the generEHlist
105 CCFP Topics Podcast

Personality Disorder

	Key Feature	Skill	Phase
1	Clearly establish and maintain limits in dealing with patients with identified personality disorders. For example, set limits for: - appointment length. - drug prescribing. - accessibility.	*Professionalism* *Communication*	*Treatment* *Follow-up*
2	In a patient with a personality disorder, look for medical and psychiatric diagnoses when the patient presents for assessment of new or changed symptoms. (Patients with personality disorders develop medical and psychiatric conditions, too.)	*Clinical Reasoning*	*Hypothesis generation*
3	Look for and attempt to limit the impact of your personal feelings (e.g., anger, frustration) when dealing with patients with personality disorders (e.g.,stay focused, do not ignore the patient's complaint).	*Professionalism* *Communication*	*Treatment*
4	In a patient with a personality disorder, limit the use of benzodiazepines but use them judiciously when necessary.	*Clinical Reasoning* *Selectivity*	*Treatment*
5	When seeing a patient whom others have previously identified as having a personality disorder, evaluate the person yourself because the diagnosis may be wrong and the label has significant repercussions.	*Clinical Reasoning* *Selectivity*	*Diagnosis* *History*

Why should a family physician learn about personality disorders? Well, to start, we are the first point of contact with the patients who have them, and often the first to recognize they have a personality disorder. While psychiatrists may have a role in their treatment, most patients do not require a referral, making family doctors the primary provider of care. Even if you do not plan on managing the personality disorder, you WILL have patients with personality disorders and this podcast will help you effectively manage challenging situations.

Personality disorders make up over 10% of the general population, and 24% of the population in primary care. They may or may not seek treatment for aspects pertaining to their personality disorder, but they sure as well will have other health concerns.

We all can remember a patient with a personality disorder. You may remember your own feeling of anger, frustration, and fatigue while interacting with this patient. This is normal, it is called countertransference. Unfortunately, these feelings can impact the way we interact with and treat this patient, and also all the patients afterwards. We are in fact, human!

The goal of this episode is not to teach you about the specific diagnostic criteria of personality disorders but how to effectively treat these patients, both with regards to their personality, but also their other issues. It will give you tools on how to monitor your own thoughts and emotions so they do not impact patient care (does this sound like CBT to you?? Because it is!).

Note that this podcast will largely focus on cluster B personality disorders, which are the ones you are most likely to come across in practice, and are most likely to present in crisis.

With that, let's get started!

So, what is a personality disorder? We all have a personality, but according the to DSM V, it becomes a disorder when there is “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to clinically significant distress or impairment.”

These individuals will often have difficulties with relationships, handling emotions and thoughts and will often find it hard to understand that it is their behaviour that is causing problems. In other words, there is a lack of insight.

That’s pretty wordy, so put a simpler way: Personality disorders, more or less, are permanent problems of behavior and human interaction, established by early adulthood that are unlikely to change throughout the life cycle.

We will start off with a brief description of the different personality disorders. The full DSM-V criteria can be found in the show notes. Personality disorders can be broken down into 3 clusters: A, B, and C, and as you may have heard before, have been referred to “mad, bad, and sad” respectively.

<u>Cluster A personalities</u> include schizoid, schizotypal, and paranoid. These are the patients you might perceive as being odd or bizarre.

Classically, we may perceive those with schizoid personalities as loners, importantly, they want to be alone, typically never take a mate, have no friends and are not close with their family members.

Interestingly, when asked about same, they appear as though it never occurred to them that social interactions are important.

Schizotypal personalities may strike you as odd, eccentric, with magical thinking and ideals of reference. If this rings some bells towards schizophrenia, there actually is some genetic association between them and schizotypal personalities may predispose.

More likely, you will encounter paranoid personalities. They have an extreme sense of distrust and hesitancy; not just in relationships with others but with the medical system as well, they are often hesitant to trust your medical advice or opinion.

<u>Cluster B personalities</u> include narcissistic, borderline, antisocial, and histrionic. These patients are the ones that will likely give you countertransference and are known for how they make others feel, which is why we sometimes refer to them and the “bad” ones.

Narcissists need showering glory and often lack empathy, though at times they may ‘fake’ empathy. Borderline personalities are known for their mood swings, feelings of emptiness,

impulsivity, poor self-esteem, and splitting behaviors which often show up as idealizaing or devaluing others.

Antisocial personalities, which are usually not criminals, are likely to have had conduct disorder as a child. They have no self-regard for others and do not abide by cultural norms; they can come across as superficially charming and complementary.
Histrionic personalities are seen as provocative personalities that need to be the center of attention. They can be quite dramatic in their tone of voice and seductive in their clothing choices.

<u>Finally, there are cluster C personalities</u> including obsessive-compulsive, dependant, and avoidant.

These are the anxious types. Obsessive compulsive personalities are quite common among us med students: we tend to be perfectionistic and stubborn. This is not to be confused with Obsessive compulsive disorder.

