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Cluster B Personality Disorder, Treatment, Comorbidity and Stigma

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Abstract: Schizoid, paranoid, and schizotypal personality disorders are examples of unusual or eccentric traits shared by Cluster A. Antisocial, borderline, histrionic, and narcissistic personality disorders all fall under the category of cluster B personality disorders. Cluster B personality disorders, such as antisocial personality disorder, borderline personality disorder, narcissistic personality disorder, and performance personality disorder, will be the focus of this paper. The problems encountered in treating the disorders are investigated by comparing the similarities and co-morbidity of Cluster B personality disorders in parallel. Highlighted how people with personality disorders can be stigmatized in their lives and therapy. Elaborated on the negative impact of stigma on treating Cluster B personality disorder and how to counteract stigma. Through discussing this kind of personality disorders, we can put forward a scientific basis for how to prevent personality disorders in the future.

Keywords: personality disorders, Cluster B, treatment, stigma

1. Introduction

There are many existing studies on personality disorders based on DSM-IV, including classification, diagnosis, and treatment. However, with the DSM-V, there is not a wealth of research papers focusing on cluster B personality disorders and treatment based on the newest edition. The DSM-5 research program has discussed the DSM-high V's rate of comorbidity between personality disorders and the volatility of personality disorder diagnoses over time [1]. Personality disorders are classified on their axis in the DSM-IV. This particular axis position has been subject to some criticism. So personality disorders were moved to axis I in the DSM-V [2]. Understanding Group B Personality Disorders is crucial for all clinicians, regardless of whether their practice is focused on this therapy area, because practically every psychiatric symptomatology has distinct therapeutic consequences for patients and clinicians. Patients with personality disorders have pathologies that, in most cases, are outside their consciousness. That is why quick treatments for these disorders are not available. It also leads to inefficiency or lack of treatment [3]. Dramatic, emotional, or erratic are words that are frequently used to describe people with cluster B personality disorder. Lack of empathy for others is a hallmark of cluster B personality disorders. Narcissistic personality disorder patients believed other people were unimportant enough to be pitied. People who have borderline personality disorder frequently believe they are the poorest victims. People with antisocial personality disorder typically lack empathy [4].

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2. Literature Review

2.1. Definition

To define personality disorder, the definition of personality should be considered first. Personality determines who we are, including a series of unique traits such as our way of thinking, feelings, perception, or behavior. Personality can be congenital or shaped by the environment. When the personal traits become inflexible, affect social functions and cause harm to the surroundings, the individual might be considered a personality disorder. A continuous pattern of inner experience and behavior that considerably deviates from societal norms is pervasive and rigid, starts in adolescence or early adulthood, lasts over time, and results in distress or impairment is referred to as a personality disorder [4].

2.2. Classification of Personality Disorder

Schizoid, paranoid, and schizotypal personality disorders are examples of unusual or eccentric traits shared by Cluster A. Antisocial, borderline, histrionic, and narcissistic personality disorders all fall under the category of cluster B personality disorders, which are frequently characterized as dramatic, emotional, or erratic. Cluster C includes personality disorders such as avoidant, dependent, and obsessive-compulsive. Anxiety or worry are typically felt by Cluster C disorder patients [4].

2.3. Diagnosis

2.3.1. Antisocial Personality Disorder

The research on antisocial personality is more widespread than any other personality disorder due to its massive impact on socioeconomics and public safety [3]. An aggressive habit of willful disdain and violation of others' rights is one of the core traits of antisocial personality disorder. Antisocial personality disorder patients fundamentally believed they were born to defy the law. This leads to repeat offenses, using others for one's advantage, and a lack of regret for wrongdoing. There are severe ramifications for societal health and public safety [5].

For the diagnostic criteria, to be diagnosed with antisocial personality disorder, the patient must be at least eighteen years old and have a history of some conduct disorder symptoms dating back to when they were fifteen. People with antisocial personality disorder frequently violate others' fundamental rights or social norms, such as destroying property, harassing others, stealing, or engaging in illegal occupations. Patients frequently gain personal gain through deception and manipulation, accompanied by repeated lying and disregard for others' feelings. Behavioral patterns are impulsive, often making decisions on the spur of the moment without considering the consequences for themselves or others. They can result in abrupt changes in jobs, homes, or relationships. Furthermore, people with antisocial personality disorder are frequently irritable and aggressive, and they are consistently and extremely irresponsible, with little remorse for the consequences of their actions. They are oblivious to harm, abuse, or theft and attempt to explain and rationalize it away [4].

