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EXPLORING ENGLISH THROUGH PSYCHOLOGY

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LETTER

Dear Readers,

This time, we again dive into the world of clinical psychology, but from a different perspective. As you may remember, in some of the later issues, we explored clinical psychology, covering topics such as pharmacology, psychotherapeutic approaches, and more. This time, we will touch on a field that can be a mystery to some and an explanation for everything to others, namely personality psychology. You may have heard about phenomena such as narcissism, psychopathy, and Machiavellianism – or about more positive traits, such as openness or extraversion. Each of them is part of our personality, and as psychology developed, psychologists found that too much of one trait or another can be destructive to an individual. They also observed and wrote about similarities among people who had these traits (such as narcissism). Eventually, personality disorders were recognised as a separate category of psychological difficulties. Pop culture has been fascinated by them and has begun to glorify them to some degree (though I suppose this has happened with almost every psychological phenomenon).

I would like to thank the writers and everyone who helped make this issue possible. I hope you enjoy reading it and find it both engaging and enlightening.

Jan Jolski

Editor-in-Chief

ASPD in a nutshell

BY AGATA STUGIENT

ASPD or dissocial personality disorder?

Antisocial personality disorder (ASPD), also known as dissocial personality disorder, is a kind of mental health condition that fascinates a lot of people. Still, a few of them can make a detailed description. In the mass media, we are often met with a distorted picture of this disorder. I am sure that many of you have watched at least once a movie, TV series or a programme about a person with psychopathic tendencies, or as producers would probably call it, a psychopath. For cinematic purposes, this kind of character is usually portrayed as an attractive, charismatic, and highly intelligent individual. While that picture may be accurate for some people diagnosed with ASPD, it certainly does not tell the whole story.

Definition according to DSM-5

ASPD is defined as an ongoing pattern of disregard for the rights, feelings and opinions of others. That leads to repeated violations of social and interpersonal norms. People with ASPD do not show remorse for the harm they caused or the deceitful actions they took to gain personal profit or pleasure. They often show aggression and irritability that can result in physical fights or assaults. Impulsivity, irresponsibility, and disregard for the safety or consequences of their actions can endanger themselves or others. They are prone to serving time in prison or other correctional facilities due to a lack of fear of the consequences and repeated violations of the law. Some character traits associated with this disorder include a lack of empathy, arrogance, self-centredness, superficial charm, and manipulative behaviour.

For somebody to be diagnosed with ASPD, they must display those patterns of behaviour (including evident signs of conduct disorder) by the age of 15 years. An individual cannot be diagnosed before the age of 18 years.

Statistics according to DSM-5

The estimated prevalence of this disorder across the general population is around 1 to 3% of people, with males being diagnosed three times more often than females. There has been a discussion about whether ASPD is being underdiagnosed in women due to the differences in symptoms. Women tend to display less aggressive and violent behaviour, making them go unnoticed more often.

An interesting fact about the prevalence of ASPD across different social groups is that we can find a lot more people with this diagnosis in prisons or other correctional facilities, as well as among people with the most severe alcohol use disorders, than in the general population.

But those are not the only groups in our society that have a higher prevalence of this disorder. We can find more people with ASPD in specific career paths, such as lawyers, medical specialists, politicians, or highly ranked managers (e.g., CEOs of large companies).

We also have to remember that people with ASPD very rarely seek a diagnosis, which might lead to underestimating the correct number of patients with this disorder in the general population. Moreover, if those patients have a higher-than-average IQ, they might figure out what answers are expected of them to appear mentally well, making it difficult to accurately assess a diagnosis.

Genes or environment?

We cannot be confident about what the core reason is for someone developing ASPD. What we do know is that this condition is caused by genetic and biological factors, as well as the environment a child grows up in. There is a connection between children being raised in unpredictable, unstable households and the development of this condition. Child abuse or neglect can also increase the likelihood that a conduct disorder diagnosed in childhood will evolve into ASPD.

ASPD patients in real life. How can we recognise them?

The highly intelligent individuals with ASPD are usually very skilled at lying and manipulating other people. That helps them understand what others perceive as right and wrong, as well as what is expected of them in social settings. They can go a long way without anybody noticing what is actually happening inside their heads. Moreover, throughout their lives, they learn to mimic emotions and understand what is appropriate to say in certain situations. However, concerning as that may sound, those patients are actually a minority within the population of people with ASPD.

Just like with any other group in our society, intelligence levels widely vary from person to person, and most would probably score an average result on an IQ test. Although most, if not all, in this specific population would lie or manipulate, only a few of them would be good enough to go unnoticed for an extended period of time.

In patients with lower intelligence, there are probably more noticeable signs of ASPD. Because they are not very good at recognising patterns of human behaviour and mimicking them, even when they try to deceive someone with manipulative tactics, it would be much easier for us to spot concerning behaviours. They have a lower ability to predict consequences or make meticulous, long-term plans to gain personal profit. Even though all people with ASPD struggle with that due to the symptoms of impulsivity and irresponsibility, those with a lower IQ level specifically tend to have more issues in these areas.

There is one thing that needs to be said as well. Even if they can predict consequences, the hardwired impulsivity in their brains can make them violate the law without a fear of going to prison. Moreover, because their emotions are so limited, we can almost say that they do not get scared in risky situations. That is also one of the reasons why they often put themselves in danger. They seek intense experiences because they need much stronger stimuli to feel a rush of adrenaline or excitement.

What about the body language? As mentioned before, people with ASPD might learn how to mask and mimic human emotions, as well as learn what the right thing to say in certain situations is. However, no matter how much they study body language, it is hard to convey feelings and honest reactions fully. What is known about patients with ASPD? In a conversation, they would probably stare directly into your eyes without needing to look away or blink. Moreover, their faces tend to remain the same, almost set in stone, regardless of what has just been said. They might try to fake their reactions, but it would probably seem dishonest or inappropriate to the situation.

With all of that said, it does not mean that everybody we see who has little to no reaction to what we are saying or seems to wear some mask is necessarily somebody with ASPD. We are all very different individuals with a variety of character traits and learned behaviours, which is why it is very important not to judge a book by its cover. These are just some of the signs we would probably look for if we were sitting in an office with a patient suspected of having ASPD.

ASPD, psychopathy or sociopathy? What do they have in common?

Antisocial personality disorder is an official diagnosis used in DSM-5, but what about the commonly used terms such as psychopathy or sociopathy? Even though it's not possible to diagnose somebody with those disorders, it's still quite common to use them when we talk about this condition.

There has been some information about how we can distinguish psychopathy from sociopathy. Some mental health specialists say that the former is a more severe case of ASPD and is caused mainly by genetic and biological factors. In contrast, sociopathy seems to develop over time due to environmental causes. Colloquially, it could be said that psychopathy is a genetic condition, while sociopaths are a byproduct of the environment they live in. Moreover, sociopaths are known to be a little bit more impulsive and less calculated than psychopaths. We should take that information with a grain of salt, though, because there hasn't been enough research on that topic.

Treatment

People with ASPD very rarely go to therapy or seek a diagnosis. The only reason they would go to a specialist is usually a court order. Individuals with ASPD do not see a reason to change themselves due to the mentioned self-centredness. They would only adjust their behaviour to get out of trouble or make themselves look good in front of others if there was anything to gain. They may even use the therapeutic relationship to gain as much practical knowledge about human behaviour as they possibly can to improve their skills in mimicking other people.

So, is there any way to successfully treat a person with ASPD? There hasn't been enough research to confirm the possibility of successful treatment, nor has there been enough evidence to prove it. It is said, though, that the most effective therapeutic approach is CBT (Cognitive Behavioural Therapy), or therapy focused on positive or negative reinforcement of specific behaviours. Even though that still might not bring expected results, because those approaches are mainly about changing undesirable behaviour or cognitive patterns, they might work in milder forms of this disorder. Partial success or failure to rehabilitate a person with ASPD depends mainly on the level of severity of their condition.

Summary

What else can be said on this topic? I think there is still so much more to learn about this condition. As we can see, it's a very complex disorder that not only affects the specific individual but also impacts a larger group. Even though the specialists still don't have all the information on that topic, the research allows us to learn about some of the signs to look out for. I hope my article helped you all better understand this condition and maybe even encouraged you to look it up on your own.

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Glossary

blink –to deliberately ignore (a fact or situation)
core – the central or most important part of something
correctional facility – a place where people are held as punishment for crimes
display – to show or present something for others to see
disregard – lack of respect or consideration for something
hardwired – built-in or naturally present, often used to describe instincts or automatic behaviours
meticulous – showing great attention to detail
mimic – to imitate or copy someone or something
ongoing – continuing to happen or exist
prevalence – the extent to which something is common or widespread
score – to gain points, achieve or obtain something desirable
set in stone – fixed, permanent

Borderline Personality Disorder

BY EZRA MILEWSKA

Worldwide problem

According to the WHO database, in 2019, 970 million people globally were living with a mental disorder, with anxiety and depression being the most common. Although millions of people are suffering from mental illnesses, some of them are still stigmatised. Fortunately, in the last few years, we have observed that society is becoming more and more understanding of the implications of mental disorders. But we can observe that whereas depression and anxiety are well-studied and mostly "accepted" in society, there are still areas of mental health that are feared by society, such as schizophrenia, bipolar disorder or personality disorders. In this article, I want to focus on the last one, especially on one subtype.

Personality disorders

But let's start with the question – what exactly is a personality disorder? As some of you know, you can identify mental conditions using the Four D's criteria: deviance, distress, dysfunction and danger. In DSM-5, we can read that "personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the norms and expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment".