OCPD can be seen as egosyntonic (meaning the same) where our actions and feelings align with our thoughts.

OCD is egodystonic (meaning distinct or different from us) where the obsessive thoughts and resulting compulsions we experience are distressing and unwanted.

Dependent personalities can be overly clingy and needing reassurance.

Finally, avoidant personalities, well avoid. They can be thought of very similarly to social anxiety disorder as they are very worried about other people's perceptions of themselves. At their core they believe that they are somehow defective and often have a very difficult time letting anyone get close to them.

This differs from patients struggling with SAD given that at their core, they can have an intact self-esteem that only gets tested when in social situations or exposed to situations where they may be judged, embarrassed or scrutinized. These patients tend to have friends and don't avoid to the extreme extent that patients with avoidant PD do.

We will explore many of the challenges in working with patients with personality disorders through a series of cases.

Our first case documents a 35 year old woman. It is Friday afternoon. She shows up to your practice at the end of your day unscheduled and she is feeling suicidal after her roommate moved out and took their cat with them. She tells you that the whole world is against her and that there is no reason for her to be alive. She requests some ativan from you and she thinks that will help. She goes as far to threaten suicide if she does not get a prescription today.

*What do you do? **check out the crisis episode***

This is a classic example of how a patient with borderline personality disorder can present in crisis. These are challenging situations to handle.

They often present with a broad range of behavuours such as behavioural disturbances, self-harm, suicidal ideation, suicidal gestures, impulsive aggression, and short-lived psychotic symptoms in addition to feelings of intesne anxiety, anger, and repression.

They are often best handled outside of a medical setting, as using your doctor or the emergency room as a coping skill are actually quite negatively adaptive. Patients need to learn skills to use on their own to deal with these situations. However, during a crisis is not the best time to have this conversation.

Because this is the first time she has done this and because you are at the end of your day, you decide to see this patient.

BEFORE you go to see the patient, or any patient who you suspect may be struggling with a PD, take a moment before entering the room to create a plan of approach:

- You must set clear boundaries
  - for instance, You will clearly let her know that you have 15 minutes with her.
  - Review clinic policies to ensure she does not expect special privileges in the future. For instance you might say “If this were any other time of the day, or if she had done this multiple times before, you would need to send her to the ER as it is not appropriate to show up to the office like this”
- don’t forget to take a deep breath.
  - You know how you feel when you work with patients like this
  - You remind yourself that you are both humans, with emotions, that will impact one another.
  - You vow to see things objectively and treat objective issues, especially because she is in crisis.
- Have a plan for medication discussion:
  - If you agree to prescribe ativan, how much? How many times a day? Having this plan ahead of time, minimizes the chances that the patient may sway or ‘convince’ you to prescribe more
    - A good rule of thumb for Ativan: VERY SHORT term, less than 1 week duration, 1mg per day as needed. Reiterate that it is only to be used in situations where behavioral interventions have failed to reduce her distress (IE it should not be her first go to when experiencing a slight irritation)
  - Anticipate her asking for other medications when she hears your boundaries. For instance, no you will not prescribe any other sedating agents.

Outline how you expect to be treated. For instance, You will not take verbal abuse. Be upfront and clear. Ask what the patient needs and don’t overstep your boundaries when providing that.

- As with any patient, make sure you feel safe. Make sure you are not alone in your office and if there is no one to supervise, conduct the interview with the door open. Ensure there is a clear exit for both you (and the patient) is possible. If you feel unsafe, leave, or call security if you are able to.

Now that you have your safety and boundaries set, how do you handle the situation?

Be mindful of your own feelings and maintain a calm and non-threatening attitude. Remember, the patient is feeling how they are feeling. Do not minimize this, and try to understand it from the patient's perspective..

Borderline personality disorder has an estimated 10% suicide rate. You must take these crises seriously, and eventually help your patient develop more appropriate coping strategies.

Unfortunately, many patients who have repeat presentations are not taken seriously and induce complacency in the assessor. A part of the disorder can be black and white thinking, a focus on the emotional rather than the rational mind.

In a crisis, you cannot rationalize with the emotional mind even though you may find yourself attempting to. This can be a difficult skill to learn.

Perform a suicide assessment. This can be challenging especially because suicide cannot be predicted. Ask about intent, access, preparation and ensure you document past attempts. A patient with a past attempt by overdosing on Ativan is going to change or influence your management, particularly if you were considering prescribing to them.

Ask What are they living for?
Who are their supporters?
Depending on how well you know the patient, come up with your suicide risk assessment. Of course, you cannot predict suicide, but those with more protective factors have a better prognosis; we want to emphasize the positives in the patient’s life, this can help them feel more hopeful.

Remember to balance the person's other comorbidities such as depression, their BPD, and the current stressor.

If the risk of suicide is high or you have any doubts, you need to call 911. You can certify a patient from the clinic (in AB this involves completing a Form 1 Mental Health certificate) that ensures they are conveyed to a hospital for further assessment. If they are not high risk, keep talking.

