Pearls for Working with People Who Have Personality Disorder Diagnoses

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KEYWORDS

• Personality disorder • Borderline personality disorder • Cluster B
• Motivational interviewing • Dialectical behavior therapy

KEY POINTS

- There is lack of general agreement and empirical evidence on how best to categorize personality problems.
- Primary care physicians should exercise great caution before assigning a personality disorder diagnosis; they should look closely at their relationship with the person in question and not use a diagnostic label to blame a patient for what is better conceptualized as a relationship problem.
- The bulk of the literature on working with personality disorders in primary care focuses on borderline personality disorder, a cluster B category.
- Primary care physicians can use principles and practices from motivational interviewing and dialectical behavior therapy to relate to people who show borderline personality disorder or cluster B traits.

INTRODUCTION

People with personality disorder diagnoses use primary care services at a higher rate than the general population.[1] People with personality disorder diagnoses are at increased risk for suicide, substance abuse, accidental injury, depression, and homicide.[2] Although there seems to be general agreement that people have personalities, and that personalities can be disordered, there is considerable controversy over how to best name and describe personality disorders. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association asks clinicians to sort people who show personality characteristics that significantly and adversely affect

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many aspects of their lives into specific "personality disorder" categories. It lists specific criteria that must be satisfied before a person can be assigned to a personality disorder category. The mere existence of these categories, and their sanctioning by the American Psychiatric Association,[3] can lead clinicians all too easily to forget that personality disorders are not diseases in any classical sense, and that there is considerable lack of agreement about the best way to describe and assess them. A 2007 review article states, "The assessment of personality disorder is currently inaccurate, largely unreliable, frequently wrong and in need of improvement."[4] As DSM-5 went to press, there was still substantial disagreement about how to categorize personality disorders—so much so that an alternative classification system was included in an appendix.[5] Because of these uncertainties, this article focuses more on broad principles than on detailed descriptions of the diagnosis and treatment of each and every DSM or International Classification of Diseases category of personality disorder.

It is important to remember that every clinical relationship has at least two participants, and that when things become interpersonally difficult, all of the involved parties bear some responsibility for the difficulty. When it seems that the clinician might be dealing with a disordered personality, he or she must reflect on his or her own contribution to what is happening moment-by-moment in that particular clinical encounter. Although the literature on working with personality disorders tends to focus on "difficult patients," it is more accurate and useful to think in terms of "difficult doctor-patient relationships."[6,7] Before deciding that any person who comes to a clinician for help should be diagnosed with a personality disorder, one needs to take a careful look at his or her relationship with that person, and at how the clinician might be bringing forth certain aspects of the patient's personality and not leaving room for others. One must understand enough about the total context of a person's life to know that the traits they show within the clinical relationship occur to a significant degree in other relationships, and that they have done so for a long time.

SCREENING AND DIAGNOSIS

Routine screening for personality disorders is not recommended, and a personality disorder should only be formally and officially diagnosed when clear, pervasive, and persistent difficulties result from aspects of a person's personality. Even then, because they can be stigmatizing, care should be exercised as to how these labels are mentioned in medical records and in communication with others.

Although the most widely used system for classifying personality disorders is the DSM-5, there is much contention as to the usefulness or accuracy of this system. In the DSM-5, the general requirements for a diagnosis of personality disorder are as follows:

- Significant impairments in functioning as it relates to personality.
- The impairments are relatively stable across time and consistent across situations.
- The impairments are not better understood as normative for the individual's developmental stage or sociocultural environment.
- The impairments are not solely caused by the direct physiologic effects of a substance or a general medical condition.

The criteria for specific personality disorders must meet all of these criteria, as well as Cluster A, B, and C personality disorder criteria outlined in the DSM-5.[3]

The 10 personality disorders are grouped into three clusters: cluster A (paranoid, schizoid, and schizotypal), cluster B (antisocial, borderline, histrionic, and narcissistic),

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