

PERSONALITY DISORDERS

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Concepts of personality sit squarely at the crossroads of the mind and the brain. No other category of mental disorder is harder to define. The diagnostic criteria in Axis II of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV)³ (which defines the personality disorders) are useful in research, in which structured interviews separate one disorder from another, but they are notoriously troublesome to apply clinically.⁶⁵ The precise nature of personality development and personality structure is still largely unknown, despite centuries of theorizing and speculation. For the internist, it may not be important to know the precise reasons why a person has certain traits, motivations, or behaviors, but a knowledge of the variety and complexity of personality types is helpful.

The key question for clinicians is whether personality diagnoses are useful therapeutically. Pharmacologic treatment choices usually are made on the basis of symptoms, not personality categories (e.g., anxiety in dependent personality disorder, unusual thinking in schizotypal personality disorder, or labile mood in borderline personality disorder). Psychotherapeutic interventions are aimed at behaviors, relationships, experiences, functioning, and emotional responses, such as regulation of self-esteem, attainment of empathy, management of interpersonal relationships, flexibility in the face of work demands, and comfort with independence or separation.⁴⁶ Dimensions of functioning determine the choice of socially based treatments (residential, vocational, or rehabilitative interventions). These matters are not specific to any single personal-

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ity category. For clinical practice (regardless of theoretic bias), an understanding of these dimensions leads to useful interventions.

Personality is a pervasive aspect of medical practice; every patient has a personality. Physicians require a guide to recognize maladaptive personality types (or personality dimensions), then select therapeutic responses. Many patients have personal characteristics that impede their participation in medical treatment. Patients may induce a physician to make hasty or poor judgments. There are patients whom the physician may dislike and shun. Some patients have unreasonable expectations about their medical care or about the nature of the physician-patient relationship. They may be disappointed easily and may blame their physician unreasonably for an undesirable outcome. With knowledge of personality types, an internist may be prepared better to manage their challenging patients.

AXIS II PERSONALITY DISORDERS: OBJECTIVE-DESCRIPTIVE DIAGNOSIS

DSM-IV provides standard definitions. *Personality traits* are "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts."³ A *personality disorder* is diagnosed only when those traits become inflexible, become maladaptive, and cause impairment or distress. The difference between trait and disorder is a matter of degree and ultimately a subjective determination.

Personality disorders are by definition enduring *maladaptive* patterns and should be distinguished from the exaggeration of traits that may occur in a specific context, such as the stress of medical illness. Ethnic, cultural, and social background influence character. Gender differences shape rates of diagnosis.⁶⁸ Antisocial personality disorder is diagnosed more frequently in men, whereas borderline personality disorder is diagnosed more frequently in women.^{15, 45}

DSM-IV describes categories of illness, but also recognizes dimensions of personality. A *categorical perspective* is one in which each personality disorder represents a "qualitatively distinct clinical syndrome."¹³ In contrast, a *dimensional perspective* describes "maladaptive variants of personality traits" that "merge imperceptibly into normality and into one another."³ Dimensional models have long been a subject of study,^{9, 33, 40, 67} and a combination of categorical and dimensional approaches is under consideration for the next edition of DSM.^{44, 65, 66} The division of the 10 DSM-IV personality disorders into three clusters (Table 1) represents an effort to place the disorders within three broad dimensions: odd-eccentric (cluster A), dramatic-emotional (cluster B), and anxious-fearful (cluster C).

TABLE 1. DSM-IV PERSONALITY DISORDERS

Cluster A	Cluster B	Cluster C
Paranoid	Antisocial	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive-compulsive
	Narcissistic	

Cluster A (Odd-Eccentric)

Cluster A includes the paranoid, schizoid, and schizotypal personality disorders. Paranoid personality disorder is characterized by extreme distrust and suspiciousness; schizoid personality disorder, by detachment from social relationships and a restricted range of emotional expression; and schizotypal personality disorder, by discomfort with relationships along with unusual perceptions or odd behavior. There is evidence that these disorders are related biologically, phenomenologically, developmentally, and genetically to their Axis I cognates—schizophrenia and delusional disorder.

