



Disorders of Personality: Another layer in caring for those living with Dementia

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Personality Disorders

Diagnostic Criteria (DSM-IV-TR)

Enduring pattern of inner experience or behaviour that deviates markedly from the expectations of the individual's culture.



Personality Disorders

(Cont'd)

Manifested by 2↑ of the following:

- **Cognition** (ways of perceiving and interpreting self, others, and events)
- **Affectivity** (range, intensity, lability, appropriateness of response)
- **Interpersonal functioning**
- **Impulse control**



Diagnostic Criteria (Cont'd)

Pattern is inflexible and pervasive across a broad range of personal/social situations

Pattern leads to clinically significant distress/impairment in social, occupational, or other important areas of functioning



Diagnostic Criteria (Cont'd)

Pattern is stable and of long duration, traced back to at least adolescence

Pattern not better accounted for by another mental disorder

Not due to physiological effects of substance (drug abuse, medications) head trauma etc.



Alfred ADLER (1870 – 1937)

- Man is a “whole person” with own unique style of life
- Evaluates experiences, opportunities in relation to self
- Man strives for unachievable goals and failure produces irrational belief of inferiority
- Man inherently altruistic



Gordon ALLPORT (1897 – 1967)

- Specific “uncommon traits” in the general population – tied to behaviour
- Not biologically predisposed to develop these traits
- Traits – developed over time, relationships and experiences with environments
- “Mature personality”



Albert BANDURA (1925 -)

Development of Social Learning Theory

- Not necessary to experience a behaviour directly to learn it
- Observation of rewards and consequences
- Negative consequences serve as general deterrent
- School, law enforcement, youth caseworkers
- ?Genetic predisposition, emulating behaviour



Albert ELLIS

(1913 -)

Development of Rational Emotive Theory

- Man is rational and cognitive
- Rejects perspective controlled by environment
- If environmental stimuli misinterpreted, responds in irrational manner resulting in undesirable results
- Assessing viable alternatives – reacting in rational manner



Erik ERIKSON (1902 – 1994)

Recognition of developmental stages associated with socialization

- Interaction with social environment (parenting, school) instrumental in development of identity
- Roles adopted, subsequent experiences, successes, failures within social environment, precipitates self-identity
- As identity established, self-imposed expectations of success/failure; if unmet – view of identity is questioned and in crisis. If met – reinforced



Erich FROMM

(1900 – 1980)

Recognition of role of Society

- Lives within society, forced to accommodate relationship with society, not just personal needs, wants, desires
- Man's desires conflict with society's demands
- Adopt several characters to adapt to society – meeting needs etc. and submitting to society's demands



R. D. HARE

Provided empirical demonstration that psychopathy is physiologically precipitated.
Maturation Retardation Hypothesis

- EEGs on adult males diagnosed with Antisocial Personality Disorder, similar to those of normal adolescents
- Arrested development
- Cessation of characteristic behaviour without intervention



Karen HORNEY

(1855 – 1952)

Understanding relationship of fear,
anxiety to behaviour (anxiety &
neurosis)

- Disturbance in child's environment threatens perception of security; demonstrates displeasure d/t anxiety provoking experiences
- Adults reduce discomfort in anxiety-producing situations
- May move towards, away from, or against stimuli



Abraham MASLOW

(1908 – 1970)

Development of the “Hierarchy of Needs”

- Recognizes irrational drives of man: hunger, thirst, shelter, warmth. Must fulfill these needs before moving up the pyramid
- When expendable income spent on basic needs, desires go unmet and growth beyond 1st step not achieved
- Dissatisfaction increases when life compared to others’
- Naturally strives to achieve acceptance and growth.
- Inability to climb the hierarchy of needs precipitates strain



Ivan PAVLOV

(1949 – 1936)

Father of Behaviourism

- Following Darwinian principles of man's irrationality and response to environment
- Via research with animals, all behaviour is merely a reflex to environmental stimuli
- Limited to analysis of conditioned reflex as research of brain rather than focusing on learning



Jean PIAGET

(1896 – 1980)

Most widely accepted model of cognitive learning

- Charts through stages of cognitive development, identifies specific skills indicative of different levels of cognitive capacity
- Cognitive growth determined against established milestones; ascertains competencies
- Age is not relative to cognitive competency



B. F. SKINNER

(1904 – 1990)

All behaviour is learned

- Dismisses role of cognition, disease in behaviour
- Behaviour may be modified through rewards
- Little acknowledgement or interest in aetiology of behaviour (regardless of source), merely its modification



Neuro-Behavioural Model

Emotional Dysregulation (Affect, Anger)

Interpersonal Dysregulation (Rel'n,
Abandonment)

Self Dysregulation (I.D. disturbance, sense of self)

Behavioural Dysregulation (Para suicidal,
impulsivity – brakes – not on, fail, gas)