Every person has some personality traits – they help us function in our surroundings, interact with others, and think about the world. At the same time, personality disorders are clusters of those personality traits that, when enhanced, limit everyday functioning or cause distress. In 2019, research showed that the worldwide pooled prevalence of personality disorders was 7.8%. In DSM-5, personality disorders are grouped into three clusters:

A (paranoid, schizoid, schizotypal);
B (antisocial, borderline, histrionic, and narcissistic)
C (avoidant, dependent, and obsessive-compulsive)

All personality disorders have two significant signs: early onset (usually before the second decade of life) and comprehensiveness: influence on many life areas, such as work, private, and social aspects. As far as I can observe, one of the most misunderstood and demonised kinds of personality disorder is Borderline Personality Disorder (BPD).

Borderline Personality Disorder

In DSM-5, you can find Borderline Personality Disorder under F60.3. The most important thing is that in Poland, you can't diagnose BPD before a person turns 21. Because personality is still developing, teenagers who show signs of BPD are typically diagnosed with "Unspecified Personality Disorder" (F60.9).

In some cases, a diagnosis can be made in underage people, but it's rare. But what are the criteria for getting the diagnosis? To be diagnosed with BPD, you must meet at least five of the following:

- frantic efforts to avoid real or imagined abandonment;
- a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation;
- identity disturbance: markedly and persistently unstable self-image or sense of self;
- impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating);
- recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour;
- affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days);
- chronic feelings of emptiness;
- inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights);
- transient, stress-related paranoid ideation or severe dissociative symptoms.

As you can see, BPD influences many parts of your life and can be very tiring. Have you ever wondered how people with it function in everyday life?

How is it to live with BPD?

I have a diagnosis of Borderline Personality Disorder. At 17 years of age, I got a diagnosis of "Unspecified Personality Disorder", leaning towards BPD. In later years, I got a BPD diagnosis from my psychiatrist. I must say, living with it is not easy. I struggled with self-harm, and I still have trouble spending money. My interpersonal relationships are no better – I have few close friends, but my romantic interactions are short, intense, turbulent, and mostly end badly. I attach to people too fast, and my fear of abandonment is so huge that sometimes I sexualise myself, thinking that if I am "useful", people won't leave me. My self-esteem is based on my relationships. I have mood swings that are fast and dependent on other people's emotions – one hour I can be suicidal, the next hour I can feel like the best person in the world. There is much more; my BPD influences all parts of my life. Thanks to my excellent therapist and medication, I am getting more stable and better every day, but I know there is much more to work on. To be honest, one of the worst parts is how society treats and sees people with Borderline. Not once have I heard that someone doesn't want any relationship with me because of it, or that people are afraid of me.

Harmful stereotypes

We live in the TikTok era, and much public debate takes place there. At least once a month, I see a short video about BPD, and out of curiosity, I go to the comments and see that people write the most hurtful things about individuals living with this disorder, such as: "They are monsters who are not able to love"; "They won't ever get better"; "(Relationship) is not worth it, unless you love them, but not even then"; "This disorder can be dangerous for people around them" and many more. Even some "psychologists" on that platform are saying things such as "And after a while, people with BPD show their real face [...] they are unpredictable". Of course, being with a person who has BPD is not easy, but it's manageable if both people are willing to work on it. You need to remember that Borderline is a spectrum, and symptoms differ from person to person. If the diagnosed person is in active therapy – working on themselves – and under medical care, they are as wonderful as any other person.

Problematic self-diagnosis

Unfortunately, in the Internet era, we face a problem with self-diagnosis. Under some posts or short videos about BPD on every platform, we can find comments, such as "It looks like I have BPD, I self-diagnosed it". It's important to remember that diagnosis takes months, even years of observation under the eye of specialists. If you have a suspicion that you may have BPD, please reach out to a psychiatrist and tell them about all your symptoms. It's not an easy path.

Treatment options and prognosis

There is no cure for Borderline Personality Disorder. The best thing you can do is work in therapy and get medication that works for you – both things can soothe the symptoms to the point that you can function "normally".

The best school of psychotherapy for people with BPD is DBT (Dialectical Behaviour Therapy). In that type of therapy, you work on managing emotions and distress, as well as on validating yourself and your feelings. With those skills, you can feel better.

On the other hand, good medication is also important. There are many mood stabilisers, such as lamotrigine. It may take some time, but eventually it makes you more stable and, more importantly, makes you feel better. So if you're struggling, please reach out for help – you have nothing to be scared or ashamed of. These days, we have really great options for support.

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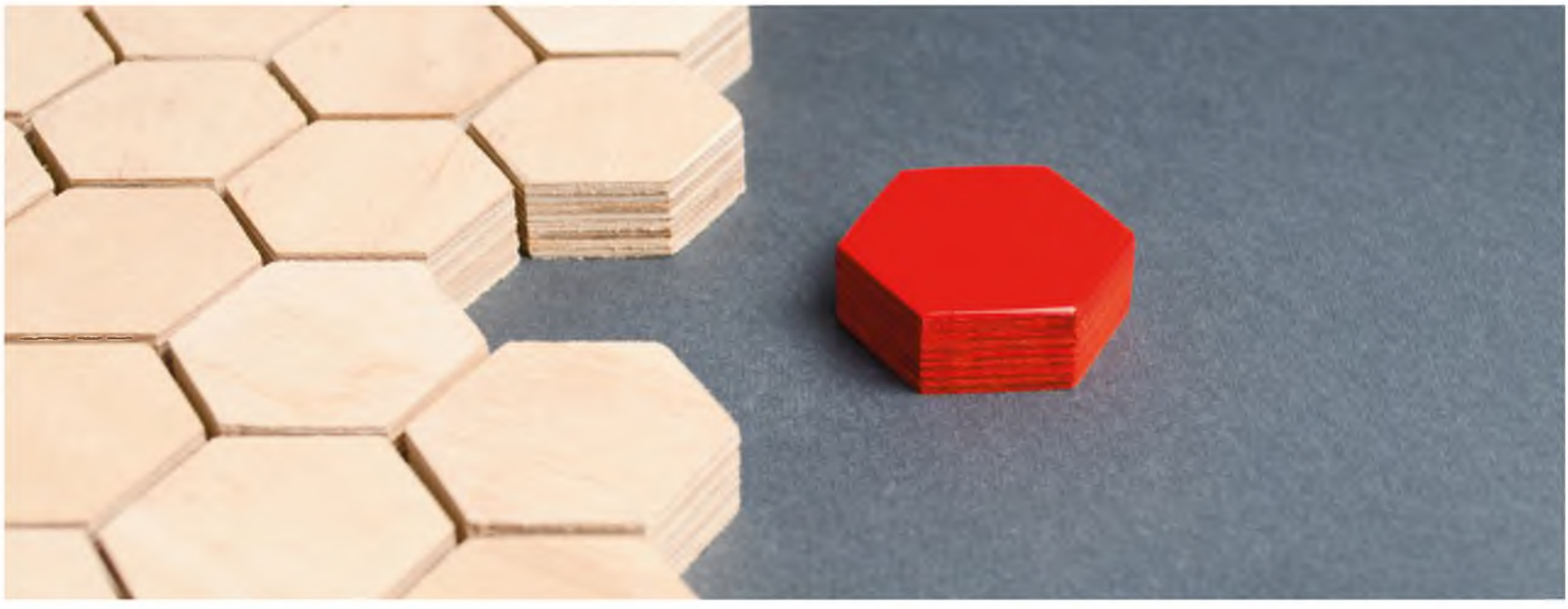
Glossary

alternate – to switch back and forth between two things; or another option
cluster – a group or category of related disorders that share similar characteristics
distress – extreme sadness, anxiety, or emotional pain
dissociative – related to feeling disconnected from thoughts, feelings, or surroundings
dysphoria – a state of deep discomfort, unhappiness, or unease
enhance – to improve or make stronger or better
frantic – very anxious, rushed, or out of control
ideation – a pattern of thoughts, especially recurring or notable thoughts (e.g., paranoid or suicidal thoughts)
implications – possible effects or results of an action or idea
mutilate – to seriously damage or injure something or someone
onset – the beginning or start of something
recurrent – happening again and again
soothe – to calm or reduce pain, stress, or discomfort
transient – temporary; lasting only a short time
validate – to recognise or accept someone's feelings or experiences as real and important

OCPD – the consuming need to control

BY AMELIA MOKIJEWSKA



Life is a weave of events, some initiated by one's actions, but most likely caused by forces in the world around us: other people, accidents, policies. While some determinist philosophers doubt the existence of free will and the idea of people carving out their fate, most people have a strong sense of agency; they feel responsible for the course of their lives. They want to control their future, and to keep themselves accountable, they often make to-do lists and create extensive backup plans, while acknowledging that some variables cannot be predicted or controlled.

OCPD, or obsessive-compulsive personality disorder, is mainly characterised by a strong, unwavering drive for perfection that is so strong that those affected by the disorder can sacrifice their personal life to achieve this unattainable goal. People with OCPD have extremely high standards, which they demand not only from themselves but also from other people in their lives. They are obsessed with controlling their environment, and they follow rules very strictly – whether those imposed by external forces, such as the workplace or society's expectations, or those they have created for themselves.

It is not difficult to see how this disorder may disturb the work-life balance. Individuals with OCPD can live as if they are meant to be productive, often putting work above everything else. Overwork is a common issue: feeling as if they have no time for leisure, refusing to meet loved ones, and denying themselves a vacation or proper rest. Their perfectionism may cause them to work on their projects endlessly to the point of satisfaction, which often means missing a deadline. Sometimes, they focus on a task that, in theory, would help later stages of the work, but in reality, doesn't bring them closer to the finish line. For example, someone might plan to decorate their Christmas tree. Still, instead of buying decorations that they find pleasing and putting them on the conifer, they might start making a list comparing prices of ornaments in different shops, which is so detailed that they never finish it on time, just to stress out on the 23rd that Christmas will not be perfect without a tree.

