Avoid Personality Disorder (Tpe)

Clinical Case Study – V.A.

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V. Andrei, 16, is a student in the 10th grade, at one of the best high schools in Braila. He comes from a family with a very good socio-economic situation, both parents run successful personal businesses. He is the second child, the older brother of 6 years, is a student in America. He lives in a locality close to the city of Brăila. This fact makes him dependent on the parents' possibility to bring him to school, to meditations, to therapy. My mother is terribly afraid of "not being kidnapped, baby." Therefore, in the frequent trips abroad of the parents, Andi is taken with them and absent from school.

"In such a dynamic world, the only strategy that guarantees your failure is risk-free"

Mark Zucherberg

A. Main Actions

Andrei came to the office in the autumn of 2016, accompanied by her mother, for speech therapy. He has **polymorphic dyslalia - sigmatism, rotacism** (flabby language, phonemic hearing impairment) and an imperial disinterest for his own expression! He attended sporadically, without making obvious progress. When the

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sound-articulating apparatus becomes aware and tense, the effect of dyslalia diminishes considerably.

Lately he is apathetic, he cries frequently, does not want to go to school, meditations and has very bad grades. He is isolated and prefers to sleep (hypersomnia - sleeps instantly and sleeps a lot) or to play on the computer, of which he is almost dependent. At my mother's request to "talk a little with him" I resorted to a cognitive-behavioral approach to counseling / psychotherapy. According to the postulate "The child is the symptom of the family", in this family the parents difficult to address, (the mother's phone sounds almost always busy), they are content to deliver the child to meditations / therapy "to be brought on the waterline". The mother is anxious (Hashimoto's autoimmune thyroiditis charge) and believes that during the pregnancy she was harassed by the former boss, which is why the child faces these problems: he is more vulnerable, more sensitive, more insecure, this perception acting as a self-fulfilling prophecy. Andrei, although "as tall as the door", is immature socio-affective. With an above average intelligence, a mixed temperament, phlegmatic dominant, with choleric notes, has a massive but flabby constitution. It moves slowly, when it sits it "gives up" on the couch. He looks like a good-natured kid, who just woke up from sleep, seemingly careless, but always sport-casual, from well-known brands, displaying a nonchalance and detachment that defies defiance. From the parents, he gets almost everything he wants and much more effortlessly, and the older brother who makes a serious lobby in this regard, besides his mother.

At speech therapy comes because of the insistence and threats of the mother. He does not realize that he expresses himself almost unintelligible, with the others needing a careful effort to understand him. Although he is not aggressive, he is withdrawn and has an attitude that keeps his other colleagues away, being perceived by them as "the bird in the golden cage". This contributes to the speech defect and the fact that it is absent frequently.

B. Medical History

Last year, in the fall, (after starting school) he was investigated in Bucharest for heart attacks, but was not diagnosed with any cardio-vascular disorder. She has a slight myopia corrected with glasses. In the meantime, he no longer had symptoms that required medical intervention / consultation.

C. Mental Status and Psychodiagnostic Assessment

a. Mental status

Andrei is well oriented spatial-temporal, but presents fatigue and depressive-anxious mood.

b. The psychodiagnostic evaluation was done with some of the following instruments; the rest will be applied during the course (permanent evaluation and reassessment);

Raven's Progresive Matrices SPM Plus SETS A-E

Level I - higher level intellect

Guide to identifying the temperament (Belov)

Mixed temperament, with phlegmatic dominance and angry notes

Self-esteem scale, Rosenberg, 1965

Eysenck personality questionnaire (EPQ-R EysenckPersonalityQuestionnaire: authors HJ Eysenck, Sibibil B G Eynsenck)

High score on neuroticism and addiction

Concentrated attention test (calculation) (AC test)

Medium level of concentrated attention

Distributional attention test (Tset DNA - Prague)

Average level of distributive attention

Profile of emotional distress (PDE; David Opriș, Bianca Macavei *

Global Assessment of Functioning Scale (EGF / GAF)

Automatic Thoughts Questionnaire (ATQ - Automatic ThoughtsQuestionnaire; Steve Hollon, Phillip Kendall) *

High level of dysfunctional thoughts

The Young Cognitive Scheme Questionnaire (YSQ - Jeffry Young) adapted by Simona Trip *

Dysfunctional Attitudes Scale (DAS - Aaron Beck et al.) Adapted by Bianca Macavei *