Cognitive Dysregulation (Paranoid)



Epidemiology

1-2% of general population, 11% 9-19y

Females more than males - 7:3

Up to 67% have Axis I Disorders (substance, eating d/o, psychosis)

Often co-occurs with Major Mood Disorder

Genetic (specific associations)

Environmental factors (Abuse pre age 18, trauma, neglect)



NARCISSISTIC PERSONALITY

Pervasive pattern of grandiosity

(fantasy/behaviour), need for admiration, and lack of empathy, beginning by early adulthood, present in variety of contexts, indicated by 5 or more of following:

Grandiose sense of self-importance

Preoccupied with fantasies of unlimited success,
power, brilliance, beauty, ideal love

Believes is special, unique, can only be understood by,
or associate with other special or high status people

Requires excessive admiration



NARCISSISTIC PERSONALITY

Has sense of entitlement (unreasonable expectations, favourable treatment, automatic compliance with wishes)

Is interpersonally exploitative (takes advantage of others to achieve his/her own ends)

Lacks empathy: unwilling to recognize/identify with feelings/needs of others

Often envious of others, or believes others envious of him

Shows arrogant, haughty behaviours or attitudes (p. 717)



Etiology/ Intervention

Combination of inheritable traits,
behavioural modeling, parenting

?Impossible to identify specific set of
precipitant variables

First degree biological relatives with same dx
– fathers

50% - 75% males

Learn nuances of behaviour, observes
rewards and consequences received and
emulates



Etiology/ Intervention

Flexible, more receptive to change –
modeling in reverse fashion

Systems: consistently applied consequences for inappropriate conduct; consequence personally meaningful. Will challenge boundaries and consistency in application of rewards/punishments



NARCISSISTIC PERSONALITIES SUMMARISED

- Frequently self-absorbed
- Have need for excessive admiration
- Lack empathy
- Grandiose sense of self-importance
- Believe are special and unique
- Have sense of entitlement – unreasonable expectations of especially favourable treatment or automatic compliance with their expectations

DEPENDENT PERSONALITY

Pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts, indicated by 5 or more of following

Difficulty making every day decisions without excessive reassurance and advise

Needs others to assume responsibility for most areas of life

Difficulty expressing disagreement with others; fear of loss of support/approval

Difficulty initiating projects/doing things on own



DEPENDENT PERSONALITY

Excessive lengths to obtain nurturance,
support from others (volunteers unpleasant things)

Uncomfortable, helpless when alone –fears

Seeks another relationship as source of care,
support when close relationship ends

Unrealistically preoccupied with fears of being left
alone to care for self (p. 725).

Etiology & Intervention

First degree biological relatives

Origin of disorder in parenting

- Father unable to care for self
- Mother provides all reassurance – reinforcing inadequacies
- Children learn by emulation – similar behaviours = same support, care etc. that father receives

Commonly found in clinical settings.

- Receptive to therapeutic intervention, however easily develops dependence on therapist



Dependent Personalities

Summarised

- **Extreme submissiveness** and dependence upon others for all decision-making and emotional support
- **Rely on others** to tell them how they should feel and tend to agree with others even when they believe them wrong

PARANOID PERSONALITY

Pervasive distrust and suspiciousness of others such that their motives interpreted as malevolent, beginning by early adulthood; present in a variety of contexts, indicated by 4 or more of the following

Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him

Preoccupied with unjustified doubts about loyalty or trustworthiness of friends

Reads hidden, demeaning, threatening meanings into benign remarks or events



Reluctant to confide in others owing to unwarranted fear that information will be used maliciously against him

Persistently bears grudges i.e. unforgiving of insults, injuries or slights

Perceives attacks on his character or reputation that are not apparent to others; quick to react angrily or counterattacks

Recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner
(p. 694)



Etiology & Course

Persons who have experienced racial, cultural, ethnic, gender discrimination – distrustful owing to experiences; Frowns v smiles

Distrustful particularly in competitive environments – blames, failure to succeed

Chronic state of mistrust forces strong independence = seething anger, hostility

Males

Poor candidates for therapeutic intervention owing to chronic mistrust of others



OBSESSIVE COMPULSIVE

Pervasive pattern of preoccupation with orderliness, perfectionism, mental and interpersonal control, at expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by at least 4 of the following

Preoccupied with details, rules, lists, orders, organization, schedules, major point of activity lost

Perfectionism that interferes with task completion (standards not met)

Excessively devoted to work, productivity to exclusion of leisure activities, friendships (0 \$)



OBSESSIVE COMPULSIVE

Over conscientious, scrupulous, and inflexible about matters of morality, ethics or values

Unable to discard worn out, worthless objects (no sentimental value)

Reluctant to delegate tasks or work with others unless submit to exactly his way of doing things

Miserly spending style towards self and others; money viewed as something to be hoarded for future catastrophies

Rigidity stubbornness (p. 729)



Etiology & Intervention

Nurtured in environment with dominant person with the disorder

Males diagnosed x2 rate of females

Family dominated by person with disorder

Manifests in late adolescence and young adulthood

Chronic, lifelong

Rigidity, stubbornness reduces possibility of successful therapeutic intervention



BORDERLINE PERSONALITY

Pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood, present in variety of contexts, indicated by 5 of following.