People with OCPD tend to think very rigidly; something is either right or wrong. This is prevalent in their worldviews, sense of morality, and criteria for completing tasks.

This makes every mistake much more distressing, since this strongly polarised way of thinking leads to considerable criticism, aimed not only at the person affected by this disorder, but also at their loved ones. Individuals with OCPD have difficulty accepting other people's views and standards as their own. This can lead to a lot of tension in relationships, whether in family or with romantic partners.

The need for everything to be perfect can make people with OCPD feel like they need to manage their family members. Parents with this disorder tend to be very strict about the upbringing of their children, their education, behaviour and appearance. They may make their offspring very dependent by making all decisions for them and harshly cutting off ideas that are not in line with their view of the child's future. Controlling behaviour can also be directed towards the partners of individuals with this condition, who worry that things are being done improperly. These partners may, in turn, feel micromanaged and used as an emotional outlet for frustration. People with OCPD may be very blunt and harsh about their anger and cold in their communication, because they often feel more competent and superior to their loved ones, who, in their eyes, do not meet their expected standards. Their inner striving for perfection makes them feel that anything less than perfection is utterly unacceptable, leading to many frustrations. Without proper help, individuals with OCPD may engage in abusive behaviours and be unable to let their loved ones take complete control and responsibility for their lives. This does not mean that people with this disorder are inherently evil – therapy might help people suffering break rigid patterns and regulate emotions more efficiently.

Unfortunately, there is little research to point to the best course of action. As yet, no medication has been approved for the treatment of OCPD; however, some studies suggest that symptoms might respond to serotonin reuptake inhibitors.

Some sources claim that cognitive behavioural therapy is the best approach, as it may effectively help with clinical perfectionism, lessen anxiety, depression and difficulties that the disorder poses; however, there isn't enough research to say it with certainty. Acceptance and commitment therapy has shown some promise, as research suggests it improves the well-being of patients with clinical perfectionism; however, more trials are needed that target ACT and OCPD specifically.

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Glossary

blunt – straightforward in speech or manner
carve out (one's fate) – to actively shape or create one's own future through personal choices and actions
conifer – a tree with needles and cones, such as a pine tree
harsh – unpleasant, unkind, cruel
impose – to force something on someone
inherently – fundamentally, naturally
lessen – to decrease in size, amount, degree, or severity
not in line with – not matching or agreeing with something
offspring – a person's child or children
rigid – not easily changed.
sense of agency – the feeling that you are in control of your own actions and decisions
serotonin reuptake inhibitors – medicines that raise serotonin in the brain to improve mood
unwavering – not changing; constant

Personality Disorders: Awareness Among Young Adults

BY KATARZYNA SAJ

Nowadays, when psychology is developing every day, we hear more about personality disorders. Some of them are better known than others, especially on social media, as more and more people share their own experiences and struggles. This article's primary goal is to familiarise you with this phenomenon.

What are personality disorders?

According to the DSM-5, a personality disorder is "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (American Psychiatric Association, 2013, p. 645).

One of the most important things to remember is that a personality disorder is classified as a disorder, not as a disease (e.g., depression or schizophrenia) – it cannot be cured. It can be managed through therapy, self-work, and, in some cases, pharmacological treatment.

Basically, personality is a set of traits we develop during childhood and adolescence. Another important thing is that a psychiatrist cannot diagnose a personality disorder before you are 18 years old. This rule was introduced because personality is constantly developing and changing, especially during the teenage years.

To examine awareness levels among young adults, I conducted an online survey involving 73 individuals aged 18–25.

Survey Results

A total of 73 young adults aged 18–25 participated in the survey. The results reveal both growing awareness and persistent misconceptions.

1. General awareness
- 76.7% reported knowing what personality disorders are.
- 21,9% had only heard something, without more profound knowledge.
- 12% admitted they did not understand what a personality disorder is.

This suggests that most young people have some knowledge, although not necessarily an accurate or complete understanding.

2. Personal experience
- 50.7% stated they do not believe they have a personality disorder.
- 37% selected maybe.
- 12.3% thought they might have one.

A large number of uncertain responses indicates confusion or difficulty distinguishing between everyday emotional struggles and personality disorders.

3. Experience in their environment
- 65.8% said they know someone diagnosed with a personality disorder.
- 34.2% did not know anyone diagnosed with a personality disorder.

This relatively high number may reflect how common personality disorders are in the general population.

4. Attitudes towards professional help
- 90.4% agreed that individuals with personality disorders should receive psychiatric, psychological, or psychotherapeutic support.
- 7.3% said it depends.
- 2.3% disagreed with the statement that individuals with personality disorders should receive psychiatric, psychological, or psychotherapeutic support.

The strong support for professional help suggests that increasing mental health awareness among young people is warranted.

5. Emotional reactions to specific disorders
(multiple answers possible)
- Borderline – 34.2%
- Narcissistic – 76.7%
- Dependent – 20.5%
- Dissocial/Antisocial – 58.9%
- Avoidant – 20.5%

The highest negative reactions were towards narcissistic and antisocial personality disorders, indicating a strong social stigma and a tendency to associate these conditions with harmful behaviour. Borderline also had a high score, which, from my experience, results mostly from stigmatising videos on social media.

6. Can personality disorders be cured?
- 23.3% believe yes, they can.
- 31.5% believe no.
- 45.2% chose maybe.

This shows a lack of clear understanding of treatment. In reality, although personality disorders are long-term conditions, many symptoms can be significantly reduced with appropriate therapy. Because they are classified as disorders, not diseases, they cannot be cured – but they can be managed.

7. Influence of Social Media
- 95.5% saw content related to personality disorders on TikTok/Instagram.
- 84.9% encountered self-diagnosis based on posts or videos.
- Only 11% had not seen any content related to personality disorders.

This highlights the overwhelming impact of social media on perceptions of mental health.

8. Self-Diagnosis after viewing content about personality disorders
- 45.2% said no, they do not suspect they have a disorder after seeing such content.
- 31% were not sure.
- 20.5% said yes.

These findings further support the concern that social media may mislead young people into self-diagnosing themselves with a personality disorder (or any other mental health-related disorders or diseases). Only a psychiatrist can diagnose mental health disorders or diseases, so if you suspect that something may be wrong, seek professional help. The internet can be misleading and may do more harm than good.

Conclusions

The conducted online survey highlights the most important topics regarding personality disorders and shows the level of knowledge, attitudes, and misconceptions surrounding personality disorders among young adults aged 18–25. Although the majority of respondents demonstrated basic familiarity with the topic, the survey data reveal that much of this understanding is shaped by online content rather than by clinical knowledge. The high prevalence of exposure to mental-health themes (often used to get teenagers' attention) on social media, particularly the widespread presence of self-diagnosis, suggests that digital platforms play a powerful but often problematic role in shaping public perception, especially among young people.

Overall, the findings demonstrate that while young adults are highly engaged with mental-health topics, their knowledge is inconsistent and heavily affected by non-scientificsources, such as TikTok and Instagram. Increasing access to reliable psychological information, both in formal education and across digital platforms, remains essential for reducing stigma and supporting individuals who may be struggling with mental health.

Glossary

encounter – to meet or experience sth, often unexpectedly
exposure – the state of being in contact with something or experiencing it
inconsistent – not being in agreement or harmony
misconception – a mistaken idea or understanding
persistent – to continue to exist or happen for a long time
pervasive – present or felt everywhere
psychotherapeutic – related to the treatment of mental or emotional problems through therapy
stigma – a negative social label or mark of shame attached to someone or something
trait – a particular quality in someone's character
warranted – justified or reasonable

Schizotypal Disorder – is it actually a personality disorder?

BY DARIA FRUŃ

It's remarkable that so far there is no agreement on this matter. DSM-5 (the classification of the American Psychiatric Association) defines it as a personality disorder (Schizotypal Personality Disorder), and its characterisation stresses the deficits in social and interpersonal functioning, while eccentric behaviour and cognitive or perceptual distortions are more of a setting in which they occur (Francois, Torrico, 2024).

ICD-11 (the classification of World Health Organisation) classifies it as a primarily psychotic disorder (Schizotypal Disorder), characterised by "an enduring pattern (i.e. characteristic of the person's functioning over a period of at least several years) of eccentricities in behaviour, appearance and speech, accompanied by cognitive and perceptual distortions, unusual beliefs, and discomfort with – and often reduced capacity for – interpersonal relationships," emphasising the patient's subjective experiences.

What's the difference between a psychotic disorder and a personality disorder?

In psychotic disorders, an individual's relationship with the real world is impaired – both the way they interact with it and how they perceive it – and this impairment manifests in the form of positive and negative symptoms. Positive symptoms, despite their name, aren't very beneficial – instead, "positive" refers to changes in a person's functioning that become "added" to their experiences. This includes delusions (detached from cultural norms, false beliefs, fixed despite evidence to the contrary), hallucinations (incorrect sensory perceptions), as well as disorganised thinking and speech (extreme version is called "word salad" and consists of seemingly meaningless and unconnected words and phrases). In turn, negative symptoms mean that something is reduced or removed – anhedonia (loss of ability to feel happiness), flat affect (reduced emotional expression), avolition (loss of will to do anything), and psychomotor disruptions (agitation or retardation) fall into this group.