2.3.2. Borderline Personality Disorder

BPD is characterized by extreme sensitivity to the slights received in interpersonal relationships, an unstable self-image, and solid and unstable emotions that might be something they have experienced and lead to impulsive behavior. People with BPD are susceptible to the reactions around them and can react violently to minor incidents. People with BPD can quickly feel strong emotions and have difficulty calming down, which is why they act impulsively. People with BPD are susceptible to rejection and can feel angry and bitter about even minor separations. When their close family member or friends are not around, it is difficult for them to feel other emotional connections as if their value is attached to others, which makes people with BPD feel lost. Suicide and self-harm can occur in BPD patients when the emotion hits them so hard that they cannot accept it [6].

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For the diagnostic criteria, a desperate endeavor to prevent actual or perceived desertion is a defining feature of borderline personality disorder. Significant alterations in self-image, mood, cognition, and behavior can result from the fear of abandonment or rejection. Borderline Personality Disorder patients are susceptible to environmental situations, whether planned or unplanned, and sufferers develop intense and feverish fears and anger of abandonment. Patients with BPD tend to have unstable and passionate relationships; they may romanticize a potential caregiver or lover during the initial meetings, insist on spending a lot of time together, and divulge the most private information right once. However, the person's perception of these people may change abruptly and dramatically. They may quickly shift from idealizing to devaluing them, believing that the other person does not care or give enough. When caretakers or loved ones are considered careless, withholding, uncaring, or abandoning, people with borderline personality disorder frequently display inappropriate, passionate, and uncontrollable anger. This manifests itself in the form of extreme sarcasm, persistent distress, or verbal outbursts. Feelings of shame and guilt frequently accompany such outbursts of rage, contributing to feelings of evil. An identity disorder characterized by a distinct and persistently unstable self-image may accompany borderline personality disorder. Borderline personality disorder patients will exhibit self-harming impulses in at least two areas, such as gambling, irresponsible spending of money, overeating, substance abuse, and engaging in risky sexual behavior. Suicidal ideation, threats, or self-harm regularly. Due to marked emotional reactivity, such as intense anxiety and irritability, which usually lasts for several hours, causing people with borderline personality disorder exhibit emotional instability. Quality BPD patients are frequently thwarted by patient anger, repeated suicides, and noncompliance with treatment prescriptions, making the diagnosis challenging to treat [4].

2.3.3. Narcissistic Personality Disorder

Narcissism is a psychological condition characterized by excessive self-worship and concern for one's perfection. An unstable sense of self is common in narcissistic personality disorder patients, which can lead to either a subjective or an objective loss of satisfaction. People with narcissistic personality disorder tend to seek opportunities to feel unique about themselves in these circumstances. Achieving high levels of performance and perfection is one of these methods. Because they are preoccupied with their arrogance, they find it difficult to be happy for others [7]. It is essential to one's emotions and sense of self-esteem, impacting how one perceives the world, the world, and relationships. A strong sense of self-worth, self-esteem, and self-acceptance, as well as taking pride in and enjoying one's successes, are all characteristics of healthy narcissism. It affects the individual's attitude towards others and whether the individual is genuinely interested in the thoughts and feelings of others and willing to share their thoughts and feelings with others. Pathological narcissism is different from healthy or exaggerated narcissism. The main difference is mood swings and dysfunctional self-esteem. Pathological narcissism may be temporary, but narcissistic personality disorder occurs when the behavior and thought pattern is prolonged, inelastic, and harmful to the individual's life. NPD does not love themselves; they love an idealized, grandiose image of themselves. They like this inflated self-image precisely because it makes them feel insecure. They need their behavior patterns to start deviating to support their exaggerated delusions. Individuals with NPD will have different experiences in different social or interpersonal environments. The same person may feel confident, competent, and dominant in a given situation. In another, they may feel ashamed or insecure, vulnerable to humiliation, and struggle with feelings of loss of control, jealousy, or resentment.

