# Personality Disorders: Social, Developmental, and Clinical Perspectives

Hasan Atak & Martin Jencius

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## How to Read This Book?

Dear Reader,

*Personality Disorders: Social, Developmental, and Clinical Perspectives* is a comprehensive resource that examines personality disorders from multiple angles. Rather than focusing solely on clinical diagnoses, this book also explores social and developmental perspectives, offering a well-rounded understanding of these disorders. As you read, consider the following points to make the most of this book:

### Adopt a Holistic Approach

This book goes beyond symptoms and diagnoses, examining how personality disorders manifest within social interactions, developmental trajectories, and life experiences. Keeping an interdisciplinary perspective in mind will help you better grasp the material.

### Connect Clinical Knowledge with Social and Developmental Perspectives

While the book provides essential clinical criteria, it also highlights the broader impact of personality disorders on individuals' social lives and personal growth. Try to relate the theoretical discussions to real-world examples for deeper understanding.

### Read According to Your Interests

If you are reading this book for academic or professional development, you may choose to start with the sections most relevant to your field. Whether you are interested in clinical psychology, social psychology, or developmental psychology, certain chapters may be more immediately useful to you.

### Pay Close Attention to Case Studies and Discussions

This book includes case studies and research findings to illustrate key concepts. These examples will help you see how personality disorders affect individuals in real-life contexts, making the material more tangible and applicable.

**Compare the Information with Your Own Experiences**

If you work in clinical or academic settings, consider how the book's insights align with your own observations. Relating the discussions on social relationships and developmental processes to cases you have encountered will deepen your understanding.

**Engage in Critical and Analytical Reading**

The book presents various theoretical approaches and encourages critical thinking. As you read, question the perspectives presented, compare them with existing literature, and form your own interpretations.

This book is designed to provide you with a comprehensive view of personality disorders, enriching both your academic knowledge and professional expertise. Take notes, make connections between concepts, and reflect on the case studies to maximize your learning experience.

Happy reading!

**Hasan Atak, Prof. Dr.**

Prof. Dr. Hasan Atak was born in Ankara. He completed his primary education in Aksaray and his secondary education in Eskişehir. After earning his bachelor's degree from Ankara University in 2001, he completed his master's degree in 2005 and his doctorate in 2010 at the same university. Since 2011, he has been working in the Department of Educational Sciences at Kırıkkale University Faculty of Education. Between 2015 and 2017, he worked in the Department of Psychology at the University of Minnesota. Since 2019, he has been serving as a Professor in the Department of Educational Sciences at Kırıkkale University Faculty of Education, teaching courses such as developmental psychology, behavioral disorders, and individual psychological counseling practice.

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## PREFACE

Personality is a construct that encompasses an individual's patterns of thinking, feeling, and behaving, remaining relatively stable over time. Individuals develop personality traits shaped by the interaction between their innate characteristics and environmental experiences. However, in some cases, these traits may become rigid, inflexible, and maladaptive, leading to significant impairments in an individual's daily functioning. Personality disorders constitute a broad domain of psychopathology that affects not only the individual but also their family, friends, work relationships, and the society in which they live.

This book goes beyond examining personality disorders solely from a clinical perspective; it also evaluates them within developmental and social contexts. To understand the origins of personality disorders, early childhood experiences, family dynamics, neurobiological factors, and sociocultural interactions are thoroughly analyzed. Additionally, the impact of these disorders on identity development, attachment patterns, and social adaptation is explored in detail.

According to the classification of the American Psychiatric Association's DSM-5, personality disorders are categorized into three clusters: Cluster A includes paranoid, schizoid, and schizotypal personality disorders, which are characterized by eccentric and peculiar behaviors; Cluster B encompasses antisocial, borderline, histrionic, and narcissistic personality disorders, which are marked by dramatic and emotional personality patterns; and Cluster C consists of dependent, avoidant, and obsessive-compulsive personality disorders, which are based on anxiety and fear. This book provides an in-depth examination of each personality disorder, discussing their symptoms, etiology, developmental dynamics, and treatment processes within different psychotherapeutic frameworks.

Prepared by expert academics and clinicians in the fields of psychology and psychiatry, this work aims to offer an interdisciplinary perspective by addressing personality disorders from both individual and societal dimensions. The book serves as a valuable resource not only for professionals in the field but also for researchers and students seeking a deeper understanding of personality disorders.

We hope this work contributes to the existing body of knowledge on personality disorders, supports clinical and academic research, and serves as a comprehensive guide for readers. Understanding personality, one of the most complex aspects of human nature, is not only crucial for diagnosing individual psychopathologies but also for comprehending social dynamics and fostering healthy relationships.

With love and respect, *March 2025,*

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***Dedicated to Aileen Jencius…***

*-also-*

*Dedicated to everyone*

*who explores the boundaries of personality,*

*questions the depths of human nature,*

*and dares to understand the complexities of the soul…*

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# CHAPTER 1

## Personality and Personality Disorders

### Personality

Throughout history, numerous definitions have been proposed regarding the concept of personality. The term "personality" originates from the Latin word *persona*, which initially referred to the masks worn in ancient theatrical performances. These masks symbolized the characteristics of the roles being played, distinguishing them from the actor's real identity. Over time, the meaning of *persona* evolved beyond theatrical representation to encompass the real and observable traits that differentiate individuals in everyday life (Konduz, 2015).

While individuals often exhibit similar reactions to fundamental life events, closer observation reveals notable variations in emotional, cognitive, and behavioral responses. These variations highlight the uniqueness of personality, which scholars have sought to define and conceptualize in different ways. In this context, Atak (2022) describes personality as "a structured combination of various traits, including emotions, thoughts, and behaviors, that make a person unique." Similarly, Burger (2006) defines personality as "a pattern of consistent behaviors influenced by internal processes that shape an individual's emotions and actions." Both definitions emphasize the stable yet dynamic nature of personality, recognizing that while certain traits remain consistent, they are also influenced by situational and environmental factors.

### The Challenges of Defining Personality

Efforts to define personality have aimed at achieving objectivity and functionality, yet an examination of various personality theories reveals that theorists' perspectives, cultural backgrounds, and personal experiences significantly shape their interpretations. As a result, different scholars emphasize different aspects of personality formation (Bilge, 2014).

For instance, psychodynamic theories suggest that early childhood experiences and unconscious motives play a crucial role in shaping

personality. Freud's psychoanalytic theory emphasizes the conflicts between the id, ego, and superego, whereas Carl Jung's analytical psychology introduces concepts such as the collective unconscious and archetypes. In contrast, humanistic approaches, such as those proposed by Carl Rogers and Abraham Maslow, focus on the individual's capacity for self-growth and self-actualization. These perspectives underscore the subjectivity inherent in defining personality, as different theoretical lenses highlight different dimensions of human behavior.

One notable example of how personal experiences influence theory development is Sullivan's interpersonal theory of personality. Sullivan's perspective was shaped by his own relationship with his mother, which influenced his belief that personality is primarily formed through long-term social interactions (Burger, 2006). According to Sullivan, these interactions vary across individuals, defining their unique self-concepts and relational patterns. A key component of Sullivan's theory is the self-system, which develops through differentiated social experiences and interactions. He emphasized the importance of emotional needs, particularly those met through maternal bonds, in shaping an individual's personality (Mohl, 2007). Sullivan's approach diverges from more intrapsychic-focused theories, such as Freud's, by arguing that personality is not just an internal construct but a dynamic product of social exchanges.

Given the diverse theoretical perspectives on personality, this book aims to explore various theories, diagnostic criteria, classification systems, measurement tools, and the prevalence of personality disorders. The study seeks to provide both theoretical insights and practical applications, helping to bridge the gap between historical and contemporary approaches. By comparing past and present perspectives on personality disorders, this book intends to contribute to the literature by identifying existing research gaps and illustrating how current theoretical frameworks influence diagnosis and treatment.

**Personality Theories**

When evaluated in terms of theories, it is evident that almost every theory defines and interprets personality from its own perspective. At its most basic level, personality can be defined as the stable characteristics and

tendencies in an individual's emotional, cognitive, and behavioral responses that cannot be solely explained by the immediate situation (Taymur & Türkçapar, 2012). This definition highlights the relatively significant and enduring aspects of psychological responses. Personality encompasses an individual's mental, emotional, and social attributes, among others.

When examining studies on the classification of personality traits, it is apparent that their origins date back to ancient times. Based on his research, Allport adopted an idiographic approach, asserting that personality is unique to each individual. According to this view, every person's personality is a distinct formation shaped by their life experiences. However, nomothetic approaches suggest that personality can be categorized and classified (Aslan, 2008).

**Table 1. Allport's Definition of Personality**

| | |
|---|---|
| **Dynamic Organization** | **Personality is a constantly changing and evolving organized system ("unitas multiplex").** |
| **It is Within the Individual** | Personality is what lies behind an individual's unique actions. |
| **It is Psychophysical** | Personality emerges from the complex interaction of psychological and biological functions. |
| **It is Determinative** | The systems that shape personality determine behaviors aimed at adapting to the environment. |
| **It is a Unique Adaptation to the Environment** | Personality is a unique adaptation process that an individual follows while sustaining life, utilizing adaptation strategies. |

Allport's definition of personality emphasizes its dynamic and multifaceted nature, highlighting both its psychological and biological foundations.

1. **Dynamic Organization** – This perspective suggests that personality is not a fixed entity but a continuously evolving and adaptable system. The phrase *unitas multiplex* reflects the idea that personality maintains coherence despite its complexity and constant change.

2. **It is Within the Individual** – Personality is deeply embedded in an individual's unique way of thinking, feeling, and behaving. It is the driving force behind personal actions and decisions, shaping how one interacts with the world.
3. **It is Psychophysical** – Allport acknowledges that personality is formed through the interplay of psychological and biological processes. This view integrates both mental states and physiological factors, suggesting that personality is neither purely mental nor purely physical but a fusion of both.
4. **It is Determinative** – Personality influences an individual's behavior by guiding adaptive responses to the environment. It shapes how people perceive, react to, and engage with the world around them, making it a crucial factor in behavioral consistency.
5. **It is a Unique Adaptation to the Environment** – Personality is not only shaped by biological and psychological factors but also by environmental influences. Individuals develop unique adaptation strategies to navigate social and environmental challenges, demonstrating the role of personality in personal development and survival.

Allport's conceptualization presents personality as a complex, evolving system that integrates internal and external influences, guiding individual behavior in a way that is both unique and adaptive. However, various theorists have examined personality from different angles. Despite efforts to maintain objectivity, theories inevitably reflect the subjectivity of their creators due to their interpretations of data. Below is an overview of these theoretical perspectives.

Freud initially explained personality through the topographical model and later introduced the structural model. The topographical model categorizes mental processes into the conscious, preconscious, and unconscious, while the structural model comprises the id, ego, and superego. Although Freud's theory has been widely criticized for its scientific limitations, it remains one of the most comprehensive explanations of personality (Millon et al., 2004; Magnavita, 2016). Classical psychoanalysis, initially focused on hysteria (Bilge, 2014), highlights early life experiences and psychosexual developmental stages as key determinants of personality (Geçtan, 1997; Millon & Lerner, 2003; Gençtanırım Kurt & Çetinkaya Yıldız,

2017). According to psychoanalysis, the ego employs defense mechanisms to mitigate anxiety caused by internal and external conflicts (Burger, 2006).

Freud's successors, often called "Neo-Freudians," modified his ideas. Alfred Adler, Carl Gustav Jung, and Karen Horney are among these theorists (Karabaş, 2021). Adler, a proponent of Individual Psychology, agreed with Freud that personality foundations develop within the first five years of life. However, he emphasized feelings of inferiority as a driving force behind human behavior (Magnavita, 2016). Jung proposed that personality consists of three levels: the conscious, personal unconscious, and collective unconscious. These interact to form the psyche, which integrates both conscious and unconscious elements. Jung (1992) introduced the concept of "persona," which allows individuals to adapt to their social environment (Millon et al., 2004).

Ego psychology, pioneered by Anna Freud and Erik Erikson, extended psychoanalytic theory beyond psychopathology to normal development. Figures like Heinz Hartmann, Edith Jacobson, Rene Spitz, and David Rapaport further explored how personality is shaped by environmental and interpersonal factors rather than just biological determinants (Schultz & Schultz, 2007; Sharf, 2017; McWilliams, 2017).

Melanie Klein, the founder of object relations theory, emphasized the impact of early relationships on personality development. These relational patterns persist into adulthood, influencing one's personality and social interactions (Geçtan, 1997). Otto Kernberg expanded on this theory through transference-focused psychotherapy, which examines how internalized relational patterns shape personality. Kohut introduced the concepts of self-representation and self-object, referring to an individual's self-perception and the significant people who influence their self-concept (Kohut, 2017; Kohut, 2022).

Behavioral and cognitive approaches explain personality through learning processes. Behaviorists argue that psychopathologies can be modified using learning principles, while cognitive theorists emphasize mental schemas that shape how individuals interpret experiences (Bilge, 2014). Bandura integrates cognition into the behavioral model, asserting that

external factors, internal cognitions, and social interactions all contribute to personality (Burger, 2006).

Harry Stack Sullivan (1892–1949) developed interpersonal theory, which emphasizes the role of social relationships in shaping personality. Unlike traditional psychoanalytic theories that focus on internal conflicts and unconscious processes, Sullivan argued that personality is primarily a product of interpersonal interactions. According to his view, personality does not exist independently within an individual but is instead a pattern of behaviors and thoughts that emerge through social exchanges.

Sullivan believed that human behavior and personality development are shaped by long-term social interactions, particularly in early childhood. He rejected the idea that personality is an innate, fixed structure and instead saw it as a dynamic process that continuously evolves through relationships with others. One of Sullivan's key arguments is that an individual's personality can only be understood in the context of their social environment. He emphasized that personal experiences, particularly those involving close relationships, influence emotional and behavioral patterns.

A central concept in Sullivan's theory is the self-system, which refers to the way individuals perceive themselves based on their interactions with others. According to Sullivan, the self-system develops in response to interpersonal experiences, especially those that involve approval or disapproval from significant others. The self-system consists of three main components: The "Good Me" emerges from experiences that are met with approval and positive social feedback, representing behaviors and traits that an individual perceives as acceptable. The "Bad Me" forms from experiences that lead to disapproval or criticism, including aspects of the personality that cause anxiety or discomfort due to negative social reactions. The "Not Me" represents the most anxiety-provoking aspects of the self, which an individual actively avoids or represses because they are associated with severe social rejection or fear.

Sullivan proposed a developmental model of personality that emphasizes the importance of social relationships at different life stages. Infancy, from birth to two years, is when the child's first interpersonal relationships, primarily with caregivers, shape early emotional responses and

basic social expectations. During childhood, from two to six years, the child begins to form relationships beyond the caregiver and learns to interact with peers and authority figures. The juvenile era, from six to nine years, is when social interactions with peers become more complex, and children start developing a sense of belonging in social groups. In preadolescence, from nine to twelve years, close friendships, particularly same-sex friendships, become important, helping to shape trust and emotional connections. Early adolescence, from twelve to fourteen years, is marked by the emergence of romantic interests and the exploration of new social roles and relationships. During late adolescence, from fourteen to twenty-one years, a stable sense of identity forms as individuals learn to balance their personal needs with the expectations of society. Adulthood, from twenty-one years onward, involves the continued evolution of personality based on interpersonal relationships, romantic partnerships, and career-related social interactions.

Sullivan believed that anxiety plays a crucial role in personality development, as individuals constantly seek to avoid social rejection and maintain a sense of security. He suggested that people use different interpersonal strategies to manage anxiety, such as seeking approval, avoiding conflict, or conforming to social norms. These strategies become habitual and form the basis of an individual's personality.

Sullivan's interpersonal theory was influential in shifting the focus of personality psychology from intrapsychic conflicts to social relationships. His ideas laid the foundation for later developments in interpersonal psychotherapy, which is widely used today for treating mood and personality disorders. His emphasis on social interactions, communication, and relational patterns also influenced modern approaches to personality disorders, particularly those that focus on attachment styles and interpersonal functioning.

Sullivan's theory highlights that personality is not an isolated entity but a product of ongoing social interactions. By emphasizing the role of relationships in shaping self-perception, emotional regulation, and behavioral patterns, his work provides valuable insights into both normal personality development and psychological disorders. His contributions continue to influence contemporary theories in personality psychology, psychotherapy, and social psychology.

The humanistic approach, led by Carl Rogers, Abraham Maslow, and Erich Fromm, views personality as an active and evolving concept (Yıldırım, 2020). Rogers emphasized the importance of self-concept, where the alignment between the ideal self and the real self significantly impacts personality development (Rogers, 2018). Maslow introduced a hierarchy of needs, proposing that personality development is influenced by an individual's progression through various levels, from basic physiological needs to self-actualization (Maslow, 1970). Fromm highlighted the role of social relationships in shaping personality (Fromm, 1982). Sullivan defined personality as "enduring patterns of interpersonal interactions that define a person's life" (Yazgan İnanç & Yerlikaya, 2012).

Trait theories describe personality as a stable set of behavioral tendencies. Allport emphasized "individual distinguishing traits," while Cattell identified 16 personality factors through factor analysis, including characteristics like emotional stability, liveliness, and social boldness (Yazgan İnanç & Yerlikaya, 2012; Dal & Eroğlu, 2009). Eysenck proposed a three-factor model comprising extraversion-introversion, neuroticism, and psychoticism, arguing that brain functions underlie personality traits (Lewis et al., 2002; Eysenck, 2006).

The five-factor model, developed by McCrae and Costa (2003), identifies five core personality traits: extraversion, neuroticism, openness to experience, agreeableness, and conscientiousness. According to this model, personality is shaped by fundamental tendencies, characteristic adaptations, and environmental influences (McCrae & Costa, 2003; Yazgan İnanç & Yerlikaya, 2012).

**Personality Disorder**

Personality refers to a distinctive pattern of an individual's behavioral responses and attitudes in daily life (Köroğlu & Bayraktar, 2010). The American Psychiatric Association (APA) defines personality disorder as "a persistent pattern of emotion, thinking, and behavior that significantly deviates from the expectations of the culture in which the individual resides, is pervasive and inflexible, emerges during adolescence or early adulthood, remains stable over time without intervention, and leads to distress or impairments in functionality" (Sezer Katar et al., 2022).

The primary criteria for diagnosing personality disorders include significant deviations from typical personality patterns, excessive rigidity in personality traits, impairment in social adaptation and functioning, and internal distress (Köroğlu & Bayraktar, 2010). Additionally, personality disorders can be described as an exaggerated manifestation of normal personality traits in a way that causes discomfort both to the individual and those around them (Öztunç et al., 2015).

Diagnosing personality disorders presents considerable challenges, primarily due to uncertainties in classification and diagnostic methods (Öztürk & Uluşahin, 2011). In reviewing the literature, two main sources are found to have significantly influenced the modern conceptualization of personality disorders. One source stems from Freud and other psychoanalysts, while the other derives from Ribot and Kraepelin. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), has been developed within this framework. Ribot and Kraepelin particularly focused on detailing and diagnosing the outward behavioral characteristics of different dysfunctional personality types and the interrelationships among various personality-based disorders (Bingöl, 2022).

A study conducted by the World Health Organization (WHO) determined the prevalence of any personality disorder to be 6.1%, with Cluster A disorders at 3.6%, Cluster B disorders at 1.5%, and Cluster C disorders at 2.7% (American Psychiatric Association, 2013). A meta-analysis study in the United States found that the prevalence of personality disorders among patients receiving outpatient psychiatric care ranged from 45% to 51% (Beckwith et al., 2014). The high prevalence of personality disorders and their frequent co-occurrence with other mental disorders highlight the importance of further research in mental health.

A 2016 study covering countries such as England, Wales, Scotland, Western Europe, Norway, Australia, and the United States reported that the prevalence of personality disorders ranged from 4.4% to 21.5%. Initial findings from this study also suggested an association between Cluster A and B personality disorders and conditions like cardiovascular diseases and arthritis (Quirk et al., 2016). This connection underscores the necessity of multidisciplinary research.

A meta-analysis involving 113,998 individuals from Western countries found that the overall prevalence of any personality disorder was 12.16%, with Cluster A, B, and C disorders ranging from 5.53% to 7.23%. The study also indicated that obsessive-compulsive personality disorder had the highest prevalence (4.32%), while dependent personality disorder had the lowest (0.78%) (Volkert et al., 2018). Another meta-analysis conducted in 2019, covering 21 countries across six continents, estimated the global prevalence of personality disorders at 7.8%. Higher prevalence rates were observed in high-income countries (9.6%) compared to low-income countries (4.3%), with Cluster A, B, and C disorders accounting for 3.8%, 2.8%, and 5.0%, respectively (Winsper et al., 2019). The higher prevalence in high-income nations is particularly noteworthy. Moreover, the global dominance of Cluster C disorders aligns with Volkert et al.'s (2018) findings, which reported obsessive-compulsive personality disorder as the most common.

In a study conducted in the Turkish province of Aydın using the DIP-Q (DSM-IV and ICD-10 Personality Questionnaire) self-report survey, the prevalence of any personality disorder was found to be 4.8% (Şenyuva, 2007). A meta-analysis study in Turkey reported a prevalence rate of 52% among individuals diagnosed with various psychiatric disorders over the past 30 years, as assessed using SCID-II (Dereboy et al., 2022). The scarcity of studies on the prevalence of personality disorders in Turkey is particularly striking.

The development of personality disorders is influenced by multiple factors, including genetic predisposition, childhood attachment experiences, traumatic events, family environment, and broader social, cultural, and political factors (Magnavita, 2016). These influences emerge through the interplay between physiological structures—such as chemical and neurological processes—and psychological, social, and cultural dynamics (Konduz, 2015).

**Common Features of Personality Disorders**

According to Öztürk (2004), common characteristics observed in personality disorders include:

1. Rigidly adhering to behavior patterns that align with one's personality in an effort to maintain consistency.
2. Deviating from socially accepted norms and displaying antisocial behaviors.
3. Persisting from childhood or early adolescence and becoming chronic.
4. Experiencing functional impairments in social and professional settings.
5. Behaviors being consistent with one's personality and adopted by the individual, yet remaining resistant to change even when inconsistent with their personality.
6. Displaying behaviors that are incompatible with the environment and attempting to conform the environment to oneself rather than adapting to it.
7. Absence of significant impairments in cognitive systems, fundamental emotional responses, and thought processes.

**Epidemiology of Personality Disorders**

The prevalence and gender distribution of personality disorders vary by type. Additionally, geographical and cultural factors influence epidemiology (Ertan & Cankorur, 2017). According to the World Health Organization, the overall prevalence of any personality disorder is estimated at 6.1%. Cluster A personality disorders have a prevalence rate of 3.6%, followed by Cluster C at 2.7%, and Cluster B at 1.5% (American Psychiatric Association, 2013). Research by Volkert, Gablonski, and Rabung (2018) found the prevalence rate of personality disorders in Western countries to be 12.16%, with Cluster A being the most common (7.23%). The most prevalent disorder was obsessive-compulsive personality disorder (4.32%), while dependent personality disorder was the least common (0.78%).

A study conducted in Turkey found the prevalence rate for Cluster A personality disorders to be 7.7%, followed by Cluster B at 4.1% and Cluster C at 6.5% (Senyuva, 2007). Research investigating gender differences in personality disorders indicates that men are 4-5 times more likely to be diagnosed than women, though some specific disorders are more frequently diagnosed in women (Ozturk, 2004).

**Etiology of Personality Disorders**

The etiology of personality disorders is complex and multifaceted (Magnavita, 2004). The causes of personality disorders can be categorized into three main factors:

*a) Genetic Factors*

Multiple genes influence neurobiological systems, shaping personality and behavior. While personality disorders cannot be fully explained by genetics, twin studies suggest a hereditary component for some personality disorders (Magnavita, 2004).

*b) Structural Factors*

Events affecting the central nervous system before, during, or after birth may contribute to the development of personality disorders. For instance, children with minimal brain dysfunction have a higher risk of developing dissocial and antisocial personality disorders (Ozturk, 2004).

*c) Environmental Factors*

According to Magnavita (2004), early attachment patterns, traumatic life events, and dysfunctional family structures significantly impact the development of personality disorders.

General Symptoms of Personality Disorders According to DSM-5

"A. A pervasive pattern of inner experience and behavior that deviates significantly from the expectations of the individual's culture. This pattern manifests in at least two of the following areas:

1. Cognition (ways of perceiving and interpreting oneself, others, and events).
2. Affectivity (range, intensity, lability, and appropriateness of emotional responses).
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 pattern leads to clinically significant distress or impairment in social, occupational, or other areas of functioning. D. The pattern is stable and of long duration, with an onset traceable at least to adolescence or early adulthood. E. The pattern is not better explained as a manifestation or consequence of another mental disorder. F. The pattern is not attributable to the physiological effects of a substance (e.g., drug abuse, medication) or another medical condition (e.g., head trauma)." (American Psychiatric Association, 2013, pp. 327-328).

Personality disorders, as outlined in DSM-5, are characterized by impairments in self-perception and interpersonal relationships. Additionally, these traits must be stable and consistent over time (American Psychiatric Association, 2013). The DSM-5 classification criteria are detailed below.

## Theoretical Perspectives on Personality Disorders

The literature indicates that early approaches to personality disorders were rooted in biological and psychodynamic theories, while contemporary models have expanded to include psychodynamic, biological, interpersonal, and cognitive perspectives. Each of these perspectives offers a unique lens through which personality disorders can be understood, emphasizing different factors that contribute to their development and manifestation.

### Biological Perspectives

Biological influences on personality can be categorized into **proximal and distal effects**. Distal effects occur through the inheritance of species-specific traits, meaning that certain personality predispositions are evolutionarily ingrained and passed down through genetic inheritance. In contrast, **proximal effects** arise from the impact of an individual's complex biological systems, including neurological structures, neurotransmitter activity, and hormonal regulation. Research suggests that these biologically driven behavioral tendencies emerge before personality fully develops, shaping the foundation upon which later personality traits and potential disorders are built (Millon et al., 2004).

Recent advances in **neuroscience and genetics** have provided further insights into the biological underpinnings of personality disorders. Studies using brain imaging techniques indicate that structural and functional abnormalities in areas such as the prefrontal cortex, amygdala, and limbic system may contribute to impulsivity, emotional dysregulation, and social impairments commonly seen in personality disorders. Additionally, **genetic studies** suggest that while no single gene determines the development of personality disorders, heritability plays a significant role, particularly in disorders such as borderline and antisocial personality disorder.

**Psychodynamic Perspectives**

Psychodynamic theories, originally proposed by **Sigmund Freud**, emphasize the role of early childhood experiences, unconscious conflicts, and defense mechanisms in shaping personality pathology. According to this perspective, personality disorders arise from unresolved **intrapersonal conflicts** and dysfunctional relational patterns established in early life. For instance, individuals with **borderline personality disorder** may have experienced inconsistent or traumatic caregiving, leading to difficulties in emotional regulation and interpersonal relationships.

Modern **object relations theory** and attachment theories build upon classical psychodynamic concepts by focusing on how early caregiver-child interactions influence self-concept and interpersonal functioning. Research suggests that insecure attachment styles, particularly disorganized or avoidant attachment, are commonly observed in individuals diagnosed with personality disorders. These early relational patterns may lead to **maladaptive coping strategies**, such as emotional detachment, dependency, or extreme fear of abandonment.

**Interpersonal and Social Perspectives**

From an **interpersonal perspective**, personality disorders are viewed as disruptions in social interactions and relational patterns. The **interpersonal theory of personality** (Sullivan, 1953) posits that personality develops through repeated social interactions, and maladaptive relational patterns contribute to personality pathology. Individuals with personality disorders

often exhibit **rigid and dysfunctional interpersonal styles**, leading to difficulties in forming and maintaining healthy relationships.

Social learning theory further supports this perspective by emphasizing the **role of environmental influences** in shaping personality traits. According to **Bandura's (1986) social cognitive theory**, behaviors and personality traits are learned through **observational learning and reinforcement**. Dysfunctional family dynamics, exposure to trauma, and societal influences can contribute to the reinforcement of maladaptive personality traits, increasing the likelihood of developing a personality disorder.

**Cognitive Perspectives**

Cognitive models of personality disorders focus on **maladaptive thought patterns** and **cognitive distortions** that contribute to dysfunctional behaviors and emotional responses. According to **Beck's cognitive theory (1990)**, individuals with personality disorders develop **core beliefs** and **schemas** that shape their perceptions of themselves and others. For example, individuals with **paranoid personality disorder** may hold a deep-seated belief that others are deceptive or malicious, leading to chronic mistrust and social withdrawal.

Cognitive-behavioral approaches suggest that personality disorders result from **long-standing maladaptive cognitive patterns** reinforced over time. These cognitive distortions contribute to **rigid and self-defeating behaviors**, making it difficult for individuals to adapt to changing circumstances or engage in healthy social interactions. Therapeutic approaches such as **Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT)** aim to modify these maladaptive thought patterns and improve emotional regulation, interpersonal effectiveness, and distress tolerance.

Theoretical perspectives on personality disorders have evolved significantly over time, integrating biological, psychodynamic, interpersonal, and cognitive approaches to provide a more comprehensive understanding of these complex conditions. While early theories focused primarily on **innate biological predispositions** and **unconscious conflicts**, contemporary models emphasize the interplay between **genetic factors, early childhood**

**experiences, interpersonal relationships, and cognitive patterns**. A holistic approach that considers multiple theoretical perspectives can enhance both the **diagnostic process** and the **development of effective treatment interventions** for individuals struggling with personality disorders.

## Classification of Personality Disorders in ICD-10 and ICD-11

In the tenth edition of the International Classification of Diseases (ICD-10), personality disorder is characterized as a profound disruption in an individual's personality development and behavioral patterns, spanning various personality dimensions and resulting in both personal and social difficulties. These disorders manifest as persistent maladaptive attitudes and behaviors, affecting emotional regulation, cognitive processes, reactions, and interpersonal relationships (Türkçapar et al., 2008).

Within ICD-10, personality disorders are categorized under the broader section of "Personality and Behavioral Disorders in Adults" and include the following specific classifications (World Health Organization, 2010):

- **F60 Specific Personality Disorders**
  - F60.0 Paranoid Personality Disorder
  - F60.1 Schizoid Personality Disorder
  - F60.2 Dissocial (Antisocial) Personality Disorder
  - F60.3 Emotionally Unstable Personality Disorder
    - .30 Impulsive Type
    - .31 Borderline Type
  - F60.4 Histrionic Personality Disorder
  - F60.5 Anankastic Personality Disorder
  - F60.6 Anxious (Avoidant) Personality Disorder
  - F60.7 Dependent Personality Disorder
  - F60.8 Other Specific Personality Disorders
  - F60.9 Personality Disorder, Unspecified
- **F61 Mixed and Other Personality Disorders**
  - F61.0 Mixed Personality Disorders
  - F61.1 Troublesome Personality Change
- **F62 Enduring Personality Changes Not Attributable to Brain Damage or Disease**

- F62.0 Enduring Personality Change after Catastrophic Experience
- F62.1 Enduring Personality Change after Psychiatric Illness
- F62.8 Other Enduring Personality Changes
- F62.9 Enduring Personality Change, Unspecified

The ICD classification system plays a crucial role in global research concerning the prevalence, causes, and consequences of diseases. It also provides the foundation for planning and executing healthcare services (Harrison et al., 2021). However, similar to criticisms directed at DSM-5, ICD-10's categorical method of classifying personality disorders has been subject to scrutiny. Research has highlighted significant challenges in this approach, such as arbitrary diagnostic cutoffs, considerable overlap between different disorder categories, insufficient empirical support for certain diagnoses, and limited practical application in clinical settings. With advances in scientific understanding and digitalization, the necessity of revising classification methods has become evident (Bach & First, 2018).

The most recent edition, ICD-11, implemented in 2022, introduced significant modifications to the classification of personality disorders (World Health Organization, 2024). Departing from the widely debated categorical structure of ICD-10, ICD-11 has adopted a severity-based evaluation system. This model assesses personality disorders along a continuum, using a five-level scale (Aydın Seyrek, 2022):

1. Personality Difficulty (not classified as a mental disorder)
2. Mild Personality Disorder
3. Moderate Personality Disorder
4. Severe Personality Disorder
5. Personality Disorder, Severity Unspecified (World Health Organization, 2021)

The severity of a personality disorder in ICD-11 is determined based on several key factors:

- The extent of distress and impairment in interpersonal relationships and self-identity

- The intensity and range of emotional, cognitive, and behavioral dysfunctions
- The level to which these maladaptive patterns result in psychological distress or functional impairment
- The potential risk of harm to oneself or others

As the severity increases, the impact on different life domains becomes more pronounced, and the likelihood of self-harm or harm to others grows more significant (Swales, 2022).

According to the ICD-11, personality disorder is identified by persistent impairments in self and/or interpersonal functioning lasting for at least two years. These impairments, which are not attributable to social or cultural influences, hinder an individual's ability to form and sustain close relationships and cause significant distress or dysfunction in personal, familial, social, educational, occupational, or other key aspects of life (WHO 2021). This definition closely mirrors previous descriptions. Unlike the traditional categorical classification of personality disorders, ICD-11 emphasizes a broader definition of personality disorder alongside five primary trait domains: "Negative Affectivity, Detachment, Disinhibition, Dissociality, and Anankastia." Additionally, within these domains, it incorporates a distinct personality condition referred to as the "Borderline Pattern" (Töre 2023).

Negative Affectivity denotes a predisposition to experiencing negative emotions like anxiety and anger. Detachment signifies a marked avoidance of social interaction. Disinhibition is characterized by impulsive behavior driven by immediate internal or external stimuli, often without consideration of long-term repercussions. Dissociality reflects a disregard for the emotions and rights of others. Anankastia manifests as an inflexible pursuit of perfectionism and control that exceeds socially accepted norms. Furthermore, for individuals exhibiting inconsistent emotional regulation and self-perception, the "Borderline Pattern" has been defined as an additional personality condition (Swales 2022).

In this updated diagnostic framework, the assessment of personality disorders follows a structured approach. Initially, clinicians determine whether the general criteria for a personality disorder are met, a process that remains largely unchanged from previous diagnostic methods. Subsequently,

the severity of the disorder is evaluated. The elimination of distinct personality disorder subtypes in this model resolves the issue of comorbid diagnoses. The final step involves characterizing the personality disorder based on specific traits and dimensions (Aydın Seyrek 2022). This structured approach facilitates targeted interventions by mental health professionals and allows for the monitoring of disorder progression, aiding in recovery assessment (Bach et al. 2021). A study by Brown and Sellbom (2023) investigated the validity and reliability of ICD-11's classification system and found encouraging evidence supporting its effectiveness in addressing issues associated with categorical classification.

**Alternative DSM-5 Model for Personality Disorders**

The Alternative DSM-5 Model for Personality Disorders (DSM-5 AMPD), found in Section III of DSM-5, presents a hybrid framework for evaluating and diagnosing personality disorders. This model retains elements of established clinical practice while addressing the shortcomings of the categorical classification approach. Although categorical diagnoses are generally reliable, they often fail to provide comprehensive information (APA 2013). A major criticism of this system is the high rate of comorbidity, wherein individuals frequently meet criteria for multiple personality disorders, complicating treatment and intervention strategies. Additionally, concerns regarding the categorical model's empirical foundation have been raised (Swales 2022).

The alternative model was developed through extensive research and is grounded in two key components:

1. The level of impairment in personality functioning (self and interpersonal), and
2. The dimensional assessment of 25 pathological personality traits categorized under five broad domains.

These criteria redefine personality disorders by focusing on functional impairments and trait-based characteristics, offering a more nuanced diagnostic process for six specific personality disorder categories (APA 2013, Skodol et al. 2015). Self-functioning pertains to "identity and self-direction,"

while interpersonal functioning includes "empathy and intimacy" (Konduz 2015).

The DSM-5 alternative model outlines the general diagnostic criteria for personality disorders as follows: "Emerging no later than adolescence or early adulthood, not better accounted for by another mental disorder, not resulting from substance use or a medical condition, appearing across diverse personal and social contexts, causing moderate or greater impairment in personality (self/interpersonal) functioning, involving at least one pathological personality trait, and displaying relative rigidity in personality traits" (APA 2013).

The severity of impairment in personality functioning (Criterion A) is evaluated using the "Level of Personality Functioning Scale (LPFS)," which categorizes impairment into five levels (Hummelen et al. 2021). The five personality domains and their corresponding 25 trait facets (Criterion B) in DSM-5 AMPD are outlined as follows:

- **Negative Affectivity**: emotional instability, separation insecurity, anxiousness, perseveration, submissiveness, hostility;
- **Detachment**: intimacy avoidance, withdrawal, anhedonia, depressivity, restricted affectivity, suspiciousness;
- **Antagonism**: manipulativeness, deceitfulness, grandiosity, attention-seeking, callousness, hostility;
- **Disinhibition**: irresponsibility, impulsivity, rigid perfectionism, risk-taking, distractibility;
- **Psychoticism**: unusual beliefs and experiences, eccentricity, cognitive and perceptual dysregulation (Töre 2023).

In DSM-5 AMPD, personality disorder diagnoses include "antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders." Additionally, the model includes a diagnostic category called "personality disorder with specified traits" for individuals meeting the general personality disorder criteria but not fitting any specific category. However, in this approach, diagnostic criteria focus on identity, interpersonal functioning, and facet traits instead of traditional disorder-specific features (Konduz 2015).

For a DSM-5 AMPD personality disorder diagnosis, an individual must exhibit moderate or greater impairment in personality functioning and demonstrate at least one pathological personality trait (Hummelen et al. 2021). This hybrid model integrates fundamental principles of personality assessment, providing a more adaptable and theoretically grounded framework. By merging clinical assessment traditions with empirical research, DSM-5 AMPD enhances case conceptualization and facilitates individualized treatment approaches (Waugh et al. 2017). Further discussion on traditional classification follows below.

**DSM-5 Personality Disorder Classification**

In DSM-5, personality disorders are categorized into three clusters: A, B, and C. **Cluster A** (Odd and Eccentric Cluster) includes paranoid, schizoid, and schizotypal personality disorders. **Cluster B** (Dramatic, Emotional, and Erratic Cluster) consists of antisocial, borderline, histrionic, and narcissistic personality disorders. **Cluster C** (Anxious and Fearful Cluster) encompasses avoidant, dependent, and obsessive-compulsive personality disorders (APA, 2013).

DSM-IV faced criticism for its categorical approach to diagnosing personality disorders. In response, DSM-5 incorporated a dimensional perspective alongside the categorical model, which is considered more effective for diagnostic purposes (Bilge, 2014). According to DSM-5's categorical classification, a personality disorder is diagnosed when an individual exhibits an enduring pattern of inner experience and behavior that significantly deviates from cultural expectations. This pattern must affect at least two of the following domains: cognition, affectivity, interpersonal functioning, or impulse control. Additionally, it must lead to clinically significant distress or impairment in social, occupational, or other key areas of life. The onset must occur in adolescence or early adulthood, and the symptoms must not be better explained by another mental disorder or the physiological effects of a substance or medical condition (APA, 2013). The following sections will provide an overview of personality disorder clusters and specific personality disorders.

**Comparison of DSM-5, DSM-5 Alternative Model, and ICD-11 Classification Systems**

The DSM-5 categorizes personality disorders into three clusters: A, B, and C. Each disorder is defined based on specific diagnostic criteria in addition to a general definition of personality disorders. The disorders classified under this system include paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive personality disorders. This method follows a categorical framework (APA, 2013).

In contrast, both the ICD-11 and the DSM-5 Alternative Model (AMP) incorporate domains related to personality functioning, such as identity, self-direction, social understanding, and interpersonal relationships. These models assess personality disorder characteristics as contributing factors to an individual's unique expression of the disorder, alongside a severity classification. While these traits alone are not sufficient for diagnosis, they provide valuable insights into treatment planning, therapeutic alliance formation, and intervention strategies (Bach, 2020).

Both ICD-11 and DSM-5 AMP identify core personality disorder traits, including negative affectivity, detachment, antagonism, and disinhibition. However, ICD-11 includes an additional "anankastic" domain, while DSM-5 AMP introduces "psychoticism" as a personality trait. Although ICD-11 describes a "borderline personality pattern" in a manner similar to personality traits, this feature is not distinctly included in the DSM-5 Alternative Model. The methods used to assess functionality and disorder severity differ between the two frameworks. Nevertheless, both emphasize personality traits and a dimensional perspective over a purely categorical classification (Töre, 2023).

Despite adopting an alternative diagnostic structure, the DSM-5 Alternative Model still retains six personality disorder diagnoses: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders (Konduz, 2015).

Table 1 outlines the classification of personality disorders in DSM-5, DSM-5 AMP, and ICD-11 (APA, 2013; WHO, 2021). As seen in Table 1, DSM-5 follows a categorical approach, while DSM-5 AMP integrates both

categorical and dimensional aspects. In contrast, ICD-11 classifies personality disorders based on severity levels rather than distinct categories. Table 2 presents a detailed comparison of personality disorders across DSM-5, DSM-5 AMP, and ICD-11 (APA, 2013; WHO, 2021).

