"Difficult" patient? Or does he have a personality disorder?

The patient who always seems to be in crisis may actually have a personality disorder. Employing these techniques can benefit the patient and your interaction with him.

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PRACTICE RECOMMENDATIONS

❯ *Evaluate a patient's sense of identity and interpersonal relationships for clues of a personality disorder (PD).* Ⓐ

❯ *Use validation, promote mentalization, and manage countertransference to help patients with PDs.* Ⓐ

❯ *Consider medications such as antidepressants or antipsychotics for patients with PDs, but only as adjuncts to psychotherapy, and only to target specific symptoms, such as impulsive aggression.* Ⓑ

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Strength of recommendation (SOR)

Ⓐ Good-quality patient-oriented evidence

Ⓑ Inconsistent or limited-quality patient-oriented evidence

Ⓒ Consensus, usual practice, opinion, disease-oriented evidence, case series

CASE ▶ Bob A, age 48, comes to his family physician (FP) to ask for authorization for extended medical leave from his job as an electrician. He frequently misses days at work and complains of stress on the job, saying his coworkers look down on him and make cruel jokes at his expense. He reports having chronic interpersonal conflicts and no significant relationships with family members or friends. Mr. A refuses a referral to a psychiatrist because he fears he will be "locked up and forced to take medications."

If Mr. A were your patient, how would you proceed?

Personality disorders (PDs) are patterns of inflexible and maladaptive personality traits and behaviors that cause subjective distress and significant social or occupational impairment.[1] An individual with a PD tends to have a limited repertoire of responses to the rough-and-tumble of life, with coping mechanisms that often perpetuate difficulty and distress. Examples include distrust and suspiciousness of others' motives (paranoid PD); disregard and violation of the rights of others (antisocial PD); instability in interpersonal relationships, self-image, and affect (borderline PD); and social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation (avoidant PD).[1]

FPs may view patients with PDs as "difficult patients" because of their frequent crises and the interpersonal problems they bring into the physician-patient relationship.[2,3] Help, of course, can come in the way of a referral to a psychotherapist who specializes in treating PDs. But you can also make use of some evidence-based psychotherapy techniques to improve your patients' lives and the quality of the physician-patient relationship. This article focuses on identifying and managing PDs in family practice, using practical strategies drawn from empirically supported therapies.

TABLE 1

DSM-5 personality disorders[1]

Personality disorder	Key features
Paranoid	Distrust and suspiciousness; others are regarded as having malevolent intentions
Schizoid	Persistent detachment from social relationships; restricted emotional expression
Schizotypal	Reduced capacity for interpersonal relationships; cognitive or perceptual distortions; eccentric behavior
Antisocial	Violation of the rights of others; impulsive and irresponsible behavior; lack of remorse
Borderline	Unstable interpersonal relationships; unstable identity and emotions; impulsivity
Histrionic	Excessive yet superficial emotionality; attention-seeking behavior
Narcissistic	Grandiose fantasies; need for admiration; lack of empathy
Avoidant	Social inhibition; feelings of inadequacy; fear of criticism or rejection
Dependent	Submissive and clinging behavior; excessive need for advice and reassurance
Obsessive-compulsive	Preoccupation with orderliness, perfectionism, and control
Personality change due to another medical condition	Persistent personality disturbance directly related to a physiological condition (eg, temporal lobe lesion)
Other specified personality disorder and Unspecified personality disorder	Meets general criteria for a personality disorder, but (1) has a PD that is not included in the DSM-5 classification or (2) has traits of several PDs, but not meeting criteria for any single PD

DSM-5, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed; PD, personality disorder.

> **Personality disorders are associated with a greater incidence of serious medical illness and reduced social functioning.**

PDs are more common than you might suspect

The overall prevalence of PD in the community ranges from 4.4% to 14.8%, with no consistent pattern of sex differences.[4] Between 31.4% and 45.5% of psychiatric outpatients and up to 24% of primary care patients likely meet criteria for at least one PD.[5-7] PDs impede recovery from other mental disorders,[8] increase the risk for suicide,[9] and are associated with substance abuse, impulsivity, and violence.[10,11] Personality pathology also is associated with greater incidence of serious medical illness[12,13] and reduced social functioning.[14] Not surprisingly, patients with PDs frequently use medical and social services.[15]

PDs tend to be underdiagnosed, perhaps partly because of concern about stigmatization, but also due to difficulties in identifying and classifying these disorders. Published in 2013, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5) originally was to include a major revision of PDs—reflecting concern about the limitations of PD categories—but ultimately the existing categories were retained (**TABLE 1**).[1] There is considerable overlap among PD categories; many patients meet the criteria for more than one PD, but it is unlikely that they actually suffer from several distinct PDs. Other patients—perhaps even the majority—are best diagnosed with "unspecified personality disorder" because they do not neatly fit into one of these categories.

