A Psicologia em suas Diversas Áreas de Atuação

Eliane Regina Pereira
(Organizadora)

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APRESENTAÇÃO

> Descobri aos 13 anos que o que me dava prazer nas leituras não era a beleza das frases, mas a doença delas.
>
> Comuniquei ao Padre Ezequiel, um meu Preceptor, esse gosto esquisito.
>
> Eu pensava que fosse um sujeito escaleno.
>
> - Gostar de fazer defeitos na frase é muito saudável, o Padre me disse.
>
> Ele fez um limpamento em meus receios.
>
> O Padre falou ainda: Manoel, isso não é doença, pode muito que você carregue para o resto da vida um certo gosto por nadas…
>
> E se riu.
>
> Você não é de bugre? – ele continuou.
>
> Que sim, eu respondi.
>
> Veja que bugre só pega por desvios, não anda em estradas –
>
> Pois é nos desvios que encontra as melhores surpresas e os ariticuns maduros.
>
> Há que apenas saber errar bem o seu idioma.
>
> Esse Padre Ezequiel foi o meu primeiro professor de agramática.
>
> (Barros, 2010, p. 319-20)[1].

Escolhi Manoel de Barros para iniciar a apresentação deste ebook. Tal escolha se dá, pelo convite de Manoel a que conheçamos os desvios, o gosto por nadas e o prazer pela doença das frases/palavras. Ele nos incita a encontrar os ariticuns maduros, a escrever, pensar, e gostar da agramática. Esta é a psicologia que acredito, aquela que se produz nas rupturas, nas frestas, nas descontinuidades, nas transgressões, mas, sempre nos encontros. Não uma psicologia enclausurada em regras ou em protocolos, mas uma psicologia que se faz ciência no contato com os sujeitos. Que constrói desvios para encontrar a beleza e a potência de vida nos sujeitos e em seus momentos difíceis.

Este ebook é resultado de uma série de pesquisas bibliográficas de cunho qualitativo e/ou quantitativo, pesquisas empíricas e relatos de experiência. Nele os autores descobrem e contam sobre seus caminhos, sobre sofrimento, dor, angústia, mas também sobre possibilidades, desvios e ariticuns maduros.

O livro está organizado em duas partes. A primeira parte intitulada “Reflexões

1. Barros, M. (2010). Poesia Completa. São Paulo: Leya. (6ª reimpressão).

em psicologia" consta trinta e um capítulos que apresentam diferentes temáticas, como: a prática grupal como estratégia de cuidado a jovens analisadas em duas perspectivas diferentes – abordagem centrada na pessoa e psicologia histórico-cultural; a gestação e o desenvolvimento humano ou os cuidados paliativos de neonatos e sofrimento da perda; a pessoa idosa no dia a dia e a prestação de serviço oferecida aos cuidadores; promoção de saúde e intervenções psicossociais; proteção a crianças e adolescentes vítimas de violência intrafamiliar; dependência química e relações familiares; doença crônica; suicídio; constituição da subjetividade; desinteresse escolar e arte no contraturno; motivação, satisfação e produtividade no ambiente de trabalho; inclusão de pessoas com deficiência na escola e no trabalho.

A segunda parte intitulada "Resumos expandidos" é composta de sete capítulos. Nesta parte, os autores apresentam em textos curtos, mas muito interessantes, diferentes temas, como: suicídio, qualidade de vida no trabalho, mediação extrajudicial, sexualidade infantil, psicologia educacional, e manifestações comportamentais.

Desejamos boa leitura a todos e que os conhecimentos aqui apresentados possam provocar um interesse pela agramática, como nos diz Manoel.