For the diagnostic criteria, consistent patterns of self-importance, a need for admiration, and a lack of empathy are characteristics of narcissistic personality disorder. This pattern of behavior begins to emerge in early adulthood. People with narcissistic personality disorder frequently overestimate their abilities and exaggerate their accomplishments, coming off as pretentious, and feeling that they are unique and superior. These behaviors are indicative of a constant sense of self-superiority. There is also an implicit underestimation of the contributions of others. They constantly think that others respect their efforts equally, so they are frequently taken aback when their expectations aren't met, or they don't receive the compliments they deserve. Patients frequently have delusions of having endless prosperity, wealth, power, or perfect love. People with narcissistic personality disorder have a strong desire for domestic admiration. Still, they also have highly fragile self-esteem since they only think about their accomplishments, compliments, and praise from others. People with Narcissistic Personality Disorder often consciously or unconsciously exploit

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others because of their sense of power, always believing that they have priority and that others should obey them. And when their expectations are not met, they show anger and confusion. Patients generally lack empathy and have difficulty recognizing other people's feelings, subjective experiences, and desires.[4].

2.3.4. Histrionic Personality Disorder

People with Histrionic Personality Disorder believe that others exist only to serve and appreciate them [8]. The self-identification of HPD patients is not a feeling of self-worth but based on the recognition of others, so they put on a mask and "act" to show what they want to be as if by doing so, they become what they like. Individuals with histrionic personality disorder can also be self-centered. They may seem lively and enthusiastic, and this trait tends to win people over at first. Of course, being overly enthusiastic can also cause inconvenience to those around you, such as being overly enthusiastic with strangers, revealing too much about personal problems with unfamiliar friends, and crying and losing your temper uncontrollably over minor frustrations. Traits of HPD are not healthy, and along with their masks, they are often accompanied by a strong, unstable, distorted self-image. Like children, they jump up and wave, hoping to be noticed. Jumping around all the time eventually exhausts them -- which is why HPD patients seek medical attention because no one's world revolves around another person forever, so they can't get satisfaction from their own "performance."

For the diagnostic criteria, an Individual with a histrionic personality disorder is always overly emotional and seeking attention. They could feel awkward or unappreciated when they become aware that they are not the centre of attention. They are frequently animated and dramatic. Initially, people with a histrionic disorder may attract attention with their enthusiasm and apparent openness. However, if the person repeatedly seeks to be the center of attention, these qualities gradually deteriorate. In addition, an individual with histrionic personality disorder tends to be inappropriately sexually provocative and seductive. However, these actions go beyond what is acceptable in a social setting; they are not just directed at someone with whom they have a particularly romantic or sexual interest. They also occur in various social, professional, and occupational situations. Such emotions could be fleeting and unstable. Histrionic personality disorder patients have an excessive preoccupation with their looks and spend a lot of time grooming and dressing to attract others' attention [4].

2.4. Etiology of Cluster B Personality Disorder

The personality disorders in cluster B seem to share social and genetic ties. The XYY chromosome, elevated plasma testosterone, reduced resting heart rate, limbic activation, ability to concentrate and problems with motor and hand-eye coordination are organic factors associated with antisocial personality disorder [3]. Cluster B personality disorder has also been shown to be hereditary. Numerous twin and twin family studies support genetic factors explaining the family aggregation of BPD, with heritability estimates in the range of 35% to 45% [9]. Hereditary temperament also affects Cluster B personality disorder. For example, sensitive people may receive more adverse environmental influences. In addition to these biogenic factors, sociocultural factors appear to be highly predictive.

males, poor temperament in infancy, low socioeconomic status, antisocial parenting, living in a high-crime community, and stress. Family divorce and discord, parental rejection, and negative and anti-social behavior modeling appear to mediate these risk factors. The chance of developing behavioral disorders, which enhance the likelihood of engaging in antisocial behavior and the emergence of antisocial personality disorder, is increased by subpar academic performance, peer isolation, and subsequent substance use in school [10]. Adverse childhood experiences were highly related to Cluster B personality disorder in a combined clinical and community sample of borderline personality disorder. For example, multiple community studies have shown that child maltreatment, such as physical and sexual abuse, dramatically increases the chance of BPD in children. Childhood trauma is the most important environmental risk factor for BPD. Many doctors

