Designed by: Kathryn Yu

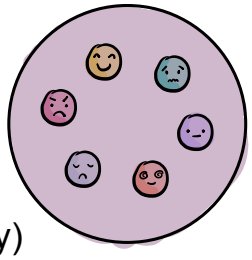
PsySOM
Psychiatry Society of Monash

Personality Disorders (PD)

*Affects approximately **12%** of the general population; it is a common diagnosis but often **stigmatising.***

In general, personality disorders are characterised by:

1. Core personality dysfunction
2. One or more prominent traits or tendencies
   a. Negative affectivity (a tendency to experience negative emotions)
   b. Detachment (unable to form and maintain close relationships)
   c. Disinhibition (impulsivity and disregard for social norms and authority)
   d. Dissociality (disregard for morals, social norms and feelings of others)
   e. Anankastia (narrow focus on one's rigid standard of perfection and of right and wrong)



PARANOID PD

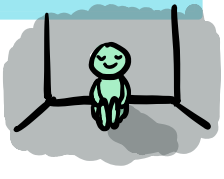
A <u>pervasive distrust</u> & <u>suspiciousness</u> of those around them.

- An unjustified suspicion that others are harming, exploiting or deceiving them.
- Is reluctant to confide in others.
- Tends to hold grudges with others.
- Has recurrent suspicions regarding fidelity of their partner.
- Elicits a strong reaction to perceived threat.

SCHIZOID PD

A <u>detachment</u> from social relationships & <u>restricted emotional expression</u>.

- Prefers social isolation.
- Does not find enjoyment in close relationships.
- Seen as emotionally 'cold' and detached.
- Has minimal desire in sexual activities or intimacy.
- Is unaffected by praise or criticism.



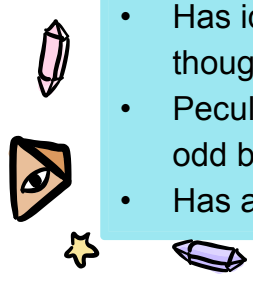
cluster A

ODD + ECCENTRIC

SCHIZOTYPAL PD

An <u>intense discomfort from close relationships</u> and often described as <u>peculiar</u>.

- Has ideas of reference, hallucinations and paranoid thoughts which may result in social withdrawal
- Peculiar thoughts may include magical thinking and odd beliefs (e.g., 6th sense, telepathy)
- Has an eccentric appearance and behaviours



cluster B

DRAMATIC, EMOTIONAL ERRATIC

HISTRIONIC PD

Often described as <u>excessively emotional</u> and <u>attention-seeking</u>.

- May feel uncomfortable if not the 'centre of attention'.
- May potentially display over-exaggerated emotions and be described as 'shallow'.
- May use physical appearance to draw attention to themselves. Thus, can be seen to exhibit seductive and/or provocative behaviour.

ANTISOCIAL PD

Has a <u>pervasive disregard for others</u> and <u>violates of others' social rights</u>.

- Often seen to be irritable, aggressive and/or impulsive.
- Has a general disregard of the law, the safety of self as well as of other's.
- Engages in illegal acts or deceitful behaviour for personal gain
- Has a lack of remorse for their behaviour.
- Consistently irresponsible (e.g., repeated failure to sustain consistent work).

NARCISSISTIC PD

Prone to <u>grandiosity</u> with an <u>excessive need for admiration</u> and <u>lacking of empathy for others</u>.

- Their grandiose nature leads to an unrealistic and inflated sense of their own entitlement and self-importance, thus, may also be seen as arrogant.
- Exhibits manipulative behaviour and lack empathy for others.
- Is often preoccupied with fantasies of success, beauty and/or power.

BORDERLINE PD

Possesses <u>low self-esteem</u> and chronic <u>inability to regulate emotions and form interpersonal relationships</u>.

- Chronic low self-esteem that leads to unstable self-image, mood and relationships.
- Tendency to act impulsively (e.g., unsafe sex, reckless driving, binge eating, spending).
- May make desperate efforts to avoid self-perceived abandonment

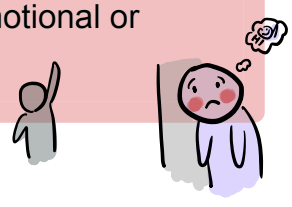
cluster C

FEARFUL, AVOIDANT, ANXIOUS

AVOIDANT PD

A tendency to <u>avoid social interactions</u>. Prominent feelings of <u>inadequacy</u> and <u>hypersensitivity to criticism or rejection</u>.

