PERSONALITY DISORDERS

Personality disorders "mad (A) /bad (B)/sad (C)"

CLUSTER A (ODD/ECCENTRIC/MAD)

Paranoid *suspicious*

Pervasive distrust with 4 of the following:
- Recurrent suspicions without justifications about other harming and deceiving them
- Unjustified doubt loyalty/trustworthiness
- Unforgiving of insults and bears grudges
- Interpret hidden/threatening meanings into benign events/remarks
- Reluctant to confide info in fear as it would be maliciously used against them

Schizoid *socially indifferent / detached*

SIR SAFE

Pervasive pattern of detachment from social relationships with At least 4 of the following
- Solitary lifestyle
- Indifferent to praise or criticism
- Relationships of no interest
- Sexual libido
- Anhedonia
- Friends lacking
- Emotionally cold and detached

Schizotypal *eccentric + distortions*

UFO AIDER

Pervasive pattern of social and interpersonal deficits marked by acute discomfort and reduced capacity to make close relationships with 5 or more of the following:
- Unusual perceptions
- Friendless except for family
- Odd beliefs / thinking and speech (magical thinking)
- Affect – inappropriate, constricted
- Ideas and Delusions of refence
- Doubts others – suspicious
- Eccentric appearance / behaviour
- Reluctant in social situations and **XS social anxiety that does NOT diminish with increasing familiarity**

Risk factors for cluster A
- Strong FHx of schizophrenia (esp. biological parents)
- *Immigrants (minority groups)*
- *transition from rural to urban*

General Mx:
1) **Always be honest and respectful to these patients**
2) **Understand that paranoid patient like to project**
3) **Minimise interactions and provide factsheets or technical information**

#1: Personality disorders (Sigmund Freud)

All disorders related to fixation to ONE psychosexual stage of development e.g. oral stage = dependent and passive characteristic

#2: B criteria for all

All do NOT **occur exclusively during course of schizophrenia or bipolar disorder or depressive disorder with psychotic features**

CLUSTER B - Bad (dramatic/emotional)

Antisocial ***CALLOUS MAN*** *NO empathy*

A. **Persistent Sx of disregard for and violation of rights of others since the age of 15yo with at least 3 or more of the following**
- **Conduct disorder before age 15y**
- **Current age at least 18**
- Antisocial acts that warrant arrest
- Lies frequently
- Lacks a superego
- **Obligations not honoured**
- Unstable
- Safety of self/others ignored
- Manipulative - others to profit, gain power or materials
- Aggressive / apathetic
- Not exclusively occurring during schizophrenia or mania

Borderline ***"I RAISED A PAIN!"*** *unstable ID*

Pervasive pattern of unstable relationships, self-image and affect and marked impulsivity starting from early adulthood with 5 or more of the following
- **Identity disturbance**
- Relationships unstable
- Abandonment frantically avoided
- *Impulsive in ≥ 2 areas = e.g. XS spending, sex, substance use, binge eating*
- Suicidal behaviours, gestures and self-mutilating behaviours
- Emptiness – chronic feeling
- Dissociative symptoms
- Affective instability
- Paranoid ideation
- Anger poorly controlled
- Idealisation followed by devaluation
- Negativity – undermine themselves with self-defeating behaviour

Rx: Dialetic behavioural therapy (MINDFULLNESS→ accept and change)

Histrionic *attention seeker*

I CRAVE SIN

Pervasive pattern of XS emotionality and attention seeking in early adulthood with 5 or more of the following
- **Inappropriate behaviour – seductive or provocative**
- **Centre** of attention
- **Relationships** seen as closer than they really are
- **Appearance** most important
- **Vulnerable** to other's suggestions (suggestive)
- **Emotions** exaggerated
- **Shifting** emotions, shallow
- **Impressionist** speaking (i.e. lack details) ➔ **Novelty** is craved

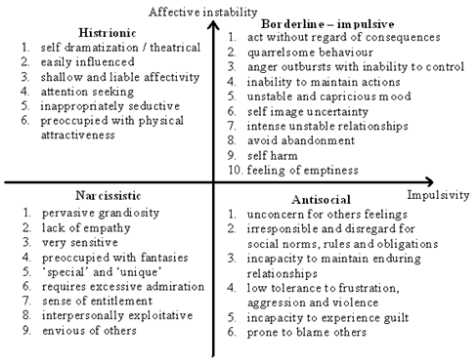
Narcistic *self-centred grandiose*

A FAME GAME

Pervasive pattern of grandiosity (in fantasy or behaviour) with need for admiration and self-entitlement with 5 or more of the following
- **Admiration** required in XS amounts
- **Fantasise** about unlimited success and brilliance
- **Arrogant / haughty behaviours - devalues others**
- **Manipulative**
- **Envious of others and thinks others enby them**
- **Grandiose** (sense of importance) **emphasise VIP status/wealth ➔ requires XS admiration**
- **Associated** with special people
- **Me first** attitude
- **Empathy** lacking for others

