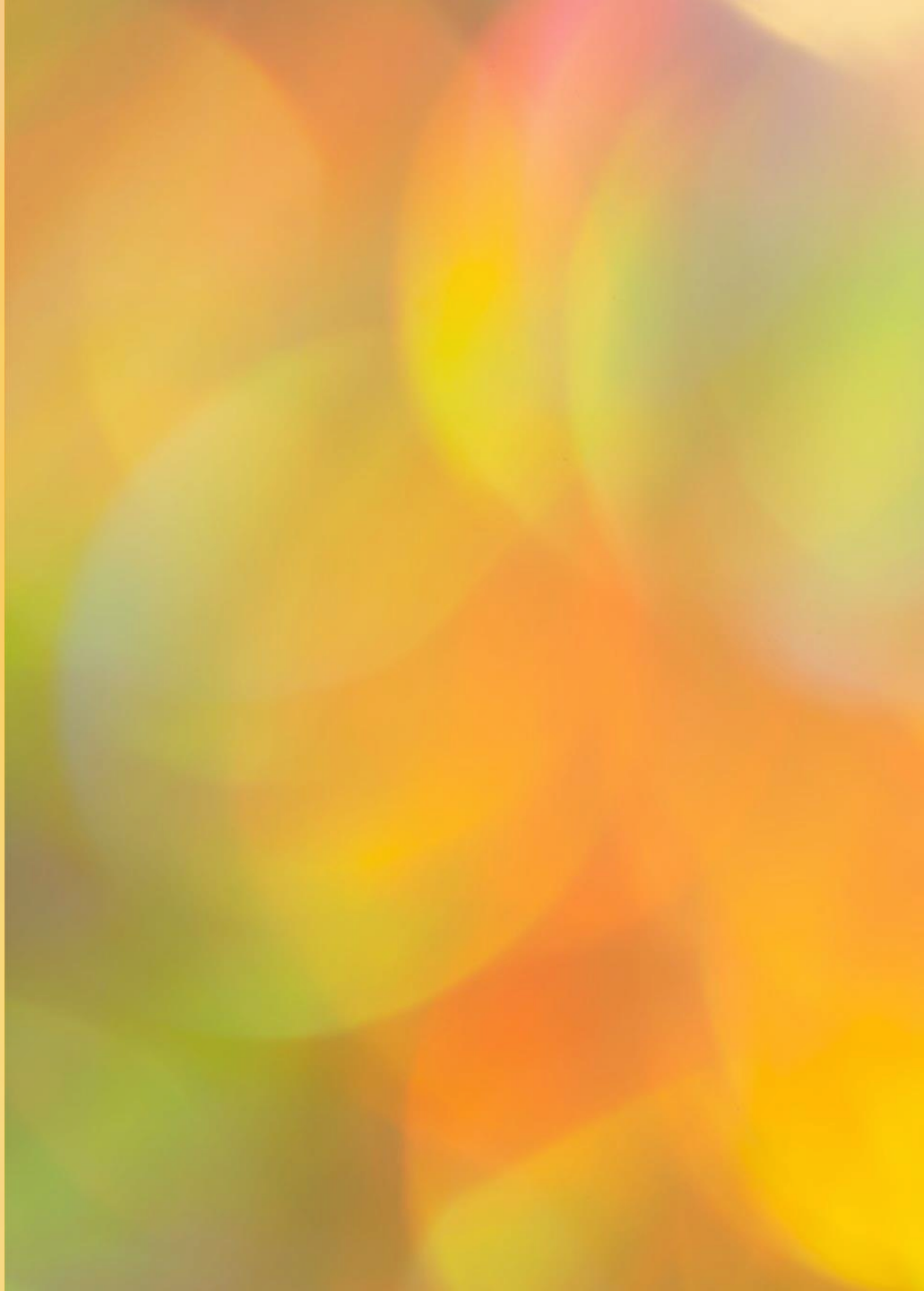
Epilepsy. Oligophrenias and developmental delays. Personality disorders

Poltava State Medical University

Department of Psychiatry, Narcology and Medical Psychology



- from Greek word *epilambanein*, meaning „to seize“ or „to attack“

Epilepsy –

- At least two unprovoked (or reflex) seizures occurring more than 24 hours apart
- One unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60%) after two unprovoked seizures, occurring over the next 10 years

Epilepsy is considered to be resolved for individuals who had an age-dependent self-limited epilepsy syndrome but who are now past the applicable age, or for those who have remained seizure-free for the last 10 years, with no seizure medication for the last 5 years.

Prevalence: **1%**

Epileptic seizure

Seizure- symptom, represents the clinical manifestation of an abnormal and excessive synchronized discharge (uncontrolled electrical activity) of a set of cortical nn. in the brain

Mechanisms: Nerve cells transmit signals to and from the brain in two ways by

(1) altering the concentrations of salts (sodium, potassium, calcium) within the cell

(2) releasing chemicals called neurotransmitters (gamma aminobutyric acid). The change in salt concentration conducts the impulse from one end of the nerve cell to the other.

Epilepsy
according to the seizure type

- **Focal epilepsies**
  (those with partial onset epileptic seizures)

- **Generalized epilepsies**
  (those with generalized onset epileptic seizures)

Epileptic seizure

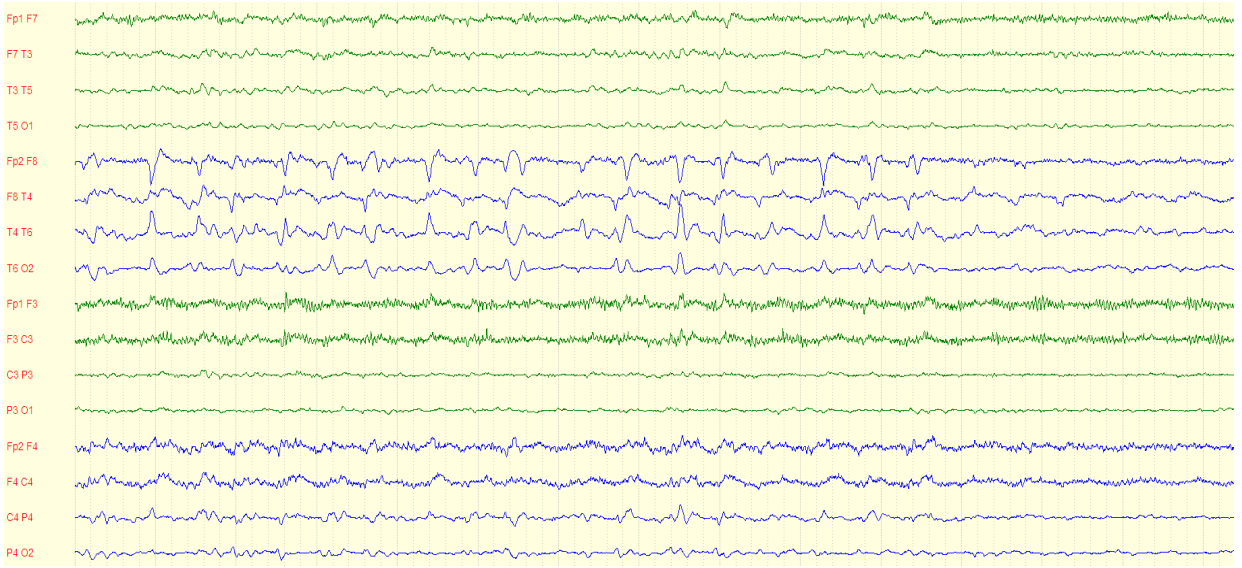
- **Focal Seizures**
  The site of origin is a localized or discreet area in one hemisphere of the brain.

- **Generalized Seizures**
  At the onset, seizure activity occurs simultaneously in large areas of the brain, often in both hemispheres.

FOCAL

Epileptic discharge

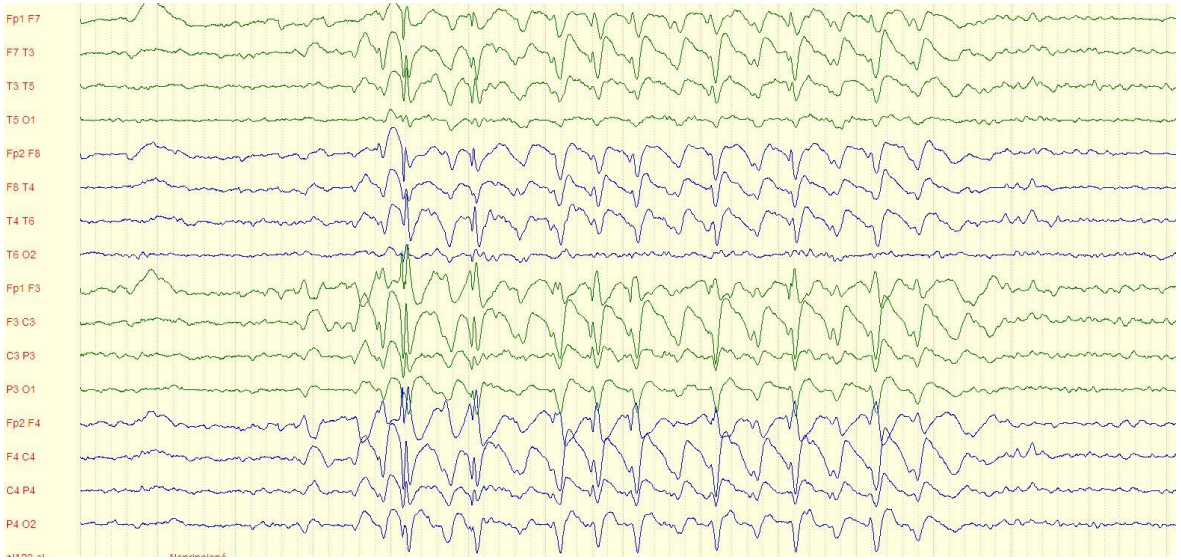
(TLE l. dx.)