Cluster B (Dramatic-Emotional)

Cluster B includes the borderline, histrionic, narcissistic, and antisocial personality disorders. People with **borderline personality disorder** are described as having **profound difficulties in sustaining relationships, regulating their emotions, and managing their impulses**. Individuals with **histrionic personality disorder** are emotional, dramatic, and attention seeking. The presentation of such individuals sometimes is described as **inappropriately seductive, shallow, or exaggerated**. Individuals with **narcissistic personality disorder** are described as **self-important, requiring the validation or admiration of others, while being unable to respond to people with empathy, presenting as arrogant and entitled to special treatment**. Antisocial personality disorder is a disorder exemplified by **deceit in relationships and a disregard for the rights of others**. Individuals with this personality disorder may have a criminal record, a history of taking advantage of others, and an absence of remorse for bad deeds done. Individuals may show **impulsive, irresponsible, reckless, aggressive, or violent behavior**.

Cluster C (Anxious-Fearful)

Cluster C includes the avoidant, dependent, and obsessive-compulsive personality disorders. In avoidant personality disorder, individuals feel inadequate, and they fear criticism or disapproval in personal rela-

tionships and at work. They are inhibited and reluctant to take risks. Individuals with dependent personality disorder cling to others, fear separation, avoid responsibility, feel helpless when alone, and experience an intense need to be taken care of by others. Individuals with obsessive-compulsive personality disorder are orderly, are perfectionistic, value work over personal relationships, are inflexible and miserly, and have a need for control, all of which interfere with productive work and pleasure.

SUBJECTIVE-DESCRIPTIVE NOSOLOGY

Criteria for diagnosis in DSM-IV are *objective-descriptive*. Such criteria demand a comprehensive aggregation of data and objective interpretation of data. Criteria are meant to be observable and measurable, rather than deductive, intuitive, or speculative. Throughout medical practice, however, categorical and dimensional approaches are combined. Physicians make observations that place pathology within a certain sphere, alerting them to problems that may occur. Patterns of behavior, responses to stress, and ways of experiencing the world do not separate into distinct, mutually exclusive, nonoverlapping patterns, but the recognition of composite pictures helps physicians conduct medical treatment. This article presents a companion *subjective-descriptive* nosology for the personality disorders.

Subjective reports and subjective impressions are inherent to physician-patient interactions and should not be discarded. With each new patient, physicians start with subjectivity, not objectivity. Objectivity is achieved only after a period of evaluation and contemplation. Subjectivity need not imply a lack of rigor or thoughtfulness.^{16,26} With a subjective typology, primary care physicians can recognize personality repertoires and provide their patients with what Balint⁷ described as the correct "dose of the doctor."

PRACTICAL GUIDE TO PERSONALITY

Neuroscientists and philosophers^{12, 59} have made it clear that clinicians should move on from the 400-year-old Cartesian dualism that splits the brain from the mind. Brain function and development, thought contents and processes, environmental and historical influences, and human experience and behavior are not distinct and separate. A meaningful classification avoids psychologic and biologic reductionism and integrates dimensions and categories of personality.⁴⁴

In this article, 12 personality types are described—10 that coincide roughly with DSM-IV Axis II personality disorders and 2 that do not. The 12 types are divided into two groups. One group (the *demanding* group) is of individuals who make special demands on their physicians. The second group (the *distant* group) is more remote or detached; their

distance sometimes keeps them from getting necessary medical treatment.

The DSM-IV diagnosis closely related to the description appears in parentheses in each heading. The two types not related to a specific DSM-IV diagnosis have depressive characteristics. (There is no *depressive personality disorder* in DSM-IV, though the category continues to be studied.) The categories are not mutually exclusive. Any individual may exhibit characteristics from more than one category. **The categories describe classes of patients, not a single person. They are average states, used for illustrative purposes.**

All physicians (not just psychiatrists) have idiosyncratic theories about personality development, formed from their own life experience or professional training. These theories can lead to critical or judgmental attitudes and an aversive response to the patient. The opposite also can occur—a tendency to identify too strongly with the patient's suffering, leading to fantasies of rescue and making promises that are difficult, if not impossible, to keep.³⁵ Every physician should recognize how difficult it is to induce changes in behavior or attitudes when there is an enduring personality pattern.

Demanding Personality Types

Demanding patients make physicians uncomfortable. They demand extra time and special treatment. They may become prickly or uncooperative if the physician does not comply. The patient may be ungrateful, may distort the nature of the physician-patient relationship, or may make the physician unfairly responsible for disappointments. The danger for these patients is that they drive the physician away or distract attention from the central medical issues, culminating in a less productive collaboration between physician and patient.