Eliane Regina Pereira

SUMÁRIO

REFLEXÕES EM PSICOLOGIA

CAPÍTULO 8

PERTURBAÇÕES DE PERSONALIDADE E QUALIDADE DE VIDA NUMA AMOSTRA CLÍNICA DE UTENTES PORTUGUESES DOS CUIDADOS DE SAÚDE PRIMÁRIOS

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ABSTRACT: ***Background:*** Personality disorders appeared to be more important statistical predictors of quality of life than sociodemographic variables, somatic health and Axis I disorders. ***Objectives:*** Determine associations between a diagnosis of personality disorder and quality of life (general and dimensions). Methods: A sample of 184 individuals (24.5% male, 75.5% female). The SCID-II for DSM-V was used to measure personality disorders, and WHOQL-bref for quality of life. Multivariate analysis was used to test hypotheses of association between personality pathology and general/specific domains of quality of life. ***Results:*** Personality disorders were diagnosed in 52.7% of the sample. Individuals with personality disorder have worse quality of life (p≤.05). A most expressive association between the social relation domain and cluster A (*r*=-.195), between environment domain and cluster B (*r*=-.155), and finally between the psychological domain and cluster C (*r*=-.223). ***Conclusion:*** The more PDs that existed and the more personality criteria fulfilled, the poorer the quality of life, pointing to the importance of comorbidity and continuity of psychopathology.

KEYWORDS: Personality disorders, primary health care, quality of life.

PERSONALITY DISORDERS AND QUALITY OF LIFE IN A PORTUGUESE PRIMARY CARE PATIENT´S CLINICAL SAMPLE

PRIMARY HEALTH CARE AND PERSONALITY DISORDERS

Health professionals that work in primary healthcare services, deal daily with psychological disorders, more specifically, with patients that show depressive features, anxiety disorders and personality disorders (Common Mental Health Disorders, 2011). Personality disorders characterize by maladaptive functioning pattern, perpetuated over time, manifesting affective and interpersonal

relationship inadequate patterns, with a ego syntonic symptoms nature; that results in a vision of self, the world, and others that stray away from which is adaptive, and expected in a given socio-cultural environment (DSM-V, 2013; Bridget, et al, 2004; Young, 1999). The patient with personality disorder usually shows maladaptive, inflexible and functionally compromised behaviours, although despite ego syntonic it leads to internal suffering (Hawke, Martin, Provencher, & Parikh, 2013; Young, 1999). Personality disorders show genetic base indicators (Kendler, Aggen, Knudsen, Røysamb, Neale, & Reichborn-Kjennerud, 2011; Kendler, Myers, & Reichborn-Kjennerud, 2011), but they came into being, through the development of early maladaptive schemes that influence the way individuals cognitively elaborate and represent inputs about themselves, others and the world (Strauss et al., 2006; Beck, Butler, Brown, Dahlsgaard, Newman, & Beck, 2001).

Considering the Portuguese Mental Health National Plan (2007-2016); it also intends to assure at the mental health level, the articulation and partnership with other community structures that allow the practise of healthcare services by group or support nucleus, composed by the healthcare centres professionals and their respective units; with specialized consultancy, screening, evaluation, attending and directing functions of clinical situations that manifest psychopathology.

This way, primary healthcare services are an excellent platform towards a first approach to patients with personality disorders, namely in the early identification of this psychopathology, promoting higher prevention in future reincidence for the patient and also for the services costs (Rendu, Moran, Patel, Knapp, & Mann, 2002; Moran, Jenkins, Tylee, Blizard, & Mann, 2000)

PERSONALITY DISORDERS AND QUALITY OF LIFE

The Constitution of the World Health Organization (WHO, 1948) defines health as a state of complete physical, mental and social well-being, not merely the absence of disease. It follows that the measurement of health and the effects of health care must include not only an indication of changes in the frequency and severity of diseases but also an estimation of well being and this can be assessed by measuring the improvement in the quality of life related to health care. Although there are generally satisfactory ways of measuring the frequency and severity of diseases this is not the case in so far as the measurement of well-being and quality of life are concerned. In this sense, WHO (1994) defines Quality of Life (QOL) as individuals' perception of their position in life in the context of the culture and value systems in which they live in relation to their goals, expectations, standards and concerns.