Suspect your patient has a PD? Evaluate these 2 areas

Identifying patients who have PDs in primary care is useful for 2 reasons: to explore the option

of specialty treatment for patients who may be amenable to it, and to improve management of the patient's complaints in the primary care setting, including a smoother doctor-patient interaction. In either case, determining the specific DSM-5 diagnosis is less important than recognizing core personality impairment: an ingrained disturbance in one's perceptions of self and others. This can be done by paying attention to how the patient adapts to life's challenges and if he or she has problematic interpersonal tendencies, including difficulties in the doctor-patient relationship.

Unfortunately, assessing and diagnosing PDs in the primary care setting can be challenging. Limited time doesn't allow for extensive, personality-focused interviews. Self-report screening tools are limited, because patients may underreport key interpersonal problems such as lack of empathy. Furthermore, very few patients seek help from their FP in addressing personality dysfunction; PDs typically are identified while investigating other complaints.

The most reliable and useful areas to evaluate in a patient you suspect may have a PD are identity (one's sense of who one is and can be) and interpersonal relationships, including the capacity for empathy and intimacy.[16,17] These should be considered longitudinally and in the context of the individual's stage of development. For example, identity is generally less stable among adolescents compared to middle-aged adults.

■ **A cohesive sense of identity** allows one to embrace life's tasks and challenges, to develop and strive toward personal goals, and to handle setbacks and disappointments. A person with a stable identity may develop a depressive reaction to difficult life circumstances, but with some assistance can generally bounce back and re-engage in his or her personal goals. By contrast, an individual with an unstable sense of self may feel chronically insecure and empty, with limited capacity to constructively deal with life's ups and downs. Patients with borderline PD, for example, try to manage a fragmented identity by frantically clinging to others, while narcissistic patients tend to suppress a fragile sense of self by putting forth an arrogant and entitled attitude.

■ **How does the patient interact with others?** As is the case with identity, an individual's capacity for interpersonal functioning is developed early in life, through interactions with primary caregivers. Mental maps of who we are and what we can expect from others are formed and reinforced in attachment relationships, such as those with our parents; traumatic attachments, including abuse or neglect by a caregiver or loved one, are strongly associated with PD.[18,19] The resulting belief structures guide subsequent interpersonal functioning, and become interactively reinforced. For example, a person whose internal map of relationships includes others abandoning him might behave in a clingy manner, which may ultimately induce others to reject him, thus creating a self-fulfilling prophecy.

Distorted interpersonal expectations can impair a person's capacity for sustained intimate connections (a troubled relationship history is characteristic of PDs) and limit empathic functioning.[20] Other people's actions may be interpreted according to the patient's belief structures rather than with an open mind about the other person's experience.

Focus on the physician-patient relationship

The interpersonal dysfunction of patients with PDs will often surface in the physician-patient relationship, serving as a clue to broader interpersonal dysfunction. An FP's relatively innocuous oversight, for example, might be taken as proof of suspected incompetence in the eyes of a patient with paranoid or narcissistic tendencies. Or a patient with a recurrent complaint who repeatedly rejects the physician's interventions probably oscillates between seeking and rejecting nurturance in other relationships, as well. A patient who tends to make sarcastic remarks regarding the doctor's earnest efforts likely holds negative views of others and sabotages potentially positive interactions.

So what strategies are best for managing these types of scenarios?

Bringing up a potential diagnosis of PD may be a delicate matter for the FP; patients might experience this as a jarring diagnosis in the absence of a thorough psychiatric evaluation. If the FP decides to explore whether the

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patient is open to discussing the relationship between moods, behaviors, and personality features, he or she can begin this conversation by noting that, as with physical health, we all have our vulnerabilities, and that these vulnerabilities may be strengthened through specialist consultation and support. In this way, the patient can view a referral as an opportunity to explore herself with professional support. If a psychiatrist or psychotherapist colleague does become involved, it is important to clarify the roles of treatment providers and to communicate with one another, should difficulties arise.

Evidence supports 2 forms of psychotherapy

Treatment for PDs has seen considerable growth over the past decade, largely due to research on therapies that target the troubling self-injurious and suicidal features of borderline PD. Considerable evidence shows that specialized psychotherapy can significantly reduce suffering and improve functioning among these patients. The 2 major evidence-based treatments for patients with borderline PD are dialectical behavior therapy (DBT) and psychodynamic therapy.