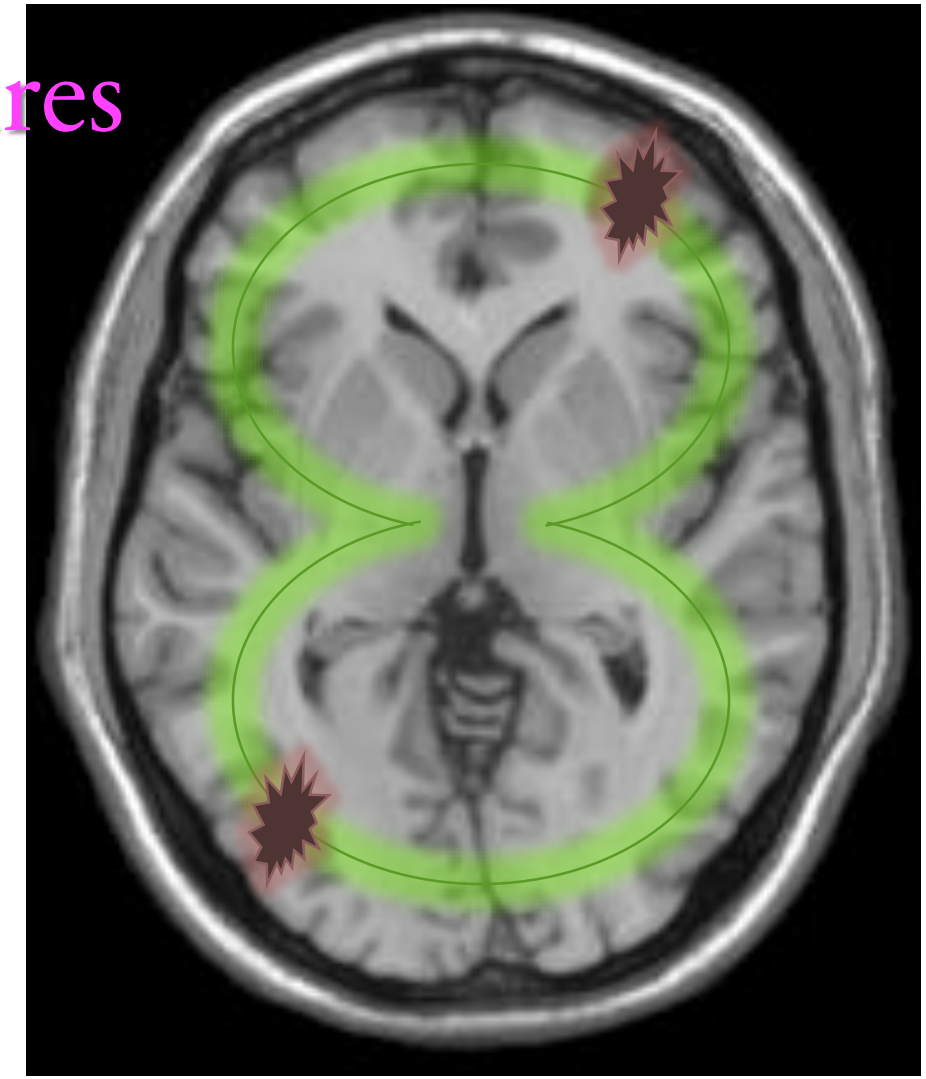
GENERALIZED

epileptic discharge

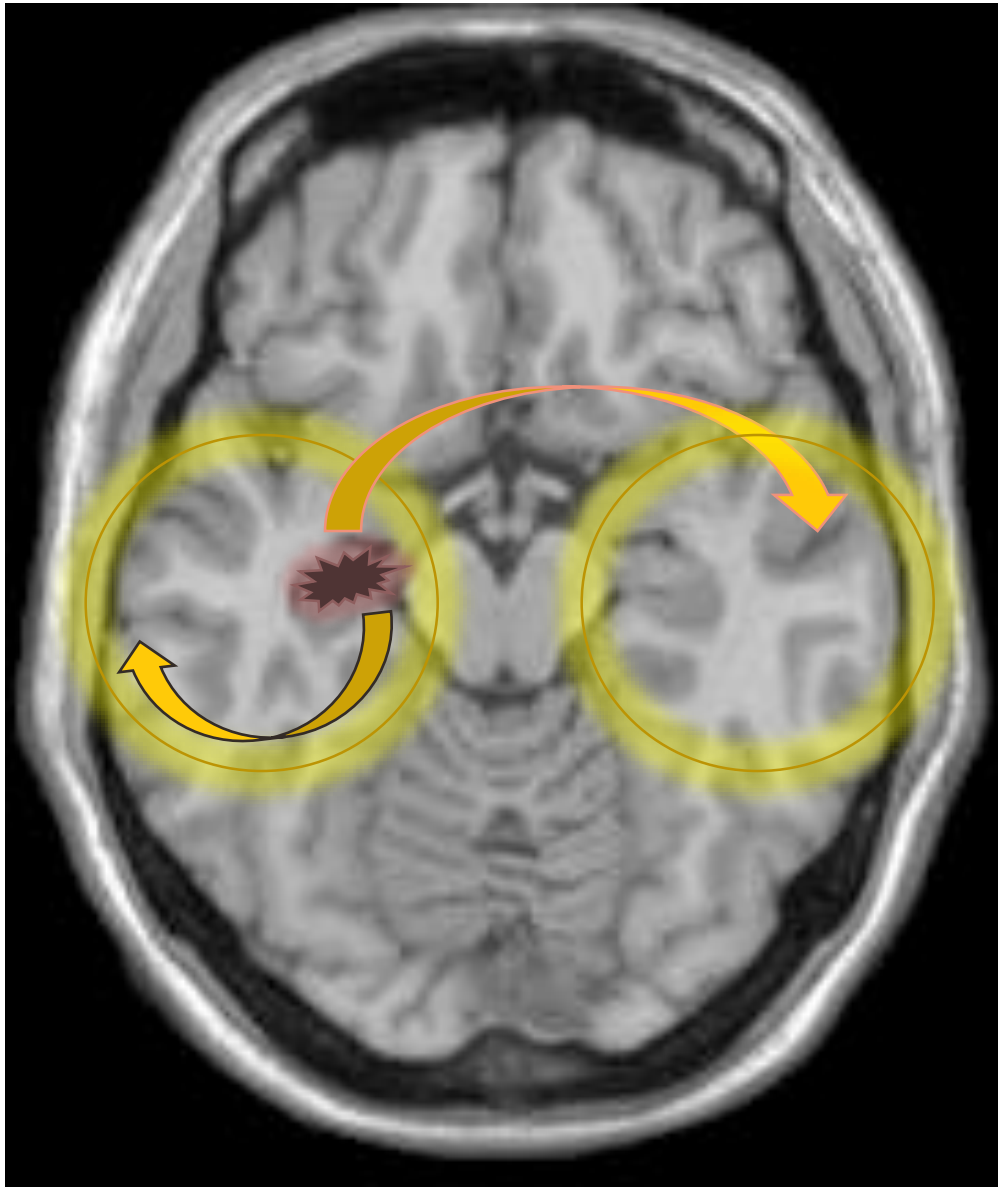
(Abcence s.)



Generalized seizures



Focal seizures



INTERNATIONAL CLASSIFICATION OF SEIZURES 1981

Partial Seizures (start in one place)

- **Simple (no loss of consciousness of memory)**
  - **Sensory**
  - **Motor**
  - **Sensory-Motor**
  - **Psychic (abnormal thoughts or perceptions)**
  - **Autonomic (heat, nausea, flushing, etc.)**
- **Complex (consciousness or memory impaired)**
  - **With or without aura (warning)**
  - **With or without automatisms**
- **Secondarily generalized**

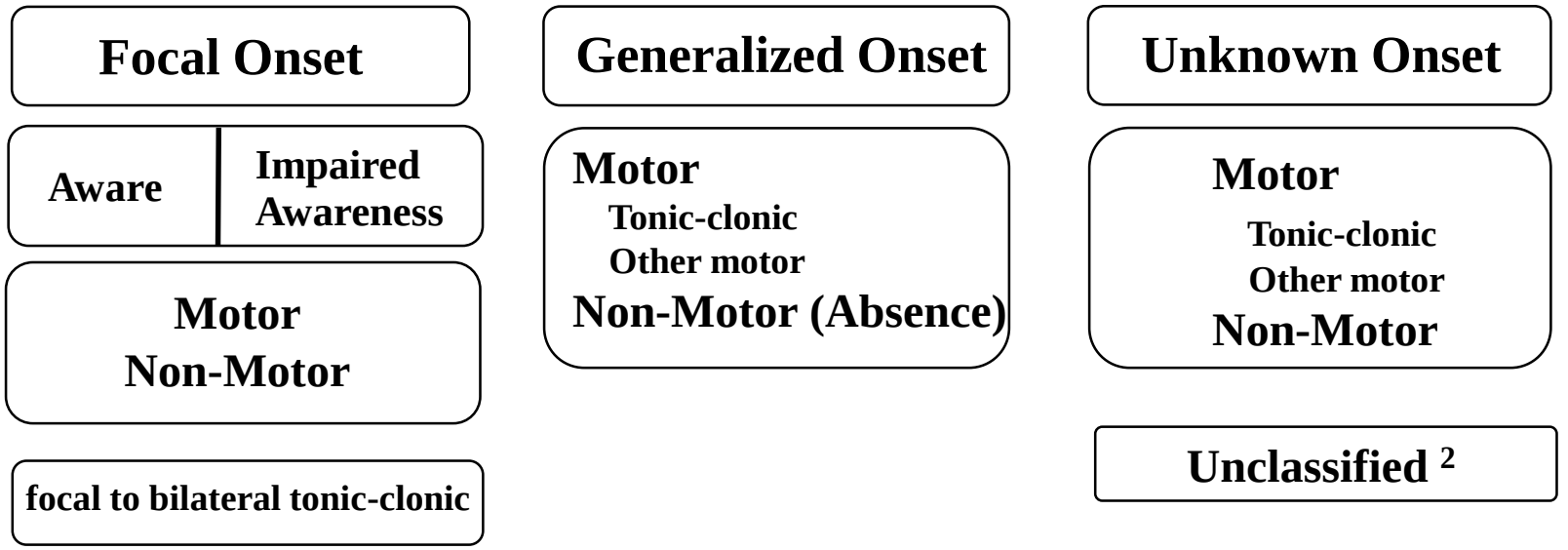
Generalized Seizures (apparent start over wide areas of brain)

- **Absence (petit mal)**
- **Tonic-clonic (grand mal)**
- **Atonic (drop seizures)**
- **Myoclonic**
- **Other**

Unclassifiable seizures

Dreifuss et al. Proposal for revised clinical and electroencephalographic classification of epileptic seizures. From the Commission on Classification and Terminology of the International League Against Epilepsy. Epilepsia. 1981;22:489-501.