**Table 1.** Classification of personality disorders according to DSM-5, DSM-5 PD alternative model and ICD-11 (APA 2013, WHO 2022)

| DSM-5 PD | DSM-5 Alternative Model PD* | ICD-11 Model |
|---|---|---|
| Borderline PD | Borderline PD | Personality Difficulty** |
| Schizotypal PD | Schizotypal PD | Mild Personality Disorder |
| Narcissistic PD | Narcissistic PD | Moderate Personality Disorder |
| Antisocial PD | Antisocial PD | Severe Personality Disorder |
| Avoidant PD | Avoidant PD | Personality Disorder (severity unspecified) |
| Obsessive-Compulsive PD | Obsessive-Compulsive PD | |
| Paranoid PD | Trait Specified PD (PD-TS) | |
| Schizoid PD | Trait Specified PD (PD-TS) | |
| Histrionic PD | Trait Specified PD (PD-TS) | |
| Dependent PD | Trait Specified PD (PD-TS) | |

*The diagnosis of personality disorders in the DSM-5 Alternative Model is based on the assessment of the level of impairment in personality functioning and pathological personality traits. / **Personality difficulties refer to personality traits that may benefit from mental health services but do not reach the level of a personality disorder diagnosis.

This table compares the classification of personality disorders across DSM-5, the DSM-5 Alternative Model, and ICD-11. The DSM-5 follows a traditional categorical approach, listing specific personality disorders as distinct diagnoses. In contrast, the DSM-5 Alternative Model assesses personality disorders based on the level of impairment in personality functioning and the presence of pathological personality traits. While most DSM-5 personality disorders are retained in the Alternative Model, Paranoid, Schizoid, Histrionic, and Dependent Personality Disorders are categorized under "Personality Disorder-Trait Specified (PD-TS)," indicating that these conditions are better conceptualized through specific pathological personality traits rather than distinct diagnostic categories.

ICD-11, on the other hand, moves away from the categorical classification of personality disorders and instead classifies them based on severity levels. Borderline Personality Disorder, which remains a distinct category in both DSM-5 and the Alternative Model, is labeled as "Personality Difficulty" in ICD-11, suggesting that while individuals may exhibit significant personality-related challenges, they do not necessarily meet the threshold for a full personality disorder diagnosis. Schizotypal Personality Disorder is classified as a "Mild Personality Disorder," Narcissistic Personality Disorder as a "Moderate Personality Disorder," and Antisocial Personality Disorder as a "Severe Personality Disorder," reflecting a dimensional approach that considers the varying degrees of impairment. Avoidant Personality Disorder is recognized in ICD-11 but without a specified severity level. Notably, Obsessive-Compulsive Personality Disorder does not appear in the ICD-11 classification, implying that it may be conceptualized differently.

Overall, the DSM-5 maintains a categorical perspective, while the DSM-5 Alternative Model introduces a hybrid approach incorporating dimensional elements. ICD-11 fully adopts a dimensional model, emphasizing severity rather than distinct personality disorder types. This shift reflects an effort to provide a more flexible and individualized framework for diagnosing personality pathology, recognizing that personality disorders exist on a spectrum rather than as discrete conditions.

**Table 2.** Comparison of personality disorders in DSM-5 according to DSM-5 alternative model and ICD-11 (APA 2013, WHO 2022)

| DSM-5 PD | DSM-5 Alternative Model PD | ICD-11 Model |
|---|---|---|
| **Paranoid PD** | - | **Trait domains:** Detachment, Negative Affectivity, Antagonism |
| | **Personality trait and trait domains:** Detachment, Negative Affectivity, Antagonism | **Trait domains:** Detachment, Negative Affectivity, Antagonism |
| **Schizotypal PD** | Schizotypal PD | "Schizotypal Disorder" is included under "Schizophrenia or other primary psychotic disorders" |
| | **Personality trait and trait domains:** Psychoticism (Cognitive and perceptual dysregulation, unusual beliefs and experiences, eccentricity), Detachment (Restricted affectivity, withdrawal, suspiciousness) | **Trait domains:** Anankastic, Detachment |
| **Schizoid PD** | - | **Trait domains:** Detachment, Negative Affectivity |
| | **Trait domains:** Detachment, Negative Affectivity | **Trait domains:** Detachment, Negative Affectivity |
| **Borderline PD** | Borderline PD | "The Borderline pattern" specifier is included to enhance clinical utility |

| **DSM-5 PD** | **DSM-5 Alternative Model PD** | **ICD-11 Model** |
|---|---|---|
| | **Personality trait and trait domains:** Negative Affectivity (Emotional liability, anxiousness, depressivity, separation insecurity), Disinhibition (Impulsivity, risk taking), Antagonism (Hostility) | **Trait domains:** Negative Affectivity, Disinhibition |
| **Narcissistic PD** | Narcissistic PD | **Trait domains:** Antagonism |
| | **Personality trait and trait domains:** Antagonism (Grandiosity, attention seeking) | - |
| **Histrionic PD** | - | **Trait domains:** Disinhibition, Negative Affectivity, Antagonism, Detachment (low) |
| | **Trait domains:** Disinhibition, Negative Affectivity, Antagonism, Detachment (low) | **Trait domains:** Disinhibition, Negative Affectivity, Antagonism, Detachment (low) |
| **Antisocial PD** | Antisocial PD | **Trait domains:** Dissociality, Disinhibition, Detachment, Negative Affectivity (low) |
| | **Personality trait and trait domains:** Antagonism (Manipulativeness, callousness, deceitfulness, hostility, high attention seeking), Disinhibition (Risk taking, impulsivity, irresponsibility), Detachment (low withdrawal), Negative | **Trait domains:** Dissociality, Disinhibition, Detachment, Negative Affectivity |

| DSM-5 PD | DSM-5 Alternative Model PD | ICD-11 Model |
|---|---|---|
| | Affectivity (low anxiousness) | (low) |
| **Avoidant PD** | Avoidant PD | **Trait domains:** Negative Affectivity, Detachment |
| | **Personality trait and trait domains:** Negative Affectivity (Anxiousness), Detachment (Withdrawal, anhedonia, intimacy avoidance) | **Trait domains:** Negative Affectivity, Detachment |
| **Dependent PD** | - | **Trait domains:** Negative Affectivity, Antagonism (low) |
| | **Trait domains:** Negative Affectivity, Antagonism (low) | **Trait domains:** Negative Affectivity, Antagonism (low) |
| **Obsessive-Compulsive PD** | Obsessive-Compulsive PD | Listed as "Obsessive-Compulsive Disorder" under "Obsessive-Compulsive or related disorders" |
| | **Personality trait and trait domains:** Negative Affectivity (Perseveration), Detachment (Intimacy avoidance, restricted affectivity), Conscientiousness (Rigid perfectionism) | **Trait domains:** Negative Affectivity, Detachment, Anankastic |
| - | Personality Disorder-Trait Specified (PD-TS) | - |
| | **Personality trait and trait domains:** Negative Affectivity (Anxiety, depression, guilt/shame, worry, anger, | - |

| DSM-5 PD | DSM-5 Alternative Model PD | ICD-11 Model |
|---|---|---|
| | dependency), Detachment (Intimacy avoidance, restricted affectivity, avoidance of socioemotional experience), Psychoticism (Odd, eccentric behaviors and cognitions), Antagonism (Callousness, manipulation), Disinhibition (Orientation toward immediate gratification) | |

This table compares the classification of personality disorders in DSM-5 with the DSM-5 Alternative Model and ICD-11, emphasizing the shift from categorical diagnoses to trait-based conceptualizations. In the DSM-5 Alternative Model, some personality disorders are retained, while others are replaced by trait-specified categories. ICD-11 further refines this approach by classifying personality disorders based on prominent trait domains rather than discrete categories.

Paranoid, Schizoid, Histrionic, and Dependent Personality Disorders are not recognized as distinct entities in the DSM-5 Alternative Model; instead, they are described using relevant personality trait domains such as Detachment, Negative Affectivity, and Antagonism. Similarly, ICD-11 conceptualizes these disorders based on dominant personality traits rather than fixed diagnostic labels. Schizotypal Personality Disorder is retained in the DSM-5 Alternative Model but is classified under schizophrenia-related disorders in ICD-11, reflecting its overlap with psychotic features.

Borderline Personality Disorder remains a recognized category in both the DSM-5 Alternative Model and ICD-11, though ICD-11 introduces a "Borderline pattern" specifier rather than listing it as a distinct disorder. The disorder is described primarily through traits of Negative Affectivity, Disinhibition, and Antagonism. Narcissistic and Antisocial Personality Disorders are preserved in the DSM-5 Alternative Model, with Antisocial PD characterized by traits of Dissociality, Disinhibition, and low Negative Affectivity in ICD-11. Avoidant, Obsessive-Compulsive, and Antisocial Personality Disorders are maintained across all three classification systems,

but ICD-11 groups Obsessive-Compulsive Personality Disorder under "Obsessive-Compulsive or related disorders" rather than as a distinct personality disorder.

The DSM-5 Alternative Model also introduces "Personality Disorder-Trait Specified (PD-TS)" for individuals who exhibit significant personality dysfunction without fitting into a specific category. This aligns with ICD-11's dimensional approach, which emphasizes personality traits such as Detachment, Negative Affectivity, Antagonism, Psychoticism, and Disinhibition rather than rigid diagnostic criteria.

Overall, the shift from the DSM-5's categorical model to the DSM-5 Alternative Model and ICD-11's dimensional approach reflects a broader movement toward a more individualized and flexible understanding of personality disorders. These changes acknowledge the complexity and variability of personality pathology, allowing for a more nuanced and tailored clinical assessment.

**Overview of Treatment for Personality Disorders**

From a mental health perspective, personality disorders are positioned between neurosis and psychosis. "Love and work" are key problem areas for individuals with personality disorders. They often struggle with emotional regulation and fail to express their emotions in an appropriate manner (Senyuva, 2007).

Individuals with personality disorders typically do not seek treatment until they experience significant interpersonal or social difficulties. This reluctance is often a characteristic of the disorder itself. They are more likely to seek psychiatric help and consider treatment only when their functional capacity in daily life is substantially impaired (Senyuva, 2007).

Treatment completion rates for both pharmacotherapy and psychotherapy in personality disorders generally range between 40-60%. Individual psychotherapy sessions for these patients can extend up to 52 sessions (Karamustafalioglu & Karamustafalioglu, 2000). Research indicates that only one in five individuals diagnosed with a personality disorder actively receives treatment (as cited in Senyuva, 2007). In clinical practice,

psychotherapy is considered the primary approach for treating personality disorders. The type of psychotherapy varies depending on the disorder, and medication may be incorporated when necessary. For example, in obsessive-compulsive personality disorder, both pharmacotherapy and Cognitive Behavioral Therapy (CBT) are commonly utilized treatment methods.

**Assessment Tools for Evaluating Personality Disorders**

Various psychometric tools are utilized for assessing and classifying personality disorders. One of the most widely used is the Minnesota Multiphasic Personality Inventory (MMPI-2), developed by Graham et al. This psychological assessment measures different aspects of an individual's mental state and includes subscales designed to evaluate specific psychopathological symptoms rather than general personality traits. These subscales, such as Depression, Hypochondriasis, Paranoia, Psychasthenia, Social Isolation, and Hysteria, help in understanding an individual's psychological profile. Each subscale targets a particular aspect of mental health; for example, the depression subscale assesses depressive symptoms, while the paranoia subscale evaluates paranoid thinking. These detailed evaluations assist in clinical assessments and treatment planning (Vatan & Dağ, 2009; Taymur & Türkçapar, 2012; Uluç et al., 2014).

The MMPI-2 is widely used in both clinical and research settings due to its comprehensive nature and ability to identify complex psychological patterns. It offers valuable insights for mental health professionals working with individuals suspected of having personality disorders. Additionally, MMPI-2 results can aid in differential diagnosis by distinguishing between different types of psychological distress and maladaptive personality traits. Its reliability and validity have been extensively studied, making it a trusted instrument in psychological assessment. Despite its strengths, some critiques highlight its length and complexity, which may pose challenges for certain populations, such as individuals with cognitive impairments or limited attention spans.

Another key tool is the Structured Clinical Interview for DSM-IV (SCID-II), developed by First et al. This structured interview is commonly used to diagnose personality disorders, offering clinicians a systematic approach to understanding an individual's personality structure. The SCID-II

features subscales tailored to different personality disorders, including Borderline Personality Disorder, Narcissistic Personality Disorder, and Obsessive-Compulsive Personality Disorder, allowing for an in-depth analysis of relevant symptoms (Taymur & Türkçapar, 2012; Bilge, 2018; Bilge & Mayda, 2023).

The SCID-II provides a standardized method for assessing personality disorders, ensuring consistency across different clinical settings. By following a structured format, it minimizes interviewer bias and enhances diagnostic accuracy. This tool is particularly useful in both research and clinical practice, as it allows for detailed exploration of personality pathology. Additionally, its structured nature makes it suitable for use in epidemiological studies, helping researchers examine the prevalence and comorbidity of personality disorders in diverse populations.

In addition to MMPI-2 and SCID-II, other assessment tools have been developed to evaluate personality disorders more efficiently. The Personality Inventory for DSM-5 (PID-5) is one such tool that assesses maladaptive personality traits across five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. Unlike traditional categorical approaches, the PID-5 provides a dimensional perspective on personality pathology, aligning with contemporary views in psychiatric classification. This instrument is particularly valuable in research exploring personality disorder spectra and individualized treatment planning.

Furthermore, the Millon Clinical Multiaxial Inventory (MCMI) is another widely used instrument for diagnosing personality disorders. Developed by Theodore Millon, the MCMI is specifically designed to assess personality disorders and clinical syndromes based on Millon's theory of personality. This tool is particularly effective in differentiating between various personality disorders and provides a nuanced understanding of an individual's psychological functioning. The MCMI has been widely used in forensic and clinical settings, further demonstrating its applicability in different contexts.

The use of standardized assessment tools is crucial in diagnosing and understanding personality disorders. These instruments not only aid in accurate diagnosis but also facilitate treatment planning and research. By

combining different tools such as MMPI-2, SCID-II, PID-5, and MCMI, clinicians can obtain a comprehensive picture of an individual's personality structure, ensuring more effective and personalized interventions. As research in personality disorders continues to evolve, refining and integrating these tools will enhance our ability to identify and treat these complex psychological conditions.

Additionally, the Structured Interview for Personality Disorders (SIDP-IV), created by Pfohl et al. consists of standardized questions that assess the presence and severity of personality disorder symptoms based on DSM-IV criteria. This structured interview helps identify specific personality traits and symptoms systematically. It is also useful in understanding the epidemiology and etiology of personality disorders, making it a valuable tool in both clinical and research settings (Svela et al., 2022). The SIDP-IV is particularly advantageous because it integrates a narrative-based approach, allowing clinicians to evaluate personality disorders in the context of an individual's life history and interpersonal relationships. This method provides a more nuanced understanding of symptom presentation, aiding in differential diagnosis and treatment planning.

Beyond these, several other instruments are used for personality disorder assessment, such as the Shedler-Westen Assessment Procedure-200 (SWAP-200), Schedule for Nonadaptive and Adaptive Personality (SNAP), Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ), Inventory of Personality Organization (IPO), and Personality Assessment Schedule (PAS). These tools vary in their methodological approach, with some focusing on psychodynamic conceptualizations of personality pathology, while others emphasize dimensional traits. For example, the SWAP-200 employs clinician ratings based on extensive patient narratives, making it useful for evaluating complex personality structures. The DAPP-BQ, on the other hand, is a self-report measure designed to assess a broad range of personality traits along a continuum, aligning with contemporary dimensional models of personality disorders.

Additionally, standardized tools like the Standardized Assessment of Personality (SAP), Millon Clinical Multiaxial Inventory (MCMI), Personality Diagnostic Questionnaire-Revised (PDQ-R), International Personality Disorder Examination (IPDE), Multimodal Assessment of Personality

Pathology (MAPP), Iowa Personality Disorder Screen (IPDS), and Personality Belief Questionnaire (PBQ) are frequently utilized (Bilge & Sertel Berk, 2017; Ertan & Cankorur, 2017). These instruments contribute significantly to both clinical diagnostics and research by providing structured, reliable, and valid measures of personality pathology. The MCMI, for instance, is widely used in clinical settings due to its strong empirical foundations and ability to assess comorbid psychiatric conditions alongside personality disorders. The PDQ-R, a self-report measure, is particularly beneficial for screening purposes, helping to identify individuals who may require further in-depth evaluation. Meanwhile, the IPDE, developed under the World Health Organization, offers a standardized approach to diagnosing personality disorders across different cultural contexts, enhancing its applicability in international research and clinical practice.

The availability of diverse assessment tools allows for a comprehensive evaluation of personality disorders, catering to different theoretical orientations and clinical needs. Whether employing structured interviews, clinician-rated measures, or self-report questionnaires, these instruments contribute to a more accurate and nuanced understanding of personality pathology, ultimately improving diagnostic precision and treatment outcomes.

Despite the wide range of available tools, the number of validated and reliable personality disorder assessment instruments in certain languages remains limited. Research suggests that commonly used tools include the SCID-II (based on DSM-III-R), an early version of the MMPI-II, and the Personality Belief Questionnaire (PBQ), which evaluates underlying cognitive patterns linked to personality disorders. These instruments have been widely used in both clinical and research settings, yet their applicability and psychometric robustness in different populations remain subjects of ongoing investigation.

Recently, the Coolidge Axis II Inventory Plus (CATI+), based on DSM criteria, has been adapted into various languages, though only the PBQ-KTF has undergone comprehensive psychometric validation in some regions. The adaptation of the CATI+ into different languages marks a significant step in expanding the range of available assessment tools, yet further validation studies are necessary to ensure their cultural appropriateness and clinical

utility. Subsequently, Bilge (2018) developed a short version of the Coolidge Axis II Inventory Plus (CATI+TR-KF) (Ertan & Cankorur, 2017; Bilge, 2018). However, its use remains limited to specific research contexts, and its integration into broader clinical practice requires additional studies to confirm its reliability and validity.

The need for validated tools in various languages is particularly critical given the increasing use of modern diagnostic frameworks. With the growing adoption of the DSM-5 Alternative Model for Personality Disorders (AMPD) and the International Classification of Diseases 11th Revision (ICD-11), several new tools have been developed to assess personality disorders. The shift towards dimensional models of personality pathology necessitates the creation and adaptation of assessment instruments that align with these contemporary frameworks. Without proper validation studies, clinicians in certain regions may struggle to accurately diagnose and treat individuals with personality disorders using these newer models.

One such tool is the DSM-5 Personality Functioning Clinical Assessment Form (Levels of Personality Functioning Scale – LPFS), a 12-item Likert-scale instrument developed by the APA's DSM-5 Personality Disorder Work Group. This tool is particularly useful for initial evaluation and monitoring clinical changes over time, providing valuable insight into the severity of personality dysfunction. However, despite its advantages, its application in clinical decision-making remains somewhat limited due to its broad and generalized nature (Konduz, 2015). A significant challenge in using the LPFS is its reliance on subjective clinician judgment, which may introduce variability in its implementation and interpretation across different cultural contexts.

To address the limitations of the LPFS, Bender et al. (2018) revised the scale and introduced the Structured Clinical Interview for DSM-5 Alternative Model of Personality Disorders, Module I (SCID-5-AMPD-I). This structured interview format has demonstrated strong validity and reliability in assessing the severity and presence of personality disorders under the DSM-5 Alternative Model (Hummelen et al., 2021). The SCID-5-AMPD-I provides a more standardized approach to diagnosis, reducing subjective bias and improving diagnostic accuracy. Nevertheless, its adaptation and validation in different linguistic and cultural settings remain pending,

highlighting the need for further research to ensure its applicability across diverse clinical contexts.

Given these developments, there is a pressing need for increased efforts to validate and standardize modern personality disorder assessment tools in multiple languages. Future research should focus on the cultural adaptation of widely used instruments such as the SCID-5-AMPD-I and LPFS, as well as the development of new measures specifically designed for non-English-speaking populations. Collaboration between researchers, clinicians, and institutions will be essential in advancing the field and ensuring that individuals with personality disorders receive accurate diagnoses and effective treatment interventions. Addressing these gaps in the literature will not only improve clinical practice in different regions but also contribute to the global understanding of personality pathology across diverse cultural settings.

Olajide et al. (2018) developed the Standardized Assessment of Personality Disorder Severity (SASPD), a brief yet effective tool for measuring the severity of personality disorders. Studies conducted on clinical populations have demonstrated that this instrument provides a simple and reliable method for assessing personality pathology. The applicability of SASPD in clinical settings, particularly given the need for rapid assessments, offers a significant advantage for psychologists and psychiatrists.

The PID-5BF+ short form, developed by Bach et al. (2020), is a 36-item adaptation of the Personality Inventory for DSM-5 (PID-5). This tool is compatible with both the DSM-5 Alternative Model (AMPD) and the ICD-11 diagnostic criteria and has been validated internationally with positive results. The PID-5BF+ short form is particularly noted for its efficiency in personality pathology assessments, saving time in research contexts while providing a comprehensive framework for personality evaluation.

In recent years, Sellbom et al. (2024) developed the Personality Disorder Severity ICD-11 Clinician Rating Form (PDS-ICD-11), a 14-item scale designed to assess the severity of personality disorders based on ICD-11 standards. This tool was derived from the self-report version of the PDS-ICD-11 and has undergone validation in clinical samples across various countries, proving to be a psychometrically reliable assessment instrument. Developed

in line with ICD-11's dimensional approach to personality disorders rather than categorical classification, this scale enables clinicians to systematically structure their subjective observations in personality disorder assessments. The development of new assessment tools for personality disorders, in conjunction with the dimensional models introduced by DSM-5 and ICD-11, allows for a more precise measurement of personality pathology.

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# Cluster A (Cold, Eccentric, and Unusual) Personality Disorders

Cluster A personality disorders are characterized by odd, eccentric, and socially detached behaviors. Individuals with these disorders often struggle with forming and maintaining relationships due to their unusual thought patterns, emotional detachment, or deep-seated mistrust of others. Unlike disorders in other clusters, which may involve impulsivity or emotional dysregulation, Cluster A disorders are primarily defined by cognitive and perceptual distortions, social withdrawal, and atypical interpersonal styles.

This cluster includes **schizotypal, schizoid, and paranoid personality disorders**, each presenting unique challenges in social and occupational functioning. People with these disorders may be perceived as distant, aloof, or peculiar by those around them, which can contribute to isolation and difficulties in daily life. Their behaviors and thought patterns often create barriers to meaningful social interactions, further reinforcing their detachment from others.

While schizotypal personality disorder is marked by cognitive distortions, odd beliefs, and discomfort in social situations, schizoid personality disorder is characterized by emotional coldness and a strong preference for solitude. Paranoid personality disorder, on the other hand, is defined by pervasive distrust and suspicion of others, leading to difficulties in forming close relationships and heightened sensitivity to perceived threats. The first personality disorder to be discussed is **paranoid personality disorder**.

# CHAPTER 2

## Paranoid Personality Disorder

The fundamental behavioral characteristics of individuals with this disorder involve interpreting others' actions as malicious, leading to a constant state of distrust and vigilance. The prevalence rate in the general population is estimated to be between 0,5 % and 2,5 %. However, its occurrence in psychiatric institutions ranges from 10% to 30% in inpatient facilities and from 2% to 10% in outpatient settings (Sahin, 2019).

Individuals with this behavioral disorder often exhibit hostile emotions, and restlessness and anger define their disposition. They tend to avoid confiding in others, believe that actions have hidden meanings, hold grudges, and are always prepared to retaliate (Koroglu & Bayraktar, 2010).

Paranoid disorder frequently manifests as a thought disorder, often including persecutory beliefs. There are some challenges in categorizing paranoid disorder diagnostically. Paranoid traits may appear as primary mental health issues or as additional symptoms of another disorder. According to Freud, individuals with this disorder use it as a defense mechanism against unconscious homosexual tendencies. Regardless of psychological factors, social isolation is considered a significant factor in the emergence of paranoid symptoms. Studies on immigrants and refugees support this notion (Geyran & Uygur, 2010).

The fundamental underlying factor of paranoid behaviors is a lack of trust, accompanied by suspicion, grandiosity, and hostility. Projection is frequently used as a defense mechanism in individuals with this disorder. Low self-confidence can lead to delusions and hallucinations associated with grandiosity. If an individual with this disorder consumes excessive caffeine, their levels of anxiety and restlessness are likely to increase (Eren, 2010).

Individuals with this disorder experience a range of challenges, including trust issues, low self-esteem, and a tendency to perceive the external world as dangerous. They often feel powerless and may avoid eating. Hostility and anger are common, along with a distorted perception of events and referential thinking. Many individuals refuse to seek treatment and may

struggle with suicidal tendencies. Social withdrawal and avoidance of responsibilities further impact their daily lives. They often exhibit reluctance to communicate and have a tendency to project guilt onto others. These difficulties contribute to significant personal and social impairments, making early intervention and support essential.

### Characteristics of Individuals with This Disorder According to DSM Diagnostic Criteria

In addition to exhibiting at least four of the following symptoms, individuals must demonstrate a pattern of pervasive distrust and suspicion of others, interpreting their motives as malevolent, which begins in early adulthood and manifests in various contexts:

1. Suspects, without sufficient basis, that others are exploiting, deceiving, or harming them. Such individuals do not trust people they have just met and may lose confidence in someone due to a minor incident, preventing them from forming genuine friendships. This also affects family relationships.
2. Has unwarranted doubts about the loyalty or trustworthiness of friends or colleagues. They believe that their friends talk behind their backs with malicious intent.
3. Is reluctant to confide in others due to an irrational fear that the information will be used against them. They tend to hide personal details even from their closest friends, fearing that such information might be used against them in the future.
4. Reads hidden demeaning or threatening meanings into benign remarks or events. They tend to misinterpret situations and events unrelated to them as personal attacks or threats, leading to misunderstandings and false assumptions.
5. Persistently bears grudges, unwilling to forgive insults, injustices, or slights.
6. Perceives attacks on their character or reputation that are not apparent to others and is quick to react with anger or counterattack.
7. Has recurrent suspicions, without justification, regarding the fidelity of their spouse or partner. They interpret even the smallest actions of their partners as signs of infidelity (Sahin, 2019).

When evaluating the factors contributing to the emergence of this personality disorder, there is suspicion of a genetic predisposition. Many individuals with this disorder have experienced specific issues during childhood, including possible exploitation.

**Psychodynamic Interpretation**

The primary defense mechanisms include projection, denial, and rationalization. The superego is projected onto authorities. Unresolved issues related to separation and autonomy may contribute to the development of this disorder (Koroglu & Bayraktar, 2010).

Emerging in early adolescence, the disorder manifests in different conditions. The main symptoms include extreme sensitivity, difficulty in making friends, various fantasies, and unusual thought patterns. Childhood traumas cannot be overlooked in the development of this disorder. Excessive pressure from the family may lead to the perception that anger is an external trait possessed only by others. Furthermore, an inability to recognize that anger and love can coexist during infancy may contribute to the disorder. In such cases, individuals may fear that hatred will eradicate love, leading to anxiety. To counteract this, they direct all negative emotions onto those around them. For them, the external world is a threatening place where they must constantly be on guard to avoid becoming victims (Sahin, 2019).

**Established Beliefs in Paranoid Personality Disorder**

1. I must not trust others.
2. Everyone has hidden agendas against me.
3. If I am not careful, others might exploit or manipulate me.
4. I must always be vigilant.
5. Trusting others is extremely dangerous.
6. When people act friendly, it means they want to use me for their own benefit.
7. People are always trying to humiliate me.
8. People deliberately try to provoke me.
9. Others should not think they can mistreat me, as it would put me in a difficult position.

10.If people learn something about me, they will immediately use it against me.

11.There is always something unsaid behind what people express.

12.The person I am close to may not be genuinely loyal, faithful, or trustworthy (Koroglu & Bayraktar, 2010).

**Treatment of Paranoid Personality Disorder**

Until recently, psychotherapy and psychoanalytic models were at the forefront of personality disorder treatment. Biological studies related to personality disorders have a history of about ten years and focus on identifying similarities and differences with Axis I disorders, which are considered closely related to personality disorders. Examples include borderline personality disorder and cyclothymia/bipolar II; schizotypal personality disorder and schizophrenia; avoidant personality disorder and social phobia; histrionic personality disorder and somatization disorder; paranoid personality disorder, delusional disorder, and paranoid schizophrenia (Karamustafaoğlu & Karamustafaoğlu, 2000).

A very small number of individuals with paranoid personality disorder voluntarily seek treatment. Along with therapy, the use of certain medications in low doses has been observed to yield successful results. However, the treatment process can be challenging due to individuals' suspicion toward medications and their exaggerated reactions to side effects. To prevent this, it is recommended that medication should not be introduced unless the client is personally committed to treating specific symptoms. As with all treatment models, and perhaps even more so in the case of paranoid personality disorder, the treatment process must proceed in collaboration with the patient. The most significant challenge in the process occurs when the client is expected to open up to the therapist, as these individuals are highly reluctant to share personal information. Gaining the client's trust is crucial in this case, and the language used should be very sincere and reassuring (Öztürk, 2004).

Group therapy is not recommended for individuals with this disorder due to their extreme sensitivity and tendency to misinterpret words used in group settings. Instead, individual therapy sessions are advised. The primary

goal of treatment is to help the client gain control over their behaviors. Behavioral therapy should focus on regulating social skills and reducing suspiciousness. Individuals with this disorder tend to rely heavily on projection as a defense mechanism. Their fears do not originate from within themselves but are instead focused on external threats. Clients should not be pressured by constantly challenging their paranoid thoughts, as discussing these thoughts will not provide any benefit to them. The main objective of therapy is to help the client evaluate the accuracy of their perception of reality and develop insight (Şahin, 2019).

The treatment goals for individuals with this disorder aim to address both their psychological and physical well-being while enhancing their ability to engage in daily life and social interactions. One of the primary objectives is to prevent self-harm and any behaviors that may pose a risk to others, ensuring both the individual's safety and the well-being of those around them. Reducing suspicious thoughts and behaviors is another crucial goal, as excessive distrust can hinder relationships and interfere with treatment progress. Building trust in the therapeutic process is essential, as many individuals may be reluctant to seek or continue treatment. Encouraging a more positive perception of therapy can improve engagement and long-term outcomes. Additionally, efforts are made to decrease ideas of reference, where individuals misinterpret neutral events or comments as being personally significant or threatening.

Physical health is also a concern, particularly when disordered eating patterns emerge. Ensuring adequate nutrition helps support both physical and mental stability, contributing to overall well-being. Strengthening collaboration between the individual and mental health professionals fosters greater participation in the treatment process, empowering the person to take an active role in their recovery.

Lastly, a key focus is on developing effective coping strategies for managing stress and feelings of worthlessness. By learning healthier ways to navigate emotional distress, individuals can build resilience, improve self-esteem, and enhance their ability to function in various aspects of life. Through these comprehensive treatment goals, the aim is to promote stability, reduce distressing symptoms, and improve the overall quality of life for individuals affected by the disorder.

## Schema Therapy Model in the Treatment of Paranoid Personality Disorder

The Schema Therapy Model, which has significantly contributed to the treatment of paranoid personality disorder, histrionic personality disorder, and Cluster C personality disorders, offers a three-stage treatment plan consisting of establishing a therapeutic bond, emotion regulation, schema, mode change, and autonomy. The process of change in this therapy model is built upon four fundamental mechanisms, as outlined by Young et al. (2003). The first mechanism, **limited reparenting**, involves the therapist providing a corrective emotional experience by offering the support, validation, and care that the individual may have lacked in early life. This approach helps to meet unmet emotional needs in a safe and structured therapeutic environment. The second mechanism, **experiential imagery and dialogue work**, focuses on accessing and processing deep-seated emotional experiences. Through guided imagery, role-playing, and inner dialogue techniques, individuals can re-examine past experiences, express suppressed emotions, and reframe their understanding of early life events. The third mechanism, **cognitive restructuring and education**, aims to challenge and modify maladaptive beliefs and thought patterns. By identifying and addressing distorted cognitions, individuals learn to replace negative self-perceptions with healthier, more adaptive ways of thinking. Psychoeducation plays a key role in this process, helping individuals gain insight into their schemas and behavioral tendencies. The fourth mechanism, **breaking behavioral patterns**, targets ingrained maladaptive behaviors that reinforce dysfunctional schemas. By developing healthier coping strategies and practicing new behavioral responses, individuals can gradually replace harmful patterns with more constructive ways of interacting with themselves and others. Together, these mechanisms form a comprehensive framework for lasting change, addressing emotional, cognitive, and behavioral aspects of personality and psychological well-being.

These mechanisms are critical components of treatment. The first step in therapy is to establish a secure and cooperative limited reparenting bond with the client. Unmet childhood needs tend to be partially fulfilled within the therapeutic relationship, making this one of the most important methods in treatment. In this process, the therapist serves as a role model for the client within professional boundaries. A strong therapeutic relationship is

considered the most beneficial element for experiential techniques and schema and mode conceptualization (Ertürk & Kaygar, 2017).

### Cognitive Behavioral Therapy (CBT) in the Treatment of Paranoid Personality Disorder

It is uncommon for individuals to seek therapy specifically for personality disorder-related complaints. Instead, they usually seek help for co-occurring issues such as depression or anxiety. Individuals with personality disorders often perceive their circumstances as independent of their own actions and behaviors. They frequently attribute their problems to external factors rather than recognizing their role in them. As a result, clients are typically unaware of the nature of their disorder, making it necessary to help them develop awareness of their behavioral patterns. Clients may become fixated on certain schemas that complicate treatment, and external societal factors may also hinder progress. Therefore, therapy should focus on these schemas, including the cognitive distortions they produce. Therapeutic examples should be used to illustrate errors created by specific schemas, enabling clients to understand their biased behaviors and thoughts. Negative life experiences may also contribute to the persistence of these schemas.

The effectiveness of therapy increases when the expectations of both the client and therapist align. Establishing a secure environment between the client and therapist is a fundamental requirement for treating this disorder. A rigid cognitive approach is not suitable for personality disorder treatment; however, a warm and supportive relationship alone may not be sufficient to alter behavioral effects of schemas. The client should be evaluated and worked with on cognitive, emotional, and behavioral levels (Yalçın & Akçay, 2016).

The primary focus of cognitive behavioral intervention is to enhance the client's sense of self-efficacy before attempting to regulate automatic thoughts, interpersonal behaviors, and core assumptions. Cooperation can be particularly challenging due to the client’s inherent distrust. Therefore, a slow, non-coercive approach should be adopted to foster a collaborative environment. The therapist must be clear and understandable, and discussions should focus more on external perspectives rather than directly on the client. Sessions should not be held more than once per week. To track behavioral

change, a 0–10 rating scale can be used within sessions. Clients with paranoid personality disorder generally do not struggle with terminating therapy. Before the counseling process concludes, discussions should include strategies for dealing with both well-intentioned and malicious individuals (Öztürk & Uluşahin, 2011).

### Focal Therapy in the Treatment of Paranoid Personality Disorder

In psychoanalytically oriented focal therapy, the therapist explicitly addresses the client's destructive behavior. Clients typically view therapists with suspicion and may either withdraw aggressively or react defensively. By analyzing the interaction between the therapist and the client, the therapist gains insight into how the client's distrust causes problems in relationships with others.

### Case Example

Mr. R, a 48-year-old elementary school principal, attended counseling at the insistence of his wife following a conflict at school. His wife, stating that their marriage had become unbearable, indicated that she would divorce Mr. R if no solution was found.

During the session, Mr. R expressed that he had been a suspicious person throughout his life; however, recently, this tendency had gotten out of control. Despite this awareness, Mr. R believed that his colleagues at school were plotting against him to undermine his position. He also saw his wife's insistence on treatment as part of this conspiracy at school. The school administration had complaints about Mr. R, and it was said that he had driven everyone to the edge, especially after being promoted to principal. Mr. R stated that he constantly strived to do his best. He believed that the administration's attitude stemmed from jealousy and the conspiracy they had orchestrated. When asked about the underlying reason for wanting to remove him, Mr. R claimed that they wanted to replace him with one of their relatives or close acquaintances. Upon deeper questioning, he admitted that he sometimes overreacted to certain situations.

In a session with his wife, she stated that Mr. R had always had a suspicious nature. However, he was someone who avoided expressing his

emotions and thoughts and had learned to keep them hidden. She mentioned that after his promotion, the situation had changed and that they constantly argued over reasons that he himself found. Fearing that Mr. R might lose his job due to the continuous conflicts at school, his wife also expressed concern that he no longer communicated with his father-in-law and mother-in-law. She believed this was because Mr. R thought they were trying to turn their daughter against him and damage their relationship.

In a session with their children, they complained that Mr. R was constantly trying to control the household, inspecting every expenditure, and even attempting to run the home with a military-like discipline. Their 10-year-old daughter was attending the school where Mr. R was the principal, and he frequently interrogated her about what other students thought of him and what was being said about him at school. The children stated that they did not have a habit of hiding things from their father, but they were exhausted by his behavior and, as a result, found it difficult to tell him anything.

It would not be incorrect to say that Mr. R's condition indicates paranoid personality disorder. The crucial point to consider is whether Mr. R's thoughts and emotions are based on rational explanations and valid reasons or whether they are a characteristic of his personality that causes him to perceive situations in this manner. To understand this, it is necessary to assess his level of suspicion in new situations, the presence of paranoid feelings, the frequency of conflicts he experiences, and the extent to which these conflicts impair his functionality. In some cases, distinguishing between these factors may not be easy. This is because a paranoid person, like Mr. R, often claims that people are hiding things from them and can even find evidence to support this belief. However, this secrecy is not necessarily an indication that their suspicions are justified, but rather a consequence of their paranoid nature, which compels others to conceal things.

During the diagnosis and treatment process, a detailed history should be carefully taken. It is important to understand whether the condition has persisted for a long time without an identifiable cause and whether the emotions and behaviors in question meet the criteria for a personality disorder rather than just personality traits. Recognizing these factors is crucial in making an accurate diagnosis.

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# CHAPTER 3

## Schizoid Personality Disorder

Schizoid Personality Disorder (SPD), one of the ten identified personality disorders, is classified within Cluster A, alongside Paranoid Personality Disorder and Schizotypal Personality Disorder (APA, 2013).

According to Budak (2000), the term “schizoid” refers to individuals who exhibit some cognitive features of schizophrenia but are not psychotic. Schizoid Personality Disorder is characterized by behaviors such as shyness, lack of interest in social life, excessive daydreaming, absence of close personal relationships, choosing to remain distant from others in society, avoiding competition, and showing indifference to humor, praise, or the emotions of others. However, it does not involve the speech, behavior, or thought peculiarities observed in Schizotypal Personality Disorder. Individuals with this disorder generally react to distressing experiences by withdrawing from life and are unable to express emotions like hostility or aggression. Their passive-aggressive tendencies and autistic thinking patterns, along with emotional isolation and difficulty adapting to social environments, further contribute to their loneliness (Öztürk & Uluşahin, 2008).

Additionally, such individuals tend to engage in introverted activities and structure their lives and career choices in ways that require minimal interaction with others. They perceive themselves not as active members of society but rather as observers. Schizoid individuals experience a sense of alienation. They exhibit a serious demeanor due to their feelings of abnormality, which cognitively and emotionally separate them from others. Their behavior makes them appear unnatural and unappealing to others. They display a passive attitude, resist change, and have a rigid and persistent resistance to external influences (Martens, 2010).

### Definition and History

The concept of "schizoid" was introduced by Eugen Bleuler in 1908, describing it as a natural formation of personality where an individual shifts focus from the external world to their inner world. According to Bleuler, schizoid individuals are calm, suspicious, shy, and simultaneously sensitive.

Their inner world is marked by emotional instability and the presence of conflicting desires (Öner & Özsan, 2002).

In 1925, Emile Kretschmer defined schizoid personality and identified three fundamental structures. The first structure consists of introverted, calm, tense, and abnormal personality traits. The second includes individuals who are easily affected, anxious, prone to boredom, sometimes impulsive, abnormal, and enjoy reading activities. The third structure describes individuals who are honest, adaptable, clear-minded, superficial, and quiet. The purpose of dividing schizoid personality into these three structures was to acknowledge that an individual might exhibit one or all of these traits simultaneously (Masterson & Klein, 2013, as cited in Alioğlu, 2019).

Melanie Klein defined the schizoid state as "splitting," arguing that schizoid individuals often struggle with an opposing pattern of sensitivity and coldness. This paradox highlights that individuals who appear very cold can actually be excessively sensitive (Spillius, 2003, as cited in Alioğlu, 2019).

In 1970, Heston categorized schizoid traits based on two different characteristics: behavioral patterns and internal tendencies. Behavioral characteristics included social abnormality, suspiciousness, sexual peculiarities, and a tendency toward alcohol dependence. Internal traits included rigid thinking, emotional deficiency, and excessive sensitivity (Öner & Özsan, 2002).

According to Akhtar (1987), schizoid personality appears to be characterized by withdrawal from life, contentment with solitude, lack of interest in sexuality, and adherence to moral norms. However, internally, these individuals are highly sensitive to situations, emotionally reactive, creative, prone to deviant thoughts, and sometimes rule-breaking. This duality reflects a division of the self, leading to a fragmented experience of life. As a result, schizoid individuals struggle to fully understand their own identities, often feeling bewildered by conflicting emotions, thoughts, and impulses (Gençtan, 2018).