Personality disorders are enduring, stable behavioural patterns that result in inflexible responses to various situations and affect a person's psychological and social functioning. These patterns deviate significantly from the typical ways individuals in a given culture perceive, think, feel, and relate to others.

Diagnostic requirements

Despite the differences in understanding and classification of SD, the diagnostic criteria are quite similar in both systems. Nonetheless, the information presented below regarding diagnostic requirements is specifically from ICD-11.

As with any other medical condition, differentiation is pivotal to SD's diagnostic process: ruling out all other possible causes of the presenting symptoms. This includes organic medical conditions, such as brain tumours or encephalitis; the effects of psychoactive substances or medication on the central nervous system; withdrawal; and other mental, behavioural, or neurodevelopmental disorders that may alone explain existing symptoms.

Essential symptoms of SD include:

- eccentric behaviour or appearance, inconsistent with cultural norms;
- peculiar beliefs and magical thinking that affect a person's behaviour;
- vague, overelaborate, metaphorical, or stereotyped thinking and speech that remains coherent, however odd;
- disordered formal thinking;
- distortions of perception, such as hallucinations in any modality, illusions, depersonalisation;
- constricted or inappropriate affect – the individual appears aloof, with emotional expressions that do not match the content of their communicates;
- tendency towards social withdrawal and isolation;
- reduced capacity to form and maintain interpersonal relationships;
- obsessive ruminations, often with aggressive, sexual, or body dysmorphic content, that are not perceived as foreign or unwanted;
- the individual has never met the diagnostic requirements for Schizophrenia, Delusional Disorder, or Schizoaffective Disorder – so while the aforementioned psychotic symptoms (delusions, formal thought disorder, hallucinations) may occur, they cannot last longer than one month;
- suspiciousness.

Additionally, for a formal diagnosis, the presence of several symptoms at the same time for at least two years is required. Moreover, they must either cause distress or significantly impair the patient's functioning in important areas, such as personal, occupational, or educational.

It's worth mentioning that the symptoms of SD are usually present even before the full onset. A person in the prodromal phase might exhibit poor social skills, a tendency towards isolation, suspiciousness of others, and unusual beliefs and thinking patterns. Although SD typically begins in late adolescence or early adulthood, symptoms may sometimes appear in childhood.

Disordered or just eccentric?

Whether Schizotypal Disorder is considered part of the schizophrenia spectrum or a personality disorder, it remains true that the threshold between its symptoms and the extravagant, eccentric behaviours and beliefs of individuals who do not meet diagnostic criteria can be difficult to determine. It's important to keep in mind a person's cultural background, as different cultures have different concepts of normative behaviour, appearance, or speech. Also, some beliefs and experiences considered common within one cultural group might seem bizarre in another.

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Glossary

depersonalisation – feeling disconnected from yourself or like you're outside your body
deviate – to go away from what is normal
disorganised thinking – confused or mixed-up thoughts that are hard to follow
distortion – a change in thinking or perception that makes reality seem different from how it really is
encephalitis – swelling or infection of the brain
enduring – lasting a long time
impair – to damage or make something weaker
magical thinking – believing that your thoughts or actions can make impossible things happen
prodromal phase – early stage when signs of a disorder first appear
retardation (psychomotor) – slowness in movement, speech, or thinking
rumination – thinking over the same thoughts again and again
withdrawal – pulling back from people and activities

PSYCHLINGO

THE DESCENT TO THE DARK SIDE OF THE MOON

BY GABRIELA GAWŁOWSKA

What is the Dark Triad?

In psychology, perhaps one of the most interesting topics is the study of mental disorders and human personality, with the Dark Triad (or, in short, DT) being among the most widely discussed concepts. The concept was first introduced by the Canadian psychologists Delroy L. Paulhus and Kevin M. Williams in 2002. The researchers, Paulhus and Williams, introduced three socially aversive traits.

The first one is Machiavellianism. For those who haven't heard about the Dark Triad in the first place or are just starting their journey in psychology, it is a construct that mainly relies on two strategies: a cynical worldview and manipulative tactics. To put it into perspective, I theorise that this construct could be represented by Tywin Lannister from *Game of Thrones*. He was shown to be a cynical and, most importantly, cunning man. He made it clear that he prioritises his position and power over emotions and sentiments. He is not above using manipulative strategies, such as flattery, deceit, and emotional detachment. As seen in the examples, people with elevated levels of Machiavellianism tend to value materialistic goods, such as money, power, status, and benefits that come from them, more than people. Aside from their cynical point of view, they display little emotion and experience it shallowly. Apparently, in terms of personality, they're similar to psychopaths. However, the difference lies in the behaviour of Machiavellians. While psychopaths tend to be more impulsive and rely on short-term gratification, Machiavellians are the opposite: they tend to create strategies and plan ahead.

The next position in the DT is psychopathy. The most essential elements of this psychological construct are deficits in affect (i.e., callousness) and self-control (i.e., impulsivity). On an everyday basis, they might appear to be "normal", maybe even charming. But that might not be the case at all, as psychopaths are described as callous, impulsive (as researchers have found in aspects of being socially adventurous and lacking self-control), selfish, remorseless, with little to no empathy. For example, a fictional character who comes to mind is Jordan Belfort from the movie *The Wolf of Wall Street*. Those who watched the movie might remember him as extremely charismatic, fearless, and always scheming.

On the other hand, he was impulsive, addicted to both substances and money, all while showing a lack of empathy and concern for the people surrounding him. As mentioned above, the key elements that differentiate psychopathy from Machiavellianism lie in their impulsivity and thrill-seeking. These are their primary motivations for using tactics such as manipulation, lying, or other callous behaviour to gain a sense of gratification. Also, this likely explains why people with this specific personality trait are more likely to engage in criminal behaviour. It helps satisfy their thirst for adrenaline (i.e., breaking the law by stealing) and, at the same time, gives them an immediate sense of gratification (i.e., gaining stolen property or admiration from others who approve of that sort of behaviour).

The final socially aversive personality that is part of DT is narcissism. While sharing with the two previous personalities the aspect of general lack of empathy, narcissism is characterised as a feeling of superiority over others, a grandiose sense of self, the need to be admired, and engaging in exploitative acts. The rather obvious example that came to mind when reading that description was Gilderoy Lockhart from the *Harry Potter* series. He fits these criteria very well, as he strived to always be the centre of attention while exploiting others by stealing credit for their work. This type of personality also shares the aspects of callousness and manipulation with Machiavellianism and psychopathy. But what mainly differs narcissism from them is the fact that narcissists engage in behaviour that will sustain their inflated ego as the primary motive, not for materialistic gain, like in the case of Machiavellianism.

According to Derloy Paulhus and Kevin Williams, who conducted the study, these three constructs share traits such as self-promotion, emotional coldness, and aggressiveness; as shown in previous studies, these features do overlap empirically.

The Dark Triad original study

Back in 2002, Paulhus and Williams asked themselves: Are these traits actually equivalent in the normal population? To answer the question, they decided to perform a study. For an extra course credit, 245 undergraduate psychology students took part in that study. Around 65% of those students were female. The procedure consisted of two steps: first, participants were given anonymous questionnaires to take home and complete; second, they returned to a supervised lab session, where they took an objective cognitive ability test and a measure of self-enhancement bias.

Derloy Paulhus and Kevin Wiliams used five measures: Dark Triad Personalities, Big Five Personality Traits, Self-Perceived Intelligence, Cognitive Ability, as well as Self-Enhancement Bias. To measure each aspect of the Dark Triad, they used different tools for each personality. For Machiavellianism, it was the Mach-IV inventory (20 Likert-scale items); for narcissism, the Narcissistic Personality Inventory (NPI, 40 forced-choice items); for psychopathy, the Self-Report Psychopath Scale (SRP III, 31 Likert-scale items).

The Big Five Personality Traits were measured using the 44-item Big Five Inventory (BFI), which assesses extraversion, agreeableness, conscientiousness, neuroticism, and openness. Regarding Self-Perceived Intelligence, participants rated themselves on four traits on a 5-point scale. For Cognitive Ability, the Canadian psychologists used the Wonderlic Personnel Test, a 50-item test that measures overall IQ, both verbal and non-verbal. Lastly, the Over-Claiming Questionnaire (OCQ) was used to measure self-enhancement bias by making participants rate their familiarity with 90 items, 20% of which were fake. This allowed the researchers to calculate an accuracy score – actual knowledge – and a bias score, which means a tendency to claim understanding of non-existent things.

Study findings

The analysis of participants' scores showed that, while the Dark Triad traits overlap, they have distinct psychological profiles. On all DT measures, statistically, males showed significantly higher scores than females. Besides, it has turned out that these traits

were moderately positively correlated with each other. They found the strongest correlations were between narcissism and psychopathy. And thus, the authors concluded that they're not equivalent constructs. When it comes to the Big Five Personality Traits, they've found key distinctions. They discovered that Machiavellianism was characterised by very low agreeableness and low conscientiousness. When it comes to narcissism, it is linked to high extraversion and openness. And lastly, psychopathy showed a unique combination of low agreeableness, low conscientiousness, and low neuroticism.

From measures of Cognitive Ability, they found minimal positive correlations or none at all between the Dark Triad and general IQ. The Verbal-Nonverbal Discrepancy showed a high non-verbal IQ compared to verbal IQ, linked to both Machiavellianism and psychopathy.