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agree that child sexual abuse is the underlying cause of this personality disorder since girls are more likely than boys to experience sexual abuse, and 75% of patients are female. As a result, many medical professionals agree that this personality disorder is mainly caused by child sexual abuse [11]. Disagreeable parenting styles, maternal kingdom involvement, parental aversion, and lack of care are also associated with the development of personality disorders. Establishing a solid identity or sense of self is crucial during adolescence and, if postponed or hampered, might result in a pathological personality. High neuroticism, low self-awareness, and limited openness to experience are characteristics of children separated from their mothers before the age of five. An unhealthy attachment to the primary caregiver can arise from separation or poor parenting in developing personality pathology. Early attachment disruption may cause problems with self-control and emotional control. Depression and anxiety are two psychological conditions that can influence the development of personality disorders in adults during childhood and adolescence.

2.5. Comorbidity

Co-occurring personality disorders also frequently appear within the different clusters. Cluster A has 5.7% of the disorders, Cluster B has 1.5%, and Cluster C has 6.0%. Other psychiatric disorders and intergroup comorbidity frequently accompany cluster B personality disorders. Borderline Personality Disorder patients may also have several other disorders, including mood disorders such as major depression or bipolar disorder, and problems linked to stress and anxiety, such as PTSD or acute stress disorder. Substance-related, dissociative, disruptive behavior, somatoform, other personality disorders, and neurodevelopmental disorders, including ADHD [6]. Cluster B personality disorder also correlates with bipolar disorder. 100 bipolar patient has been undertaking the evaluation through a clinical interview. 30% of bipolar disorder patients meet DSM IV criteria for cluster B personality disorder(17% borderline disorder, 8% narcissistic disorder, 6% antisocial disorder, 5% histrionic disorder). Around 10 percent of BPD patients had Bipolar I disorder, and another 10 percent of patients had bipolar II disorder [12].

2.6. Prognosis and Treatment

Research has demonstrated that medication and psychotherapy can reduce the disorder, but psychotherapy appears more effective in cluster B personality disorder. Treatment for antisocial personality disorder is incredibly challenging. Even though several treatments have been proposed, there have been few controlled studies. On the other hand, individual psychotherapy appears to be the treatment of choice. It is widely accepted that positive reinforcement, a reality-based approach, educationally oriented anger management or impulse control programs, and developing the patient's cognitive, behavioral, and moral abilities are critical components of individual psychotherapy with antisocial patients. As an alternative, it ought to be insight-driven [13]. Early intervention in childhood and adolescence, primarily through parental teaching, can boost treatment success [14]. Changes that occur as the patient enters adulthood depend on their willingness to engage in therapy. The self-integration of the symptoms and the antisocial patient's irrational mistrust of people complicate this. The most crucial treatment-related problem impacting borderline individuals is suicidal ideation. A whopping 75% of patients will attempt suicide, and 8–10% will succeed [15]. Some treatments are efficacious for borderline personality disorder. For instance, Dialectical Behavioral Therapy (DBP), Combines individual and group components of the Cognitive Behavioral Model to emphasize patient building for self-harm and emotion regulation. Mentalization-based treatment (MBT), The individual and group components of the combined developmental model emphasize the patient's consideration of the impact of the self on others [6]. Baker and Freeman used a cognitive therapy approach to identify three extremely uncomfortable

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"basic assumptions" held by people with borderline disorder. "The world is dangerous and malevolent," "I am powerless and vulnerable," and "I am inherently unacceptable" [16]. Breaking these all-or-nothing cognitive patterns is the aim of therapy. The therapist should use a combination of encouragement, counsel, and cognitive inquiry based on the psychodynamic ideas of splitting and projective identification, as well as a conceptualization of the patient's upsetting object connections. Although long-term supportive work is currently seen to be the most successful treatment for histrionic personality disorder, individual psychodynamically focused treatment has historically been the most popular. A three-step method based on a clinical formulation clarifies the patient's concerns and problems in the first stage, the mental state in the second, and the defensive barriers in the third. The integration of psychodynamic and cognitive concepts is emphasized [17]. The debate on whether narcissistic personality disorder can be cured is still ongoing. The current stage of treatment uses an integrated model where the treatment depends on the patient's personal, relational skills, such as impulse control and anxiety tolerance. The patient's personality structure is challenging to change, so increasing the patient's level of adjustment is the primary aim. For patients with narcissistic personality disorder, treatment focuses on impulse control and developing empathy [18].