Fairbairn also examined the concept of schizoid personality. Establishing social bonds is challenging and anxiety-inducing for schizoid individuals. In response, they turn inward and maintain a certain distance in

relationships. This distance and their inner world serve as a protective shield against anxiety (Fairbairn, 2013, as cited in Alioğlu, 2019). Fairbairn identified key traits of schizoid individuals: they regulate the closeness of social interactions, exhibit self-sufficiency, manage their distance from social environments, devote significant time to their inner world, and place great importance on their internal experiences. He also suggested that the development of schizoid disorder may stem from childhood experiences in which an individual perceives either excessive maternal possessiveness or neglect, leading to a belief that they are unloved (Masterson & Klein, 2013, as cited in Alioğlu, 2019).

Guntrip outlined nine fundamental personality traits of schizoid individuals: introversion, withdrawal, a sense of superiority, self-sufficiency, emotional inadequacy, preference for solitude, self-admiration, loss of self, and regression (Özakkaş, 201, as cited in Alioğlu, 2019).

Schizoid Personality Disorder was included in the first edition of the DSM, though its definition was quite brief. Only three characteristic traits were mentioned: avoidance of close relationships, inability to express aggression, and autistic thinking (Candel & Konstantin, 2017).

Prior to DSM-III, schizoid disorder was primarily considered in relation to schizophrenia. DSM-III provided a more comprehensive definition with detailed criteria. Symptoms included introversion, social isolation, thought disturbances, sexual peculiarities, and difficulty maintaining social communication. These characteristics also led to confusion in differentiating between Schizoid and Schizotypal Personality Disorders. Upon re-evaluating the definitions proposed by various scholars, it was observed that schizoid traits bore similarities to Schizotypal Personality Disorder.

In DSM-III, traits that were previously categorized under schizoid personality were redistributed among three distinct personality disorders: Schizoid, Avoidant, and Schizotypal Personality Disorders (Öner & Özsan, 2002). Schizoid individuals were described as having an introverted problem with connecting to their environment. In contrast, individuals with Avoidant Personality Disorder were depicted as eager to form social connections but refrained from doing so due to fear of rejection and humiliation. The key distinction between the two was that while avoidant individuals desired social

interaction, schizoid individuals lacked such interest. Schizotypal individuals, on the other hand, exhibited peculiar behaviors in their social interactions and had genetic ties to schizophrenia. The schizotypal traits in this classification resembled a type of schizophrenia from earlier years. In the DSM-III diagnostic criteria, the following were included: “lack of enjoyment in close relationships, preference for solitary activities, rare expression of intense emotions such as pleasure or anger, reluctance towards sexual experiences with others, indifference to criticism from others, absence of close and trustworthy friends except for first-degree relatives, and emotional restriction (coldness, rare use of facial expressions, infrequent smiling)” (Öner, Özsan, 2002).

In short, the diagnostic criteria in the DSM-III were both highly comprehensive and made it difficult to reduce the disorder to a simplistic form. Additionally, the terms "sexuality" and "aggression" in the criteria were preceded by the notion of difficulty, and explanations such as “expressing” and “appearing” suggested that internal experiences and their external reflections might differ. The final criticism was that anxiety, avoidance, and reluctance in avoidant personality disorder seemed to resemble a phobic condition (Öner, Özsan, 2002).

In the DSM-IV, schizoid personality disorder was revised and reintroduced. The DSM-IV stated that schizoid individuals neither desired nor enjoyed close relationships. It was noted that they preferred engaging in only a single activity in life, had very little or no desire for sexual intimacy with another person, had no close friends or confidants except for their closest relatives, were indifferent to praise or criticism from others, and experienced emotional deficiency. Additionally, it was specified that schizoid individuals had expressionless facial features, rarely used facial expressions, occasionally smiled, and even during moments of anger, emotional insufficiency was observed. When faced with anger, they imagined withdrawing from the situation. They very rarely expressed emotions openly. They could be perceived as having no clear goals in life. In significant moments, they might fail to provide appropriate responses, which could hinder their professional advancement. However, when boundaries were well-defined, they could exhibit expected behaviors in social settings. Schizoid men and women generally did not marry because they did not seek close relationships, but some schizoid women might approve of marrying an aggressive man. In such

cases, they might experience anxiety and stress, and transient psychotic episodes lasting minutes could occur. Additionally, depression could sometimes accompany the condition. According to the DSM-IV, this disorder was often observed alongside schizotypal, paranoid, and avoidant personality disorders (Öner, Özsan, 2002).

**DSM-5 Diagnostic Criteria**

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

1. Neither desires nor enjoys close relationships, including being part of a family.
2. Almost always chooses solitary activities.
3. Has little, if any, interest in having sexual experiences with another person.
4. Takes pleasure in few, if any, activities.
5. Lacks close friends or confidants other than first-degree relatives.
6. Appears indifferent to the praise or criticism of others.
7. Shows emotional coldness, detachment, or flattened affectivity.

B. The disorder does not occur exclusively during the course of schizophrenia, a bipolar disorder, a depressive disorder with psychotic features, or an autism spectrum disorder and is not attributable to the physiological effects of another medical condition." (APA, 2013)

**General Characteristics, Signs, and Symptoms**

According to the widely recognized diagnostic manual ICD-10, schizoid personality disorder is described in terms of diagnostic criteria such as: a preference for solitary activities, an inward focus on one's inner life, a lack of emotional and environmental interaction, and a limited capacity for expressing and articulating emotions (WHO, 2019, cited in Çakır & Bilge, 2020).

Schizoid individuals can continue their lives independently, without needing anyone. They prefer engaging in a single activity. They do not enjoy the presence of others around them and struggle to communicate comfortably or make eye contact. Their emotional expression is inadequate and highly superficial. They may appear inexplicably serious in social settings, which may disturb others, or they may remain completely indifferent. They do not laugh at jokes and show minimal reactions. Their speech is direct, and they avoid giving lengthy responses. They do not initiate communication, and at times, their speech may include a great deal of metaphorical language. They may be influenced by unreal objects and believe in imaginary or fantastical scenarios. They are often drawn to philosophical and astronomical movements. They do not feel or seek emotional closeness with people, but they may form attachments to animals. Their sexuality is confined to thoughts, and they generally do not prefer to marry (Köroğlu, 2014).

The inadequacy of schizoid individuals in the balance of give-and-take with others quickly becomes apparent in their environment. In social settings, they generally appear cold and unresponsive, often seeming lost in their own world. Participating in social activities is challenging for them, and in mandatory events, they maintain a formal stance without establishing genuine connections. They display an official demeanor that clearly indicates they are attending out of obligation (Köroğlu, 2014).

Their speech is clear, slow, and monotone. The emotional aspect of their interpersonal communication and conversations is quite weak and ambiguous. Since they do not engage in social settings, their speech is often convoluted, making it difficult to understand what they are saying. Their movements are slow, and they do not use hand, arm, gestures, or facial expressions while speaking. On rare occasions, they may appear joyful and respond emotionally to those around them, albeit slowly; however, this is not a deliberately rude reaction. They frequently engage in deep but trivial subjects. They live as if they are the only ones in the world, disconnected from others, preferring to be on their own (Köroğlu, 2014).

No significant emotional fluctuations are observed. In other words, they do not distinctly express emotions such as happiness, sadness, or anger. Schizoid individuals are cold, indifferent, and repelling toward those who show them affection, attempting to distance themselves from them. Some may

develop interests in various fields, while others remain restricted, showing no engagement in either their internal or external life. In some individuals with schizophrenia, schizoid traits can be observed in their pre-illness behavior and movements (Öztürk, Uluşahin, 2008).

They are perceived as asocial in their environment. In most situations, they do not react. They remain unresponsive to circumstances that would typically anger, amuse, or sadden others. They rarely express or reflect emotions such as sadness, anxiety, or anger. Indifference, detachment, and emotional unresponsiveness are key symptoms of this disorder. Additionally, schizoid individuals are not energetic, enthusiastic, or striving individuals. When they do engage in activities, these are usually solitary pursuits such as knitting, reading books, watching television, or painting (Köroğlu, 2014).

Schizoid individuals experience emotions on a superficial level and therefore rarely engage in self-reflection. This is because superficial people do not derive satisfaction from self-examination. As schizoid individuals do not engage in introspection, their self-awareness is naturally low, which contributes to their other characteristics. Their emotions and thoughts are always superficial, disorganized, and impoverished (Köroğlu, 2014).

Schizoid individuals generally focus on unnecessary details of events while disregarding the overall information presented. As a result, their comprehension tends to be scattered. Consequently, their communication and interaction with others are often meaningless and dysfunctional.

When describing themselves, schizoid individuals portray themselves as sensitive, mild-mannered, introverted, and understanding. They are content with their current state and consider their life to be functional and satisfying in a way that meets their expectations. They are also happy because, unlike others, they are not ambitious or competitive, and they openly express their satisfaction with this. However, they are not clear or precise in their speech or self-expression. Their lack of clarity about themselves does not imply that understanding them is complicated or that they are denying themselves. Rather, this stems from their inability to adequately articulate their emotions and thoughts. Schizoid individuals, who lack clarity about themselves, also struggle to express themselves in social settings. They describe themselves as

shy and distant, knowing that other people do not concern them. At the same time, they are aware that those around them are also indifferent toward them.

Because schizoid individuals experience emotions superficially and remain unresponsive in interactions, they are not affected by situations and do not use intrapsychic mechanisms. Additionally, due to this, they lack strategies for coping with difficult relationships with people. Instead of engaging with others and dealing with complex relationships, they prefer to avoid interaction altogether. They have no desires or wishes and do not form close bonds. Unlike those with avoidant personality disorder, they distance themselves from others not due to impulsivity but because they feel comfortable doing so (Köroğlu, 2014).

The core beliefs of schizoid personality disorder are as follows:

I do not care what others think of me.

Being free and separate from others is very important to me.

Being alone in my current state is much better.

I enjoy engaging in activities alone.

I am not influenced by the people around me when making decisions.

I have my own unique goals and desires.

Others are unreliable.

I can handle situations on my own.

My life is more important than being close to other people.

I am not affected by what other people think.

Communication with others is complicated and takes away my freedom (Köroğlu, 2014).

**Social Relationships and Self-Perception**

The situations or events that lead to the emergence of abnormal behaviors characteristic of schizoid personality disorder are close relationships. The behaviors of schizoid individuals appear slow and indifferent. Their speech is slow and progresses in a monotone. Their communication and movements are unnatural. In their interactions with others, they are neither warm nor sincere. They prefer to spend time alone. Their lives mostly revolve around a single activity. They feel discomfort in social interactions and being part of a community, often avoiding such situations. They do not wish to participate in group work and prefer to stay away from social events because they cannot adapt to them (Köroğlu, 2014).

They appear distant, detached, and emotionless, avoiding joy and amusement within their inner world. They seem indifferent to compliments or criticism, as if they do not care. This does not appear normal to outsiders. They cannot form attachments to those around them and struggle to establish and maintain communication. They fail to understand the emotions of others, and their emotional sharing is limited (Köroğlu, 2014).

They perceive themselves as sufficiently capable and believe they can handle everything on their own. Since they do not form emotional bonds, they do not respond to those around them and, consequently, cannot develop friendships. Their communication and relationships with others do not progress (Köroğlu, 2014).

Their thoughts about themselves are clear. They state that they are individuals who do not fit into their surroundings and insist that they do not need others. They also express their lack of interest in people or events around them. Their worldview is: *"The world is already difficult and complex. I should not trust anyone and must keep my distance from others. That way, I can protect myself from harmful things."* (Köroğlu, 2014).

Schizoid individuals believe in handling their affairs independently and think they are self-sufficient. They perceive others as people who forcibly interfere in everything. Their perspective on people around them is: *"I should avoid communication because they restrict my freedom."* (Köroğlu, 2014).

**Diagnostic Features**

The most fundamental characteristic of schizoid personality disorder is the tendency to avoid and detach from environmental situations and events, along with an inability to express emotions in social settings. This condition emerges in early adulthood and manifests in various ways (Köroğlu, 2014).

Individuals with schizoid personality disorder do not form close relationships with others, nor do they desire to do so. If a relationship develops, they feel uncomfortable. They do not enjoy being part of a group, social circle, or family. Instead of interacting with others and spending time with them, they prefer to be alone. They are typically withdrawn from society and take pleasure in solitude. Their hobbies and activities are solitary and do not require social interaction. They are often interested in fields such as astrology, mathematics, and technology. Their areas of interest are usually abstract and mechanical. They have little desire for sexual relationships and do not find satisfaction in sexual experiences. They have no close friends, confidants, or companions, but their close relatives are often present in their surroundings (Köroğlu, 2014).

Individuals with schizoid personality disorder are unresponsive and indifferent to criticism, attention, and compliments. Just as they do not care about what the people around them think of them, they also do not worry about what others think of them. Their behavior lacks refinement because it is generally monotonous. Instead of responding to events as expected, they approach them superficially and unresponsively. They appear rigid and unreactive, and they rarely exhibit responses such as smiling or approval toward others. There is a deficiency and dullness in their affective response to events, and they cannot comfortably express their emotions as they are. They rarely verbalize situations and emotions that disturb them. Even when strongly provoked, they do not fully experience moments of anger or frustration, displaying emotional unresponsiveness. From an external perspective, individuals with schizoid personality disorder appear to lack purpose, and they seem to drift wherever the wind blows. They exhibit a passive attitude toward life and struggle to respond appropriately. In their professional lives, they prefer to avoid activities that require social participation and generally choose jobs that do not involve interaction with people (Köroğlu, 2014).

**Differential Diagnosis**

Individuals with schizoid personality disorder can be confused with individuals with avoidant personality disorder. Individuals with both disorders tend to avoid and withdraw from social activities. However, the distinguishing point is that individuals with avoidant personality disorder want to be in social environments but avoid them due to fear of embarrassment or rejection. (Öner & Özsan, 2002) Additionally, individuals with avoidant personality disorder are overly sensitive to negative evaluations. In contrast, individuals with schizoid personality disorder are indifferent both to the people around them and to what those people think. Individuals with avoidant personality disorder engage in social relationships only when they are sure they are accepted and withdraw from social environments due to fear of embarrassment in front of others (Winarick & Bornstein, 2015). On the other hand, individuals with schizoid personality disorder have no desire for closeness or participation in social settings, which is why they avoid them.

Both individuals with schizoid personality disorder and individuals with schizotypal personality disorder are characterized by noticeably limited social communication. Additionally, both disorders involve insufficient emotional responses. However, the key difference between them is that individuals with schizotypal personality disorder display peculiar, unusual, magical thinking, cognitive disturbances, distorted perceptions, and thought patterns, which are not present in individuals with schizoid personality disorder. Individuals with schizoid personality disorder are detached from others, self-contained, and introverted. Furthermore, while individuals with schizoid personality disorder are indifferent to what others think about them, individuals with schizotypal personality disorder are affected by others and can be sensitive to their opinions (Çakır & Bilge, 2020).

Individuals with both schizoid personality disorder and obsessive-compulsive personality disorder experience emotional insufficiency and limitations in expressing emotions. Individuals with both disorders appear rigid, superficial, and cold. (Çakır & Bilge, 2020) However, these disorders are different. Individuals with obsessive-compulsive personality disorder have the potential to express their emotions. They are capable of reflecting anger, joy, and sadness. Additionally, they do not experience personality disintegration or fragmentation (Öner & Özsan, 2002).

There are also commonalities between individuals with schizoid personality disorder and individuals with narcissistic personality disorder. In both disorders, individuals experience problems with separation-individuation and superego development. Additionally, both personality disorders exhibit avoidant tendencies and coldness in close relationships. However, there are differences that distinguish the two disorders. Individuals with narcissistic personality disorder can exploit others. Individuals with schizoid personality disorder, on the other hand, believe they are self-sufficient and do not express their desires to others. Furthermore, individuals with narcissistic personality disorder are active, ambitious, and competitive, whereas individuals with schizoid personality disorder are passive and lethargic. Individuals with narcissistic personality disorder are actively involved in social environments to seek validation, whereas individuals with schizoid personality disorder are avoidant and uninterested in others' thoughts, respect, or affection (Öner & Özsan, 2002; Çakır & Bilge, 2020).

**Epidemiology**

It is estimated that schizoid personality disorder affects 7.5% of the general population. Additionally, this rate is higher in the close relatives of individuals with schizophrenia. (Köroğlu, 2014) According to another study conducted in Turkey with adolescents aged 13–24, the prevalence of schizoid personality disorder was recorded as 3.75% (Bilge & Bilge, 2019). Furthermore, based on recorded data, schizoid personality disorder is among the least diagnosed personality disorders, and it has been observed more frequently in men than in women (Türk, 2021).

**Causes of Emergence**

Genetic influences can be mentioned, and it is also thought that individuals with schizoid personality disorder experience disrupted family communication during childhood (Köroğlu, 2014). Having emotionally cold, neglectful, and distant caregivers during childhood may contribute to the development of schizoid personality disorder by fostering a sense that interpersonal relationships are not satisfying. Additionally, twin studies have estimated that the heritability rate for schizoid personality disorder is approximately 30% (Reichborn-Kjennerud, 2010).

According to Millon's (1999/2019) research, individuals with schizoid personality disorder may have different brain structures, particularly in the limbic system or reticular activation system. These differences may explain the characteristic emotional deficiency and lack of interest observed in individuals with schizoid personality disorder (Çakır & Bilge, 2020).

**Treatment**

Individuals with schizoid personality disorder rarely seek treatment because they are isolated in society and are not bothered by this condition. They do not voluntarily seek clinical help unless a family member insists or unless the disorder results in another issue (Attademo, Bernardini, & Spatuzzi, 2021).

According to Salzman (1974), individuals with schizoid personality disorder may initially seek treatment due to a crisis but struggle to continue therapy because their ego strength is limited. Additionally, due to patients' lack of motivation, limited insight, and difficulties in expressing emotions, the treatment success rate is quite low. The main goal of therapy is to encourage individuals with schizoid personality disorder to engage with their environment, even to a small extent, in order to reduce their loneliness and social withdrawal. Within this framework, social skills training can be provided. Furthermore, group activities can be beneficial and productive in improving communication and social skills during the treatment process (Öner & Özsan, 2002).

According to Siever (1981), individuals with schizoid personality disorder who enter therapy may exhibit significant resistance. Therefore, the therapist should be careful throughout the process and follow a structured approach. By working on emotions, the therapist can help the individual become aware of the feelings they develop toward people around them. Generally, individuals with schizoid personality disorder are accustomed to living alone, and this has become normalized for them. The patient does not expect long-term treatment from the therapist but rather seeks help in resolving crises. For this reason, the decision to implement group therapy should be made based on the patient's condition (Öner & Özsan, 2002).

The therapist should not adopt a harsh or rigid attitude toward individuals with schizoid personality disorder but should manage the process at the patient's pace, considering their condition. During this process, the patient may use defense mechanisms. The therapist should be careful not to engage in countertransference and should strive to establish a harmonious emotional interaction. Over time, the patient may develop dependence on the therapist. The individual may experience a temporary sense of emptiness as they become aware of their internal processes. During these times, the therapist should provide maximum support to the patient and ensure continuity in therapy sessions. At this stage, the patient's rigid defenses may begin to relax, and this phase can take a long time. Once this period has passed, efforts can be made to motivate the patient to interact and communicate with others. The patient will start considering their interactions with the therapist and will begin to express emotions such as anger and frustration. The termination of therapy should be done gradually, taking the entire process into account (Öner & Özsan, 2002).

Unfortunately, for many individuals with schizoid personality disorder, the described process is too fast and not as feasible as it seems. This is because not every patient can easily adapt to the process, and breaking their resistance takes time. In such cases, the therapist is expected to maintain a supportive interaction with the patient (Öner & Özsan, 2002).

**Gestalt Therapy Approach to Schizoid Personality Disorder**

Diagnosis forms the foundation of treatment. In the Gestalt school, diagnosis is made using different maps that focus on the interaction between the individual and their social environment. The various maps used in diagnosis include:

1. Capacity for Contact
2. Completion of the Need Cycle
3. Forms of Contact

These maps guide the therapist from the beginning of the process regarding the steps to be followed, and they must be modified according to new steps and developments throughout the therapy process (Daş, 2014).

*Maps*

1. **Capacity for Contact:** One of the maps used in Gestalt theory to evaluate the client is the capacity for contact. The characteristics considered in relation to contact capacity include the ability to empathize, establish close relationships, engage in dialogue, and express anger or joy (Daş, 2014).

Individuals with schizoid personality disorder cannot understand the emotions and thoughts of others, nor can they see life from other people's perspectives. Similarly, they are cold and distant in their relationships. They cannot form close relationships and do not have friends outside of their immediate family members. Schizoid individuals cannot present themselves warmly and sincerely for an extended period.

Dialogue encompasses expressing one's perspective, listening to and understanding another's viewpoint, reaching an agreement, demonstrating perseverance to achieve a goal, continuing a relationship despite difficulties or emotional wounds, knowing when to withdraw, and being able to let go. However, schizoid individuals do not enjoy expressing themselves to others or understanding others. They experience emotional deficiency, remain isolated, and avoid communication unless necessary. They refrain from expressing themselves and, in short, do not engage in dialogue with their surroundings. Additionally, schizoid individuals cannot express their anger or joy and exhibit emotional bluntness (Daş, 2014).

2. **Completion of the Need Cycle:** Another diagnostic tool used in the Gestalt approach is the need cycle. Life consists of the emergence of needs, the fulfillment of these needs to maintain balance, and the re-emergence of needs over time. This is a dynamic cycle. However, if needs are not adequately met or if obstacles arise in this cycle, interactions with the environment become disrupted, leading to problems (Daş, 2014).

An individual must develop the necessary skills to go through each stage and complete the cycle. Blockages experienced in this cycle result in rigid, fixed, and unchanging behaviors (Clarkson, 1993, cited in Daş, 2014). Furthermore, the earlier these blockages are observed, the more it indicates

that the behavioral traits were acquired at an early age, have a physiological basis, and are more resistant to therapeutic change. Identifying the stages where the individual gets stuck in the need cycle helps determine the therapeutic interventions to be applied in therapy (Daş, 2014).

When examining the need cycle completion map, individuals with schizoid personality disorder experience difficulties at the movement and contact stages. The goal at this stage is to eliminate the factors that prevent the individual from taking action. The therapist helps the client explore their thoughts and attitudes toward themselves and others, supporting them in modifying and integrating necessary aspects. The therapist also guides the client in facing and overcoming their fears and hesitations.

At the contact stage, schizoid individuals cannot fully connect with their surroundings through what they do, see, or hear. Due to their inability to establish contact with others, they do not have close friends in their social lives. They are cold and distant toward those around them, uninterested in what others say, and tend to withdraw. The therapist should assist schizoid individuals in making contact, helping them focus on the present moment and become aware of their emotions. In short, the goal is to aid in establishing and maintaining contact (Daş, 2014).

*Forms of Contact*

One of the most important issues in the Gestalt approach is establishing a healthy contact with the environment. If there is an obstructed contact, the primary goal is to recognize and modify it. Forms of contact can be examined using the contact forms map (Daş, 2014).

*Introjection*

Introjection refers to how a person perceives the world and evaluates themselves and others. It consists of information learned and internalized, particularly during childhood. Beliefs such as “I must not trust anyone,” “I can do everything on my own,” and “Others are unreliable,” commonly found in schizoid individuals, can be addressed and examined during therapy (Daş, 2014).

*Desensitization*

Individuals who use this form of contact are unaware of both their own emotions and needs, as well as the emotions and needs of their surroundings and other people. Schizoid individuals are also highly indifferent and cold toward their environment. They do not care about or show interest in the emotions and thoughts of others (Daş, 2014).

*Therapeutic Goals and Process*

In the Gestalt school, the goal of therapy for personality disorders is to make rigid, fixed, and static behavior patterns more flexible. In other words, the aim is to integrate the personality—allowing the individual to embrace aspects of their personality that they have disowned and to adapt to new alternatives in different circumstances. The function of therapy depends on the therapeutic relationship. Establishing a relationship in personality disorders takes a long time.

In schizoid personality disorder, individuals experience disruptions in the movement and contact stages of the need cycle. In other words, the ability to establish contact is highly dysfunctional in schizoid individuals. By explaining the contact forms they use, therapy can focus on how the individual has learned these forms of contact. Recognizing contact forms may take a long time, and patience is required. Additionally, therapy can work on the client's needs.

Schizoid individuals do not prefer to talk, share things with others, understand emotions, or generally engage with people around them. Therefore, in therapy, the individual should first be encouraged to express themselves adequately and to articulate their emotions. Any Gestalt technique beyond the dialogic relationship should not be applied hastily; in fact, there should be no rush in increasing awareness at the beginning. The most critical point is to first ensure that the client feels understood and accepted.

The therapist should be active, calm, patient, and participatory, guiding the individual in opening up and expressing emotions. Since schizoid individuals are preoccupied with their internal processes during contact and use desensitization and introjection contact forms, they struggle to establish a

dialogic relationship. When the therapist encounters difficulty in establishing contact, they should patiently persist in maintaining dialogue. The intensity of contact should be carefully adjusted.

Schizoid individuals are unaware of the rigidity and stagnation in their behavior. The therapist should help the client recognize how they establish contact with their surroundings and utilize their observations effectively. The process should be managed in a harmonious manner rather than with a blaming attitude. The client should be informed about the Gestalt perspective on personality disorders, particularly how a rigid personality becomes fixed. Throughout this process, the therapist should emphasize not whether the client's personality is good or bad but rather that it is rigid and fixed (Daş, 2014).

**Cognitive Therapy in Schizoid Personality Disorder**

The fundamental issue in individuals with schizoid personality disorder is a lack of communication and interaction with their environment, as well as indifference toward others. Schizoid individuals are isolated and define themselves as self-sufficient and people who enjoy being alone. They perceive others as intrusive and controlling. Consequently, schizoid individuals naturally struggle to establish a therapeutic relationship in therapy as well. They may have difficulty trusting the therapist throughout the process.

The individual is asked to outline the advantages and disadvantages of continuing or discontinuing therapy. This issue should be discussed and examined in depth. The core beliefs of schizoid individuals include: "I am fundamentally alone," "Close relationships with people are meaningless and contaminating," and "If others did not hinder me, I could achieve better things." Their conditional beliefs include: "If I get too close to people around me, I won't be able to progress," and "I cannot be happy unless I am free." Their compensatory beliefs include: "Do not get too close," "Maintain your boundaries," and "Do not interfere in everything." These dysfunctional beliefs can be addressed in therapy.

Working on dysfunctional beliefs involves discussing them and conducting behavioral experiments throughout the process. It is well known

that changes in behavior lead to changes in beliefs. In therapy, a problem and goal list should be created with the schizoid individual. This list helps determine the direction of therapy. The Socratic questioning method can be used to examine and challenge these beliefs (Beck, Freeman, Davis, 2008).

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# CHAPTER 4

## Schizotypal Personality Disorder

Schizotypal Personality Disorder (STPD) is classified under Cluster A personality disorders and is characterized by a spectrum of schizotypal traits that increase an individual's vulnerability to schizophrenia (Esterberg et al., 2010). While STPD shares certain cognitive and perceptual abnormalities with schizophrenia, it remains distinct in its course and severity, typically presenting with less severe psychotic symptoms and greater functional retention. Historically, STPD has been conceptualized as a subclinical variant of schizophrenia, given its genetic, neurobiological, and phenomenological overlap with the disorder (Cochrane et al., 2012).

The defining characteristics of STPD include cognitive and perceptual distortions, eccentric behaviors, and significant social and interpersonal deficits. Individuals with STPD often exhibit magical thinking, unusual beliefs, and experiences that challenge conventional perceptions of reality (Raine, 2006). Their social relationships tend to be marked by discomfort and avoidance, often resulting in social withdrawal and isolation. These individuals may also display peculiar communication styles, characterized by vague, metaphorical, or overly elaborate speech patterns (Kwapil & Barrantes-Vidal, 2015).

To better understand the spectrum of schizotypal traits, researchers have proposed multidimensional models of schizotypy. The three-factor model, one of the most widely used frameworks, categorizes schizotypy into three core dimensions (Vollema & van den Bosch, 1995):

- **Positive Schizotypy:** Encompasses traits such as suspiciousness, hypersensitivity, unusual perceptual experiences, bodily illusions, superstitious beliefs, clairvoyance, preoccupation with bizarre fantasies, and magical thinking (Ettinger et al., 2015).
- **Negative Schizotypy:** Involves social withdrawal, emotional constriction, anhedonia, a lack of close relationships, peculiar communication styles, and poor social adaptation (Kwapil et al., 2008).

- **Disorganized Schizotypy:** Manifests in eccentric behaviors, disorganized speech, and unconventional dressing styles (Fonseca-Pedrero et al., 2016).

While the three-factor model remains influential, recent research suggests that schizotypy may be best represented by a four-factor structure that includes positive schizotypy, negative schizotypy, interpersonal sensitivity, and social isolation/introversion (Bedwell et al., 2014). This expanded model highlights the role of social anxiety and heightened interpersonal sensitivity as distinct factors contributing to schizotypal traits.

The DSM-5 includes STPD in **Section III: Emerging Measures and Models**, indicating that further research is needed to refine its diagnostic criteria (American Psychiatric Association, 2013). Section III adopts a dimensional approach, emphasizing the variability of personality traits rather than categorical diagnoses. According to the Five-Factor Model of Personality, individuals with STPD demonstrate impairments in self-identity, goal-setting, perspective-taking, and intimate relationships (Widiger & Crego, 2019). They also exhibit heightened levels of:

- **Psychoticism** (cognitive-perceptual distortions, unusual beliefs, eccentric behaviors).
- **Detachment** (social withdrawal, restricted emotional expression, and suspiciousness).

These traits contribute to the pervasive social and cognitive dysfunction observed in STPD.

Core Characteristics of Schizotypal Personality Disorder

Individuals with STPD typically exhibit four core symptom clusters (Grant et al., 2018):

1. **Unusual Experiences** – Includes extraordinary perceptual and cognitive distortions, such as magical thinking and idiosyncratic beliefs.

2. **Cognitive Disorganization** – Manifests as disordered thought patterns, disrupted associative thinking, and a lack of structured reasoning.
3. **Impulsive Inappropriateness** – Refers to difficulties in adhering to social norms, leading to erratic emotional responses and unpredictable behavior.
4. **Introverted Anhedonia** – Encompasses emotional monotony, social withdrawal, and reduced interest in external stimulation.

Schizotypal Personality Disorder (STPD) represents a unique intersection between personality pathology and psychotic spectrum disorders. While its diagnostic criteria continue to evolve, research supports a multidimensional conceptualization that captures the cognitive, social, and behavioral aspects of schizotypy. Future studies should focus on refining assessment tools and developing targeted interventions that address the cognitive and interpersonal difficulties associated with STPD (Kwapil & Barrantes-Vidal, 2015).

According to the World Health Organization (WHO), schizotypal disorder is characterized by symptoms such as eccentric behavior, abnormal thought patterns, and unusual emotional experiences resembling schizophrenia. However, unlike schizophrenia, STPD does not involve definitive delusions or other hallmark psychotic symptoms. Although symptoms of STPD can lead to significant social and occupational impairment, they do not typically cause a dominant or overtly apparent disorder in affected individuals (World Health Organization, 2019).

To diagnose a person with schizotypal disorder, the WHO states that at least four of the following features must persist consistently or over an extended period, typically up to two years:

1. Eccentric, unusual, or peculiar appearance or behavior.
2. Inappropriate or restricted affect.
3. Behaviors influenced by beliefs or thought patterns inconsistent with cultural norms.
4. Patterns of maladaptation and a tendency toward social withdrawal.

5. Paranoid or highly suspicious thought patterns.
6. Excessive preoccupation with one's physical appearance or thoughts, often leading to obsessive reflections on emotional states.
7. Unusual perceptual experiences, including illusions, detachment from reality, or sensory distortions.
8. Speech patterns characterized by inconsistency, unusual expressions, stereotypical thinking, or rigid thought structures.
9. Occasional illusions, auditory hallucinations, or psychosis-like experiences that the individual believes to be real.

Research indicates that STPD has strong genetic links to schizophrenia, suggesting a shared neurobiological foundation between the two disorders (Esterberg et al., 2010). However, debate persists regarding whether STPD should be conceptualized primarily as a personality disorder with pronounced cognitive and affective disturbances or as a milder form of chronic psychotic illness (Raine, 2006).

The concept of schizotypy, introduced by Sandor Rado, was initially described as a phenotype indicative of schizophrenia susceptibility. Rado defined schizotypy as a "schizophrenia-like phenotype," incorporating unusual thoughts, behaviors, social isolation, odd beliefs, and paranoia (Rado, 1953). His work laid the foundation for further exploration into the genetic and neurobiological underpinnings of schizotypy.

Eugen Bleuler, based on his observations of relatives of individuals with schizophrenia, proposed that certain symptoms observed in schizophrenia might manifest in a latent form among close family members. Previously, terms such as schizoid, borderline schizophrenia, and pseudoneurotic schizophrenia were used to describe these latent characteristics. However, Rado's contributions helped refine these classifications under the term "schizotypy" (Bleuler, 1911).

Building on Rado's theory, Paul Meehl introduced the concept of "schizotaxia," suggesting that a genetic predisposition, which he termed the "schizogene," led to "hypokrisia" in the central nervous system. This neurological defect, Meehl proposed, resulted in cognitive and perceptual abnormalities characteristic of schizotypy and schizophrenia (Meehl, 1962). According to Meehl, schizotaxia—when combined with environmental

influences—could result in either schizotypy (a mild form of the condition) or schizophrenia (a severe clinical disorder). His theory implied that schizophrenia followed a categorical distribution rather than a probabilistic one, a claim that has since been the subject of considerable debate (Lenzenweger, 2010).

Meehl's model has been criticized for oversimplifying the genetic and environmental interplay in schizophrenia development and for assuming that schizotypal traits necessarily indicate an inherited vulnerability to schizophrenia. Despite these critiques, his work has contributed significantly to research on schizotypy, schizotypal personality disorder, and schizophrenia risk assessment (Lenzenweger, 2018).

Neurobiological studies have identified several genetic and neuroanatomical correlates of STPD. For instance, genetic studies have linked STPD to variations in the COMT-Val158-Met polymorphism, dopamine transporter dysfunction, and abnormalities in the D4 dopamine receptor gene (Savitz et al., 2005). Additionally, neuroimaging studies have reported structural abnormalities in individuals with STPD, including enlarged ventricles, reduced superior temporal gyrus volume, decreased thalamus and basal ganglia volume, and corpus callosum asymmetries (Suzuki et al., 2005).

Schizotypal Personality Disorder remains a complex and multifaceted condition that bridges personality pathology and psychotic disorders. Advances in genetic, neurobiological, and psychological research continue to refine our understanding of STPD. Future research should prioritize the development of reliable diagnostic tools and targeted interventions that address the cognitive and interpersonal impairments associated with the disorder.

**Diagnosis of Schizotypal Personality Disorder**

The assessment of schizotypal traits and Schizotypal Personality Disorder (SPD) relies on various psychometric tools designed to capture the multifaceted nature of the condition. One of the most comprehensive instruments for evaluating schizotypy is the Structured Interview for Schizotypy-Revised (SIS-R). This tool enables clinicians to systematically assess schizotypal symptoms based on a structured diagnostic framework.

Self-report measures are also widely used in both clinical and research settings. Among these, the Schizotypal Personality Questionnaire (SPQ) is one of the most extensively validated instruments. The SPQ consists of 74 self-report items designed to assess schizotypal traits across three primary dimensions:

- **Cognitive-Perceptual Schizotypy:** Characterized by unusual perceptual experiences, referential thinking, magical thinking, and suspiciousness.
- **Interpersonal Schizotypy:** Includes social anxiety, lack of close friendships, restricted affect, and suspiciousness.
- **Disorganized Schizotypy:** Encompasses odd behaviors and speech patterns.

Research indicates that the three-factor structure of the SPQ aligns with the symptomatic presentation of SPD and contributes to its utility in both clinical diagnostics and personality research.

Another significant tool is the Composite International Diagnostic Interview (CIDI), a structured assessment that evaluates the frequency, distress, and functional impairment associated with psychotic experiences. The CIDI effectively differentiates between psychotic symptoms, such as delusions and hallucinations, and mood-related disturbances. Its structured format facilitates the identification of schizotypal traits within broader psychiatric assessments.

**Treatment of Schizotypal Personality Disorder**

Schizotypal Personality Disorder (SPD) is a complex psychiatric condition characterized by cognitive and perceptual distortions, social deficits, and eccentric behaviors. Although there is no well-established definitive treatment for SPD, both psychotherapeutic and psychopharmacological approaches have been employed to alleviate symptoms and enhance social functioning.

### Psychotherapeutic Approaches

Psychotherapy remains a fundamental component of SPD treatment, aiming to improve social skills, reduce cognitive distortions, and enhance interpersonal functioning. Cognitive-behavioral therapy (CBT) has been shown to be effective in addressing maladaptive thought patterns and increasing social engagement (Coutinho et al., 2021). Additionally, social skills training has demonstrated efficacy in improving adaptive functioning and reducing the risk of progression to psychotic disorders (Gumley et al., 2017). Group therapy can also provide a structured environment for patients to practice social interactions and develop healthier relational patterns (Fonseca-Pedrero et al., 2020).

### Pharmacological Treatments

Pharmacotherapy is often used to manage specific symptoms of SPD, particularly those associated with cognitive impairment, perceptual distortions, and co-occurring psychiatric conditions. Antipsychotic medications, particularly second-generation antipsychotics such as risperidone and olanzapine, have shown moderate efficacy in reducing psychotic-like symptoms and improving cognitive function (Siever & Davis, 2018). Risperidone, in particular, has been associated with improved social functioning and decreased paranoia (Koenigsberg et al., 2014).

Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), have been utilized in cases where SPD patients exhibit significant depressive or obsessive-compulsive symptoms (Gurvits et al., 2021). However, the evidence supporting their effectiveness in treating core symptoms of SPD remains limited. Some studies have explored the use of dopamine agonists, such as pergolide, and noradrenergic agents, such as guanfacine, for improving cognitive deficits associated with SPD, particularly in working memory and executive functioning (McClure et al., 2010).

### Treatment Guidelines and Considerations

Despite the available treatment modalities, there are currently no universally accepted clinical guidelines specifically for SPD. The World Federation of Societies of Biological Psychiatry (WFSBP) provides general

recommendations for personality disorder treatments, but SPD-specific guidelines remain underdeveloped due to limited empirical evidence (Herpertz et al., 2020). Given the overlap between SPD and schizophrenia spectrum disorders, some treatment strategies for schizophrenia, such as cognitive remediation and structured psychosocial interventions, have been proposed for SPD patients (Hazlett et al., 2012).

Overall, treatment for SPD should be individualized, combining psychotherapy with targeted pharmacological interventions when necessary. Future research should focus on refining treatment protocols and identifying specific pharmacological and psychosocial interventions that yield the greatest benefits for individuals with SPD.

Schizotypal Personality Disorder (SPD) remains a complex and under-researched condition, particularly regarding pharmacological and psychotherapeutic treatment options. Recent studies have explored the use of antipsychotic medications such as Risperidone to alleviate symptoms. For instance, a clinical trial administered Risperidone at doses ranging from 0.25 to 2 mg/dL over a nine-week period to patients diagnosed with SPD, resulting in a significant reduction in symptom severity (Siever & Davis, 2004). However, despite these findings, randomized placebo-controlled trials specifically targeting SPD remain insufficient.

The primary treatment goals for SPD focus on reducing psychotic symptoms and cognitive impairments. In cases where cognitive deficits are particularly pronounced, dopamine agonists like Pergolide and noradrenergic agents such as Guanfacine have been suggested as potential alternatives (Mitropoulou et al., 2002). For individuals exhibiting psychotic symptoms, Risperidone and other second-generation antipsychotics can be considered viable treatment options (Koenigsberg et al., 2003). However, further research is needed to determine the long-term efficacy and tolerability of these medications.

A crucial aspect of managing SPD involves distinguishing it from schizophrenia and other psychotic disorders. Understanding these distinctions is essential for developing targeted and effective interventions. Research into the etiology of SPD may provide new insights, potentially leading to improved diagnostic criteria and therapeutic strategies.

Beyond pharmacological treatments, psychological interventions play a significant role in managing SPD. Cognitive-behavioral therapy (CBT) is among the most widely utilized approaches, particularly for addressing cognitive distortions and social anxiety (Cather et al., 2005). Therapists working with SPD patients must adopt a nonjudgmental and empathetic stance, as these individuals often display unusual behaviors, thoughts, and emotions. A dismissive or critical approach may exacerbate symptoms and hinder therapeutic progress. In severe cases, hospitalization may be necessary to ensure patient safety and provide intensive treatment.

Comorbid psychiatric conditions, including anxiety and depression, frequently accompany SPD. Research indicates that positive schizotypy is associated with elevated levels of depression and anxiety, whereas negative schizotypy is more strongly linked to the schizophrenia spectrum (Lewandowski et al., 2006). This highlights the importance of comprehensive treatment plans that address both SPD symptoms and co-occurring psychological disorders.

In addition to CBT, other therapeutic modalities such as psychosocial skills training, group therapy, and family therapy have shown promise in managing SPD symptoms. Electroconvulsive Therapy (ECT) is occasionally considered for treatment-resistant cases, particularly when severe depressive or psychotic features are present (Turkington et al., 2006). While pharmacological treatments primarily target positive symptoms, they are often insufficient as standalone interventions. Therefore, combining medication with psychotherapeutic approaches enhances treatment efficacy, facilitates social skill development, and reduces social withdrawal.