It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, and level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.

Personality disorders may harden certain daily life aspects, leading to interference with quality of life. These patients manifest difficulties in interpersonal relationships, punctuated by conflicts in laboral, family and marital relationships and low quality of life and high societal costs (Feenstra, Hutsebaut, Laurenssen, Verheul, Busschbach, & Soeteman, 2012; Hoffman, Gschwendwer, & Schmitt, 2005).

A longitudinal research lead by Skodol et al. (2005), reveals that patients with personality disorders have a lower average life expectancy than the general population, since this patients are more prone to accumulate other health problems, such as substance abuse, anxiety, depression, hypertension and cardiovascular diseases (Moran et al.; 2007; Mulder, Joyce, & Luty, 2003). Soeteman, Verheul, & Busschbach (2008) points out that the total number of personality disorder diagnoses was related to quality of life. Also findings from the general adult population indicate that personality disorders are significant predictors of quality of life, even more so than somatic health, sociodemographic variables and Axis I disorders (Korsgaard, Torgersen, Wentzel- Larsen, & Ulberg, 2015; Cramer, Torgersen, & Kringlen, 2006; Cramer, Torgersen, Kringler, 2007)

Specifically the risk increase for the mentioned clinical cases, are not fundamentally explained by the difference in socioeconomic status, but by the comorbid pathologies management, which by its turn leads to an increase in personality pathology complexity (Newton, Tyrer, & Johnson, 2006).

Cramer, Torgersen, and Kringlen (2006) studied the relationship between the different personality disorders dimensions and quality of life, detecting that avoidant personality is strongly correlated with low quality of life, followed by borderline, schizotypal, dependent, paranoid, schizoids and antisocial patents (they show negative quality life indicators related with aggressiveness and impulse control difficulties). Patients with obsessive-compulsive, histrionic and narcissistic personalities did not show highly differentiating quality of life impacts, when compared to the previous personality disorders described, and relative to DSM-IV Axis I disorders (Cramer, Torgersen, & Kringlen, 2006; Skodol et al., 2005).

Overall, it's the avoidant, schizotypal and schizoid personality disorders that are more strongly associated with interpersonal relationships and quality life general indicators (family, workplace, marital, friendships and personal). However it`s the patients with borderline personality that show higher correlation with the low subjective well-being perception associated with negative life events (Cramer, Torgersen, & Kringlen, 2006; Skodol et al., 2005). Relatively to the distribution of these groups, literature reveals a higher prevalence of personality disorders in poorer neighbourhoods and city centres, justifying this occurrence with the childhood adversities in poor family settings, with a lot of parenthood risk factors - particularly higher correlation with B group - (Cramer, Torgersen, & Kringlen, 2006; Skodol et al., 2005).

To conclude, we can equate, the different personality dimensions valorisation,

and their own correlation with quality of life factors; and the necessity for these to contribute as diagnosis entities to define and characterize different personality disorders.

Aims: The objective was to study the differences in the quality of life, between primary health care patients with and without personality disorders (and depending on the severity of same). We hypothesis that patients fill the criteria for at least one personality disorder, and manifest reduced quality of life by comparison with patients without personality disorders. It is also expected that personality disorder higher severity (higher number of criteria filled) correspond to worse quality of life.