The Dependent, Demanding Patient (Dependent)

Although a degree of dependency is universal and normative,⁸ some individuals perpetually occupy a dependent position. When they become patients, they may show unrealistic fears of medical illness or naive expectations of medical treatment. They have difficulty grappling with serious illness head on. The need for reassurance may be so great that the patient suspends judgment and puts faith in the physician overoptimistically. Small setbacks may cause overwhelming anxiety, and the ability to function or be responsible becomes compromised. Anxiety may turn to anger if the patient's demands are not met. Unable to tolerate uncertainty, the patient may demand quick fixes when a more patient, wait-and-see approach makes more sense.

This personality pattern may be associated with an anxiety disorder.^{43, 50, 57} In response to bad news, the patient may experience overwhelming distress, further reducing his or her capacity for functioning

and decision making. The patient may have little confidence in independent functioning or decision making. Even with reasonable support, the patient may experience people as depriving and abandoning.

Pharmacologic treatments for anxiety may help, including selective serotonin reuptake inhibitors, venlafaxine, tricyclic antidepressants, buspirone, and benzodiazepines, as may a referral for psychotherapy. There is a small risk of benzodiazepine dependence, but undertreating anxiety is a more common problem in these patients than is dependence or addiction.⁵⁴

Interpersonally the predominant hazard for the physician is to become irritated and angry, to withhold reasonable reassurance or support, or to set punitive limits in response to the patient's demands. The task is to avoid the tendency to withdraw, patronize, or scold. In setting a limit, the physician assiduously should avoid expressing impatience or frustration. Rather, anticipating the patient's anxiety, the physician should explain the reason for the limits, that doing less is often an active and helpful course of medical treatment. If the patient makes unreasonable time demands, the physician should point out that the schedule does not permit spending more time, but the patient should not interpret the demands of a busy schedule as a lack of interest.

The Dramatizing, Emotional Patient (Histrionic)

Some individuals respond to events in their lives in a predominantly emotional way, using less rational or logical thought. They emphasize subjective impressions over objective data. When seeking medical care, they may come into conflict with physicians because physicians value (and sometimes overvalue) objective data. Emotional patients may place more value in the relationship with the physician than they do in the physician's knowledge, expertise, or therapeutic skill. To that end, the patient may behave in an exaggerated, even seductive manner with the aim (often misguided) of eliciting a warm, personal response. The patient may present distress dramatically, showing an inability to cope with stress of any type. The patient may want more than the usual degree of comfort and support from the physician.

Ironically, as is the case with many maladaptive personality attributes, the patient's efforts often are met with a response precisely opposite to what is desired. That is, the eagerness for a relationship and the demand for comfort are experienced as coercive, are off-putting, and create more distance than closeness.

The style, which may be more dramatic or more sexualized than in a dependent personality type, nonetheless shares many of the same features, and some of the same recommendations apply. The patient may have an underlying anxiety disorder deserving treatment. In addition to hazards mentioned in the previous section on dependency (feeling irritated or angry, having an aversive response, withholding support, and setting punitive limits on the patient's demands), the physician should take care to avoid anything that could be perceived as a crossing of

professional boundaries.^{56, 64} The patient may have conflict about sexuality⁶ and invite boundary crossings and may perceive intimacy when there is none offered or intended. The dilemma for the physician is that to appear too reserved or cold may alienate the patient or create obstacles to a working relationship, whereas to be too warm may invite misunderstanding.²⁰ A discussion of the patient's personal life need not be avoided. Taking a history of any problem is helpful. The physician can acknowledge the limits of his or her expertise in counseling patients on such matters and offer a referral to a psychiatrist or other mental health professional when the patient's distress is great.

