Management of Personality Disorders

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Jesse Markman, MD, MBA Disclosures:

Sadly, I have nothing to disclose

Objectives

- At the end of this workshop, participants will be able to:
  - Recognize and diagnose personality disorders in the clinical setting
  - Describe common treatment interventions for patients with personality disorders
  - Discuss the role of medication-based treatment in the treatment of personality disorders

Case

Case - Tracy

Tracy is a 46 yo, cis-woman whom you just started seeing as her PCP. You saw her for her intake appointment ~6 months ago and the intake was pretty unremarkable (at least from what you can remember). She has a history of chronic back and knee pain, obesity, PCOS, HTN, HLD, and "some mental health stuff… people have told me that I have bipolar." She comes to clinic telling you that her chronic pain has been really bad of late and that she has "just been feeling terrible." She has been having some strange pain in her chest, but has been to three different EDs and cardiac workups have been negative. When they gave her lorazepam in the ED, the pain went away right away.

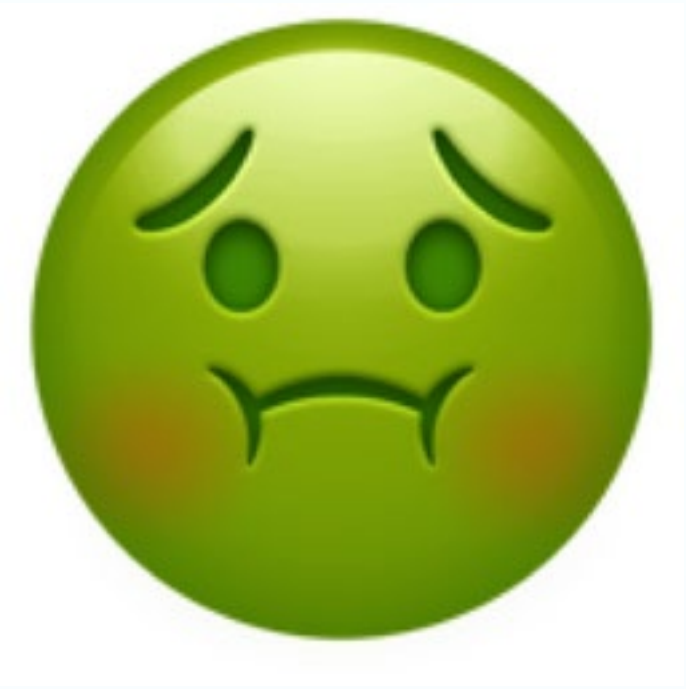
Case - Tracy

Tracy is very tearful as she describes this to you as people in the ED were “so mean to me.” She relates that she has just been feeling really sad all the time. She has also been feeling anxious and scared a lot. “What if something is really wrong with me?” She becomes more tearful as she asks you this last question and wants to know what she should do.

Let's Hear It

What is your differential from a MH standpoint?

What would help you tease this out?



Some definitions and phenomenology

Bipolar Disorder vs Personality Disorder

- Bipolar Disorder
  - Defined episodes of:
    - Mania (bipolar I)
    - Hypomania (bipolar II)
    - Depression (both)
  - Episodes persist for days to weeks
  - Return to baseline between episodes
- Personality Disorder
  - Enduring aspects of the construction of the self that characterize ability to regulate emotions and interact interpersonally
  - Can see many of the same symptoms as a manic or depressive episode… in short bursts
    - Emotional dysregulation is common, but often does not persist to the degree of a prolonged mood episode

Bipolar I: Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently goal-directed behavior or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility, as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Publishing. Arlington, VA. 2013.

Bipolar II: Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently goal-directed behavior or energy, lasting at least 4 days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility, as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions).

C. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

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Historical Classification

- DSM III, III-TR, IV & IV-TR
  - Cluster A
    - Paranoid Personality Disorder
    - Schizoid Personality Disorder
    - Schizotypal Personality Disorder
  - Cluster B
    - Antisocial Personality Disorder
    - Borderline Personality Disorder
    - Histrionic Personality Disorder
    - Narcissistic Personality Disorder
  - Cluster C
    - Avoidant Personality Disorder
    - Dependent Personality Disorder
    - Obsessive Compulsive Personality Disorder

Angstman KB, Rasmussen NH. Personality Disorders: Review and Clinical Application in Daily Practice. American Family Physician. 2011.84;11:1253-1260.

Antisocial Personality Disorder

- There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (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 obligations
  7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- Individual is at least 18 years of age

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Borderline Personality Disorder

- 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 five (or more) of the following:
  1. Frantic efforts to avoid real or imagined abandonment
  2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
  4. Impulsivity in at least two areas that are potentially self-damaging
  5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior
  6. Affective instability due to marked reactivity of mood
  7. Chronic feelings of emptiness
  8. Inappropriate intense anger or difficulty controlling anger
  9. Transient, stress-related paranoid ideation or severe dissociative symptoms

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Histrionic Personality Disorder

- A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts and indicated by five (or more) of the following:
  1. Is uncomfortable in situations in which he or she is not the center of attention
  2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
  3. Displays rapidly shifting and shallow expression of emotions
  4. Consistently uses physical appearance to draw attention to self
  5. Has a style of speech that is excessively impressionistic and lacking in detail
  6. Shows self-dramatization, theatricality, and exaggerated expression of emotion
  7. Is suggestible
  8. Considers relationships to be more intimate than they are

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Narcissistic Personality Disorder

- A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
  1. Has a grandiose sense of self-importance
  2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
  3. Believes that he or she is "special" or unique and can only be understood by, or should associate with, other special or high-status people
  4. Requires excessive admiration
  5. Has a sense of entitlement
  6. Is interpersonally exploitative
  7. Lacks empathy
  8. Is often envious of others or believes that others are envious of him or her
  9. Shows arrogant, haughty behaviors or attitudes

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New classification system?

- DSM V toyed with dimensional classification… and stepped back
- ISD 11 moved forward
  - Now there is just a diagnosis of: "personality disorder"
    - Modified in terms of severity:
      - Mild Personality Disorder
      - Moderate Personality Disorder
      - Severe Personality Disorder
    - Further specified with prominent trait qualifiers
      - Negative Affectivity, Detachment, Dissociality, Disinhibition, and Anankastia

Bach B, First MB. Application of the ICD-11 classification of personality disorders. BMC Psychiatry (2018) 18:351.

Personality Disorders – ICD 11

- An enduring disturbance characterized by problems in functioning of aspects of the self, and/or interpersonal dysfunction
  - The disturbance has persisted over an extended period of time (> 2 years).
  - The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behavior that are maladaptive
  - The disturbance is manifest across a range of personal and social situations
  - The patterns of behavior characterizing the disturbance are not developmentally appropriate and cannot be explained primarily by social or cultural factors, including socio-political conflict.
  - The symptoms are not due to the direct effects of a medication or substance, and are not better explained by another Mental and Behavioral Disorder, a Disease of the Nervous System, or another health condition.
  - The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

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Gender differences in personality disorders?

- The clinical diagnosis of specific personality disorder subtypes appears to have gender bias
  - Women: Histrionic & Borderline
  - Men: Antisocial & Narcissistic
  - Studies of actual prevalence rates (that remove biases) do not show these differences

- Borderline Personality Disorder
  - Most heavily studied personality disorder
  - 1.4% prevalence in the general population
  - But… ~75% of clinical diagnoses are made in women

You Made It!!

Now back to Tracy

So what do you want to do for Tracy?

- She is presenting with:
  - Increased pain
  - Intermittent chest pain
  - Distress
  - Complaints of anxiety
  - Complaints of symptoms of depression
- She is tearful in your office and wants to know what to do?

Let's Hear It

What do you think?