Then, work on de escalation. Listen to your patient without too much interruption. Validate their emotions, but not necessarily their actions. Let them get their feelings out and feel safe to do so.

One way to support a patient in crisis is to ask small manageable questions. Large open ended questions like “how can I help” or “what happened” are big and daunting. Instead, ask “how long

have you been feeling this way" or "do you know why you are feeling like this" may be more approachable.

It may be easier for the patient to speak as they get going. Sometimes all people need it a chance to vent and feel connected, and like someone is listening. What they dont need is you to tell them solutions.

Foster autonomy and choice, but also realize when acute intervention is or is not needed. We can be quick to admit these patients when in reality, rapid hospital admissions can often prevent the person from developing appropriate coping skills and may foster an inappropriate dependency on having others take on and solve their problems for them.

Your patient may go one of 2 ways. They calm down. Fantastic. We'll move onto the next step in a moment.

Or they continue to escalate. There is little evidence for the benefit of medications. Try to stay away from benzos if possible.

It may be appropriate to prescribe when there is a concern of self-harm or violence, but these patients really should be sent to emergency. Consider the chances of alcohol or other illicit drugs being on board. Consider how this will change your relationship with this patient in the future.

For example, will this hinder their ability to form good coping strategies? Will they expect this from you for every crisis? If you do decide to prescribe a drug, only provide ONE at a time.

Make it a short, limited time prescription, maximum one week and ideally in an amount that would not be lethal if they were to take all in an overdose attempt. Tell them this. It is only one tool in the eventual tool box that you will provide the patient with. Tell them why it is so short and that it is non-negotiable.

If you cannot stop the drug within 1 week, ensure you monitor closely and document its effectiveness, side effects, misuse, and dependency

For all of the above 3 scenarios: Book follow up. Book it now and soon. Ensure that the patient knows, this will help the patient feel seen, heard and validated knowing you care and are booking them in again at your earliest convenience.

It is critical to have scheduled follow up with these patients. It gives them certainty that they will see you again which in and of itself is helpful to prevent situations escalating to self harm. It is a tool to help patients work at keeping themselves safe, but keep in mind we can never predict or 100% confidently ensure patient safety; this is not our responsibility as physicians It prevents them from showing up unsolicited.

Tell them that it is inappropriate for them to show up whenever they need, but that you are happy to book a weekly appointment with them. If something happens between weekly appointments, develop a management plan for them. We will discuss this later.

Great, you have made it through managing your first crisis, successfully at that. Now it is Tuesday afternoon. You booked your patient in as the last patient of the day (just in case the countertransference is strong, you don't want to set yourself up for a bad day).

She comes and is not in crisis. She apologises about what happened last week and thanks you for your patience with her. She doesn't understand why she gets this way, no one else in her life seems to react the way she does.

What are the risk factors for borderline personality disorder?

Like everything, it is a complex interplay of genetic and environmental factors. People are born with inherent personality and temperament which are shaped by experiences.

Research has shown that there are certain areas of the brain related to impulsive behaviour, emotional instability, and the way people perceive events. The incidence of BPD is increased in families with other related mental health conditions. It is more common in females than males. Environmental factors that contribute to the development of BPD include separation, neglect, abuse, or other traumatic childhood events. Unfortunately, many of these individuals have a history of PTSD, often stemming from childhood trauma including abuse, often sexual.

Both you and the patient will likely agree on at least one thing: we all want to avoid another crisis. How will the patient do this?

Firstly, if the patient meets criteria for BPD, share this with them. So often we are 'afriad' that the patient may reject this diagnosis and impact rapport so we go about treating them without actually naming what it is they struggle with.

When we take time to educate the patient on the diagnosis, we give them something to understand as a diagnosis so that we can move on to discussions about management and treatment together, from the same place of understanding.

Take time to reflect on the last crisis. What happened? Where were they and who were they with? Were there any signs that told them a crisis was about to hit?

Some in office counselling can be effective, however more rigorous outpatient Dialectical Behavioral Therapy is the gold standard, especially for a patient that is appropriately help-seeking, DBT is similar to CBT and mindfulness.

It has 4 main domains including:

- emotional regulation,
- interpersonal effectiveness,
- mindfulness, and

- distress tolerance.

If the patient cannot get into a treatment like this soon, you can work on some skills in the office or refer them to a book.

The DBT skills training manual written by Marsha Linehan is linked in the show notes. We have also linked some websites that your patients can refer to with dbt skills.

It is important to make a crisis management plan with the patient. This involves filling out a contract with the patient that outlines previous crisis duration, frequency, triggers, and behaviours during that crisis.

It also elaborates on safety concerns such as self harm, suicidality, or safety for others. It plans who the person will contact during a crisis both within and outside of the house with a planned response. It has a section for indications for admission.