Risk factors for cluster B
- Cluster B have Genetic component
- *Strong assoc. between histrionic & somatisation disorders*
- **High risk of antisocial PD developing somatisation disorder**
- High TT levels = impulsive traits
- Tendency to talk more than listen

General Mx:
1) **Gain an understanding of personality factors (***sometimes including their family of origin)*
2) **Reduce idealisation of unit before admission to reduce devaluation after**
3) **Appreciate that self-harm** (e.g. cutting self) may be *protective mechanism* to halt suicidal execution
4) **Pharmacotherapy (**for antisocial PD)
   - **Nb: firm limit setting BEFORE therapy**
   - **Anti-psychotics** for anxiety, rages
   - **Anti-depressants (SSRI)** → depression
5) **Dialetic behavioural therapy** for **borderline** PD
6) **Validation through positive feedback (sandwich method),**
   - Important for **narcissistic PD** to accept narcissism **before** they can make progress



CLUSTER C - (anxious/fearful)

Avoidant *Inhibited – feeling inferior to others* ***RIDICULE***

Social inhibition (feeling inadequate) and hypersensitive with at least 4 of the following
- Restrained within relationships
- Inhibited in interpersonal situations
- Disapproval expected at work
- Inadequate view of self
- Criticism (expected in social situations)
- Unwilling to get involved
- Longs for attachment to others
- Embarrassment is the feared emotion

Nb: If blushing (DDx: social anxiety disorder)

Dependent *submissive anxious* ***DARN HURT***

Submissive and fear of separation with 5 of the following
- Disagreement is difficult to express
- Advice- needs XS input
- Responsibility delegated to others
- Nurturance – VOLUNTEER to do unpleasant things to obtain nurturance and support
- Helpless when alone
- Unrealistically preoccupied with being left to care for self
- Relationships desperately sought after
- Tasks – difficulty to start projects

Obsessive *rigid perfectionist (self-critical)*

Orderliness, perfectionism, mental and interpersonal control with 4 or more:
- Pre-occupied with orderliness (rules, lists, schedules) ➔ Interferes with task completion
- XS devotion to work/productivity at expense of leisure and friendship
- Overly conscientious – inflexible about morality/values/ethics
- Cannot discard worthless objects or delegate tasks
- Rigid and stubborn (miserly pending)
- **Does NOT spend time on self** ***(unlike anti-social and narcistic personalities)***

Risk factors
- Nb: some cultures emphasise passivity, politeness, while others discourage dependence

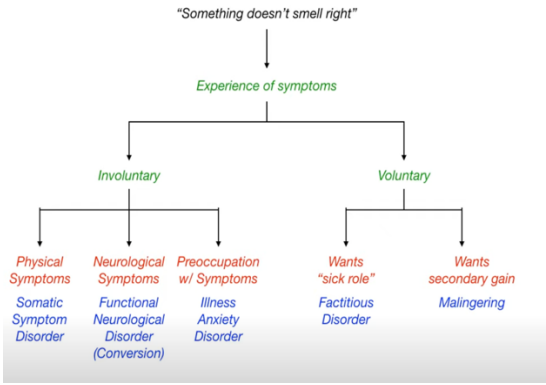
Hallmarks
- risk of burnout
- always staying back after work
- constant worry

General Mx:
1) Psychotherapies - give time, things may need to be repeated, meet when not hectic
2) Goal to become independent, assertive and self-reliant
3) Provide support to avoid burnout as work very slowly

THE 'CHALLENGING' PATIENT & BEWARE OF TRANSFERANCE

Psych disorders of unknown cause

	Sx	Assoc.
Conversion disorders	• Sensory or motor loss caused by stress with no foci e.g. **pseudo-seizures** • la bell indifference (not worried about Sx)	**Anti-social PD** Rx: Reassurance that symptoms will improve with time
Somatisation disorders	Concerned about **physical Sx** (pain, headache, cough)	**Functional pain Rx** • biofeedback • psychodynamic psychotherapy • SSRI • Simple analgesia
Illness anxiety disorders (*hypochondriac*)	Concerned about **illness** (e..g cancer) -ve test results	
Factitious "munchausen"	**Voluntary – agrees to tests** Desire for internal gain	• **Borderline PD** • Histrionic PD
Malingering disorder	Desire for external gain (*financial reward, escape from formal duty*)	• Borderline PD • Narcissistic PD
Conduct disorder	Unlawful behaviour Rx: Jail in keeping with offence	• FHx of Anti-social or EtOH



