

Personality disorder in a catholic nun: A Case Report

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ABSTRACT:

Personality disorder is characterized by problems in functioning in aspects of the self and /or interpersonal dysfunction (e.g ability to understand others perspectives and to manage conflict in relationships) that have persisted over an extended period of time. The disturbances manifest in patterns of cognition, emotional experience, emotional expression and behaviors that are maladaptive In moderate personality disorder, there are marked problems in most interpersonal relationships and the performance of most expected social and occupational roles are compromised. Relationships are characterized by conflicts, e.g persistent conflicts in work relationships and consequent occupational problems, the disturbances are of moderate severity.

A case report on a 30 year old nun who presented with a history of frequent interpersonal conflicts with different individuals and groups is presented here. These caused her much distress and affected her occupational and social functioning. A diagnosis of moderate personality disorder was made and she commenced psychological therapies.

Keywords: Disorder, Personality, Nun.

INTRODUCTION:

Personality disorder may be defined as “deeply ingrained maladaptive pattern of behavior beginning in adolescence or earlier and continuing throughout adulthood leading to suffering in the individual and others’¹.

The characteristic and enduring patterns of behaviour differ markedly from the cultural norm and in more than one of the following areas: cognition, affectivity, control of impulses and gratification, and ways of relating to others. The behaviour is inflexible, and maladaptive or dysfunctional in a broad range of situations. Personal distress is caused to others and/or to self. The presentation is stable and long lasting, usually beginning by late childhood or adolescence. The behaviour is not caused by another mental disorder, or by brain injury, disease, or dysfunction.

The ICD-11 general diagnostic requirements include problems in functioning of aspects of the self and /or interpersonal dysfunction that have persisted over an extended period of time e.g 2 years or more. The

disturbance is manifest in patterns of cognition, emotional experience, emotional expression and behaviors that are maladaptive and manifests across a range of personal and social situations and is associated with substantial distress or significant impairment in personal, social, educational, occupational or other important areas of functioning²

In moderate personality disorder, the general diagnostic requirements for personality disorder are met. Disturbances affect multiple areas of personality functioning e.g ability to form intimate relationships, ability to control impulses and modulate behavior. However, some areas of personality functioning may be relatively less affected. there are marked problems in most interpersonal relationships. And the performance of most expected social and occupational roles are compromised. Relationships are characterized by conflicts ,persistent conflicts in work relationships and consequent occupational problems, Specific manifestations of personally disturbance are generally of moderate severity and is associated with marked

impairment in personal , family , social , occupational , educational or other important areas functioning although functioning in circumscribed areas may be maintained.

They are suspicious and constantly on the lookout for attempts by others to deceive or exploit them, which makes them difficult for others to get on with. They have difficulty making friends and avoid involvement in groups. They are usually mistrustful and often jealous. They may appear secretive and self sufficient to a fault. They take offence easily and see criticism where none was intended. Suspicious ideas can be so intense that they are mistaken for persecutory delusions. With many sensitive ideas of reference, these individuals can be resentful and bear grudges, engaging in litigation, often against all advice³.

CASE SUMMARY:

Sister A.K, a 30 year old Roman Catholic nun came to the Psychiatry out patients clinic of Jos University Teaching Hospital accompanied by her lawyer and her mother. She is the first child in a monogamous christian family. At a tender age, her family migrated and settled among a neighboring ethnic group. While in primary school, her school mates constantly made fun of her by twisting the pronunciation of her tribal name to a word which means "witch" in their own dialect and used it to make a caricature of her. This action pitched her against her school mates and was a constant reasons for quarrels. She felt isolated and traumatized for most part of her early school days. When she proceeded to secondary school within the same community, She believes the antagonism towards her worsened towards the end of her secondary school years when she became the school head girl. She reported fellow students to the school authority for punishment, she reported instances when she cried profusely when she felt people hated her unjustly.

She graduated from secondary school and applied twice to read nursing but did not pass the exams. The third year she got admitted to a seminary to be trained to become a reverend sister (nun) where again she frequently had issues with her mates, teachers and even the bishop. She confessed that for the past decade, no year passes without a major conflict with different people or groups.

After completing her training, she was posted to a boarding school as a matron, there she again had frequent misunderstandings with her superior. She wrote a petition to the senior bishop against her superior.. She was suspended once for falsely accessing a reverend father of having immoral thoughts.

When her bishop introduced her to men, she accused him of a hidden immoral plan which made them to label

her a mad person and invited a psychiatrist who prescribed some medications for her.

Recently, she got admission into a Catholic University and also applied for a job there to get her fees then she claimed her HOD started sexually harassing her in his office. She reported to the VC and it was discarded after investigations found no evidence of harassment. Her purpose of coming to the hospital is to confirm her sanity and use the report to sue her HOD and University authority.

She made a post on Facebook recently saying she may convert to Islam. In another Facebook post, she wrote that reverend fathers should stop using reverend sisters as their wives or concubines. These Facebook posts generated so much anxiety among her family and church community who insisted that she seeks psychiatric treatment. A few weeks after coming to our hospital for assessment, she received a letter from the same University informing her that her appointment has been terminated.