Lastly, when it comes to Self-Enhancement Bias, only narcissism was significantly linked to claiming knowledge of non-existent items (over-claiming bias). Moving on to Oveestimating intelligence, narcissists showed a clear tendency to overestimate their own intelligence. Psychopaths showed smaller but still significant tendencies. Machiavellians showed no statistically significant tendencies. In conclusion, the study's findings helped differentiate the three "dark" personalities. To sum up the differences, Machiavellians are disagreeable, unreliable, and pragmatically grounded in reality, showing no self-enhancement bias. Narcissists are outgoing, open to experience, somehow smarter, and prone to obvious and unrealistic self-enhancement. Psychopaths are disagreeable, unreliable, anxiety-free, and show higher non-verbal IQs and mildly inflated self-views.

Conclusions

The Dark Triad, consisting of Machiavellianism, narcissism, and psychopathy, comprises personality traits that aren't desired in society. I think it's worth remembering that these three personalities aren't the same thing, but they overlap. They share traits such as manipulation and callousness. Although these types of personalities are socially aversive and most probably don't feel the need to change, since they don't view their behaviour as erosive, there are some ways they can work on themselves. Different types of psychotherapies can be matched with a diagnosed DT personality.

For example, for a narcissistic personality, a psychologist can use Schema Therapy (ST). This particular form of therapy is effective in tackling the schemas of self-deception and self-entitlement, employing a more empathetic approach and setting clear limits. However, there are ways to help DT personalities, and beyond the fact that they don't view their behaviour as something worth working on with professional help, deficits in empathy might make psychotherapy have a lesser impact on them. And for psychologists who work with DT personalities, it's good to focus on properly constructing therapy, because poorly constructed therapy can strengthen high-triad beliefs (i.e., manipulation strategies or self-entitlement). Or it's worth paying attention to their motivation as to why they're in therapy in the first place – is it because they truly want to work on their behaviour, or are they seeking the achievement of a short-term goal that they've set up? So, in those cases, supervision and setting strict boundaries are essential.

In some situations, they can be treated as an adaptive personality. For example, reaching short-term goals by using ruthlessness when it comes to Machiavellianism, oozing confidence from the subclinical narcissists, or fearlessness is a case of subclinical psychopathy. The cluster of such traits can be used in high-stakes situations, aggressive decision-making, or gaining resources. Those are especially seen during negotiations or when choosing a leader.

However, from the perspective of being in long-term relations with the Dark Triad personalities, those types of relations can often erode in terms of trust and emotions in the long run. Those people are difficult to work with, since they probably won't listen to you, and their deficits in empathy won't make them reliable or understanding people. The duality of the nature of the Dark Triad varies across contexts; on the one hand, if viewed in the short term and with long-term costs removed, they are adaptive; on the other hand, they cause harm.

In the end, it's worth spreading awareness about the Dark Triad personalities, including the difference between them and knowing when to seek professional help if one thinks they have that kind of person in their life and wants to know how to act. All while it's important not to label high-triad people. In the academic world, there's a distinction between traits and behaviours, and of course, contexts in each case.

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Glossary

aversive – unpleasant
callous – emotionally insensitive; showing no concern for others
distinct – clearly different or separate
distinction – a difference or contrast between similar things
erosive – gradually damaging or wearing away
exploitative – using others selfishly for one's own advantage
flattery – insincere praise given to please someone
grandiose sense of self – an inflated view of one's own importance or abilities
gratification – satisfaction or pleasure from fulfilling a desire
ooze – to slowly exude or display a quality or feeling
self-entitlement – belief that one deserves special treatment or privileges
self-enhancement bias – tendency to view oneself more positively than is accurate

INTERVIEW WITH AN EXPERT

BY JAN WOLICKI

Piotr Brud, PhD, is a psychologist and certified integrative psychotherapist. Assistant professor at the Institute of Psychology at UKSW (the Cardinal Stefan Wyszyński University in Warsaw). His academic work focuses on issues in personality and clinical psychology. He conducts individual psychotherapy and couples therapy. In the therapeutic process, he works with both adults and adolescents.

Jan Wolicki: Which personality disorders do you find the most interesting in a research and therapeutic context?

Piotr Brud, PhD: Generally speaking, when it comes to personality disorders, what fascinates me most is not the disorder itself as a label, but how a given personality structure came about – what survival strategies once helped but today have begun to cause harm. In my consultation room, I rarely think in textbook terms. I am more interested in what this person must have gone through to organise their world in this way. And that is probably the most interesting thing for me. But to answer the question…
If I were to be completely honest, I am most interested in those personality disorders that show how incredibly flexible and, at the same time, fragile a person can be. When I say flexibility, I don't mean flexibility of character in the colloquial sense. I mean that the human psyche can adapt incredibly well to the conditions in which it grows up. Therefore, I would point to personality disorders such as borderline, narcissistic, or obsessive-compulsive.

JW: Why these?

PB: Let me start with borderline personality disorder. It reveals something fundamental: how much we need relationships and how much we can fear them at the same time. Everything is extreme – love, anger, fear, feelings of emptiness. It's a bit like living without emotional skin. From a research perspective, it's a goldmine of knowledge about emotion regulation, trauma, and attachment. Therapeutically, it is a huge responsibility because the relationship with such a patient can be intense and painfully real, but also difficult and exhausting.

On the other hand, I am also fascinated by narcissistic personality disorder, but not the stereotypical, conceited kind, but the more fragile, sensitive kind. In the consultation room, you often see that beneath the grandiose narrative lies shame and fear: "I am not enough." This shows how ingenious defence mechanisms can be – we build armour so that no one can see how deeply we are hurt. And finally, perhaps less obvious, obsessive-compulsive personality. There is an extraordinary tension between the need for control and the fear of chaos. Perfectionism, rigidity, excessive responsibility – these traits often describe people who keep the world in check, but at their own expense. Research-wise, it is an interesting area to look at how control reduces anxiety, but also how it gradually narrows life. In fact, I am most interested in the moment when the patient begins to understand that their traits are not a structural defect but rather a very sensible adaptation. It is, in essence, a story of how a person tried to survive as best they could. And also, when perfectionism, withdrawal, or hypersensitivity are no longer something to be ashamed of, but become something that can be consciously regulated.

PIOTR BRUD, PHD

JW: How can we imagine, as individuals, the everyday life of a person with a personality disorder?

PB: Let's take borderline personality disorder as an example, because it clearly shows how intense everyday life can be. Imagine that you wake up in the morning and your stress level is already higher than most people's. Someone hasn't replied to your message? The thought that pops into your head isn't "they must be busy", but rather, "what did I do wrong?" or "they're going to leave me". Your emotions immediately reach 8-9 on a ten-point scale. And this is not a choice; it is an automatic reaction. At work, someone gives you a cold look, says something a little dry, and it can trigger an avalanche. Feelings of rejection, anger, shame, and a moment later, the thought: "I'm not good enough. I'm hopeless." Or the opposite – idealisation: "This is the only person who understands me." This internal image of yourself and others can change very quickly. This is particularly difficult in relationships.

Closeness is extremely important, even essential, for a sense of stability. But at the same time, any sign of distance hurts twice as much. It's a bit like living without emotional skin – everything feels more intense. Joy too, but suffering above all. Or another image: someone comes back home from work and suddenly feels empty. There is no drama; no one has done anything wrong. And yet, inside, there is a feeling of meaninglessness, as if something has been turned off. For many people, this is difficult to understand because everything may look fine from the outside. But this inner emptiness can be very real and painful. From the outside, someone might say, "She's exaggerating", "She's unstable", "There's always something going on". And from the inside, it often feels like a constant struggle to maintain relationships while not falling apart under the weight of emotions. And importantly, it's not that such a person doesn't see that they are reacting intensely. They often do. And that further deepens the shame. That's why everyday life can be very exhausting. If I had to put it in one sentence, it's like living with a very sensitive alarm system that goes off faster and louder than most people's.

JW: What difficulties does a person diagnosing personality disorders face?

PB: Formally speaking, a psychiatric diagnosis is made by a psychiatrist. They are authorised to diagnose disorders in a nosological sense and, if necessary, prescribe pharmacotherapy. In the case of a psychologist or psychotherapist, it is more of a psychological or structural diagnosis – that is, understanding the personality pattern we are dealing with, the dominant defence mechanisms, how a given person regulates emotions, builds relationships, and reacts to frustration. Sometimes this results in a formal diagnostic opinion; other times, it is a working diagnosis for therapy. Perhaps I will focus on this working diagnosis. The first issue that comes to mind is the co-occurrence of other problems. Very often, I see patients experiencing anxiety, depression, relationship crises, or addiction. And that is what is in the foreground. The personality pattern is in the background and easy to overlook if we focus only on the symptoms. There is also something very human about it: a person with a personality disorder often does not see the problem in themselves, but in their environment. "Others are too demanding", "My partner is oversensitive". And sometimes, the environment is indeed difficult. So, we have to be very careful to separate real external factors from established patterns of response.

JW: What should we be very careful about?

PB: Discussing a personality disorder reaches far deeper than, say, an episode of depression. It touches on the way of being, experiencing oneself, and building relationships. If it is labelled too quickly or too bluntly, it is easy to shut the patient down and embarrass them, rather than really help them.

JW: In your opinion, has our approach to personality changed over the years? If so, how do we view it now?

PB: Definitely yes, but to be honest, the old way of thinking has not completely disappeared. We are increasingly looking at things dimensionally. Instead of thinking in terms of categories – "They have a disorder or do not have one"- we increasingly ask: "To what extent does a person have difficulty regulating their emotions?" "How stable is their sense of self?" "How do they function in close relationships?" In short, fewer categories, more of a continuum. This is a big step forward. Our understanding of the causes has also changed. In the past, a more descriptive way of thinking dominated – a list of characteristics and symptoms. Today, much greater emphasis is placed on attachment, developmental trauma, and the neurobiology of emotion regulation. We understand that personality does not break down; rather, it is shaped under certain conditions.

