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A Review on the Second Group of Personality disorders.

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ABSTRACT

When we talk about personality disorders, we mean certain maladaptive patterns of inner experience or behavior that occur constantly in different environments and vary from the culture. They also have affected the cognition of the patient. The American Psychiatric Association has published the criteria for diagnosing personality disorders. According to the DSM-V criteria, personality disorders are among other mental disorders that are varied behaviors from normal social standards. The way that affected people might experience emotions, or handle relationships and social situations are different than others. Their prevalence is very high and is comorbid with many other psychiatric disorders. Personality disorders are classified into three main subtypes and each subtype has its own characteristics. Patients with any of these personality disorders are often diagnosed with several other subtypes. This review article will generally define main characteristics of schizotypal personality disorder along with their second type and explains their specifications, diagnose and treatment is a simple and understandable matter.

Keywords: Personality disorder, schizotype, Review

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Schizotypal Personality Disorder

These people look like eccentric due to style of thinking, behavior, communication with others and clothing. They detach from others and are isolated. They are rather attracted to internal stimuli than environmental stimuli [1]. They rather react to internal stimuli than environmental stimuli. For this purpose, their thoughts and statements are not coherent [2]. They are absent-minded and do not stick to one point and move on from one subject to another when communicating with others [3]. Their excitement is not consistent with emotional stimuli. They considerably believe in telepathy and clairvoyance. They are skeptical to others. They have ideas of reference (e.g., they have incorrect interpretations of casual incidents and external events as having a particular and unusual meaning specifically for the person [4-6]. If two cops were speaking to each other in the street, the schizotypal patient believe that the two cops were speaking behind his back because the two were looking at him or indicating him) [3,7]. People with this disorder may be unusually superstitious or preoccupied with paranormal phenomena that are outside the norms of their subculture [8]. They feel uneasy beside anyone. For this purpose, they do not have a close relationship with others [2, 3]. They make stories to respond to a simple question and often give eccentric responses. They speak of a perceptual experience as an illusion [6]. They feel they have metaphysical powers. For example, they say they can see what will happen in other places. They fancy that such metaphysical powers as telepathy and clairvoyance can help them and keep them out of danger when they fell socially anxious [4,6].

Diagnostic Criteria

Schizotypal personality disorder diagnostic criteria include disability and impairment in social and interpersonal relationships, usually associated with dissatisfaction or little ability to establish relationships and eccentric behavior and perceptual distortion. This disorder is characterized by with five of the following items [9-12].:

1- Ideas of reference (excluding delusions of reference (believing that the behavior of others or a random subject or event refers to them)
2- Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or “sixth sense”;
3- Unusual perceptual experiences, including bodily illusions
4- Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
5- Suspiciousness or paranoid ideation
6- Inappropriate or constricted affect
7- Behavior or appearance that is odd, eccentric, or peculiar
8- Lack of close friends or confidants other than first-degree relatives
9- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

Treatment

Supportive psychotherapy with an emphasis on communication with others, close relationships and identifying emotions may be helpful [7].

Group therapy may be useful. Environmental therapy may be helpful for some patients [13].

Pharmacotherapy: Some antidepressants, mental stimuli or low dose anti-psychotic may be effective. The patients may leave treatment since close relationships threaten them [8].

Group II Personality Disorders

They have excessive emotional thinking or relationships:

Antisocial Personality Disorder

Antisocial personality disorder is characterized by persistent anti-social and criminal behavior but not as a criminal. Nevertheless, the patient cannot conform to social norms [4, 7].

This disorder was more studied more than other disorders due to broad impact on public safety and economic well-being of society. The prevalence of this disorder is 3% among men and 1% among women. This disorder is mostly observed among nomadic inhabitants of urban impoverished areas. This disorder is more common among boys than girls. The disorder begins before age 15. The prevalence of this disorder among prisoners may be up to 75 percent. Prevalence of this disorder is five times greater in the first-degree relatives [2, 5, 14].

Diagnosis

According to (DSM-IV-TR) criteria, antisocial personality disorder is diagnosed when a person's pattern of antisocial behavior has occurred since age 15 and consists of the majority of these symptoms [15-17]:

1- Failure to conform to social norms
2- Deceitfulness
3- Impulsivity
4- Irritability and aggressiveness
5- Reckless disregard for safety of self or others
6- Consistent irresponsibility
7- Lack of remorse

Minimum age is 18 years. Evidence of behavioral disorder begins before age 15 [16].