ILAE 2017 Classification of Seizure Types Basic Version [1]



[1] Definitions, other seizure types and descriptors are listed in the accompanying paper & glossary of terms

[2] Due to inadequate information or inability to place in other categories

From *Fisher et al. Instruction manual for the ILAE 2017 operational classification of seizure types. Epilepsia doi: 10.1111/epi.13671*

ILAE 2017 Classification of Seizure Types Expanded Version[1]

Focal Onset

Aware | Impaired Awareness

Motor Onset

- automatisms
- atonic[2]
- clonic
- epileptic spasms[2]
- hyperkinetic
- myoclonic
- tonic

Non-Motor Onset

- autonomic
- behavior arrest
- cognitive
- emotional
- sensory

focal to bilateral tonic-clonic

Generalized Onset

Motor

- tonic-clonic
- clonic
- tonic
- myoclonic
- myoclonic-tonic-clonic
- myoclonic-atonic
- atonic
- epileptic spasms[2]

Non-Motor (absence)

- typical
- atypical
- myoclonic
- eyelid myoclonia

Unknown Onset

Motor

- tonic-clonic
- epileptic spasms

Non-Motor

- behavior arrest

Unclassified[3]

1 Definitions, other seizure types and descriptors are listed in the accompanying paper and glossary of terms.

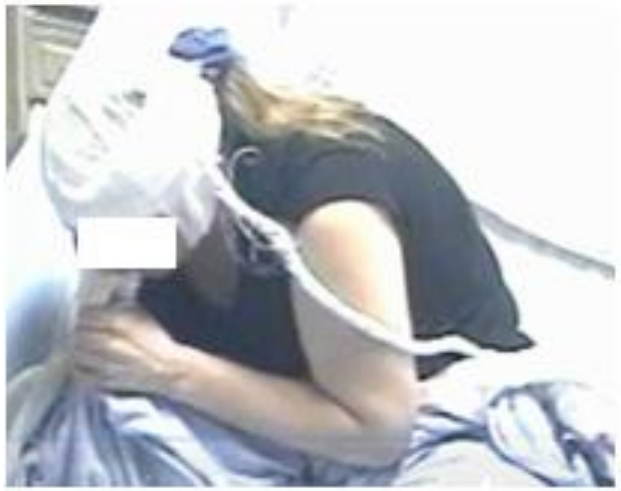
2 These could be focal or generalized, with or without alteration of awareness

3 Due to inadequate information or inability to place in other categories

From *Fisher et al. Instruction manual for the ILAE 2017 operational classification of seizure types. Epilepsia doi:*

Loss (or Impairment) of Consciousness

Two types of seizures with loss of consciousness



Some Seizure Onsets can be Focal or Generalized

Focal Onset

atonic

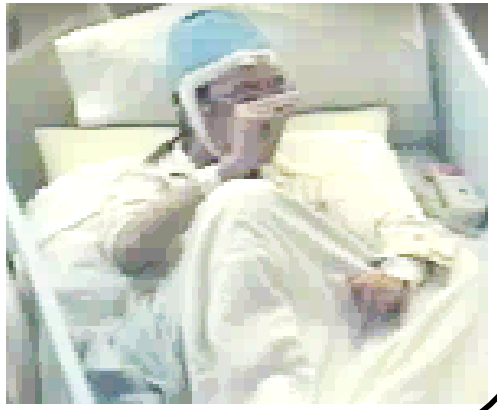
clonic

epileptic spasms

myoclonic

tonic →

tonic-clonic



Generalized Onset

atonic

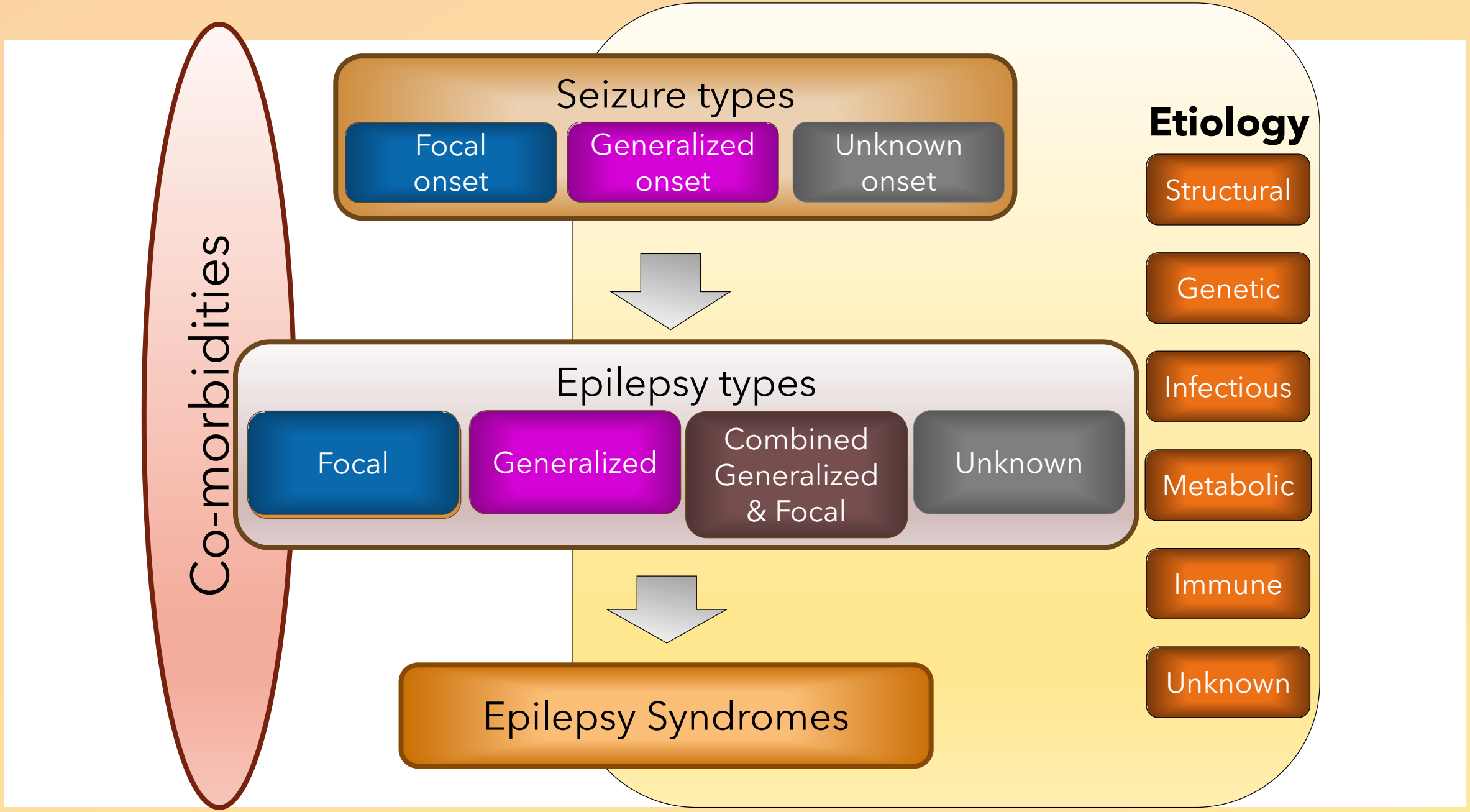
clonic

epileptic spasms

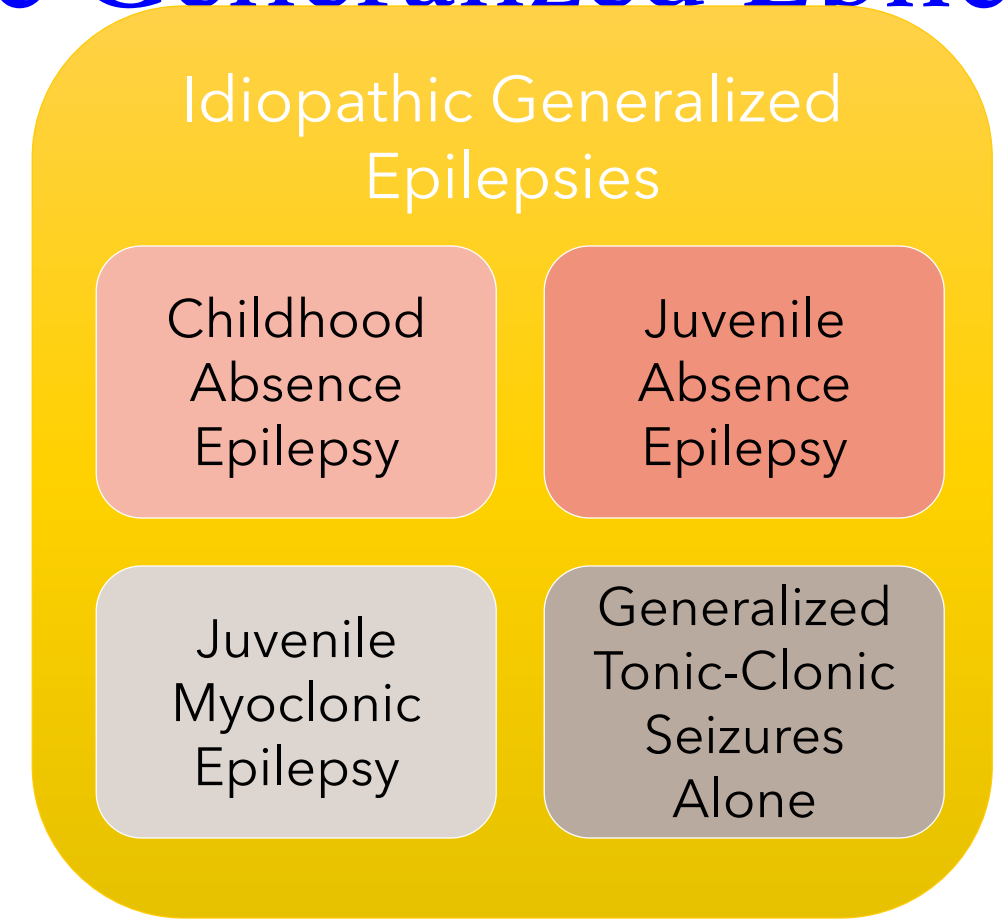
myoclonic

← tonic

tonic-clonic


Co-morbidities
Seizure types
Focal onset
Generalized onset
Unknown onset
Epilepsy types
Focal
Generalized
Combined Generalized & Focal
Unknown
Epilepsy Syndromes
Etiology
Structural
Genetic
Infectious
Metabolic
Immune
Unknown