Overall, SPD treatment requires an integrative approach that incorporates both pharmacological and psychological strategies. Continued research is essential to refine existing treatments and develop novel interventions that effectively address the diverse symptomatology of SPD.

**Cognitive Behavioral Therapy (CBT)**

Cognitive Behavioral Therapy (CBT) is a widely used therapeutic approach developed by Aaron Beck, which focuses on how individuals perceive, interpret, and emotionally respond to events. According to this

model, mental disorders arise from distorted and dysfunctional automatic thoughts that shape an individual's emotions, behaviors, and attitudes (Beck, 1976). Schizotypal Personality Disorder (SPD), characterized by cognitive-perceptual distortions, social deficits, and eccentric behaviors, has been targeted by CBT interventions to help individuals manage their symptoms more effectively (Beck & Freeman, 1990).

Automatic thoughts are spontaneous cognitive responses that individuals accept without critical evaluation. These thoughts develop rapidly and can manifest as both verbal and imaginal fragments. In individuals with SPD, automatic thoughts often include paranoid ideation, magical thinking, and unusual perceptual experiences (Beck et al., 2004).

CBT aims to help individuals recognize, evaluate, and modify these automatic thoughts. By challenging dysfunctional beliefs and replacing them with more adaptive cognitions, patients can reduce distress and improve their social functioning. Research has shown that structured CBT interventions can significantly reduce the severity of SPD symptoms by promoting cognitive flexibility (Rector et al., 2005).

*The A-B-C Model in CBT*

A central framework in CBT is the A-B-C model, which illustrates how individuals process experiences and react to them:

- **A (Activating Event):** Represents life events or situations that trigger cognitive and emotional responses.
- **B (Beliefs):** Includes automatic thoughts, intermediate beliefs, dysfunctional schemas, and core beliefs stored in memory.
- **C (Consequences):** Reflects the emotional and behavioral reactions resulting from one's beliefs about the activating event.

This model emphasizes that cognitive restructuring, or modifying maladaptive beliefs (B), can lead to more adaptive emotional and behavioral responses (C). As SPD is associated with maladaptive cognitive styles, interventions that target these distorted thinking patterns have been shown to enhance social adaptability and reduce distress (Davidson et al., 2009). CBT techniques used in the treatment of SPD include:

- **Psychoeducation:** Educating individuals about SPD symptoms and their cognitive underpinnings.
- **Cognitive Restructuring:** Identifying and modifying maladaptive thought patterns.
- **Attentional Shifting:** Redirecting focus from distressing thoughts to more neutral or positive stimuli.
- **Problem-Solving Training:** Enhancing adaptive coping mechanisms for daily challenges.
- **Behavioral Experiments:** Encouraging patients to test and challenge their distorted beliefs in real-life situations.
- **Exposure Therapy:** Gradual exposure to social interactions to reduce social anxiety and avoidance behaviors.
- **Relaxation Techniques:** Utilizing mindfulness and breathing exercises to manage anxiety symptoms (Beck et al., 2011).

CBT has been shown to be an effective treatment for SPD, particularly in addressing social anxiety, paranoid ideation, and cognitive distortions. Studies indicate that CBT can lead to sustained improvements in social functioning, self-perception, and emotional regulation in individuals with SPD (Cather et al., 2014). However, given the chronic nature of SPD, long-term therapeutic engagement and support may be necessary to maintain treatment gains. Future research should continue to refine CBT approaches tailored specifically to the unique cognitive and interpersonal difficulties associated with SPD. Research suggests that psychological and pharmacological treatments complement each other in managing schizophrenia (Wykes et al., 2008).

Although schizophrenia and related disorders involve genetic, environmental, biological, and structural factors in their etiology, pharmacological treatment alone is often insufficient. For individuals experiencing functional impairment, medication does not fully eliminate symptoms. Therefore, integrating CBT-based psychoeducation helps individuals increase their awareness of schizophrenia symptoms and develop coping strategies against social and internalized stigma (Garety et al., 2008).

CBT-based psychoeducation aims to change individuals' perspectives on their experiences, reduce the severity and frequency of schizophrenia symptoms, prevent relapses, and enhance functional recovery (Lincoln et al.,

2012). Despite the challenges of applying CBT-based psychoeducation to individuals with schizophrenia, studies have demonstrated that these individuals can benefit significantly from such interventions (Pilling et al., 2002).

*Psychosocial Skills Training*

Psychosocial skills training is based on structured behavioral interventions that focus on improving patients' daily functioning and social interactions. Through psychosocial skills training, individuals with schizophrenia and related disorders receive guidance in areas such as:

1. Strengthening cognitive skills
2. Developing communication skills
3. Enhancing problem-solving abilities
4. Understanding psychosis and schizophrenia
5. Learning about antipsychotic medication and its adverse effects
6. Evaluating the treatment process
7. Learning to cope with persistent symptoms
8. Recognizing and monitoring warning signs
9. Avoiding substance abuse
10. Managing stress effectively
11. Boosting self-confidence
12. Improving daily functioning and time management
13. Strengthening friendships
14. Engaging in social activities (Kurtz & Mueser, 2008).

Training sessions can be conducted in groups or individually, though group-based therapy has been found to provide a better learning environment. It is suggested that groups consist of four to eight participants for optimal effectiveness. Group therapy offers patients opportunities for peer support, role modeling, and feedback, which facilitate learning even in challenging program components such as problem-solving (McGurk et al., 2007).

Despite the difficulties schizophrenia patients may experience in interpersonal relationships, structured group therapy settings provide valuable opportunities for education, social support, and reality testing. Participants can

share and address long-standing struggles with their illness. Since all members face similar challenges, they connect more quickly and collaboratively develop coping strategies. The program helps individuals acquire skills necessary for maintaining healthy relationships.

Group therapy contributes positively to reducing social difficulties, improving communication abilities, fostering social skills, and increasing participation in daily activities. Group interventions for schizophrenia are more effective under the leadership of active and encouraging therapists. A structured, reality-oriented, problem-solving approach in a supportive environment enhances treatment effectiveness (Penn et al., 2009). The effectiveness of training programs can be assessed by comparing pre-test and post-test scores upon completion.

### Family Therapy in the Treatment of Schizophrenia and Related Disorders

When family therapy is integrated into pharmacological treatment for schizophrenia, it has been observed that the duration between relapses increases, and patients have greater opportunities to rebuild social relationships, enhance existing skills, and develop new ones (Rodolico et al., 2021). One of the primary goals of family therapy is to support the patient's hopes for the future while fostering realistic expectations. Family-based interventions help reduce familial stress, improve medication adherence, and enhance overall social functioning (Lincoln et al., 2012).

Research has demonstrated that family therapy effectively reduces symptom severity, lowers relapse rates, improves adherence to pharmacological treatment, and enhances general functioning (Gingerich & Peterson, 2013). These interventions typically include psychoeducation, communication skills training, problem-solving techniques, and emotional support for family members. Family therapy also facilitates a supportive environment, enabling patients to better cope with their condition and reducing the burden on caregivers (Rodolico et al., 2021).

**Electroconvulsive Therapy (ECT) in the Treatment of Schizophrenia and Related Disorders**

Electroconvulsive Therapy (ECT) is one of the primary somatic interventions for schizophrenia. ECT involves electrical stimulation of the brain to induce generalized seizures. Although advancements in antipsychotic medications have reduced its widespread use, ECT remains a beneficial adjunct therapy for patients who exhibit limited response to pharmacological treatments (Pompili et al., 2013).

ECT has been particularly effective in specific schizophrenia subtypes, such as catatonic schizophrenia and schizoaffective disorder (Fink & Sackeim, 1996). It has also shown promising results in treatment-resistant schizophrenia cases, contributing to clinical improvements when standard pharmacological interventions fail (Pompili et al., 2013).

Despite its proven efficacy and safety, ECT is often underutilized and considered a last-resort treatment in schizophrenia. However, its use remains relevant, especially in cases where pharmacotherapy alone does not yield sufficient symptom reduction (Fink & Sackeim, 1996).

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# Cluster B (Impulsive, Unstable, and Dramatic) Personality Disorders

Cluster B personality disorders are characterized by emotional instability, impulsive behaviors, and dramatic interpersonal relationships. Individuals with these disorders often exhibit intense emotions, erratic actions, and difficulties in maintaining stable relationships due to their unpredictable and sometimes manipulative behaviors. Unlike Cluster A, which is marked by detachment and eccentricity, Cluster B disorders involve heightened affectivity, impulsivity, and a strong desire for attention or control over others.

This cluster includes **antisocial, borderline, histrionic, and narcissistic personality disorders**, each presenting unique challenges in emotional regulation and interpersonal functioning. People with these disorders may be perceived as volatile, attention-seeking, or even reckless by those around them, often leading to conflicts in both personal and professional settings. Their intense emotional reactions and impulsive tendencies frequently result in unstable relationships and self-destructive behaviors.

While **borderline personality disorder** is characterized by extreme emotional instability, fear of abandonment, and self-destructive behaviors, **antisocial personality disorder** involves a disregard for social norms, deceitfulness, and a lack of empathy. **Histrionic personality disorder** is marked by excessive emotional expression and an overwhelming need for attention, whereas **narcissistic personality disorder** is defined by grandiosity, entitlement, and a lack of concern for others' feelings. The first personality disorder to be discussed is **antisocial personality disorder**.

# CHAPTER 5

## Antisocial Personality Disorder

Antisocial Personality Disorder (ASPD) is a personality disorder characterized by a persistent violation of others' rights, a lack of empathy, impulsivity, and irresponsibility (Yıldırım & Türeli, 2015). Individuals with this disorder often disregard social norms and rules, may have a tendency to commit crimes, and can harm others without feeling remorse (Sardoğan & Kaygusuz, 2006). Due to their lack of empathy, they struggle to understand others' emotions and show sensitivity toward them. Their impulsivity and lack of planning lead them to make sudden decisions and act without considering long-term consequences (Beck, 2008). They tend to exhibit manipulative behaviors, deceive others for personal gain, lie, and engage in fraudulent acts. They may display aggression and hostility, resort to physical or psychological violence, and frequently engage in fights and aggressive behaviors (Çöpür, Elmas & Can, n.d.).

They experience significant difficulty in taking responsibility, struggle to fulfill obligations in work, family, and social life, and may evade financial or legal responsibilities. They may have a tendency to commit crimes, and individuals who exhibit conduct disorder symptoms in childhood have a high likelihood of developing ASPD in adulthood. Due to their lack of remorse and guilt, they do not feel any conscience or regret for their mistakes or the harm they inflict on others (Yıldırım & Türeli, 2015). According to the DSM-5, a diagnosis of this disorder requires that the individual be over 18 years old and that symptoms must have been present since at least the age of 15. ASPD is believed to result from the interaction of biological, environmental, and genetic factors.

Antisocial personality disorder is characterized by an individual's disregard for others and noncompliance with societal rules. These individuals lack a sense of responsibility toward their surroundings and exhibit aggressive and reckless behaviors. They frequently engage in illegal activities, do not feel remorse for their actions, and experience no moral discomfort. Their defining traits include indifference to the emotions and needs of others, an inability to show genuine affection, impulsive speech, and exploitative behavior masked by politeness. Additionally, despite appearing honest and

kind, they can be deceptive, engage in theft, use false identities, and exhibit a tendency toward violence.

They are emotionally cold and distant, often intimidating those around them with their angry demeanor. Manipulative behaviors are common, and they become adept at evading the consequences of their crimes. They perpetually perceive others as threats and may adopt aggressive attitudes as a means of self-protection. Antisocial tendencies generally manifest alongside aggression and criminal behavior (Çetin, 2002). Even during treatment, they may continue to lie, threaten, steal, and act irresponsibly (Geçtan, 1997). They act impulsively and avoid making plans for the future. They have no long-term goals and typically pursue only immediate gratification.

**Symptoms and Findings**

Individuals with antisocial personality disorder exhibit a blatant disregard for social norms and rules, ignoring the rights and emotions of others. One of their most prominent characteristics is their lack of remorse. When they commit a crime or harm someone, they do not experience guilt and are inclined to repeat such behaviors (Geçtan, 1997).

From an early age, these individuals tend to run away from home. They resist family rules and authority figures. This pattern typically begins in childhood or adolescence and may persist into adulthood (Çetin, 2002). They also struggle significantly with impulse control. They act without planning, have sudden outbursts of anger, and make risky decisions without considering future consequences. This impulsive nature leads to instability in both their personal and professional lives.

Their disregard for the rights of others, lack of empathy, and exploitative tendencies cause severe problems in their social relationships. They fail to fulfill assigned responsibilities, avoid accountability, and constantly burden others, leading to negative consequences in many areas of their lives. They are also incapable of being good parents or partners. They may be indifferent to their spouses and children, exploiting them emotionally and financially.

These individuals struggle to maintain stable and healthy romantic relationships. They find it difficult to develop loyalty and often form short-term and superficial connections. They also have a high tendency toward aggression and hostility. Even in minor conflicts, they may resort to physical or verbal violence, displaying a threatening and bullying attitude (Geçtan, 1997).

They become bored easily and grow irritable quickly. In their pursuit of constant excitement, they engage in risky activities, which can lead them into dangerous situations. Behaviors such as lying and stealing are frequently observed in individuals with antisocial personality disorder. They prioritize their own interests through deception, manipulation, and fraud.

Moreover, they exhibit reckless and thoughtless behaviors, disregarding the rights of others. Their emotional coldness and distance make them prone to manipulation. Even when engaging in malicious acts, they may claim innocence and attempt to justify themselves (Çetin, 2002). These individuals tend to perceive others as threats. In their view, those around them are inclined to cause harm, so they believe they must strike first to defend themselves. This mindset creates a constant atmosphere of conflict.

They generally avoid making future plans and have no long-term goals. They pursue only immediate gratification and focus solely on satisfying their present desires. Aside from seeking revenge, they lack any long-term motivation. Even during treatment, they may continue to lie, threaten, steal, and act irresponsibly (Geçtan, 1997). Individuals with antisocial personality disorder have an impulsive, manipulative, and aggressive nature, making it difficult for them to adhere to societal rules. Due to these characteristics, they encounter significant problems in both their personal lives and social environments.

**DSM-5 Diagnostic Criteria**

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for the safety of oneself or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least 18 years old.

C. There is evidence of conduct disorder with onset before age 15.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

**Prevalence**

Antisocial personality disorder is approximately three times more common in men than in women in the general population. The prevalence of this disorder is around 3.4% in men and approximately 1% in women (Çetin, 2002). This discrepancy may be related to men's higher tendency to take risks, their greater levels of aggression, and the influence of societal expectations.

One of the groups with the highest prevalence of this disorder is prison inmates. Research indicates that approximately 75% of individuals in prison have been diagnosed with antisocial personality disorder (Geçtan, 1997). Their high tendency to commit crimes, difficulties with impulse control, and inability to conform to social norms contribute to their frequent encounters with legal issues.

Additionally, antisocial personality disorder is commonly observed among individuals with psychoactive substance dependence. Studies show

that between 18% and 40% of people with substance addiction also suffer from this disorder (Çetin, 2002). Substance use negatively impacts impulse control, increasing the likelihood of engaging in risky and criminal behaviors.

Overall, although antisocial personality disorder is not a rare condition in society, it is significantly more prevalent in certain groups—particularly among individuals prone to criminal behavior and substance abuse. This reality underscores the profound impact of the disorder on both individuals and society.

**Underlying Causes**

Multiple factors are known to play a role in the development and progression of antisocial personality disorder. Research indicates that insufficient parental attention and excessive restrictions on individual freedoms are significant contributors to the emergence of this disorder. Lacking adequate emotional support during childhood or growing up in an overly oppressive environment can negatively impact an individual's ability to conform to social norms, thereby laying the groundwork for antisocial personality disorder in later years (Reti, Samuels, Eaton, Bienvenu, Costa & Nestadt, 2002). Additionally, negative childhood experiences such as neglect, physical or emotional abuse are also noted as influential factors in the development of this disorder. Particularly, childhood abuse can disrupt the process of developing empathy, leading to a personality structure that disregards the rights of others and fails to adhere to rules.

Biological research has revealed the neurological and hormonal foundations of this disorder. Specifically, dysfunctions in the prefrontal and frontal lobes negatively affect impulse control and decision-making mechanisms, increasing the likelihood of antisocial behaviors. Poor functioning of these brain regions can cause individuals to act without considering long-term consequences and to exhibit risky and aggressive behaviors. Furthermore, the relationship between high testosterone levels and low serotonin levels is noteworthy. Testosterone is known to increase aggression and risk-taking tendencies, whereas serotonin plays a crucial role in impulse control. Therefore, low serotonin levels can lead individuals to act aggressively and recklessly (Reti et al., 2002). Additionally, some studies on the dopamine system suggest that individuals with high reward sensitivity

tend to overvalue short-term gains, making them more prone to impulsive and illegal behaviors. These findings indicate that individuals with antisocial personality disorder exhibit significant biological and psychosocial differences compared to the general population.

Environmental factors also play a major role in the development of this disorder. Individuals raised in low socioeconomic conditions are more likely to be exposed to adverse living conditions. Severe marital conflicts within the family, parents' inclination toward criminal behavior, or struggles with mental illnesses can directly impact a child's developmental process. For instance, a father's tendency to engage in criminal activities or a mother's severe psychiatric disorders can increase the likelihood of a child exhibiting antisocial behaviors. Additionally, children raised in large, patriarchal family structures often receive less individual attention and grow up in restrictive environments, making them more susceptible to such personality disorders. These circumstances can lead to childhood hyperactivity and attention deficit problems, ultimately contributing to the development of antisocial personality disorder during adolescence. However, the emergence of this disorder cannot be attributed solely to environmental factors; genetic influences are also known to play a significant role.

Genetic factors may have a substantial impact on the development of antisocial personality disorder. Studies have shown that individuals with this disorder are more likely to have first-degree relatives with similar antisocial tendencies. Genetic predisposition can affect an individual's impulse control mechanisms, ability to empathize, and capacity to adhere to social norms. For example, specific variations in the monoamine oxidase A (MAOA) gene have been found to increase susceptibility to aggressive and impulsive behaviors. However, genetic predisposition alone is not determinative; when combined with environmental stressors, the likelihood of developing this disorder increases significantly.

The interaction between environmental factors and genetic predisposition is highly influential in the development of antisocial personality disorder. When an individual's biological tendencies combine with environmental stressors, the probability of developing this disorder rises. Psychodynamic approaches suggest that childhood traumas and growing up in an unloving and neglectful environment can leave lasting effects on

personality development. Disruptions in early emotional bonding processes can negatively impact an individual's ability to develop empathy and establish healthy relationships in later life. Additionally, the behaviors of the adults that a child models in early life can reinforce antisocial tendencies. If a child frequently observes adults engaging in deception, displaying criminal tendencies, or harming others, they are more likely to normalize such behaviors.

Scientific research has demonstrated that both genetic and environmental factors play a significant role in the development of antisocial personality disorder. Studies conducted on adopted children indicate that this disorder is not solely linked to the environment in which an individual is raised but may also be associated with hereditary predisposition. Specifically, children born to parents with antisocial personality disorder have been found to have an increased risk of developing the condition themselves (Çetin, 2002).

Furthermore, research on adopted children has shown that even when raised by different families, children whose biological parents had antisocial personality disorder exhibited similar behaviors. This finding is considered strong evidence supporting the influence of genetic factors on antisocial tendencies (Geçtan, 1997). However, genetic predisposition alone is not sufficient; environmental factors also play a crucial role in the emergence of this disorder.

For example, adverse environmental conditions such as neglect, mistreatment, abuse, or inconsistent parenting during childhood can amplify antisocial personality traits in genetically predisposed individuals. Additionally, exposure to domestic violence, growing up in a crime-ridden environment, or interacting with delinquent peer groups can accelerate the development of antisocial personality disorder (Çetin, 2002).

Neurobiological studies also provide data supporting the influence of genetic factors. Dysfunction in the frontal lobe region of the brain has been associated with a lack of empathy, impulse control issues, and a tendency toward risky behaviors. In individuals with antisocial personality disorder, decreased activity in this region has been observed. This suggests that genetic factors influence not only behavior but also brain structure and function.

Although antisocial personality disorder is largely influenced by genetic predisposition, environmental factors shape the manifestation of this genetic risk. Therefore, early intervention, healthy parent-child relationships, and appropriate psychosocial support are crucial in preventing individuals with genetic predispositions from developing antisocial behaviors. With advancements in both genetic research and studies examining environmental factors, more effective strategies for preventing and treating antisocial personality disorder can be developed.

Individuals with antisocial personality disorder often have a tendency toward pathological lying. Distorting facts and deception are common defense mechanisms they employ. From the outside, they may appear confident and self-assured; however, beneath this façade lies a deep sense of insecurity. Internally, they feel unsafe and threatened, which reinforces their manipulative and aggressive behaviors (Geçtan, 1997).

From a psychodynamic perspective, significant deficiencies in ego functioning are evident in these individuals. Since ego development has not been completed in a healthy manner, impulse control mechanisms do not develop adequately. This leads to outbursts of anger, impulsive and risky decision-making, and acting without thinking. Due to their impulsive behaviors, they are highly likely to harm others and do not feel remorse as a result (Çetin, 2002).

It is believed that individuals with antisocial personality disorder do not develop a sufficient sense of basic trust and love. Those who do not experience a healthy attachment process in childhood struggle to develop empathy and commitment in adulthood. The lack of love and trust creates instability and superficiality in their relationships. While they remain indifferent to the emotions of others, they prioritize their own needs and act selfishly.

From a neurobiological perspective, it is suggested that these individuals have structural differences in their cortico-limbic systems. The cortico-limbic system plays a crucial role in an individual's ability to adapt to society and adhere to social norms. However, research indicates that individuals with antisocial personality disorder may have a congenitally smaller cortico-limbic region, which could explain their lack of empathy,

tendency toward risky behaviors, and disregard for moral values (Geçtan, 1997).

Antisocial personality disorder is a condition shaped by both psychodynamic and neurobiological factors, significantly impairing an individual's ability to adapt to society. Their impulsivity, manipulative nature, and emotional deficiencies cause major issues in their social relationships and overall societal functionality.

**General Information**

Antisocial Personality Disorder (APD) is a psychiatric condition synonymous with psychopathy, sociopathy, or dissocial personality disorder. This disorder typically begins in childhood or early adolescence and continues into adulthood, representing a persistent personality pattern. Individuals with antisocial personality disorder do not exhibit severe impairments in fundamental cognitive functions or thought processes. Instead, the disorder primarily manifests on a behavioral level (Alpay, 2006).

These individuals often exhibit a harsh, rude, and combative attitude. They tend to behave insensitively toward the emotions of others and approach sincere interactions with suspicion. They do not trust the people around them and do not feel close to anyone. They act without thinking and often live with a pleasure-seeking focus. Some antisocial individuals perceive danger as a source of excitement and do not shy away from taking risks. This can lead them to frequently engage in criminal behaviors. Additionally, these individuals get bored easily and therefore tend to avoid situations that require long-term commitments, such as marriage, friendships, and work. However, when they achieve what they want, they can appear cheerful, sociable, and charming (Sardoğan & Kaygusuz, 2006).

Although antisocial individuals lack insight and the ability to foresee the long-term consequences of their actions, they are highly skilled at empathy. However, this empathy is used to identify others' weaknesses and manipulate them. They are adept at influencing and controlling people, establishing dominance, and using various deceptive tactics to protect their own interests. When they are guilty or face a negative situation, they excel at distorting events to portray themselves as innocent. They also pay close

attention to their physical appearance, valuing being well-groomed and attractive. When they deceive others, they often avoid responsibility with justifications like "They shouldn't have been fooled." Common behavioral patterns among them include aggression, fraud, theft, gambling addiction, irresponsibility in family and society, frequent criminal activity, and substance abuse (Sardoğan & Kaygusuz, 2006).

Some individuals with antisocial personality disorder, even if they do not exhibit aggressive behaviors, project an image of assertiveness, energy, and high self-confidence. These individuals adopt a power-oriented life philosophy known as the "law of the jungle." According to them, being right comes from being strong. They prefer to speak frankly and directly; however, when they observe that this is not always well received in society, they begin to communicate indirectly. At this point, they use three main defense mechanisms: rationalization, sublimation, and projection.

The seemingly kind or considerate behaviors of individuals with antisocial personality disorder often conceal an ulterior motive. They are not genuinely sincere or heartfelt. They may derive pleasure from others' suffering and interpret such situations to their advantage. Frequently, they rationalize their harmful actions with thoughts like, "If I hadn't done this to them, they would have done it to me." This mindset further reinforces their aggression and manipulative nature.

One of the most defining characteristics of these individuals is their defiance of authority figures and societal rules. Laws and regulations are not binding for them; on the contrary, they tend to overstep boundaries and disdain authority. They view defying authorities and societal norms as a display of power. However, since they fear being harmed by others, they constantly engage in a "survival" struggle. In their view, if they do not deceive others, others will inevitably deceive them. Consequently, they adopt a relationship approach focused on gaining advantage rather than being honest (Alpay, 2006).

Antisocial personality disorder is observed in approximately 3% of men and 1% of women in society. Research has identified significant dysfunctions in the prefrontal and frontal lobe functions of individuals with this disorder. Furthermore, high levels of testosterone and low levels of

serotonin (5-hydroxytryptamine) have been reported to have a significant correlation with antisocial personality disorder (Cited in: Sardoğan & Kaygusuz, 2006). These findings reveal that individuals with antisocial personality disorder exhibit distinct differences from normative individuals both psychosocially and biologically.

Environmental factors play a crucial role in the development of this disorder. Particularly, adverse experiences such as low socioeconomic status, large family structures, a father prone to criminal behavior, patriarchal family dynamics, severe marital conflicts, and the mother's mental health issues may lay the foundation for antisocial tendencies during childhood and adolescence. One of the primary reasons for the higher prevalence of this disorder among men is the greater significance attributed to male children in patriarchal societies, while female children are raised under stricter control. Encouraging boys to be independent and strong at an early age, combined with a lack of discipline and unpunished aggressive behaviors, can reinforce antisocial tendencies over time.

Antisocial personality disorder shares similarities with other psychiatric disorders, particularly narcissistic personality disorder. Individuals with both disorders have the ability to perceive people around them as mere objects, and their levels of empathy are either extremely low or entirely absent. The primary goal of individuals with both antisocial and narcissistic personality disorder is to satisfy themselves by any means necessary. However, there are significant differences between these two disorders. For instance, while antisocial individuals are indifferent to the opinions of those around them, narcissistic individuals seek approval and admiration. Although narcissists perceive themselves as superior, they consider others' reactions to protect their social status. In contrast, antisocial individuals completely disregard societal rules and moral values, acting solely in their own interests.

Moreover, individuals with both disorders tend to see themselves as superior to others and have significant difficulty admitting their mistakes. Antisocial individuals attempt to achieve their goals through direct criminal behavior, manipulation, and exploitation, whereas narcissists typically pursue them indirectly while maintaining their social status. The most striking distinction lies in their moral perspectives: narcissists tend to rationalize their

behaviors when it comes to moral issues, whereas antisocial individuals act without any moral concern whatsoever.

In conclusion, antisocial personality disorder is a condition influenced by both biological and environmental factors, characterized by a disregard for societal norms, a lack of empathy, and impulsive behaviors. While it shares certain similarities with narcissistic personality disorder, it differs significantly, particularly in terms of moral considerations and the importance given to social status.

**Established Thoughts and Their Explanations**

1. **I am okay; others are not.** This thought reflects how individuals with antisocial personality disorder perceive themselves as superior and flawless. According to them, the problem does not lie within themselves but in the people around them. As a result, they do not respect others' emotions, thoughts, or rights. For example, an employee in a workplace constantly belittles their colleagues, highlights their mistakes, and always sees themselves as correct and superior.
2. **I must take great care of myself.** Antisocial individuals often adopt survival and self-interest as fundamental principles. This thought demonstrates their tendency to prioritize their own safety and advantage without concern for the harm caused to others. For instance, a person at work might sabotage their colleagues' projects to ensure their own promotion.
3. **The best way to get things done is through coercion or cunning.** Antisocial individuals view unethical methods as legitimate means to achieve their goals. They resort to bullying, manipulation, or deceit to get what they want. For example, an employee might spread false information about their competitors to their managers in order to secure a promotion.
4. **The strong survive.** This thought reflects social Darwinism. Antisocial individuals do not believe that weaker individuals should be protected or supported. According to them, only the strong are worthy of survival. For example, an employer might conduct mass layoffs during an economic crisis, disregarding the rights of employees just to secure their own financial stability.

5. **If I don't control people, they will control me.** This thought is related to the desire for power and control. Antisocial individuals strive to dominate others to prevent themselves from being controlled. For instance, a person in a relationship may constantly control their partner, dictating what they wear and who they interact with.
6. **As long as I don't get caught, I can lie.** For antisocial individuals, truthfulness is not an ethical value but a matter of avoiding detection. If their lies remain undiscovered, they see no problem with them. For example, a student who has not completed their assignment might falsely claim to their professor that they were sick to get an extension.
7. **I don't have to keep my promises.** Antisocial individuals do not see their promises as binding. To them, a promise is only valid as long as it benefits them. For example, a businessman might assure customers of high-quality products to make sales but then deliver substandard goods.
8. **I have been treated unfairly, so I will seek justice by any means necessary.** Antisocial individuals justify revenge without regard for ethical boundaries when they perceive real or imagined injustices. For example, a fired employee might leak confidential customer information to harm the company.
9. **Weak people deserve to be deceived.** Antisocial individuals see exploiting weak or vulnerable people as legitimate. To them, a deceived person suffers due to their own weakness. For instance, a scammer might target elderly people by selling them fake insurance policies.
10. **I can deceive people; they should have been more careful.** This thought reflects a tendency to deny responsibility and blame the victim. Antisocial individuals justify deception by arguing that the victim should have been more vigilant. For example, a person might use fake checks to shop and, when caught, say, "It's their fault for not noticing."
11. **If I don't get caught, I can do anything.** Antisocial individuals believe that laws and social norms only apply to them if they are caught. If they believe they won't be caught, they consider any illegal or unethical behavior justifiable. For example, a driver might speed excessively on roads without traffic cameras, disregarding the safety of other drivers.

12. **I don’t care what others think about me.** Antisocial individuals do not value social approval and disregard the opinions of others. For example, a person may consistently behave rudely and aggressively, disturbing those around them. However, when criticized, they respond by saying, "I don’t care; I’ll act however I want."

These thought patterns reflect the typical perspective of individuals with antisocial personality disorder and form the basis of their maladaptive behaviors in society.

**Environmental Relationships and Self-Perceptions of Individuals with Antisocial Personality Disorder**

Environmental Relationships

- **They do not conform to societal values and rules.** Individuals with antisocial personality disorder reject the general rules and norms of society. Instead of accepting laws, ethical values, and social contracts, they act according to their own rules. For example, they may evade taxes or resort to unethical practices in the workplace.
- **They act impulsively and get angry quickly.** They make decisions based on momentary impulses without planning ahead. They struggle with anger management, which leads to constant conflicts with those around them. For instance, they may resort to violence over a minor argument in traffic.
- **They avoid taking responsibility in human relationships.** They do not take on responsibilities within their family, workplace, or social circles. For example, despite receiving a salary, they may neglect their duties at work, or as a parent, they may ignore their child's needs.
- **They are not well received by society due to their rule-breaking behavior.** Since they frequently violate legal or moral rules, they tend to be excluded from society. However, they are often unaware of this or simply do not care.
- **They enjoy taking risks and do not shy away from criminal behavior.** They find dangerous and illegal activities appealing. They do not hesitate to engage in risky activities such as gambling, illegal trade, or fraud.

- **They are indifferent to the emotions and safety of others.** Other people's suffering or harm does not matter to them. Due to their lack of empathy, they behave selfishly and insensitively toward those around them. For instance, a con artist does not care about how victims are affected while stealing their life savings.
- **They do not trust others and manipulate people.** They do not approach human relationships with trust; instead, they try to manipulate and deceive people for their own benefit. For them, relationships are merely a game of personal gain.
- **They can be either successful businesspeople or criminals.** Due to their cunning and ability to manipulate people, some may achieve success in the business or political world, while others may become dangerous figures in the criminal world.
- **They have the ability to adapt to social values, but they are not sincere.** They keenly observe societal expectations and may appear to conform when necessary. However, this is merely a tactic for personal gain. For example, a politician may create a false image to gain public trust.
- **They perceive sincerity as a weakness.** They do not form genuine emotional bonds and see sincere individuals as naive or as people to be exploited.

Self-Perceptions

- **They see themselves as right in everything.** They believe they are justified in all their decisions and actions. It is rare for them to think they are wrong or to acknowledge their mistakes.
- **They act according to the principle of "thinking is believing."** They perceive their own beliefs and thoughts as absolute truth. They do not consider the opinions of others and blindly believe in their own reality.
- **They believe that negative consequences will not occur.** They have a strong belief that they will not face the consequences of their dangerous or illegal actions. They are overly confident that they will not get caught or harmed.

This way of thinking causes individuals with antisocial personality disorder to be incompatible with society and to frequently engage in conflicts.

Despite experiencing significant problems in both personal and social relationships, they are generally unwilling to change their perspectives.

### Differences between Antisocial Personality Disorder and Its Forms

The table below examines the differences between antisocial personality traits and antisocial personality disorder. Antisocial personality traits include characteristics such as being independent, not strictly adhering to rules, enjoying a day-to-day lifestyle, and being intelligent and enterprising. In contrast, antisocial personality disorder is characterized by severe maladjustment to society, violation of laws, and the display of aggressive and irresponsible behaviors.

| Form | Disorder |
|---|---|
| They prefer to work independently without being tied to a specific place. They live quite well thanks to their talents and quick wit. | They have difficulty maintaining a stable job. |
| They live according to their own values and do not care much about the values of others or society. | They engage in illegal activities and commit acts that could lead to their arrest. |
| They are mischievous during adolescence. | They are highly aggressive and prone to fights and physical altercations. |
| They are generous with money. | They frequently fail to fulfill their financial responsibilities. |
| They enjoy living in the moment but still make short-term plans and build relationships. | They do not plan for the future and may live aimlessly. They may quit their job immediately without securing a new one. |
| They are charming and make friends easily. | They tend to lie constantly, adopt fake identities, and use others for their own benefit. |
| They are tough and never allow themselves to be exploited. | They disregard their own safety and that of others, often driving under the influence and at high speeds. |

| Form | Disorder |
|---|---|
| They do not feel much empathy for others, believing that everyone faces the consequences of their own actions. | They do not behave as responsible parents and tend to be neglectful. |
| They have high sexual desires. They can be either monogamous or engage in multiple relationships. | They cannot maintain a long-term monogamous relationship. |
| They live in the moment and do not feel guilt. | They do not feel remorse and always justify their actions, regardless of how they affect others. |

Individuals with antisocial personality traits are fond of their freedom and prefer to work independently. They act according to their own value judgments and do not care about others' norms. With their charm and sociability, they can easily establish relationships with people. However, in individuals with antisocial personality disorder, this takes on a more problematic dimension. These individuals struggle to maintain a job for a long time, frequently violate laws, and may commit serious crimes. They may appear generous with money, but they often fail to meet their financial responsibilities.

Individuals with antisocial personality disorder can be aggressive and angry. A person who was mischievous during adolescence may develop a tendency toward fights and violence as they age. While individuals with antisocial personality traits may live in the moment but still make some plans for the future, those with the disorder may lead an aimless life and quit their jobs on impulse. Additionally, individuals with antisocial personality disorder tend to lie frequently and exploit others for their own benefit.

There are also significant differences between the two groups in terms of relationships. Individuals with antisocial personality traits may be sexually active and engage in either monogamous or polygamous relationships. In contrast, individuals with the disorder struggle to maintain long-term monogamous relationships. A lack of empathy is a prominent characteristic; while individuals with antisocial personality traits may be indifferent to the

suffering of others, those with the disorder may exhibit irresponsible behavior even within their own families.

Finally, there is a distinct difference between the two groups regarding remorse and guilt. Individuals with antisocial personality traits enjoy living in the moment and do not dwell much on their past mistakes. However, individuals with the disorder never feel remorse for harming others and always perceive themselves as justified. This is one of the fundamental factors that make it difficult for them to live in harmony with society and their surroundings.

**Diagnostic Features**

The most fundamental characteristic of antisocial personality disorder is a pattern of behavior that begins in early childhood or adolescence and persists into adulthood, characterized by a disregard for the rights of others and a tendency to harm them (Geçtan, 1997). In the literature, this behavioral pattern has also been referred to by different terms such as psychopathy, sociopathy, or dissociative personality disorder (Çetin, 2002). Deception and manipulation are the primary behavioral tendencies in individuals with antisocial personality disorder. For this diagnosis to be made, the individual must be at least 18 years old and must have exhibited signs of this behavioral disorder before the age of 15 (Geçtan, 1997).

Conduct disorders, which are prominently observed in childhood and adolescence among individuals with this disorder, manifest as attacks on others' fundamental rights, disregard for social values, and a persistent tendency to violate laws. Conduct disorder is categorized into four main types:

1. **Aggressive behaviors toward people or animals:** Inflicting physical harm, torturing animals, engaging in threatening or violent actions.
2. **Destruction of property:** Deliberately setting fires, damaging others' belongings.
3. **Deception and fraud:** Habitual lying, using fake identities, deceiving people for financial or emotional gain.

4. **Severe rule violations:** Skipping school from a young age, running away from home, demonstrating a persistent tendency toward criminal behavior (Çetin, 2002).

Individuals with antisocial personality disorder frequently engage in illegal activities and exhibit behaviors that lead to frequent arrests. They prioritize their own interests and completely disregard the rights of others. This significantly endangers both their own lives and those of the people around them. Due to their manipulative nature, they excel at exploiting others and do not hesitate to deceive people for their own benefit. These individuals struggle to maintain stability in one place and often have a tendency to relocate frequently. They fail to establish a structured social and professional life and exhibit major deficiencies in fulfilling their responsibilities (Geçtan, 1997).

Antisocial individuals are generally irritable and prone to aggression. They may experience sudden outbursts of anger over minor incidents, provoke fights, and exhibit physical aggression. They engage in reckless behaviors that disregard the safety of themselves and others. For example, they frequently engage in reckless driving, drive under the influence of alcohol, or engage in unprotected and high-risk sexual activities (Çetin, 2002).

These individuals also neglect their roles within the family. They are indifferent to their spouses and children and fail to fulfill their parental responsibilities. They may neglect their children, avoiding providing the necessary emotional and physical support. In their professional lives, they exhibit significant irresponsibility; they cannot maintain a steady job and frequently cause problems in their workplaces. They may manipulate their colleagues for their own benefit, putting others in difficult situations (Geçtan, 1997).

Their insensitivity to the consequences of their actions prevents them from feeling remorse. They constantly justify acts such as stealing, violating others' rights, and putting people in difficult situations. They never feel guilty and do not take responsibility for their wrongdoing. Instead, they try to justify their actions by blaming the victims. For instance, when they defraud someone, they may defend themselves by saying, "If they weren’t so naive, they wouldn’t have believed me" (Çetin, 2002).

Individuals with antisocial personality disorder often act without considering the future and lack the ability to make long-term plans. They engage in risky behaviors by prioritizing immediate gratification. Due to their failures in maintaining long-term relationships, their avoidance of responsibility, and their tendency to disregard social norms, they experience serious individual and social adaptation problems. Their treatment process is usually challenging because these individuals do not wish to change and resist therapy (Geçtan, 1997).

Antisocial personality disorder refers to a personality structure characterized by manipulative, aggressive, and remorseless behaviors that emerge in childhood or adolescence and persist into adulthood, making the violation of others' rights a habitual pattern. These individuals have poor social adaptation, face significant problems in both their professional and personal lives, and tend to harm those around them.

Individuals with antisocial personality disorder display an indifferent, careless, and insensitive attitude toward others. They lack the ability to understand and empathize with other people's emotions (Çetin, 2002). Their demeanor is often cynical and contemptuous. While they perceive themselves as highly valuable and superior, they regard others as insignificant and worthless. This leads them to be rigid, lacking flexible thinking skills, and exhibiting inflexible attitudes. Their self-confidence is excessively high, and this arrogance often overlaps with narcissistic tendencies (Geçtan, 1997).

These individuals generally enjoy attracting attention. They take great care of their appearance, place significant importance on looking well-groomed, and can easily impress those around them with their looks. When they wish, they can appear kind, friendly, and charming, making them highly successful in gaining people’s interest and trust. However, this warmth and sympathy are often superficial and serve a manipulative purpose (Çetin, 2002). Characteristics such as a lack of sympathy, an exaggerated sense of self-worth, and superficial charm are distinctive traits in diagnosing antisocial personality disorder (Geçtan, 1997).

The sexual lives of antisocial individuals are often unsatisfying, irresponsible, and exploitative. They do not show loyalty in their relationships and struggle to adhere to monogamy. Even when they have a spouse or

partner, they constantly seek new relationships and tend to use their partners rather than form emotional bonds. Additionally, they behave extremely irresponsibly as parents. They fail to provide their children with adequate attention, love, and basic care, neglecting even fundamental needs such as nutrition, clothing, and safety. In some cases, they may leave their children home alone or engage in neglectful behaviors that endanger their children's safety (Geçtan, 1997).

