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A TRANSIENT PERSONALITY DISORDER INDUCED BY FOOTBALL MATCHES

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SUMMARY

Background: *Personality disorders are a class of mental diseases characterized by inflexible and maladaptive patterns of behavior, cognition, and inner experience, involving several areas of functioning, such as affectivity, impulse control, ways of perceiving and thinking and reaction to stress factors. In the literature, personality disorders have always been described as stable patterns of long duration, and their onset can be found during adolescence or early adulthood. These patterns are associated with significant distress or impairment in a patient's life in which a main element affects every aspect of living, and in which no biological or other pathologies exist to assist in its identification. Therefore, they often lead to comorbidities such as dysfunctional anxiety, drug abuse, major depression and suicide.*

Subjects and methods: *We present a case of a 37-year-old man, who came to the outpatient department needing support to quit smoking. During the follow up, he described some transitory changes in his personality while watching football (soccer) games. These episodes were characterized by inappropriate anger crises, rapid and dramatic shifts in emotional tone, dysphoria and superstitious and magical beliefs with paranoid elements; connecting himself, his family and friends to players in the match and to the unfolding of the game. Every manifestation was induced by the football match, and there were no signs of difficulty in handling impulses and in managing relationships, or any superstitious beliefs, outside of it.*

Results: *The combination of all the symptoms led us to think about a diagnosis of the borderline personality disorder. There was a lack of managing impulsivity, intense uncontrollable emotional reactions, and episodes of psychotic decompensation with unreal and paranoid connections made between the patient's entourage and the results of the match.*

Conclusions: *With this case, we propose to consider the personality disorder, not just as a stable and inflexible pattern, but also as a transitory dysfunction induced by stress factors, as in this case, a football match, introducing therefore a new entity: transient personality disorder.*

Key words: *borderline - personality disorders - stress factors - transitory dysfunction*

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INTRODUCTION

Personality is defined as the combination of habitual behaviors, cognitions and emotional patterns that evolve from biological and environmental factors.

It consists of enduring patterns of thinking, perceiving and connecting in relationships that are exhibited across numerous social and personal contexts.

A personality disorder is diagnosed when personality traits are so inflexible and maladaptive across a wide range of situations that they cause significant distress and impairment of social, occupational, and role functioning. The thinking, the management of emotions and the interpersonal behavior of the individual must deviate markedly from the expectations of the individual's culture to qualify as a personality disorder (Skodol et al. 2017).

In the literature, personality disorders have always been described as stable patterns of long duration, and their onset can be found during adolescence or early adulthood. These patterns are associated with significant distress or impairment in a patient's life, in which a main element affects every aspect of living and interrelating, and in which no biological or other pathologies exist to assist in its identification. This enduring pattern is not better explained as a manifestation or consequence of another mental disorder and it is not attributable to the physiological effects of a substance or another medical condition. These disorders are highly comorbid with other mental diseases, including major depression, alcohol abuse, drug abuse, and suicide.

The DSM-5 includes 10 personality disorders grouped into three main clusters, based on descriptive similarities (American Psychiatric Association 2013):

Cluster A characteristics

Individuals may appear odd and eccentric, including the Paranoid, the Schizoid and the Schizotypal personality disorder;

Cluster B characteristics

Individuals often appear dramatic, emotional, or erratic including the Antisocial, the Borderline, the Histrionic and the Narcissistic personality disorder;

Cluster C characteristics

Individuals often appear anxious or fearful including the Avoidant, the Dependent and the Obsessive-compulsive personality disorder.

The estimated international prevalence of personality disorders in the community is 11 percent (Oldham et al. 2014). Individual personality disorders differ on gender and age. The prevalence of personality disorders in clinical populations has been estimated to be over 64%.

Between the different personality disorders, Borderline personality disorder (BPD) affects 2% of the adult general population, 10% of psychiatric outpatients and 20% of psychiatric inpatients. The associated morbidity is high, mainly related to impulsive behavior and self-harm danger such as cutting or suicide attempts (Lieb et al. 2004, American Psychiatric Association 2013, Bourvis et al. 2017). This personality disorder is also related to a high mortality caused by suicide; in fact, among borderline patients, 10% of subjects die from suicide, a rate 50 times higher than that in the general population (Lieb et al. 2004, Bourvis et al. 2017).