MATERIAL AND METHODS

Participants

The sample consisted of 184 individuals aged between 21 and 50 years old, 45 masculine (24.5%) and 139 (75.5%) feminine from Dão Lafões II Primary Health Care Centre. There aren`t statistically significant difference between genders in the variables age (t= 1.425; p=-156), and school years (t= -.490; p=.624). All referred patients in the study´s age group were asked to participate. Clinical psychology consultancy works closely with the family medicine practice. The sample inclusion criteria include individuals referred for consultation by family physicians; 1- The subjects of the sample are referred by general and family physicians for clinical psychology service (of ACES Dão Lafões II Health Care Systems) with possible diagnostic Axis I mental disorder according DSM-IV, with or without drug therapy; 2- Belong to the age group between 21 and 50 years; 3- Applications must be accompanied by detailed information on the history and the clinical condition of the patient, with the exclusion of organic pathology associated, in order to justify the need for clinical psychology consultation. Exclusion criteria were: individuals under the age of 21 or over the age of 50 years; Subjects with a diagnosis of bipolar disorder, schizophrenia, and cognitive deficits or diagnosis.

	n=184	
	M	**SD**
Age	37.09	7.70
years of education	8.90	3.61
	n	**%**
Sex		
Male	45	24.5
Female	139	75.5

Social-economic status		
Low	139	75.5
Medium	36	19.6
High	2	1.1
Students	7	3.8

Table 1 – Socio-demographic and socio-economic characteristics of the sample (n=184; 100%)

Measures

Personality disorders. Participants interviewed with the SICD-II - Structured Clinical Interview for DSM-IV Axis II Personality Disorders (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; Portuguese version by Pinto-Gouveia, Matos, Rijo, Castilho, & Salvador, unpublished) to assess personality disorders. It has been used in several studies in different countries and includes a semi- structured diagnostic interview that assesses 10 Axis II Personality Disorders from the DSM- IV (APA, 2000), and the Depressive and Passive-Aggressive Personality Disorders (included in DSM-IV's appendix). The Portuguese translation was realized in consultation with the original authors and the application was pre-tested in different clinical settings.

Quality of life. Quality of life was evaluated through WHOQOL-BREF (WHO, 1993; Portuguese version by Canavarro et al., 2009) instrument an abbreviated 26 item version of the WHOQOL-100, which measure the following broad domains: physical health (Energy and fatigue pain and discomfort sleep and rest); psychological health (bodily image and appearance negative feelings, positive feelings, self-esteem, thinking, learning, memory and concentration); social relationships (personal relationships, social support, sexual activity); and environment (financial resources, freedom, physical safety and security health and social care). The instrument produces scores relating to particular facets of quality of life (e.g. positive feelings, social support, financial resources) and scores relating to larger domains.

Those scales have shown good internal consistency in original version and also in this study (α = .77 to α= .89). The study protocol included sociodemographic variables (such as age, gender, education and marital status) and broad aspects of quality of life.

Procedures and Statistical Analysis: This study was approved by the Head of Health Care Services – ARS - and was carried out by a clinical psychologist who had special training in the diagnosis of Personality Disorders and previous experience administering the SCID-II interview and works on primary care. Participants were invited to participate voluntarily and anonymous and confidentiality were guaranteed. All participants signed an Informed Consent Form prior to the administration of the interview and questionnaires. In a first moment, participants aged 21-50 were forward by a primary care physician to attend a clinic psychology office. For statistical analysis,

it was used the SPSS program, version 22, and it was assumed a significance of $p \leq .05$. In addition to descriptive statistics we used multivariable studies to test association hypothesis between personality pathology and quality of life.

RESULTS

Total sample personality disorder prevalence

As can been seen, figure 1 indicates the absolute frequencies and the percentages of individuals with personality disorders and of individuals without disorder.