Individuals with antisocial personality disorder struggle to lead a socially compatible life. Their impulsive and uncontrolled behavior frequently leads to conflicts with authority figures. They may be discharged from military service due to noncompliance, struggle to sustain stable employment and support themselves, and face the risk of poverty and homelessness due to being excluded from social support systems (Çetin, 2002). Given their high tendency toward criminal behavior, they are also more likely than others to be incarcerated.

Additionally, the life expectancy of antisocial individuals may be shorter compared to other members of society. Due to their tendencies for high-risk behaviors, impulsivity, and aggression, they are more likely to find themselves in dangerous situations. Their involvement in violent incidents, engagement in criminal activities, and inclination toward illegal actions increase their risk of early death due to homicide, accidents, or suicide (Geçtan, 1997).

In conclusion, individuals with antisocial personality disorder exhibit distinct characteristics such as a lack of empathy, superficial charm, manipulative behaviors, impulsivity, and irresponsibility. They demonstrate significant maladjustment both in their personal lives and at a societal level, leading to harmful consequences for themselves and those around them.

**Treatment**

Unlike other personality disorders, antisocial personality disorder is the only disorder that cannot be definitively diagnosed during childhood. Conduct disorders that emerge in childhood may be precursors to this condition; however, a formal diagnosis requires the individual to be at least 18 years old (Çetin, 2002). Therefore, illegal behaviors, aggression, lack of

empathy, and absence of conscience observed during childhood and adolescence may later result in a diagnosis of antisocial personality disorder.

The treatment process is particularly challenging because individuals with antisocial personality disorder typically do not seek, accept, or adhere to treatment. Their lack of self-awareness regarding their problematic behaviors and their failure to internalize the consequences of their actions increase their resistance to therapy (Geçtan, 1997). As a result, while those around them often believe they need to change, they themselves do not perceive their condition as an issue.

Individuals with antisocial personality disorder who attain positional or financial power may still fulfill their desires for power and authority despite their severe psychological issues. Due to their manipulative and strategic thinking abilities, they may appear successful in society and reach high-status positions. However, in achieving this success, they do not adhere to ethical principles, exploit those around them, and misuse their power (Çetin, 2002). Consequently, they do not feel the need to seek treatment because they do not view their condition as a problem affecting their lifestyle.

Medications are not directly effective in treating antisocial personality disorder. However, if the individual experiences accompanying symptoms such as anxiety disorders, depression, or impulsivity, certain psychiatric medications may be used to alleviate these symptoms. Nevertheless, the primary treatment method consists of psychotherapeutic approaches. One of the most effective methods for helping these individuals live independently, productively, and harmoniously within society is behavioral therapy. This therapy can assist in developing social skills, adapting to rules, and fostering empathy (Yılmaz, 2018).

Additionally, education and support programs for families are of great importance. Families of individuals with antisocial personality disorder should be informed about how to manage their negative behaviors. By equipping family members with methods that encourage positive behavior, the individual's aggressive and manipulative tendencies can be controlled (Yılmaz, 2018). Early interventions targeting behavioral problems that emerge at a young age can contribute to a more adaptive life in later years.

The treatment of antisocial personality disorder is a complex and long-term process. Due to their resistance to treatment, predisposition to criminal behavior, and tendency to violate the rights of others, engaging these individuals in therapy is often challenging (Geçtan, 1997). However, certain therapeutic approaches have been found to be effective in specific cases.

### Cognitive Behavioral Therapy (CBT) and Behavioral Interventions

Cognitive behavioral therapy focuses on changing the negative thought patterns of individuals with antisocial personality disorder and developing healthier behavioral patterns. This therapy method can be particularly helpful in managing symptoms such as impulsivity, aggression, and lack of empathy. CBT aids individuals in understanding their thought processes, fostering empathy, and adopting more positive attitudes in social relationships (Çetin, 2002). Behavioral therapies include structured programs aimed at fostering responsibility and adherence to social norms. These therapies, which are based on a reward and punishment system, seek to reduce undesirable behaviors and reinforce positive ones. Such programs are particularly implemented in prisons and rehabilitation centers (Yılmaz, 2018).

### Cognitive Therapy in the Context of Antisocial Personality Disorder

Cognitive therapy for antisocial personality disorder aims to diversify cognitive functioning rather than attempting to establish a more acceptable moral structure through the imposition of anxiety-like emotions (Beck & Freeman, 1990). For example, cognitive therapy employs and recommends a cooperative strategy when working with antisocial personality disorder (Davidson et al., 2004). As with other personality disorders, symptoms in antisocial personality disorder can manifest with varying intensities for patients and therapists (Linehan, 1993). For a therapist to succeed in this challenging process, they need a strong and determined assistant. A specialized training and supervision process for the therapist are crucial supportive elements (Young et al., 2003).

Before initiating the consultation process, the therapist should adequately inform the patient about the diagnosis of antisocial personality

disorder and the necessity of participating in treatment (Beck et al., 2004). This informational process is critical because a patient with an antisocial personality may not perceive any reason or purpose for continuing treatment. In cognitive therapy, it is essential to establish boundaries for both the patient and the therapist in each interaction and to define the expected behaviors (Blackburn, 1993). As the treatment process takes shape, it should be explicitly explained to the patient with antisocial personality disorder.

During therapy, the therapist should be aware of the patient's transference behaviors and not only respond calmly but also monitor their own emotional and often negative reactions (Davidson et al., 2004). For instance, a therapist might feel manipulated by a patient who frequently misses sessions with suspicious and even absurd excuses. Additionally, in cognitive therapy, the responsibility lies more with the therapist compared to other forms of therapy (Beck & Freeman, 1990). This situation prolongs the treatment process of antisocial personality disorder and causes feelings of fatigue and stress in the therapist (Linehan, 1993). According to cognitive therapy, one of the fundamental elements of recovery is motivation (Young et al., 2003). This is because antisocial individuals are often under intense stress; since this stress level may increase during treatment, the therapist should approach the patient with an awareness of potential boundary violations and strive to understand them. Of course, following the above-mentioned steps in cognitive therapy does not guarantee absolute recovery, but they are crucial for improvement.

**Group Therapy and Social Skills Training**

Group therapies can help antisocial individuals improve their social skills. However, since individuals with this disorder can be manipulative, they may influence others in the group and undermine the purpose of therapy. Therefore, group therapy should be carefully managed and conducted under the supervision of a professional therapist (Geçtan, 1997). Additionally, social skills training can help individuals develop healthier responses in interpersonal relationships. Training programs that focus on skills such as empathy, anger management, and conflict resolution can enable individuals to lead a more harmonious life within society (Çetin, 2002).

**Pharmacological Treatment**

There is no direct pharmacological treatment for antisocial personality disorder. However, certain psychiatric medications may be used to address common comorbid symptoms such as anxiety, depression, mood swings, and impulsivity. For example:

- **Mood stabilizers** (e.g., lithium, valproate): May be effective in reducing anger and aggression.
- **Selective serotonin reuptake inhibitors (SSRIs)** (e.g., fluoxetine, sertraline): Can have positive effects on impulsivity and aggression.
- **Antipsychotic medications** (e.g., risperidone, olanzapine): Can be used to manage extreme aggression and behavioral dysregulation (Yılmaz, 2018).

However, it should be considered that individuals with antisocial personality disorder may have a tendency to misuse medications, and pharmacological treatment should be conducted with caution.

**Family and Environmental Interventions**

The close relatives of individuals with antisocial personality disorder are often negatively affected by their condition. Therefore, family therapy and psychoeducational programs are highly important. Family members should be taught how to recognize manipulative behaviors and set boundaries (Çetin, 2002). Families should adopt a supportive attitude while also ensuring that the individual takes responsibility for their actions. The treatment of antisocial personality disorder is a long and challenging process. However, cognitive-behavioral therapy, social skills training, group therapies, and certain pharmacological treatments can help manage symptoms. For treatment to be successful, the individual's motivation and active participation in therapy are of utmost importance.

**Case Study 1**

**Name-Surname:** F.

**Gender:** Male

**Age:** 35

**Marital Status:** Married

**Place of Birth:** Siirt

**Occupation:** Construction Supervisor

**Education Level:** High School

**Reason for Seeking Help:** At his wife's request

Born in 1986 in Siirt, F.'s parents were field workers. He is the fourth child in a family of seven. After getting married, he moved to Istanbul, and following his mother’s death, he never contacted his family again. He is a handsome and well-groomed man, standing at 1.85 meters tall, and is physically striking. He has scars on his body. He lives in Istanbul with his wife and one child. He has no physical health issues and is socially active.

**Previous Treatments**

After causing a traffic accident while driving under the influence, he got into a fight with the owner of another vehicle. As a result, the hospital referred him to psychiatry, but he only attended two sessions and then discontinued treatment. Additionally, he never regained his driver’s license and has continued to drive without one.

**Education and Work Life**

F. graduated from high school through open education after being expelled. He did not attend university. Before starting therapy, his wife reported that he took workers' profit margins for himself, exhibited aggressive behavior towards his colleagues, sometimes went to work intoxicated, was frequently late, and received complaints from other employees due to these behaviors.

**Family Life**

Born in 1986, F. comes from a large and poor family. His father was authoritarian and frequently used violence against him and his siblings. After school, the children were forced to work in the fields, and their family did not provide them with adequate care and affection. His mother also suffered frequent abuse from his father. During his school years, F. displayed highly aggressive and combative behaviors, leading to multiple expulsions. As a result, he was beaten severely by his father. His mother was unable to intervene when her children were beaten. She also worked intensively, but due to their large family, they struggled financially. Because of the father's strict authority and the mother's workload, the children did not receive sufficient parental attention.

F.'s father had frequent conflicts with people around him and was imprisoned multiple times. When his father was in prison, his mother struggled financially, leading F. to engage in theft attempts. He developed substance abuse habits at the age of 15. Due to substance-related reasons, he was frequently involved in violent altercations and assaults, which resulted in multiple stays in juvenile detention centers. At 17, he lost his mother to cancer and married a girl from his village.

**Social Life**

His social circle mostly consists of people from whom he can borrow money, use substances, or benefit in some way. He does not have long-term friendships, and most of his relationships end in conflict. He has attempted to start businesses with his friends multiple times but failed due to irresponsible behavior and engaging in unfair financial gains. Because he constantly suspected his friends of exploiting him, he defrauded many of them.

**Relationships with the Opposite Sex**

F., being handsome and noticeable, has had short-lived relationships. However, since he married at an early age, he could not remain monogamous. He frequently cheated on his wife, attributing his infidelity to being forced into an early marriage with someone he never loved. He never developed a deep emotional bond with his partners. Unable to establish sincere

connections, F. also engaged in risky sexual behaviors. During periods when he was unemployed, he frequently relied on his wife's income and spent a significant amount of money on alcohol. His wife has many complaints about him. He claimed that since she was a gloomy person, he cheated on her. He admitted that they had intense arguments, that he occasionally resorted to physical violence, but justified it by saying that his wife "truly deserved it."

**His Story**

He was unable to form close relationships due to growing up in a large family with financial difficulties, where every member was subjected to violence by his father. The family bonds were weak. He stated that whenever he was beaten, he blamed his mother or siblings excessively and believed that he was always wronged. He said that when he grew up, he dreamed of becoming strong and wealthy so that he could handle everything on his own without being deceived by others.

When he started using substances during adolescence, he claimed that true happiness lay in them and that the only thing he could attach himself to in life was drugs. During his time in a juvenile detention center, he got into many fights and was even stabbed once. He explained that he resorted to theft because his family did not take care of him and his father was in prison, making it necessary for him to steal. Since his mother had died of cancer, he saw no reason to maintain contact with his family. Having been forced into marriage, he took his wife and moved to Istanbul.

In Istanbul, he started working in a garment factory with his wife. He stated that he worked there for three months, while his wife continued to work and had even been promoted to a managerial position. He believed that he was capable of achieving much bigger things and did not want to work under anyone's orders. He mentioned that he had a daughter, whose care was primarily handled by his mother-in-law because he was too busy. He expressed anger over not having time for his family and frequently feeling wronged.

He claimed to form friendships very quickly and that people would obey him. F. stated that gullible people could be easily deceived and admitted to tricking his friends into engaging in illegal activities by promising wealth.

Once he made a profit, he would end the friendship, believing they deserved it. He admitted to cheating on his wife whenever he had money and frequently fighting with her as a result. He justified his alcohol consumption by blaming his wife for constantly provoking arguments. Due to drinking and driving, he lost his license multiple times and was eventually forced into psychotherapy, which he did not continue because he believed he did not need it.

He blamed his car accident on the other driver, whom he claimed was blind, insisting that he would never have crashed otherwise and, therefore, deserved to be beaten. He stated that he only attended therapy to silence his wife.

F. spoke in a composed and measured manner. Although he tried to conceal his anger, underlying rage sometimes became apparent. Since he viewed everyone as an enemy, he believed that he needed to defend himself to avoid being taken advantage of, and at times, even act aggressively. When discussing his plans for revenge, he would stare blankly and say, “They brought it upon themselves.”

**Diagnosis**

Mr. F. does not show remorse for his actions. He believes that the person he fought with in traffic deserved to be beaten and justifies the violence he inflicted on his wife by claiming she deserved it. He does not comply with legal obligations and repeatedly engages in behaviors that lead to his arrest. After being involved in a traffic accident while driving under the influence, he got into a fight with the other driver and was referred to psychiatry by the hospital. However, he discontinued therapy after only two sessions. Despite losing his license, he continues to drive illegally. Additionally, he has a tendency toward substance use and frequently commits theft to gain financial benefits.

Mr. F. frequently lies, uses fake identities, and deceives others for personal gain. He quickly forms friendships and assumes that people will obey him. Believing that gullible individuals are easy to manipulate, he has repeatedly tricked his friends with promises of wealth, leading them into illegal activities. After profiting, he ended these friendships, claiming that they deserved it. He has also attempted to unjustly seize workers’ rights and

earnings. He exhibits impulsivity and lacks the ability to plan for the future. As a child, he believed that he would grow up to be strong and wealthy, assuming that he could outsmart people before they deceived him and maintain control over everything. His tendency toward irritability and aggression is high. He frequently engages in fights, violates others' rights, and has a history of violent behavior toward his wife. Due to repeated conflicts, he was expelled from school and has displayed aggressive behaviors both in traffic and among his social circles.

Mr. F. struggles to maintain stable employment and does not fulfill his financial responsibilities. He frequently arrives late to work and refuses to work under the orders of those in higher positions. As a result, he frequently changes jobs. Finally, he rationalizes his actions in a way that prevents him from feeling guilt. He justifies his violence against his wife by blaming her moodiness, normalizes his infidelity by citing his forced marriage, and blames his traffic accident on the other driver, arguing that he would never have crashed if they had been more careful.

**Case Study 2**

**Person:** Ahmet K.

**Age:** 27

**Gender:** Male

Ahmet is a 27-year-old young man who recently got married and lives in Lyon, France. During his childhood, he was unable to establish good relationships with his parents and was neglected. The biggest emotional blow Ahmet experienced in his childhood was when his father left his mother and married another woman. All of these events prevented Ahmet from having a good childhood and negatively affected his subsequent developmental stages.

During his high school years, Ahmet constantly engaged in mischief and defied rules. He damaged objects on the street, disregarded people’s rights and values, and got into fights after school almost every day, rarely spending a day without ending up at the police station. One day, his parents decided that things could not continue this way and made a decision that

would perhaps be their biggest mistake. First, Ahmet's father employed him at his own car repair shop. Later, they decided to marry Ahmet off to a distant relative. His family believed that marriage might help him settle down and that he would become more composed, but this decision would lead to even worse consequences.

In the first few months of his marriage, things seemed to go as his family had hoped. Ahmet was keeping up with his job and taking care of his wife. They were even expecting a child, which created a joyful atmosphere in their home. However, as time passed, things began to deteriorate. Ahmet started coming home late at night and received several speeding tickets. He began drinking alcohol until late at night, spending time with sex workers, and having serious arguments with both his wife and father. One day, he even stole his father's car and got involved in a minor accident. As a result of his father's complaint, he spent a few days in detention.

After being released, Ahmet started engaging in intense conflicts at home. He blamed his wife for everything that was happening, subjected his pregnant wife to violence, and hurled humiliating words at her, showing no remorse for his actions. The final straw was when he was caught by his wife cheating on her with another woman in their own bed. When confronted, he threatened his wife with death. Following this incident, his wife decided to file for divorce and return to her home country. However, Ahmet continued to threaten both her and their unborn child. As a result, his wife sought security measures for protection.

Unable to achieve his goals, Ahmet fell into depression. He stopped talking to anyone, suffered from irregular sleep and eating habits. In light of these developments, his family sought help from a renowned psychiatrist. After six months of consultations and evaluations, Ahmet was diagnosed with antisocial personality disorder. The psychiatrist provided the family with the necessary recommendations. Accepting these recommendations, the family ensured that Ahmet attended regular therapy sessions every week, preventing his condition from worsening further. Additionally, Ahmet was hospitalized for a certain period and began medical treatment.

**Disclaimer:** The case described has no connection to real-life events. The individuals mentioned in the case are entirely fictional. The purpose of

this case study is to better understand and analyze the fundamental characteristics and thought patterns of individuals with antisocial personality disorder. Unfortunately, although this case is fictional, similar cases are believed to be prevalent both in our country and globally. In a way, this case, despite being fictional, reflects real-life cases.

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# CHAPTER 6

## Borderline Personality Disorder

Borderline personality disorder (BPD) was included in the class of personality disorders with the DSM-III in 1980. Previously, this pathology, which could not be classified into either the neurotic or psychotic groups, carries characteristics of both groups (Çalışır, 2008). The concept of "borderline" has been used for patients who exhibit both neurotic and psychotic features, whose egos are weaker than those of neurotics but more connected to reality than those of psychotics, and who are in a relatively better position in terms of maintaining their own lives. Borderline patients possess characteristics of both the neurotic and psychotic groups but do not fully belong to either, placing them in a borderline position (Rugancı, 2003). These individuals, who are constantly "in distress," may experience periods where their ability to assess reality is impaired, accompanied by paranoia or dissociative symptoms. They struggle to establish consistent relationships with themselves and others, engage in harmful impulsive behaviors, and attempt suicide. Fear of abandonment and the thought of being alone shape their relationships, leading them to maintain dependent relationships. Individuals with BPD exhibit highly manipulative behaviors and have disorganized and complex sexual lives (Köroğlu & Bayraktar, 2010). They display extraordinary, fluctuating affect and temperament traits. Individuals with BPD experience inconsistencies in identity and affect due to problems in self and object relations. They have impulse control problems and do not hesitate to engage in behaviors that may harm themselves or others. Due to their fear of being alone and abandoned, they constantly seek relationships (Eren, 2016). Since they cannot remain consistent in their views, goals, and desires, they lack a continuous self-concept. Unable to attribute meaning to their existence, these individuals exhibit impulsive, indecisive, and disorganized behaviors due to their uncertainty about where to anchor themselves (Köroğlu & Bayraktar, 2010). It is thought that individuals exhibiting BPD symptoms, in addition to identity confusion, also show symptoms of depression and anxiety and possess narcissistic traits (Morsünbül, 2020). When approached from an eclectic perspective, BPD syndromes are classified into four areas:

1. Cognitive-perceptual symptoms
2. Affective instability
3. Impulsivity
4. Interpersonal pathology (Rugancı, 2003).

Parental attitudes are known to play a significant role in the development of the disorder. A review of the literature indicates that its prevalence ranges between 1.2% and 6%. Although there is insufficient research in our country, it is known that the prevalence rate may increase due to the high occurrence of defective parental attitudes (Algaç Kutlu, 2018). When analyzed by gender, the disorder is more commonly observed in women. In women, the most frequent comorbid diagnoses are PTSD and eating disorders following physical and sexual abuse, whereas in men, the most common comorbid diagnoses are substance use disorder, schizotypal personality disorder, narcissistic personality disorder, and antisocial personality disorder (Morsünbül, 2020).

In the DSM-5 diagnostic manual published by the American Psychiatric Association, personality disorders are classified under Axis II and are divided into three clusters. Borderline personality disorder falls within Cluster B, characterized by self-destructive behaviors, emotional instability, and unstable relationships (Eren, 2016). For a diagnosis of BPD, an individual must meet five out of nine criteria, which must be observed in multiple areas of the individual's life beginning in adolescence:

1. Making extraordinary efforts to avoid abandonment
2. Intense and unstable interpersonal relationships that oscillate between idealization and devaluation
3. Identity disturbance
4. Impulsivity in at least two areas that are potentially self-damaging
5. Recurrent suicidal behavior or self-harming behaviors
6. Affective instability
7. Chronic feelings of emptiness
8. Inappropriate, intense anger and difficulty controlling anger
9. Transient, stress-related paranoid thoughts or dissociative symptoms (Algaç Kutlu, 2018).

In the ICD-10, BPD is referred to as "emotionally unstable personality disorder." The disorder is divided into "borderline" and "impulsive" types. The "borderline type" includes affective instability, whereas the "impulsive type" includes both affective instability and impulsivity (Çalışır, 2010).

Table 1: Differences between Borderline Personality Disorder and Personality Form

| **Form** | **Disorder** |
|---|---|
| Passionate in all relationships, does not take any aspect of a relationship lightly. | Engages in unstable relationships that fluctuate between idealization and devaluation. |
| Does not hesitate to express emotions, is emotionally active and responsive. | Engages in impulsive behaviors in at least two areas that may be self-damaging. |
| Behaves sincerely without role-playing. | Experiences rapid emotional changes and inconsistencies in affect. |
| Displays attractive, lively, creative, and enterprising traits. | Exhibits inappropriate and intense anger, struggles to control anger. |
| Does not hesitate to dream and is curious about other cultures. | Experiences significant and persistent identity disturbance in various areas of life. |
| Can establish a deep relationship with one person. | Makes excessive efforts to avoid real or imagined abandonment. |

(Köroğlu & Bayraktar, 2010).

The table highlights the contrast between certain personality traits and the symptoms of a psychological disorder, likely borderline personality disorder (BPD). On one side, it presents characteristics such as being passionate in relationships, emotionally expressive, sincere, creative, and deeply connected to others. However, these traits have pathological counterparts when taken to extremes. For instance, while passion in relationships can be seen as a positive quality, in the context of BPD, it manifests as unstable relationships marked by cycles of idealization and devaluation. Similarly, emotional expressiveness transforms into impulsive behaviors that may lead to self-damaging consequences. The sincerity and

authenticity of an individual contrast with the emotional instability and rapid mood shifts experienced in BPD. Creativity and charisma, which are often seen as attractive traits, are juxtaposed with intense and uncontrollable anger. Additionally, a natural curiosity about different cultures and an inclination to dream are overshadowed by a deep and persistent identity disturbance that affects various areas of life. Finally, the ability to form deep and meaningful connections is undermined by an excessive fear of abandonment, leading to desperate attempts to avoid real or imagined rejection. This comparison illustrates how traits that are typically viewed as positive can take on a maladaptive and destructive form when influenced by an underlying psychological disorder.

In BPD, attitudes and emotions toward others can change suddenly and inconsistently. These changes can be even sharper than those observed in major depressive disorder. (Algaç Kutlu, 2018) Another problem in interpersonal relationships is intense and difficult-to-control anger outbursts. These outbursts can drive individuals toward harmful and destructive behaviors by fostering negativism. Impulsivity also emerges at this point. Behaviors performed to escape negative emotional states, such as self-harm, suicide attempts, substance use, gambling, and random sexual encounters, pose a significant threat to an individual's life. (Algaç Kutlu, 2018) Individuals with BPD struggle with a stable and continuous self-concept, leading to difficulties in crucial aspects of life such as values, commitments, and career choices. One of the most fundamental symptoms of the disorder, intense fear of abandonment, drives individuals to make extraordinary efforts to avoid being alone. When abandoned, they struggle to control their intense anger and may engage in harmful behaviors toward themselves and others (Algaç Kutlu, 2018).

Impulsive behaviors, which hold a significant place in the diagnostic criteria of Borderline Personality Disorder (BPD), include risky, sudden actions that can lead to unwanted consequences and cause harm to oneself or others. Individuals may engage in non-suicidal self-injury behaviors. These harmful actions, which do not result in death, are a form of self-punishment (e.g., harming one's body with a razor blade, pressing a cigarette onto one's arm, etc.). Approximately 66% of individuals with BPD attempt to harm themselves through these harmful behaviors at some point in their lives (Algaç Kutlu, 2018).

The concept of suicide is also a crucial issue for individuals with BPD. In a study involving 621 individuals diagnosed with BPD, it was found that 15.5% had attempted suicide (cited in Algaç Kutlu, 2018).

When examining the course of BPD, 75% of diagnosed individuals no longer met the diagnostic criteria after the age of 40. Depression, anxiety, and substance use disorders are the most commonly encountered comorbid diagnoses in BPD. Additionally, a large proportion of individuals diagnosed with BPD were observed to have been diagnosed with ADHD during childhood. Emotional deprivation and potential abuse experienced by children with ADHD may create a foundation for the development of BPD (Algaç Kutlu, 2018).

**Etiological Approaches**

*1) Cognitive-Behavioral Theory:*

CBT focuses on three core perceptions observed in individuals with BPD:

1. "The world is a dangerous and harmful place."
2. "I am weak and can be harmed."
3. "I have been an unaccepted person since birth" (cited in Algaç Kutlu, 2018).

Individuals holding these thought patterns feel the need to be constantly alert, vigilant, and in control. This, in turn, leads to anxiety, hypersensitivity to potentially dangerous situations, and overly cautious behaviors. Regarding their relationships with others, these individuals perceive others as unreliable and potentially harmful. Consequently, they develop a "watchful-defensive" attitude.

Additionally, their thought patterns align with "black-and-white thinking," which refers to extreme, dichotomous thinking. This cognitive style results in sudden emotional shifts and maladaptive behaviors (cited in Algaç Kutlu, 2018). These individuals also perceive relying on others for strength as highly dangerous. If they trust others, they believe abandonment, rejection, and attack are inevitable. Therefore, they see themselves as alone and

helpless. This cognitive style prevents them from forming secure relationships and instead leads to dependent relationships (Oruçlular, 2016).

*2) Psychoanalytic Theory:*

Psychoanalytic theory considers borderline and narcissistic personality disorders as different extremes of the same structure. It suggests that narcissistic personality disorder sheds light on borderline personality disorder. In a study conducted by Anıl and Bahadır in 2007, narcissism was found to be the strongest predictor of BPD after depression. Borderline Personality Disorder (BPD) and Narcissistic Personality Disorder (NPD) are often seen as two manifestations of the same underlying self-structure issues, differing in how individuals regulate their sense of self. While BPD is characterized by a fragmented and unstable self-concept, leading to deep insecurity and emotional instability, narcissism represents the opposite extreme—a rigid and exaggerated sense of self-importance and superiority. In this framework, BPD can be understood as a deficiency in self-concept, where individuals struggle with identity instability and an overwhelming fear of abandonment, whereas narcissism manifests as pathological grandiosity, where individuals construct an inflated self-image to compensate for underlying vulnerabilities (Anıl & Bahadır, 2007).

The concept of narcissism itself can be divided into two primary components: the "grandiose self" and the "idealized parental image." The "grandiose self" represents the inflated, often defensive self-image that individuals create to maintain a sense of superiority and self-worth. On the other hand, the "idealized parental image" refers to an internalized vision of a perfect, nurturing caregiver who provides stability, validation, and emotional security. When individuals experience traumatic disappointments related to this idealized caregiver—such as neglect, abandonment, or emotional unavailability—they may develop BPD instead of maintaining a narcissistic defense. In moments of psychological distress, individuals with BPD fluctuate between two extreme states: the grandiose self, where they feel powerful and invulnerable, and the desperate need to merge with an idealized figure who can offer them the love and validation they crave. However, this oscillation prevents them from internalizing the calming and stabilizing characteristics of a caregiver, leaving them emotionally dysregulated and unable to self-soothe (Algaç Kutlu, 2018). This dynamic helps explain the intense emotional shifts,

unstable relationships, and deep-seated fears of rejection that characterize BPD, as well as its complex relationship with narcissistic traits.

According to Mahler, patients who develop BPD remain stuck in the "reapproachment" subphase of the separation-individuation process. Kernberg also argues that these individuals fail to integrate "good" and "bad" self and object representations, resulting in an inability to internalize objects. Since they failed to internalize their mother's soothing presence during childhood, they lack object constancy and spend their lives searching for external sources to fill this void—constantly seeking someone to soothe them (cited in Anıl & Bahadır, 2012).

*3) Schema Theory:*

The development of Borderline Personality Disorder (BPD) is closely linked to early childhood experiences, particularly the failure to meet a child's fundamental emotional needs, exposure to trauma, and problematic relationships with caregivers. These early adversities contribute to the formation of maladaptive schemas—deeply ingrained patterns of thinking and feeling that shape an individual's perception of themselves, others, and the world. According to schema theory, individuals with BPD often exhibit a wide range of maladaptive schemas, with all 18 identified in the framework potentially present. However, certain schemas appear more frequently and play a central role in the disorder. Among these, the most common are *abandonment* (a deep-seated fear of being left alone), *mistrust* (the expectation that others will betray, hurt, or take advantage of them), *emotional deprivation* (the belief that one's emotional needs will never be met), *subjugation* (a tendency to surrender personal needs and desires to avoid conflict or abandonment), *defectiveness* (a pervasive feeling of being inherently flawed or unworthy), and *punitiveness* (a harsh self-critical attitude that reinforces the idea of needing to be punished for mistakes or perceived failures).

To manage these painful and distressing schemas, individuals with BPD develop specific coping mechanisms known as *modes*, which are different states of being that they shift between depending on the situation. The most frequently observed modes in BPD include the *abandoned child*, a state characterized by overwhelming sadness, fear, and a desperate need for

reassurance; the *angry child*, which emerges when frustration and emotional pain turn into intense rage; the *detached protector*, a defense mechanism where individuals emotionally shut down or become numb to avoid feeling pain; the *punitive parent*, an internalized critical voice that reinforces feelings of worthlessness and self-loathing; and the *healthy adult*, which represents a more balanced and rational state of mind but is often underdeveloped in individuals with BPD. The constant fluctuation between these modes contributes to the emotional instability, impulsivity, and difficulties in relationships that are characteristic of BPD, making treatment particularly challenging but also highlighting the importance of therapeutic interventions that aim to strengthen the *healthy adult* mode.

Schema therapy attributes sudden mood changes and impulsivity to rapid transitions between modes. Impulsive behaviors also vary depending on the mode the individual is in. The main goal of this approach is to establish a healthy adult mode if it does not exist in the individual or, if it does exist, to ensure its permanence by transitioning into that mode (Algaç Kutlu, 2018).

**4) Genetic Factors.** Genetic transmission in BPD is effective up to 40%. Genetic susceptibility and serotonergic dysfunction increase the risk of BPD. Additionally, deficiencies in neurotransmitters such as dopamine, MAO, and vasopressin may be associated with BPD (Algaç Kutlu, 2018).

**5) Neurobiological Factors.** Neurobiological factors such as a reduction in gray matter in certain areas of the cortex, increased activity in the amygdala, and disruption in the connection between the prefrontal cortex and the amygdala are considered fundamental to BPD. The amygdala is the part of the brain responsible for emotions, and it plays a significant role in explaining BPD (Algaç Kutlu, 2018).

**6) Attachment Theory.** Bowlby examined attachment as either secure or insecure. Children with insecure attachment fail to form an image of their caregiver and, in their absence, become anxious, panicked, and insecure. One of the core criteria of BPD, "inability to tolerate loneliness," is related to insecure attachment. An individual with insecure attachment fears being unable to soothe themselves when alone because they have not internalized their caregiver’s behaviors. Furthermore, insecure attachment and BPD share common characteristics, such as clinging tightly to others, fear of loneliness,

and anxiety about abandonment (Algaç Kutlu, 2018). Since the attachments individuals experience are not secure and satisfying, they constantly feel uncertain about their identity. Individuals with BPD, who need secure attachments to form a satisfying identity, are in a continuous state of exploration. This exploration leads to a persistent feeling of emptiness (Morsünbül, 2020).

**7) Biosocial Theory.** According to the biosocial theory developed by Linehan, BPD arises from dysfunction in the emotion regulation system. When this dysfunction interacts with a dysfunctional environment, the necessary conditions for BPD are met. (Cited in: Algaç Kutlu, 2018) Linehan defines BPD as the inability to cognitively and behaviorally cope with emotional stress and interpersonal relationships (Cited in: Oruçlular, 2016). A child growing up in a family that does not acknowledge their emotional existence from birth may develop BPD due to the disadvantages caused by their biological makeup (Rugancı, 2003). Families that ignore a child's emotional problems and do not allow them to cope with negative emotions lay the foundation for BPD. Instead of using strategies to manage negative emotions, which they did not learn in childhood, individuals engage in self-destructive behaviors as a means of release when confronted with negative emotions (Cited in: Oruçlular, 2016).

8) Childhood Traumas. Childhood traumas provide a significant foundation for BPD. Early parental loss and sexual abuse are among the most frequently encountered traumas. When sexual abuse is perpetrated by the primary caregiver, the impact of the trauma intensifies, increasing the likelihood of developing BPD. Childhood traumas are highly significant for BPD; however, it is not functional to assume that every child who experiences trauma will develop BPD or that every individual with BPD must have a history of trauma (Algaç Kutlu, 2018).

## Treatment

The treatment of BPD aims to teach patients methods for emotion regulation and expressing emotions appropriately. By helping individuals avoid situations where they might exhibit impulsive behaviors, their impulsivity is controlled. Patients are encouraged to become members of a supportive social group. Assisting them in establishing enduring activities and

relationships to replace their conflicting and opposing self-perceptions with an integrated self-concept is one of the main objectives of treatment (Eren, 2016).

Psychopharmacology and psychotherapy can be used in the treatment of BPD (Sayın et al., 2005). Different treatment methods can be applied depending on the domain in which the patient's symptoms are most prominent. For example, while pharmacological interventions may be effective for patients experiencing cognitive disorganization and psychotic episodes, dialectical behavior therapy may be suitable for those engaging in self-harming or life-threatening behaviors. While relational issues can be addressed using interpersonal relationship theories, self-related problems can be approached through self-psychology methods (Sayın et al., 2005). Different therapeutic schools apply various techniques in psychotherapy. Dialectical behavior therapy includes individual therapy, skills training, phone coaching, and consultation team meetings. In schema therapy, the therapist aims to meet the needs of the neglected and abandoned child through limited reparenting, set boundaries for the demands of the angry and impulsive child, and deactivate punitive parental behaviors, ultimately guiding the individual into a healthy adult mode (Algaç Kutlu, 2018).

The biosocial theory emphasizes that preventing difficulties in emotion regulation should be the primary goal. Contemporary behavioral interventions aim to reduce behaviors that ignore emotions by reinforcing cognitive and behavioral skills that increase emotional acceptance and help individuals live with their emotions (İlk & Bilge, 2020).

Pharmacological interventions can provide short-term relief, while psychotherapy sessions that teach emotion regulation and explore past traumas, in addition to pharmacological interventions, can help individuals gain long-term benefits and achieve better control over their lives (Rugancı, 2003).

Therapists' styles may vary based on the theoretical framework they adopt. Therapists influenced by self-psychology tend to adopt a warmer and more empathetic approach, while existential relationship-based therapists take a more realistic approach, emphasizing flexibility and the establishment of meaningful emotional connections (Sayın et al., 2005).

**Borderline Personality Disorder and Criminal Behavior**

Impulsive behaviors, which are associated with strong autonomic arousal, can lead to rapid emotional changes, creating a foundation for violent behavior. Impulsivity results in unplanned, contextually inappropriate, and excessive actions. When anger, unstable affect, and impaired risk assessment are combined with impulsivity and a fear of rejection, the conditions for violence become more likely. Although the described violent behaviors resemble those seen in antisocial personality disorder, there is a key difference: while individuals with antisocial personality disorder exhibit intentional anger and outbursts, individuals with BPD display impulsive anger (Algaç Kutlu, 2018).

**Differential Diagnosis in Borderline Personality Disorder**

Given the relational cycles experienced by individuals with BPD, the concept of revictimization becomes crucial. Due to difficulties in emotion regulation, efforts to prevent abandonment, and tendencies toward violent behaviors, individuals with BPD may experience trauma. Female patients with BPD are at a higher risk of revictimization, as they are more likely to encounter abusive partners and experience repeated traumas (Algaç Kutlu, 2018).

Emotional instability is a common symptom in both disorders; however, impulsive aggression distinguishes BPD from bipolar disorder. While emotional instability in BPD is often accompanied by impulsive aggression, bipolar disorder is characterized by fluctuations between depression and euphoria (Rugancı, 2003). In bipolar disorder, the course of the illness either worsens over time or remains stable, whereas in BPD, individuals tend to no longer meet the diagnostic criteria, especially in middle age (Morsünbül, 2020). In a study conducted in 2000, Silk summarized the differences between bipolar disorder and BPD as follows:

1. In BPD, emotional shifts occur much more rapidly than in bipolar disorder.
2. In BPD, emotions are much shorter in duration but felt much more intensely than in bipolar disorder.

3. In BPD, emotions are experienced in a much more reactive manner compared to bipolar disorder (as cited in Rugancı, 2003).

There are many overlapping characteristics between narcissism and BPD. However, these pathologies differ in the following aspects:

1. Narcissistic individuals do not want to engage in dependent relationships, whereas individuals with BPD do not avoid them.
2. Narcissistic individuals fluctuate between feelings of inferiority and grandiosity, while individuals with BPD experience a much wider range of emotions.
3. Narcissistic individuals do not have difficulty establishing social relationships, but they feel isolated within them, making it difficult for them to maintain these relationships. In contrast, individuals with BPD do not want to disconnect from their social relationships (Morsünbül, 2020).

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# CHAPTER 7

## Narcissistic Personality Disorder

In Greek mythology, Narcissus was born with a beauty so enviable that even the gods were jealous. When he rejected the love of the nymph Echo, he was punished by being made to gaze at his reflection in a mountain lake. Narcissus fell in love with his own reflection but, unable to touch it and consumed by longing, he wasted away (Behary, 2018). The first person to establish a connection between the myth of Narcissus and the concept of narcissism—especially in women, as a form of self-directed sexual attraction driven by admiration—was Havelock Ellis (Ellis, 1898; as cited in Üzümcü, 2016; Rozenblatt, 2020; as cited in Karaaziz & Erdem Atak, 2013). Initially examined from a psychoanalytic perspective, narcissism later became a concept of interest in the fields of object relations and self-psychology (Üzümcü, 2016).

In his article *On Narcissism: An Introduction*, Freud defined narcissism as the inward redirection of libido from the external world. He also introduced the concepts of primary and secondary narcissism. According to Freud, primary narcissism is a healthy part of psychosexual development, whereas secondary narcissism occurs when, in the object relations phase, the absence of a desired love object leads to frustration, causing sexual drives to be redirected toward the self (Freud, 1914 & Freud, 1957; as cited in Üzümcü, 2016).

Kohut (1971) viewed narcissism as a healthy part of developmental processes, defining unhealthy narcissism as a disruption in this development. According to him, narcissistic development, which is a normal part of growth, consists of two parallel channels: the *grandiose self* and the *idealized parental imago*, both of which help shape an individual's values and goals in later life. However, if parents fail to respond to the developmental needs of their child, failing to meet their demands, this results in profound disappointments and developmental disruptions (Anlı & Bahadır, 2017). Kohut described individuals with narcissistic personality disorder as those who struggle in relationships, lack sensitivity to the emotions and needs of others, and expect attention from the external world while internally experiencing intense feelings of worthlessness and rejection. He also conceptualized narcissism as

a spectrum ranging from normal to pathological (Kohut, 1971; as cited in Üzümcü, 2016).

Unlike Kohut, Kernberg did not see narcissism as a healthy part of development but instead as a pathological condition. Explaining narcissistic personality through the lens of borderline personality organization, Kernberg (1975) argued that the failure to integrate "good" and "bad" representations of the self and others in childhood—or the pathological integration of these representations—leads to narcissistic personality disorder (Anlı & Bahadır, 2017). He suggested that pathological narcissism emerges in families where children experience rejection from their parents, encounter inconsistent parental behavior, or are used as tools to fulfill parental needs (Levy, Ellison, & Reynoso, 2011; as cited in Demirci & Ekşi, 2017). In such cases, the good and bad aspects of the parent cannot be integrated (Kernberg, 1975; as cited in Anlı & Bahadır, 2017). To cope with their distant and non-accepting parents and to attempt to repair this negative dynamic, children resort to self-aggrandizement (Levy, Ellison, & Reynoso, 2011; as cited in Demirci & Ekşi, 2017). Kernberg (1975) described narcissistic individuals as highly self-absorbed, prone to grandiose fantasies, lacking empathy, and exploitative toward others (as cited in Üzümcü, 2016).

**Normal and Pathological Narcissism**

Narcissism has been studied from various perspectives, with some researchers distinguishing between normal and pathological forms. The difference between normal and pathological narcissism lies in the contrast between healthy self-confidence and artificially inflated self-esteem. Low self-esteem, which can disrupt a person's life, is characterized by feelings of inadequacy, worthlessness, and inferiority. On the other hand, excessive self-confidence manifests as arrogance, a sense of superiority over others, and an inability to empathize. From this perspective, the relationship between self-esteem and the spectrum of normal to pathological narcissism can be represented by a U-shaped curve. Those positioned at the midpoint of this curve, referred to as "normal narcissists," should be able to empathize with others, value their thoughts and emotions, experience social concerns, and acknowledge their own contributions to problems when they arise (Millon, Grossman, Millon, Meagher, & Ramnath, 2004).