Treatment

Antisocial personality disorder treatment is very challenging. In fact, there is no special treatment for this disorder. Antisocial personality disorder is a chronic disease; as a result, long-term treatment in needed to treat this disorder. Other conditions caused by the disorder, such as depression, anxiety and thyroid disorders should be treated too [17, 18].

There are several options for antisocial personality disorder treatment [19-22]:

1- Psychotherapy
2- Stress and anger management skills
3- Pharmacotherapy
4- Hospitalization

The best option for treatment depends on severity of the patient's state and symptoms [21].

Antisocial character will be more motivated to change when he finds himself among the same people. For this purpose, self-help groups have been more useful than imprisonment and mental hospitals [23].

Pharmacotherapy is used to deal with such debilitating symptoms as anxiety, depression or anger. The medications should be prescribed with caution because these patients often suffer from drug abuse [6].

Individual Psychotherapy

Antisocial personality disorder treatment is very difficult. While several methods have been proposed, there have been few control studies. Individual psychotherapy is the best treatment. Earlier intervention (during

childhood) is associated with more satisfactory results. The psychologists generally agree that insight-based approaches (such as psychoanalysis approach) should be avoided. Instead, positive reinforcement approach, reality-based approach, objective interventions, anger control and other cognitive-behavioral techniques should be used. The primary focus of treatment is based on the patient's aggression [22-25].

Psychotherapy involves a number of methods.

Cognitive Behavioral Therapy

This method is a combination of cognitive therapy and behavioral therapy, which eliminates and replaces negative and unhealthy beliefs and behaviors with healthy and positive beliefs and behaviors [26].

Psychodynamic Psychotherapy

This type of therapy is based on psychoanalysis. It is focused on raising awareness of unconscious thoughts and behavior and creates a new insight [27].

Psychoeducation

The patient, his family and friends are given instructions about the disorder and relevant issues and coping strategies and solutions to this type of treatment [28].

Anger and Stress Management

Group Therapy

Patients with antisocial disorder may discuss with the group leader and want to take control of the group. Group therapy is an exceptional condition for independence, intimacy and group involvement. In this kind of treatment, the patients learn about relationships. Family therapy or couples therapy were also found effective [29,30].

Anti-social characters lose motivation for change in presence of similar individuals. For this purpose, self-help groups have been more useful than imprisonment and mental hospitals [31].

Pharmacotherapy

No special treatment is approved by the FDA for treatment of antisocial personality disorder. However, several types of medications can be effective in reducing symptoms [12, 26, 32].

1- Anti-Depressant Medications: antidepressants can effectively reduce such symptoms as depression, frustration, irritability, strictness.
2- Mood Stabilizing Medications: these medications are prescribed to stabilize mood in the patients as the name of these medications suggests.
3- Anti-Anxiety Medications: These medications effectively improve anxiety, restlessness and insomnia. However, these medications cause rebellious and impulsive behaviors in some cases.
4- Anti-Psychotic Medications: These medications are used to treat psychosis and are prescribed to reduce anxiety and anger in some cases.

Hospitalization and Patient Care

In some cases, the symptoms may be so severe that need special care. Usually, the patient is only hospitalized when he is not able to take care of himself or may harm himself and others. Patient care should be 240hours hospitalization. The patient may be hospitalized for several hours daily. The patient may be hospitalized at home [33].

Borderline Personality Disorder

Patients with this disorder lie on a border between neurosis and psychosis. This disorder is characterized by excessive volatility of emotion, mood, behavior, relationships with objects and self-visualization. This disorder is more common in women. Three patients are women among four patients with borderline personality disorder. People with this disorder have distorted and unstable self-image or sense of self and unstable relationships. They usually have a pattern of intense and stormy relationships with family, friends, and loved ones, often veering from extreme closeness and love (idealization) to extreme dislike or anger (devaluation). Extreme anger and signs of emotional instability and frequent acts of suicide are important characteristics of this disorder. Their emotional instability is associated with high levels of impulsivity, which often leads to self-destructing behaviors such as "reckless driving". Suicidal acts are often deceptively are clinical representation of the disorder. However, these measures are not always deceptive. Self-harming is another characteristic of this disorder. Self-harming behaviors usually free the patients from anxiety or boredom. Main symptoms of borderline personality disorder are as follows. An individual with five of the following symptoms has this disorder [34-38].