The Idealizing, Easily Disappointed Patient (Borderline)

The idealized, easily disappointed patient has difficulty regulating his or her self-esteem and has trouble feeling secure in relationships.^{11, 63} The patient may be ready to feel rejected by the physician, but if the initial meeting is at all positive, the patient may idealize the physician and become overly invested in the relationship. Disappointment may come later, either when treatment does not live up to expectations or when the patient gets less attention than desired (e.g., the physician fails to return a phone call, is late to an appointment, or has a distracted manner during a busy clinical day). Torrents of anger can result, and in some cases, if anger is connected with a bad outcome (however minimal), the patient may vent his or her rage through litigation.¹⁸

Although not frankly psychotic, the patient may distort reality to a considerable degree.^{1, 24} Interactions may be remembered in error. The patient may read hostile intent into a facial expression or a passing comment. It may be impossible to correct the patient's misinterpretation. The more the physician attempts to challenge what appears to be an obvious distortion, the more contentious the patient may become.

A bad interaction may be impossible to foresee or avoid. If the patient is in psychiatric treatment, the doctor-patient relationship may go more gently. There is considerable overlap in this personality type with the dramatizing, emotional patient. The patient may present initially sympathetically, and the physician may be enthusiastic about providing help and may be tempted to exert an unusual amount of effort on the patient's behalf. The relationship may be more prone to boundary crossings because in the initial phases, the patient may be generous with praise for the physician's technical skill and humanity. Under the influence of the patient's admiration, the physician unwittingly may make promises that cannot be kept or predict an unrealistically positive outcome from treatment. When the inevitable disappointment occurs, the relationship may become unpleasant quickly.

The inability to predict how any patient will respond to disappointment dictates that in all professional relationships physicians conduct themselves with clear boundaries and limits.^{19, 23} Physicians adopt needle precautions because they do not know which patients are infected with blood-borne pathogens. Professional boundaries have the same universal

nature because the patient's sensitivities may become apparent only later in the relationship.

The Long-Suffering, Complaining Patient (Manifestly Depressive)

Some individuals become attached to the sick role or victim position. They may never describe any meaningful improvement in response to medical treatment. They may fail to comply with treatment recommendations. A combination of inconclusive medical findings and variable treatment compliance makes it difficult to judge the nature or severity of the underlying medical disorder. In some instances, an undiagnosed dysthymia or depression is present. Antidepressant therapy or psychotherapy may be helpful. If pharmacologic treatment provides no relief, the biggest challenge is to take complaints seriously enough to evaluate properly the competing strategies of aggressive investigation and watchful waiting.

The introduction of any psychiatric treatment is difficult because the patient may be reluctant to see his or her difficulties in psychiatric terms. The patient wants his or her suffering validated so that a psychiatric referral may be experienced as dismissive. The physician should explain that regardless of its cause, the suffering is real but is experienced through the brain. Coping with poorly defined medical illness is an important goal. For both reasons, it is important to include mental health clinicians as part of the medical team, while the primary care physician continues to follow the patient, showing interest in his or her symptoms.

The Orderly, Controlled Patient (Obsessive-Compulsive)

When a medical problem arises, many individuals rely on the knowledge and skill of the physician. Some patients are uncomfortable giving up that degree of control. They become educated consumers of health care. Physicians, who themselves are systematic and orderly, may be comfortable with methodical patients. Some method goes beyond reason, however, and to the extent that method becomes tyranny, it can impede progress, become a substitute for action, prevent decision making, or interfere with the productive sharing of control between physician and patient.^{2, 17}

In some patients, there are symptoms of obsessive-compulsive disorder, with intrusive thoughts, ruminative worries, irrational fears, and behaviors devised to counter those fears (such as hand washing, checking, ritualized prayers).^{49, 52} In others, there is an obsessional style, characterized by orderliness, rigidity, and a compelling need for control.¹³ In either case, it may take extra time to answer detailed, seemingly irrelevant questions. If (as is sometimes true) the patient fails to show gratitude for the physician's extra effort or becomes critical or angry

about minor lapses in procedure or process, the physician may become irritated.

Being helpful depends on accepting the patient's inability to relax his or her standards. Attempts to cajole the patient are likely to backfire. Selective serotonin reuptake inhibitors have been shown to be helpful for true obsessive-compulsive disorder.^{48, 61} Occasionally the symptoms are severe enough and the patient's thinking is so distorted that antipsychotic medications are appropriate.²⁹ In many cases, however, physicians are confronted with a personality pattern rather than a symptom cluster, requiring management of the relationship.

After providing detailed explanations, the physician can be firm about the limits of his or her time and knowledge. Because the patient is invested in his or her intellectual ability and high standards, it may help the patient tolerate limits if the physician can praise the patient for these qualities and for the patient's ability to participate so actively in medical decision making. The superior patient (next category) has similar characteristics so that some of the subsequent suggestions can be applied here.