When considered as narcissistic personality and narcissistic personality style, individuals with a narcissistic personality experience a grandiose self-esteem even in the absence of sufficient skills, talents, and achievements. In contrast, individuals with a narcissistic personality style have a healthy self-esteem that is associated with their concrete achievements and presents their existing abilities as better than they actually are. Particularly in pathological narcissism, individuals are often preoccupied with fantasies such as power and beauty, and they seek closeness with people who resemble them and whom they perceive as special like themselves. Additionally, they feel a need to influence others and make efforts to achieve this.

In the narcissistic personality style, however, individuals have self-confidence and goals; they have mapped out the road to achieving them. They do not look down on people who lack sufficient skills and abilities, and they respond moderately to others' attention and praise without exhibiting grandiosity in their self-confidence (Millon, Grossman, Millon, Meagher, & Ramnath, 2004).

Kernberg described non-pathological narcissism as individuals having self-confidence and not experiencing catastrophic effects on their self-esteem due to criticism. He stated that there is no harm in investing libidinal energy into the self and that "good-bad" representations integrate in a healthy manner (Kernberg, 1975; as cited in Üzümcü, 2016; Kernberg, 1985; as cited in Karaaziz & Erdem Atak, 2013). In pathological narcissism, there is a noticeable narcissistic resistance, accompanied by extreme sensitivity to external criticism and insatiable demands. Pathological narcissistic individuals, when feeling worthless or confronted with undesirable traits, react with excessive sensitivity, displaying anger or aggression. They attempt to rid themselves of these distressing feelings by using the defense mechanism of projection, attributing them to others (Kernberg, 1975; as cited in Karaaziz & Erdem Atak, 2013).

Masterson, on the other hand, defined pathological narcissism as the presence of unrealistic self-assessments and the frequent reliance on defense mechanisms to escape from intense, unpleasant emotions (Masterson, 1993; as cited in Kalın, 2020).

**Narcissistic Personality Disorder**

The American Psychiatric Association first defined pathological narcissism in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). In the subsequent revised version, diagnostic criteria were also included. In the fourth edition of the DSM, personality disorders were classified into three clusters: Cluster A, Cluster B, and Cluster C (Üzümcü, 2016).

In DSM-5, narcissistic personality disorder (NPD) is described as a pervasive pattern that begins in early adulthood and manifests in various contexts. It is characterized by grandiose fantasies or behaviors, a need for admiration from others, and a lack of empathy (American Psychiatric Association, 2014). For an individual to be diagnosed with this disorder, at least five of the following symptoms must be present (American Psychiatric Association, 2014):

1. Exhibits grandiosity (e.g., exaggerates achievements and talents; expects to be recognized as superior regardless of actual accomplishments).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that they are "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with their expectations).
6. Exploits others for personal gain (i.e., takes advantage of others to achieve their own ends).
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of them.
9. Shows arrogant, haughty behaviors or attitudes.

When examining the diagnostic criteria of the DSM-5, it is evident that the manual primarily focuses on grandiose narcissism while failing to address the concept of vulnerable or covert narcissism. Due to this limitation, it has been criticized for offering an inadequate definition (Cooper & Ronnigstam, 1992, cited in Üzümcü, 2016). Additionally, to determine whether these symptoms reflect a personality disorder or merely a personality style, the persistence of these symptoms and the extent to which they cause impairment in a person's life must be considered. If the symptoms are enduring, inflexible, and significantly disrupt major life domains, they are more likely to indicate a personality disorder (Köroğlu, 2011, cited in Üzümcü, 2016).

**Grandiose and Vulnerable Narcissism**

Although DSM criteria emphasize grandiose narcissism, the literature suggests that narcissism consists of two distinct types. Kernberg defines narcissism as characterized by grandiose attitudes, lack of empathy, emotional emptiness, and self-centeredness, whereas Kohut describes it in terms of vulnerability, depressive mood, emotional emptiness, lack of empathy, and fragility (Kernberg, 1975; Kohut, 1977, cited in Eldoğan, 2016). This difference in definitions suggests that narcissism cannot be reduced to a single dimension and that these theorists may have worked with individuals exhibiting different types of narcissism (Eldoğan, 2016).

Beyond these two dimensions, Bursten (1973) proposed a four-subtype model of narcissism, categorizing narcissists as paranoid, manipulative, craving, and phallic (Gabbard, 1989). According to this classification, paranoid narcissists are suspicious and accusatory, often displaying hostility and conflict; manipulative narcissists lie without guilt and deceive others when their interests are at risk; craving narcissists are dependent on others, making constant demands while fearing disappointment; and phallic narcissists exhibit grandiosity, aggression, and self-display as prominent traits (Bursten, 1973, cited in Eldoğan, 2016).

Grandiose narcissists possess a narcissistic sense of self-confidence, exhibit exaggerated self-presentation, seek admiration by capturing others' attention, focus solely on their own needs, and tend to be aggressive (Wink, 1991). These individuals may also deny their weaknesses, make excessive

demands on others, react with anger and aggression when their expectations are unmet, and devalue others as a means of compensating for their fragile self-esteem. They lack awareness of how unrealistic their expectations are and how these expectations affect their relationships. Any conflict in the external world is not perceived as a result of their own inappropriate expectations but is entirely experienced as an external issue (Dickinson & Pincus, 2003).

The second dimension of narcissism, vulnerable/covert narcissism, is characterized by an outward appearance of self-confidence, yet these individuals are more sensitive, anxious, and avoidant, often avoiding responsibility and appearing insecure. However, upon closer relationships, they reveal grandiose fantasies (Kernberg, 1986, cited in Wink, 1991). Both types share narcissistic traits such as exploitative tendencies and entitlement (Wink, 1991). Although vulnerable narcissists may appear empathetic, anxious, and shy, their underlying traits include unrealistic expectations and entitlement. They rely on external validation to regulate their self-esteem. Due to their excessive demands, they are more likely to experience conflicts with others, and when their expectations are not met, they become frustrated and attempt to deny their disappointment. This frustration leads to anger, followed by shame and depressive moods, creating a cycle of emotional instability. Their low self-esteem and sensitivity to unmet expectations make them socially anxious and avoidant in relationships (Cooper, 1998, cited in Dickinson & Pincus, 2003; Kraus & Reynolds, 2001; Wink, 1991).

**Therapeutic Approaches**

From a psychoanalytic perspective, Kernberg (1975), who argues that a parent's rejecting, cold, and neglectful attitude towards their child leads to the development of narcissism, states that individuals' display of grandiose self-esteem is actually a defense mechanism. This mechanism protects individuals from the possibility of reliving the abandonment they experienced in childhood during adulthood. Kernberg (1970) aimed to integrate internal representations that were not healthily unified by revealing the defensive aspect of the self when the grandiose self is activated during transference. The analyst, through this activation, enables the client's relationships with others to be revived in the therapy room. Thus, they systematically interpret the positive and negative aspects that emerge during transference. According to Kernberg, if the negative aspects are ignored during transference, the

narcissistic patient's anxiety regarding their already unaccepted aggression increases, leading to a greater activation of defense mechanisms and a stronger emergence of the pathological grandiose self. By the end of the therapy process, the patient is guided to become aware that the feared and hated mother and the longed-for mother are the same person, confronting and expressing the split perception of good and bad objects (Russell, 1985).

Kohut (1971) states that what is reactivated during transference is the "grandiose self" and the "idealized parental imago," which did not develop in a healthy and sufficient manner during early childhood. He aims to make these two structures visible in transference and thus facilitate the development of primitive narcissism, which did not develop healthily in the early period. When primitive narcissism appears in transference, patients attempt to receive the approval they did not get from their parents for their early narcissistic needs through "mirroring transference." When the idealized parental imago is activated during transference, "idealizing transference" occurs. In this process, the analyst acts as a self-object, allowing the patient to feel a sense of wholeness in their self. Kohut argues that if the patient is approached without judgment and with an empathetic attitude, this underdeveloped structure from childhood can develop (Russell, 1985).

Schema therapy works with dysfunctional thought patterns that individuals develop in early life, which significantly impact their development and their relationships with themselves and others. If a child's needs are not adequately met during early childhood and there is neglect by the caregiver, it is suggested that these experiences, combined with the child's innate temperament and biological factors, lead to the formation of early maladaptive schemas (Young, 1999; Young, 2003, as cited in Behary & Dickman, 2012). These schemas are presented in Table 1.

**Table 1**. Domains and Schemas of Early Maladaptive Schemas

| Schema Domains | Schemas |
|---|---|
| **Disconnection and Rejection** | Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation |
| **Impaired Autonomy** | Dependence/Incompetence, Vulnerability, Enmeshment/Undeveloped Self, Failure |
| **Impaired Limits** | Entitlement/Grandiosity, Insufficient Self-Control |
| **Other-Directedness** | Subjugation, Approval-Seeking, Self-Sacrifice |
| **Unrelenting Standards and Inhibition** | Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards/Hypercriticalness, Punitiveness |

Adapted from *Schema Therapy for Narcissism. The Handbook of Narcissism and Narcissistic Personality Disorder*, Behary, W. T., & Dieckmann, E., 2012, pp. 445–456.

Although there is no scientific evidence confirming these schema domains, the schema model is considered functional and successful in the therapy of narcissistic personality disorder (Young, Klosko, & Weishaar, 2003, as cited in Üzümcü, 2016). According to the schema therapy approach, the foundation of narcissism includes emotional deprivation, characterized by feelings of not being understood, listened to, or receiving attention from anyone; defectiveness, characterized by feeling bad, flawed, and worthless, experiencing shame due to one's flaws, and hesitating to connect with others; and the entitlement/grandiosity schema, which emerges as an overcompensation for the other two schemas. This schema is marked by a belief in one's special status compared to others, an effort to exert control over others, competitiveness, lack of empathy, and disregard for rules (Young, Klosko, & Weishaar, 2003, as cited in Üzümcü, 2016).

**Schema Modes**

Schema modes can be defined as individuals' activated schemas and the resulting schema activities (Young, Klosko, & Weishaar, 2003; as cited in Şenkal Ertürk & Kaynar, 2017).

*Child Modes*

- **Vulnerable Child**: A mode in which the individual feels lonely, sad, misunderstood and neglected by others, worthless, and inadequate.
- **Angry Child**: A mode in which the individual experiences intense anger, frustration, and resentment.
- **Impulsive/Undisciplined Child**: A mode in which the individual acts impulsively and selfishly to fulfill their desires, struggling to control their impulses. When these impulses are not met, they experience significant anger.
- **Happy Child**: A mode in which the individual feels validated, fulfilled, self-confident, competent, accepted, and strong.

*Maladaptive Parent Modes*

- **Punitive Parent**: A mode in which the person believes that either themselves or others deserve punishment and continuously tends to blame and punish themselves or their surroundings.
- **Demanding Parent**: A mode in which the individual believes that everything must be under control to achieve perfection.

*Maladaptive Coping Modes*

- **Surrender**: A mode in which the individual excessively complies and behaves submissively to avoid conflict and gain acceptance, disregarding their own needs and devaluing themselves.
- **Avoidance**: A mode in which the person withdraws into themselves, rejects support from others, emotionally detaches from others, and consequently feels bored and empty, seeking more exciting and impulsive pleasures.
- **Overcompensation**: A mode in which the individual sees themselves as superior, behaves in a more controlling, aggressive, dominant, and attention-seeking manner.

*Adult Mode*

- **Healthy Adult Mode**: A mode in which the person understands and accepts the vulnerable child, sets boundaries for the impulsive child, attempts to change maladaptive coping modes, neutralizes or makes maladaptive parent modes functional, and supports healthy modes.

The goals of schema mode therapy in personality disorder treatment include addressing child modes, maladaptive parent modes, and maladaptive coping modes, which frequently emerge in personality disorders, and making the healthy adult mode more functional (Karaosmanoğlu & Şaşıoğlu, 2015; as cited in Şenkal Ertürk & Kaynar, 2017). Additionally, the schema therapist acts as a role model for the healthy adult mode by providing "limited reparenting," offering support and validation to the patient. The therapist then encourages the patient to adopt this mode, revises existing maladaptive coping modes, and reduces the dysfunctional effects of maladaptive parent modes (Young, Klosko, & Weishaar, 2003; as cited in Şenkal Ertürk & Kaynar, 2017).

Similar to schema theory within the cognitive-behavioral approach, narcissism is argued to result from the interaction between an individual's temperament and their environment. Therefore, the primary cause of narcissistic personality disorder is considered to be the lack of unconditional acceptance from parents, excessive emphasis on materialistic aspects such as success and performance, inadequate boundaries, insufficient teaching or modeling of empathy, kindness, and tolerance, and a dismissive or discouraging attitude toward the child's innate interests and emotional expressions—thus failing to meet early fundamental emotional needs (Beck, Davis, & Freeman, 2005).

It is argued that narcissistic individuals—although difficult to notice from the outside—fundamentally hold dysfunctional beliefs such as **"I am inferior to others, unlovable, alone, flawed, worthless, and powerless."** At this point, incorporating schema theory, these beliefs are embedded within schemas such as **defectiveness/shame, emotional deprivation, failure, and mistrust** (Young, Klosko, & Weishaar, 2003, as cited in Beck, Davis, & Freeman, 2005). These individuals organize their lives around relentless

standards and seeking approval, using material possessions or social status as representations of their self-worth. Consequently, their core belief becomes **"To prove my worth to others, I must be the best, and they must recognize it."** Their assumption **"If I am not the best, I am inferior"** leads them to perceive experiences of looking bad, failing, or feeling bad as threats to their self-esteem, triggering anxiety and shame (Beck, Davis, & Freeman, 2005).

Narcissistic individuals also believe in their exceptional importance, adopting the beliefs **"I have special rules"** and **"Because I am special, I should get what I want"**—which serve as a defense against feelings of inadequacy. In the face of failure, thoughts such as **"This cannot happen to me"** become dominant. To justify their avoidance of fulfilling normal expectations or resisting them, they hold the belief **"This should be easy for me, and I should not have to make an effort"** (Beck, Davis, & Freeman, 2005).

Cognitive-behavioral therapy (CBT) for narcissistic personality disorder (NPD), as outlined by Beck, Davis, and Freeman (2005), aims to address the dysfunctional patterns that characterize the disorder and promote healthier psychological functioning. One of the primary goals is to help individuals recognize maladaptive coping mechanisms, such as grandiosity, entitlement, or avoidance, and to minimize their negative impact on daily life. Many individuals with NPD rely on these coping strategies to protect their fragile self-esteem, often at the expense of their relationships and personal growth. By increasing awareness of these patterns, therapy enables clients to adopt healthier ways of managing distress and self-perception.

Another key objective is enhancing emotional regulation by improving tolerance for everyday frustrations, imperfections, and typical emotional experiences. Individuals with NPD often struggle with feelings of inadequacy and react defensively to criticism or failure. Therapy encourages them to develop a more balanced emotional response, allowing them to experience setbacks without resorting to extreme defensiveness or aggression.

Additionally, CBT seeks to foster respect and empathy for others by helping individuals understand and appreciate the emotions, thoughts, individuality, and boundaries of those around them. Many narcissistic

individuals struggle with interpersonal difficulties due to their limited capacity for empathy and their tendency to view relationships as means for self-enhancement. Therapy works to cultivate genuine emotional connection and patience, enabling clients to delay immediate social gratification and interact with others in a more reciprocal and respectful manner.

A further goal is strengthening self-esteem by emphasizing personal strengths in a realistic and stable manner. Individuals with NPD often exhibit fluctuating self-worth, oscillating between feelings of superiority and deep insecurity. Therapy aims to build a more consistent and authentic sense of self-worth, reducing dependence on external validation. By reinforcing the Healthy Adult Mode—a balanced, mature psychological state—CBT helps clients integrate a more stable self-concept and engage in healthier interpersonal dynamics.

Despite these therapeutic efforts, understanding and treating NPD remains challenging. The disorder is primarily conceptualized based on clinical observations rather than extensive empirical research, as individuals with NPD rarely seek treatment unless prompted by external crises, such as relationship breakdowns or professional failures. Moreover, there is ongoing debate regarding the nature of narcissism. Some theorists distinguish between grandiose and vulnerable subtypes, yet the DSM-5 criteria focus exclusively on grandiose narcissism, overlooking the more introverted, hypersensitive manifestations of the disorder. This limitation has been criticized for failing to capture the full spectrum of narcissistic pathology. Given the complexities of NPD, different therapeutic approaches have sought to improve the overall functioning of individuals with the disorder, each offering unique insights into how to facilitate emotional growth and interpersonal change.

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# CHAPTER 8

## Histrionic Personality Disorder

Histrionic personality disorder is a personality disorder characterized by a persistent desire to be the center of attention, an attention-seeking and well-groomed appearance, theatrical behaviors, and superficial emotionality. Sometimes referred to as "hysterical personality," this disorder is classified in Cluster B of the DSM-5, which includes personality disorders involving dramatic or erratic behaviors. Closely related to the concept of hysteria, histrionic personality disorder traces its roots back to ancient times when hysteria was first introduced in medical literature and practice—though it is no longer recognized as a medical diagnosis in contemporary diagnostic manuals. This chapter aims to provide a comprehensive overview of histrionic personality disorder from multiple perspectives.

### The History of Histrionic Personality Disorder

To explore the history of histrionic personality disorder, it is best to begin with the origins of the concept of hysteria. The term "hysteria" derives from the Greek word *hystera*, meaning "uterus" (Budak, 2000). The naming of the disorder after an organ specific to the female body reflects the early belief that hysteria was exclusive to women and resulted from uterine abnormalities (Lewis & Mastico, 2017). According to Hippocrates, one of the causes of hysteria was a lack of moisture in the uterus. Following this idea, Plato suggested that sexual intercourse could serve as a functional treatment for the disorder (Çoban, 2020).

During the Middle Ages, this perspective was replaced by an entirely opposite belief: hysteria came to be associated with sexual pleasure, demonic possession, and witchcraft (Novais, Araujo, & Godinho, 2015). In the Renaissance, the prevailing belief continued to be that hysteria was a condition exclusive to women, emerging as a result of certain genital anomalies.

Until the 19th century, many researchers investigated the causes and symptoms of hysteria, attributing it at times to biological differences in the

brain, at other times to uterine anomalies, and sometimes to sexual frustrations (Gilman et al., 1993, as cited in Novais et al., 2015).

In the 19th century, Jean-Martin Charcot (1825–1893) introduced a neurological approach to hysteria, providing a new perspective by identifying and classifying hysteria crises and their stages (Sheppard, 2012). One of Charcot's students, Sigmund Freud, collaborated with Dr. Joseph Breuer to publish *Studies on Hysteria* in 1895, presenting their theoretical framework on hysteria. Later, in 1896, Freud expanded on this theory in his work *The Etiology of Hysteria* (Abdullah, 2016).

In *Studies on Hysteria*, Freud discussed his own cases, while Breuer presented the case of Anna O. In this work, they introduced the "cathartic method," a technique involving patients expressing the life events and emotions that triggered their symptoms (Putgül Köybaşı, 2020). Breuer treated Anna O. (real name: Bertha Pappenheim) for symptoms including muscle spasms, temporary paralysis, sleep and eating disorders, a sudden shift from speaking her native German to exclusively speaking English, and spontaneous hypnosis every evening. The cathartic method emerged during the year of her treatment (Sheppard, 2012).

In the following years, Freud continued his research on hysteria with Anna O. and other patients. Over time, he abandoned hypnosis and developed methods such as concentration technique and free association, introducing concepts like transference and the unconscious. These developments are regarded as the foundation of psychoanalysis in the literature.

Hysteria was not included as a diagnostic category in the first edition of the DSM. However, in DSM-II (American Psychiatric Association [APA], 1968), it was classified as a personality disorder characterized by excitability, emotional instability, excessive reactivity, and dramatization. In DSM-III, published in 1980, the term "hysterical personality disorder" was replaced with "histrionic personality disorder" due to the historical association of hysteria with women, which created a bias problem (Lewis & Mastico, 2017). The term *histrio* comes from Latin, meaning "theatrical," and does not carry any gender connotations, making it more consistent with the disorder's characteristics. In the currently used DSM-5 (APA, 2013), the disorder continues to be referred to as histrionic personality disorder.

### Diagnostic Criteria

The diagnostic criteria for Histrionic Personality Disorder as defined in the DSM-5 (APA, 2013) are listed as follows:

A pervasive pattern of excessive emotionality and attention-seeking behavior that begins in early adulthood and manifests in a variety of contexts, as indicated by five (or more) of the following:

1. Feels uncomfortable when not the center of attention.
2. Interactions with others are often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow emotions.
4. Consistently uses physical appearance to draw attention.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Exhibits exaggerated, theatrical, and dramatic emotional expressions.
7. Is easily influenced by others or circumstances.
8. Considers relationships to be more intimate than they actually are. (p. 333)

### Comorbidity

Studies have shown that somatization disorders (Atasoy, 2019), narcissistic personality disorder, borderline personality disorder, dependent personality disorder (Perrotta, 2021), antisocial personality disorder, substance abuse, and sexual disorders are among the most common comorbid conditions associated with histrionic personality disorder (Köroğlu & Güleç, 2007).

### Differential Diagnosis

When diagnosing histrionic personality disorder, clinicians may ask the client questions about how their relationships with others begin and end, how others perceive them, and what complaints others have about them (Beck et al., 2008). The responses to these questions can be instrumental in

identifying behavioral and cognitive patterns characteristic of histrionic personality disorder.

*Narcissistic Personality Disorder*

Both narcissistic and histrionic individuals seek attention, but the type of attention they desire differs. For histrionic individuals, the nature of the attention is irrelevant—they feel satisfied even if others think negatively about them, as long as they receive attention. In contrast, narcissistic individuals seek admiration and praise (Perrotta, 2021). Additionally, while histrionic individuals actively engage in role-playing and effort to gain attention, narcissists believe they inherently deserve attention and admiration and do not actively seek it (Köroğlu & Güleç, 2007).

*Borderline Personality Disorder*

Unlike individuals with histrionic personality disorder, those with borderline personality disorder frequently experience relationship breakdowns due to outbursts of anger (Köroğlu & Güleç, 2007). Furthermore, borderline individuals experience intense and deep emotions and have a negative self-image, whereas histrionic individuals, despite their self-esteem being dependent on how others perceive them, do not have a negative self-image (Perrotta, 2021).

*Dependent Personality Disorder*

Like histrionic individuals, those with dependent personality disorder also desire close interpersonal relationships. However, individuals with dependent personality disorder are more restrained and submissive due to their fear of rejection, whereas histrionic individuals appear enthusiastic and do not feel repressed (Perrotta, 2021).

*Antisocial Personality Disorder*

Both histrionic and antisocial individuals exhibit manipulative behaviors. However, while antisocial individuals use manipulation for tangible benefits such as privileges and financial gain, histrionic individuals

engage in manipulative behaviors to satisfy their need for attention and approval (First, 2013, cited in Atasoy, 20190).

**Prognosis**

Histrionic personality disorder symptoms begin in early adulthood (APA, 2013) and persist throughout life; however, due to a decrease in energy levels, the severity of symptoms tends to diminish with age (Sadock & Sadock, 2008, as cited in Atasoy, 20191). Individuals suffering from histrionic personality disorder generally have a high level of functionality.

**Epidemiology**

The prevalence rate in the general population is 2–3%, and it is more commonly observed in women compared to men (Köroğlu & Güleç, 2007). Some perspectives suggest that this gender difference arises because diagnostic criteria emphasize feminine characteristics. It is estimated that if diagnostic bias were eliminated, the rate of diagnosis of histrionic personality disorder would not show a significant gender difference (Atasoy, 2019).

**Etiology**

Various perspectives in the literature offer different explanations for the factors contributing to the development of histrionic personality disorder.

The psychodynamic perspective suggests that the development of histrionic personality disorder is influenced by faulty parenting styles and problematic family environments. According to this view, it is common for histrionic individuals to form faulty identifications with the parent of the same sex and to develop seductive relationships with the parent of the opposite sex (Köroğlu & Bayraktar, 2011). This is primarily attributed to the neglectful attitudes of the mother. A baby who desires care from the mother learns to engage in exaggerated behaviors to attract attention, and these behaviors persist into later life. Additionally, the excessive femininity and masculinity observed in histrionic individuals are believed to stem from the same situation. A girl neglected by her mother learns to gain the attention she needs through affectionate behaviors toward her father, which later manifests as excessive femininity and seductive traits (Atasoy, 2019). Male histrionic

individuals, on the other hand, interpret their neglect by their mothers as "being chosen over by another man." The underlying motivation behind their exaggerated masculine behaviors and appearances is either to compensate for this neglect or to avoid experiencing a similar situation again (Gabbard, 2014, as cited in Atasoy, 2019, p. 13).

The psychosocial perspective also emphasizes the early years of life in the development of histrionic personality traits. According to this view, histrionic individuals faced significant difficulties in having their care needs met during infancy. They were appreciated by their parents for being entertaining and attractive but were not valued for their intrinsic characteristics. Since they only received the care they needed when they were sick, it is frequently observed that they display illness-like behaviors in adulthood (Perrotta, 2021).

The cognitive-behavioral approach asserts that personality disorders arise as a result of learned experiences, particularly in early life, and that emotions are shaped by thoughts. According to this perspective, histrionic individuals develop a belief in "self-inefficacy" due to the parental attitudes they perceive in their early years. This belief leads to the perception that they are dependent on others, which, in turn, causes them to desire continuous close relationships and to seek constant attention (Atasoy, 2019).

From a biological perspective, the excessive sensitivity and attention-seeking behaviors of histrionic individuals are considered to be related to their temperament, meaning these traits are innate (Perrotta, 2021). Some studies also suggest that the exaggerated expression and variability of emotions in histrionic individuals stem from certain differences observed in the hypothalamus (Sperry, 2004, as cited in Atasoy, 2019, p. 14).

## Clinical Presentation

### Sexuality

The seductive appearance and sexually suggestive speech of histrionic individuals may lead to the assumption that they have highly active sexual lives. However, individuals suffering from histrionic personality disorder often experience difficulties engaging in sexual intercourse. One study

highlighting this finding was conducted by Apt and Hurlbert (1994). According to the results, women diagnosed with histrionic personality disorder exhibited significantly higher rates of orgasmic disorders, low sexual desire, and sexual boredom compared to women without the diagnosis. From a psychodynamic perspective, this situation arises because histrionic individuals unconsciously substitute their intimate partners for their parents, from whom they did not receive the expected attention in early childhood. As a result, they may perceive their sexual experiences as incestuous.

**Suicide**

Suicidal behaviors can be observed in individuals suffering from histrionic personality disorder. In a study conducted by Slavney and McHugh in 1974, it was found that 80% of a sample of 32 hospitalized patients diagnosed with histrionic personality disorder exhibited suicidal tendencies, depression, or both; however, most of the suicide attempts did not pose a significant life-threatening risk (cited in Beck et al., 2008, pp. 329-330). While suicide attempts may serve as a means of attracting attention, as seen in the study sample, in cases where depression is also present, the intent to end one's life may be genuine. Therefore, special caution must be taken in therapy when addressing suicidal tendencies or behaviors.

**Conversion Symptoms**

Some individuals with histrionic personality disorder exhibit conversion symptoms, such as fainting. These symptoms emerge as a defense mechanism that projects psychological distress onto the body in an attempt to divert the mind from traumatic thoughts (Abdullah, 2016).

**Core Beliefs**

A fundamental core belief of histrionic individuals is that they must be the center of attention (Atasoy, 2019). When they are not the focus of attention, they tend to feel worthless and inadequate. Köroğlu and Bayraktar (2011) provided examples of such core beliefs, including: "If I cannot maintain others' interest in me, they will not love me," "I cannot tolerate boredom," "Unless I act excessively, people do not pay attention to me," and "If I can entertain people, they will not notice my weaknesses" (p. 83).

### Subtypes of Histrionic Personality Disorder

Millon and colleagues (2004) identified six common subtypes of histrionic personality disorder. These subtypes are listed below.

### Appeasing (Soothing) Subtype

Individuals with this subtype exhibit behaviors aimed at reconciling differences, soothing conflicts, offering constant praise, avoiding arguments even at the expense of compromising their own desires, and calming others even at the cost of personal harm. They desire to be seen as innocent or as victims. Dependent and compulsive traits are frequently observed in individuals with this subtype (Millon et al., 2004).

### Life-Filled Subtype

These individuals synthesize the fundamental characteristics of histrionic personality, namely charm, with a very cheerful and life-filled demeanor. Their behavior and speech exhibit impulsive expressiveness, and they can be described as "fickle." Narcissistic traits are commonly observed in most individuals suffering from this disorder (Millon et al., 2004).

### Turbulent Subtype

Individuals with this subtype exhibit personality traits such as pessimism, excessive reactivity, dramatization, hypersensitivity to criticism, and intolerance to disappointment. Behavioral patterns include frequent boredom, oscillation between highly positive and highly negative emotional states, and frequent use of illnesses to gain attention (Millon et al., 2004).

### Insincere Subtype

These individuals often possess antisocial personality traits. Initially, they appear sincere and sociable, reducing their interlocutor's defensive motivations in relational contexts. They then exploit this situation for manipulative behaviors aimed at satisfying their histrionic attention-seeking. They do not adhere much to social contracts and are highly self-centered (Millon et al., 2004).

### Theatrical Subtype

Individuals of this subtype modify their exhibited characteristics according to the expectations and attributes of their environment. Their primary goal is to be perceived as attractive and seductive (Millon et al., 2004). These individuals enjoy assuming the role of a "sexual object," meaning they prefer to appear as charming rather than possessing inner depth. They frequently engage in flirtatious behaviors.

### Childlike Subtype

Borderline personality traits are observed in these individuals. They exhibit highly demanding attitudes toward significant figures in their lives and develop dependent relationships. Their emotions change unpredictably, and they often complain about feeling unloved or being treated unfairly (Millon et al., 2004).

### Defense Mechanisms

The most frequently used defense mechanisms by histrionic individuals include identification, repression, externalization, regression, denial, conversion, somatization, and dissociation (Köroğlu & Bayraktar, 2011). It is known that for both genders, there is a positive correlation between perceiving oneself as highly attractive and the tendency to use immature defense mechanisms (Bornstein, 1999).

The **identification** defense mechanism emerges during adolescence and adulthood when individuals start considering the groups they belong to in their self-evaluations (Geçtan, 2017). Since the group they are part of and that group's attitudes toward them hold excessive importance for histrionic individuals, the use of identification defense mechanisms is more prevalent among them. This excessive reliance may also lead to adverse consequences, such as depression, if the group's attention is lost.

Histrionic individuals are genuinely unaware that they try to act seductively, feel uncomfortable when they are not the center of attention, or that their behavior and appearance are often exaggerated. This lack of awareness is due to their use of the **repression** defense mechanism. This

mechanism allows the individual to distance inappropriate desires and memories from consciousness, preventing them from recognizing the disconnect between repressed material and reality (Geçtan, 2017).

Unlike other defense mechanisms, the use of **denial** creates a dual impact in terms of primary gains in the lives of histrionic individuals. Due to this mechanism, they can overlook their manipulative and sexually provocative behaviors. On the other hand, the denial mechanism also leads to ignoring knowledge and skills, resulting in feelings of helplessness (MacKinnon et al., 2016, as cited in Atasoy, 2019, p. 6).

The **conversion** defense mechanism enables individuals to avoid distressing situations or keep unpleasant thoughts and emotions in the unconscious. This mechanism manifests through physical illness symptoms that have no biological cause and is also known as "conversion-type histrionic neurosis" (Geçtan, 2017). The fainting episodes observed in histrionic individuals serve as a concrete example of this defense mechanism.

The activation of the **somatization** defense mechanism is characterized by directing one's aggressive impulses toward their own body (Geçtan, 2017). This defense mechanism, frequently seen in histrionic individuals, is closely related to the belief that being ill is a good reason to attract attention from others.

**Intervention Methods**

A common view regarding the motivation of individuals suffering from histrionic personality disorder to seek treatment is that they voluntarily apply to psychiatric clinics with various complaints (Köroğlu & Güleç, 2007). The most common reason for seeking treatment is their inability to cope with negative emotions following the end of a close relationship due to intense separation anxiety (Beck et al., 2008).

One important detail to keep in mind when conducting a psychotherapy process with histrionic individuals is that they determine their behavioral patterns according to the person they are interacting with. Even if the client appears to have accepted the therapist, is satisfied with the therapy

process, and shows improvement, this may be due to their desire to meet perceived expectations.

The possibility of transference is also one of the key issues that must be carefully considered in psychotherapy sessions with histrionic individuals. Transference can always emerge in psychotherapy sessions; however, if the therapist fails to recognize the transference that occurs when working with histrionic individuals, feels like a hero, and manages the process with these emotions, no recovery can be achieved. On the contrary, deeply ingrained thoughts associated with histrionic personality disorder may become even stronger (Beck et al., 2008).

There is no specific medication for the treatment of histrionic personality disorder (Daş, 2020). However, when pharmacotherapy is used to treat accompanying disorders, the possibility of the patient misusing medication should be considered (Köroğlu & Güleç, 2007). Individuals with histrionic personality disorder may exhibit suicidal behavior to gain the desired attention. The primary aim of this behavior is not to end their life but to attract attention. Therefore, instead of using definitive methods such as firearms, they are more likely to choose methods that can be quickly remedied with medical interventions, such as taking a large number of pills at once.

The treatment of histrionic personality disorder, like the treatment of other personality disorders, takes a long time.

**Dynamically Oriented Supportive Psychotherapy**

Supportive psychotherapy interventions are functional in the treatment of histrionic individuals due to their susceptibility to influence and suggestibility (Köroğlu & Güleç, 2007). Dynamically oriented supportive psychotherapy interventions aim to enhance the client's ability to adapt and express their inner experiences, increase their level of insight, and strengthen their self-efficacy beliefs (Tunç, 2019). During therapy, priority is given to providing a safe space where the client can express emotions; defense mechanisms are not addressed unless they lead to maladaptive behaviors; and when the therapist is exposed to the client's negative emotions, they continue the therapy process, thereby offering an experience that serves as a model for social acceptance (Gabbard, 2009, as cited in Tunç, 2019, pp. 160-163).

**Schema Therapy**

Schema therapy is based on the idea that psychological disorders stem from early maladaptive schemas. According to the prevailing view, histrionic personality disorder emerges as a result of neglectful parental attitudes perceived during the early years of life. These two parallel approaches indicate that schema therapy is a suitable intervention method for the treatment of histrionic personality disorder.

In a study conducted by Lobbestael et al. (2008), the most commonly observed modes in individuals suffering from histrionic personality disorder were found to be the "impulsive child" and "wounded child" modes. When working with these modes, the therapist teaches the client how to cope with dysfunctional defense mechanisms using the "limited reparenting" method (Şenkal & Kaynar, 2017). Limited reparenting is a method in which the therapist, within the framework of the therapeutic relationship, meets the unmet emotional needs that led to the development of the disorder (Ar, 2014).

Experiential techniques are also used in schema therapy. An example of this would be asking the histrionic client, during the therapy process, to talk as if they were speaking to their parent, expressing their needs and expectations regarding the neglect they experienced in childhood while imagining themselves in those neglected periods.

**Cognitive Behavioral Interventions**

When using cognitive behavioral intervention methods, the client's automatic thoughts are first identified. Direct questioning and guided discovery techniques can be used to determine automatic thoughts. The direct questioning method involves asking the client what thoughts went through their mind when experiencing the emotions or behaviors they complain about, or what they were thinking while discussing life events that led to negative emotions (Türkçapar, 2018). The automatic thoughts of histrionic individuals are often linked to the belief that they are unloved, inadequate, and helpless. Identifying these automatic thoughts in histrionic individuals may take time due to their use of the defense mechanism of denial.

In the guided discovery method, an attempt is made to identify the momentary thoughts that the client has difficulty recalling (Türkçapar, 2018). If the client states that they are unaware of the thoughts causing them to feel bad, they are asked to describe the moment when these negative emotions arose. This helps the client realize that these emotions do not emerge without reason but rather result from automatic thoughts, increasing their awareness of which thoughts generate negative emotions. This awareness will help histrionic individuals develop skills to cope with feelings of helplessness.

The problem-focused nature of cognitive behavioral methods and their goal of improving interpersonal relationship skills can lead to resistance to treatment in histrionic individuals. Overcoming this resistance is possible if the therapist establishes a cooperative relationship with the client and manages the process flexibly and patiently. By the end of the process, the client will acquire a new way of perceiving (Beck et al., 2008).

In the treatment of histrionic personality disorder, tasks such as writing down automatic thoughts and noting the pros and cons of daily experiences are effective ways to enhance awareness that emotions can be controlled. Additionally, techniques such as asking the client about their favorite movies and songs during sessions can help them develop skills to cope with feelings of inadequacy (Atasoy, 2019).

For histrionic clients, cognitive behavioral homework assignments may seem like a waste of time or appear boring. If motivation to complete these tasks cannot be sustained, adaptations that seem more enjoyable and functional to the client can be made. For example, when writing about their daily reactions as a homework task, the client can be encouraged to be dramatic as well as realistic. Alternatively, during a session, the therapist can act out the client's automatic thoughts and ask the client to respond in a manner that aligns with the scenario (Beck et al., 2008). This approach strengthens the client's motivation to continue therapy.

"Assertiveness training," which is used to develop social skills such as refusing requests or expressing disagreement (Güneş, Arslan, & Eliüşük, 2014), is a particularly functional method for histrionic individuals, especially those of the appeasing (soothing) subtype. This method aims to teach the client how to use communication elements such as tone of voice, body

posture, speech content, and facial expressions. In therapy, these skills are practiced in work-related contexts.

Another technique from social skills training, "expanding the response repertoire," can also be used in therapy with histrionic clients. This technique helps prevent histrionic individuals from displaying conversion symptoms instead of defending themselves or expressing anger in response to negative life events.

Histrionic individuals tend to spend a large portion of therapy sessions dramatically recounting their daily experiences from the past week. In such cases, the therapist can allocate a clearly defined portion of each session to these topics (Beck et al., 2008). This way, the client's tendencies are not directly challenged, and at the same time, their weekly experiences are reviewed.

**Gestalt Therapy**

Gestalt therapy can be adapted and applied to all clients in need of psychotherapy, and in this psychotherapeutic approach, therapists are encouraged to be creative in their interventions and to experiment (Corsini & Wedding, 2012). Gestalt therapists often adopt an eclectic approach. Therefore, it can be said that the number of techniques that can be used in this approach is countless. However, some fundamental Gestalt techniques that can be applied when working with a histrionic client are explained below.

The **role-playing technique** can be used in various ways in the psychotherapy of histrionic individuals. If the client's emotions and thoughts are related to a specific person present in the therapy room, they may be encouraged to express these feelings directly to that person. If the relevant person is not present, the **empty chair technique** can be used, where the client role-plays as if the person were there and expresses their emotions and thoughts (Corsini & Wedding, 2012). Through this technique, the emotions and needs that the client has been trying to suppress since childhood are acknowledged and addressed in the "here and now."

Another technique that can be used in the therapy of histrionic clients is the **dialogue technique**. This method aims to establish communication

between the polarities of the client's personality and to achieve integration within the personality (Kunter Balcı, 1995). By using this technique, the histrionic individual's **denied needs and negative emotions** can be brought into conscious awareness.

There may be instances where a histrionic client struggles to connect with their **childhood self**. In such cases, **photo exercises** can be used (Daş, 2020). This technique involves the client bringing a childhood photograph to therapy. The client is then asked to establish a dialogue with the photo—speaking both as their present self and as their childhood self. This helps the client connect their early life experiences with their present self and recognize their unmet needs.

**Dream work** is another concept explored in Gestalt therapy. When discussing a client's dream in therapy, it is assumed that all elements within the dream represent parts or characteristics of the self. This method helps uncover unconscious mechanisms that the client may find difficult to verbalize but that significantly impact their life.

The concept of **contact** holds a crucial place in the Gestalt approach. Contact allows a person to recognize the distinction between themselves and their environment, defining the boundary between the self and the surroundings (Daş, 2020). The histrionic individual's belief in the necessity of being the center of attention suggests an inability to perceive this boundary. Through **awareness of contact**, the client can begin to recognize this distinction.

**Group Therapy**

Group therapy provides clients with a space where they can **practice social skills** and learn to build **supportive relationships** (Gabbard, 2007). In this context, group therapy can be considered an effective treatment environment for histrionic individuals. Being part of a **supportive group** where their **demanding and insincere behaviors are not positively reinforced**, yet where they are accepted unconditionally in exploring the dynamics behind these behaviors, can help them learn to form genuine relationships **instead of relying on seduction or attention-seeking behaviors**.

**An Example of a Histrionic Character in Cinema: Angela from *American Beauty***

The character Angela from the 1999 American film *American Beauty* exhibits behavioral patterns reminiscent of histrionic personality disorder. Although Angela's age does not align with the DSM-5 diagnostic criteria for histrionic personality disorder, her behaviors provide a strong example for understanding this condition.

Angela is a high school student and is popular among her peers. She attracts attention with her beauty and takes great care of her appearance. In various scenes of the film, she is seen telling her friends that she has had sexual relationships with many people. From these scenes, it is inferred that those around her perceive her as having an active sexual life.

