Personality and personality disorders

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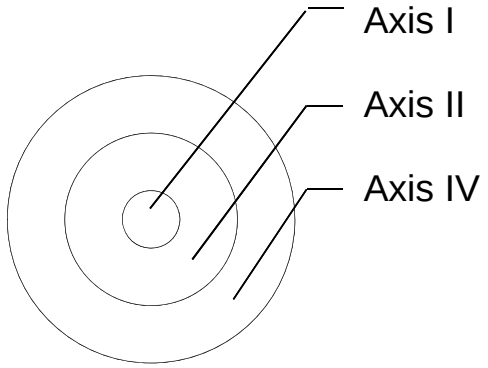


What is personality?

- A characteristic pattern of thoughts, feelings and behavior
- Or:
  - How you interpret experiences
  - Emotional and behavioral responses
- Personality:
  - Is dynamic
  - Is regulated by psycho-biological systems
  - Modulates adaptation to a changing internal and external environment

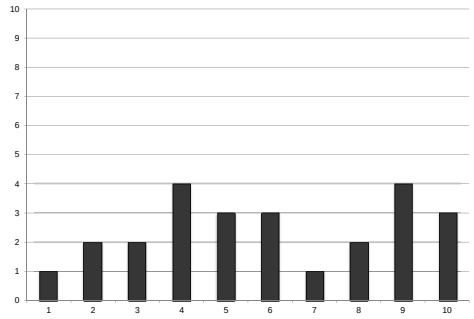
Personality

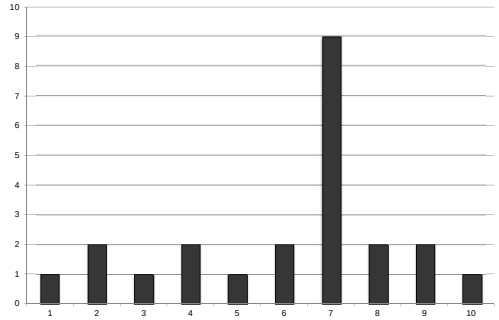
- Temperament:
  - The innate predisposition to behave in a particular manner, appears soon after birth
  - "Disposition of affect"
- Character:
  - Shaped by the interaction between temperament and experiences
  - "Disposition of will", representing values, attitudes and coping strategies

What is mental health?

- To be able to work, love and play
- To develop, to grow
- Maturity: self-directedness, cooperativeness, self-transcendence

What is a personality disorder?





Personality disorder

- **Distinguishing features:** a maladaptive pattern of responses to personal and social stress that are:
  - Stable and enduring since teens
  - Inflexible and pervasive
  - Causing subjective distress
  - Impaired work or social relations
- **Consistent features**:
  - Lack of foresight
  - Strong emotional reactions elicited from others
  - Efforts to blame and change others

An Axis I diagnosis is enough, e.g. in treating MDD. True?

- PD: 50 % of psychiatric patients, 10 – 20 % in the general population
- To see the patient as person - and not only her symptoms - helps to establish a therapeutic alliance and respect
- Knowing the personality can help to predict what other disorders are likely to occur
- Helps with treatment planning

The importance and place of personality assessment

- The assessment is very often neglected, often linked to an anxiety that a PD might be intractable, chronic
- Lack of proper care
- Personality disorders do change over time
- A substantial number of patients achieve full remission in the long term
- Natural course of recovery; can be accelerated by psychotherapy - years
- Treatment of co-morbid conditions might also lead to change

In any treatment assess

- Who is this patient?
- What personality traits are present? Three areas to assess are:
  - Life orientation: pleasure or pain?
  - Adaptation to environment: passive or active?
  - Interpersonal relations: detached, ambivalent, confused / disorganized vs. secure
- Is there a personality disorder? (18 years or older)
- How will his or her personality influence the treatment?

Option II

Specific types of PD

Mad	Weird	Odd, detached, aloof, eccentric	Paranoid Schizoid Schizotypal
Bad	Wonderful	Dramatic, impulsive, erratic	Antisocial Borderline Histrionic Narcissistic
Sad	Worried	Anxious, fearful	Avoidant Dependent Obsessive-compulsive

DSM-IV

- A categorical model: PD or not.
- A problem of this system is co-morbidity = it is possible to diagnose more than one PD in a patient.

- But it can be used in a dimensional way. How?
- By describing traits.
- Traits: a disposition to respond in a determined way to a specific situation, e.g. anxiousness, rejection, submissiveness, novelty seeking ….

A 1: Paranoid PD

1. Cognitive style: suspicious
2. Expressive behavior: defensive
3. Interpersonal conduct: lack confidence in others, provocative, ready to counter-attack which is linked to intense interpersonal sensitivity, induce hostility
4. Defense mechanisms: projection
5. Mood / temperament: grumpy, irritable
6. Self-image: inviolable, non-negotiable, absolute; because underlying to this they are easily hurt and their pride easily damaged

A 2: Schizoid PD

1. Cognitive style: socially indifferent
2. Expressive behavior: impassive, cold, reserved
3. Interpersonal conduct: unengaged, lacking interest in others
4. Defense mechanisms: intellectualization, withdrawal
5. Mood / temperament: apathetic, unemotional
6. Self-image: complacent

A 3: Schizotypal PD

Social and interpersonal deficits, discomfort and reduced capacity for close relationships.