Case - Continued

Case - Tracy

Tracy is not happy with what you want to do. She wants to know why you don't want to give her lorazepam. It worked really well in the ED and she thinks that you are listening to her. She moves quickly from tears to obvious frustration and anger. She tells you that "good doctors listen to their patients." She had come to you because you have good reviews and she thought things would be different. She wants to know "what are you going to try to push that won't work?"

Let's Hear It

What do you think?

Is there a role for medication in the treatment of personality disorders?

I wish…

- Medication based treatment has previously been recommended by practice guidelines for the treatment of borderline personality disorder (APA 2001)
  - SSRIs recommended for mood dysregulation
  - Mood stabilizers recommended for mood variability
  - Atypical antipsychotics recommended for dissociative episodes

- There does not appear to be consistent evidence that supports these recommendations or any consistent data to support medication-based treatments of ANY personality disorder
  - More recent recommendations indicated medications should NOT be used except in emergency situations for limited periods (UK NICE)

Crawford MJ et.al. The Clinical Effectiveness and Cost-Effectiveness of Lamotrigine in Borderline Personality Disorder: A Randomized Placebo-Controlled Trial. Am J Psychiatry. 2018. 175:8; 756-764.
Stoffers-Winterling J, Storebo OJ, Lieb K. Pharmacotherapy for Borderline Personality Disorder: an Update of Published, Unpublished and Ongoing Studies. Current Psychiatry Reports. 2020. 22:37.
Bateman AW, Gunderson J, Mulder R. Treatment of personality disorder. Lancet. 2015; 385:735-743.

Do patients with personality disorders often get prescribed psychiatric medications?

- Yes!!!
  - 70-80% of outpatients with personality disorders are prescribed antidepressants
  - 35-60% of outpatients with personality disorders are prescribed antipsychotics

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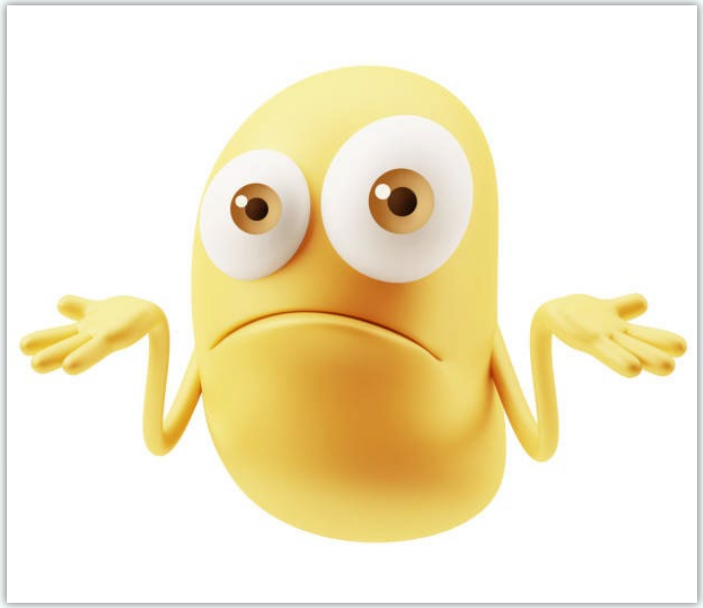

So what does work?

Treat cooccurring disorders

- There is still a clear role for use of medications in the treatment of cooccurring/comorbid disorders
  - Cooccurring disorders are VERY common (as high as 85%)
    - Mood disorders
    - Anxiety disorders
    - Substance use disorders

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Psychotherapy

- Psychotherapy is the mainstay of treatment
  - Antisocial personality disorder has no clear, effective treatment
- Treatment of borderline personality disorder has been most heavily studied
  - Dialectical Behavioral Therapy has the most evidence for efficacy
    - "Third Wave" cognitive behavioral therapy developed to treat women with borderline personality disorder
      - Has since shown efficacy to treat a number of other disorders
    - Developed at the University of Washington by Marsha Linehan
    - Oriented around "dialectics," the most central being acceptance vs. change
    - Formal DBT takes years and involves weekly, individual psychotherapy with weekly, skills group training

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OK… but I have 10 minutes

What can the general practitioner do?