Old term ‘Idiopathic Generalized Epilepsies’

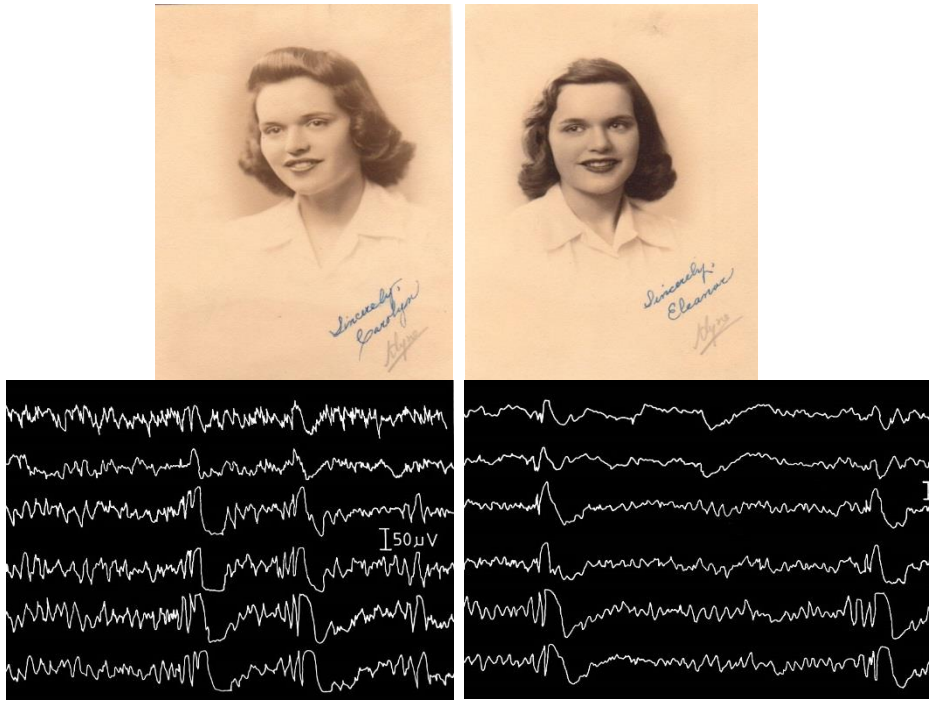


Genetic *versus* idiopathic

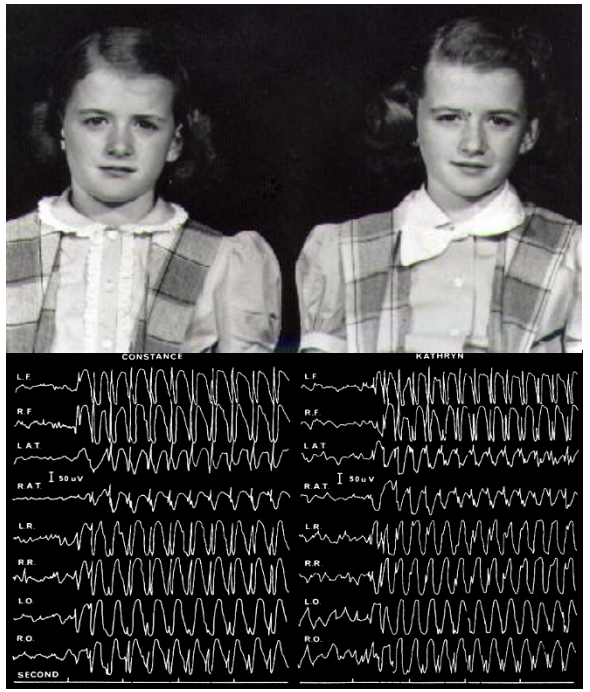
- 'Idiopathic' = presumed hereditary predisposition
- Genetic ≠ inherited
  - Importance *of de novo* mutations in both mild and severe epilepsies
- Critical problem of stigma in some parts of the world

Genetic ≠ Gene testing

- Usually the mutation is *not* known
- Access to molecular genetic testing *not* necessary
- Diagnosed on clinical research eg. twin, family studies



JME pair; Lennox 1941



CAE pair; Lennox 1950

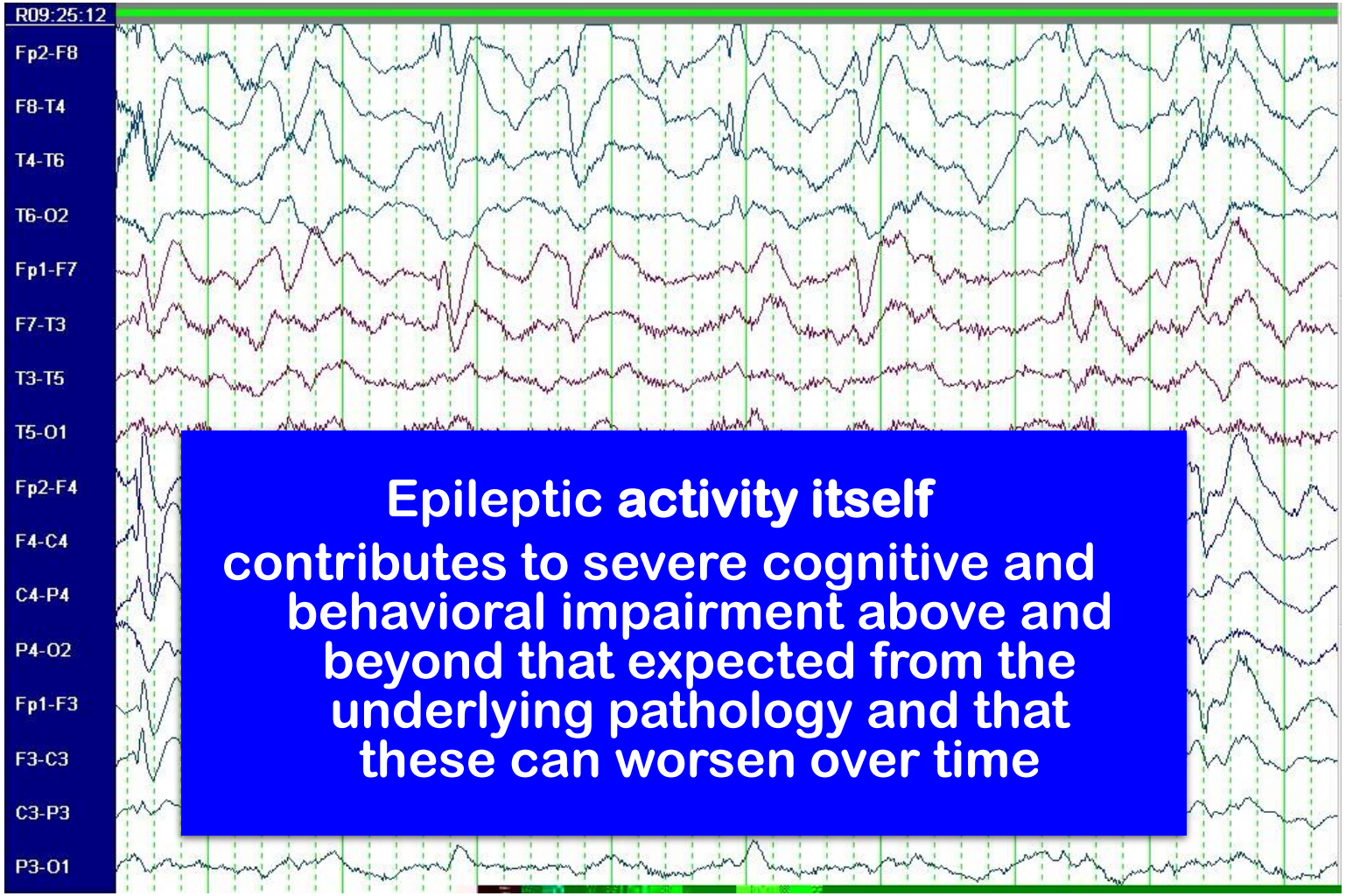
Epilepsy
according to the natural evolution

- **Epilepsy controlled by treatment**
  - **complete seizure control** unther the treatment
- **Pharmacoresistant epilepsy**
  - **the failure to achieve seizure control with the first or second trial of an anticonvulsant medication given at the appropriate daily dosage**

Self-limited/Pharmacoresponsive: Developmental /Epileptic encephalopathies

- Many epilepsies are not benign
  - Childhood absence epilepsy – psychosocial impact
  - Bening epilepsy with centrotemporal spikes – learning concerns
- Replaced by terms:
  - Self-limited
  - Pharmacoresponsive
- No longer use
  - Malignant
  - Catastrophic

Developmental and/or Epileptic encephalopathies



Developmental *and/or* Epileptic Encephalopathy

- For many encephalopathies, there is a developmental component *independent* of the epileptic encephalopathy
- Developmental delay may precede seizure onset
- Co-morbidities
  eg. cerebral palsy, autism spectrum disorder, intellectual disability
- Outcome poor even though seizures stop
  eg. KCNQ2, STXBP1 encephalopathies