1. Cognitive style: Autistic, unusual, peculiar, vague
2. Expressive behavior: Eccentric, odd
3. Interpersonal conduct: Secretive
4. Mood / temperament: Distraught
5. Psychotic symptoms: brief episodes; otherwise ideas of reference, unusual perceptual disturbances e.g. sensing the presence of others or illusions

B 1: Antisocial PD

1. Cognitive style: disagreeable, hostile, glibness
2. Expressive behavior: impulsive, reckless
3. Interpersonal conduct: irresponsible, manipulative, exploitative, can be charming
4. Defense mechanisms: acting out
5. Mood / temperament: callous
6. Self-image: autonomous

B 2: Borderline PD

1. Cognitive style: capricious
2. Expressive behavior: unstable in all aspects of life
3. Interpersonal conduct: paradoxical
4. Defense mechanisms: splitting, projective identification
5. Mood / temperament: labile
6. Self-image: uncertain, identity crisis

B 3: Histrionic PD

1. Cognitive style: flighty, impressionistic
2. Expressive behavior: dramatic, colorful, excessive emotionality, sexually provocative and seductive
3. Interpersonal conduct: attention seeking
4. Defense mechanisms: dissociation, exhibitionism
5. Mood / temperament: fickle
6. Self-image: gregarious

B. 4: Narcissistic PD

1. Cognitive style: expansive, grandiose
2. Expressive behavior: haughty, self-centered
3. Interpersonal conduct: exploitative, bored
4. Defense mechanisms: rationalization
5. Mood / temperament: unconcerned, anger and resentment if slighted
6. Self-image: admirable

C 1: Avoidant PD

1. Cognitive style: inhibited
2. Expressive behavior: ill at ease, shy
3. Interpersonal conduct: aversive
4. Defense mechanisms: fantasy, withdrawal
5. Mood / temperament: anguished
6. Self-image: alienated

C 3: Dependent PD

1. Cognitive style: naïve
2. Expressive behavior: incompetent
3. Interpersonal conduct: submissive
4. Defense mechanisms: somatization, regression
5. Mood / temperament: pacific
6. Self-image: inept

C 4: Obsessive-compulsive PD

1. Cognitive style: constricted, perfectionistic
2. Expressive behavior: disciplined, controlling, orderliness
3. Interpersonal conduct: respectful
4. Defense mechanisms: reaction formation
5. Mood / temperament: solemn
6. Self-image: conscientious

Antisocial, narcissistic and histrionic spectrum

- Shown to aggregate in the same family and to co-occur in the same person.
- Symptoms tend to group around impulsivity, aggression and dramatic effects.
- Antisocial behavior increases: histrionic (manipulation), narcissistic (exploitation), antisocial (crime).

Co-morbidity and problems

- NB: Co-morbidity is the norm!!

- Mood disorders
- Anxiety disorders
- Substance abuse
- Relationship problems
- Somatoform disorders
- Non-compliance

Management / treatment

Transference and counter-transference

- Transference
- Counter-transference:
  - Contribution of patient
  - Contribution of physician
- People with PD do not usually form good relationships with doctors or therapists.

The patient as person: treatment informed by the personality of the patient

Holistic treatment:

- Medication
- Psychotherapy
- Social intervention
- OT
- Lifestyle changes
- Addressing spiritual needs

The role of the GP in pts with PD

- Focus on the patient as person
- Does his personality negatively affect his Axis I or III disorder?
- Become aware of counter-transference
- Offer support and guidance for minor Axis II problems. Assess his strengths.
- Refer those with major personality problems.
- Assess symptoms, discuss whether medication could help

Pharmacotherapy for PD – main principles

- A co-morbid Axis I disorder obviously has to be treated
- In the absence of an Axis I disorder the use of medication is more controversial
- Keep in mind that the main treatment for PD is psychotherapy
- But: proper treatment of Axis I disorders can “dissolve” or improve many Axis II problems

The demanding patient

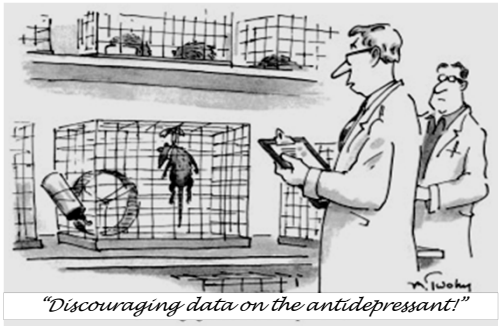
"I think the dosage needs adjusting. I'm not nearly as happy as the people in the ads."

Prescribing in the ***absence*** of an Axis I disorder

- Little evidence to guide prescribing for patients with PD
- The use of antipsychotics for years is worrying because of SE profile, and people with PD have a high rate of CV disorders
- Antidepressants work better for depression in those without a PD
- Limit the use of antidepressants to clinical depression
- Nonetheless: SSRI's or low dose antipsychotics do have their place in the treatment of many of these patients

Prescribing in the absence of an Axis I disorder - continued

- Borderline PD: mood stabilizers (valproate, lamotrigine and topiramate) and SGA might help. Flupentixol depot can also be of value. Antidepressants usually do not work
- Be aware of counter-transference feelings of negativity or helplessness or feeling overwhelmed
- Specialist clinics for PD prescribe less medication



"Discouraging data on the antidepressant!"

To conclude

It is of great importance to understand the patient as person, and in this:

- To attend to how you interact with this personality type, your counter-transference etc.
- To understand resistances to treatment that might surface
- To change you approach with this type of patient