JW: And all the while staying in the context of stepping into the shoes of a person with a personality disorder. What is your view on the popularisation of terms such as borderline, narcissism, etc., in mainstream culture? How do you feel about the tendency to label everyday behaviours with these clinical terms and create quick social diagnoses?

PB: This is a very complex phenomenon, and I have mixed feelings about it. On the one hand, it's good that we've started talking about mental health at all. Twenty or thirty years ago, terms such as borderline personality disorder and narcissism were only used in medical consulting rooms and textbooks. Today, people are trying to name their experiences and so on. This is a step towards greater awareness.

However, when these concepts leave the clinical context and take on a life of their own in culture, they lose precision. "He's a narcissist", "She's borderline" begin to function as labels rather than a description of a complex pattern of behaviour. Then a tool for understanding becomes a tool for judgment. If we try to put ourselves in the shoes of a person with a personality disorder, such simplifications can be very painful. Imagine someone hearing the word "borderline" only in the context of dramatic, unstable, manipulative. Or "narcissist" as a synonym for a monster without empathy. This does not help in understanding oneself. It reinforces shame. When it comes to quick social diagnoses, they simplify relationships. Instead of saying, "This relationship is difficult for me, I feel invisible", we say, "He's a narcissist". It sounds stronger, it gives a sense of order, but it also cuts us off from the nuances. Still, I wouldn't demonise this phenomenon completely. The fact that the language of psychology has permeated culture shows that people need to understand themselves and others in emotional terms, not just moral ones. The issue is not with the words themselves, but with how they are sometimes used superficially. I think the biggest challenge is restoring context. Once we stop seeing the person and focus only on the slogan, we lose something important: complexity. And personality, even a disturbed one, is always complex.

JW: What are the myths that you would consider the most harmful? Or the most helpful facts that have entered popular culture?

PB: The most harmful myths? People with personality disorders do everything on purpose. That they manipulate, provoke, and dramatise out of calculation. In clinical practice, we most often see the opposite – these are automatic, ingrained ways of coping with anxiety, shame, and feelings of threat. The intention is usually not to hurt, but to cope with tension. Or that a personality disorder is

synonymous with a character flaw. In the public sphere, a narcissist is often seen as an egoist without a conscience, and a person with borderline personality as a dramatic and manipulative individual. This is a very simplistic and dehumanising view. In reality, behind these labels are usually enormous sensitivity, fear of rejection, and difficulty regulating emotions. These are not moral traits, but patterns of coping with tension. And what is helpful? The fact that concepts such as boundaries, emotion regulation, and childhood patterns have entered the culture. More and more people understand that challenging behaviours do not come out of nowhere.

JW: How, then, can this be prevented or corrected? What can be done about it?

PB: I would say this: don't fight words, just change the way we use them. We cannot undo the fact that narcissists and borderline personalities exist in pop culture. However, we can consistently show that these are not epithets but mental shortcuts that describe complex mechanisms. And another important thing: encourage self-reflection instead of labelling others.

JW: How can you support a person who is on their way to coping with personality disorders?

PB: So let's stick with borderline. The most important thing a close person can do is to be stable. How? In practice, this means predictability, keeping your word, and clear communication. People with borderline often have a very sensitive alarm system in relationships. If something is unclear or understated, they easily become afraid of rejection. The second issue is separating emotions from facts. When someone reacts very intensely, it's not about saying: "You're overreacting", but rather: "I can see that this is really difficult for you". Acknowledging emotions does not mean agreeing with every behaviour. This is an important distinction. And here we come to another issue – boundaries. True support is not about tiptoeing around someone or rescuing them at all costs. Clear, calm boundaries are, paradoxically, something that regulates a person with borderline personality disorder. They give a sense that the relationship is safe and predictable. To sum it up. Supporting means being both empathetic and consistent. Seeing in this person not a disorder, but someone learning new ways to regulate their emotions and build relationships.

JW: And what personality traits should a support person or a therapist have?

PB: I would also point to emotional stability. Such a person needs to be in contact with someone who does not react harshly to their impulsiveness. Someone who does not escalate the situation, does not take offence, and does not withdraw under the influence of strong emotions. Next, consistency, predictability, honouring agreements, and clear boundaries. This builds a sense of security. Chaos on the other side only reinforces the internal turmoil.

JW: What is insufficiently emphasised in our understanding of personality disorders?

PB: I think we talk too little about underlying suffering. In public debate, we frequently focus on how difficult a person's behaviour when they have a personality disorder, can be for their partner, family, and others around them. And that's important, because these relationships can be really demanding. But much less is said about the fact that inside, there is often chronic tension, shame, fear of abandonment, and a feeling of being inadequate.

JW: What message would you like to leave for those who want to work with people with personality disorders?

PB: That they take care of themselves as attentively as they want to take care of their patients. In this job, our inner balance is one of the most important resources.

JW: Thank you for the interview.

Translated by Alicja Capała and Jan Wolicki

Glossary
bluntly – saying something in a very direct and honest way, sometimes rude
consistency – the quality of always being the same
flaw – a mistake, weakness, or fault in something or someone
hypersensitivity – being too easily affected by things emotionally or physically
ingrained – fixed firmly and difficult to change
nosological – related to the classification of diseases
offence – the feeling of being hurt or upset at something that somebody has said or done
permeate – to spread through something completely
restore – to bring back to a previous state or condition
sensible – practical, reasonable, or showing good judgment
tiptoe around sb – to be very careful about what you say or do to avoid upsetting someone
turmoil – a state of confusion, excitement, or worry
understated – not overly showy, not exaggerated

A Life on Stage

BY AT

The term **histrionic personality** comes from the Latin **histrio**, meaning **actor**. It describes a way of functioning in which life becomes a stage and the self is constantly staged for an audience. The goal is not deception, but visibility — to be seen, noticed, and reacted to.

This is also why the word **histrionic** is used instead of **hysteric**. **Hysteric** comes from the Greek **hystera**, meaning **uterus**, and is rooted in the ancient belief that many emotional or psychological disturbances in women were caused by a "wandering womb", an organ thought to move freely around the body. Histrionic shifts the focus away from emotional instability towards theatricality, stylisation, and performance.

I once knew a girl who, in retrospect, seems almost textbook histrionic. M was in the same university group as me, but she dropped out early.

She was always late, yet she knew exactly how to make an entrance. Unlike the other students, M never dressed casually. Her clothes looked as if they had been taken straight from a costume department or a film set where period dramas from different eras were being shot.

She most often drew from the 1950s and 1960s, but she also copied styles from other decades. What mattered was that every element of her outfit was perfectly put together: the skirt, blouse, jacket, shoes, and a handbag so small it couldn't possibly hold any books or notebooks. M always had to ask others for a sheet of paper to write on. And she knew how to carry herself in these clothes. She moved in small, measured steps, her back straight, never rushing, even when others did.

After some time, I thought I had seen it all. So you can imagine my surprise when I ran into her outside the dean's office wearing a chador.

At the time, I didn't know much about histrionic personality disorder, but it was clear to me that style was never the point. What really mattered was the scene and the role she was performing.

Glossary
chador – a large, usually black cloth worn by some Muslim women to cover their heads and bodies, but not faces
deception – a trick or scheme used to get what you want
womb – the organ in women where a baby develops before birth

REVIEWS

BY JAN WOLICKI

Eternal Sunshine of the Spotless Mind

Oh yes. This one is beautiful. In this movie, we can see the unforgettable Jim Carrey. Though primarily known for his comedic roles in movies like *Ace Ventura* and *The Mask*, we have also seen him in dramatic roles, such as *The Truman Show*. Here, Carrey plays Joel, a man struggling with anxiety, introversion and insecurity.

But then, he meets Clementine, portrayed by the phenomenal Kate Winslet. Clementine is unpredictable and vibrant, and her behaviour varies widely. Winslet's portrayal hints at borderline personality traits, not a clinical study, of course, but surprisingly accurate nevertheless. I would even call it joyfully beautiful (although I know many may not agree). Michel Gondry gave us quite a masterpiece that evokes anger, joy, and tears, and that stays with us long after the credits roll.