- Avoids interpersonal contact due to a chronic fear of disapproval, criticism or rejection from other.
- Has low self-confidence.
- Fears sharing close emotional or intimate relationship.



DEPENDENT PD

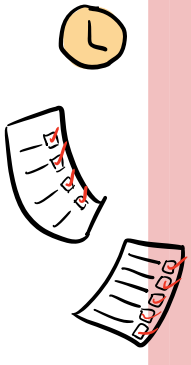
Significantly <u>emotionally dependent</u> on other people and spends <u>great effort trying to please others</u>.

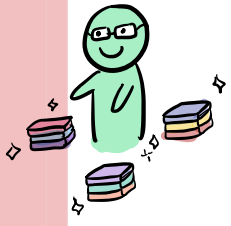
- Lacking of self-confidence.
- Has difficulty making daily decisions without reassurance from others.
- Often non-confrontational to please others.
- Has an intense fear of separation.
- Feels significantly distraught when abandoned.

OBSESSIVE COMPULSIVE PD

A <u>rigid adherence to rules</u> with an <u>overwhelming need for order</u> and <u>unwillingness to yield to others</u>. Has a <u>sense of righteousness</u> about the way things "should be done"

- Excessive devotion to work that impairs social and family activities
- Excessive fixation with lists, rules and minor details
- Perfectionism that interferes with finishing tasks
- Rigid following of moral and ethical codes
- Unwillingness to assign tasks unless others perform exactly as asked
- Lack of generosity; extreme frugality without reason
- **Egosyntonic** – not distressed by these obsessions





Contributors: Simran Bhopal & Amin Hajamohideen
Reviewer: Ajeeta Singh

Borderline Personality Disorder

Definition 	Borderline personality disorder (BPD) is a cluster B personality disorder. Affects 1% of the general population . Up to 23% of patients engaged in community mental health services.
DSM-5 Criteria 	A **pervasive pattern** of **instability in interpersonal relationship**s, self-image and affects, and marked impulsivity, beginning in early adulthood, indicated by **5/9 of DSM-V : "I DESPAIRR"** **Note:** **Blue= questions to help make the diagnosis** - **I=** Identity disturbance + Low self esteem- **How do you view yourself?** - **D=** Disordered, unstable affect (intense episodes of dysphoria, irritability, anxiety that lasts hours-days)- ***Do you feel like your emotions can change quickly from high to low, like a roller coaster?*** - **E=** Emptiness- ***Do you often feel empty inside?*** - **S=** Suicidal behaviour (Recurrent threats, behaviour, gestures, or self mutilation)- ***When something goes wrong do you often self harm?*** - **P=** Paranoid ideation- ***When under stress do you feel that you lose touch with the environment or that people are ganging up on you?*** - **A=** fear of Abandonment - **I=** Impulsivity in at least 2 areas (spending, reckless driving…) that is potentially self damaging- ***Do you often act on an impulse?*** - **R=** Rage- ***What do you do when you get angry?*** - **R=** Relationships **(**a pattern of intense and unstable interpersonal relationships with alternating extreme idealisation and devaluation)- ***Do your relationships tend to have lots of ups and downs?***
Defence mechanism 	- **SPLITTING:** viewing everything as "black or white" or in absolute terms. I.e one person is good, another is bad, they did right/ wrong. There is no grey.
Etiology/ Risk factor/ Pathophysiology 	**BPD AND STIGMA** - Often mislabelled as "manipulative" or "difficult" by the medical community, leading to insufficient care. Patients often act in erratic ways or self destructive tendencies as it is the only way they can cope with their distress. **BPD vs COMPLEX POST TRAUMATIC STRESS DISORDER (PTSD)** - Ongoing debate for BPD to be called "COMPLEX PTSD". - 85% of patients with BPD have experienced trauma in their early development (e.g. physical, sexual or emotional abuse) - Hence , BPD symptoms could manifest in response to this trauma. **<u>RISK FACTORS FOR BPD</u>** **BIOLOGICAL:** - 5x more likely in first degree relatives of BPD - A higher sensitivity to stress **PSYCHOLOGICAL** - In adolescence: Conduct disorder, ADHD, Depression, Oppositional defiant disorder **SOCIAL** - Early trauma - Disorganised attachment (maladaptive parenting, disruption of caregiver bonding) - Substance use

How to diagnose?