For various situations, there is a clearly outlined intervention for response. This should be filled out with the patient and ideally someone else close to them such as a parent, partner, or friend. They should all have a copy.

We have linked a template that you may consider using in the show notes. Once you and the patient have completed the crisis management plan, encourage them to hang this in a visible place that they will see daily. Reiterate that the plan will work IF the patient works it.

Medications can be helpful, but are not the mainstay of treatment. They can be used to treat comorbid disorders such as anxiety and depression, or for certain symptom clusters. Use them judiciously and avoid polypharmacy.

For example, if a patient's prominent symptoms are depression, interpersonal sensitivity, impulsivity, and aggression, SSRIs are first line with the most evidence in Sertraline up to doses of 200 mg. A mood stabiliser can be used to augment.

If the prominent symptoms are mood lability, impulsivity, aggressiveness, and there is a family history of bipolar disorder, mood stabilizers such also valproic acid, carbamazepine, or lithium are first line. Similarly, an SSRI can be used to augment this.

FInally, if the most prominent symptoms are paranoid, psychoticism, hostility, and anxiety; you can consider starting with an atypical antipsychotic such as quetiapine (doses are less than that used in patients with schizophrenia). This can be augmented with an SSRI or mood stabilizer.

Again, avoid polypharmacy and continue to reassess the meds. If you're considering medication augmentation with anti-psychotics, it might be best to get a psychiatry consult for management. Always remember, in patients with impulsivity, and especially those with history of OD attempts, weekly prescribing may be necessary.

Of course, it is also important to treat any comorbid psychiatric disorders.

Common comorbidities for BPD include:
- depression,
- anxiety,
- eating disorders,
- addiction and
- suicidality.

Of course, treating the BPD can help alleviate many of these comorbidities, but other medications and counselling may also be useful. Please refer to all the relevant podcasts including depression, anxiety, and eating disorders for more on that!

Now, suppose you were just referred to a new patient to see by a colleague. There is a big red flag in the chart bolded in red: antisocial personality beware. How do you approach this case?

You get shivers down your spine and panic thinking about the interaction to come. All the preconceived assumptions of this patient cross your mind: they must be a criminal, they probably use drugs, they will be abusive to me.

Allow these thoughts to pass but again, take a deep breath. It is important to assess this for yourself. Not every patient labeled with a personality disorder actually has a personality disorder.

Maybe this other physician had a poor relationship with the patient, or has a personality disorder themselves.

Maybe it was a label they were given in their teen years and has just followed them around.

These labels have big repercussions and should not be used lightly. Think about the way you felt when you heard this. If this is not accurate, it is important that patients are not seeing doctors who already have a negative attitude towards them before even meeting them.

Before labelling someone with a personality disorder, it is important to consider other differentials that could contribute to their behaviour. Remember, as we mentioned before, personality disorders are long standing and pervasive.

They should not be suspected if there is a sudden shift in character. Instead, consider an adjustment reaction, especially if the patient has recently experienced a life altering event such as the loss of a loved one or is a new partner. Consider other psychiatric mood or anxiety disorders.

Substance use is another important consideration.

Neurological disorders may present with character shifts, for example, if there was a recent stroke or traumatic brain injury involving fronto-temporal lobes. Consider imaging these patients if the history is suggestive of this or if they are over 50 years old.

Consider medications they are using. Similar to substance use, certain medications like stimulants or steroids can alter aspects of a person's behavior.

Finally, consider medical disorders. Similar to when you begin the workup for a patient with a mood or anxiety disorder, it is important to rule out simple reversible causes including thyroid dysfunction, arrhythmias, diabetes, or hypoglycemia. Consider ordering an ECG, CBC, electrolytes, TSH, and glucose/HbA1C.

Unfortunately we weren't able to cover much regarding the treatment and diagnosis of cluster A and cluster C personalities.

In brief, cluster A personalities are challenging to treat because often, they do not want to change. However, due to he relationship with schizophrenia, it is believed that the dopaminergic pathway may be involved. Thus, there is some evidence that antipsychotics such as risperidone can be helpful in patients seeking treatment.

Ultimately, maintain a professional stance with these patients. Provide clear explanation and rationale. Avoid over involvement in social and personal issues. Tolerate any behaviours you may perceive as odd. Paranoid patients may need extra reassurance and provision of evidence. Show them their lab results, for example.

Cluster C personalities have a lot of overlap with anxiety disorders, and thus can be treated as such. Provide reassurance, validate their concerns. Be thorough, especially for those with OCPD. CBT can be beneficial for these patients, as often they do express interest in changing.

We have linked AAFP's personality disorder article in the show notes which has fantastic tables outlining the treatment of these conditions.

You have had a heck of a week but are proud of the way you have handled all the challenging situations. You have a 23 year old female named Sarah scheduled. She has a history of an eating disorder and self harm in addition to a traumatic childhood. Fortunately, together, you recognized these early and she put in the hard work to change by attending a year of DBT. She has been quite well for 2 years, but presents as downcast and tearful today.