Developmental *and/or* Epileptic Encephalopathy

- Developmental encephalopathy
  - May begin in utero
  - Post birth
- Epileptic encephalopathy
  - Can occur at any age
  - May have remediable component – right vs wrong AED
- Move towards *GENE* encephalopathy
  - eg. *CDKL5* encephalopathy, *SCN2A* encephalopathy

Benign epilepsy with centrotemporal spikes (idiopathic focal epilepsy)

- Childhood (3-13yy)
- Predominance of nocturnal seizures- focal onset epileptic seizues with Impaired awareness, less frequently evolving into bilateral tonic-clonic ES
- EEG: Centrotemporal spikes
- Nearly all (95%) patients uotgrow the disorder

Juvenile myoclonic epilepsy (JME)

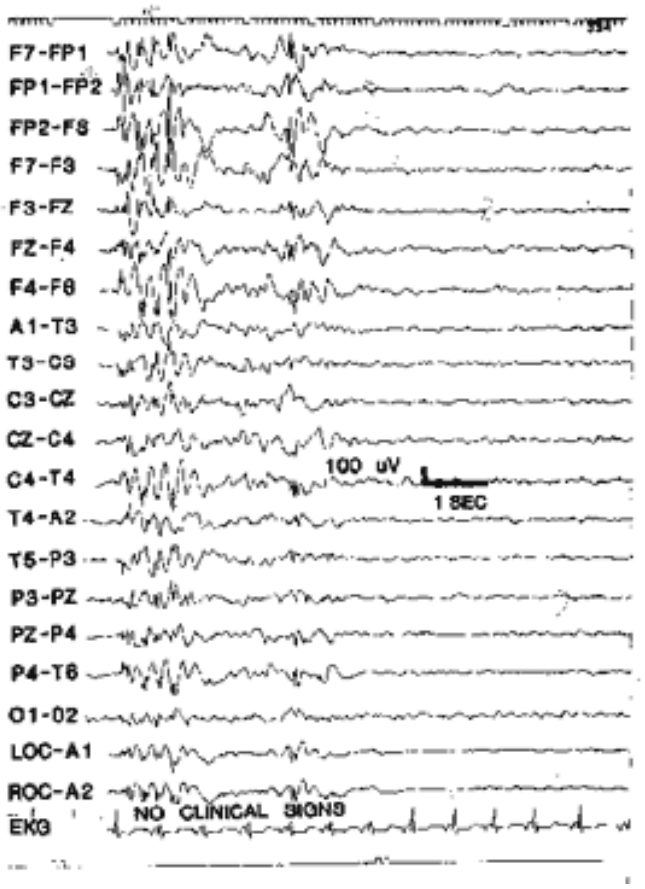
GENERALIZED EPILEPSY

Different types of generalized onset seizures

- Myoclonic jerks on awakening in the morning („patient may spill or drop things, seldom falls“)
- Tonic clonic seizures
- Absence seizures

Inherited condition

EEG: Multiple spike and wave complexes precipitated by photic stimulation



Lennox-Gastaut syndrome

-devastating disorder in children

- Mix types of seizures
- Mental retardation= epileptic encepahlopathy
- EEG: slow (less than 2,5Hz) spike and wave patterns

Mesial temporal lobe epilepsy

- Hippocampal sclerosis- the most common pathology
- Temporal lobe epilepsy- focal onset epileptic seizues:
  - Vegetative auras or affective symptoms (fear)
  - Automatims- oroalimentary, gestural or reactive automatisms
  - Asymetric posturing with impairment awareness
  - Rare evolving into bilateral tonic clonic ES
- Onset: before puberty

Epilepsy- diagnose

- complete patient **history** (details of birth, childhood, family history, and medication regimen; medical history, history of drug and alcohol use)
- A detailed **description of the seizures** (important to distinguish seizure types)
- **Neurological examination**
- **Electroencephalogram (EEG)**
  EEG is a diagnostic test used to investigate a seizure disorder. It identifies abnormal electrical activity in the brain, provides information about the type of seizure disorder, and locates the area of seizure focus.
- **Neuroimaging**
  Magnetic resonance imaging (MRI scan) or computed tomography (CT scan or CAT scan) are performed when a lesion or other structural cause, such as stroke or tumor, is suspected.

Epilepsy- differencial diagnose

- Neurological
  - Transient ischaemic attack
  - Migraine
  - Sleep disorders
    - Narcolepsy with cataplexy
    - REM behaviour disorder
    - somnambulism
- Cardiac
  - Vasovagal syncope
  - Arrhythmias
  - Hypotension
  - Reflex anoxic seizure
- Endocrine/metabolic
  - Changes of blood glucouse, ions
- Psychological
  - Non-epileptic psychogenic seizures

Epilepsy treatment

- Medication- depends on seizure type
  - Focal seizures- LEVETIRACETAM, LAMOTRIGINE (carbamazepine)
  - Generalized- VALPROATE/ LEVETIRACETAM
  - New generation: topiramate, gabapentin, pregabalin, zonisamide, perampanel, brivaracetam, lacosamide

- Other- Ketogenic Diet , ...

- Surgery
  - VNS
  - Resection of the lesion
  - Calosothomy...

EMERGENCY IN EPILEPSY

- Status epilepticus = seizures lasting for 5 minutes or more or recurrent seizures without recovery of consciousness to baseline between the attacks.
- Refractory SE is defined as SE persisting despite sufficient dose of benzodiazepines and at least one antiepileptic drug, irrespective of time.
- Super refractory SE = SE that continues for 24 hours or more after the use of anesthetic therapy, including cases that recur on weaning of the anesthestic agent.

Look for infection, trauma, consider autoimmune/paraneoplastic origin

Epileptic seizure- first aid

- A person experiencing a generalized tonic-clonic seizure or a simple partial seizure that has become convulsive requires first aid.
- Call an **ambulance** if the seizure lasts longer than **5 minutes**, one seizure follows another without the person regaining consciousness, or the person is seriously injured= STATUS EPILEPTICUS.

The goals of first aid are to

- prevent injury,
- maintain an open airway,
- provide reassurance to the patient and bystanders,
- recognize an emergency condition, and
- know when to call for help

BZD- i.v., per rectum

Epileptic seizure- first aid

First aid for epilepsy tonic-clonic seizures

Common symptoms: the person goes stiff, loses consciousness and falls to the floor

Do...

- Protect the person from injury (remove harmful objects from nearby)
- Cushion their head
- Look for an epilepsy identity card/identity jewellery
- Aid breathing by gently placing the person in the recovery position when the seizure has finished (see picture)
- Stay with them until recovery is complete
- Be calmly reassuring

Don't...

- Restrain the person's movements
- Put anything in their mouth
- Try to move them unless they are in danger
- Give them anything to eat or drink until they are fully recovered
- Attempt to bring them round

Call 999 for an ambulance if...

- You know it is the person's first seizure
- The seizure continues for more than five minutes
- One seizure follows another without the person regaining consciousness between seizures
- The person is injured
- You believe the person needs urgent medical attention

Status epilepticus
algorhithm of treatment

Time	Drug treatment	General measures	Investigations
0 min	**IV Access available: Inj Lorazepam**- 0.1 mg/kg/IV (max 4 mg) **OR Inj Midazolam**-0.15-0.2 mg/kg/IV (Max 5 mg) **IV accessnotavailable: Buccal Midazolam** 0.3 mg/kg (Max 5 mg) OR **PR Diazepam** 0.5 mg/kg (Max 10 mg)	▪ Airway ▪ Breathing ▪ Circulation ▪ Establish IV access ▪ Temperature	Glucose, Sodium, Potassium, Calcium, Magnesium
5 min	**Inj Lorazepam**- 0.1 mg/kg/IV (max 4 mg) **OR Inj Midazolam**-0.15-0.2 mg/kg/IV (Max 5mg)	▪ Oxygen inhalation ▪ Cardio respiratory monitoring: ECG, BP, SpO_2	Glucose May consider: CRP, complete blood counts, AED level, Toxic screen, BUN
10 min	**IV Phenytoin*** 20 mg/kg (Max: 1000mg) in NS @ 1 mg/kg/min (Max 50 mg per min), **OR Inj Fosphenytoin** 20 mg PE/ kg, Rate: 3 mg PE/kg/min **Repeat** inj. Phenytoin 10 mg/kg / Inj Fosphenytoin 10 mg PE/ kg, if no response to initial dose	▪ **Check whether the child is on AED* (please see next page for the dose adjustment)**	
Refractory SE-- even after 10 min of phenytoin/ fosphenytoin administration	**IV Valproate** 20- 30 mg/kg-IV @ max 6 mg/kg/minute. **OR** **IV Phenobarbitone** 20 mg/kg in NS @ 1.5 mg/kg/min; **Repeat** 10 mg/kg if no response to initial dose **OR** **IV Levetiracetam** (If Liver disease/Metabolic disease/coagulopathy/ on chemotherapy) - 20-30 mg/kg @ 5 mg/kg/min infusion	▪ Continue monitoring as above ▪ Use vasopressors, if needed ▪ Identify and treat medical conditions and electrolyte disturbances	Consider: • CT head • LP- for CNS infections • EEG
	Consider IV **Pyridoxine** 100 mg infusion in children <2 years of age without clear etiology for seizures, and in those with Isoniazid overdose		
Coma induction - seizure continues 10 min after completion of phenobarbitone infusion			

Febrile convulsions

- 2-5% of children
- Period 3 months to 5 years
- During a sudden rise in temperature early in the course of illnes
- in the absence of intracranial infection

Mental retardation (MR)

- is a generalized disorder appearing before adulthood, characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors.
- It has historically been defined as an Intelligence Quotient score under 70

Intelligence Quotient (IQ)

- An intelligence quotient, or IQ, is a score derived from one of several different standardized tests designed to assess intelligence.

Grades of IQ

- 140 + Genius
- 120 to 140 Very superior intelligence
- 110 to 119 Superior intelligence
- 90 to 109 Normal or average intelligence
- 80 to 89 Dull
- 70 to 79 Borderline deficiency
- Under 70 Definite feeble mindedness

Classification :

- **It is classified as:**

1-Down`s syndrome.