Angela frequently visits the home of her close friend, Jane. During these visits, Jane's father, Lester, repeatedly shows interest in Angela. Aware of Lester's attention, Angela enjoys the situation and chooses to appear "seductive" when interacting with him. Histrionic individuals tend to engage in sexual relationships with inappropriate people in inappropriate contexts. In this case, Lester is an unsuitable partner for Angela both contextually, as he is her friend's father and a married man, and in terms of age, as he is in his 40s while Angela is still an adolescent.

Despite these inappropriate circumstances, Angela and Lester experience a moment of sexual intimacy toward the end of the film. During this scene, Angela confesses that she has never actually had a sexual relationship before. This confession aligns with the tendency of histrionic individuals to display sexually provocative behavior while simultaneously harboring fears or hesitations about actual sexual intimacy.

In some scenes, Angela states, "Being ordinary is awful." This statement reflects her inclination toward behaviors that make her appear unconventional in order to attract attention.

Angela spends a lot of time with Jane, but given her popularity and concern for her appearance, one would expect her social circle to consist of people similar to herself. However, Jane does not resemble Angela in this

regard. Toward the end of the film, Jane's boyfriend suggests that Angela's real motivation for maintaining a friendship with Jane is the pleasure of having someone around who makes her feel more beautiful in comparison. Considering the validity of this idea, the number of Angela's behaviors that align with histrionic personality disorder seems even greater.

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# Cluster C (Anxious and Fearful) Personality Disorders

Cluster C personality disorders are characterized by pervasive anxiety, fearfulness, and a strong need for control or reassurance. Individuals with these disorders often struggle with chronic feelings of insecurity, excessive worry, and difficulties in making independent decisions. Unlike Cluster A, which is marked by social detachment, and Cluster B, which involves emotional volatility, Cluster C disorders primarily revolve around avoidance, dependence, and rigid adherence to rules or perfectionism.

This cluster includes **avoidant, dependent, and obsessive-compulsive personality disorders**, each presenting unique challenges in social and occupational functioning. People with these disorders may be perceived as overly cautious, submissive, or perfectionistic, often leading to struggles in relationships and work environments. Their fear-driven behaviors and need for certainty can result in social isolation, excessive reliance on others, or an overwhelming preoccupation with order and control.

While **avoidant personality disorder** is characterized by intense social inhibition, fear of rejection, and feelings of inadequacy, **dependent personality disorder** involves an excessive need for reassurance, difficulty making decisions, and a fear of being alone. **Obsessive-compulsive personality disorder**, on the other hand, is marked by perfectionism, a rigid need for control, and an excessive focus on rules, order, and efficiency. The first personality disorder to be discussed is **avoidant personality disorder**.

# CHAPTER 9

## Dependent Personality Disorder

Dependent Personality Disorder is characterized by difficulty in living independently, a strong need to be in close relationships with others, lack of self-confidence, and prioritization of others' needs and desires over one's own. Individuals with this disorder constantly seek someone who can make decisions on their behalf and provide approval. Once they find such a person, they form a pathological attachment and exhibit submissive behavior, making any necessary concessions to avoid losing them. The DSM-5 diagnostic criteria for Dependent Personality Disorder are shown in Table 1.

### DSM-5 Diagnostic Criteria for Dependent Personality Disorder

A pervasive and excessive need to be taken care of, leading to submissive and clinging behavior and fears of separation, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following (APA DSM-5, 2014, p. 335):

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of their life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution.)
4. Has difficulty initiating projects or doing things on their own (due to a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering for unpleasant tasks.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for themselves.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.

8. Is unrealistically preoccupied with fears of being left to take care of themselves.

**ICD-10 Diagnostic Criteria for Dependent Personality Disorder**

A personality disorder characterized by the following:

(a) Encouraging or allowing others to make most of one's important life decisions.

(b) Subordinating one's own needs to those of others and being excessively compliant with their wishes.

(c) Unwillingness to make even reasonable demands on the people one depends on.

(d) Feeling uncomfortable or helpless when alone because of exaggerated fears of being unable to care for oneself.

(e) Preoccupation with fears of being abandoned by a close person and having to fend for oneself.

(f) Limited ability to make everyday decisions without excessive advice and reassurance from others.

Associated features may include perceiving oneself as helpless, incompetent, and lacking endurance. Included terms: asthenic, inadequate, passive, and self-defeating personality (disorder) (WHO, 1992, pp. 206-207).

**Comorbidity**

Comorbidity is observed in individuals with dependent personality disorder, particularly in the form of alcohol misuse motivated by stress reduction (Evren, 2004). Additionally, a study conducted by Loas et al. (2002) tested the comorbidity between dependent personality disorder and separation anxiety. The findings of the study concluded that dependent personality disorder is associated with separation anxiety in healthy individuals,

individuals with alcohol and substance dependence, and individuals with anorexia and bulimia.

**Epidemiology**

It has been reported by Köroğlu and Bayraktar (2010) that dependent personality disorder constitutes 2.5% of all personality disorders and is more frequently observed in women than in men.

**Etiology**

The majority of perspectives regarding the origins of dependent personality disorder are based on psychosocial factors. According to the psychoanalytic theory, which explains dependent personality disorder, individuals exhibiting patterns of dependent personality disorder are fixated at the oral stage, the first stage of psychosexual development. This theory argues that orally fixated, or orally dependent, individuals remain dependent on others for nourishment, protection, and guidance and continue behaviors similar to those in this stage into adulthood (e.g., excessive preoccupation with oral activities and using eating as a coping strategy) (Bornstein, 2012). Although research in this area is limited, it is believed that frustration or excessive gratification during the oral stage can lead to high levels of dependency (Faith, 2009, citing Bornstein, 1996).

Many assumptions regarding the role of psychosocial variables in dependent personality disorder are based on the parent-child relationship. Parenting styles, which express parents' attitudes and behaviors toward their children, influence children's dependency behaviors. Bornstein and Bornstein (1992) state that authoritarian and overprotective parenting styles reinforce children's dependent behaviors while inhibiting their independent and autonomous behaviors. In both of these parenting styles—albeit for different reasons—children’s new initiatives are not supported by parents and are either interrupted or terminated due to parental intervention.

In the authoritarian parenting style, the reason parents restrict their children is their fear that the child might challenge the rules and prohibitions they have imposed or disregard their authority. A child raised under this parenting style develops the belief that they must submit to the wishes,

expectations, and demands of others to maintain good relationships (Bornstein, 1996, citing Ainsworth, 1969, and Baumrind, 1971). In the overprotective parenting style, however, the reason for restricting the child is the desire to take precautions against potential harm and protect the child. Children with overprotective parents may feel inadequate, powerless, and in need of protection, leading them to develop a negative self-image. Consequently, in later life, they may feel the need for another person to help them make decisions, make choices, and take responsibility, and they may develop the belief that their needs will continue to be met by this other person. These parents hold irrational beliefs that their children's independence will lead to disaster and that every moment is filled with dangers. The fears they transmit to their children through these beliefs may evolve into scenarios where the child perceives trusting themselves as catastrophic in later years (Millon, Grossman, Millon, Meagher, & Ramnath, 2004).

**Interpersonal Characteristics**

Millon et al. (2004) state that individuals with dependent personality disorder assume a passive role in their relationships, live their lives for others, and feel happy only when the people they value are happy. These individuals are generally known to be compliant in relationships, and in reality, they are the submissive party in the relationship due to the anxiety and fear that their dependency brings. To cope with the anxiety caused by the possibility of losing the other person, they frequently engage in behaviors such as apologizing excessively and buying gifts.

**Core Beliefs**

Understanding an individual's core beliefs in any personality disorder is crucial for both comprehending the person better and determining the appropriate intervention method. The core beliefs held by individuals with dependent personality disorder, as well as those they are likely to hold, have been categorized and exemplified by researchers in Table 3 (Köroğlu & Bayraktar, 2010; Millon et al., 2004).

**Table 1.** Core Beliefs in Individuals with Dependent Personality Disorder

| Source of Belief | Core Belief |
|---|---|
| **Negative Self-Perception** | "I am weak and powerless; I need others." |
| | "Trusting myself is not wise." |
| **Intense Fear and Anxiety Related to Being Alone or Abandoned** | "Being abandoned and alone is the worst thing that can happen to me." |
| | "There must always be someone to tell me what to do or to help me when I face difficulties." |
| **Submissiveness to Maintain Relationships and Conditions Imposed by Others** | "I must avoid behaviors and choices that might hurt or anger the person who is with me and helps me." |
| | "If I am to benefit from the security that this relationship provides, I must improve myself in certain areas." |

## Intervention Methods for Dependent Personality Disorder

Individuals with personality disorders lack the insight to recognize their own problems and seek help. They are often compelled to undergo treatment by their close ones when their maladaptive behaviors begin to cause issues in relationships or when their mental and somatic symptoms become complicated (Cloninger & Svrakic, 2008). However, individuals with dependent personality disorder develop interpersonal relationships centered on pleasing others, which provides certain advantages that facilitate treatment compared to other personality disorders (Simonelli & Parolin, 2017).

There are several crucial points that a therapist working with individuals with dependent personality disorder should consider. The therapist's authority and power provide a sense of security for the client, and the therapist is often perceived as an idealized caregiver who can rescue them (Millon et al., 2004). While this relationship may initially seem to indicate a

rapid and effortless change, it can reinforce dependency to a degree that may harm the therapeutic relationship. The client exhibits highly compliant behaviors to gain the therapist's approval and acceptance, attempting to create an image where the therapist is strong while they themselves are weak and in need of help. The therapist must be cautious about this dynamic and ensure that the therapeutic relationship evolves into a process involving secure attachment rather than a cycle reinforcing this dependency.

In this study, Schema Therapy and Gestalt Therapy, which emphasize early life experiences in psychotherapy interventions for dependent personality disorder, have been examined. These therapeutic approaches have been explored through a case example to provide a clearer understanding of their perspectives and applications regarding dependent personality disorder. The demographic details and life history of the case example are fictional.

Sinem is a 32-year-old married woman. She married her husband, Kemal, five years ago after dating for some time, and they do not have children. When examining Sinem's family background and childhood history, it is observed that she had an overly protective mother and a relatively balanced father who, although somewhat distant in comparison, provided adequate love and attention to his children. Three years before Sinem was born, her older brother had a severe household accident and was injured. As a result of this incident, the mother became extremely anxious and overly protective regarding her children, implementing increased safety precautions at home. She would check on Sinem and her brother at night to monitor their breathing and never left them alone at home until they started high school. She also intervened in even the most trivial daily decisions of her children, justifying her actions by prioritizing their safety. Sinem once stated, "While everyone else bought snacks after school, I couldn't, even if I had money, because I was afraid my mother would get mad." She recalls that all the conflicts between her parents stemmed from her mother's overprotective behaviors.

Sinem's decision to seek therapy was influenced by her husband's insistence. She wants to have a child, but her husband believes their marriage is not yet ready for that responsibility. He argues that Sinem's excessive dependency and suffocating behaviors are the primary reasons. During their dating period, Sinem experienced a brief breakup with Kemal, which led her

to develop major depression, requiring nearly a year of medication and psychotherapy. Sinem, who exhibits entrenched thought patterns related to dependent personality disorder along with associated interpersonal patterns, experiences intense anxiety at the thought of losing her husband. She frequently rereads his messages throughout the day to assess whether he is becoming distant. She is highly motivated to fulfill all of her husband's requests, viewing these extreme sacrifices as "the secret to a happy marriage and a woman's duty." She even stated, "As long as he is happy, I don't even cook the meals I like; I have gotten used to eating what he prefers."

Having a very limited social circle, Sinem mentions that people perceive her as a compliant person. However, she tries to minimize her participation in social gatherings because she fears being labeled as "a woman who neglects her husband" and worries about being cheated on. She also notes that her husband frequently expresses feeling overwhelmed by her behavior and insists that she should find a job or enroll in a course. Additionally, her husband, who opposes having a child at this stage, told her: "You can't even take care of yourself. You can't cook a meal without asking me first. If I come home two hours late, you call me 40 times. If something happens to me or if we break up, you'll fall apart again. Who will take care of the child? It's too early for us to have a child unless you change and I believe in that change." Upon hearing this, Sinem agreed to start therapy, stating that she was willing to do anything to regain her husband's trust and prove that she could be a good mother.

Upon analyzing this case example, it is evident that the client developed dependent personality traits due to an overly protective parental attitude. The role of the attachment figure from her childhood, her mother, has now been transferred to her husband in marriage. She experiences excessive anxiety over the possibility of losing her husband and prioritizes her marriage and husband's needs over her own. Furthermore, she chooses to be obedient to maintain her marriage, unconditionally accepting the conditions set by her husband.

Schema Therapy Approach in the Intervention of Dependent Personality Disorder

Schema therapy, a holistic method that integrates cognitive, experiential, behavioral, and interpersonal techniques, is an effective psychotherapy approach with proven efficacy in the treatment of personality disorders (Bamelis, Evers, Spinhoven, & Arntz, 2014). Expanding upon traditional cognitive-behavioral therapy, schema therapy focuses on the origins of psychological problems in childhood and adolescence, emotional techniques, the therapeutic relationship, and maladaptive coping strategies (Young, Klosko, & Weishaar, 2003).

The foundation of schema theory is based on the concept of early maladaptive schemas. These maladaptive schemas are assumed to develop as a result of negative experiences in early life and the failure to meet fundamental emotional needs (Gör, Yiğit, Kömürcü, & Şenkal Ertürk, 2017). Young et al. (2003) identified four types of early life experiences that contribute to the development of maladaptive schemas—deeply ingrained patterns of thinking and feeling that shape an individual's perception of themselves and the world. These early experiences often lead to negative core beliefs that persist into adulthood and influence personality traits and interpersonal relationships.

1. **Imbalanced Fulfillment of Needs**: When a child's fundamental emotional needs—such as love, security, validation, and autonomy—are either insufficiently or excessively met, maladaptive schemas can form. For example, a child who experiences inconsistent emotional support may develop a belief that relationships are unreliable, while one who is excessively indulged may struggle with self-discipline and frustration tolerance.
2. **Traumatization and Victimization**: Experiencing trauma, neglect, or abuse in early life can lead to the formation of schemas centered around fear, helplessness, and unworthiness. Children exposed to chronic mistreatment may internalize beliefs that they are powerless or undeserving of care, which can manifest in adulthood as patterns of self-sabotage, submissiveness, or heightened sensitivity to rejection.
3. **Exposure to an Overly Protective Attitude**: Overprotection by caregivers can hinder a child's ability to develop autonomy and

resilience. When parents excessively shield their child from challenges or discomfort, the child may internalize a belief that they are incapable of handling difficulties on their own. This can contribute to dependency, anxiety, and a lack of confidence in one's own abilities later in life.

4. **Selective Internalization and Identification with Significant Others**: Children tend to internalize the attitudes, behaviors, and beliefs of their caregivers or other significant figures in their lives. If a child observes a parent engaging in rigid, self-critical, or emotionally repressive behavior, they may adopt similar patterns. This process can shape the development of schemas related to self-worth, emotional expression, and interpersonal expectations.

Based on these early life experiences, Young et al. (2003) categorized maladaptive schemas into five broad dimensions:

1. **Disconnection/Rejection**: This dimension includes schemas that stem from a lack of secure attachment, emotional deprivation, or neglect. Individuals with these schemas may believe that others are untrustworthy, relationships are unsafe, or they are inherently unworthy of love. This can lead to social withdrawal, difficulty forming close connections, and heightened sensitivity to rejection.
2. **Impaired Autonomy and Performance**: This dimension encompasses beliefs related to dependency, failure, and lack of self-efficacy. Individuals with these schemas may feel incapable of handling responsibilities independently, struggle with self-doubt, and fear failure. Such patterns are often rooted in overly protective or controlling early environments that limited the development of personal competence.
3. **Impaired Limits**: This category includes schemas associated with entitlement, poor impulse control, and difficulty respecting boundaries. Individuals with impaired limit schemas may have trouble regulating their behavior, struggle with frustration tolerance, and exhibit difficulty adhering to social norms. These schemas often develop in children who were overly indulged or lacked structure in their upbringing.
4. **Other-Directedness**: This dimension involves schemas centered around prioritizing the needs and approval of others over one's own

desires and well-being. Individuals with these schemas may have deep-seated fears of disappointing others, leading to excessive compliance, self-sacrifice, or difficulty asserting their own needs. These patterns often develop in response to conditional love or the expectation of selflessness within the family environment.

5. **Hypervigilance and Inhibition**: This category includes schemas related to excessive self-control, emotional suppression, and an overemphasis on rules and performance. Individuals with these schemas may fear expressing emotions, avoid taking risks, and hold themselves to rigid perfectionistic standards. Such beliefs are often formed in childhood environments that emphasized criticism, punishment, or the suppression of emotions.

In the context of dependent personality disorder, maladaptive schemas related to **Impaired Autonomy and Performance** and **Other-Directedness** are particularly relevant. Individuals with this disorder often believe they are incapable of making decisions without guidance, fear abandonment, and rely excessively on others for emotional and practical support. By identifying these underlying schemas, schema therapy aims to help individuals challenge and restructure their core beliefs, ultimately fostering greater independence and self-confidence.

**Table 2.** Examination of Maladaptive Schemas and Core Beliefs in Schema Dimensions Observed in the Sample Case

| Schema Dimension | Core Beliefs |
|---|---|
| **Disconnection and Rejection** | **Belief in abandonment**: "I am afraid my spouse will leave me. That's why I call frequently and check messages to see if they are being distant." |
| **Mistrust** | "I have no one to rely on in this life except my spouse. If they leave me, I won't be able to continue my life." |
| **Impaired** | **Dependence/Incompetence**: "I am not capable enough to make decisions on my own. I need to consult |

| Schema Dimension | Core Beliefs |
|---|---|
| **Autonomy** | others even for small choices, like buying snacks after school or deciding on dinner." |
| **Enmeshment** | "My spouse's happiness is enough for both of us. If I make them happy and satisfied, then I deserve to be happy too." |
| **Other-Directedness** | **Subjugation**: "If my spouse wants something from me, they must have a good reason. I am attending therapy because they see it as necessary." |
| **Self-Sacrifice** | "If I spend too much time with my social circle, my spouse and household needs might suffer. If I sacrifice in this regard, everything will be fine, and our happiness will continue." |
| **Approval-Seeking** | "I am willing to do anything to prove to my spouse that I am a good wife and deserving of children." |
| **Hypervigilance** | **Pessimism**: "Being abandoned by my spouse and ending up alone is always a possibility—just like in the past." |
| **Unrelenting Standards** | "If I fail to be a good spouse and cannot prove to my spouse that I will be a good mother, I do not deserve to have children. Therefore, I must do my best to overcome this." |

*This table was adapted from the Early Maladaptive Schemas table by Gör et al. (2017).*

Gör et al. (201711) define maladaptive schemas as "…cognitive structures inherited from the past that provide a map for future experiences." These maladaptive schemas, which result from certain adversities experienced

in early life, are addressed in therapy using techniques such as limited reparenting and empathic confrontation, aiming to transform the client's maladaptive coping responses into more adaptive ones.

Through the "limited reparenting" technique, one of the methods used in schema therapy, the therapist aims to assist the client in fulfilling unmet childhood needs (Yakın, 2014). A common misconception about this technique is the belief that the therapist is trying to act as a parent in therapy and intends to foster dependency in the client. However, limited reparenting aims for the therapist to balance meeting the client's needs within their own boundaries to heal maladaptive schemas (Young et al., 2003).

Considering a case example, the client, Sinem, exhibits a behavioral pattern that inclines her to project certain dependency patterns onto her therapist. For instance, just as she checks for distance in her spouse's messages, she may also probe for distance in her therapist's statements or seek approval from her therapist for every decision she makes until the next session. In such a scenario, the therapist adopts a stance that supports the client's autonomy and clarifies boundaries, helping the client recognize the ideal form of relationship dynamics.

Another fundamental technique in schema therapy, empathic confrontation, aims to help the client gain awareness of the patterns that sustain their schema-driven behaviors and the underlying reasons for them (Yakın, 2014). Another goal of this technique is to show the client that while these schemas may have been adaptive coping mechanisms in early childhood, they are now maladaptive. It helps the client differentiate between past and present realities and accept their past (Young et al., 2003).

This technique must be applied carefully in cases of dependent personality disorder. If the therapist fails to maintain a balance between empathy and confrontation, it can negatively reinforce the client's existing maladaptive schemas. For example, a therapist who overly emphasizes the maladaptive nature of the schemas in a confrontational manner may inadvertently reinforce the client's belief that "I can't do anything right without others," thereby strengthening their maladaptive schemas of dependency and submission.

The following dialogue illustrates the use of this technique through a fictional case example:

**Client:** ...How do you think I should respond to my spouse's behavior? What should I say, for instance?

**Therapist:** Are you asking me to decide what you should say to your spouse? Am I understanding you correctly?

**Client:** Well, a little help wouldn't hurt. Whenever I come up with my own answers, I end up causing trouble for myself.

**Therapist:** I recall that your goal in coming here was to take more initiative and stand by your decisions. But now you believe that if you take responsibility, it will cause trouble for you. That seems a bit contradictory. Right now, what you're saying sounds like avoiding responsibility. Also, you said, "I cause trouble for myself." What evidence do you have for this?

**Client:** I mean, I make wrong decisions. Everything falls apart, things go bad. I wasn't referring to a specific incident. My mom used to say this a lot. "If children do something without asking their mothers, they will bring great trouble upon themselves and get hurt. Don't talk to strangers without asking me, don't stop anywhere after school." I guess it became a habit for me.

**Therapist:** Sinem, I see that you are using a phrase your mother said to protect you from dangers and strangers in childhood for an everyday decision now. I understand your perspective, and it's true that sometimes we may face unexpected dangers. However, this doesn't happen very often. From what I understand, you frequently anticipate such risks. How about talking about the things that make you feel on edge even in such ordinary situations?

As seen in the dialogue, the client projected her dependency schema onto the therapist by seeking help for a routine situation. The therapist first confronted the client by highlighting the contradiction between her goal and behavior. Then, adopting an empathic approach regarding her underlying schema, the therapist acknowledged the client's feelings while emphasizing that her maladaptive schema was not relevant to the present situation. Finally,

by asking a question, the therapist encouraged the client to engage in further discussion on the subject.

### The Gestalt Therapy Approach in the Intervention of Dependent Personality Disorder

The Gestalt therapy approach considers the individual as a whole, including the mind, body, and environment, emphasizing that growth and development occur only through contact with others. This approach focuses on needs, contact, and unfinished business. The Gestalt therapy perspective argues that self-development occurs through an individual's interaction with their environment, meaning through contact (Daş, 2020). Needs represent the motivations that drive a person to make contact. If an individual is blocked from making contact at any moment, either by themselves or by others, the contact ends before satisfaction is achieved, leading to unfinished business. Unfinished business continuously preoccupies the individual's mind without their awareness, making it difficult to stay present and causing discomfort. The fundamental goal of Gestalt therapy is to help clients gain awareness of how they do what they do, based on the assumption that increased awareness brings about change (Corey, 2015).

In the Gestalt therapy approach, there is no clear distinction between “healthy” and “psychopathological” (Francesetti, Gecele, & Roubal, 2013). From the perspective of diagnosis and psychopathology, labeling is rejected because it would fragment the uniqueness of the individual and carry the risk of transforming the client into an “other” to be worked on, which contradicts the humanistic perspective of the theory (Clarkson & Cavicchia, 2013). For this reason, the concepts of health and dysfunctionality are used instead. According to theorists and therapists who adopt the Gestalt approach, dysfunctional behavior is a creative adjustment that was developed in response to a challenging situation in the past. They argue that while this adjustment was functional at the time, it is no longer functional in the present (Murdock, 2018, citing Yontef & Jacobs, 2005).

When dependent personality disorder is examined through the Gestalt perspective on dysfunctionality, attention should be given to the creative adjustment behavior developed in response to past challenging experiences. The individual's persistent dysfunctional behaviors in the here and now result

from this creative adjustment. Fundamentally, all concepts within the theory are closely interconnected. Contact is necessary to fulfill a need. Any challenging experience or obstacle to contact during the moment of contact either makes contact difficult or completely terminates it. Consequently, an unmet need leads to unfinished business, which in turn causes discomfort and confusion in the individual. To cope with this, the individual develops a creative adjustment specific to the situation and uses it to overcome the tension caused by unfinished business. However, when this creative adjustment continues to be used in inappropriate situations over time, it results in dysfunctional behavior. The primary aim of Gestalt therapy is to help the client become aware of this process. According to Corey (2015), Zinker expects the client to: take responsibility for their thoughts, emotions, and actions instead of blaming others; move toward internal rather than external support; develop the ability to meet their own needs without disregarding the rights of others; and become competent in asking for, receiving, and giving help.

When dependent personality disorder is examined through the concept of contact in the Gestalt therapy approach, it is observed that individuals with this disorder frequently use the enmeshment contact style. Enmeshment refers to a contact style in which the boundary between individuals disappears or becomes very unclear, creating a sense of fusion between the “self” and the “other.” As seen in the case example, the client adopts the enmeshment contact style in interactions first with their mother and later with their spouse. The client has adapted to eating the foods their spouse prefers, has made many sacrifices in their own life for their spouse, and has even tied their own happiness to their spouse’s happiness. When working with such a client, the therapist's goal is to help the client become aware of their own needs, emotions, and choices and to understand that they can be loved and exist even when they differ from those around them (Daş, 2020).

In this process, the therapist should also strive to transform the client's language into “I” statements. Clients who use this contact style often employ the pronoun “we” and avoid personalizing events and situations. Additionally, frequently drawing attention to the client's needs and emotions in the here and now is a highly beneficial intervention. Below is an example of a possible intervention a therapist might use in this context:

**Client:** ...They don't see anything I do for us anyway. As a spouse, they don't need anything. Look, I do whatever is necessary for us, for our marriage. (Referring to attending therapy.)

**Therapist:** Sinem, I'd like you to pause for a moment and think. Independently of your marriage and your spouse, as an individual, what does Sinem need?

**Client:** I think our only need is a child. If we have a child, my spouse will see how good a mother I am.

**Therapist:** Sinem, you're still saying "we," but I am asking about your need. Let's try again. "My need is..."

**Client:** My need is... (pauses for a long time). My need is... I think my need is just... just to be understood. I realize this now. I've never asked myself this, and no one has ever asked me. (Eyes fill with tears.) Could it be that I want a child for this reason? So that my spouse understands me? Because if I can prove to them that I am a good mother, then I will feel understood.

Of course, such dialogues do not always progress this quickly. It has been kept brief and limited for the sake of the example. During this process, the client should be supported with exploratory questions and guided toward using "I" statements until they become aware of their needs and emotions.

A Gestalt therapist working with a person who has dependent personality disorder can support the individual in accepting the disowned and rejected aspects of their personality by using the internal dialogue exercise (Corey, 2015). The self of the individual is engaged in a dual struggle between a dominant voice and a submissive voice. The dominant voice is the internal controlling voice, which constantly tries to regulate the individual through "should" and "must" statements. The submissive voice, on the other hand, constantly plays the victim role, making the individual feel weak and inadequate. In this exercise, known as "Top Dog–Underdog," the goal is to have the dominant and submissive voices within the individual engage in a dialogue, allowing these two opposing poles of the personality to listen to and integrate with each other.

The exaggeration experiment—referred to as an experiment rather than a technique in the Gestalt approach—is another method used in therapy. The therapist asks the client to exaggerate and act out certain characteristics, aiming to increase the client's awareness. Recall the example of a fictional client who stated that they wouldn't even prepare dinner without asking their spouse. A therapist working with a client exhibiting dependency could ask them to exaggerate this behavior. For instance, the client might come up with statements like, "I need to call my spouse to inform them that I am drinking water," or "I should ask my spouse whether I should wash the colored or white laundry today." Through this exaggeration, the client gains awareness of their dependence on their spouse. This experiment can also be used for behaviors the client exhibits unconsciously. For example, if the client rubs their hands while talking about their mother, the therapist may draw attention to this and ask them to do it more. This helps the client become aware of their bodily reaction while discussing their mother. Since the Gestalt therapy approach considers the person as a whole—body, mind, and environment—bodily reactions serve as valuable material for therapy. Therefore, it is crucial for the therapist to be a keen observer of the client's bodily cues.

In summary, whether a therapist working with a person who has dependent personality disorder follows a Schema or Gestalt orientation, they must consider the client's past history. This is because both the origin of maladaptive schemas and the roots of creative adjustment stem from past experiences, usually childhood. While Schema Therapy focuses on the individual's beliefs and thoughts, Gestalt Therapy emphasizes needs and contact. When applied correctly, both therapy approaches are highly functional in helping individuals develop awareness of their dependent behavioral patterns and move their behaviors toward autonomy and independence. As with every personality disorder and therapeutic approach, the key factor here is the therapist's mastery of the disorder's origins, interpersonal relationship patterns, and ingrained beliefs. Additionally, the therapist must thoroughly understand the nature, methods, and limitations of the chosen approach and possess the necessary competence to apply it effectively.

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# CHAPTER 10

## Avoidant Personality Disorder

Avoidant Personality Disorder is classified under Cluster C personality disorders, which are known as the anxious and fearful cluster. Avoidant Personality Disorder affects individuals who are highly sensitive to situations such as rejection, criticism, and lack of acceptance, leading them to feel uncomfortable in social settings and interpersonal interactions (Davison & Neale, 2004). As a result, they may experience significant difficulties in social life. Since these individuals fear experiencing anxiety, they avoid being in the spotlight and refrain from engaging in attention-seeking behaviors (Karalonsky, 2019). Despite isolating themselves from social environments and avoiding interactions, they still harbor a desire for social acceptance.

Although individuals with Avoidant Personality Disorder escape anxiety through avoidance behaviors, this avoidance also brings other difficulties. Their reluctance to engage in social interactions makes them appear awkward, exposing them to ridicule and scorn from others (Köroğlu & Bayraktar, 2010). Those who expect acceptance in interpersonal relationships may find themselves trapped in a vicious cycle under such circumstances.

Additionally, individuals with Avoidant Personality Disorder experience emotional inadequacy, struggling to recognize and express their emotions (Antonella et al., 2021). For instance, they may fail to understand how certain experiences make them feel, struggle to identify their emotions, and find it difficult to perceive emotions in others' behaviors. Three core characteristics have been identified for Avoidant Personality Disorder: poor awareness of one's emotional and cognitive processes, maladaptive interpersonal schemas, and negative coping strategies (Antonella et al., 2021). These three features are also considered in treatment processes. Due to their maladaptive schemas, individuals with Avoidant Personality Disorder tend to view themselves as inadequate and incompetent, which reinforces their low self-esteem.

**DSM-5 Diagnostic Criteria for Avoidant Personality Disorder**

1. Avoids occupational activities that involve significant interpersonal contact due to fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships due to fear of being shamed or ridiculed.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views themselves as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or engage in new activities due to fear of embarrassment (APA, 2013).

Some studies in the literature categorize avoidant personality types into two subtypes: fearful avoidants and rejecting avoidants (Karalonsky, 2019). Fearful avoidants hold negative thoughts about both themselves and others, while rejecting avoidants hold positive thoughts about themselves but negative thoughts about others. However, both types desire interpersonal interaction but fear engaging in it (Karalonsky, 2019). Nonetheless, such a classification has not been widely recognized in other studies.

Certain characteristics of Avoidant Personality Disorder overlap with other psychological disorders, including Schizoid Personality Disorder, Dependent Personality Disorder, Depression, and Social Phobia (Sevinçok, Dereboy & Dereboy, 1998). The avoidance of social interaction and the presence of shallow emotions in individuals with Schizoid Personality Disorder resemble traits of Avoidant Personality Disorder. However, individuals with Schizoid Personality Disorder derive no pleasure from relationships, willingly isolate themselves, and view emotional expression as a weakness. In contrast, individuals with Avoidant Personality Disorder desire relationships but fear rejection and non-acceptance.

Similarly, Dependent Personality Disorder shares some features with Avoidant Personality Disorder, such as individuals' lack of self-confidence and their behaviors driven by fear of not being accepted by others. However, in Dependent Personality Disorder, these behaviors stem from an excessive need for care (APA, 2013). In Depression, individuals' concerns about negative evaluation by others align with traits observed in Avoidant Personality Disorder (Sevinçok, Dereboy & Dereboy, 1998).

The differential diagnosis that perhaps shows the most similarity to Avoidant Personality Disorder (AvPD) is Social Phobia. Due to the resemblance between Avoidant Personality Disorder and Social Phobia, it is thought that they may be related disorders (Sevinçok, Dereboy, & Dereboy, 1998). When examining the diagnostic criteria in DSM-5, it is noticeable that some diagnostic criteria for Social Phobia are similar to those of Avoidant Personality Disorder:

> 1. "A marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech)."
> 2. "The individual fears that they will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., be humiliating or embarrassing, lead to rejection, or offend others)."
> 3. "The social situations are avoided or endured with intense fear or anxiety" (APA, 2013).

When looking at the diagnostic criteria, it is observed that avoidance of social situations, anxiety, and impairments in work and social life due to avoidance are common features of both disorders (Sevinçok, Dereboy, & Dereboy, 1998). Social Phobia has both generalized and non-generalized types. In generalized Social Phobia, individuals generally experience anxiety in social environments, while in the non-generalized type, individuals fear specific social situations (Sayar et al., 2000). Given that Avoidant Personality Disorder involves persistent and enduring behavioral patterns and internal experiences, it is understood to share similarities with generalized Social Phobia. In a study conducted by Sayar et al. (2000), it was reported that 17 out

of 24 Social Phobia patients also had Avoidant Personality Disorder, and that anxiety and depression levels were found to be higher in generalized Social Phobia patients with co-occurring Avoidant Personality Disorder than in those without the personality disorder (Sayar et al., 2000). The same study noted that although there are overlaps in diagnostic criteria, the two disorders address different conditions. While Social Phobia emphasizes anxiety in performance situations, Avoidant Personality Disorder highlights inhibition in social interactions, and these conditions exhibit different levels of symptoms (Sayar et al., 2000).

### Explanations Regarding the Causes of Avoidant Personality Disorder

There are different explanations from various studies regarding the causes of Avoidant Personality Disorder. One such explanation relates to parenting styles (Karalonsky, 2019). The parental attitudes that occur when parents communicate with their children are important. In this regard, Diana Baumrind made a significant classification. Four parenting styles have been proposed:

1. **Authoritarian parenting style:** This parenting style is characterized by parents making constant demands on the child but rejecting or ignoring the child's requests. It is a punitive and restrictive parenting approach. Children raised with this parenting style may develop poor communication skills, become fearful and anxious.
2. **Authoritative (Democratic) parenting style:** This parenting style involves controlling and setting boundaries for the child while also encouraging independence in a supportive, warm, and regulated manner. Children raised with this parenting style may become self-confident, cooperative, and cheerful.
3. **Permissive parenting style:** This parenting style involves giving continuous attention to the child but not making any demands or exerting control. Children raised with this parenting style may become disrespectful to others, self-centered, and noncompliant.
4. **Neglectful parenting style:** This parenting style is characterized by a lack of interest in the child, making no demands on the child, and ignoring the child's needs and requests. Children raised

with this parenting style may have poor self-control, low self-esteem, and difficulties in social relationships (Santrock, 2014).

Neglect and deprivation experienced in early life can be risk factors for children. This deprivation, which hinders the child's healthy development, can directly lead to negative outcomes or accelerate the development of severe psychopathology (Savi Çakar, 2020). In a study by Karalonsky (2019) examining the relationship between mothers' parenting styles and Avoidant Personality Disorder in children, it was indicated that a neglectful parenting style could be a contributing factor to Avoidant Personality Disorder. The same study also reported that excessive authoritarian parenting was associated with higher levels of social anxiety in children (Karalonsky, 2019).

There are also studies focusing on the relationship between avoidant personality disorder and attachment (Guına, 2016). Attachment is the first relationship established between an infant and a caregiver. If the infant feels secure in this relationship and their needs are consistently met, an emotional bond is formed with the caregiver. These infants satisfy their needs for approval and acceptance, developing a sense of trust and perceiving the world as a reliable place (Savi Çakar, 2020). Freud, Erikson, and Bowlby have provided explanations regarding attachment. In particular, secure attachment is crucial for developing a sense of trust, empathy, and emotional recognition in infants. However, secure attachment may not always be established in infancy. Secure attachment can be acquired or persistent, and acquired secure attachment is an important contribution to the field of mental health (Guına, 2016). Acquired secure attachment is particularly significant for a patient receiving psychodynamic therapy. During therapy, a therapist who establishes an empathic and patient-centered therapeutic relationship can provide a corrective attachment experience (Guına, 2016).

**Intervention Methods in Avoidant Personality Disorder**

There is limited research available on the treatment of avoidant personality disorder. However, recent studies provide effective insights and case study examples related to treatment. Although studies on treatment are scarce, cognitive-behavioral and psychodynamic approaches are generally known to be effective (Antonella et al., 2021).

In this study, the treatment of avoidant personality disorder will be presented within the framework of Metacognitive Interpersonal Therapy and Schema Therapy. Additionally, case studies from research using these therapies will be summarized.

**Metacognitive Interpersonal Therapy**

As mentioned above, Metacognitive Interpersonal Therapy focuses on three key aspects in the treatment of avoidant personality disorder. These aspects and their explanations are as follows:

1. **Low awareness of emotional and cognitive processes:** Individuals with avoidant personality disorder are unaware of the emotions and thoughts underlying their avoidance in interpersonal relationships, and they cannot explain these behaviors to the therapist.
2. **Having maladaptive interpersonal schemas:** Individuals with avoidant personality disorder generally have negative self-evaluations. People generally desire acceptance, recognition, and romantic relationships and seek to fulfill these desires. However, due to their maladaptive schemas, individuals with avoidant personality disorder hold negative beliefs and emotions about themselves, leading to difficulties in engaging in social behaviors.
3. **Using negative coping strategies:** The aforementioned factors create a foundation for negative coping strategies. The most common coping strategy is emotional, behavioral, and cognitive avoidance. Another strategy is perfectionism. These individuals tend to prioritize pleasing others (Antonella et al., 2021).

Metacognitive Interpersonal Therapy is an integrative approach that incorporates elements of cognitive, behavioral, psychodynamic, and narrative-based therapies (Gordon King, Schweitzer, & Dimaggio, 2019). The goals of Metacognitive Interpersonal Therapy are to improve individuals' self-perception and interpersonal relationships while reducing the severity of personality disorder symptoms. The therapy focuses on enhancing individuals' metacognitive skills (Gordon King, Schweitzer, & Dimaggio, 2019).

Two key elements stand out in Metacognitive Interpersonal Therapy: formulating a shared understanding of functionality and promoting change. In

the functionality component, the client's maladaptive schemas are examined by integrating and analyzing their personal narratives. Experiential techniques such as guided imagery and rewriting, role-playing, two-chair techniques, and behavioral experiments are used for this purpose. One goal of these techniques is to help individuals better understand their cognitive and emotional processes, thereby reducing emotional deficits. Another goal is to help individuals connect with healthier aspects of themselves and adaptive schemas, allowing them to develop a broader and more flexible perspective (Antonella et al., 2021).

The therapist's role is to encourage the client to recall personal interactions, construct scenarios based on these interactions, and use these scenarios to help the client identify relationships between their behaviors, thoughts, and emotions (Gordon King, Schweitzer, & Dimaggio, 2019).

Before presenting a case example, it is essential to highlight the importance of the therapeutic relationship. As is well known, the therapeutic relationship is a trust-based connection between the client and the therapist. Since individuals with avoidant personality disorder experience difficulties in interpersonal relationships and exhibit avoidance behaviors, they may also avoid forming a relationship with the therapist and struggle to express their internal experiences. To prevent difficulties in the therapeutic relationship, it is crucial to use experiential techniques in the early stages of therapy (Antonella et al., 2021).

**Case Example**

Charles sought help due to difficulties in interpersonal relationships and chronic anxiety. He describes himself as highly perfectionistic and frequently explains that he feels disconnected or detached during social interactions.

Charles’s family is authoritarian and controlling, with an angry and tense mother. He struggled to get along with his peers at school and had difficulty adapting. When he began experiencing feelings of inferiority, he also had episodes of anger outbursts.

Charles's therapist formulated his case as follows: Based on Charles's memories of his family, it is evident that his parents also exhibited emotional dysregulation, suggesting a potential familial predisposition to developing BPD symptoms. Charles, who had a weak self-concept rooted in his family, further reinforced his sense of disconnection when he faced rejection from peers and punitive behaviors from teachers at school. Due to his childhood experiences, Charles developed schemas centered on seeking acceptance from others and wanting to feel good enough. As coping strategies, he relied on external achievements and unrealistic standards, leading to the development of perfectionism.

When discussing his internal experiences, Charles frequently used metaphors. This was interpreted as an indicator of his difficulty and reluctance to engage with intense emotions. Additionally, Charles struggles to understand others' experiences and regulate his own mental states.

Therapist's Treatment Plan

The treatment plan was structured as follows (Gordon King, Schweitzer, & Dimaggio, 2019):

- Establishing an effective therapeutic alliance.
- Developing metacognitive skills related to identifying, understanding, and expressing emotions.
- Encouraging Charles to gain awareness of his interpersonal schemas by repeatedly reflecting on interpersonal events and relating them to past experiences.
- Using homework and exercises to encourage Charles to behave differently from his current schemas and develop a sense of identity beyond his achievements.

