Personality Deviation

Personality deviation is the deviation of a person's personality from the normal. It may be defined as the variation of personality from commonly established way. When a person tends to show an offensive or act of a sin in his behaviour is termed as personality behaviour.

In the instance of personality disorder, which is sometimes called character disorder, the individual's problematic behaviours appear in two or more of the following areas:

1. Perception and interpretation of the self and other people.
2. Intensity and duration of feelings and their appropriateness to situations
3. Relationships with others.
4. Ability to control impulses.

American Psychiatric Association's DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders):

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSM-V), listed 10 distinct types of personality disorders. The different personality disorders are put into one of three clusters based on similar characteristics assigned to each cluster:

Characteristics or types of personality disorder

Cluster A: (Odd and eccentric disorders):

People whose behaviour appears odd or eccentric

- Paranoid Personality Disorder.
- Schizoid personality Disorder.
- Schizotypal personality disorder.

Paranoid Personality Disorder:

Paranoid Personality Disorder characterised by a pattern of distrust and irrigational suspiciousness and mistrust of others such that their motives are interpreted as malevolent beginning by early adulthood and present in variety of contexts.

Incidence
More common in men than in women.

Predisposing Facts

- Hereditary
- Parental antagonism & harassment

They learn to perceive the world as harsh and unkind.

CLINICAL PICTURE

- Constantly on guard, hyper-vigilant and ready for any real or imagined threat.
- Appear tense and irritable.
- Insensitive to the feelings of others.
- Avoid interactions with others.
- Always feel that others are taking advantage of them.
- Extremely oversensitive.
- Do not accept responsibility for their own behaviour.

Diagnostic Criteria

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

- Suspects without sufficient basis those others are exploiting harming or deceiving him or her
- Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
- Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
- Persistently bears grudges.
- Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.

The symptoms are not limited to or solely caused by schizophrenia, a mood disorder with psychotic symptoms (like bipolar disorder or depression with psychosis), or any other psychotic disorder. Additionally, they are not the result of a physical medical condition affecting the body.

Treatment

- Psychotherapy - Interpersonal psychotherapy
  Psychoanalytical psychotherapy

- Group therapy

- Behavioural therapy

- Psychopharmacology.

Schizoid Personality Disorder

Schizoid personality disorder is lack of interest and detachment from social relationships, apathy, and restricted range of emotional expression or Characterized by primarily by a profound defect in the ability to form personal relationships or to respond to others in any meaningful, emotional.

Prevalence

3 – 7.5 %
Gender Ratio: Not known but diagnosed frequently in men.

PREDISPOSING FACTORS

- Hereditary:-
  Unclear, the feature of introversion appear to be a highly inheritable characteristic.
- Psychosocially:-
  The development of schizoid personality is influenced by early interactional patterns that the person found to be cold & unsatisfying.
- The childhood of these individuals have often been characterized as bleak, cold, un-empathic & notably lacking in nurturing.
- Schizoid personality disorder occurs in adults who experienced cold, neglectful & un-gratifying relationships in early childhood.

CLINICAL PICTURE

- Appear cold, aloof & indifferent to others
- They prefer to work in isolation & are unsociable with little need or desire for emotional ties.
- In the presence of others they appear shy, anxious or uneasy.
- They are inappropriately serious about everything and have difficulty acting in a light hearted manner.
- They are unable to experience pleasure and their affect is commonly bland and constricted.

DIAGNOSTIC CRITERIA

A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by 4 or more of the following:

- Neither desires nor enjoys close relationships including being part of a family.

- Almost always chooses solitary activities.
- Takes pleasure in few, if any activities.
- Lacks close friends, or confidants other than first- degree relatives.
- Lack of interest or no interest in sexual activities.
- Appears indifferent to the praise or criticism of others.
- Shows emotional coldness, detachment or flattened affectivity.

Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiological effects of a general medical condition.

Treatment

- Psychotherapy - Interpersonal psychotherapy
  Psychoanalytical psychotherapy

- Group therapy

- Behavioural therapy

- Psychopharmacology.

Schizotypal personality disorder

- Schizotypal personality disorder is acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.
- Behaviour is odd and eccentric, but does not decompensate to the level of schizophrenia

PREVALENCE

Less than 3%

PREDISPOSING FACTOR

▸ Hereditary:-More common among first degree relatives of people with schizophrenia.

▸ Anatomical deficits or neurochemical dysfunctions resulting in diminished activation diminished pleasure-pain sensibilities and impaired cognitive functions.

Family dynamics:- characterized by indifference, impassivity or formality, leading to a pattern of discomfort with personal affection and closeness.