Rational and irrational cognition scale (GABS-SF - General attitudeandBelifs Scale –ShortForm; authors Raymond Di Giuseppe et.al) sponsored by Bianca Macavei *

Structured Clinical Interview for DSM – IV AXA II Personality Disorders (StructuredClinicalInterview for DSM-IV SCID - II; authors First, Spitzer, Gibbon, Williams, 1995)

Personality belief questionnaire (PBQ - PersonalityBeliefQuestionnaire; authors Beck and Beck, 1991) adapted in Romania under the coordination of Prof. Dr. Daniel David

c. DSM diagnostics

Categorical diagnosis. From a taxonomic perspective, a pervasive pattern characterized by social inhibition, the feeling of being inadequate and an exaggerated sensitivity to negative appraisals, which begins at the young adult age, manifests itself in various situations and fulfills all seven criteria:

Axis I Clinical disorders

- Neurodevelopmental disorders / Communication disorder / Pronunciation disorder - 315.39
- Depressive disorders - subclinical - presents some symptoms without meeting the criteria for any of the depressive disorders
- Anxiety disorders - subclinical - presents some symptoms without meeting the criteria for any of the anxiety disorders

Axis II - Personality disorder: subclinical. The patient presents with avoidable personality traits

Axis III - Somatic diseases or other medical conditions: nothing significant. Eritem pudic.

Axis IV - Psychosocial stressors - hyperprotective family environment, “golden cage”, which does not give him the freedom to confront as much as is the case at his age, with reality. The fact that he is obliged, of necessity, to follow his parents through hotels and various locations in the country and abroad.

Axis V - General operating index - GAF 70

We can conclude that these are the result of the interaction between the particularities of a vulnerable personality, of the cultural and situational factors - hyperprotective parents, a "learned disability", reduced exposure to the influences of the social environment - does not participate in extracurricular activities, is not left in camps, trips, on the names of colleagues, etc. But he cultivates this condition because it has secondary benefits: he can quit school "motivated", he apologizes for the small notes, the unfinished homework - he was missing because he was away with the parents and the mother overwhelms him with "everything the child wants, only not- I can see it that way, that my soul is broken! "He cannot stand to be criticized, disapproved and rejected and cannot control his anxiety. That's why he prefers to protect himself by avoidance, but he has a strong sense of sadness - he often cries and often goes through depression.

List of Problems. After establishing the diagnosis, we agreed with the client the following list of problems:

a. Anxious character

1. He declares that he is not lucky, the most embarrassing situations happen to him, in class, at training, etc.

2. He is worried that his mother foresees him for an uncertain future.

3. Manifest eritem pudic and this fact causes him to avoid speaking in public

b. Relationship problems

1. He feels humiliated because he is perceived by his colleagues as a "child of ready money", he considers that they manipulate him.

2. Parents do not let him out of town with his new friends, they do not agree with their behavior.

c. Avoiding intimacy

3. Girls, classmates do not like it, they consider themselves ugly.

4. He would like to get rid of the mask he puts on his relationship with the others, he would like to learn to say "NO!", But because he cannot control his emotions, he prefers to look "crazy", withdrawn, insignificant.

b. Emotional management problems

5. He longs for his brother and feels abandoned by him because he does not communicate with him as much as he would like.

c. Problems of optimization, learning of abilities

6. Write slowly and fail to finish the work on time, which is why it gets low marks.

7. Correcting speech disorders is a necessity in communication - for others to understand their speech, desires, etc.

D. Cognitive-Behavioral Conceptualization

The conceptualization of the case, namely the interpretation of the client's clinical picture, was made based on the stress-vulnerability model. This implies that certain stressful events interact with a biological or psychological vulnerability, generating the clinical picture.

The psychological vulnerability can be generated by the dysfunction of the family environment, the philosophy of life, the general cultural environment and its values. In the case of Andi, the values of his cultural environment are centered on the need for security, but this security is not based on his family on communion / community. On the contrary, adopting the western lifestyle, due to frequent outings, the nuclear family carries with it the “nest” and “the chick”, whenever they go, wherever they go. They do not trust to leave the child with a relative, (extended family, community) or to allow him to manage alone, at home, and to see for themselves, and he, for school. Thus, they induce disturbances with consequences that are difficult to appreciate. The security and the apparent calm of the parents, Andi pays her with the psycho-emotional balance. This hybridization between the western / individualistic and the non-traditional / non-traditionalist style, between emancipation, free action and community dependency / security seems to be dysfunctional in this family's case. This is the price that this family considers worth paying for their own comfort.