2-Phenylketonuria (PKU).

3-Cretinism (Thyroid Deficiency).

4-Cranial Anomalies.

5-Microcephaly.

6-Hydrocephalus.

Down Syndrome

- Down syndrome is a chromosomal condition characterized by the presence of an extra copy of genetic material on the 21st chromosome, either in whole (trisomy 21) or part (such as due to translocations).

Down Syndrome (cont)

- The incidence of Down syndrome is estimated at 1 per 733 births, although it is statistically more common with older parents due to increased mutagenic exposures upon some older parents' reproductive cells. Other factors may also play a role.

Down Syndrome (cont)

- Often Down syndrome is associated with some impairment of cognitive ability and physical growth, and a particular set of facial characteristics. Individuals with Down syndrome tend to have a lower-than-average cognitive ability, often ranging from mild to moderate disabilities.

Down Syndrome (cont)

- The average IQ of children with Down syndrome is around 50, compared to normal children with an IQ of 100.[5] A small number have a severe to high degree of intellectual disability.

Down Syndrome (cont)

Phenylketonuria (PKU)

- Phenylketonuria is a rare metabolic disorder. In PKU the baby appears normal at birth but lacks an enzyme needed to break down phenylalanine, an amino acid found in protein foods. When this condition is undetected, the phenylalanine builds up in the blood and leads to brain damage.

Phenylketonuria (PKU)(cont)

- The disorder usually becomes apparent between 6 and 12 months after birth, although such symptoms as vomiting, a peculiar odor, infantile eczema, (a skin disorder in infants), and seizures (fits) may become apparent during the early weeks of life.

Phenylketonuria (PKU)(cont)

- Often the first symptoms noticed are signs of mental retardation, which may be moderate to severe, depending on the degree to which the disease has progressed. Motor incoordination and other neurological manifestations relating to the severity of brain damage are also common, and often the eyes, skin, and hair of untreated PKU patients are very pale.

Phenylketonuria (PKU)(cont)

- PKU is thought to result from metabolic alterations involving recessive genes, and 1 person in 70 is thought to be a carrier.

Cretinism (Thyroid Deficiency)

- Cretinism provides a dramatic illustration of mental retardation resulting from endocrine imbalance. In this condition, the thyroid either has failed to develop properly or has undergone degeneration or injury. In either case, the infant suffers from a deficiency in thyroid secretion. Brain damage resulting from this insufficiency is most marked during the prenatal and early postnatal periods of rapid growth.

Cretinism (Thyroid Deficiency)

- Typical descriptions of cretins involve cases in which there has been a severe thyroid deficiency from an early age, often even before birth. Such a cretin has a dwarflike, thick-set body and short, stubby extremities. His height is usually just a little over 3 feet, the shortness accentuated by slightly bent legs and a curvature of the spine.

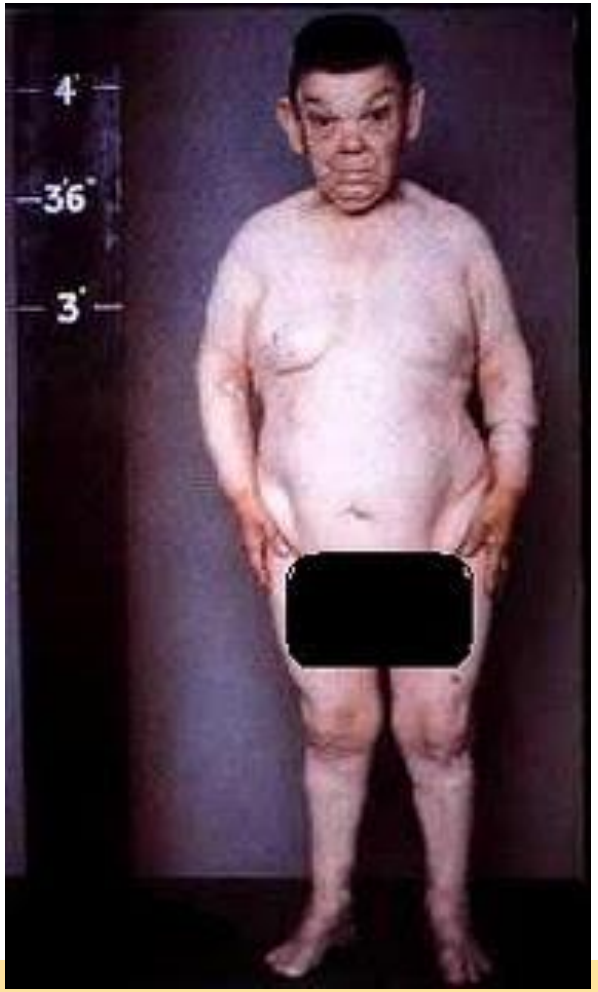
Cretinism (Thyroid Deficiency)

- He walks with a shuffling gait that is easily recognizable. His head is large, with abundant black, wiry hair; his eyelids are thick, giving him a sleepy appearance; his skin is dry and thickened and cold on the touch. Other pronounced physical symptoms include a broad, flat nose, large and flappy ears, a protruding abdomen, and failure to mature sexually.

Cretinism (Thyroid Deficiency)

- The cretins reveal a bland personality, and his thought processes tend to be sluggish. Most cretins fall within the moderate and severe categories of mental retardation, depending on the extent of brain damage. In cases with less pronounced physical signs of cretinism, the degree of mental retardation is usually less severe.

Cretinism (Thyroid Deficiency)



Cranial Anomalies

- Mental retardation is associated with a number of conditions in which there are relatively gross alterations in head size and shape, and where the causal factors have not been definitely established. In **macrocephaly** ("large headedness"), for example there is an increase in the size and weight of the brain, an enlargement of the skull, and visual impairment, convulsions, and other neurological symptoms resulting from the supporting structure for brain tissue. Other cranial anomalies include **microcephaly** and **hydrocephalus**.

Microcephaly

- The term *microcephaly* means "small headedness". It refers to a type of mental retardation resulting from impaired development of the brain and a consequent failure of the cranium to attain normal size. The most obvious characteristics of microcephalic is his small head, the circumference of which rarely exceeds 17 inches, as compared with normal of approximately 22 inches.

Microcephaly

- Microcephalics differ considerably from each other in appearance, although there is a tendency for the skull to be coned shaped, with a receding chin and forehead. Microcephalics fall within the **moderate**, **severe**, and **profound** categories of mental retardation, but the majority shows little language development and is extremely limited in mental capacity.

Hydrocephalus

- Hydrocephalus is a relatively rare condition in which the accumulation of an abnormal amount of cerebrospinal fluid within the cranium causes damage to the brain tissues and enlargement of the cranium. In congenital cases of hydrocephalus, the head is either already enlarged at birth or begins to enlarge soon thereafter, presumably as a result of a disturbance in the formation, absorption, or circulation of the cerebrospinal fluid.

Hydrocephalus

- The disorder can also develop in infancy or early childhood following the development of a brain tumor, subdural hemetoma,(clot in the brain covering), meningitis,(infection of brain covering) or other such conditions. Here the condition appears to result from a blockage of the cerebrospinal pathways and an accumulation of fluid in certain brain areas.

Hydrocephalus

- The clinical picture of hydrocephalus depends on the extent of neural damage, which, in turn, depends on the age at onset and the duration and severity of disorder. In chronic cases the chief symptom is the gradual enlargement of the upper part of the head out of all proportion to the face and the rest of the body. While the expansion of the skull helps minimize destructive pressure on the brain, serious brain damage occurs nonetheless, leading to intellectual impairment and such other effects as convulsions and impairment or loss of sight and hearing.

Causes Of Mental Retardation:

- Prenatal
- Natal
- Postnatal

Common features

- Delays in oral language development
- Deficits in memory skills
- Difficulty learning social rules
- Difficulty with problem solving skills
- Delays in the development of adaptive behaviors such as self-help or self-care skills .

Grades of MR :

- According to IQ :
- Profound mental retardation Below 20
- Severe mental retardation 20–34
- Moderate mental retardation 35–49
- Mild mental retardation 50–69
- Borderline intellectual functioning70--84

Management :

- Management of mental retardation (MR) begins with breaking the news to parents of affected children sensitively, compassionately, and culturally appropriately

- By most definitions mental retardation is more accurately considered a disability rather than a disease.
- Currently, there is no "cure" for an established disability, though with appropriate support and teaching, most individuals can learn to do many things

- The mainstay of treatment of MR is developing a comprehensive management plan for the condition. The complex habilitation plan for the individual requires input from care providers from multiple disciplines, including special educators, language therapists, behavioral therapists, occupational therapists, and community services that provide social support and respite care for families affected by MR.

Prevention :

- Genetic: Prenatal screening for genetic defects and genetic counseling for families at risk for known inherited disorders can decrease the risk of inherited mental retardation.

- Social: Government nutrition programs are available to poor children in the first and most critical years of life. These programs can reduce retardation associated with malnutrition. Early intervention in situations involving abuse and poverty will also help.

- Toxic: Environmental programs to reduce exposure to lead, mercury, and other toxins will reduce toxin-associated retardation. However, the benefits may take years to become apparent. Increased public awareness of the risks of alcohol and drugs during pregnancy can help reduce the incidence of retardation

- Infectious: The prevention of congenital rubella syndrome is probably one of the best examples of a successful program to prevent one form of mental retardation. Constant vigilance, such as limiting exposure to cat litter that can cause toxoplasmosis during pregnancy, helps reduce retardation that results from this infection.

What is a personality disorder?