The Superior, Critical Patient (Narcissistic)

Primo Levi's³¹ horrifying description of his arrival at a Nazi concentration camp shows the universal nature of narcissistic need. An SS man tells the new prisoners to discard their clothes. A man with a truss is told to remove it. Ninety-six pairs of shoes are swept in a heap out of the room. The prisoners are shaved and shorn of hair. They wait for hours, standing naked in a few inches of cold water, until they are "disinfected" with hot water, then thrust outside in the cold air, carrying the rags and wooden shoes that will be their uniforms. They are, in the length of one night, turned into "phantoms." Levi's writing captures the polar opposite of narcissistic validation:

Then for the first time we became aware that our language lacks words to express this offence, the demolition of a man. In a moment, with almost prophetic intuition, the reality was revealed to us: we had reached the bottom ... consider what value, what meaning is enclosed even in the smallest of our daily habits, in the hundred possessions that even the poorest beggar owns: a handkerchief, an old letter, the photo of a cherished person. These things are part of us, almost like limbs of our body; nor is it conceivable that we can be deprived of them in our world, for we immediately find others to substitute the old ones, other objects which are ours in their personification and evocation of our memories. Imagine now a man who is deprived of everyone he loves, and at the same time of his house, his habits, his clothes, in short, of everything he possesses: he will be a hollow man, reduced to suffering and needs, forgetful of dignity and restraint, for he who loses all often easily loses himself . . .

The dreadful image of Auschwitz explicates human narcissistic needs. Modern medicine recognizes the ignominy of being stripped bare except for a skimpy hospital gown, but most patients, secure enough in their self-worth, can manage that necessary indignity. All humans feel

narcissistic vulnerability when someone or something threatens to strip them of the things that make them feel good about themselves. It is normal to enjoy talking about the things that make one proud. The extent to which one must trumpet one's own horn may be correlated with feeling deficient,⁵⁸ but it is easy to identify with the impulse to speak up for oneself. Those who come across as most arrogant, however, may be the most vulnerable.

A vulnerable person needs sympathy but may not be skilled at eliciting it. Superior patients shore themselves up by becoming more self-important, overconfident, patronizing, or critical.⁵¹ Such patients have a talent for making the physician feel inferior. They may test the physician's knowledge, skill, or experience, asking for proof, such as "How many cases like mine have you seen?" or "How long have you been in practice?" The proper response to the patient's request for special handling and treatment is to provide sincere reassurance and encouragement.^{28, 60} If the physician hears only the *demand* for special treatment, he or she may take a withholding stance. If the physician hears the plea for reassurance, he or she may find it easier to be kind.

Superior patients have in common with orderly patients the wish to control the interaction. The physician should resist the temptation to "cut him down to size." The physician need not jump through hoops, but also the physician need not be defensive about the limits of his or her knowledge and experience. The physician can point out that other skilled physicians are available should there be a need for specialized knowledge or skill. Expressing interest in the patient's life and achievements shows the physician's interest in being helpful. If the physician feels vulnerable and has to prove his or her self-worth, the physician may lose sight of his or her limitations.

The Cold, Deceitful Patient (Antisocial)

Some patients disregard the rules of moral conduct and fair play. They use relationships for self-serving reasons. They may be fraudulent, which the physician realizes only after he or she has been deceived. Patients may malingering for financial or social benefit or to avoid an obligation or debt. Patients may be overtly criminal or dangerous. Some individuals are skillful actors, and the deception goes undetected. Many awaken suspicions at the outset, however. It is grating when a patient takes unfair advantage. Narcissistic patients have little capacity for empathy, but antisocial patients have none, or they use their empathy to their advantage without regard for others. Some view sociopathy of this type as an extension of narcissism.⁶²

Even liars sometimes tell the truth. Although many antisocial individuals feign or exaggerate illness, they do get sick. Similar to the storied "Boy Who Cried Wolf," these patients may need medical help, but may not be believed.