**Schema Therapy**

Schema therapy is an integrative therapeutic approach that shares common features with cognitive, psychodynamic, Gestalt psychotherapy, and object relations approaches but does not fully overlap with any of them (Farrell, Reiss, & Shaw, 2018).

Schema therapy posits that the interaction between childhood experiences, biological factors, and the environment leads to the frustration of core childhood needs, which in turn results in the development of early maladaptive schemas and dysfunctional schema modes (Nathan & Arnoud, 2021).

The primary goal of therapy is to help patients understand their emotional needs, gain the freedom to express emotions, and learn adaptive ways to meet their fundamental emotional needs. Achieving this requires modifying maladaptive schemas, dysfunctional coping strategies, and schema modes (Nathan & Arnoud, 2021).

When maladaptive schemas are activated, schema modes—emotional, behavioral, and cognitive states that a person experiences at a given moment—are triggered. Schema modes are categorized as follows:

- **Instinctive child modes** (e.g., vulnerable child, angry child, impulsive child).
- **Maladaptive coping modes** (e.g., avoidant, overcompensator, submissive surrenderer).
- **Dysfunctional parent modes** (e.g., punitive parent, demanding parent).
- **Healthy modes** (e.g., happy child, healthy adult) (Farrell, Reiss, & Shaw, 2018).

Essentially, therapy is designed to help clients develop and strengthen a healthy mode. When maladaptive schemas are activated, individuals may experience psychological distress and typically employ three coping strategies:

1. **Surrender** (accepting and conforming to the schema).
2. **Avoidance** (avoiding full activation and awareness of the schema).
3. **Overcompensation** (rebelling against the schema and acting in the opposite way) (Nathan & Arnoud, 2021).

At the core of schema therapy is the concept of **limited reparenting**. Limited reparenting refers to the therapist acting as a parent figure within the

therapeutic relationship to meet the client's unmet childhood needs. The goal is to create a warm and secure environment where the client can recognize their emotions and needs (Farrell, Reiss, & Shaw, 2018).

Schema therapy can be applied both individually and in groups. In **group schema therapy**, the therapist acts as a parental figure, and group members take on sibling-like roles. Group therapy provides additional advantages over individual therapy by fostering mutual support, trust, and emotional expression among members (Nathan & Arnoud, 2021). Techniques such as imagery rescripting, role-playing, the two-chair technique, and cognitive-behavioral methods are used in group schema therapy (Nathan & Arnoud, 2021).

Schema therapy is commonly used to treat personality disorders. Among the schema modes associated with **avoidant personality disorder**, the **avoidant protector**, **vulnerable child**, and **punitive parent** modes have been identified (Şenkal Ertürk & Kaynar, 2017).

**Treatment in Group Schema Therapy**

Before starting group therapy, individual sessions are conducted to formulate the case, provide psychoeducation, and identify events that may have contributed to the formation of schemas. Group schema therapy consists of three stages: the development of mode awareness, work on mode management using new behavioral techniques, and experiential mode exercises to apply new skills in personal contexts.

**Case Example**

Jim is a patient who has received various therapies and treatments for complaints such as depression, migraines, avoidant personality disorder, and binge eating disorder.

Jim grew up in an insecure family environment with a strict father, an emotionally unstable mother, and a sibling who displayed aggressive behaviors. His brother, grandfather, and uncle were convicted of sexual abuse. In this family environment, Jim grew up feeling unimportant and unworthy. When Jim got married, he faced difficulties with his spouse, and one of his

two children was diagnosed with autism while the other was diagnosed with attention deficit disorder. When Jim was unable to work due to his symptoms, he remained in constant contact with his parents. He felt continuously controlled and judged by his parents regarding his parenting skills.

**Therapist's Case Formulation**

In the first two sessions, the therapist focused on building a therapeutic relationship by encouraging Jim to express his emotions and thoughts while providing basic information about schemas and modes. Jim's main issue was identified as avoiding conflicts with others and struggling to express his emotions and thoughts (Avoidant Protector Mode). Jim had many self-critical thoughts (Punitive Parent Mode). Because he struggled with emotions such as anger and sadness, he coped by avoiding emotions, engaging in self-harm and vomiting (Detached Protector Mode), or overeating and obsessively watching movies (Self-Soothing Mode). In group schema therapy, Jim's goals were set as becoming more assertive, reducing avoidance behaviors, and being less self-punitive.

**Therapist's Treatment Stages**

1. **Stage One:** At this stage, efforts were made to develop mode awareness. By the end of this stage, Jim was able to open up more and reveal what was behind his neutral behavior in the group (Detached Protector Mode), his vulnerable feelings of worthlessness (Vulnerable Child Mode), and his intense self-criticism (Punitive Parent Mode).
2. **Stage Two:** This stage focused on reducing Jim's negative self-judgment (Punitive Parent Mode), decreasing avoidance of assertive behaviors (Avoidant Protector Mode), and reducing behaviors such as overeating and self-harm (Self-Soothing Mode).
3. **Stage Three:** In this final stage, the focus was on stopping self-criticism (Punitive Parent Mode), demonstrating assertive behavior toward his children, parents, and ex-spouse, and expressing his emotions and thoughts (Healthy Adult Mode). Role-playing exercises were conducted to help Jim stand up to his self-critical mother regarding his parenting skills. Group therapy allowed Jim to build connections with other group members. By practicing

expressing emotions and new behaviors within the group, he developed trust and connections with others. Dysfunctional beliefs were modified through reparenting by group members, particularly through chair exercises and imagery work. By the end of this stage, Jim felt valuable and connected to others (Nathan & Arnoud, 2021).

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# CHAPTER 11

## Obsessive-Compulsive Personality Disorder

The term obsession, derived from the Latin word "obsidere," means to be uneasy, to feel disturbed, and is commonly referred to as fixation or preoccupation. Thoughts that disturb a person involuntarily are called obsessions. These are repetitive, intrusive, and ego-dystonic words and images that cause distress and anxiety, making them difficult to eliminate. Examples of obsessions include fears of contamination by saliva or germs, concerns about losing control and becoming aggressive, persistent doubts that keep circulating in the mind, and unwanted religious or sexual thoughts. Individuals who experience such fixations are called obsessive.

Compulsions, on the other hand, are involuntary, repetitive behaviors performed to eliminate obsessions and reduce anxiety. These behaviors follow rules, serve a purpose, and are persistent. While they provide temporary relief from obsessions and reduce tension, they do not offer a permanent solution. Common examples of compulsions include excessive handwashing, counting, and checking behaviors.

### Types of Obsessions

*Contamination Obsessions*

This involves a fear of being contaminated by substances such as dirt, germs, semen, urine, or blood. Examples include an inability to touch money, reluctance to shake hands, avoidance of objects touched by others, and the fear of contamination from urine, feces, or sperm in restrooms.

*Magical Thinking Obsessions*

This occurs when a person believes that their thoughts influence real-life events. An example would be thinking of a bad event while crossing a doorway and then feeling compelled to cross the threshold again to prevent the event from occurring.

*Sexual Obsessions*

These are intrusive erotic images that cause shame and appear in unwanted situations. Examples include the fear of feeling sexual desire toward family members or experiencing inappropriate thoughts during religious rituals.

*Religious Obsessions*

These are more common among devout individuals and involve questioning the existence of God or experiencing urges to commit sinful acts.

*Order and Symmetry Obsession*

This entails a strong need to keep objects in a specific order, continuously arranging items to ensure they remain symmetrical, and feeling distressed if they are not perfectly aligned.

*Doubt/Uncertainty Obsession*

This refers to the inability to be certain about whether a task has been completed. Individuals frequently check their actions yet remain unsure. Examples include repeatedly checking whether the iron is unplugged or the door is locked.

*Metaphysical Obsessions*

These involve paradoxical thoughts that a person continuously questions without finding satisfactory answers. Examples include: *What happens after death? Is this really me? How am I speaking? Is today actually today or tomorrow? Is life real?*

*Aggression Obsessions*

This is the fear of losing control and harming oneself or others. Examples include thoughts such as: *Will I stab myself with this knife? Will I strangle my baby? Will I run people over while driving? Will I jump out of the window?*

*Somatic Obsessions*

This involves an excessive fear of contracting illnesses, particularly serious conditions like AIDS or cancer. Even after multiple medical examinations, the fear persists, and minor symptoms are catastrophized. Examples include: *My head hurts; I must have a brain tumor. My stomach aches; I might have colon cancer.*

**Types of Compulsions**

*Hoarding Compulsions*

This is the inability to discard items, even those that are not needed. Regardless of their material or emotional value, the person finds it impossible to let them go. Hoarding disorder and extreme cluttered homes are examples of this compulsion.

*Touching Compulsions*

This involves feeling compelled to touch specific objects, believing that doing so offers protection or prevents harm. Some individuals repeatedly touch an item they consider significant, especially when feeling distressed.

*Arranging Compulsions*

This refers to the persistent need to organize items to achieve perfect symmetry. Even if no one touches the objects afterward, the individual may feel the need to rearrange them repeatedly.

**Checking Compulsions:** It is the condition of constantly checking due to uncertainty about the tasks one has performed. It involves repeatedly checking the stove, gas, faucet, and electrical outlets to prevent something bad from happening.

**Counting Compulsions:** It is the condition of constantly counting objects seen without any purpose. It is a mental obsession. License plates, building floors, and passing pedestrians are involuntarily counted.

**Repetition Compulsions:** It is the repetition of an action with the belief that it must be performed a certain number of times and in a particular manner. Examples include washing hands three times or knocking on wood five times.

**Cleaning Compulsions:** It is the condition of constant cleaning due to the belief that dirt or germs have been acquired. Examples include taking showers for hours, spending long periods at the sink, or disinfecting the inside of the mouth.

**History**

The condition has undergone many phases throughout history. In the Middle Ages, it was explained through magical or religious perspectives. Over time, it was replaced by medical definitions. In obsessions related to sexuality, it was believed that the person was being guided by the devil and could be cured through exorcism. Some holy books also mention that individuals were exposed to certain thoughts by the devil and that playing a musical instrument was a way to eliminate them. In the 17th century, Shakespeare's character Lady Macbeth is considered an example of obsessive-compulsive disorder.

Obsessive-compulsive disorder was first defined by Étienne Dominique Esquirol in 1838. He argued that this condition resulted from depression and melancholy. Morel was the first to use the term "obsession" in 1860. In the 19th century, French psychiatrists described it as an inability to make decisions due to experiencing doubt and insecurity. German clinicians explained the cause of obsessions as being based on irrational thoughts. At the beginning of the 20th century, Pierre Janet classified phobias, obsessions, and compulsions under the category of psychasthenia. He suggested that obsessions and compulsions arose due to a weakening of the willpower and introduced diagnostic criteria:

1. The presence of a feeling of being compelled to think, feel, or act in a certain way,
2. The obsession having a content that is alien to the self, absurd, or irrational,

3. The presence of resistance to the obsession (Solyom et al., 1985).

In the 1950s, behaviorists explained the disorder using learning theory and proposed exposure and response prevention as a treatment method. Freud, on the other hand, viewed it separately from phobias, arguing that it stemmed from sexual and aggressive impulses. He suggested that defense mechanisms emerged as a reaction to this tension. In 1952, the American Psychiatric Association (APA) classified the disorder as "Obsessive-Compulsive Reaction" in the DSM-I, "Obsessive-Compulsive Neurosis" in the DSM-II, and "Obsessive-Compulsive Disorder" in the DSM-III. While it was included under the category of anxiety disorders in the DSM-IV, it was placed under a new category, "Obsessive-Compulsive and Related Disorders," in the DSM-5.

Obsessive-compulsive personality disorder, which is often confused with obsessive-compulsive disorder due to its similarities, is a personality disorder characterized by perfectionism, cognitive rigidity, and a need for control. In the DSM-5, it is classified under personality disorders and involves an obsessive-compulsive personality pattern.

Obsessive-compulsive disorder tends to emerge later in life, whereas obsessive-compulsive personality disorder appears earlier and is more resistant to change. Individuals with obsessive-compulsive disorder are aware that their condition is not normal and feel distressed by it. They recognize that their actions are irrational but cannot prevent them. In contrast, individuals with obsessive-compulsive personality disorder have adapted to their condition and believe that they are normal while everyone else is abnormal and should conform to them. Not every OCD patient has OCPD (Tan, 2004). The prevalence of OCPD among individuals with OCD typically ranges from 7% to 17.5% (Torres & Del Porto, 1995). Parents of individuals with OCD are more likely to exhibit traits of perfectionism, hoarding, and obsessive-compulsive personality disorder (Calvo et al., 2009).

**DSM-5 Criteria for Obsessive-Compulsive Personality Disorder**

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency, as indicated by at least four of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion.
3. Devotes himself to work and productivity to the extent that he excludes leisure activities and friendships.
4. Is excessively conscientious, scrupulous, and inflexible about matters of morality, ethics, or values.
5. Cannot discard worn-out, worthless, or useless objects.
6. Is reluctant to delegate tasks or work with others unless they do things exactly as he does.
7. Is miserly when it comes to spending money both for himself and for others.
8. Is rigid and stubborn.

**Obsessive-Compulsive Personality Traits**

*Perfectionism*

They are perfectionists. They pay extreme attention to detail in everything they do. They are meticulous and value order. They take great care not to make mistakes and work very hard. Due to their expectations of perfection, they are never satisfied with their work. Their excessive perfectionism prevents them from completing tasks; they keep redoing things over and over again.

*Distrust*

They cannot trust others and hesitate to delegate tasks. They believe that any work done by someone else will inevitably be incomplete or incorrect. They think that no one is as responsible or as competent as they are.

*Rigid, Stubborn, and Intolerant*

Their lives are governed by rules, and they strictly adhere to them. They do not allow others to disrupt their order. They never deviate from what they believe to be right. They are rigid, inflexible, and stubborn. If rules are broken, they act intolerantly. When someone who does not follow the rules

faces difficulties, they believe that person deserves it. For them, there is no gray area—only black or white.

*Honesty*

Their rigid attitude toward others also applies to themselves. They are morally conservative. They make sure not to take advantage of anyone or be indebted to anyone. Even if it harms themselves or others, they always tell the truth.

*Indecisiveness*

They are extremely indecisive because they fear making mistakes. They constantly weigh the pros and cons but fail to reach a conclusion, leading to perpetual postponement. Since they are perfectionists, they always want the best possible outcome. As a result, they struggle with decision-making and taking action.

*Hoarding*

They are miserly. They save money for potential hard times and avoid spending it. They are highly attached to objects. Even if something is old or unusable, they cannot bear to throw it away. They worry that they might need it one day, so they refuse to get rid of it.

*Emotional Self-Control*

They are rational and logical. They suppress their emotions. They rarely change their minds or experience emotional shifts. There is always an internal dictator trying to keep them under control.

*Anxiousness*

They can create disaster scenarios out of even the smallest situation. They immediately start worrying and struggle to remain calm. If they have a stomachache, they might start thinking about funeral expenses—turning a minor issue into a catastrophe.

Obsessive-Compulsive Personality Disorder Core Beliefs

- I am responsible for both myself and others.
- Other people do not take their work seriously and act irresponsibly.
- To do something correctly, it must be done in an orderly manner and according to the rules.
- If something is not done in the best possible way, then it is meaningless. If it is not the best, I cannot consider myself successful.
- Details are extremely important.
- Mistakes and errors are unacceptable.
- I must suppress my emotions (Köroğlu & Bayraktar, 2010).

**Typical Emotions of Obsessive-Compulsive Personality Disorder**

Individuals with Obsessive-Compulsive Personality Disorder (OCPD) often experience a complex range of emotions, primarily driven by their rigid perfectionism, high standards, and intense self-criticism. They tend to set unrealistically high expectations for themselves and others, which frequently leads to feelings of **disappointment and regret** when they inevitably fall short of these standards. Even minor mistakes can provoke excessive self-blame and a persistent sense of failure.

**Anxiety and distress** are common emotional experiences for individuals with OCPD. Their relentless pursuit of perfection creates constant pressure, making them prone to **worrying about details, organization, and control** in various aspects of life. They may obsess over completing tasks flawlessly and struggle with uncertainty, fearing that any deviation from their plans will result in failure. This chronic tension can contribute to **irritability and frustration**, especially when their high expectations are not met by themselves or those around them.

In addition to anxiety, **depressive symptoms** frequently emerge as individuals with OCPD grapple with their inability to attain the perfection they desire. Their rigid thinking patterns and reluctance to delegate tasks can lead to **feelings of exhaustion, dissatisfaction, and loneliness**. They may struggle to relax or enjoy leisure activities, as they often view such pursuits as

unproductive or a waste of time. Over time, this inability to experience pleasure or spontaneity can deepen feelings of emptiness and sadness.

Furthermore, individuals with OCPD may experience **guilt and shame**, particularly when they perceive themselves as having failed to meet their moral or ethical principles. Their strong sense of duty and responsibility can make them hyper-aware of their actions, leading to **persistent self-doubt and fear of making the wrong decisions**. The emotional landscape of individuals with OCPD is dominated by **perfectionistic concerns, anxiety, frustration, and sadness**, making it challenging for them to find contentment and inner peace. These emotional struggles highlight the importance of therapeutic interventions aimed at helping them develop **self-compassion, flexibility, and healthier coping mechanisms** to manage their perfectionism and self-criticism more effectively.

**Relationships with the Environment**

The way individuals with Obsessive-Compulsive Personality Disorder (OCPD) interact with others is significantly shaped by their rigid beliefs, hierarchical thinking, and perfectionistic tendencies. Their relationships are often structured around strict rules, formality, and a strong emphasis on duty and responsibility. One of the defining characteristics of their interpersonal style is their **excessive loyalty and submissiveness toward authority figures**. They show a deep respect for hierarchy and are highly influenced by their superiors, often going to great lengths to gain approval and recognition. Their need for order and structure leads them to strictly adhere to rules, making them appear obedient and highly disciplined in professional and social settings.

However, their behavior toward subordinates and those they perceive as less competent is **markedly different**. They tend to be **intolerant, rigid, and highly critical**, often dismissing others as inadequate or irresponsible. Their perfectionistic nature makes it difficult for them to trust others with tasks, leading to an unwillingness to delegate or collaborate. They often disapprove of the way others complete their work, believing that their own approach is the only correct one. This makes teamwork and task distribution extremely challenging, as they struggle to accept different working styles and perspectives.

In social interactions, individuals with OCPD maintain a **formal and serious demeanor**, avoiding casual or emotionally expressive behavior. They place a high value on **rationality and logic**, considering emotional warmth or spontaneity as a sign of weakness or incompetence. As a result, their relationships may feel distant, rigid, and transactional, lacking the warmth and emotional connection typically found in close personal bonds. Their interpersonal relationships are characterized by **hierarchical deference, rigidity, and emotional restraint**. While their structured approach may be effective in certain professional settings, it can lead to difficulties in forming deep, meaningful connections with others. Their reluctance to show vulnerability or flexibility often results in **strained relationships, misunderstandings, and social isolation**. Developing greater emotional awareness and openness to collaboration can help improve their interpersonal experiences and overall well-being.

**Epidemiology**

According to epidemiological studies, the prevalence in society is inconsistent but is estimated to be between 1% and 2%. Based on clinical findings, the prevalence is around 26%. It is considered the most common personality disorder among all personality disorders. Regarding gender distribution, studies based on DSM-III concluded that it is twice as common in men as in women, while another study using DSM-IV found no gender difference. According to DSM-IV-TR, it is twice as common in men as in women. Additionally, it has been found to be more prevalent in the eldest child of a family. Cultural studies have indicated that it is less common among Asians and Hispanics and more common among Caucasians and African Americans. Findings regarding its presence in childhood show that a study conducted with children aged 9-19 found obsessive-compulsive personality disorder (OCPD) symptoms in 13.5% of them.

**Etiology**

*1. Genetic and Environmental Factors*

Twin studies indicate that heredity plays a significant role. It has been suggested that a genetic mechanism supporting OCPD may exist. One study

found that obsessive-compulsive personality traits are more common in identical twins compared to fraternal twins.

Studies on the influence of environmental factors on OCPD have been examined under three main categories. The first is an overly controlling parental attitude. Excessive pressure on the child's behavior and reliance on punishment are believed to play an important role in developing this personality pattern. The second is the child's learning of compulsive behaviors. Through imitation and modeling, they adopt this method to avoid punishment and gain parental approval. They develop an obsessive-compulsive personality pattern by observing their parents. The third factor is the responsibilities children learn. Children raised with constant emphasis on order, system, and meticulousness act according to this consciousness and do not deviate from it.

*2. Biological Factors*

Studies on OCPD have shown that serotonin levels in the brain decrease and do not function effectively. Medications that increase serotonin levels have a significant impact on treatment. Additionally, studies on both animals and humans have found a relationship between high dopamine levels and obsessive-compulsive personality traits. Other studies on obsessive individuals have observed an increase in glutamate levels in the brain while GABA levels decrease.

Brain imaging studies have shown that the basal ganglia are more active during compulsions and less active during normal times. In brain imaging studies of adults with the disorder, changes have been detected in cortical blood flow and brain metabolism. In children, differences in metabolism and blood flow speed in the prefrontal cortex have been observed. According to brain imaging studies, differences exist in the orbitofrontal cortex, cingulate cortex, basal ganglia, and thalamus.

**Perspectives of Different Schools of Thought**

*1. Psychodynamic Perspective*

According to the psychodynamic perspective, there is a significant relationship between toilet training in the anal stage and OCPD. The concepts of retention and release, learned during the anal stage, remain important throughout life. A child who encounters an inappropriate and rigid parental attitude may exhibit retention behavior out of fear of contamination or develop release behavior in opposition to their parents. They may develop either an anal-retentive or non-anal-retentive personality. This stage is when the child first learns an action they can control by their will.

Some parents may impose strict discipline during this period. A child subjected to strict discipline may resort to defense mechanisms to cope with opposing emotions such as contamination, aggression, stubbornness, and defiance. The most commonly used defense mechanisms in OCPD include reaction formation, isolation, repression, displacement, and undoing. Individuals may develop reaction formation by behaving in a manner completely opposite to their subconscious inappropriate impulses and tendencies. They may exhibit extreme cleanliness in response to subconscious contamination impulses. While they can recall an event in terms of place, time, and setting, they suppress its emotional aspect into the unconscious, using the isolation mechanism. Individuals with OCPD frequently use this mechanism to maintain emotional control. A person represses and forgets events that cause pain and shame. Displacement occurs when a person redirects negative feelings about an object onto another, unrelated object to gain relief. Obsessives who feel mentally contaminated frequently wash their hands and clean everything around them. Engaging in an alternative behavior to mitigate and relieve a negative situation is known as undoing. Repetitive behaviors in obsessives are also examples of undoing.

*2. Cognitive Perspective*

According to the cognitive perspective, OCPD manifests as intrusive, uncontrollable thoughts, irrational long-term beliefs, and their interpretations. Shapiro described individuals with OCPD as being overly focused on how they will do something rather than what they want to do, becoming

excessively preoccupied with their thoughts. Guidano and Liotti argued that perfectionistic beliefs lead to indecisiveness, skepticism, and procrastination. Beck and Freeman suggested that individuals with OCPD have rigid and stubborn thoughts about avoiding mistakes and maintaining self-control, causing them to perceive everything in black-and-white terms.

*3. Behavioral Perspective*

According to the behavioral perspective, OCPD is learned through imitation and modeling. It is particularly observed in individuals raised under strict parental control during childhood. The environment may serve as a reinforcement for compulsive behavioral models.

**Differential Diagnosis**

**Obsessive-Compulsive Disorder (OCD):** OCPD is a personality disorder in which the individual maintains a persistent personality pattern. In contrast, OCD is an anxiety disorder. The clinical symptoms of OCD and OCPD largely overlap. Hoarding and symmetry obsessions, as well as ordering and arranging compulsions, are seen in both. However, the severity of symptoms differs between the two disorders. Individuals with OCD recognize that their condition is abnormal, whereas individuals with OCPD perceive their behavior as normal. It has been found that in individuals with both OCD and OCPD, symptoms tend to be more pronounced.

**Depression:** Although studies suggest a relationship between depression and OCPD, the results are not entirely consistent. According to one study, 75.8% of individuals with OCPD also had major depressive disorder. The destructiveness and dissatisfaction stemming from perfectionism contribute to depression.

**Body Dysmorphic Disorder (BDD):** In body dysmorphic disorder, there is a real or imagined physical defect, which represents the obsessive aspect of the disorder. The behaviors aimed at correcting the perceived defect represent the compulsive aspect. According to one study, 14-28% of individuals with OCPD also have body dysmorphic disorder.

**Avoidant Personality Disorder (AvPD):** OCPD and avoidant personality disorder, both classified under Cluster C personality disorders, are believed to be related. Some studies suggest that obsessive-compulsive personality disorder is highly likely to co-occur with avoidant personality disorder. The comorbidity rate of OCPD and AvPD has been found to be 27.5%.

**Schizoid Personality Disorder (SPD):** Restricted affect is a common characteristic of both OCPD and SPD. In OCPD, this is due to self-control, whereas in SPD, it results from a lack of social experience and inadequacy.

**Narcissistic Personality Disorder (NPD):** Both obsessive and narcissistic personalities share a drive for perfection and a tendency to be dissatisfied with others' work. In narcissistic personality disorder, there is a belief that perfection has been attained, whereas in OCPD, the individual never feels they have fully achieved perfection and continuously strives for it. Additionally, unlike narcissistic personality disorder, self-admiration is not seen in OCPD. One study found that 7.2% of individuals with OCPD also had NPD.

**Antisocial Personality Disorder (ASPD):** Although stinginess is a feature observed in both disorders, the underlying motives differ. In OCPD, stinginess is directed toward hoarding and saving for the future, whereas in ASPD, it manifests as an attitude toward others rather than oneself. Unlike individuals with antisocial personality disorder, those with OCPD exhibit extreme adherence to moral rules.

**Tic Disorders:** These are repetitive, rhythmic movements that occur involuntarily. The majority of individuals with Tourette syndrome display compulsive symptoms. Between 40-60% of individuals with Tourette syndrome exhibit obsessive-compulsive symptoms (Bayraktar & Kala, 2000).

**Parkinson's Disease:** Studies suggest that OCPD is one of the disorders accompanying Parkinson's disease. Certain characteristics of "Parkinsonian personality" overlap with OCPD, including punctuality, orderliness, rigidity, and introversion. OCPD is the most frequently observed personality disorder among individuals with Parkinson's disease, with a prevalence of 40%.

**Eating Disorders:** OCPD is commonly observed in eating disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder. It is the most frequently encountered personality disorder in eating disorders. In both anorexia nervosa and bulimia nervosa, the desire for control and perfectionism emerge as common goals. Behaviors such as binge eating, dieting, excessive chewing, self-induced vomiting, attempts at weight loss, and calorie counting are associated with obsessive-compulsive disorder, but they are not sufficient for a diagnosis of OCPD.

## Treatment

### Pharmacological

Although medication alone is not very functional in treating OCDP, its use helps individuals control some of their impulses. Serotonergic antidepressants or antipsychotic medications have been used in obsessive-compulsive disorder for many years. Antidepressants do not change or improve personality but help individuals feel better. Commonly used antidepressants include Clomipramine, Fluvoxamine, Fluoxetine (Prozac), Paroxetine (Paxil, Pexeva), and Sertraline (Zoloft). Additionally, drugs that inhibit enzymes responsible for serotonin reuptake are also effective.

### Electroconvulsive Therapy (ECT)

Electroshock therapy, which was used years ago for various psychiatric disorders, has also been used in personality disorders. This method has been applied in resistant and severe cases that do not respond to medication and psychotherapy. It is administered by applying low-voltage electricity for a short time to the temple region.

### Transcranial Magnetic Stimulation (TMS)

Similar to electroshock therapy, this is an older method. It involves sending magnetic currents to selected regions of the brain. Magnetic currents are transmitted to the brain through coils placed on the head. This method has been used primarily for depression patients and has been rarely applied to OCDP, with no proven effectiveness in treatment.

Vagus Nerve Stimulation (VNS)

This method, used in epilepsy and depression patients, is applied by sending stimulation currents to the left vagus nerve. It has been tried in OCDP cases where resistance was shown and medication was ineffective, but it has not yielded effective results.

Neurosurgical Treatment

The brain surgery method was first used in psychiatric disorders in the 1930s. This method was employed as a last resort in patients who did not respond to treatment. It involves severing the connection between the brain's frontal region and other regions. The goal was to disconnect the link between the limbic system and the frontal lobe or between the orbitofrontal cortex and the thalamic nucleus.

Behavioral Therapy

Behavioral therapy is a treatment method that focuses on observable and concrete behaviors, shaped by learning experiences. It is argued that obsessive individuals resort to compulsions to rid themselves of intrusive thoughts, and compulsions act as reinforcers in this context. To extinguish this conditioning, the aim is not to try to eliminate the thought but to neutralize it. The goal is to create habituation in behavior so that the body's biology can adapt accordingly. Victor Meyer has been using this approach effectively in OCDP treatment for over 40 years.

Cognitive Therapy

In cognitive therapy, the goal is to change not behaviors but the thoughts within the mind. Mental errors that complicate a person’s life are identified and analyzed, aiming to replace them with functional thoughts. The focus is not on how these thoughts emerged but on how they can be changed. The aim is to create insight by making individuals aware of certain thinking patterns referred to as cognitive errors.

The first cognitive error is **arbitrary inference**, where individuals make negative assumptions about their situation without sufficient evidence.

For example, someone with a cleanliness obsession may avoid germs, believing that contamination could have fatal consequences.

The second cognitive error is **selective abstraction**, where a person focuses only on the negative aspects of their situation or experience while ignoring other factors. For example, an individual with an obsession for order may overlook their spouse's positive traits and fixate only on improperly ironed pants or asymmetrically arranged objects.

Another cognitive error is **personalization**, where individuals blame themselves for events that are not related to them and hold themselves responsible for everything. An example is someone thinking, "My guests got food poisoning because I didn't wash the vegetables well." Another cognitive error is **overgeneralization**, where individuals derive broad conclusions from a single experience and apply it to many aspects of their lives. Another cognitive error is **black-and-white thinking**, which is particularly common among obsessive individuals. They believe that if they cannot do something perfectly, it is meaningless to do it at all. The final cognitive error is **minimization or magnification**—successes are often downplayed, while mistakes and failures are exaggerated. In cognitive psychotherapy, the client's thought patterns and cognitive errors are analyzed. These mental mistakes are identified and corrected to improve the individual's cognitive approach.

**Cognitive Behavioral Therapy**

The fundamental principle is to confront the distressing situation. Another principle is response prevention. Therapy begins by listing the obsessive and avoided situations of the client. For example, if a client has a cleanliness obsession and washes their hands for an extended period after shaking hands with someone, they may initially be assigned simple tasks such as waiting 10 minutes before washing their hands after shaking hands. As the client progresses, the tasks become more challenging, and the hand-washing duration is gradually extended. This method may not yield positive results in all cases. Some individuals may not complete the assignments, some may be unable to cope with the anxiety they experience, or in cases of sexual obsessions, applying this method may lead to negative outcomes instead of positive ones. In some situations, confrontation can also be implemented imaginatively. Through visual imagination, the individual can confront the

situation as if they were experiencing it. Cognitive behavioral therapy is one of the most frequently used treatment methods with observable effectiveness. The treatment can be effectively utilized based on the severity and progression of the disorder.

**Schema Therapy**

Based on cognitive behavioral therapy, schema therapy focuses on maladaptive early schemas and works on them. An individual's early life experiences, family, and self-perceptions create schemas. It is used to treat psychological problems that arise when emotional needs from childhood or adolescence remain unmet and are triggered in adulthood. Schema therapy is particularly effective for individuals who have been emotionally deprived, raised by punitive or rejecting parents, or experienced childhood traumas. It is believed that maladaptive parenting practices play a role in the development of Obsessive-Compulsive Personality Disorder (OCPD). Therefore, like in other personality disorders, schema therapy can also be beneficial for OCPD. In the first stage of therapy, the unmet needs from the client's childhood are addressed. This stage is called "limited reparenting." Then, experiential imagery and dialogue exercises are conducted. The therapy works on the client's schemas, and later, cognitive restructuring is used to break the client's existing behavioral patterns to facilitate change.

**Humanistic Therapy**

Developed as a response to behaviorism, humanistic therapy asserts that individuals are inherently born with the potential for goodness and does not classify clients as "patients." The goal is to help individuals realize their potential and achieve self-liberation. It focuses on the present moment rather than the cause of the problem, emphasizing the client's current emotional state. In cases of OCPD, humanistic therapy can be used to provide insight and a sense of freedom to the client. However, before employing this therapy, it is crucial to assess the severity of the client's condition.

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# CHAPTER 12

## Epilogue

Personality disorders are psychological disorders characterized by long-term, rigid patterns of thinking, feeling, and behaving. These disorders can significantly impair an individual's quality of life by negatively affecting their internal experiences and interpersonal relationships (American Psychiatric Association [APA], 2022). Personality disorders typically become apparent in early adulthood and can hinder an individual's environmental and social adaptation (Clark, 2009).

Within traditional classifications, the DSM-5 categorizes personality disorders into ten distinct types, grouped into three clusters: A (odd and eccentric), B (dramatic, emotional, and impulsive), and C (anxious and fearful) (APA, 2022). Cluster A disorders include paranoid, schizoid, and schizotypal personality disorders; Cluster B consists of antisocial, borderline, histrionic, and narcissistic personality disorders; and Cluster C encompasses avoidant, dependent, and obsessive-compulsive personality disorders (Krueger & Markon, 2014).

However, this categorical classification has been criticized for its rigid boundaries, and it is argued that personality disorders should be examined from a longitudinal and dimensional perspective (Widiger & Trull, 2021). Instead of the traditional categorical model, the Alternative Model for Personality Disorders (AMPD) in DSM-5 proposes evaluating personality disorders in the context of an individual's personality functioning and specific pathological traits (Morey et al., 2015). This model allows for a more flexible and comprehensive understanding of personality disorders and is suggested to be more useful in clinical decision-making processes (Hopwood et al., 2018).

The etiology of personality disorders is also a crucial research area. Genetic, environmental, and neurobiological factors are noted to play a critical role in the development of these disorders (Livesley, 2018). Childhood traumas, attachment issues, and neurotransmitter dysfunctions, in particular, may contribute to the formation of personality disorders (Fonagy et al., 2017). For example, early life experiences, especially neglect and abuse, have been

shown to be significant factors in individuals with borderline personality disorder (Gunderson & Lyons-Ruth, 2008).

Personality disorders remain a subject of great interest in both clinical and academic fields and continue to evolve. Given the criticisms of traditional classifications and the increasing support for dimensional approaches, it is clear that more flexible and individualized approaches should be developed for the assessment and treatment of personality disorders. Future research should focus on better understanding the neurobiological and psychosocial foundations of personality disorders and emphasize evidence-based intervention methods for their effective management (Samuel & Widiger, 2021).

Personality disorders should not be considered solely a clinical issue but also examined from developmental and social perspectives. The formation of personality and the emergence of disorders are significantly influenced by an individual's early life experiences and societal context.

It is well established that early childhood traumas and parent-child relationships play a critical role in shaping personality. According to attachment theory, individuals who fail to develop secure attachments are at a higher risk of personality pathology later in life (Fonagy et al., 2018). Numerous studies support the link between childhood abuse and neglect, particularly with borderline and antisocial personality disorders (Cicchetti & Toth, 2019). In this context, it is emphasized that adverse experiences in early life can have long-term effects on an individual's emotional regulation abilities, self-perception, and interpersonal relationships (Belsky & de Haan, 2011).

Moreover, personality disorders are closely linked not only to individual developmental processes but also to societal and cultural factors. It has been suggested that social environments, cultural norms, and economic conditions influence the emergence and maintenance of personality disorders (Hopwood et al., 2018). For instance, findings indicate that narcissistic personality traits are more rewarded and encouraged in individualistic and competitive societies (Twenge & Campbell, 2017). The cultural context is proposed to be a determining factor, particularly in the prevalence and

expression of narcissistic and antisocial personality disorders (Foster et al., 2015).

Social changes can also influence the prevalence and nature of personality disorders. For example, various studies have examined how the rise of the digital age and the use of social media shape individuals' self-perception and interpersonal relationships. These studies indicate that excessive use of social media can increase narcissistic tendencies and reduce levels of empathy (Andreassen et al., 2017). Additionally, societal traumas such as economic crises, wars, and migration are emphasized as potential triggers for disorders like borderline and paranoid personality disorders by exacerbating difficulties in emotion regulation (Johnson et al., 2020).

Evaluating personality disorders in interaction with developmental and social factors can lead to a better understanding of these conditions and the development of effective intervention methods. In addition to clinical interventions, increasing preventive efforts at an early age and developing strategies to regulate societal factors can play a significant role in reducing the prevalence and impact of personality disorders.

In recent years, holistic approaches have gained prominence in the treatment of personality disorders. Dialectical behavior therapy (DBT), schema therapy, and mentalization-based therapies have achieved significant success in treating personality disorders (Bateman & Fonagy, 2019). DBT, in particular, has been proven effective in cases where emotional regulation issues are prominent, such as borderline personality disorder (Linehan, 2018). Schema therapy focuses on early adverse life experiences and aims for cognitive, emotional, and behavioral changes, thereby facilitating lasting improvements in the treatment process (Young, Klosko, & Weishaar, 2003).

However, the treatment resistance of personality disorders highlights the necessity of a long-term and interdisciplinary approach (Leichsenring et al., 2020). Psychopharmacological treatments are considered an important supportive element, particularly for alleviating symptoms and managing comorbid disorders. For instance, mood stabilizers and atypical antipsychotics can help control specific symptoms in some types, such as borderline and antisocial personality disorders (Gunderson et al., 2018). However,

pharmacotherapy alone has been shown to be insufficient, and its combination with psychotherapy is found to be more effective (Paris, 2018).

Additionally, in recent years, neuroscience-based approaches to the treatment of personality disorders have been gaining increasing interest. Brain imaging studies have shown that dysfunctions in the prefrontal cortex and amygdala are associated with personality disorders (New et al., 2021). In this context, neuromodulation techniques, such as transcranial magnetic stimulation (TMS) and deep brain stimulation (DBS), have shown promising results in some cases (Schulze et al., 2016).

The importance of an individualized and multidisciplinary approach in the treatment of personality disorders is increasingly recognized. The integration of different methods, such as psychotherapy, pharmacotherapy, and neuromodulation, contributes to the long-term recovery processes of patients. Future research is of great importance for enhancing the effectiveness of these treatment approaches and developing more specific intervention strategies.

Future research in the field of personality disorders should focus on developing multidimensional approaches. Interdisciplinary studies that examine genetic, neuroscientific, and environmental factors together can expand theoretical and applied knowledge in this field (Paris, 2021). With advancements in neuroimaging techniques, brain structures and functions associated with personality disorders can be examined in greater detail (DeYoung & Krueger, 2018). Such studies can provide more comprehensive insights into the neurobiological foundations of personality disorders, contributing to both diagnosis and treatment processes.

Furthermore, it is evident that social and cultural factors will help us better understand how personality disorders take shape in different societies (Bach & First, 2018). Culturally sensitive psychopathology research can reveal which personality traits are more acceptable or marginalized in certain societies. In this context, integrating cultural factors into clinical assessment processes can enable more accurate diagnoses (Widiger & Mullins-Sweatt, 2009).

In addition, longitudinal studies can contribute to a better understanding of the developmental processes of personality disorders. The relationships between risk factors in early childhood and symptoms that emerge in adulthood should be examined in greater depth (Cicchetti, 2016). In particular, the potential of early intervention programs to reduce the severity of personality disorders and their impact on functionality is considered an important area for future research (Zanarini et al., 2020).

Finally, integrating the social, developmental, and clinical perspectives discussed in this book will help us better understand personality disorders and develop effective intervention methods. Future research should develop innovative approaches that take individual differences into account, consider cultural context, and offer a biopsychosocial perspective. Such holistic studies will make significant contributions to both clinical practice and the fundamental theories of psychopathology.

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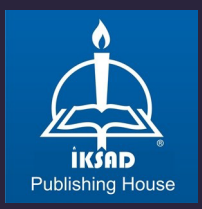
*Personality disorders are enduring patterns of inner experience and behavior that markedly deviate from the expectations of an individual's culture. These patterns manifest in at least two or more areas, including cognition, affectivity, interpersonal functioning, and impulse control. Rigid and inflexible by nature, these behavioral patterns lead to significant distress and impairments in various aspects of life. They are not attributable to substance use, medical conditions, or the symptoms of another mental disorder. Typically, personality disorders emerge during adolescence or early adulthood and persist throughout life (American Psychiatric Association, 2014).*

*The DSM-5 classifies personality disorders into three clusters: Cluster A includes paranoid, schizoid, and schizotypal personality disorders; Cluster B encompasses antisocial, borderline, histrionic, and narcissistic personality disorders; and Cluster C consists of avoidant, dependent, and obsessive-compulsive personality disorders (American Psychiatric Association, 2014).*

*This book provides a comprehensive examination of personality disorders from social, developmental, and clinical perspectives. It explores their etiology, symptoms, diagnostic criteria, and treatment approaches while shedding light on their impact on individuals and society. Offering insights from contemporary research and case studies, this work is an essential resource for psychologists, clinicians, researchers, and anyone interested in understanding the complexities of personality disorders.*

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