She had no complaints of abnormal beliefs, no feelings of undue sadness nor excitement. No history of psychoactive substance use nor head injury. She appeared well groomed and appropriately dressed in white regalia, well kempt with spontaneous, coherent and logical speech. There were no perceptual abnormalities and no formal thought disorders. Her cognitive functions were essentially normal. She had good fund of knowledge and current affairs.

A diagnosis of moderate personality disorder was made and she commenced supportive psychotherapy and cognitive behavioral therapy.

DISCUSSION:

The disturbances affected multiple areas of her functioning (i.e ability to form intimate relationships, ability to control impulses and modulate behavior). She has marked problems in interpersonal relationships and her performance of most expected social and occupational roles are compromised. She has persistent conflicts in work relationships and consequent occupational problems. However, her family functioning is relatively less affected and the disturbances are generally of moderate severity. This fits the description of moderate personality disorder causing marked impairment in her social, occupational, educational and other important areas of her functioning. This fits the diagnosis of moderate personality disorder causing marked impairment in her social, occupational, educational and other important areas of her functioning.

Aetiology:

Several theories have been put forward to explain its aetiology. The psychodynamic theory says defensive non

adaptive patterns develop as a result of disruptive early environment. Reality testing is distorted by intense internal needs and conflicts leading to habitual distortion of thought, judgment and perception obvious to others but not to the individual.

Genetics:

There is now an impressive volume of research into biological factors in borderline personality disorder (New et al., 2008)⁴, and some evidence for the importance of genetic factors. Twin studies show heritability scores of 0.65 to 0.76 (Ji et al., 2006)⁵. First-degree relatives of patients with borderline personality disorder are 10 times more likely to be treated for borderline personality disorder or 'similar personality disorder' (Loranger et al., 1997)⁶.

Some investigators have also reported that paranoid personality disorder is more frequent among first degree relatives of probands with schizophrenia than among the general population (Kendler et al., 1985)⁷. Moreover, some genes and loci associated with personality disorder have even been identified (Lubke et al., 2014)⁸.

Personality:

Personality, the innate behavioral traits, has long been used to categorize people. Hippocrates classified people as either choleric, sanguine, phlegmatic or melancholic based on prevailing traits, Kretschmer described mesomorphic (muscular, active); ectomorphic (restrained, aloof) and endomorphic (social, relaxed) while Henderson classified people as 'aggressive', 'creative' or 'inadequate'.

Several studies have observed that the structure underlying both normal personality (McCrae et al.; 2005)⁹ and personality disorders (PDs) is stable across cultures (Dahourou and Rossier, 2008)¹⁰. A study conducted by Rossier et al. (2008)¹¹ in nine African countries and Switzerland observed that the relationship between PDs and normal personality was stable across countries.

Incidences:

Personality disorders are rare. The prevalence rates for any personality disorder range from 4% to 16%. One international survey sampling seven countries across five continents (Huang et al., 2009)¹² found a point prevalence of 6.1%, lowest in Europe (2.4%) and highest in North and South America (7.6% USA, 7.9% Colombia). In contrast to clinic populations, personality disorder is as common in men as women (Coid et al., 2006)¹³ and it is as common in ethnic minority as in host populations (Crawford et al., 2012)¹⁴. There are very few studies in Nigeria and Africa on personality disorder.

Prevalence of PDs in Africa is largely unknown. There are some findings such as the report on the overall PD rate in South Africa, which is 6.50%, and the general prevalence of 2.70% in Nigeria (Huang et al., 2009)¹²

Management:

Supportive psychotherapy has been the mainstay of treatment of people with personality disorder and Cognitive behavior therapy focusing more on schemas (the underlying assumptions patients make rather than exclusively on automatic thoughts) (Davidson, 2000)¹⁵

For some, modest but useful progress can be achieved by having a secure point of reference and a sense of being taken seriously over a period of months or, sometimes, years. Support may be provided by a member of the psychiatric team.

Systematised programmes such as dialectical behavioural therapy and mentalisation based therapy, may be useful in management of border-line personality disorder¹⁶.

Medication plays only a small part in the treatment. It should not be the first choice, and when it is prescribed it should be part of a wider plan that embraces psychological and social care.

NICE guidance (2009b) advises against the use of medication unless a clear comorbid disorder (e.g. major depression) is present, but a review by Lieb et al. (2010)¹⁶ got some limited evidence that anxiolytics, antipsychotics and anticonvulsant mood stabilizers could have beneficial effects on aspects of personality disorder.

Prognosis:

In the USA (Skodol et al., 2005)¹⁷, remission occurred in 38% of obsessive-compulsive personality and 23% of schizotypal personality disorder within 2 years.

The prognosis (Stone, 1993)¹⁸ is varied; while 50 to 60% of personality disorders had clinical recovery, 3 to 9% of those with co-morbid depression had suicide.

CONCLUSION:

Personality disorders are rare clinical conditions which requires careful assessment for diagnosis. The management is challenging, the individual and sometimes the family tend to see it as the person's "usual" behavior although they may acknowledge that the degree of distress is unusual and causes concern.

Conflict of interest:

None.

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Authors contributions:

D.M Concept, literature review, writing the manuscript
Y.T data, review; I.S literature, literature; S.D review,
data collection, review, All authors read and approved
the final manuscript.

Ethics:

Ethical clearance was obtained from the head of
department of Psychiatry for this case report and the
patient consented that we write the article omitting her
name

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