagnostic Criteria for Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by 3 (or more) of the following:
   1) Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
   2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
   3) Impulsivity or failure to plan ahead
   4) Irritability and aggressiveness, as indicated by repeated physical fights or assaults
   5) Reckless disregard for safety of self or others
   6) Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligation
   7) Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.
C. There is evidence of conduct disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.


PREVALENCE AND COMORBIDITY

Community samples reveal that antisocial PD occurs in approximately 3% of men and 1% of women; prevalence in psychiatric samples varies between 3% and 30% depending on the assessment criteria used.\(^8\) Antisocial PD is more common in first-degree relatives of individuals with the disorder than in first-degree relatives of those without the disorder. Patients with antisocial PD often share symptoms with, or meet full criteria for, other cluster B PDs (narcissistic, borderline, and histrionic).\(^21\) A diagnosis of antisocial PD in a patient with a substance-related disorder can be made only if signs of antisocial PD in adolescence have continued into young adulthood. Although traits of antisocial PD can be found in individuals with paranoid PD (eg, getting into physical fights), these traits in antisocial PD are rarely motivated by personal gain or exploitation, but rather by a desire for revenge. Patients with antisocial PD may also present with dysphoria, anxiety, or depression. Patients with antisocial PD can also meet criteria for anxiety disorder, depressive disorder, substance-related disorders, somatization disorder, or pathological gambling disorder.\(^8\)

CASE ILLUSTRATION

A 24-year-old man presents with injuries to his right hand resulting from a fight the previous night while working as a security guard at a local dance club. The patient is quite affable during the interview and states that he broke the same hand in a fight 2 years ago. He lives with his girlfriend (of 3 months) and her 2-year-old daughter. He has 1 child, a 7-year-old son, but has not had contact with him “since his mother left the state last year.” The patient seems perturbed when asked if he has ever been arrested. The patient states that, at age 16 years, he was incarcerated for 6 months in a youth facility for stealing a car. At age 21 years, he was arrested again for assault and spent 3 months in a county jail. He claims that he is a full-time criminal justice student at a local community college and plans to become a lawyer.

During the encounter, the physician feels that the patient exhibits some antisocial PD features; however, he chooses not to recommend psychological treatment because the patient’s behavior/personality is not causing him any distress, and it would be unlikely that he would accept such a recommendation. After treating the patient’s hand injuries, the physician overhears the patient invite the receptionist to visit the club where he works and promise her free admission. As the patient leaves the office, the physician’s concerns shift to the safety of himself and the clinical staff.

TREATMENT

Antisocial PD is probably the most difficult of all PDs to treat. Patients with antisocial PD rarely seek psychological treatment on their own and may do so only when mandated by a court. There are no known evidence-based treatments for antisocial PD. Some patients with antisocial PD can be quite charming before taking advantage of others. Physicians need to be respectful yet direct and firm with such patients and give equal weight to their own protection and that of their staff.

BORDERLINE PERSONALITY DISORDER

Perhaps no other personality disorder evokes more reaction and has a greater stigma than borderline PD. This disorder was first named by Grinker et al\(^26\) after conducting a cluster analysis of 60 patients who did not fit neatly into any diagnostic category but shared many features, including anger as the primary affect, problems in interpersonal relationships, a poor sense of identity, and pervasive depression. Concurrently,
Kernberg described individuals with borderline PD as patients who lacked anxiety tolerance and impulse control and demonstrated poor sublimation of impulses into socially accepted outlets. Likewise, these patients tended to engage in highly self-centered thinking and lacked the capacity to tolerate frustration or ambivalent feelings in interpersonal relationships. These patients tended toward the use of defense mechanisms, such as splitting (seeing others as mainly “all good” or “all bad” without the capacity to accept the frustrating and gratifying qualities that each person has), as well as idealization, projection, denial, omnipotence, and devaluation.

These qualitative descriptions remain true today, and many are reflected in the DSM-IV-TR criteria (Table 4). Patients with borderline PD are plagued with a sense of loneliness or emptiness, despite the fact that they are highly dependent on others to support their fragile sense of self. This disorder also consists of affective dysregulation, with a chronic sense of anger or irritability commonly observed in the clinical setting. Suicidal ideation, gestures, and attempts are not uncommon. Because of their poor impulse control, patients with borderline PD engage in activities that could and do lead to significant danger (eg, compulsive buying, sexual relationships, substance abuse, physical expressions or outbursts of anger). When distressed, patients with borderline PD manage their frustration in diverse, maladaptive ways, including self-mutilation and acting out.