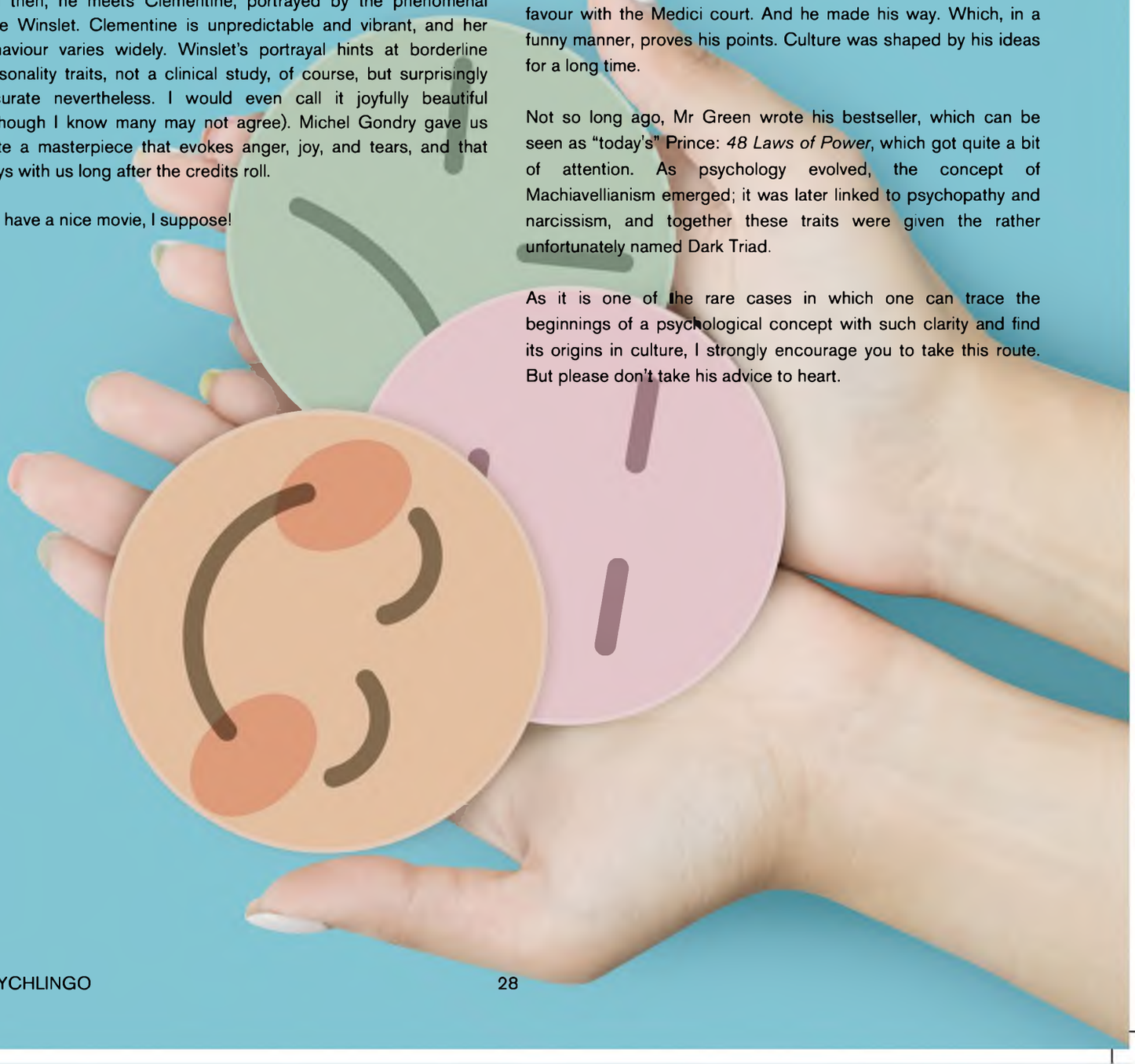
So, have a nice movie, I suppose!

The Prince

One would never expect that someone would write about manipulating the court in the 16th century, and a few hundred years later, we would see his ways as a personality trait. But that is exactly what happened. Machiavelli writes about how to rule when ruling is the only thing that matters. One shouldn't consider others; the only objective is power. In his interpretation of human behaviour, human nature is evil and egoistic. He wrote it to gain favour with the Medici court. And he made his way. Which, in a funny manner, proves his points. Culture was shaped by his ideas for a long time.

Not so long ago, Mr Green wrote his bestseller, which can be seen as "today's" Prince: *48 Laws of Power*, which got quite a bit of attention. As psychology evolved, the concept of Machiavellianism emerged; it was later linked to psychopathy and narcissism, and together these traits were given the rather unfortunately named Dark Triad.

As it is one of the rare cases in which one can trace the beginnings of a psychological concept with such clarity and find its origins in culture, I strongly encourage you to take this route. But please don't take his advice to heart.



WISE & WITTY

Proverbs

- *Fear has many eyes*
When you are afraid, you worry about everything.

- *A stiff tree breaks in the wind*
Being too stubborn or rigid can lead to failure.

- *Trust is gained in drops and lost in buckets*
Trust takes a long time to build but can be lost very quickly.

- *A merry heart does good like medicine*
A joyful mindset helps the body heal and stay healthy.

- *Much cry, little wool*
Complaining or making noise doesn't always get results.

- *Fools rush in where angels fear to tread*
Impulsive people act without thinking, while cautious people are careful.

- *A troubled mind makes a weary body*
Anxiety, worry, or stress directly causes physical exhaustion and weakness.

Idioms

- *A wolf in sheep's clothing*
Someone who seems kind but is actually dangerous.

- *Cold fish*
A person who is unfriendly or shows little emotion.

- *Make a mountain out of a molehill*
To exaggerate a small problem.

- *Look over one's shoulder*
Always expecting danger, betrayal, or criticism.

- *Set in one's ways*
Resistant to change.

- *Jump at one's own shadow*
To be overly nervous, suspicious, or anxious.

Jokes

I was diagnosed with Narcissictic Personality Disorder...
.... or as I call it, Handsome Disease.

- What do you call a homeless horse with a Borderline Personality Disorder?
- Unstable.

- What's the difference between being crazy and being eccentric?
- Your bank account.

EXERCISES

Exercise 1.
Complete each sentence with the correct idiom or proverb.

1. Poppy pretends to be helpful, but she secretly spreads rumours about everyone. She is _____.
2. Greg never shows his feelings and seems unemotional, even in exciting situations. He's a _____.
3. Laura is panicking over a minor mistake at work and treating it like a disaster. She is _____.
4. Sharon is always worried that someone might betray her. She is constantly _____.
5. Every slight noise in the house makes Peter jump. He always _____.
6. Jack and Mary have been friends for months, but one small lie could destroy their friendship. _____.
7. Naturally anxious people often worry about even small things. _____.
8. Robin is extremely stubborn and refuses to compromise, even when it's harmful. _____.
9. I've noticed that _____ because whenever I'm stressed out, I feel completely drained.
10. Impulsive people often rush into situations without thinking carefully. _____.

Exercise 2.
Match the words from the two columns to form collocations.

1. dark	a) experience
2. callous	b) affect
3. exploitative	c) reaction
4. grandiose	d) triad
5. magical	e) behaviour
6. disorganised	f) thoughts
7. depersonalised	g) bias
8. aversive	h) sense of self-importance
9. self-enhancement	i) attitude
10. constricted	j) thinking

Exercise 3.
Use the collocations from Exercise 2 to complete the sentences.

1. People with antisocial personality disorder dsplay a _____ towards the feelings and suffering of others.
2. He often engaged in _____, taking advantage of his friends or colleagues for his own benefit.
3. Individuals exhibiting _____traits, such as narcissism and Machiavellianism, often manipulate others for personal gain.
4. While under severe stress, the man shows _____, which makes it difficult for others to follow what he is saying.
5. The patient sometimes engages in _____, believing that his thoughts and actions can influence real-world events.
6. Individuals with narcissistic traits may show a(n) _____ when they perceive criticism or challenges.
7. A(n)_____ leads her to consistently overestimate her abilities and achievements.
8. Her colleagues tried to steer clear of her whenever possible because of her _____ and neglect of others' opinions.
9. In conversations with her fellow patients, she consistently showed a(n) _____, revealing almost no emotion.
10. Severe anxiety triggered a(n) _____, making the patient feel detached from his own body and thoughts.

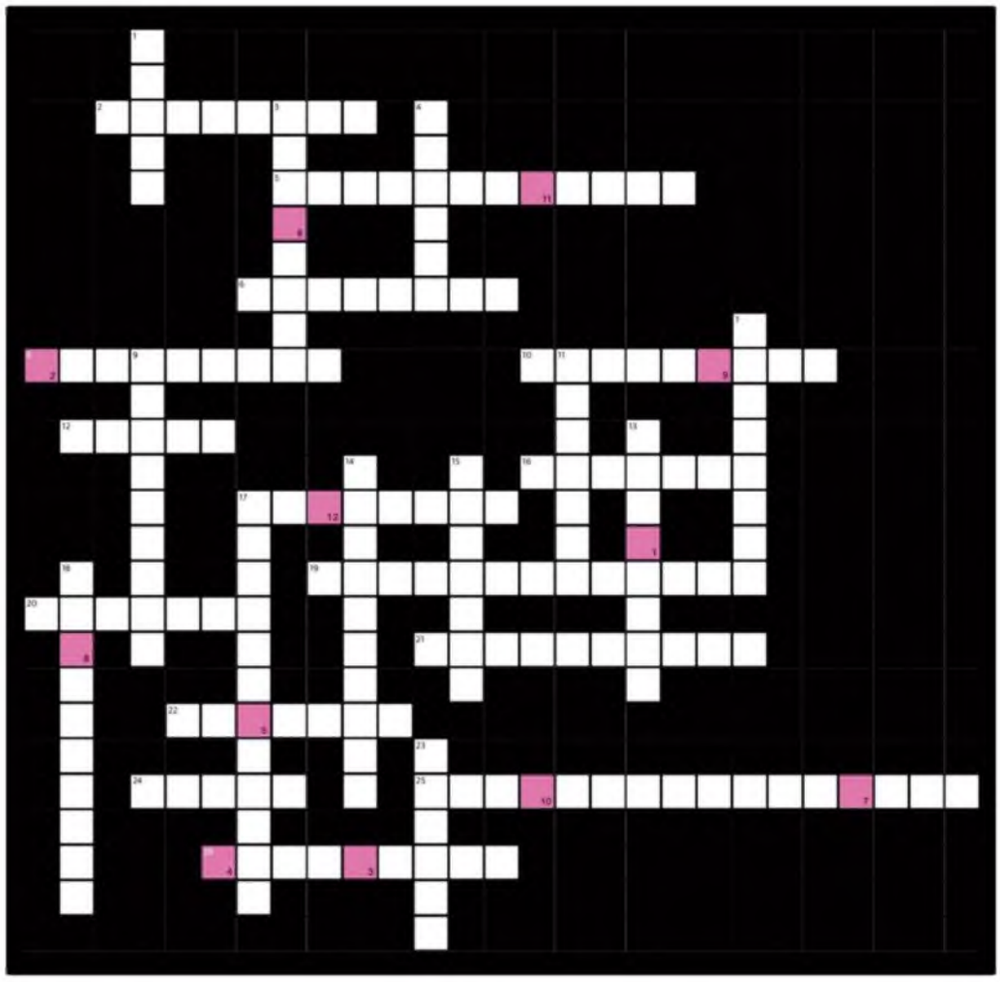
Key

Exercise 1
1. a wolf in sheep's clothing
2. cold fish
3. making a mountain out of a molehill
4. looking over her shoulder
5. jumps at his own shadow
6. Trust is gained in drops and lost in buckets
7. Fear has many eyes
8. A stiff tree breaks in the wind
9. a troubled mind makes a body weary
10. Fools rush in where angels fear to tread