Frantic efforts to avoid real/imagined abandonment

Pattern of unstable, intense interpersonal relationships characterized by alternating idealization and devaluation

Identity disturbance: markedly and persistently unstable self image or sense of self

Impulsivity in 2 of: spending, sex, substance abuse, reckless driving, binge eating



BORDERLINE PERSONALITY

Recurrent suicidal behaviour, gestures, threats;
or self-mutilating behaviours

Affective instability due to a marked reactivity of
mood (intense episodic dysphoria, irritability, anxiety
usually lasting for few hrs, not more than few days)

Chronic feelings of emptiness

Inappropriate, intense anger/difficulty controlling
anger: frequent display of temper, constant anger,
physical fights

Transient stress-related paranoid ideation or
severe dissociative symptoms



Etiology & Course

5x more common in 1^o biological relatives

Research – serotonin (aggression, impulsivity)

- Sustained child abuse = ↓serotonin

75% found in females

Nature v nurture

- Nature (hormones, females of mother)
- Nurture (direct behaviour, emulated behaviours)

Treatment: Foll. Suicide attempts/aggression -

↓ with age, pharmacological, counselling



Borderline Personalities Summarised

- Mood extremes
- Poor self-image
- Unable to maintain relationships
- Impulsive, suicidal threats common



PASSIVE-AGGRESSIVE PERSONALITIES

Resist, in an underhanded way, the demands made on them for adequate performance at work or in social situations

Procrastinators, become sulky, argumentative

Seem to work deliberately slowly

Believe themselves to be doing a much better job than others think



DISORDERED PERSONALITIES: Main Features

- Maladaptive behaviour as a lifestyle
- Inflexibility in dealing with others
- Chronic personal problems
- Multiple physical, interpersonal, and social problems
- Lifelong inability to accept responsibility for, and consequences of, their own behaviour



DEFINITION

Flaw in characters that allows them to react to, and interact with, the world in a manner that is not quite normal. As a result, it is difficult for them to live fulfilling, happy lives.



Questions worth considering

What works best for you when interacting with difficult people? Worse way?

Have you ever been considered a difficult person? If so, why? How was the situation resolved?



Treatment & Management

Reverse remediable organic factors – neuro exam, CT, u/a, cbc, EKG, chemistry etc. (CNS tumours, stroke, temporal lobe disease)

Pharmacotherapies

Neuroleptics, A/D, Lithium, Anxiolytics, Omega-3 acid

Psychotherapies

Ward management (Staff/Patient/Family issues)

General Considerations



Limit Setting

Ensure that expectations are known. Care plan goals and approaches have to be very specific, very clearly defined, with little opportunity for misinterpretation.

Place the responsibility where it belongs

Ensure that choices are known and define consequences. Areas of choice should be clearly specified and clearly communicated

Keep limits clear, specific, and concise

Keep limits reasonable and enforceable

- Can I use it?
- Am I willing to use it?
- How will it be enforced?



Survival of the Fittest

Recognize that they will not change.

There are no pills that can erase or repair childhood trauma or genetic predisposition at the root of a personality disorder.

Do not take things personally

Recognize your own limitations



GUIDELINES

Efforts directed towards problem solving vs.
taking care of a difficult/problem person

Prepare in advance (DB and assertiveness)

Practice custom-designed methods

De-escalate by modeling

Know yourself and triggers for emotional response

Take responsibility for own feelings

Acknowledge others' feelings

Seek temporary way out



SUMMARY

Personality disorders are pervasive, life long patterns of perceiving, relating to, and thinking about others that cause significant functional impairment and/or subjective distress

Since people with personality disorders cope rigidly with living, they are vulnerable to breaking under stress. The losses, role changes, and dependency that come with ageing make adapting particularly difficult for these persons



Summary (Cont'd)

Personality disorders may coexist with and complicate the diagnosis and management of other psychiatric disorders

The demands of institutional living cause ingrained behavioural patterns to surface and because they are unaware of their contribution to their problems, they may blame others.



Summary (Cont'd)

If the powerful impact of these behavioural patterns is not understood, it may interfere with clinical judgment, team functioning, and the person's care

Setting realistic treatment goals involves accepting the person's limitations and working within those limitations to promote the optimal co-existence of the person with others



**Working with the
person diagnosed with a
disordered personality
is extremely
challenging!**



QUESTIONS