The therapeutic relationship defined its coordinates more clearly when we moved the center of gravity from speech therapy to psychological counseling. The child has opened, is more compliant, cooperative, declares himself interested in self-knowledge. Make comments and come up with pertinent arguments during the hearing. They “write down” their experiences, situations, special events that happened between the two sessions to discuss them together. However, the fact that it does not respect the weekly schedules, comes with the unfinished theme,

demonstrates distrust and non-involvement. Because I cannot control how objectively I am in the reasons the mother invokes when the child cannot be brought to therapy, (avoidance), in this case I feel the feeling of helplessness, frustration.

In the first sessions, Andi told me some situations from which the basic schemes resulted, the maladaptive cognitions that make him feel lonely and hopeless, but still choose isolation instead of other integration strategies.

Psychoeducation and familiarity with the intervention. I explained to Andi that certain predisposing factors, in his case the cognitive distortions (catastrophe and negative global evaluation such as: "I am a nullity", "I am ugly" and everyone humiliates me, I only make mistakes), they determined to misinterpret some life situations, perceiving them as threatening.

The life experiences that led to the structuring of the personality disorder were related mainly to the fact that the parents have demanding services. They often leave the country, do not have enough time to devote to it, and when they go together, he actually spends time alone, at the hotel pool or on the laptop, playing games. Depression has been heightened since his brother left for school. At school, in the peer group he feels humiliated and persecuted. Even teachers do not get along very well, due to frequent absences and gaps in knowledge.

The key conflict around this child's struggle with himself is that he would like to prove to others his value, to be with them, in their company, but fears that he will make mistakes, that he will be ridiculed, that will not be successful / good luck. He is upset that he cannot control his fear / agitation / anger. He stated that he is a completely different person than the mask he displays at school, but already colleagues know this and could no longer perceive him that way. as he is, in fact, it would not be credible if he showed them his true personality. The dominant fear / main threat is that others might discover how lacking they are and that they will reject him. Others consider him critical, determined to reject him.

At the base are the fundamental beliefs that structure

- Self-image - feeling insecure. He is considered "ugly", "stupid", "inexperienced" and "unlucky / unlucky".

- The image about the alter - sees in colleagues some aggressive, unfriendly people, who are just trying to manipulate him and put him in embarrassing situations,

teachers, parents ridicule him, do not take him seriously, do not appreciate him, do not - i love him.

- The image about the World - was educated in the perception that "life is a jungle", it is hard and it is feared that it cannot adapt, it will not cope.

The main / central beliefs - global evaluation: "I am a nullity", "I am bleg", "I cannot bear and I cannot control my emotion"

Conditional beliefs / inferences: "if people knew how weak / bleg / unpopular they were, they would manipulate me, they would make fun of me, they would remove me, which I could not bear!"

Instrumental beliefs: "To not make me laugh, not to feel humiliated, I better not go on the trip", "To not take a small note at the Olympics and to laugh at my school, I better not participate."

The main emotional reaction is dysphoria, a combination of anxiety and sadness, which he perceives with anger, because he cannot control it. He accuses the fact that because of the emotion when he is taken to the lesson he forgets what he learned. Anticipating rejection generates dysphoria, all the more painful as it considers the rejection attitude of others to be justified. "If someone holds me, he either doesn't know me, or has any hidden interest. I'm better off now, not to be hurt again". The flow of automatic thoughts predicts in a negative sense what will happen: "I will not succeed", "I will be ashamed.", "I will not like it,". Tolerance low dysphoria prevents him from developing strategies for overcoming timidity and assertive assertion of his desires. The result was materialized in an attitude of social, cognitive, behavioral and emotional avoidance.

The personal strategies are positioned on a downward continuum, at one pole being strongly manifested the tendency of social vulnerability, avoidance and inhibition and at the other a weak manifestation of assertiveness and sociability. The coping strategies adopted by Andi are: avoiding social contacts and limiting the expression and experimentation of emotions. His conduct, his actions are dominated by his low tolerance for any inconvenience, He is very sensitive to failure and rejection and instead of coming to meet the help offered by his family, teachers, colleagues, he feels humiliated and inconsiderate. To avoid suffering, avoid confrontation,

situations in which it is evaluated. The tendency of "cognitive avoidance", makes him hide "like the ostrich", his own thoughts and the interpretation of his feelings.