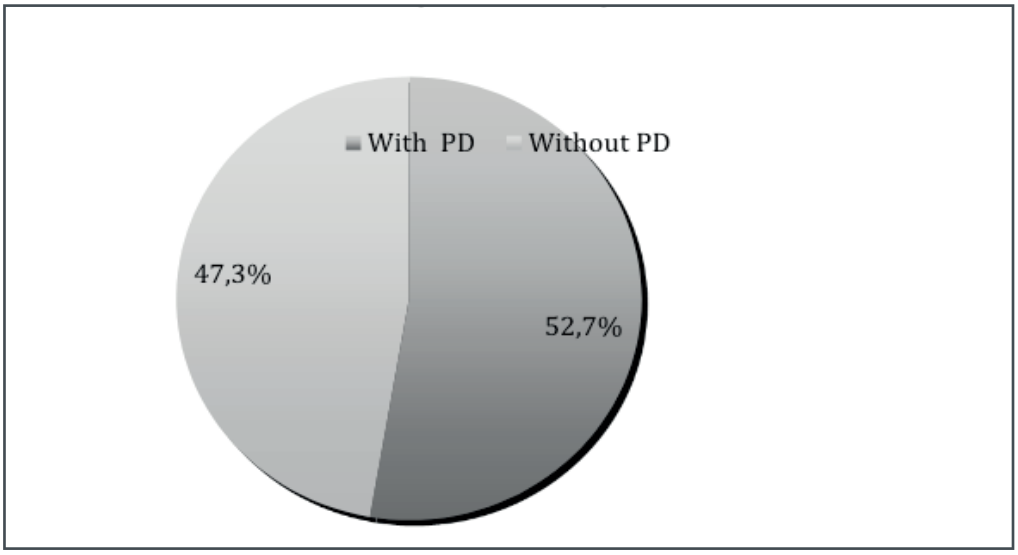

Figure 1 - General prevalence of personality disorders in the sample (n=184; 100%)

As shown in the figure, from the 184 individuals, 97 fit the criteria for at least one personality disorder, or 52,7%. Over half the sample shows at least criteria for one personality disorder.

Prevalence of personality disorders by clusters in total sample

The Figure 2 illustrates personality disorder prevalence by cluster. To classify each subject in each cluster, it was considered the main diagnose through SCID-II. From this study 9 subjects were excluded who`s main diagnose was passive-aggressive personality disorder and depressive personality disorder; being reduced the sample to 175 subjects.

It was mentioned in the previous study 87 individuals (49.71%) do not fit the criteria for personality disorder. The remaining, 37 individuals (21.14%) show has main diagnostic a group B personality disorder, 35 subjects (20 %) show a group C

disorder; and 16 individuals (9.14%) show a group A disorder.

Overall, despite all groups showing considerable prevalence, B group is the highest.