- An enduring pattern of maladaptive behavior
- Features of these disorders usually become recognizable during adolescence or early adult life
- Should not be confused with personality trait

Three Types of Personality Disorders:

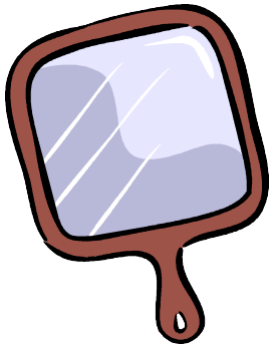
- Cluster A
- Cluster B
- Cluster C

Cluster A

- Paranoid
- Schizoid
- Schizotypal

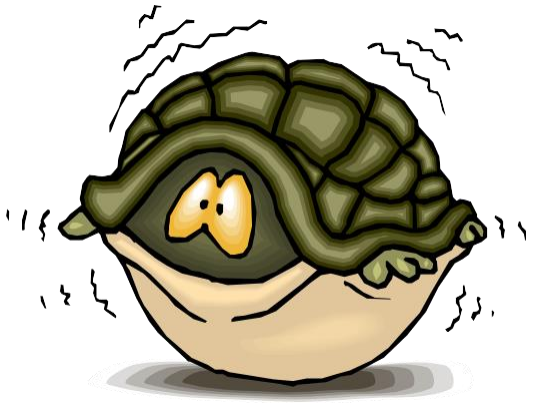
Cluster B

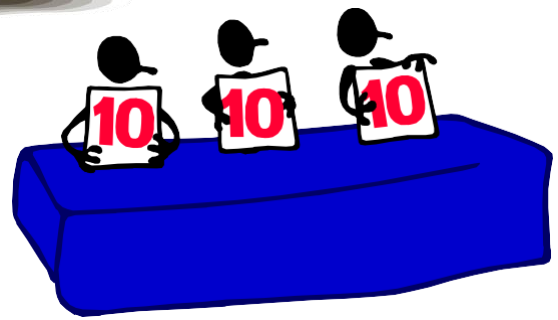
- Antisocial
- Borderline
- Histrionic
- Narcissistic



Cluster C

- Avoidant
- Dependent
- Obsessive-Compulsive





OCD

- Don’t confuse Obsessive-Compulsive Personality Disorder with Obsessive-Compulsive Disorder (OCD)
- Obsessive-Compulsive Personality Disorder individuals are “neat-freaks”

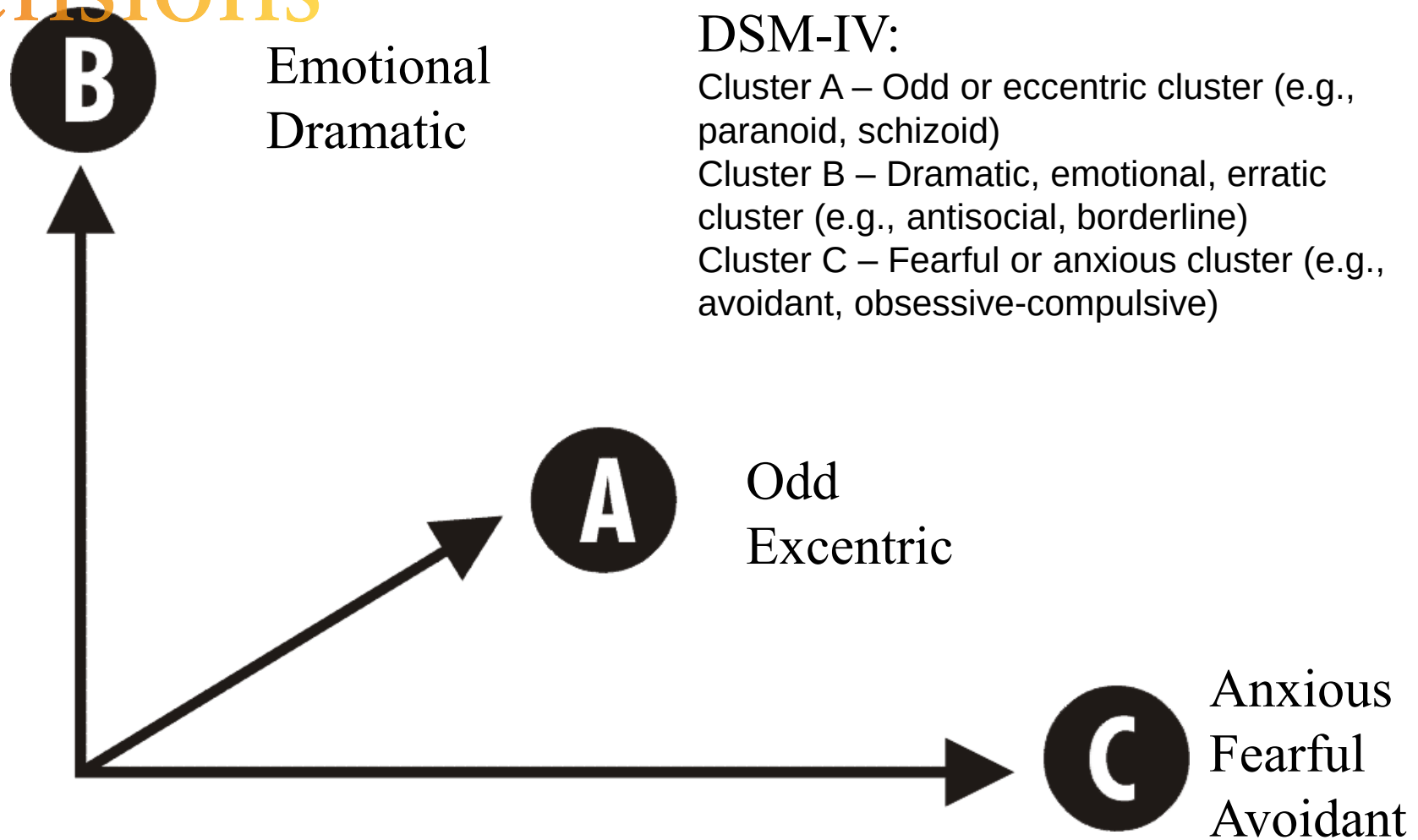
Disruptive Behavior Disorders

- Temper Tantrums
- Physical Aggression
- Excessive argumentativeness
- Stealing
- Defiance
- Resistance to authority

Characteristics of Personality Disorders

- 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.

Dimensions



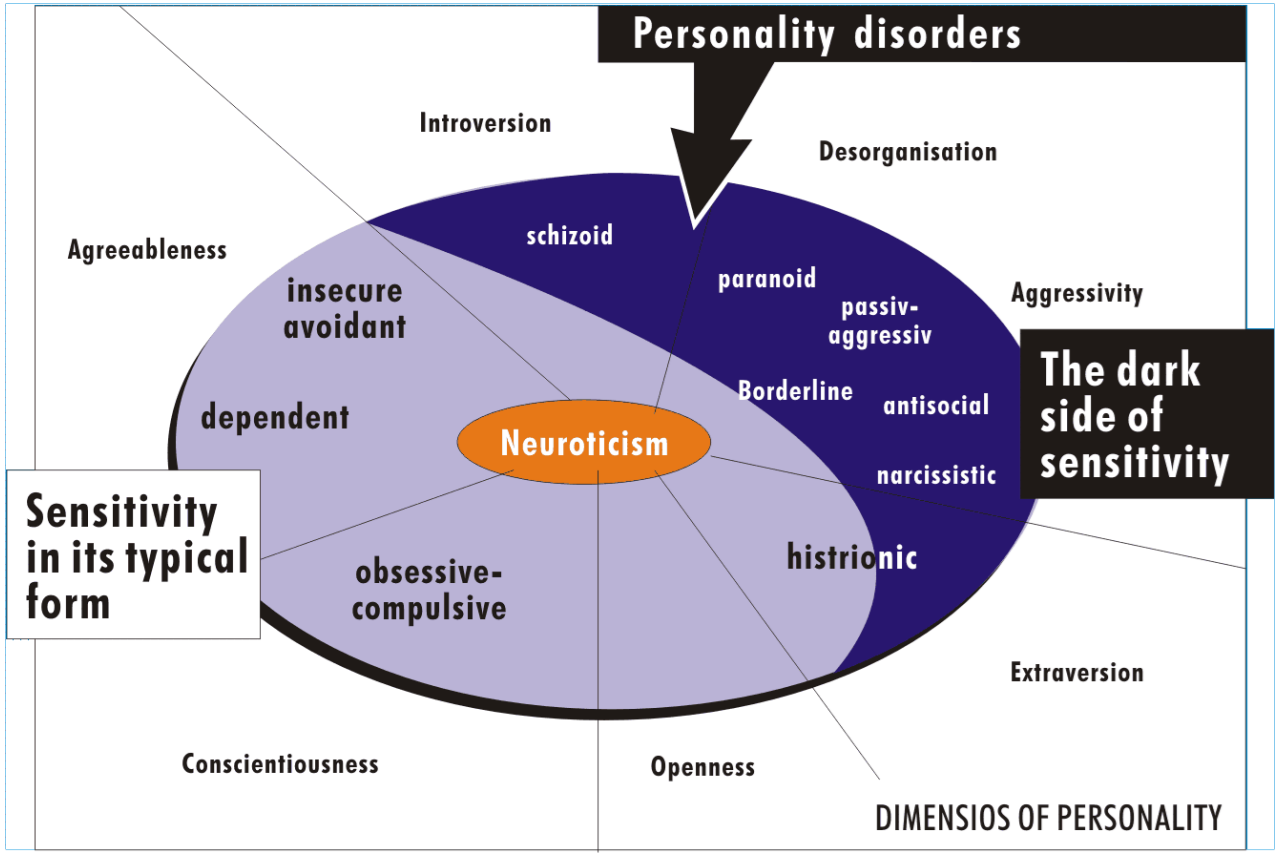
DSM-IV:

Cluster A – Odd or eccentric cluster (e.g., paranoid, schizoid)
Cluster B – Dramatic, emotional, erratic cluster (e.g., antisocial, borderline)
Cluster C – Fearful or anxious cluster (e.g., avoidant, obsessive-compulsive)

Personality Disorders: Facts and Statistics

- *Prevalence of Personality Disorders*
  - Affect about 0.5% to 2.5% of the general population
  - Rates are higher in inpatient and outpatient settings
- *Origins and Course of Personality Disorders*
  - Thought to begin in childhood
  - Tend to run a chronic course if untreated
- *Co-Morbidity Rates are High (depression, anxiety)*