Managing and identifying transference & counter-transference:

Transference	**REPETITIVE Re-enactment of patient's internalised emotions felt from past childhood/ experiences / relationship patterns and projecting onto therapist** • **Ex 1 (positive): .** if patient has had good relationship with mother during childhood, would perceive me "as if" I was Dr Mum and assert a child role - translates into positive interaction (**beware if becoming way too seductive esp. if therapist is idealised rather than trusted– causing splitting)** • **Ex 2. (negative)** Patient with **childhood sexual and physical abuse and neglect** would perceive you "as if" I was an authority figure of harm **or** that no one can help him (helpless, guilt, abandonment, rejection) and may appear clamped up, dissociated • **Ex 3: (negative) = paternal transference (**projecting therapist as paternal figure or sexualisable figure**)**
Counter-transference	**Redirection of therapist's feelings/bias/experience towards client.** (**how do you feel in the presence of the patient**?) –**caught up in re-enactment**. • **Ex 1: SELF-HARMING patient** with bg history of sexual abuse where her father tied her up has repeated admission for hand cuts – hand surgeon frustrated that he has to perform repeat operations (puts double arm cast on pt) – recreating trauma!!

***You need to understand and recognise this during ED → NEED to use mature defense mechanisms to manage situation effectively**

- More out of character you feel (the easier to recognise about transference)
- Who you think you are may **NOT** be how others perceive you to be (*if patient treats you with fear, it is not you!! – find the reason behind it – don't take it personally!!)*

IMMATURE DEFENCE MECHANISMS (LOW LEVEL)

	Definition	Association
DISPLACEMENT	Channelling feeling/thought from actual source to something/object or someone else E.g. if mad at someone, you break glass against the wall	
INTELLECTUALISATION	Dealing with emotional conflict or stressors with an XS use of abstract thinking to control or minimise disturbing feelings – making them appear unconcerned ➔ **rehash events over and over again**	
RATIONALISATION	Justifying one behaviour and motivations by substituting good acceptable reasons for these motivations	
SPLITTING	Everything in the world is perceived as all good or all bad (nothing in between)	
IDEALISATION	Attributing XS positive qualities to another	Borderline
DEVALUATION	Attributing XS negative qualities to another → DEVALUING and DENIGRATING	Borderline
REACTION FORMATION	Adopting beliefs and attitudes **contrary** to what you believe (when you say you're not angry but you really are)	
ISOLATION OF AFFECT	Avoiding a painful thought or feeling by objectifying and emotionally detaching oneself from that feeling (e.g. remaining calm and aloof when with a person you hate)	
REPRESSION	Unconscious Lapse in memory and idea blocking	Histrionic

MATURE DEFENCE MECHANISMS (HIGH LEVEL)

	Definition	Association
ANTICIPATION	devotion of one's effort to solving problems before they arise (e.g. practicing their answers to the toughest questions for upcoming interview)	Anxiety (GAD, social, agora)
SUBLIMATION	Substitute their more aggressive or problematic impulses with healthier and more positive alternatives. (e.g. playing a contact sport like football to channel anger healthily)	Anxiety
ALTRUISM	provide help to others to help relieve feelings of anxiety	Anxiety, depress
SUPPRESSION	Consciously choosing to block ideas or impulses that are undesirable (unlike repression which is unconscious)	PTSD
HUMOUR	Using humour to overcome the burden of suffering or misfortune.	

Challenging Patients: Case Scenarios

Co-existence between mental health and co-morbidity

- **Most common comorbidity** was anxiety disorder **PLUS** physical condition, affecting around 1.4 million Australian adults
- comorbidity increased with decreasing socioeconomic status (SES)
- comorbidity group had the highest proportion of smokers
- 10 times as likely to report high levels of psychological distress
- more than 7 out of the past 30 days out of role

Case 1

- Ms X is a 21 year old woman with a background history of Major depression and generalized anxiety disorder. She has been prescribed Amitriptyline 100 mg by her private psychiatrist since the beginning of 2018. Today she presents with an overdose of 25 tablets of her antidepressants in the context of recent stressors and ongoing depressive symptoms. She is agitated and behaviourally disturbed.
- As the junior registrar you are requested by the medical team to review this patient and " admit this woman"
- What is your initial approach and why?