Borderline personality disorder is a mental disorder characterized by a pervasive pattern of difficulties with emotion regulation, impulse control, instability in relationships and low self-image (Skodol et al. 2017). We can categorize this complex symptomatology in:

- Affective symptoms, such as affective instability, chronic and major depression, chronic anger and frequent acts of anger, chronic anxiety and chronic feelings of loneliness or emptiness.
- Cognitive symptoms like quasi-psychotic thought, serious identity disturbance, odd thinking and unusual perceptual experiences or non-delusional paranoia.
- Impulsive symptoms, such as substance abuse and dependence, dangerous behavior, general impulsivity in reactions and non-suicidal self-injury.
- Interpersonal symptoms, such as stormy relationships, devaluation/manipulation/sadism, demandingness, abandonment engulfment or annihilation fears, counter dependency or serious conflict over help/care, countertransference problems and beliefs in "special" treatment relationships, dependency and masochism (Zanarini et al. 2016).

Patients with Borderline personality disorder are often considered to be "complicated to work with" by healthcare providers. Every problematic issue may be presented by the patient as a crisis or an emergency, and this kind of interactions can leave the healthcare providers feeling mentally exhausted or overwhelmed (Sheppard & Duncan 2018).

While personality disorders are supposed by their definition to be a structural and stable diagnosis, this definition has been recently challenged suggesting that the personality disorders could be an unstable or fluctuating entity. A study conducted by Zanarini et al. in 2016 involving a cohort of 290 patients showed that after two years of follow-up, 93% of subjects showed a partial remission of the symptoms that led them out of the diagnosis criteria for personality disorder (Bourvis et al. 2017, Zanarini et al. 2016). The aim of our case report is to propose a different approach to the personality disorders suggesting that they may be, in some cases, transitory dysfunction.

SUBJECTS AND METHODS

In this article, we present the case of a 37 years old man with no history of psychiatric disorders, who came to the inpatient department needing support to quit smoking. He didn't have a family history of psychiatric disorders. He was Caucasian, he was born and grew up in Belgium and he was a university researcher in economics. He had smoked ten cigarettes per day for several years. He had quit smoking for a period of two years, two years earlier, and then he restarted consumption. During the follow up the patient started to describe some episodes in his daily routine. He reported a transitory change in his personality while he was watching a football match on the TV, when the team he supported was playing.

RESULTS

During the matches, he described himself as having violent anger crises, characterized by shouting and breaking objects, with rapid and dramatic shifts in emotional tone and the progressive instauration of a depressive mood. The patient was persuaded that there was a link between his life and the unfolding of the match. He started to believe that there was a connection between himself, his friends and the football players, the team managers and the team coach. In his perception, the connections were stable and real and they played a role in the unfolding of the match. In this absurd link between his entourage and the game, he assumed different kinds of positions between idealization and devaluation of his best friends until he started to develop distrustfulness towards them. He also started to believe that there were some base political and economic conspiracies aiming for the defeat of his team in the match. In some cases, he was convinced that he was cursed by some magic influences to the point where he refused to watch the matches to avoid bringing bad luck, because he was sure to cause certain defeat to his team. Outside these episodes, the patient didn't show any interest in any kind of superstition and he declared himself to be an atheist, even though he came from a catholic family. Anytime his team lost, he even presented some brief phases of dysphoria and excessive irritability, followed by a feeling of emptiness that he tried to manage with alcohol abuse, never reaching the point of intoxication, even though in his daily life he was just an occasional drinker. All the described manifestations were totally connected with, and induced by, the football match. There wasn't any difficulty in handling feelings or impulses, in dealing with relationships, or any superstitious conviction, outside of it.

DISCUSSION

A lot of studies on the etiology of BPD (Crowell et al. 2009, Koenigsberg et al. 2009, Linehan et al. 1993) propose that this personality disorder is conceived as an

emotion dysregulation disorder, caused by an increased emotional sensitivity and an inability to regulate emotional responses. The incapacity to handle and regulate the emotional circuit of impulses and responses might lead to marked impulsive behavior, characteristic for BPD patients (Bourvis et al. 2017) (Figure 1).

In our case, the patient presents 6 out of 9 of the borderline disorder criteria (DSM-5), consisting in: affective instability due to a marked reactivity of mood with intense episodes of dysphoria, chronic feelings of emptiness, inappropriate and intense anger with difficulty in controlling it with frequent burst of rage, a lack of control of his impulses with alcohol abuse, a pattern of unstable and intense interpersonal relationships, characterized by alternating between extremes of idealization and devaluation, in particular towards his friends and the influence he believed they had on the results of the match; and lastly, he presented a transient stress-related paranoid ideation: during the matches he felt like he was surrounded by magic influences, and that his actions could either bring good luck or curse his team, leading him in the second case to even not to watch the game. As we all know, there is a connection between stress exposure and BDP, and, among the clinical signs of the disorder, the acute features, like anger management and impulsivity control, that are the less stable dimensions (Roberts et al. 2006, Blonigen et al. 2008, Zanarini et al. 2016), are mostly triggered by acute stressful situations (Bourvis et al. 2017). A direct and unequivocal connection between past traumatic events and BPD symptomatology has never been formally proven; recent works support models that associate individual genetic vulnerability with different experiences of early adversity in development. The characteristics of these stressful factors are variable and consequently may not be easily detectable by questionnaires or predefined scales (Bourvis et al. 2017). In our particular case, the stressful factor cannot be found in the patient's general past or formative years. The only specific scenario able to induce all the symptoms was watching his team playing a football match. Among the new proposals for the DSM-5, the position of personality disorders has been a topic of debate (Robin and Rechtman 2014, Bourvis et al. 2017). As we know the division into axis of the DSM-IV, was erased. Proposals were made to deeply change the diagnosis framework for personality disorders, and adopt preferentially a dimensional approach (Guelfi 2014, Bourvis et al. 2017).