Your first thought is that the DBT didn't actually work, but then you remind yourself, the risk factors for personality disorders are very similar to those of depression and they commonly co-occur.

In fact, they should commonly be screened for as 83% of those with borderline personality disorders also report depression. It is also important to remember that schizotypal personality disorders have genetic similarities to schizophrenia and this should be monitored for.

Unfortunately, it can be very difficult to distinguish between a mood disorder and personality disorder due to the dysregulation of emotions. For example, those with borderline personality

disorder may have chronic suicidality and self-harming behaviours while those with avoidant personalities may have socially anxious tendencies.

Why is it so important to differentiate between personality disorders and mood disorders anyways?

It is because the treatment may differ. Medications will not change someone's personality, but they may help the way the person feels. Personality disorders are most effectively treated through psychotherapy. If personalities are mislabeled as mood disorders, they may not receive the psychotherapy that is most helpful.

However, if those with personality disorders also have an unrecognised mood disorder, they may not receive quality of life improving medication.

How can we tell if it is a personality disorder or a co-morbid mood disorder?

The short answer is there is no good way.

The long answer is through careful assessment and sometimes trial and error

Using borderline personality disorder as an example, the depressive symptoms occurring as a part of borderline personality disorder are often transient and related to interpersonal stress, quickly resolving once the stress is gone.

The “depression” is often a result of maladaptive ways they communicate their dissatisfaction with a situation. Antidepressants will not fix this. MDD requires a person to meet the DSM V criteria for MDD, including these feelings to be present for 2+ weeks.

Another differentiating factor is the timecourse. Personality disorders are pervasive and longitudinal. Although mood disorders can be chronic, they are usually episodic. Remember to obtain collateral with the patients content because friends and family may be able to better tell you if this is a change from their baseline.

Ultimately there is a fine line between the two, and sometimes it is easier to differentiate them than in others. Always resort back to the DSM V criteria if you are stuck. Also remember, we treat patients, not diagnosis.

The NICE clinical guidelines suggest that those with borderline personality disorder should not use medication specifically for the borderline personality or individual symptoms associated with the disorder.

However, they suggest that pharmacologic treatment may reduce symptoms of anger, anxiety, depression, hostility, and impulsivity. We have linked the CANMAT recommendations for treating concurrent personality and mood disorders in the show notes,

If you believe your patient has both a personality disorder and a mood disorder, then feel comfortable treating both. Remember that personality disorders may make treatment of mood disorders more complicated by impacting the development of therapeutic alliance, adherence to treatment, self-harm, and substance use.

At this time, there are no clear guidelines on whether a sequential or concurrent approach is better, so work with the patient to find out which is best. Please refer to our episodes on anxiety and depression to learn more about the diagnosis and treatment of these comorbidities.

So, back to our case. You feel pretty lucky because you have known Sarah for so long and have seen her improve so much to recognize that this is a change from her baseline. You learn that she has felt this way on and off for the past 5 months since graduating, for up to 3 weeks at a time. She has been looking for a job with no success. While she acknowledges this is normal, she feels guilty everyday because she is not doing enough.

This has impacted her sleep and she has lost 10 lbs because she had not been able to eat. She does not feel suicidal, but she admits her mood is very low and she expressed no interest her the activities she used to enjoy. You are happy to find out she still has regular appointments with her counsellor.

You suggest lifestyle changes she can make, and learn she has done her best to implement them as she learned these in therapy. You decide together to start her on an SSRI. After 2 months, she thanks you. She has not yet found a job, but she is much more motivated to look for one.

Personality disorders are not only challenging to treat, they can pose challenges to establishing a therapeutic alliance with your patient. Your own personality can affect the way a patient acts and vice versa. Remember, keep the big picture in mind: what is the patient there for. Stay calm. Set boundaries. Keep yourself safe.

References

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https://medfam.umontreal.ca/wp-content/uploads/sites/16/CANMAT_Comorbidity_Mood-Disorders-and-Personality-20121.pdf

A guide for families: https://www.camh.ca/-/media/files/guides-and-publications/borderline-guide-en.pdf

DBT tools for patients
https://dbt.tools/index.php
https://ilovedbt.wordpress.com/

Crisis management plan:
https://www.spectrumbpd.com.au/images/BPD_Crisis_plan_template_NHMRC.pdf

DBT skills training manual:
https://behavioraltech.org/store/books/dbt-skills-training-manual-second-edition/