Exercise 2
1. d; 2. i; 3. e; 4. h; 5. j; 6. f; 7. a; 8. c; 9. g; 10. b

Exercise 3
1. callous attitude; 2. exploitative behaviour; 3. dark triad; 4. disorganised thoughts;
5. magical thinking; 6. aversive reaction; 7. self-enhancement bias;
8. grandiose sense of self-importance; 9. constricted affect; 10. depersonalisation experience

Crossword Puzzle



SOLUTION

1	2	3	4	5	6	7	8	9	10	11	12
_	_	_	_	_	_	_	_	_	_	_	_

DOWN

1. straightforward in speech or manner
3. unpleasant
4. to calm to reduce pain, stress, or discomfort
7. a false belief
9. a state of deep discomfort, unhappiness, or unease
11. to improve or make stronger or better
13. insincere praise
14. thinking over the same thoughts again and again
15. continuing to happen or exist
17. swelling or infection of the brain
18. showing great attention to detail
23. to damage or make something weaker

ACROSS

2. to seriously damage or injure someone
5. using others selfishly for one's own advantage
6. extreme sadness, anxiety, or emotional pain
8. built-in or naturally present, often used to describe instincts or automatic behaviours
10. happening again and again
12. the beginning or start of something
16. emotionally insensitive
17. lasting a long time
19. a mistaken idea or understanding
20. to go away from what is normal
21. not changing; constant
22. very anxious, rushed, or out of control
24. to imitate or copy
25. believing that your thoughts or actions can make impossible things happen
26. to ignore or pay no attention to something

PODCAST

It's All Aboute Me: But Is Narcissism A Disorder?

You will listen to a recording about personality disorders. Listen carefully and complete the tasks that follow.

Exercise 1.
Decide if each statement is *True*, *False*, or *Not Mentioned* based only on the information in the text.

1. Dr Keith Campbell believes that all reality TV stars have narcissistic personality disorder.
2. He thinks social media is causing a rise in narcissism.
3. Narcissistic personality disorder may be removed from the DSM.
4. The American Psychiatric Association is considering removing ten personality disorders.
5. Histrionic personality disorder is associated with being dramatic or outgoing.
6. Narcissism only affects how a person behaves behind closed doors.
7. Clinical narcissism interferes with life and relationships.
8. If someone has moderate narcissism, their treatment differs from someone with severe narcissism.
9. Personality disorders are considered completely separate from normal personality.
10. There are currently 10 recognised personality disorders in the DSM.
11. Extreme narcissists cannot hold a job.
12. Schizoid personality disorder is under consideration for removal from the DSM.

Exercise 2.
Fill in the gaps using the words from the recording so that each sentence makes sense..

1. According to Dr Campbell, a personality disorder becomes _____ when it affects all aspects of life.
2. When narcissism is severe, it can _____ decision-making and relationships.
3. People with narcissistic traits constantly seek _____ from others.
4. _____ narcissism differs from casual narcissism in that it significantly interferes with life.
5. Dr Campbell says that personality disorders may be a combination of traits that lie on the _____.

Discussion
Read each question carefully and discuss your ideas with a partner. Give examples and explain your opinions where you can.

1. Is there a difference between being confident and being narcissistic? Where is the line?
2. Do you think modern culture encourages people to be more narcissistic?
3. How can narcissistic behaviour distort a person's relationships with others?
4. Can a small amount of narcissism ever be good?

Key

Exercise 1
1. F; 2. NM; 3. T; 4. F; 5. T; 6. F; 7. T; 8. F; 9. F; 10. T; 11. NM; 12. T

Exercise 2
1. pervasive; 2. distort; 3. admiration; 4. Clinical; 5. spectrum

LAST BUT NOT LEAST

BORDERLINE PERSONALITY DISORDER THROUGH THE LENS OF EVOLUTION & NEUROSCIENCE
VALERIE PORR | TEDXKI

LINGUISTIC TIDBITS

Disease vs disorder

People often use the terms **disease** and **disorder** interchangeably in medical terminology, but clinically they have different meanings.

A disease (e.g., Alzheimer's Disease) has a specific biological or neurological cause and can often be diagnosed and treated.

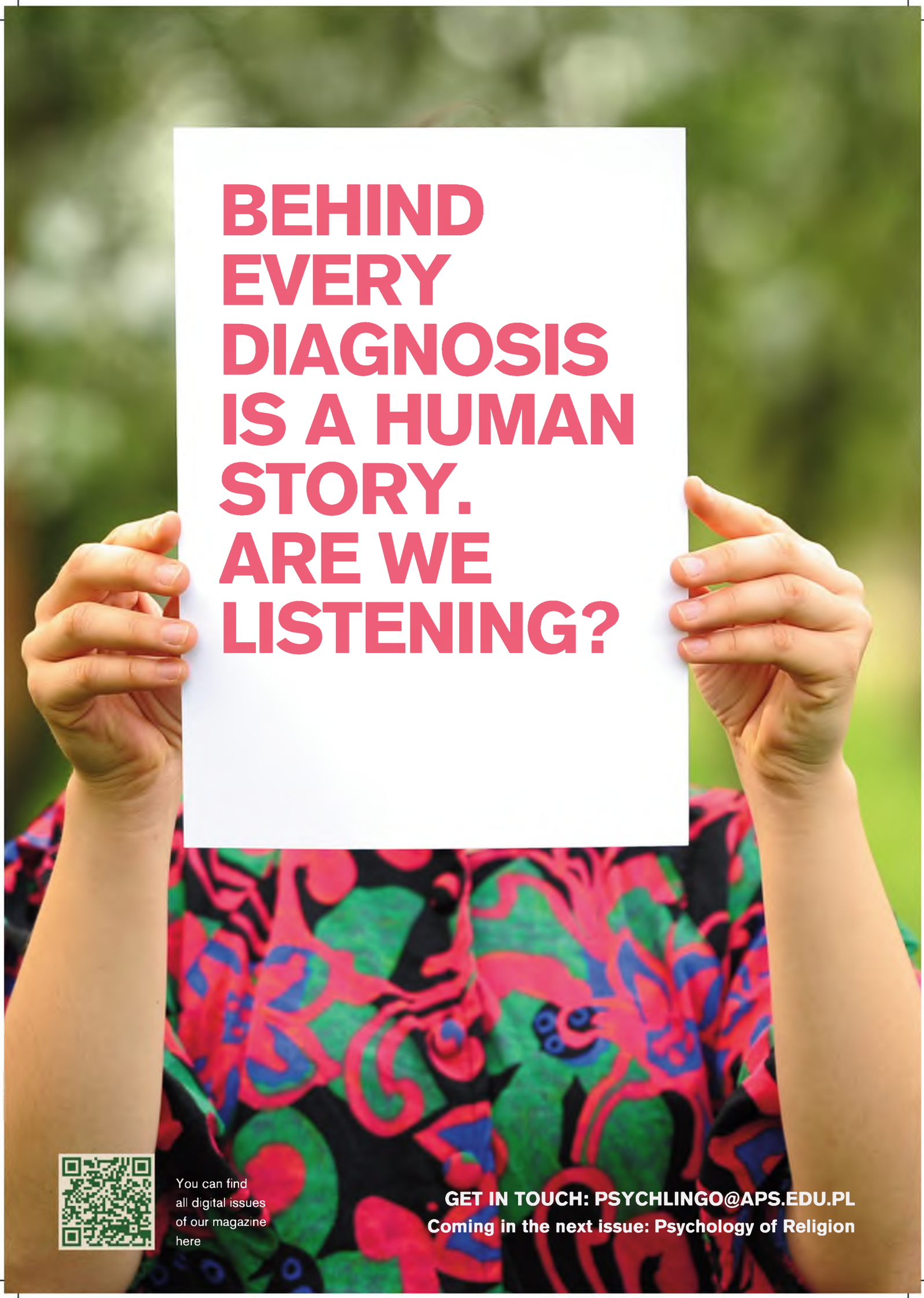
A disorder (e.g., paranoid personality disorder), on the other hand, is an abnormality or disruption that affects a person's mental or physical well-being. Unlike diseases, disorders do not always have a clear underlying cause and are mainly defined by patterns of behaviour, thoughts, or mood.

Did you know that...

comorbid means that an individual has two or more health conditions at the same time? This word is often used in mental health. For example, a person with borderline personality disorder may have depression at the same time, or a person with paranoid personality disorder may have a substance use disorder. We call these conditions comorbid.

E.g., People with schizotypal personality disorder usually have other comorbid disorders, such as social anxiety disorder.

Comorbidity does not mean that one disorder causes the other. It only means they exist together in the same person.



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