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PERSONALITY DISORDERS

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Abstract

Personality disorders form a class of mental disorders that are characterized by long-lasting rigid patterns of thought and behaviour which cause serious problems with relationships and work (Grohol, 2015).The Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision (DSM-IV-TR, 2000) defines a personality disorder like "an enduring pattern of inner experience and behavior that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment". Those who struggle with a personality disorder tend to be inflexible, rigid, unable to respond to the changes and demands of life and find it difficult to participate in social activities.

Personality disorders usually begin in the teenage years or early adulthood and causes significant problems and limitations in relationships and social encounters.

DSM-IV-TR has organized clinical assessment into five axes, addressing the different aspects and impact of disorders and personality disorders were designated to Axis II. Later, the mental health specialists considered that that there is no fundamental difference between disorders described on DSM-IV's Axis I and Axis II and DSM-5 has shifted to a single axis system, which combines the first three axes outlined in past editions of DSM into one axis with all mental and other medical diagnoses (www.dsm5.org). Personality disorders fall within 10 distinct types: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder and obsessive compulsive personality disorder (www.dsm5.org).

Keywords*: personality disorder, axis, DSM*

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1. ETIOLOGY OF PERSONALITY DISORDERS

In the past, some believed that people with personality disorders "were just lazy or even evil", but researchers are beginning to identify some possible factors behind personality disorders (www.apa.org). The most common etiologies for personality disorders are multifactorial, but these conditions may also be secondary to biologic, developmental, or genetic abnormalities (Bienenfeld, 2013).

American Psychological Association identified the following etiologic factors in developing a personality disorder (www.apa.org):

- Genetics, such as a malfunctioning gene that may be a factor in obsessive-compulsive disorder or genetic links to aggression, anxiety and fear — traits that can play a role in personality disorders;

- Childhood trauma, which is associated with borderline personality disorder (Gunderson et. al, 2000);

- Verbal abuse in the childhood, which is associated with borderline, narcissistic, obsessive-compulsive or paranoid personality disorders in adulthood; Huff (2004) underlined the fact that the role of abuse is particularly controversial among family members of people with a borderline disorder;

- High reactivity children are more likely to develop shy, timid or anxious personalities; a study conducted by Kagan (2002) concluded that a temperamental bias for high reactivity in infancy is predictive of a personality profile marked by shyness, timidity and anxiety to unfamiliar events;

- Peers**:** a strong relationship with a relative, teacher or friend can offset negative influences.

A study conducted by Klein, Roniger, Schweiger, Späth & Brodbeck (2015) concluded that the presence of avoidant personality pathology may interact with the effect of childhood trauma in the development of chronic depression.

2. DIAGNOSTIC OF PERSONALITY DISORDERS

The Structured Clinical Interview for Axis II disorders in the DSM-IV-TR, SCID II (First et al., 1997) is an efficient instrument that helps researchers make standardized diagnoses of the 10 DSM-IV Axis II personality disorder. We can use

also Personality Disorder Examination – PDE (Loranger, Susman, Oldham, & Russakoff, 1987).

A study conducted by Cloninger (2000) concluded that the general criteria for the diagnosis of personality disorders are provided based on rating a few items describing four core features: a low self-directedness, low cooperativeness, low affective stability and low self-trancendence.

Presently, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition-DSM 5 defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment" (APA, 2013). The criteria for personality disorders in Section II of DSM-5 are the same with those in DSM-IV; there are 10 personality disorders which fall into 3 clusters: A, B, and C (APA, 2013):

Cluster A includes paranoid, schizoid and schizotypal personality disorders and individuals with these disorders seem to be odd or eccentric;

Cluster B includes antisocial, borderline, histrionic and narcissistic disorders and individuals with these disorders often appear dramatic, emotional or erratic;

Cluster C includes avoidant, dependent and obsessive-compulsive disorders and individuals with these disorders often appear to be anxious or fearful.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition-DSM 5 established the following criteria for a general personality disorder (APA, 2013):

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two or more of the following areas:

1. Cognition;
2. Affectivity;
3. Interpersonal functioning;
4. Impulse control.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not attributable to the psysiological effects of a substance or another medical condition.

The diagnosis of personality disorders requires an evaluation of the individual's long term patterns of functioning and the particular personality features must be evident by early adulthood (APA, 2013).

Berghuis, Kamphuis, Verheul, Larstone and Livesley (2013) suggest that the General Assessment of Personality Disorder – GAPD represents a self-report questionnaire designed to evaluate general personality disorder; it is suitable for assessing both personality dysfunction and personality traits.

The Structured Clinical Interview for DSM-5 (SCID-5) is the most widely used structured diagnostic instrument for assessing DSM-5 disorders and the SCID-PD (formerly SCID-II) is used for the evaluation of the DSM-5 personality disorders (First, 2015).

A study conducted by Clark (2007) concluded that "personality disorders features include both more acute, dysfunctional behaviors that resolve in relatively short periods and maladaptive temperamental traits that are relatively more stable, with increasing stability until after 50 years of age".

3. TREATMENT OF PERSONALITY DISORDERS

The psychopharmacological treatment of patients suffering from a personality disorder focuses on distinct symptoms and its comorbidity; since symptoms of personality disorders are ego-syntonic, it is unlikely that a solely psychopharmacological treatment will be successful in most patients with a personality disorder (Quante, Röpke, Merkl, Anghelescu, Lammers, 2008).

There is evidence that both psychodynamic therapy and cognitive behavior therapy are effective treatments of personality disorders, but further studies are necessary to examine specific forms of psychotherapy for specific types of personality disorders (Leichsenring & Leibing, 2005).

A study conducted by Bender, Dolan, Skodol et al (2001) concluded that the contribution of personality disorders to functional impairment and treatment are underappreciated despite the documented co-occurrence of personality disorders with other disorders and the negative effects of personality disorders on the

treatment and course of axis I disorders. Sperry (2002) stated that "the basic goal of treatment is to facilitate movement from personality-disorder functioning to adequate personality style functioning or even optimal functioning."

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