Recent empirical studies of borderline PD have found that the traits of disinhibition and negative affectivity are most strongly predictive of borderline PD features. Other etiologic factors that have been associated with borderline PD include the presence of parental psychopathology; a history of physical, sexual, and/or emotional abuse; and chronic negative expectations of relationships, which lead to an underlying sense of negativity and suspiciousness of others’ intentions.

PREVALENCE AND COMORBIDITY

Borderline PD is estimated to occur in 2% of adults, mostly in young women. Borderline PD is often diagnosed with coexisting major depressive disorder, dysthymia, substance abuse disorder, and/or bipolar disorder. The latter disorder may be inappropriately diagnosed when the health care provider does not attend to the patient’s personality as a whole and instead focuses almost exclusively on the affective dysregulation component. In terms of comorbid Axis II disorders, all of the remaining cluster B PDs (antisocial, histrionic, and narcissistic) share similar features with borderline PD, given the extent to which impulsivity, aggression, excessive self-focus, and common defense mechanisms occur. Dependent PD also may coexist in patients with borderline PD because these patients are highly dependent on others; however, the dependent PD patient’s sense of dependency does not wax and wane like that of the borderline PD patient, who experiences strong dependency feelings when his/her needs are being met and aggressive and hostile feelings toward others when these needs are not met.

CASE ILLUSTRATION

A 24-year-old woman presents with a complaint of “migraines.” However, she says that the main reason she made the office appointment was to “get everyone off my back.”

When asked about her headaches, the patient describes them as pain and pressure on both sides of her head, like somebody grabbing my head and squeezing it.” She says the headaches are tolerable but bother some, “especially when they last a few hours,” and that acetaminophen provides some relief. She denies any

Table 4. DSM-IV-TR Diagnostic Criteria for Borderline Personality Disorder

<table>
<thead>
<tr>
<th>A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by 5 (or more) of the following:</th>
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<tbody>
<tr>
<td>1) Frantic efforts to avoid real or imagined abandonment*</td>
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<tr>
<td>2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation</td>
</tr>
<tr>
<td>3) Identity disturbance: markedly and persistently unstable self-image or sense of self</td>
</tr>
<tr>
<td>4) Impulsivity in at least 2 areas that are potentially self-damaging (eg, spending, sex, substance abuse, reckless driving, binge eating)**</td>
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<tr>
<td>5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior</td>
</tr>
<tr>
<td>6) Affective instability due to a marked reactivity of mood (eg, intense episodic dysphoria, irritable, or anxiety usually lasting a few hours and only rarely more than a few days)</td>
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<td>7) Chronic feelings of emptiness</td>
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<tr>
<td>8) Inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, recurrent physical fights)</td>
</tr>
<tr>
<td>9) Transient, stress-related paranoid ideation or severe dissociative symptoms</td>
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*Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.
A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by 5 (or more) of the following:

1) Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
2) Needs others to assume responsibility for most major areas of his or her life
3) Has difficulty expressing disagreement with others because of fear of loss of support or approval*
4) Has difficulty initiating projects of doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation)
5) Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7) Urgently seeks another relationship as a source of care and support when a close relationship ends
8) Is unrealistically preoccupied with fears of being left to take care of himself or herself

*Note: Do not include realistic fears of retribution.


The patient says that her friends have expressed concern about her erratic behavior since she broke up with her boyfriend, whom she had been dating for 3 months. She sees nothing wrong with her behavior, which includes frequent shopping at a local mall. She states that she spent $600 one day, which is her weekly income. She notes that she has been eating much more than usual and having difficulty falling asleep since the breakup, and she admits she has even had thoughts of suicide. However, she sees nothing unusual about these behaviors. She describes her relationship with her boyfriend as a “rollercoaster ride.” She says sometimes she hates him, but other times she is convinced he is the man of her dreams. When they argued, she found it particularly upsetting that her boyfriend said she was “like a firecracker that could explode at any time.” After these fights, she would find herself “spacing out,” which was followed by numerous frantic phone calls to the boyfriend to be assured of his interest in her.

After ruling out alcohol and substance misuse, the physician tells the patient that the tension headaches may be related to her difficulty in managing her feelings when things go wrong with her relationships and that there are treatments that can help her with these problems. The patient states that she only needs something to stop the headaches. The physician asks if she would be willing to talk more about her relationships and the difficulties she has managing her feelings at her follow-up appointment, and the patient agrees.