- Extreme reactions—including panic, depression, rage, or frantic actions—to abandonment, whether real or perceived
- A pattern of intense and stormy relationships with family, friends, and loved ones, often veering from extreme closeness and love (idealization) to extreme dislike or anger (devaluation)
- Apparent and pervasive distorted and unstable self-image or sense of self
- Impulsiveness at least in two potential fields, which is self-harming (such as spending sprees, substance abuse, reckless driving, and binge eating
- Recurring suicidal behaviors or threats or self-harming behavior, such as cutting
- Intense and highly changeable moods (e.g. a period of intense boredom, irritability, or anxiety, which usually lasts a few hours and only in rare cases will remain stable over the next few days)
- Inappropriate, intense anger or problems controlling anger
- Having stress-related paranoid thoughts or severe dissociative symptoms

These people are very sensitive to environmental conditions. They suffer from intense fears of rejection and abandonment and inappropriate anger even when they experience a realistic short break or when changes are unavoidable in the plan [35, 38].

People with this disorder potentially tend to self-harming behavior in at least two areas. They show impulsivity. They gamble. They spend extravagantly. They eat too much. They tend to substance and unsafe sex abuse. They drive recklessly. People with "borderline personality disorder" show repeated suicidal behavior, self-harming and self-threatening behaviors [39, 40].

Causes of Borderline Personality Disorder

The cause of the disease is probably genetic backgrounds and childhood experiences. Unhappy childhood experiences, rejecting the child, instability of the mother or nurse and insecure attachment in the first three years of growth are root causes of the disorder [41,42].

Borderline Personality Disorder Treatment

Psychotherapy

"Psychotherapy" is selected for treatment. Likewise, it is difficult for the patient and therapist. This is because the patient is instable and impulsive (instantaneous) and uses a "splitting" defense mechanism (a mechanism that causes borderline personality to alternatively like or dislikes the therapist or other people)

Behavioral Therapy is effective, especially social skills training with videotapes according to which the patient observes how his behaviors affect others. In addition to individual psychotherapy, group therapy is also beneficial [43-47].

Pharmacotherapy

To obtain better results, "pharmacotherapy" is used in addition to "psychotherapy". "Antipsychotic" medications are used to control anger and hostility and transient psychotic episodes while "antidepressant" medications are used to improve the patient's mood. "Anticonvulsants" and "Lithium carbonate" are also used. Psychiatrists should prescribe these medications [48-53].

Personality Disorder

The patients with histrionic personality disorder (HPD) are irritable and emotional. They show vivid, dramatic and extrovert behaviors [54]. Despite flamboyant and flashy behaviors, they often cannot establish long-term relationships. These patients believe that they are similar to superstars. They want to be the ostentatious star in a group and try to be the center of attention using charm, visual appeal, and seduction and coquetry. Their excitements and passionate relationships are often shallow and constantly changing [55, 56]. They boast about being shareholders of large organizations or having sports skills [57]. They try to attract others' attention. Their habits and attitudes are easily influenced by others or the role they are currently playing. They rapidly establish intimate and passionate relationships but quickly get tired of them and feel they were not appreciated [58].

Diagnosis

The patients with histrionic personality disorder often properly cooperate in an interview and are keen to provide a detailed history of their own. They often use dramatic gestures, emphasis, and pauses when they are talked to. Slip of the tongue in speech is high [59]. They speak splendid and vivid. They often stick to emotional comments. If they were forced to show their feelings (such as anger, sadness, and sexual desires), they will be surprised, dissatisfied, or disputed [43]. Cognitive examination usually shows normal results. However, they did not persist to focus on mathematics homework in cognitive examination. Surprisingly, they forgot emotional issues soon. Excessive emotion and attention seeking as a pervasive pattern begins in early adulthood in various fields. The symptoms include at least five of the following [59-64]:

1. Is uncomfortable in situations in which he or she is not the center of attention
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
3. Displays rapidly shifting and shallow expression of emotions
4. Consistently uses physical appearance to draw attention to themselves
5. Has a style of speech that is excessively impressionistic and lacking in detail
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion
7. Is highly suggestible, i.e., easily influenced by others or circumstances
8. Considers relationships to be more intimate than they actually are

Treatment

Psychotherapy

Histrionic personality disorder patients are often unaware of their true feelings. Thus, explaining their inner feelings is an important therapeutic process. Psychotherapy-based psychoanalysis, either as a group or individually, may be selected for treatment of histrionic personality disorder [65].

Pharmacotherapy

Medications can be used for some symptoms (e.g. antidepressants for depression and physical symptoms, anxiolytic for anxiety and antipsychotics for errors of fact and distorted perceptions) [66].