It is human to turn away in revulsion, but even sociopaths come to this adaptation through a combination of inborn temperament and life

experience. Being used is part of being a physician, and so from time to time is being misused.²¹ This notion does not explain away criminal activity or malingering, but it does focus attention on the question of the physician's clinical role as opposed to his or her moral attitude.⁵ The clinical role is to set aside personal likes and dislikes and to apply the knowledge of human behavior for diagnostic and therapeutic purposes. Suspicions of antisocial behavior are confirmed through the application of clinical skill, and a physician makes the *medical* judgment about the proper extent of evaluation or treatment.

By filtering out the *noise* created by overt or suspected inappropriate demands, the physician can pay more attention to objective assessment. After pursuing a conscientious medical course, the physician can provide appropriate care more easily and have a fair-minded appreciation for when the patient's demands go out of bounds.

When saying no to a demand, the physician should refer firmly (but dispassionately) to medical reasoning and the limits of data or of expertise. The patient may ask the physician for a favor (e.g., a physician's note excusing work, a letter on a court matter) or ask for a desired, gratifying treatment (a prescription or a hospital stay). A straightforward response is best. "I can write a brief letter saying that I evaluated you, but I don't have an opinion (about whether you can return to work; about the legal issue)." Or, "I'm sorry. I know you want the prescription. I don't know your situation well enough yet and I may be misreading it, but I don't see a medical reason to prescribe (clonazepam, pain medication) now." The physician may initially decide to comply in some small way (e.g., a small benzodiazepine prescription), giving the patient the benefit of the doubt. This first step may allow the physician to confront the patient's problem more sympathetically later because a helping attitude has been shown first. The physician can be more confident, calm, and sympathetic after conducting an assessment from objective, nonjudgmental territory.

A physician is not obliged to put himself or herself in harm's way. The physician should avoid argumentative interactions. If there are explicit or implied threats, the physician should terminate the interaction and move the patient to a safer setting. Although violence is hard to predict, physicians should take their fear seriously and take security precautions.³⁷

Distant Personality Types

Distant personalities are less of a burden to physicians because they do not show overtly that they or their problems deserve attention. Often, these patients suffer quietly, not reporting their medical (or psychiatric) symptoms. A patient may be self-critical and feel undeserving of help or be timid and afraid to assert his or her needs. Some patients minimize symptoms in an effort to avoid anxiety-provoking news. Some are aloof or odd. These people steer clear of the physician. In an age when there

is pressure to manage time efficiently, they are convenient patients to treat. Yet their tendency *not* to report essential history or symptoms may compromise their access to care.

The Timid, Apprehensive Patient (Avoidant)

Most people fear serious illness. It is human to be apprehensive about medical procedures. In this personality category, however, the anxiety reaction is more pronounced. These patients are anxious about any human contact and, by extension, contact with the physician. This is a patient who may be soft-spoken to the point of unintelligibility. It may appear like torture for the patient to be in the physician's office.^{42, 55}

Adults with this personality pattern call to mind the developmental milestone of *stranger anxiety* (9 months of age). It is correlated with the development of cognitive functions (the ability to store and retrieve mental representations, or working memory) and with maturational changes in the brain.²² Most children leave this degree of anxiety behind, but some continue to be inhibited or fearful, with accompanying social anxiety.²⁵ Forms of childhood anxiety do not correlate with adult personality patterns, but they highlight the fact that severe anxiety is part of a human continuum.

A busy physician's schedule constrains efforts to manage the patient's timidity. The physician may not have the time (or the patience) to draw the patient out slowly. A family member or spouse may provide information that the patient is unable or too afraid to provide. The patient may prefer a written health questionnaire to reporting symptoms face-to-face. A well-designed computer questionnaire may be able to elicit authentic reporting about sensitive matters.³⁴

A physician may become impatient and annoyed, the response this patient hopes to avoid. Or the physician may go along with the patient's reluctance to report, potentially missing clinical information. The physician should consider medication or psychotherapy for an underlying anxiety or depressive disorder.³⁹ Severe avoidant behavior may indicate unusual, distorted, or psychotic thinking, frustrating the efforts of the most patient physician. In those instances, the need for psychiatric treatment is clear.