CLINICAL PICTURE

- Aloof & isolated & behave in a bland and apathetic manner
- Magical thinking
- Ideas of reference
- Illusions
- Depersonalization
- Bizzare speech pattern
- They cannot orient their thoughts logically and become lost in personal irrelevancies.
- Under stress they may decompensate and demonstrate psychotic symptoms.
- Affect is bland or inappropriate.

DIAGNOSTIC CRITERIA

A pervasive pattern of social and interpersonal deficits marked by acute discomfort with and reduced capacity for close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood and present in a variety of contexts as indicated by 5 or more of the following:

- Ideas of reference
- Odd beliefs or magical thinking that influences behaviour and is inconsistent with sub cultural norms.
- Unusual sensory experiences, such as feeling strange sensations in the body or perceiving things in a distorted way.
- Odd or peculiar patterns of thinking and speech, which may include being vague, overly detailed, metaphorical, or repetitive.
- A tendency to be overly suspicious or have paranoid thoughts.
- Emotional expressions that are either inappropriate for the situation or seem limited and restrained.

- Behaviours or appearances that are unconventional, odd, eccentric, or noticeably unusual.
- Intense social anxiety that persists even in familiar settings, often linked to paranoid concerns rather than self-esteem issues.
- Lack of close friends.

These experiences do not occur solely as part of conditions like schizophrenia, mood disorders with psychosis, other psychotic disorders, or developmental disorders.

TREATMENT

- Psychotherapy - Interpersonal psychotherapy

  Psychoanalytical psychotherapy

- Group therapy.
- Behavioural therapy.
- Psychopharmacology.
- Antipsychotics for psychotic symptoms.

Cluster B
Dramatic, Emotional, Erratic.

There are three types of disorder under Cluster B Personality disorder.

1. **Antisocial Personality Disorder**

i) Antisocial personality disorder is character by chronic antisocial behaviour that violates other rights or social norms which predisposes the affected person to the criminal behaviour**.**

ii) The person is unable to maintain consistent, responsible functioning at school or as a parent.

SIGN AND SYMPTOMS

i) Failure to sustain the relationship.
ii) Impulsive actions.
iii) Low tolerance to frustration.
iv) Tendency to cause violence.
v) Lack of guilt
vi) Inability to maintain close personal or sexual relationship.

CLINICAL FEATURES

i) Indifferent to the needs of others
ii) Fails to pay debts
iii) Usually loners
iv) Aggressive, violent involves in fights
v) Frequent encounters with the law
vi) Persistent lying or stealing
vii) Inability in keeping jobs

CAUSES

i) Heredity
ii) Environmental influence
iii) Difficulty in developing emotional bonds
iv) Few healthy role models for behaviour
v) No rewards for socially acceptable behaviour

TREATMENT

i) Psychotherapy
ii) Pharmacotherapy

2. Borderline personality Disorder

Marked by a pattern of instability in personal relationship, mood, behaviour and self – imagine .

Signs and symptoms

4 main categories

i) Unstable relationship
ii) Unstable self- images .
iii) Unstable emotions.
iv) Impulsive.

Others

v) Uncertain about personal identity.
vi) Chronic feeling of emptiness.
vii) Recurrent suicidal threats and behaviour.
viii) Lack of control of anger.

Treatment

i) Psychotherapy
ii) Pharmacotherapy

3. Histrionic Personality Disorder

i) Persons with histrionic personality disorder are excitable and emotional and behave in a colourful, dramatic, extroverted fashion.

ii) Characterized by a pervasive pattern of excessive emotionality and attention-seeking.

EPIDEMIOLOGY

i) 2 to 3 percent of general population.

ii) 10 to 15% of clinical population.

iii) More in women than in men.

iv) Studies have found an association with somatization disorder and alcohol use disorders.

CLINICAL FEATURES

i) Fluctuation in emotions

ii) Attention seeking, self-centered attitude

iii) Attentiveness to own physical appearance.

iv) Dramatic, impressionistic speech style

v) Vague logic lack of conviction in arguments

vi) Shallow emotional expressions.

vii) Craving for immediate satisfaction

viii) Complaints of physical illness, somatization

ix) Use of suicidal gestures and threats to get attention

TREATMENT

i) Psychotherapy.

ii) Pharmacotherapy

iii) Symptomatic

iv) Antidepressants for depression and somatic complaints.

v) Antianxiety agents for anxiety

vi) Antipsychotics for psychotic symptoms.