REFERENCES

[1] Smith C, Chakraburtty A, Nelson D, Paradis I, Kesinger S, Bak K, et al. official publication of the North American Transplant Coordinators Organization. 1999;9(2):109-13 .

[2] Koenigsberg HW, Anwunah I, New AS, Mitropoulou V, Schopick F, Siever LJ. Depression and anxiety. 1999;10(4):158-67 .

[3] Bunce SC, Coccaro E. Depression and anxiety. 1999;10(4):147-57 .

[4] Allen JG, Huntoon J, Evans RB. Journal of personality assessment. 1999;73(3):449-71 .

[5] Davison S, Jamieson E, Taylor PJ. The British journal of psychiatry : the journal of mental science. 1999;175:224-7 .

[6] Kernberg OF. The International journal of psycho-analysis. 1999;80 (Pt 5):899-908 .

[7] Kaylor L. Issues in mental health nursing. 1999;20(3):247-58 .

[8] Linehan MM, Schmidt H, 3rd , Dimeff LA, Craft JC, Kanter J, The American journal on addictions. 1999;8(4):2 . 92–79

[9] Maples JL, Carter NT, Few LR, Crego C, Gore WL, Samuel DB, et al. Psychological assessment. 2015 .

[10] Wapp M, van de Glind G, van Emmerik-van Oortmerssen K, Dom G, Verspreet S, Carpentier PJ, et al. European addiction research. 2015;21(4):188-94 .

[11] Leppanen V, Hakko H, Sintonen H, Lindeman S. Community mental health journal. 2015 .

[12] Schienle A, Wabnegger A, Schongassner F, Leutgeb V. Social cognitive and affective neuroscience. 2015 .

[13] Linehan MM, Korslund KE, Harned MS, Gallop RJ, Lungu A, Neacsiu AD, et al. JAMA psychiatry. 2015 .

[14] Gudmundsson E. Journal of affective disorders. 2015;178:107-11 .

[15] Bedics JD, Atkins DC, Harned MS, Linehan MM. Psychotherapy. 2015;52(1):67-77 .

[16] Hummelen B, Pedersen G, Wilberg T, Karterud S. Journal of personality disorders. 2014:1-13 .

[17] Gamache D, Diguer L. Sante mentale au Quebec. 2012;37(1):135-55 .

[18] Coolidge FL, Estey AJ , Segal DL, Marle PD. Comprehensive psychiatry. 2013;54(2):141-8 .

[19] Clarke G. The International journal of psycho-analysis. 2012;93(1):203-18 .

[20] Lenzenweger MF, Willett JB. Development and psychopathology. 2009;21(4):1211-31 .

[21] Kosson DS, Blackburn R, Byrnes KA, Park S, Logan C, Donnelly JP. Journal of personality assessment. 2008;90(2):185-96 .

[22] Borisova D. Zhurnal nevrologii i psikhiatrii imeni SS Korsakova / Ministerstvo zdravookhraneniia i meditsinskoi promyshlennosti Rossiiskoi Federatsii, Vserossiiskoe obshchestvo nevrologov [i] Vserossiiskoe obshchestvo psikhiat. 2007;107(6):26-30 .

[23] Javanbakht A. American journal of psychoanalysis. 2006;66(1):63-71 .

[24] Tomotake M, Ohmori T. Ryoikibetsu shokogun shirizu. 2003(39):341-3 .

[25] Sass H, Junemann K. Fortschritte der Neurologie-Psychiatrie. 2001;69 Suppl 2:S120-6 .

[26] Hebebrand J, Henninghausen K, Nau S, Himmelmann GW, Schulz E, Schafer H, et al. Acta psychiatrica Scandinavica. 1997;96(1):64-7 .

[27] Hoek HW, Susser E, Buck KA, Lumey LH, Lin SP, Gorman JM. The American journal of psychiatry. 1996;153(12):1637-9 .

[28] West M, Rose MS, Sheldon-Keller A. Canadian journal of psychiatry Revue canadienne de psychiatrie . . 1995; 40(7): 411-4.

[29] Wolff S, Townshend R, McGuire RJ, Weeks DJ. The British journal of psychiatry : the journal of mental science. 1991;159:620-9 .

[30] Akhtar S. American journal of psychotherapy. 1987;41(4):499-518 .

[31] Neenan P, Felkner J, Reich J. The Journal of nervous and mental disease. 1986;174(8):483 .

[32] Abril A, Valle J, Moreno D, de Miguel D, Molina D. Archivos de neurobiologia. 1991;54(3):89-97 .