Most patients have a gradual remission of the symptomatology over time, and this remission can be facilitated by psychosocial treatments. In our case, the ensemble of the symptoms confirmed the diagnosis of borderline personality disorder, but there wasn't any evolution or gradual remission. There wasn't any manifestation outside of the context of the football match. The total absence of these symptoms in all the other circumstances of his life, even in other stressful situations, led us to propose a new approach to the diagnosis of personality disorder in general and to formulate the diagnosis of a transient borderline personality disorder induced by a football match. The limit of our study is related to the fact that we present only one case report, and to the fact that the personality disorders have always been studied as constant and enduring patterns; as consequence, a possible transient dysfunction has never been detected as a separate diagnosis. To better understand the real incidence of the transient personality disorder we need more studies towards this direction to confirm our theory and to have statistically significance with solid data.

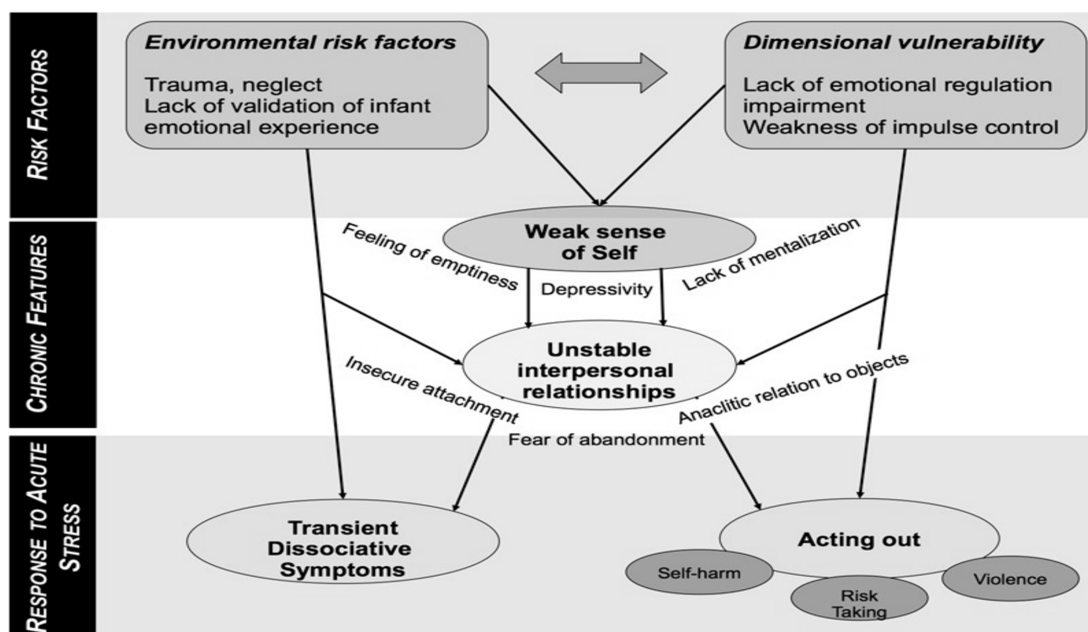

Figure 1. Putative relationships between risk factors and emergence of symptoms in BPD distinguishing chronic features and acute response to stress (Bourvis et al. 2017)

CONCLUSIONS

With this case report, we propose to consider personality disorder not just as a stable and inflexible pattern with repercussions on every aspect of life that has its origins in the person's development and/or trauma, but also as a transitory dysfunction induced by determined stress factors, in this case football matches, introducing therefore a new entity: the transient personality disorder.

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Contribution of individual authors:

The authors certify that the work described has not been published before and that it is not under consideration for publication anywhere else. All the authors contributed to the article, they participated to the literature search and medical writing. All are answerable for published reports of the research. Dr. Tecco came up with the idea of the manuscript, Dr. Franco wrote the first draft.

The final draft was written under Dr. Tecco close supervision. This publication has been approved by all co-authors, as well as by responsible authorities where there work has been carried out.

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