Recognize what is in the room

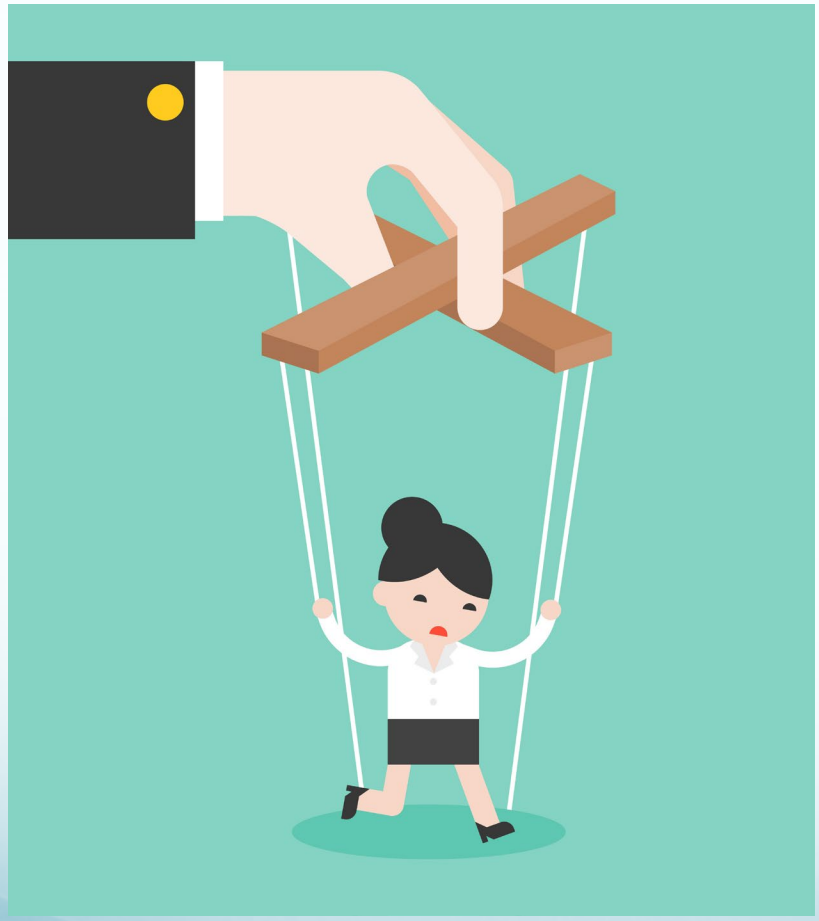
- This is their stuff…
- This is NOT your stuff

Projective Identification

- Psychanalytic term developed by Melanie Kleine
  - The patient projects an undesirable part of their self onto the therapist (object) as a defense
  - The therapist begins to enact that part of the self

- Practical Digest: The experience whereby the treating provider takes on and begins to feel some of the qualities that the patient experiences themselves
  - Watch for it… it's tricky… and instructive

Manipulation



- Manipulation is the perpetrator getting the victim to do something that is not in their own best interests

- Often, I find patients are trying to get things that are in their OWN best interests. They are not trying to manipulate me… they are trying to be effective

Avoid the somatic spiral

- Chasing affect with psychotropics will have limited results
  - Recognition that medications have limited long-term benefits can be very helpful in setting limits
  - Considering limits before appointments can be helpful

Work as a team and set limits

- Remember that you are unlikely to directly treat a personality disorder
  - Connection to psychotherapy is extremely important
    - Collaborative problem solving towards identifying goals can be helpful for motivation and engagement
- Approach patients with personality disorders as a team
  - If possible, collaborate with MH providers
  - Collaborating with colleagues and documenting clear behavior plans and approaches to behavior can be very useful for consistency
- Clear boundaries for care are very useful for both patients and providers