The Indifferent, Pessimistic, Possibly Self-Destructive Patient (Quietly Depressive)

Although absent from DSM-IV, there has been ongoing debate about the exclusion of depressive personality disorder.^{47, 53} The existence of biologic roots for depression cannot be disputed.⁴¹ The diagnosis of dysthymic disorder, a form of depression that is milder, more persistent, and less episodic than major depression, is a suitable appellation for patients with chronic depressed mood. Living with depressed mood over a lifetime is likely, however, to have an impact on a person's character.²⁷ Patients with mildly depressed mood may not be aware they

are depressed but simply may think of themselves as having lower energy, more disappointment and burden, and less pleasure and joy than others. One hazard to the patient is a tendency to take less interest in health. The patient may have trouble getting to the physician ("It's not worth it," or, worse, "I am not worth it") and have little motivation for following through on the physician's advice.

A patient with this style may minimize or underreport physical symptoms.^{30, 69} Men may be more vulnerable to this kind of presentation than women. They are vulnerable patients in an era of time pressure because they convey, "No, no, Doc, I'm fine." The physician may not have a clue that anything is wrong.

As with the timid patient, family informants can help because they may appreciate subtle changes in the patient's baseline. Questionnaires prompt the patient to consider categories they might not have considered because of low energy or lack of interest. The physician should be alert for an occult depression worthy of treatment.

The Distant, Aloof Patient (Schizoid)

The term *schizoid*, similar to the term *schizophrenic*, often is misused. The reason lies partly in its origin. Roughly translated from Greek, *schizophrenia* means *split-mindedness*. Contrary to popular conception, neither term refers to a *split* in a person's character (a phenomenon that is dealt with in the controversial literature on dissociation) but rather to a withdrawal from social relationships.

These patients do not withdraw manifestly because of anxiety, but rather because they prefer to be separate. The patient is a loner. The patient has few if any close friends outside the immediate family and rarely has intimate or sexual relationships. Such individuals may show minimal anxiety about the mechanical aspects of medical care. Emotional expression may be flat. The patient may not like personal questions. The patient may not talk about his or her discomfort or distress in social interactions and relationships.

The patient's unemotional style can put the physician off guard regarding significant medical problems. To the extent that medical illness brings the patient into unwanted social contact with others (i.e., health professionals), the patient may not pursue treatment. It is important not to misinterpret the desire for separateness as indifference.

Patients who meet criteria for schizoid personality disorder may represent one end of a spectrum that also includes schizotypal personality disorder and schizophrenia.^{10, 32} These patients can be thought of as having *negative symptoms* of schizophrenia.^{4, 14}

It is helpful if the physician maintains a respectful distance. In patients who have concrete thinking or trouble with reality testing, there is a great need for clear medical advice. If the individual's thinking is idiosyncratic, he or she may benefit from a low-dose antipsychotic. Given the evidence that newer, atypical antipsychotics are good treat-

ment for negative symptoms,³⁸ they also may be helpful in this population.

The Odd Patient (Schizotypal)

The odd patient type is also in the schizophrenic spectrum. Beyond the same tendency toward social isolation, these patients are eccentric, sometimes with unusual thinking or behavior. Deeply held beliefs may have no basis in reality. They may have strange attitudes. Holistic and natural remedies have always been and continue to be popular, but some individuals have idiosyncratic convictions about the causes of illness or methods of cure that are linked neither to scientific principles nor popular culture.

In addition to respecting a patient's need for distance, an added problem may be how to respect a patient's point of view when it contradicts science or common sense. It is difficult to negotiate with a person whose belief system runs so contrary to accepted, obvious scientific principles. Persuasion rarely works.

The physician can acknowledge differences in point of view and explain medical information. If the patient rejects recommendations, the physician must accept the patient's refusal. The one exception is if there is evidence that the patient cannot understand or manipulate information. In that case, a psychiatrist may need to evaluate the patient's competency to make medical decisions.³⁶ Seeking guardianship is a cumbersome, often upsetting procedure. It may be necessary, however, when a patient is refusing potentially life-saving treatment. Family members that are available, involved, and supportive may be enlisted to discuss and negotiate treatment. Antipsychotic medication may be helpful.

The Guarded, Suspicious Patient (Paranoid)

Paranoia as a character style is difficult to distinguish from paranoia as a psychotic symptom. The clinical impact is relative, not distinctly different. Similar to *schizophrenia*, the word *paranoia* has become part of the popular lexicon, describing everything from anxiety to self-consciousness to extreme, unrealistic fear.