Patient resources:
BC Partners for Mental Health and Addictions Information
Visit www.heretohelp.bc.ca for the Managing Mental Illnesses series, more info sheets and personal stories about personality disorders. You'll find information, tips and self-tests to help you understand mental health. You'll also find the Borderline Personality Disorder issue of Visions Journal.
Canadian Mental Health Association, BC Division
Visit www.cmha.bc.ca or call 1-800-555-8222 (toll-free in BC) or 604-688-3234 (in Greater Vancouver) for information and community resources.
Resources available in many languages:
*For each service below, if English is not your first language, say the name of your preferred language in English to be connected to an interpreter. More than 100 languages are available.
1-800-SUICIDE
If you are in distress or are worried about someone in distress who may hurt themselves, call 1-800-SUICIDE 24 hours a day to connect to a BC crisis line, without a wait or busy signal. That's 1-800-784-2433.
Alcohol & Drug Information and Referral Service
If you're concerned about your alcohol or drug use or concerned about some else's use, call the Alcohol and Drug Information and Referral Service at 1-800-663-1441 (toll-free in BC) or 604-660-9382 (in Greater Vancouver). This service is available seven days a week, 24 hours a day.
HealthLink BC
Call 811 or visit www.healthlinkbc.ca to access free, non-emergency health information for anyone in your family, including mental health information. Through 811, you can also speak to a registered nurse about symptoms you're worried about, or talk with a pharmacist about medication questions.
Crisis lines aren't only for people in crisis. You can call for information on local services or if you just need someone to talk to. If you are in distress, call 310-6789 (do not add 604, 778 or 250 before the number) 24 hours a day to connect to a BC crisis line, without a wait or

busy signal. The crisis lines linked in through 310-6789 have received advanced training in mental health issues and services by members of the BC Partners for Mental Health and Addictions Information.

Cluster A, characterized as "**mad / weird**", **odd or eccentric** personalities:

- Familial association with psychotic disorder
- Common defense mechanisms: intellectualization, projection, **magical thinking**

1. **paranoid** – pervasive distrust and suspiciousness of others
    - Risk Factors: family h/o schizophrenia & delusional d/o, paranoid type; child hood abuse, minority, immigrant, deaf
    - Approach:
        - Provide a formal, honest, and professional discussion without being too friendly, too warm, or too humorous.
        - Physicians should expect belittling comments, accusations, and potentially litigious threats from these patients, yet they should allow these patients to express grievances without confirming or confronting the paranoid beliefs.
    - Tx: CBT & insight-oriented counselling
    - Meds: low dose antipsychotics, SSRI (if comorbid depression, OCD, or agoraphobia)
2. **schizoid**– detachment from social relationships
    - Risk Factor: male, family h/o schizophrenia, troubled family relationships
    - Approach: Adapt a professional stance, provide clear explanations, tolerate odd beliefs and behaviors, and avoid over involvement in the patient's personal or social issues.
    - Tx of choice = insight psychotherapy
    - Tx: supportive therapy: ID emotions
    - Meds: antipsychotics, antidepressants, psychostimulants
3. **schizotypal** – acute discomfort with and reduced capacity for close relationships, as well as cognitive or perceptual distortions and behavioral eccentricities
    - Risk Factors: relative with schizophrenia, genetic (monozygotic >dizygotic twin)
    - Approach: Pt may have intense anxiety in social situations with unfamiliar people, it is important to establish a therapeutic relationship
    - Tx like residual schizophrenia
    - Tx: insight-oriented, supportive tx, milieu therapy
    - Meds: low dose neuroleptic (pimozide), haloperidol for eccentric thoughts

Cluster B, characterized as **"bad", dramatic, emotional, or erratic** personalities:

- Familial association with mood disorder
- Common defense mechanisms: denial, acting out, **regression** (histrionic), **splitting** (borderline), projective identification, idealization/devaluation

1. **antisocial** – disregard for and violation of the rights of others
    - associated with substance abuse, acute anxiety, delusional states, and factitious disorders

- Risk factors: familial, maternal depression, lower SES; abandonment or abuse, repeated harsh punishments; 100% conduct /o as child
- Approach:
  - This disorder may have social, legal, and financial implications; therefore, multiple treatment options must be considered.
  - Because of the risk of manipulative behaviors by the patient, the physician should use caution (especially in dealing with new, ill-defined illnesses), be fair and consistent, and set clear limits
- Tx: CBT
- Assess spousal/child abuse, drunk driving

2. **borderline**– instability of interpersonal relationships and self-image, with marked impulsivity
   - Risk factors: childhood abuse / neglect, abandonment; 5x ↑ if d/o present in 1° relative
   - Approach:
     - second-generation antipsychotics, mood stabilizers, and dietary supplementation with omega-3 fatty acids have some beneficial effects
     - Avoid excessive familiarity with these patients because it can lead to mistrust
     - Understand that although angry outbursts may occur, limits must be set, a venue for frequent follow-up (e.g., telephone or office visits) must be created, and clear explanations without technical jargon must be provided
   - Tx: CBT
   - Meds: SSRIs (aggression/anger), low-dose antipsychotics (impulsivity & psychotic episodes)
   - Assess suicide risk often
3. **histrionic** – excessive emotionality and attention-seeking behavior
   - Risk factors: pt often seek Tx, but are emotionally needy & hesitant to stop therapy
   - Approach:
     - Pt require empathy with boundary setting to limit potentially manipulative behaviors, such as suicidal gestures
     - Emphasizing objective data while maintaining a professional concern for the patient's feelings and emotions may be helpful
   - Tx: insight-oriented psychotherapy
   - Meds: SSRIs – aware pt can use it to OD
   - Assess suicide risk
4. **narcissistic**– grandiosity, need for admiration, and lack of empathy
   - Risk Factors: childhood abuse & neglect
   - Approach:
     - focus on concrete points and attempt to channel patient traits into improving their health (demanding, with an attitude of entitlement and "specialness)
     - acknowledge that the patient's behavior is protective of his or her sense of internal control and self-esteem
     - constructive criticism to patients with narcissistic personality disorder should be carefully worded, because these patients may interpret this as humiliating or degrading and react with disdain, or they may counteract
   - Tx: CBT