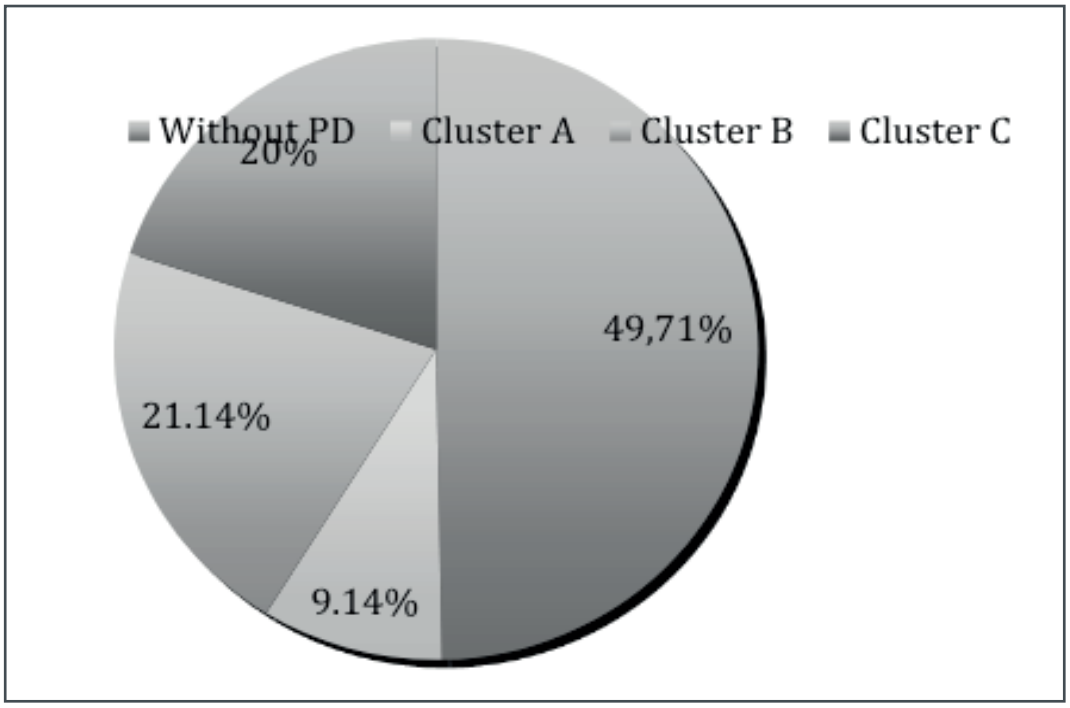

Fig 2 – Prevalence of personality disorder by cluster in total sample (n=175; 100%)

Personality disorder severity by clusters

Table 2 shows for total SCID criteria and 10 PD- total criteria of personality disorder in total sample, the averages and standard deviations.

	Male n=45		Female n=139			
Clusters	**M**	**SD**	**M**	**SD**	**F**	**p**
Cluster A	6.66	3.19	5.60	3.11	5.223	.023
Cluster B	5.40	3.41	5.63	4.51	.009	.924
Cluster C	6.24	3.52	6.20	2.74	.681	.410

Table 2 - Personality patology severity by clusters (n=184;100%).

As can been seen in table 2, individuals of both genders, don´t differ in average of total criteria of clusters B and C. Although, in cluster A total criteria average, men show more severity (higher number of fulfilled criteria) than women (F=5.223; *p*=.023).

Personality disorder and quality of life association

In these studies we evaluate the relationship between personality disorder and

quality of life. To evaluate quality of life it was used the brief version of WHO`s official instrument to evaluate quality of life.

Comparison between with and without personality disorder diagnostic individuals and quality of life indicators

We intend to analyse quality of life differences among individuals with and without personality pathology, in primary health care services.

In table 3, it is presented, the comparisons between with and without personality disorder individuals in the WHOQOL-bref quality of life specific domains.

	Without PD		With PD			
	M	SD	M	SD	F	p
WHOQOL-general	4.66	1.37	4.37	1.29	2.457	.119
WHOQOL-physical	20.62	.45	20.49	4.24	.44	.834
WHOQOL-psychological	16.91	.37	15.76	.36	5.024	.026
WHOQOL-social relationship	7.77	.20	6.96	.19	8.679	.004
WHOQOL -environment	23.47	.42	21.96	.39	6.995	.009

Table 3 - Comparison between individuals with and without PD in quality of life (n=184; 100%)

note: without PD - without personality disorder; with PD - with personality disorder

We can observe in table 3 the averages and standard deviations in WHOQOL-bref domains, in individuals with and without personality disorders. As we can see there are significant difference in Environment (p=.009), Relation (p=.004) and Psychological (p=.026) dimensions in terms of the averages of the dimensions in each WHOQOL-bref domain.

All comparisons that achieve statistical significance, behave as expected, that is, it`s the individuals with at least one personality disorder that possess worse quality of life in the analysed domains.

Personality disorders criteria and quality of life indicators association.

We intend to evaluate the existence of differences in personality disorders clusters in terms of quality of life, on the personality disorder criteria total and on the total of criteria by 10 personality disorders.

In table 4 it is shown the correlations between the personality disorder total number of criteria and each group number of criteria on one hand, and the scores obtained in WHOQOL-brief specific quality of life domains on the other.