3. Future Implication

It is commonplace for mental illness to be stigmatized. Personality disorders may experience more significant stigma than other psychiatric diagnoses [19]. The complex stigma structure, which contains components relating to the public, the individual, and the structure, impacts people with mental illnesses and their support networks, provider networks, and community resources[20]. Due to the characteristics of personality disorders, the behavior of the sufferer is more likely to be perceived as complex and misbehaving than the disease. This has led to a less sympathetic public towards patients with personality disorders, who are perceived as not needing professional help compared to patients with other categories of mental illness [21]. In society, there is an absence of understanding of mental illness due to the general public. Mentally ill people are always associated with specific stereotypical influences. Negative labels include the inability to take care of oneself, incompetence, violent tendencies, etc. For example, an individual with a personality disorder may face setbacks at work, such as employers questioning their ability to work and avoiding hiring people with personality disorders. Recovery efforts stall when the patient accepts the stigmatized incompetence mentality. Furthermore, those who do not seek treatment for fear of being labeled as insane are more likely to miss out on opportunities for recovery. Another study on the effects of a BPD diagnosis on parents found that these parents' parenting was negatively impacted by their fear of stigma and being judged by services [22]. Parents worried their sickness would stigmatize them and cause them to be scrutinized by loved ones, service providers, or social organizations. Their fear of stigma also influenced their parents' behavior in seeking treatment. One father gave the following example: “I think that's one of the key barriers to why parents might not seek treatment at the earliest feasible time because they're terrified of having their kids taken away [23]”. Stigma can exacerbate the patient's condition and deny the individual access to care and social support. The combined effect of stigma and mental illness creates a vicious cycle and has a detrimental effect on many individuals. Stigma can add a tremendous burden of stigma to the mentally ill individual, leading to a decreased capacity to deal with the difficulties of daily life, difficulty managing relationships, and an increased perception of negative emotions. In addition to being in society, people with personality disorders may also face discrimination in the process of treatment. During the treatment of BPD patients, it is expected that people with BPD may face stigma and harshness, leading to negative attitudes from physicians about their care and treatment outcomes in the medical setting. A survey of 706 mental health clinicians supports this assertion. A self-reported survey was

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sent to 703 psychiatrists within different areas, including residents, social workers, nurses, psychologists, and clinicians. Results indicated that mental health clinicians held negative attitudes toward patients with BPD and rated them lower regarding empathy, comfort, treatment, and overall prognosis. A significant proportion of clinicians indicated that they would be less willing to treat patients with BPD if they had the choice [24]. To minimize discrimination and the negative impact it brings. Anti-stigma interventions for personality disorders are necessary. Education is a strategy for changing people's stigma by correcting misconceptions and providing information about personality disorders. This does not only include the general public; eliminating mental health professionals' prejudices is also necessary. There is a need for ongoing education for mental health professionals. As attitudes affect treatment outcomes, clinicians should learn to resist negative attitudes. This can be achieved through additional training. As reported, while mental health professionals are considered competent to care for people with BPD, most acknowledge the difficulties of treating people with BPD and the general need for further training. Bringing people with personality disorders into personal contact with others can also and will combat stigma. For example, interactive presentations about their perspective as a person with a personality disorder, the prejudices they have suffered, and the recovery process [25].

4. Conclusions

Personality disorders can be complex and confusing to diagnose due to their characteristics. Therefore, individuals with certain personality disorders frequently also have other personality disorders or mental conditions, including depression and anxiety disorders. The more effective form of treatment for Cluster B personality disorder is thought to be psychotherapy. However, the ineffectiveness of treatment is caused by a variety of factors. Misdiagnosis is expected due to cluster B personality disorder, particularly BPD, and its resemblance to bipolar illness nonterms of how it presents. With misdiagnosis, people with BPD do not receive effective, immediate treatment and often face worsening of their condition. At the same time, the stigma also leads to stagnation in the recovery of patients. Patients undergoing treatment are often stigmatized by psychiatrists and nurses, which harms their recovery. In addition to hospital stigma, social stigma is also prevalent. Many people are reluctant to seek help and try to hide their mental illness because they fear the perceptions of others due to stigma. This is especially common among parents with mental illnesses who fear that society will conclude that they cannot care for their children.

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