**TREATMENT**

Unlike many PDs, borderline PD is often treated with pharmacotherapy in conjunction with psychotherapy. It is preferable that an assessment for medicare be made by a psychiatrist. Selective serotonin reuptake inhibitors and anticonvulsants have been commonly used to address the underlying affective dysregulation and impulsivity. Despite the challenges of treating patients with borderline PD, it is recommended that these patients be strongly encouraged to seek and maintain psychotherapy. In this case, however, the physician noted that the patient was not ready to acknowledge her problems and thus was not ready for a recommendation for treatment of her borderline PD. In future visits, the physician should talk with this patient about her distress, its association with how she manages her feelings and relationships, and how it affects her health.

**DEPENDENT PERSONALITY DISORDER**

DSM-IV-TR criteria for dependent PD are listed in Table 5. Patients with dependent PD are excessively reliant on others to care for them and to provide the comfort and self-assurance that they are not able to provide for themselves. The dependent PD patient’s sense of agency is significantly reduced, such that others take on an important psychological role in the patient’s pursuit of independence and self-efficacy. The patient with dependent PD characteristically has others make everyday decisions for him/her and requires much support before taking action. Contrary to what might be
expected, patients with dependent PD are not passive; they actively seek out the care of someone else when they lose or believe they might lose their caretaker.35

To receive the care and help that they desire, patients with dependent PD often agree to conditions or situations that most others might find aversive. For example, it is not uncommon to find a dependent woman married to a narcissistic man, who expects her to submit to his idiosyncratic and self-serving requests, which many people would find excessive, controlling, and possibly demoralizing. In the context of primary care, it would not be unexpected to find the patient with dependent PD scheduling more than the usual number of visits within a year or seeking a physician’s support and care for minor issues.

PREVALENCE AND COMORBIDITY

Dependent PD is frequently seen in mental health facilities.1 Dependent PD qualities and traits are often observed as part of avoidant and borderline PDs. As such, dependent PD may be inappropriately diagnosed in borderline or avoidant patients or may coexist. Eating disorders, anxiety disorders, substance abuse disorders, and obesity are commonly observed in patients with dependent PD or in those with PDs that have dependent features.36–40 There also are strong links between depression and dependency, and patients with dependent PD are vulnerable to experiencing depressive episodes.8 Thus, when assessing patients with these comorbid disorders, it is helpful to evaluate for dependent personality qualities or the conflicts that an individual feels regarding his/her sense of dependence or independence.

CASE ILLUSTRATION

A 45-year-old woman presents to the clinic for the fifth time in 4 months. At this appointment, the patient notes that she cannot overcome a cold, and she wants assurance from her physician that she is going to be fine. The patient often presents for guidance and reassurance about common maladies, and her physician notices that these appointments tend to occur when her husband of 18 years is out of town on business. The patient comments how she dislikes her husband’s absences. The patient says she had not considered that option but that she would think about it. The physician makes a note in the patient’s chart to follow up on the issue of mental health care at the next visit.

TREATMENT

Psychotherapy is strongly recommended for patients with dependent PD. The focus is on restoring the patient’s sense of agency and self-efficacy and on the underlying reasons maintaining the patient’s wish for a caregiver. As dependent PD patients often experience much anxiety when faced with decision-making or the need to be independent, attention is often devoted to reducing anxiety and fostering a sense of safety and efficacy. In this case, the physician reassured the patient that her condition was not serious, acknowledged her strengths, provided information about therapy, and suggested an important issue for her to focus on in therapy. Physicians should monitor their level of emotional involvement with dependent patients, be realistic and open about time limitations for such encounters, acknowledge limitations in solving the patient’s problems, resist the temptation to make major decisions for the patient, and help the patient seek alternate forms of support from others (eg, family members, member of the clergy, a therapist) in times of increased need.41 It should be noted that increased dependency following the loss of a loved one, a traumatic experience, or the onset of a significant illness may be temporary and lessen with time as long as the patient has adequate social support.

SUMMARY

PDs may be more difficult to assess than Axis I conditions such as depression. PDs can negatively affect the physician-patient relationship, interfere with the treatment of other medical and psychiatric disorders, and cause significant functional impairment in patients who struggle with them. Physicians can assess PDs by paying close attention to patients’ descriptions of past and present interpersonal relationships and through observing the way the patient interact with them within the clinical encounter. Repetitive maladaptive patterns are likely to emerge as primary care physicians get to know these patients and their families. In managing patients with PDs, it is important to develop a collaborative stance and remain empathic. Before referring
these patients to mental health providers knowledgeable in treating PDs, physicians should assess the patients’ awareness of their problems and readiness for change. By being aware of the diagnostic criteria, diagnostic methods, and management strategies for these more difficult PDs, primary care physicians can more effectively care for patients with these disorders.

REFERENCES