Angstman KB, Rasmussen NH. Personality Disorders: Review and Clinical Application in Daily Practice. American Family Physician. 2011.84;11:1253-1260.
Combs G, Oshman L. Pearls for Working with People Who Have Personality Disorder Diagnoses. Prim Care Clin Office Pract. 2016;43:263-268.
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Validation

- Level 1: Show up and stay awake
- Level 2: Reflect what you hear
- Level 3: Put yourself in their shoes
- Level 4: Validate based on pt's history
- Level 5: Validate based on circumstance
- Level 6: Radical Genuineness

Case - Continued

Case - Tracy

Things continue to not go well with Tracy. You had recommended some collaborative relaxation techniques, a therapy referral, and even propranolol or hydroxyzine for treatment of acute anxiety, but Tracy had rejected all of these. She wants to feel better "now" and she wants what works for her. She starts to cry harder in your office and tells you she just doesn't know what to do. She tells you she cuts herself when she gets horribly overwhelmed, but she doesn't want to keep doing it. Sometimes when she starts to cut, she feels like she should just press down harder and end things. "If I can't have Ativan, I'm not sure what I'm supposed to do."

Let's Hear It

What do you think?

Suicide Risk Assessment

- Assessment of Ideation
  - Acute vs. chronic thoughts
  - Passive vs. active thoughts
  - If active thoughts are present, is there a plan?
  - If there is a plan, what is the method?
  - Have preparations been made
  - What is the level of intent?

Suicide Risk Assessment

- Non-modifiable Risk Factors (Demographic) include:
  - Caucasian or Native American decent
  - Male sex
  - Age >65
  - Same-sex sexual orientation
  - Unmarried
  - Living alone
  - Family history of suicide in a first degree relative
  - Personal history of suicide attempt
  - Hx psychiatric illnesses
  - Chronic medical illness (inc TBI)
  - Recent interpersonal loss
  - Recent psychiatric hospitalization

Suicide Risk Assessment

- Modifiable risk factors:
  - Substance use,
  - Acute psychiatric symptoms including:
    - Agitation,
    - Severe anxiety
    - Depression, hopelessness, anhedonia or apathy
  - Current sleep disturbance,
  - Social isolation
  - Lethal means available (particularly firearms)
  - Homelessness
  - Unemployment
  - Physical pain

Suicide Risk Assessment

- Protective factors:
  - Actively making plans for the future
  - Verbalized hope for the future
  - Cognitive flexibility
  - Responsibility to dependents
  - Therapeutic relationship with treatment provider
  - Social network or family
  - Belief that suicide is immoral or will be punished
  - Fear of social disapproval of suicide
  - Fear of the act of suicide

Action Steps

- If not admitting the patient (or referring the patient for emergent psychiatric evaluation), have a structured plan for follow-up care, including whom they will stay with, and a crisis plan if SI returns. This plan should include names, phone numbers and places to go when in crisis.
- Plan for management of sx such as anxiety, drug cravings.
- Be certain that you know the answer to the following: Why do you feel you can be safe now? What is different now compared to when you walked into the office/ emergency room?

Conditional Suicidal Statements

- Conditional statements that involve suicide are extremely difficult to navigate
  - Response to these statements depend on
    - Safety assessment
    - How well you know the patient
    - Treatment setting
    - Options and resources
    - Provider comfort
- Every situation is very different, but consider what you are reinforcing… and make sure to document very thoroughly

Take Home Points

- There is only a very limited role (if any at all) for the use of medication in the direct treatment of personality disorders
- Psychotherapy is the best treatment we have to date for long-term impact on personality base psychopathology
- Medical providers in the medical office setting benefit from collaborative teamwork, clear limit setting, and comfort with suicide risk assessment when working with patients with personality disorders