1. Complete psych hx with special focus on **developmental history**
2. Risk assessment:
    a. Note: many patients with BPD experience chronic suicidality without requiring hospital admission. It is important to determine the pattern/ regularity of suicidal thoughts and the lethality of their plans. Any change to the pattern or lethality may require admission for acute management.
3. Assess against criteria
    - DSM-5 criteria
    - BPD questionnaire (BPQ)
    - Minnesota multiphasic personality inventory (MMPI)
    - NOTE: Patients must be older than age 12 to diagnose
4. Rule out differentials + assess for comorbid conditions
    - **Personality changes due to a medical condition or substance:** dementia, hormone imbalance/ PCOS, autoimmune conditions...
    - **Schizophrenia:** BPD can have brief psychosis, but schizophrenia lasts longer.
    - **Depressive or bipolar:** often depression or mania comes in longer episodes than BPD mood changes.
    - **Other personality disorders:** self destructive behaviour is only seen in BPD:
        - **Histrionic:** attention seeking
        - **Schizotypal**: paranoid ideas
        - **Antisocial:** manipulate others to get gain
        - **Dependent:** hates abandonment, but moves on to find a new relationship, rather than BPD, who experience rage and hopelessness with abandonment.
5. Physical exam: look for signs of self harm + underlying disease
6. Investigations
    a. Baseline: FBE, UEC, LFT
    b. Ddx: Iron, folate, B12, Vit D, TFT, PCOS screen, ESR, CRP, EBV serology
    c. Comorbid: bHCG or STD screen if appropriate
    d. Urine drug screen- note: can affect patient rapport

Management

ACUTE SETTING

- Crisis assessment + assessment order for those who frequently self harm
- Consider short term Benzodiazepine or quetiapine
- Only hospitalise for a short period of time (<48hr)

- We try not to admit patients with BPD because admission can be detrimental to their overall recovery in the following ways:
    - Reinforcing pathological help seeking behaviour and dependency
    - Escalating means of self harm on discharge
    - Transference and countertransference issues
    - Team splitting, leading to staff conflict

AT DIAGNOSIS

- Explain the symptoms before giving them the diagnosis
- Explain they have BPD + treatment strategies
- Assure them it is a valid mental disorder
- Provide information, fact sheets (BPDAustralia.org)
- Invite them to ask Q + discuss with family for support (if consent is obtained)

	LONG TERM
	AIM:
	- Treat in the community
	- Suicide and self harm prevention 
	- Avoid long term hospitalization
	HOW:
	- Management plan: Roll of team, goals, triggers for distress, self management, who to contact
	- Psychotherapy:
	  - **1): Dialectical behavioural therapy (DBT)** 
	  - 2) Acceptance and commitment therapy (ACT)
	  - 3) Mentalisation based therapy (MBT) - second line
	- MANAGE COMORBIDITIES: antidepressants as needed.
	
	PREVENTION:
	- Support good parent infant attachment 
	- Identify families and children at risk and provide psychological support early

Complication and prognosis 	Comorbidities - Major depressive disorder - Bipolar disorder - Bulimia Nervosa - PTSD - ADHD - Substance use Prognosis - 8% commit suicide  - 20% remission at 1 year with therapy - 85% remission at 5yr with therapy


Contributor: Tess Ryan
Reviewer: Amin Hajamohideen

References

Personality Disorders

- Health Direct - Personality Disorders
- MSD Manuals - Personality Disorders
- https://bmcpsychiatry.biomedcentral.com/track/pdf/10.1186/s12888-018-1908-3.pdf

Borderline Personality Disorder

- DSM-5
- Year 4C Psychiatry online modules - ADULT, Credit Sarah Rb
- “What is BPD” by Eastern Health : https://vimeo.com/298914008
- Kaplan and Saddocks 11th ed