[33] Apt C, Hurlbert DF. Journal of sex & marital therapy. 1994;20(2):125-33 .

[34] Bakkevig JF, Karterud S. Comprehensive psychiatry. 2010;51(5):462-70 .

[35] Blagov PS, Westen D. The Journal of nervous and mental disease. 2008;196(11):785-97 .
[36] Blais MA, Hilsenroth MJ, Fowler JC. Journal of personality assessment. 1998;70(2):355-64 .
[37] Cale EM, Lilienfeld SO. Journal of personality disorders. 2002;16(1):52-72 .
[38] Cooper SA , Collacott RA. Journal of intellectual disability research : JIDR. 1995;39 (Pt 5):450-3 .
[39] Hirashima N. Ryoikibetsu shokogun shirizu. 2003(39):354-6 .
[40] Horowitz MJ. The Journal of psychotherapy practice and research. 1997;6(2):93-104 .
[41] Kellett S. Psychology and psychotherapy. 2007;80(Pt 3):389-405 .
[42] Oude Elberink AM, Oudijn MS, Kwa VI, Van HL. Tijdschrift voor psychiatrie. 2011;53(6):371-6 .
[43] Rubino IA, Saya A, Pezzarossa B. Perceptual and motor skills. 1992;74(2):451-64 .
[44] Schotte C, De Doncker D, Maes M, Cluydts R, Cosyns P. Journal of personality assessment. 1993;60(3):500-10 .
[45] Shahar G, Scotti MA, Rudd MD, Joiner TE. Depression and anxiety. 2008;25(10):892-8 .
[46] Smith C, Kesinger S, Nelson D, Paradis I, Paris W. Progress in transplantation. 2001;11(2):88, 9 .
[47] Sulz S, Hysteria I. Der Nervenarzt. 2010;81(7):879-87 .
[48] Cambanis EV. Journal of child and adolescent mental health. 2012;24(1):99-109 .
[49] Frankel-Waldheter M, Macfie J, Strimpfel JM, Watkins CD. Personality disorders. 2015;6(2):152-60 .
[50] Snir A, Rafaeli E, Gadassi R, Berenson K, Downey G. Personality disorders. 2015 .
[51] Yen S, Frazier E , Hower H, Weinstock LM, Topor DR, Hunt J, et al. Acta psychiatrica Scandinavica. 2015 .
[52] Kramer U, Pascual-Leone A, Berthoud L, De Roten Y, Marquet P, Kolly S, et al. Clinical psychology & psychotherapy. 2015 .
[53] Ferrer M, Andion O, Bendeck M, Calvo N, Prat M, Aragones E, et al. The journal of mental health policy and economics. 2015;18(1):17-25 .
[54] Sinai C, Hirvikoski T, Nordstrom AL , Nordstrom P, Nilsonne A, Wilczek A, et al. Psychiatry research. 2015 .
[55] Lawn S, McMahon J. Journal of psychiatric and mental health nursing. 2015 .
[56] Sansone RA, Elliott K, Wiederman MW. Innovations in clinical neuroscience. 2015;12(1-2):10-1 .
[57] Lobbestael J, Arntz A. Journal of behavior therapy and experimental psychiatry. 2015;48:125-32 .
[58] Eisenlohr-Moul TA, DeWall CN, Girdler SS, Segerstrom SC. Biological psychology. 2015 .
[59] Wieland J, Van Den Brink A, Zitman FG. Nordic journal of psychiatry. 2015:1-6 .
[60] Krause-Utz A, Keibel-Mauchnik J, Ebner, Priemer U, Bohus M, Schmahl C. European archives of psychiatry and clinical neuroscience. 2015 .
[61] Ryan J, Graham A, Nelson B, Yung A Early intervention in psychiatry. 2015 .
[62] Winsper C, Marwaha S, Lereya ST, Thompson A, Eyden J, Singh SP. Psychological medicine. 2015:1-15 .
[63] Whalen DJ, Kiel EJ, Tull MT, Latzman RD, Gratz KL. Personality disorders. 2015 .
[64] Rausch J, Gabel A, Nagy K, Kleindienst N, Herpertz SC, Bertsch K. Psychoneuroendocrinology. 2015;55:116-27 .
[65] Yeomans F. Tusiani B, Tusiani P, Tusiani-Eng P. New York, Baroque Press, 2013, 336 pp., $28.95. The American journal of psychiatry. 2014;171(12):1341-2 .
[66] Tohen M. The American journal of psychiatry. 2014;171(11):113-9.