❚ **DBT is an intensive cognitive-behavioral approach** that teaches patients how to regulate their emotions and develop an accepting, mindful attitude toward their mental experience.[21] Several randomized controlled trials (RCTs) have demonstrated the effectiveness of DBT in reducing hospitalizations and self-injurious and suicidal behavior in patients with borderline PD.[22]

❚ **Psychodynamic therapy,** which focuses on helping patients discover how unconscious conflicts influence their present moods and behaviors, has also been validated by multiple RCTs for patients with borderline PD.[23-25] Like DBT, empirically supported psychodynamic therapy tends to be structured, long-term (>12 months), and often intensively delivered in multiple sessions per week. However, a recent study found that a less-intensive, general psychodynamic therapy, along with occasional medication management, was equivalent to intensive DBT.[26]

Although the research has focused primarily on borderline PD, these approaches can be applied to other PDs. These therapies focus on understanding one's emotional and behavioral patterns, developing a healthy self-concept, and improving interpersonal relationships—areas that are relevant treatment targets across all PD types.

Indeed, studies of day treatment programs that explicitly welcome patients with a range of PD types have had promising findings.[27] Day treatment involves an intensive array of therapies, mostly in a group format; patients work together to support and embolden one another to make positive changes. Unfortunately, FPs may be challenged to find appropriate services for patients who are amenable to psychotherapy; public mental health resources tend to lag far behind best practices in the case of PD.

Medication might improve symptoms, not personality deficits

Most research on pharmacotherapy for PDs has focused on borderline PD; findings have been mixed and fairly limited.[28] Medication cannot address underlying identity and relational deficits, and will not result in remission of PD. Nonetheless, judicious, circumscribed use of medications to target specific symptoms may be helpful for some patients. Selective serotonin reuptake inhibitors can reduce anger and impulsive aggression in patients with borderline PD.[28,29]

Atypical antipsychotics may help reduce impulsive aggression or transient psychotic symptoms.[28-30] For example, olanzapine and aripiprazole can reduce anxiety, anger/aggression, paranoia, and interpersonal sensitivity in borderline PD.[31,32] Mood stabilizers such as valproate, lamotrigine, and topiramate may also help some borderline patients, although they do so by reducing impulsivity and aggression rather than improving core unstable identity and affect.[28,29]

Carefully obtained informed consent is necessary because of the danger of adverse effects with many of these medications; for example, antipsychotics have been associated with metabolic syndrome and weight gain that can

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threaten a patient's already fragile self-image.[33] Polypharmacy is also a potential problem: Well-intentioned physicians may be prompted to offer multiple medications in response to patients' unremitting complaints of distress, when a psychotherapeutic approach may need to be the primary treatment. The bottom line is that medications do not resolve personality dysfunction, and are best used symptomatically as adjuncts to psychotherapy.[28,30]

Steps you can take during the office visit

Although it is not feasible for most FPs to provide comprehensive treatment for PD, key elements from specialized therapies can be integrated into your management of these patients. Steps you can take include using validation, promoting mentalization, and managing countertransference.

▎**Validation,** which is a component of DBT, is providing the expressed acknowledgement that the patient is entitled to her feelings. This is not the same as agreeing with a position the patient has taken on an issue, but rather conveying the sense that one sees how the patient might feel the way she does. A study of women with borderline PD and substance abuse found a validation intervention by itself was significantly helpful.[34] Validation can contribute to a "corrective emotional experience." For instance, your supportive acknowledgement of a patient with a history of abuse or neglect may counter the patient's expectation of being invalidated, and over time this can reduce the patient's defensive rigidity.

▎**Mentalization.** Psychodynamic treatment involves a similar tack; clinicians empathize with the patient's emotional state while also demonstrating a degree of separateness from the emotion.[23-25] This promotes mentalization in the patient—the ability to contemplate one's own and others' subjective mental states.[18] Mentalization is often impaired in PD patients, who presume to "know" what others are thinking. A patient, for instance, "just knows" that her friend secretly hates her, based on a vaguely worded text message.

You can help patients with mentalization by taking an inquisitive "not knowing" stance and by emphasizing a collaborative and reflective approach toward a given problem—to examine the issue together, from all sides. You can point out that while a patient is entitled to feel whatever he is feeling, it may not be in his best interest to act on the feelings without adequately considering the potential consequences of the action. This helps the patient to distinguish thoughts, feelings, and impulses from behavior. It also teaches the value of anticipatory thinking, impulse control, and affect regulation.

▎**Countertransference.** Managing your emotional reactions to a patient with PD is a well-documented challenge.[35] Your feelings about the patient, known as countertransference, can range from considerable concern and sympathy to severe frustration, bewilderment, and frank hostility. A common reaction is the sense that one must "do something" to respond to the patient's emotional distress or interpersonal pressure. This may trigger an impulse to give advice or offer tests or medications despite knowing that these are unlikely to be helpful. A more useful response may be to tolerate such feelings and listen empathically to the patient's frustration. Recognizing subtle countertransference can guard against extreme reactions and maintain an appropriate clinical focus. Discussion with a trusted colleague can be helpful.