A paranoid idea, as opposed to a paranoid delusion, is an idea or belief that one is being harassed, persecuted, or treated unfairly.³ The patient may suspect that all people are motivated by a desire to hurt him or her. All relationships are dangerous. The inability to trust may prevent the patient's seeking care until late in the course of an illness. If the patient does come for consultation, he or she may throw obstacles in the physician's way.

One source of anxiety may be the confidentiality of medical records. The patient may ask the physician not to discuss his or her case with colleagues, to send letters, or keep records. The patient may have numerous questions about the use of clinical data, such as information about

habits and lifestyle. Because the patient's questions impede the physician's work, the physician may try to dismiss the patient's concerns and reassure him or her not to worry. Telling a paranoid person not to worry, however, is like telling a cat not to stalk birds. The patient may interpret the reassurance as an attempt to conceal a malevolent plan.

Moving along the spectrum from *distant* to *odd* to *suspicious*, the level of difficulty managing the patient rises. Although odd patients may contest the physician's belief system, they often do believe the physician wants to be helpful. In contrast, the suspicious patient may be convinced the physician is hostile to his or her needs and safety.

The difference between suspiciousness and a paranoid delusion is important to keep in mind. Although delusions are fixed ideas, suspiciousness may be a bit easier to work with. A suspicious person may come across merely as a curmudgeon, one who is bad-tempered, holds grudges, and is preemptively hostile. It may work to accept the patient's position and speak facts plainly without dressing them up. In response to questions, the physician should be precise in responding because approximations or euphemisms may be misinterpreted as deception. When a physician meets resistance to a logical recommendation, he or she may redouble efforts at persuasion. The patient may become wary of the physician's therapeutic zeal. The physician paradoxically may be more persuasive by being less eager to win the patient over, simply emphasizing the information the patient needs to make a good decision.

The same pharmacologic advice applies as for odd patients; psychotropic medication can help, but it may be rejected. Although not overtly or floridly psychotic, patients sometimes respond to antipsychotic medication. Sometimes *paranoia* is a feature of mood or anxiety disorders; there is sometimes a role for antidepressants, antianxiety agents, and mood stabilizers.

SUMMARY

Some general recommendations can be made, collected from these subjective descriptions of personality types. Because determining an accurate psychiatric diagnosis is not the internist's aim, it is better for him or her to have a stance that generalizes to all patients, which can be refined as personality characteristics emerge.

- Tolerate the patient's affect (such as anger or anxiety), being firm and kind, rather than punitive or overinvested. Accept dependency and vulnerability. Accept and respect the underlying coping style. Understand that the patient's personality style is the best (and usually only) way he or she knows to have a relationship, including a relationship with the physician.
- Understand that personality traits additionally may have a function (e.g., to guard against anxiety or depression).

- Recognize that personality traits do not come in pure form. One personality trait is likely to blend into or overlap with other traits.
- Identify and treat any underlying symptom disorder, such as anxiety, depression, irritability, or thought disorder.
- Educate the patient clearly (and without patronizing) about medical illness.
- Document what was explained to the patient and how the patient responded, including dispassionate observations about behavior and emotional expression.
- Appreciate the patient's possible attachment to medical symptoms.
- Avoid arguments with patients who make unreasonable demands. Make timely judgments about whether or not to accede to a demand.
- When in doubt about a patient's honesty, give the patient the benefit of the doubt.
- Do not worry about being used because all patients use their physicians to some extent.
- Go to the limits of your tolerance for a patient's personality, but know your limits and refer to a colleague when you cannot work with the patient.
- Terminate an interaction and get help if there is a risk (or fear) of violence.
- Given the time it takes to manage the relationship and the psychiatric elements of treatment, a referral to a psychiatrist or other mental health professional often is wise if the patient will accept it. Include the mental health professional as part of the medical team.

Although these various recommendations have been emphasized in connection with certain personality types, one can be flexible about their application in a variety of patients. It is important also to reiterate the limits of subjective descriptions. It is rare to find any of the aforementioned subjective descriptions in unmodified form; characteristics of more than one personality type usually appear in the same person. The descriptions are composites that provide a starting point for the physician. The physician should edit the composites based on experience with real patients. This article has described human characteristics and rough guidelines for helpful human responses and possible pharmacologic interventions. So equipped, the primary care physician may find it less troubling and more interesting to face the wide variation in human character.

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