- Meds: SSRI (impulsivity or depression), mood stabilizers (impulse or bipolar)

Cluster C disorders, characterized as “**sad”, anxious or fearful**, are more prevalent:

- Familial association with anxiety disorder
- Common defense mechanisms: isolation, avoidance, hypochondriasis

1. **Avoidant** – social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation\
    - Risk Factors: childhood abuse or neglect
    - Approach:
        - Pt routinely respond to direct questions with “I’m not sure,” and may seem evasive.
        - Encouraging the patient in a nonjudgmental manner to report symptoms and validating the patient’s concerns are helpful
    - Tx of choice: individual psychotherapy – improve self-esteem
    - Tx: behavioural therapy
    - Meds: MAOI, beta-blocker, stimulant
2. **Dependent** – submissive and clinging behavior, and fears of separation
    - Risk Factors: chronic physical illness in childhood or separation anxiety d/o, early childhood parental loss
    - Approach: Provide reassurance and schedule routine follow-up (e.g., telephone or office visits) with the understanding that the patient may feel that urgent evaluations are necessary based on his or her sense of need, rather than on the medical necessity of the situation
    - Tx of choice: insight-oriented CBT
    - Tx: anxiety management, assertive training
    - Tx: Set Limits
    - Meds: TCA, MAOI, **BDZ** for s/sx
    - relatively favourable prognosis
3. **obsessive-compulsive** – preoccupation with orderliness, perfectionism, and mental and interpersonal contro
    - **OCD** the symptoms are **ego-dystonic** (i.e. the patient realizes the obsessions are not reasonable) whereas in **OCPD** the symptoms are **ego-syntonic** (i.e. consistent with the patient’s way of thinking).
    - Risk Factors: genetic: monozygotic > dizygotic, 1° with OCD or Tourette syndrome
    - Approach:
        - Be thorough with examinations and explanations, but should not focus on variables or uncertainties.
        - Psychotherapeutic therapies, including short-term inpatient therapy, have been successful
        - Treatment with SSRI may be helpful, especially if anxiety is present
    - Tx: CBT, r/o coexisting Tourette syndrome
    - Meds: SSRI or clomipramine

5 When seeing a patient whom others have previously identified as having a personality disorder, evaluate the person yourself because the diagnosis may be wrong and the label has significant repercussions. (DSM5)

Paranoid Personality Disorder

Pervasive distrust and suspiciousness of others, interpret motives as malevolent (blame problems on others); Dx req ≥ 4 **SUSPECT**

- **S**pousal infidelity suspected, without justification
- **U**nforgiving – persistently holds grudges
- **S**uspicious – Suspects that others are exploiting or deceiving them
- **P**erceives attacks – not apparent to others and is quick to counterattack
- **E**nemy or friends? – **unjustified doubts** about trustworthiness of acquaintances
- **C**onfiding in others is feared – **Reluctant to confide** in others
- **T**hreats perceived in benign remarks

Schizoid Personality Disorder

Lifelong pattern of social withdrawal – neither desires nor enjoys close relationship, including being a part of a family, prefers to be alone. Dx req ≥ 4 **DISTANT**

- **D**etached or flattened affect – shows emotional **coldness**
- **I**ndifference to the praise or criticism of others
- **S**exual activity of little to no interest
- **T**asks done solitary – chooses solitary activities
- **A**bsence of close friend
- **N**either desire nor enjoys **close relationships**, including being part of a family
- **T**akes pleasure in few, if any, activities

Schizotypal Personality Disorder

Eccentric behaviours , peculiar thought patterns, dx req ≥ 5 **ME PECULIAR**

1. **M**agical Thinking – odd beliefs inconsistent with cultural norm
2. **E**xperience Unusual perceptions**,** including odily illusions
3. **P**aranoid ideation or suspiciousness
4. **E**ccentric behavior or appearance (involved in cults)
5. **C**onstricted or inappropriate affect
6. **U**nusual thinking and speech (e.g. vague, circumstantial, metaphorical, overelaborate, or stereotyped)
7. **L**ack of close friends or confidants other than first-degree relatives
8. **I**deas of reference (excluding delusions of reference)
9. **A**nxiety in social situations that does not diminish with familiarity
10. **R/o** psychotic or pervasive developmental d/o