Psychodynamic approaches consider managing countertransference to be a therapeutic intervention, even when psychotherapy is not explicitly being carried out. Strong emotional responses may reflect something that the patient needs the physician to experience, as the patient cannot bear to experience it himself. The patient needs to see—and learn from—the physician's handling of unbearable (for the patient) feelings. This occurs at a level of unconscious communication and may be repeated over time. Although not discussed with the patient, a physician's capacity for self-containment and provision of undisrupted, good medical care is in itself a psychotherapeutic accomplishment.

CASE ▶ Based on Mr. A's history of interpersonal conflicts and perceived persecution by

> **A supportive acknowledgement from you may counter a patient's expectation of being invalidated, and over time, reduce the patient's defensive rigidity.**

TABLE 2

Case vignettes: Practical tips for managing patients with personality disorders

> Point out that while your patient is entitled to feel what he's feeling, it may not be in his best interest to act on those feelings without considering the consequences.

CASE 1

Amy B, age 26, is a graduate student who lives with her boyfriend. She complains to her family physician (FP) of lifelong depression, emptiness, and frequent "meltdowns." Although never suicidal, she secretly cuts her arms after arguments with her boyfriend. She demands to be seen urgently when in crisis, but when she comes in, she indignantly discards her FP's advice.

Diagnosis: Borderline personality disorder (PD) with narcissistic features

Treatment plan: Medication could be considered to target impulsive aggression, but would best serve as an adjunct to specialized psychotherapy. Supportive management can preserve a collaborative relationship and promote referral to dialectical behavior therapy or psychodynamic therapy.

Validation: "You've really been in a lot of emotional pain lately."

Mentalizing: "I think sometimes you feel so awful you can barely stand it, and perhaps you feel that help isn't there right when you need it. But we can think about these issues now—try to put your feelings into words."

Managing countertransference: The FP feels perplexed and rejected—feelings that Ms. B probably struggles with herself. The physician regards these feelings as a reflection of Ms. B's unstable self-image. He calmly sets limits regarding her use of urgent appointments.

CASE 2

Bill C, age 35, is unemployed and lives with his parents. Recently he went to the emergency department for suicidal ideation. He feels resentful that others seem to "have it all." Mr. C has been fired from several jobs due to outbursts; he feels his supervisors were all inept. He fantasizes about becoming a famous musician—then he will be appreciated and admired. Several antidepressants have had little effect.

Diagnosis: Narcissistic PD

Treatment plan: Mr. C's "depression" is likely related to feelings of emptiness, resentment, and an underdeveloped identity. Additional antidepressants are unlikely to be helpful, and he should be encouraged to consider psychotherapy. His FP should limit giving advice, as Mr. C may resent and devalue his physician, and sabotage the treatment relationship.

Validation: "It's hard for you when you see others moving forward while you feel so stuck."

Mentalizing: "Let's try to think about your thoughts and feelings a bit more—maybe we can identify some of what's going on under the surface."

Managing countertransference: The FP feels frustrated by Mr. C's immaturity and sense of entitlement. He refrains from lecturing Mr. C about developing a work ethic, realizing Mr. C would only feel more embittered.

coworkers, the FP consults with a psychotherapist colleague, who says Mr. A's chronic mistrust and social isolation suggest he may have a severe identity disturbance and unspecified PD with paranoid and schizoid features. Because Mr. A refuses to see a therapist, his FP decides to focus on promoting small improvements in Mr. A's interpersonal interactions and reducing absenteeism at work.

The FP validates Mr. A's feelings ("It can be very stressful to constantly feel like others are at odds with you") and tries to promote mentalizing ("I want to understand more about what you think regarding your work situation and your coworkers. Let's try to look at this from all perspectives—maybe we can come up with some new ideas.")

Despite wanting to help his patient, the FP feels uneasy and reluctant to engage with Mr. A, who likely evokes such feelings to keep others at a distance. The FP tactfully seeks to remain Mr. A's ally without endorsing his distorted interpretation of events. Given Mr. A's paranoid rejection of therapy,

the FP refrains from making further such recommendations. The FP's interventions, however, may help Mr. A warm to the idea of further help over time, and the FP's supportive stance will help to ameliorate the patient's distress. (For 2 additional examples of how FPs can use the strategies described in this article to help patients with PDs, see **TABLE 2**.) **JFP**

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> **Recognizing countertransference can guard against extreme reactions and maintain an appropriate clinical focus.**

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