Types of Personality Disorders



Cluster A: Paranoid Personality Disorder

- *Overview and Clinical Features*
  - Pervasive and unjustified mistrust and suspicion
- *The Causes*
  - Biological and psychological contributions are unclear
  - May result from early learning that people and the world is a dangerous place
- *Treatment Options*
  - Few seek professional help on their own
  - Treatment focuses on development of trust
  - Cognitive therapy to counter negativistic thinking
  - Lack good outcome studies showing that treatment is efficacious

Cluster A: Schizoid Personality Disorder

- *Overview and Clinical Features*
  - Pervasive pattern of detachment from social relationships
  - Very limited range of emotions in interpersonal situations
- *The Causes*
  - Etiology is unclear
  - Preference for social isolation in schizoid personality resembles autism
- *Treatment Options*
  - Few seek professional help on their own
  - Focus on the value of interpersonal relationships, empathy, and social skills
  - Treatment prognosis is generally poor
  - Lack good outcome studies showing that treatment is efficacious

Cluster A: Schizotypal Personality Disorder

- *Overview and Clinical Features*
  - Behavior and dress is odd and unusual
  - Most are socially isolated and may be highly suspicious of others
  - Magical thinking, ideas of reference, and illusions are common
  - Risk for developing schizophrenia is high in this group
- *The Causes*
  - Schizoid personality – A phenotype of a schizophrenia genotype?
  - Left hemisphere and more generalized brain deficits
- *Treatment Options*
  - Main focus is on developing social skills
  - Treatment also addresses comorbid depression
  - Medical treatment is similar to that used for schizophrenia
  - Treatment prognosis is generally poor

Cluster B: Antisocial Personality Disorder

- *Overview and Clinical Features*
  - Failure to comply with social norms and violation of the rights of others
  - Irresponsible, impulsive, and deceitful
  - Lack a conscience, empathy, and remorse
- *Relation Between Psychopathy and Antisocial Personality Disorder*
- *Relation Between ASPD, Conduct Disorder, and Early Behavior Problems*
  - Many have early histories of behavioral problems, including conduct disorder
  - Many come from families with inconsistent parental discipline and support
  - Families often have histories of criminal and violent behavior

Cluster B: Borderline Personality Disorder

- *Overview and Clinical Features*
  - Patterns of unstable moods and relationships
  - Impulsivity, fear of abandonment, coupled with a very poor self-image
  - Self-mutilation and suicidal gestures are common
  - Most common personality disorder in psychiatric settings
  - Comorbidity rates are high
- *The Causes*
  - Borderline personality disorder runs in families
  - Early trauma and abuse seem to play some etiologic role
- *Treatment Options*
  - Few good treatment outcome studies
  - Antidepressant medications provide some short-term relief
  - Dialectical behavior therapy is the most promising psychosocial approach

Cluster B: Histrionic Personality Disorder

- *Overview and Clinical Features*
  - Patterns of behavior that are overly dramatic, sensational, and sexually provocative
  - Often impulsive and need to be the center of attention
  - Thinking and emotions are perceived as shallow
  - Common diagnosis in females
- *The Causes*
  - Etiology is largely unknown
  - Is histrionic personality a sex-typed variant of antisocial personality?
- *Treatment Options*
  - Few good treatment outcome studies
  - Treatment focuses on attention seeking and long-term negative consequences
  - Targets may also include problematic interpersonal behaviors
  - Little evidence that treatment is effective

Cluster B: Narcissistic Personality Disorder

- *Overview and Clinical Features*
  - Exaggerated and unreasonable sense of self-importance
  - Preoccupation with receiving attention
  - Lack sensitivity and compassion for other people
  - Highly sensitive to criticism
  - Tend to be envious and arrogant
- *The Causes*
  - Link with early failure to learn empathy as a child
  - Sociological view – Narcissism as a product of the "me" generation
- *Treatment Options*
  - Extremely limited treatment research
  - Treatment focuses on grandiosity, lack of empathy, unrealistic thinking
  - Treatment may also address co-occurring depression
  - Little evidence that treatment is effective

Cluster C: Avoidant Personality Disorder

- *Overview and Clinical Features*
  - Extreme sensitivity to the opinions of others
  - Highly avoidant of most interpersonal relationships
  - Are interpersonally anxious and fearful of rejection
- *The Causes*
  - Numerous factors have been proposed
  - Early development – A difficult temperament produces early rejection
- *Treatment Options*
  - Several well-controlled treatment outcome studies exist
  - Treatment is similar to that used for social phobia
  - Treatment targets include social skills and anxiety

Cluster C: Dependent Personality Disorder

- *Overview and Clinical Features*
  - Excessive reliance on others to make major and minor life decisions
  - Unreasonable fear of abandonment
  - Tendency to be clingy and submissive in interpersonal relationships
- *The Causes*
  - Still largely unclear
  - Linked to early disruptions in learning independence
- *Treatment Options*
  - Research on treatment efficacy is lacking
  - Therapy typically progresses gradually
  - Treatment targets include skills that foster independence

Cluster C: Obsessive-Compulsive Personality D.

- *Overview and Clinical Features*
  - Excessive and rigid fixation on doing things the right way
  - Tend to be highly perfectionistic, orderly, and emotionally shallow
  - Obsessions and compulsions, as in OCD, are rare
- *The Causes*
  - Are largely unknown
- *Treatment Options*
  - Data supporting treatment are limited
  - Treatment may address fears related to the need for orderliness
  - Other targets include rumination, procrastination, and feelings of inadequacy

Therapies for Personality Disorders

Disorder  Style

- Ultimate goal is to turn disorder into style
- Often treated in context of comorbid Axis I diagnosis
- Psychotropic medication may be prescribed based on Axis I features it resembles
- Psychodynamic therapy looks at childhood problems underlying personality disorder
- Behavioral and cognitive approaches look at individual problems that reflect personality disorder

The inner struggle

- „I find then a law, that, when I would do good, evil is present with me.
- For I delight in the law of God after the inward man:

- But I see another law in my members warring against the law of my mind, and bringing me into captivity to the law of sin which is in my members,

- (The apostle Paul – Romans 7,21–23)

„the other law“

- attitudes, actions and words which can h **„SIN“** .
- Drives, feelings, and thoughts which can poison our inner world

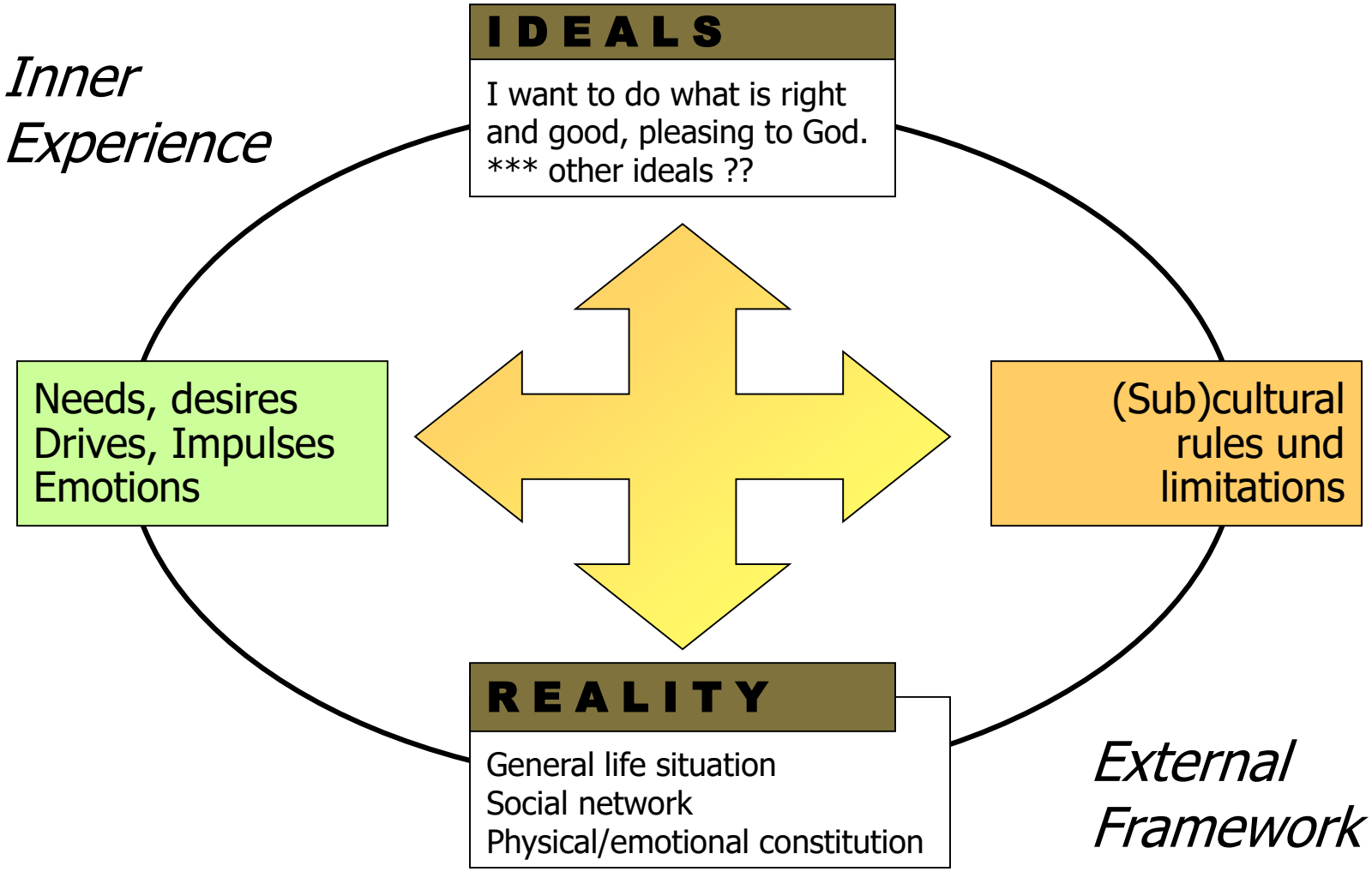
- Anxiety (Neuroticism)

WEAKNESS

- Lack of energy (gr. oligopsychos, astheneia)

(1. Thess. 5,14; 2. Kor. 12,9)

Areas of tension



Conflicts: Which values are important to us?