Antisocial Personality Disorder

Violation of the rights of others occurring since age 15 years, as indicated by ≥3: **CORRUPT**

1. **C**an't conform to social norms / laws by committing unlawful acts
2. **O**bligations ignored – Irresponsibility, can't sustain work or honor financial obligations
3. **R**eckless disregard for safety of self or others
4. **R**emorseless, being indifferent to or rationalizing having hurt, mistreated, or stolen from others
5. **U**nderhanded – Deceitfulness**,** repeated lying, use of aliases, or conning others for personal gain
6. **P**lanning insufficient – Impulsivity or failure to plan ahead
7. **T**emper – Irritability and aggressiveness, repeated **physical fights or assaults**

B. The individual is at least age **18 years**.
C. There is evidence of **conduct disorder** with onset before age 15 years.

Borderline Personality Disorder

Instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood; dx ≥ 5 **DESPAIRER**

1. **D**isturbance of identity – Unstable self-image or sense of self
2. **E**motionally labile – Affective instability due to a marked reactivity of mood

3. **S**uicidal behavior, gestures, threats, or self-mutilating- recurrent – 10% suicide rate!
4. **P**aranoia or dissociation – transient, stress-related
5. **A**bandonment – Frantic efforts to avoid real or imagined abandonment
6. **I**mpulsivity: ≥2 areas that are self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
7. **R**elationships – Unstable – alternating between extremes of idealization and devaluation
8. **E**mptiness – chronic feeling
9. **R**age – Inappropriate, intense anger or difficulty controlling anger

Histrionic Personality Disorder

Excessive emotionality and attention seeking; dx ≥ 5 ACTRESSS

1. **A**ppearance focused – uses **physical appearance to draw attention** to self
2. **C**enter of attention – Not comfortable unless the center of attention
3. **T**heatrical – Shows self-dramatization and exaggerated expression of emotion
4. **R**elationships – Considers to be more intimate than they actually are
5. **E**asily influenced – Is suggestible by others or circumstances)
6. **S**exually seductive or provocative behavior – inappropriate
7. **S**hallow expression of emotions- rapidly shifting
8. **S**peech that is excessively impressionistic and lacking in detail

Narcissistic Personality Disorder

Grandiosity (in fantasy or behavior), need for admiration, and lack of empathy; ≥ 5: **GRANDIOSE**

1. **G**randiosity (e.g., exaggerates achievements and talents)
2. **R**equires excessive admiration / ATTENTION
3. **A**rrogant – haughty behaviors or attitudes
4. **N**eed to be "special" and should associate with, other special or high-status people
5. **D**ream of unlimited success**,** power, brilliance, beauty, or ideal love
6. **I**nterpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends)
7. **O**thers: **Lacks empathy**; is unwilling to recognize or identify with the feelings and needs of others
8. **S**ense of entitlement (i.e., unreasonable expectations of especially favorable treatment)
9. **Envious** of others or believes that others are envious of him or her

the generEHlist
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Avoidant Personality Disorder

Timid & socially awkward, Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation; ≥ 4: **CRINGES**

1. **C**riticism or rejection preoccupies thoughts in social situations
2. **R**estraint within intimate relationships because of the fear of being shamed or ridiculed
3. **I**nhibited in new interpersonal situations because of feelings of inadequacy
4. **N**eeds to be sure of being liked before engaging socially
5. **G**ets around occupational activities with need for interpersonal contacts
6. **E**mbarrassment prevents new activity or taking risks
7. **S**elf viewed as **socially inept**, personally unappealing, or inferior to others

Dependent Personality Disorder

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A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation; ≥ 5: **RELIANCE**

1. **R**eassurance required – **d**ifficulty making everyday decisions without an excessive amount of advice and reassurance from others
2. **E**xpressing disagreement difficulty – fear of loss of support or approval
3. **L**ife responsibilities assumed by others for most major areas of life
4. **I**nitiating projects difficulty or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
5. **A**lone – feel uncomfortable or helpless when alone because of exaggerated fears of being unable to care for oneself
6. **N**urturance – goes to excessive lengths support from others
7. **C**ompanionship sought urgently when a relationship ends
8. **E**xaggerated fears of being left to take care of onself

Obsessive-Compulsive Personality Disorder

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Preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency; ≥ 4: **SCRIMPER**

1. **S**tubborn & Rigidity
2. **C**annot discard worthless objects of no sentimental value
3. **R**ule obsessed – details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
4. **I**nflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
5. **M**iserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
6. **P**erfectionism that interferes with task completion
7. **E**xcessively devoted to work and productivity to the exclusion of leisure activities and friendships
8. **R**eluctant to delegate tasks or to work with others unless they submit to exactly his/her way of doing things