4. NARCISSISTIC PERSONALITY DISORDER

i) Enduring patterns of inner experience and behaviour that are sufficiently rigid and deep seated to bring a person into repeated conflicts with his/her social and occupational environment.

ii) A pattern of grandiosity in the patient's private fantasies or outward behaviour, a need for constant admiration from others and lack of empathy for others.

EPIDEMIOLOGY

i) Common in late adolescence and early adulthood.
ii) It occurs in 1% to 2% of the general population and 2% to 16% of the clinical population.
iii) 50% to 75% of people with this diagnosis are men.

CAUSES

i) Arrested psychological development.
ii) Young child's defence against psychological pain.
iii) Problems or unsatisfactory relationship in parent- child relationship or interaction.
iv) Harsh and punishing super ego.

PREDISPOSING FACTORS

i) Child need not met- sense of emptiness.
ii) (Mark 2002)-Narcissistic parents.
iii) Physical or emotional abuse or neglect.
iv) Environment- parents forcing the child to achieve which they were not able to achieve.
v) Not setting limits.

TREATMENT

i) Antidepressant- to relieve narcissistic grandiosity.
ii) Psychotherapy.
iii) Hospitalization- if low functioning.

CLUSTER C

People who appear anxious and fearful.

AVOIDANT PERSONALITY DISORDER

i) Extreme sensitivity to rejection and may lead a socially withdrawn life.
ii) Although shy, not asocial
iii) Show a great desire for companionship, unusually strong guarantees of uncritical acceptance.
iv) Described as having inferiority complex.
v) ICD 10...anxious personality disorder.

EPIDEMIOLOGY

i) 1-10% of the general population.
ii) No information on sex ratio or familial pattern.

CLINICAL FEATURES

i) Hypersensitivity to rejection
ii) Main personality trait is timidity.
iii) Desires warmth and security of human companionship.
iv) When talking with someone, they express uncertainty.
v) Lack of self-confidence.
vi) Afraid to speak up in public.
vii) Misinterpret others comments.
viii) Refusal of requests makes them withdraw.
ix) Shy & eager to please.
x) Have no close friends.

TREATMENT

i) Psychotherapy:

- Group therapy.
- Assertiveness therapy
- Pharmacotherapy.

ii) Used to manage anxiety and depression.
iii) Serotonergic agents may help rejection sensitivity.

2. DEPENDENT PERSONALITY DISORDER

Dependent Personality Disorder (DPD) is a mental health condition characterized by an excessive need to be taken care of, leading to submissive and clingy behaviour and fears of separation. People with DPD often struggle with making everyday decisions without reassurance, have difficulty expressing disagreement, and go to great lengths to avoid being alone.

SYMPTOMS

i) Difficulty making decisions without excessive advice or reassurance.
ii) Fear of abandonment and being alone.
iii) Trouble initiating projects or doing things independently.
iv) Willingness to tolerate mistreatment to maintain relationships.
v) Urgent need to find a new relationship when one ends.
vi) Low self-confidence and feelings of helplessness.

EPIDEMILOGY

i) More common in women.
ii) 2.5% of personality disorders as falling in this category.
iii) More common in younger children than older ones.
iv) Persons with chronic physical illness in childhood may be more susceptible.

CAUSES AND RISK FACTORS

I) Childhood trauma (abuse, neglect, or overprotective parenting).
II) Genetic predisposition.
III) Cultural or societal influences emphasizing dependence.
IV) History of anxiety disorders.

TREATMENT :

i) **Psychotherapy:** Cognitive-behavioural therapy (CBT) can help build independence and self-confidence.
ii) **Medication:** Antidepressants or anti-anxiety medications may be used for associated symptoms but don't treat DPD directly.
iii) **Lifestyle Changes:** Developing assertiveness, self-reliance, and support networks can help.

Obsessive-Compulsive Personality Disorder (OCPD)

Preoccupation with order, perfectionism, and control, often at the expense of flexibility and efficiency. Unlike OCD, OCPD is more about personality traits rather than intrusive thoughts and compulsions.

EPIDERMIOLOGY

- 1 to 2% of general population.
- 3 to 10% in the clinical population.
- Twice in men than in women.
- Most often in oldest children.

CLINICAL FEATURES

- Preoccupation with perfection, organization, structure and control.
- Excessive devotion to work.
- Difficulty relaxing.
- Rule-conscious behaviour.
- Self-criticism and inability to forgive own errors.

CAUSES

- Genetics .
- Early Childhood Experiences.
- Brain Structure and Functioning.
- Cultural and Environmental Influences.

TREATMENT

- Psychotherapy.
- Pharmacotherapy

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