

ALETHEA LEARNING SESSION RECAP

Personality Disorders in Family Practice: Practical Assessment, Safety, and Treatment Strategies presented by Dr. Jadah Johnson



DR. JADAH JOHNSON

Our recent learning session, led by Dr. Jadah Johnson, provided a structured clinical framework for understanding and managing personality disorders within primary care settings. While personality disorders are highly prevalent, they are frequently under-recognized due to their presentation as longitudinal patterns of interpersonal difficulty, emotional dysregulation, and complex care interactions rather than discrete diagnostic entities.

The session emphasized a shift from diagnosis-centric approaches toward pattern recognition and functional management. Drawing on established perspectives in psychiatry and attachment theory, the discussion highlighted how Cluster B personality traits, particularly those associated with Borderline, Narcissistic, Antisocial, and Histrionic presentations, shape patient behaviour, influence therapeutic relationships, and contribute to increased healthcare utilization and clinician burden.

A central objective of this session was to equip primary care providers with practical, evidence-informed strategies to navigate these challenges. This includes developing competence in identifying maladaptive behavioural patterns over time, maintaining therapeutic boundaries, conducting nuanced risk assessments, and fostering structured, sustainable care relationships. In doing so, the session reinforced the role of primary care not only as a point of access, but as a critical setting for continuity, stability, and effective longitudinal management.

By integrating clinical insights with pragmatic approaches to care delivery, this session aimed to enhance provider confidence and resilience in managing one of the more complex and demanding areas of primary care practice.

CLINICAL FRAMING: PERSONALITY DISORDERS IN PRIMARY CARE

The session emphasized that personality disorders are frequently encountered but often under-recognized in primary care settings. Rather than presenting as discrete diagnoses, these conditions typically emerge through patterns of interpersonal difficulty, emotional dysregulation, and complex care dynamics.

Dr. Johnson highlighted that the clinical challenge is not simply diagnosis, but rather:

- Recognizing maladaptive patterns over time
- Managing therapeutic boundaries
- Assessing and mitigating safety risks
- Maintaining effective, structured care relationships

The discussion focused primarily on Cluster B personality disorders, including:

- Borderline Personality Disorder (BPD)
- Narcissistic Personality Disorder (NPD)
- Antisocial Personality Disorder (ASPD)
- Histrionic Personality Disorder

These presentations are often associated with high healthcare utilization, interpersonal strain, and clinician fatigue, making structured approaches essential.

CORE DIAGNOSTIC AND CLINICAL FEATURES

A. Pattern-Based Recognition

A key takeaway is that personality disorders are best understood as enduring patterns, not episodic conditions. Diagnosis should be considered when there is:

- Persistent interpersonal conflict
- Emotional reactivity disproportionate to context
- Rigid or maladaptive coping strategies
- Recurrent crises or instability across settings

B. Differentiating Cluster B Presentations

Dr. Johnson emphasized practical distinctions relevant to primary care:

- **Borderline Personality Disorder (BPD):**
 - Emotional instability and rapid mood shifts
 - Fear of abandonment
 - Impulsivity and recurrent crises
 - Self-harm or suicidality as a coping mechanism
- **Narcissistic Personality Disorder (NPD):**
 - Grandiosity or vulnerability to perceived criticism
 - Difficulty with empathy
 - Sensitivity to status and validation
- **Antisocial Personality Disorder (ASPD):**
 - Disregard for social norms
 - Manipulation or exploitation
 - Limited remorse
- **Histrionic Personality Disorder:**
 - Attention-seeking behaviours
 - Emotional expressiveness that may appear exaggerated
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Rather than formal diagnosis in primary care, the focus should be on recognizing patterns that influence care delivery.

ATTACHMENT AND THE CLINICAL RELATIONSHIP

A central theme of the session was the role of attachment patterns in shaping patient behaviour and clinician–patient dynamics.

Patients with Cluster B traits may demonstrate:

- Intense dependency or rapid shifts between idealization and devaluation
- Testing of boundaries
- Heightened sensitivity to perceived rejection or inconsistency

Dr. Johnson emphasized that these behaviours are not intentional manipulation, but rather reflect maladaptive coping mechanisms rooted in attachment disruption.

Clinical Implications:

- Consistency and predictability are critical
- Boundaries should be clear, explicit, and maintained
- Emotional reactions from clinicians (countertransference) should be recognized and managed

RISK ASSESSMENT: SUICIDE AND VIOLENCE

Risk assessment is a core component of managing personality disorders, particularly in Borderline Personality Disorder.

A. Suicide Risk

Key considerations include:

- Chronic baseline risk vs. acute escalation
- History of self-harm or prior attempts
- Triggers such as interpersonal conflict or perceived abandonment

Dr. Johnson emphasized the importance of:

- Avoiding overreaction to chronic risk
- Identifying acute changes from baseline
- Maintaining a structured, calm approach

B. Violence Risk

While less common, violence risk may be relevant in certain presentations (e.g., ASPD).

Assessment should consider:

- Impulsivity and emotional regulation
- Substance use
- History of aggression

TREATMENT APPROACHES AND MANAGEMENT STRATEGIES

A. Role of Psychotherapy

The session reinforced that psychotherapy is the primary treatment modality, with the strongest evidence for:

- Dialectical Behaviour Therapy (DBT) in BPD
- Structured, skills-based interventions

Primary care providers play a key role in:

- Reinforcing therapeutic principles
- Supporting adherence
- Coordinating care

B. Role of Medication

Medications are adjunctive, not curative. They may be used to target:

- Mood instability
- Anxiety symptoms
- Impulsivity

However, prescribing should be:

- Targeted and cautious
- Avoidant of polypharmacy where possible

PRACTICAL STRATEGIES FOR PRIMARY CARE

Dr. Johnson emphasized several high-yield strategies for day-to-day practice:

A. Set and Maintain Boundaries

- Define visit structure and expectations clearly
- Avoid reactive changes to scheduling or prescribing
- Maintain consistency across encounters

B. Use Structured Communication

- Keep interactions focused and goal-oriented
- Validate emotional experiences without reinforcing maladaptive behaviours

C. Avoid Reinforcing Crisis Cycles

- Recognize patterns of recurrent urgent presentations
- Focus on long-term management rather than short-term rescue

D. Support Without Overextending

- Provide continuity and reliability
- Avoid assuming sole responsibility for complex psychosocial needs

REFERRAL CONSIDERATIONS

Referral to psychiatry is appropriate when:

- Diagnostic uncertainty persists
- Risk becomes difficult to manage
- Specialized psychotherapy (e.g., DBT) is required

However, access limitations mean that primary care often remains the primary point of continuity, reinforcing the need for practical management strategies.

KEY TAKEAWAYS

- Personality disorders, particularly Cluster B, are common in primary care and require a pattern-based, longitudinal approach
- The clinical relationship is central to management, with emphasis on boundaries, consistency, and awareness of attachment dynamics
- Risk assessment should distinguish between chronic baseline risk and acute escalation
- Psychotherapy is the cornerstone of treatment, with medications playing a limited, supportive role
- Effective management focuses on structured, sustainable care strategies, rather than reactive or crisis-driven approaches