It seems that this strategy is a "cultural characteristic", "of the nation", because even his younger cousin has the same principles: "why should I help a stranger, and then he will hurt me?! I don't need friends, Mom and Dad are best friends" (she is only 9 years old).

Diagram of Cognitive-Behavioral Conceptualization

Relevant information from early childhood: Mom, anxious, overwhelmed with fears about the situation of her children. The father is very little involved in family problems, being very busy with the service. The older brother of 6 years, the substitute of parents, friends, has left for 4 years to study in France, a fact that he felt very painful about the subject.

Fundamental beliefs "I cannot be loved, I am worthless" "I am vulnerable to negative emotions"

Conditional assumptions "If I succeed and hide from what I am in reality, I could be accepted by others" "If I show who I really am, how good I am for not being rejected" "If I manage to control my emotions, I'll be fine." "If I lose control, I will feel bad and I will not be able to bear it" "If I avoid talking in public / in class, I don't grow red at the tip of my ears!"

Coping strategies She avoids starting conversations, her mother solves her problems at school, she has no friends in class among colleagues, she avoids opening up in front of them, approaching them. Avoid attending collegiate meetings, wedding days, etc. Nor does he invite his colleagues home. It does not endure conflict situations, confrontations, avoid them. He has no friends on Facebook, he has a page, but he doesn't open it for months. He is depressed by his brother's longing, and consumes this condition through gaming.

Situation 1 Her mother blames her school failures,	Situation 2 The colleague asked for money to	Situation 3 She liked a girl and was trying to "get in	Situation 4

she blames her for nothing, that "the dust will be chosen", by him, "the garbage man will come." Automatic thinking Mom doesn't love me	stay with them in the bank. Automatic thinking My colleagues are manipulating me	the way". She reacted disproportionately to his joke. Automatic thinking Girls don't like me	When he speaks in public he manifests erythema pudic Automatic thinking I am embarrassing myself
The meaning of automatic thinking "I'm a nullity!"	The meaning of automatic thinking "I'm a jerk!"	The meaning of automatic thinking "I am ugly, repulsive"	The meaning of automatic thinking "I'm sorry!"
Emotion Agitation, anger, crying	Emotion humility	Emotion Fear, sadness	Emotion / metaemotion Anger, shame
Behavior She locks herself in the room and refuses to go to meditation.	Behavior He avoids his colleagues, does not attend their jokes at breaks, at parties, does not go to camps.	Behavior He avoids the company of his colleagues, he has no friend	Behavior He avoids answering at times, even when he knows, he avoids asserting his opinions in a group.

E. Model A-B-C

A situation-stimul1. When he speaks in public	B. Automatic thinking dysfunction I am ashamed and red like a cancer! “	C.Consecinţă - Cognition “I'm sorry!” - Emotion Anger, shame (dysphoria) - Behavior Avoid answering at the right time.

F. Intervention Plan

The goal of the therapy is not the complete elimination of dysphoria but the increase of tolerance for negative emotions. to establish a new reality reading grid, we have jointly established the following general objectives:

a. Overcoming cognitive and emotional avoidance

b. Skills training

c. Identification and testing of fundamental maladaptive beliefs

The techniques used:

- Imagery
- Psychodrama
- The journal with predictions

d. Building positive beliefs

- Journal for positive experiences

From the list of problems, we have agreed together to address the specific embarrassment of speaking in public as “reddish as a cancer”

E. Model A-B-C

A. The stimulus situation1. When he speaks in public	B. Automatic thinking dysfunction I think I blushed like a cancer! “	C. Consequence - Cognition “I'm sorry!” - Emotion / meta-emotion Anger, shame (dysphoria) - Behavior I'm blocking myself.

A 2 = C ⟶ **B** **2 C** ⟶

A2.Metaemoţia. I feel sorry	B2. Automatic thinking dysfunction It's terrible, I have to do something.	C2. Consequence - Cognition “I'm sorry!” - Emotion / meta-emotion Anger, shame (dysphoria) - Behavior Avoid answering at the right time.

When I speak in public (A), I think that I am flushed like a cancer (B) which is unfortunate for me / ashamed / blocked (C = A2). It's terrible (B2). In order not to make me laugh (mocking - shameful), I no longer respond to hours / I no longer speak in public.