	WHOQOL general	WHOQOL physical	WHOQOL psychological	WHOQOL social relationship	WHOQOL environment
Cluster A	_____	___	___	´- 0, 195 **	_____
Cluster B	_____	_____	_____	_____	´- 0,155*
Cluster C	_____	_____	´- 0,223 **	_____	_____
SCID-total criteria	´- 0,176*	_____	´- 0,223**	´- 0,204**	´- 0,168*
SCID-total criteria 10PD	´- 0,150*	_____	´- 0,173*	´- 0,200**	´- 0,154*

Table 4 - quality of life among individuals and clusters personality disorders criteria

note: Total SCID criterias 10 PD - total criterias of personality disorder, excluding depressive personality disorder and agressive-passive personality disorder

** p≤ .01

* p≤ .05

As can been seen in table 4 in the majority of cases, correlations are not significant. All those that are closely from statistical significance, although with low magnitude, occur in concordance with expectations, this is higher severity of personality disorder pathology means a lower quality of life. The only quality of life domain that does not appear to be associated with any personality disorder indicators is the physical indicator.

DISCUSSION

The main findings of this study verify that patients with at least one personality disorder have inferior quality of life in the analysed domains. Also that a higher personality disorder severity translate into a worse quality of life.

In terms of the association between personality disorder and quality of life, we conclude that there is an association between psychological, environment and relation domain, which meets the expected and reference literature (Skodol et al., 2005; Newton et al., 2006; Moran et al., 2007; Fossati et al. 2003; Mulder, 2004; Cramer et al. 2006). In its turn, relative to the personality disorder groups, we verify a most expressive association between the relations domain and group A (Mulder, 2004; Narud, Myketun, & Dahl, 2005; Cramer et al., 2006), between environment domain and group B (Cramer et al., 2006) and finally between the psychological domain and group C (Hoffman, Gschwendner, & Schmitt, 2005; Cramer, Torgersen, & Kringlen, 2006; Moran et al., 2007).

In the context of this study and taking into account the author`s clinical practise in this field and also literature review, we verify that individuals with personality disorders, from the different diagnose groups, manifest distinct quality of life characteristics. Group A shows more complains associated with interpersonal, family and friends relationships. Group B manifests a higher impulse and aggressiveness control

difficulty, and group C reveals more psychosomatic, humour fluctuations and anxiety complains. Literature mentions the existence of an association between group C and relationship domain, which is not found in the present study (Hoffman, Gschwendner, & Schmitt, 2005; Rapaport, Clary, Fayyad, & Endicott, 2005; Cramer, Torgersen, & Kringlen, 2006).

CONCLUSION

The present study shows that more PDs that existed and the more personality criteria fulfilled, the poorer the quality of life, pointing to the importance of comorbidity and continuity of pathology. This further emphasizes the necessity to continue to research the personality characteristics of this specific population, with the intention of preventing, screening and direct earlier this type of psychopathology in primary healthcare services; and also the need for continued development of services to met the needs of people with personality disorders (Farrand & Woodford, 2013; Rijo, 2009; Beck, Butler, Brown, Dahlsgaard, Newman, & Beck, 2001).

Being that so, and not only because the personality disorder diagnostic reveals difficulties in one or more areas of individual functioning, not only due to the inflexible, rigid and lasting character of personality characteristics, but also, because these tend to contribute family and individual maladaptive behaviours and attitudes, exacerbating the symptomatic psychopathology, and excluding them further more from society, condemning the therapeutic interventions that individuals are targeted to failure.

Following this line of reasoning, personality disorders and quality of life assessment in the general diagnosis procedures used should have a vital importance in the public health intervention domain, namely with specialized mental health professionals, since they have a significant impact over the primary healthcare services, even when they are not the treatment focus (Korsgaard, Torgersen, Wentzel-Larsen, & Ulberg, 2015).

Limitations and strengths: the present study enrolled a clinic population - convenience sample – of the 205 individuals eligible for inclusion, 184 were ultimately included. Also the participants were included during a limited amount of time, and we do not know if there were prevalence fluctuations over time. The present study shows that quality of life in individuals is affected by the personality disorder. This also suggest the clinic necessity and importance of include quality of life and personality disorder assessment in general diagonis.

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