Initial approach

1. Assess her mental state and admit her to the psychiatric ward
2. Administer IMI Haloperidol
3. Assess her safety risks and then admit her to a psychiatric unit
4. **Assess her safety risks, consider her potential side effects of an overdose of Amitriptyline on her mental state and request a medical review [BEST ANSWER – check suicidal risks, mental health act, duty of care, any more tablets or sharp objects on her]**
5. Medical review and request consultation liaison psychiatry to follow up

What are the potential risks with a TCA / amitriptyline overdose?

1. **Anticholinergic delirium** - fever, HTN, mydriasis, tachycardia, coma, ileus, hallucinations, agitation
2. Long QTc prolongation on ECG
3. Serotonergic side effects → ANS and CNS upregulated

Case 2

- Mrs S is a 56 year old woman with Multiple Sclerosis and she presents with symptoms of mania and psychotic features. She is elevated in her mood, grandiose delusions of being god, has not slept for days, irritable and easily distracted with random thoughts.
- You have been asked to assess this woman and present a management plan for the medical team.
- What further information would you like to know prior to seeing her and why?

Further information needed?

1. Medications for MS – steroids (?acute psychosis)
2. ?any history of bipolar mood disorder
3. ?is she on any medications – compliant?
4. ?has she been on mood stabiliser?
5. ?any drug usage
6. ?is it delirium (check MMSE, MoCA)→ does she have fluctuation in behaviour? → reversible causes

Case 3

- Mr H is a 45 year old gentleman with a background history of Schizophrenia currently on a community treatment order and receives a monthly injection of Paliperidone for his illness. He was brought in by the police after being found to be agitated and confused at a shopping centre. He does not have a history of illicit substance use.
- He arrives at the ED, agitated, responding to external stimuli and behaviourally disturbed.
- The ED registrar and RN request that you review him immediately and admit him to the mental health unit

Initial approach

1. **Assess risk**
2. **Determining his**
3. **mental health act status**
4. Sedate him with antipsychotics or IV benzos and admit him to the mental health unit
5. **Assess his mental state and gather collateral information from his case manager and family members [BEST ANSWER- check safety 1st prior, ask family if there is sudden change in behaviour, check for organic causes- med compliance, other co-morbidities]**
6. Restraint him and get security to be present

His CM informs you he also has a history of Epilepsy and is not compliant to his antiepileptics. What do you do next?

1. Administer Haloperidol and admit him to the mental health unit
2. IV Phenytoin loading dose by the ED team and admit him to MH unit
3. **Request a neurological review and ensure appropriate blood investigations have been taken; including blood levels of the various antiepileptics he is on. Consider either a medical or mental health admission after this has been done. [BEST ANSWER- check for organic cause or if this is indeed a psychiatric cause]**
4. Neuro review then admit to the mental health unit

Case 4

- Mrs J is a 49 year old woman with an established diagnosis of Schizophrenia on Zuclopenthixol Depot 200mg 2 weekly. She is admitted to the neurological ward with severe dystonia.
- Name the common extrapyramidal side effects from medications.

Common treatment principles

- REMOVE/REDUCE Offending drug
- Clozapine – less D2 blocking
- Consider - 1st gen antipsychotic effect (haloperidol, chlorpromazine)

Specific treatment for EPSE - *common for 1st gen atypical anti-psychotics*

EPSE	Solution
Acute or chronic dystonia "sustained increased and painful tone"- *laryngospasm, upward eye movement (oculogyric crisis), trismus, lordosis, scoliosis, opisthotonic crisis (hypertext body*	**RF:** male, young, 1st gen anti-psych (haloperidol), stimulant use • IV/IM Benztropine (anti-chol) • 2ND LINE = BZD
Parkinsonian side effects- Tremors, Bradykinesia, Rigidity, reduced arm swing, shuffling gait "Simpson Angus side effect"	• Consider drug causes- change or reduce dose • 2ND LINE = Benztropine
Tardive dyskinesia (TD) (Involuntary movements – lip smacking, automatisms) → irreversible if chronic	• **Change of meds** – clozapine (best evidence) • **2ND LINE = 2nd gen anti**-psychotics • *Other* = **Tetrabenazine**, • Vitamin K, Gingko (low evidence)
Akathisia (inner feeling of restlessness) acute motor agitation, reversible) – *restless leg, rocking, pacing*	• BB, BZD, Mirtazapine • Clozapine (best)
XS PrL (galactorrhea, amenorrhoea, **sexual dysfunction**)	• **Discontinue and use Dopamine agonists (e.g. aripiprazole**