- irrational friends;
- I think I'm blushing like a cancer;
- it's awful;
- I'm sorry / mocking.

As a preamble to therapy, in order to strengthen the therapeutic relationship and to address something concrete and feasible, we have addressed as the first problem “pudic erythema”. Being a child with a high level of culture and understanding, I allowed myself an “academic” style, to give more weight to the task:

- I informed him about the connection between thoughts and emotions;

- I explained the mechanism of pudic erythema, one of the most obvious manifestations of emotional expressivity;

T: Why do you think that being red in public is humiliating?

P: My colleagues call me “Bashful” - the shameful dwarf in White as the Snow ... I feel the crap…

T: Although it is a reflex mechanism, so it is harder to control, yet being associated with a state of emotional tension, this phenomenon can be mastered. That is why I propose you to start practicing some relaxation techniques together. Through exercise, practicing once or twice a day, you will manage to control this discomfort and more than that, you will have a better control over your emotions in general. It's like a home theme.

P: I don't have much time, but I'll try.

T: To know that these exercises give you such a pleasant state that it creates addiction...

In addition, I would like to look at the board (I illustrated on Beck's flipchart, with its elements and the particular way of its particular situation). Note, please the fact: consequence C, erythema, is actually A2 stimulus situation, for the feeling of shame / discomfort / dysphoria you experience every time you realize that you are reddening. And look, a vicious circle is formed. Coognitive restructuring involves highlighting irrational beliefs about activating situations based on the ABC model (Ellis, 2006), disputing and reformulating them and replacing them with more adaptive ones;

A. Situation-stimul1. When he speaks in public	B. Functional beliefs I think I'm saying interesting things and trying to be convincin	C. Consequence - Cognition "Even if I blushed, it is natural, I look like my mother!" - Emotion Slight tension and agitation. - Behavior I'm focusing on someone specifically, with their eyes.

Arguments to dismantle his negative attribution - cognitive restructuring:

- having emotions means being alive, transmitting life;
- at the court of the Sun-King the nobles were powdered, chewed, to be expressive;
- and now women are looking to have an "attractive" face
- this is your personal charm; you inherit your mother;
- fix your gaze on a kind colleague in the classroom and speak as if you were in a snoop, or as if you wanted to convince him of something important

The psychological intervention plan also includes other aspects:

- breathing control exercises and progressive relaxation for self-control and anxiety reduction;
- mindfulness exercises
- short-term, collaborative and resource-oriented therapeutic interventions and solutions for strengthening robustness;

- rational-emotional and behavioral techniques (Ellis, 2006) for reinforcing self-esteem (by unconditional acceptance of oneself and unconditional acceptance of others);
- context reframing and meaning exercises to improve the interpersonal relationship;
- assertive training;
- use of scales to evaluate the outcome of psychological intervention
- tracking each evolution session through Feedback InformedTreatment (F.I.T.).
- to identify together the automatic thoughts in vivo, during the session
- learn to identify and classify distorted automatic thoughts
- specific intervention targets: self-criticism
- techniques for counteracting negative automatic thoughts
- the dispute over the underlying adaptive adjustments
- we identify together the target of the therapy - the behavioral excess / deficit,
- to acquire during the session assertive skills - role play
- have more positive social contacts
- techniques for developing problem solving skills
- finding resources to improve the interrelation skills;
- focus attention on the correct expression, without making it an additional stress
- strengthening self-esteem and robustness;
- restoring the proactive way in overcoming difficulties;
- increasing assertiveness;
- an efficient style of time management;

Obstacles and blockages in therapy. The main obstacles are caused by absences and the fact that they do not execute homework. I have not been able to establish with

certainty whether the motivation it brings is real, but the fact that it does not come with the homework done, demonstrates reduced compliance to therapy and the same avoidant attitude, in the "up and down" balance of interest towards requests, no matter what their nature.

Homework

a. *Permanent program*

- to take his teammate - my mother;
- to conclude a partnership contract;
- to execute twice a week together with the mother the relaxation program and the concentration program (stick with the program https://www.curteaveche.ro/devolution-intelligentei-motionale-tehnici-de-a-cultiva-puterea-launtrica- to children.

b. To complete the Dysfunctional Attitudes Scale (DAS - Aaron Beck et al.) adapted by Bianca Macavei

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