



Personality Disorders: A Review of the Current State of Knowledge

Peer review status:

No

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Article ID: WMC005089

Article Type: Review articles

Submitted on: 26-Apr-2016, 09:56:32 PM GMT **Published on:** 28-Apr-2016, 11:48:07 AM GMT

Article URL: http://www.webmedcentral.com/article_view/5089

Subject Categories: PSYCHOLOGY

Keywords: Personality Disorders, Borderline Personality Disorder

How to cite the article: Volkan K. Personality Disorders: A Review of the Current State of Knowledge. WebmedCentral PSYCHOLOGY 2016;7(4):WMC005089

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Source(s) of Funding:

None

Competing Interests:

None

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Abstract

Personality disorders are the most common serious mental illness. People suffering from these disorders tend to exhibit emotional patterns and behaviors that seem troubling to the majority of people and are not necessarily explicable by immediate environmental stimuli. Nevertheless, many clinicians are unfamiliar with the most recent research on these disorders and the latest approaches to treatment. This study will review the current diagnostic conceptualization of personality disorders, their clinical treatment, and their relationship to cultural characteristics and culture-specific disorders.

Introduction - Diagnosis of Personality Disorders

In the creation of the new DSM-V there was some debate about what to do with the diagnostic category for personality disorders. In the end the creators of the DSM-decided to holdover the different types of personality disorders from the DSM-IV but to remove these disorders from a separate axis. The DSM-V also keeps the same cluster structure as in the DSM-IV. The DSM-V: Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) defines the following criteria for the diagnosis of a personality disorder:

An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
3. Interpersonal functioning.
4. Impulse control.
5. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
6. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other

important areas of functioning.

7. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

8. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

9. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma). (p.646-647)

There are ten types of personality disorders recognized in the DSM V: Schizotypal, Paranoid, Schizoid, Antisocial, Borderline, Obsessive-Compulsive, Dependent, Avoidant, Narcissistic, and Histrionic. Briefly, these can be understood to have the following characteristics:

Antisocial Personality Disorder: People suffering from this disorder are characterized as having a disregard for moral or legal standards of their culture. They have trouble getting along with others and/or following the rules of society. They used to be called psychopaths or sociopaths.

Avoidant Personality Disorder: People suffering from this disorder have heightened social inhibitions combined with feelings of inadequacy. These people generally are extremely sensitive to criticism.

Borderline Personality Disorder: People with this disorder lack a stable identity. They may be emotionally labile and have unusually intense, yet unstable relationships with others. Persons suffering from this disorder also have marked impulsivity, and often are dissociated from their emotions.

Dependent Personality Disorder: People with this disorder have an extreme need of other people. They have trouble doing anything on their own and are often unable to make decisions or be independent in any aspects of their lives. They have an intense fear of separation, which may manifest itself in extremely submissive and conciliating behavior. People with this disorder lack self-confidence and self-esteem.

Histrionic Personality Disorder: People with this

disorder are overly dramatic with highly exaggerated and/or inappropriate emotional displays. They manifest sudden and rapidly shifting expression of emotions that often seem fake or shallow.

Narcissistic Personality Disorder: People with this disorder see themselves as most important person in the universe, emanating grandiosity and omnipotence. They also lack empathy toward others while at the same time needing other people's admiration and attention. This lack of empathy makes it difficult for them to understand other's points of view making them intolerant and hypersensitive to criticism.

Obsessive-Compulsive Personality Disorder: People suffering from this disorder tend to be perfectionists and are inflexible. The disorder manifests as repetitive patterns of thought and/or behavior that the person feels are out of his or her control.

Paranoid Personality Disorder: This disorder is characterized by an extreme distrust of others. This distrust can become extreme to the point where a person's paranoid beliefs (i.e. that others are exploiting, harming, or trying to deceive) are thought disordered, containing their own set of internal logic unrelated to consensus reality. People suffering from this disorder often believe that they have been betrayed and that there is hidden significance in the behavior of others. People with this disorder are often unforgiving and hold grudges.

Schizoid Personality Disorder: Those suffering from this disorder have a very limited range of emotional expression and experience. They present as being very 'flat', withdrawn and uninterested in social relationships.

Schizotypal Personality Disorder: This disorder is similar to schizophrenia except that it does not include frankly psychotic features such as hallucinations. Like schizophrenia however, it does include disordered thoughts, magical beliefs and thought patterns[1]. People with this disorder may appear or behave in an eccentric or disordered fashion as well as evincing belief in things that make no logical sense.

Also included in the DSM-V are two further categories, which are self-explanatory:

Personality change due to another medical condition is a persistent personality disturbance that is judged to be due to the direct physiological effects of a medical condition (e.g., frontal lobe lesion).

Other specified personality disorder and unspecified personality disorder is a category provided for two situations: 1) the individual's personality pattern meets the general criteria for a personality disorder, and traits of several different personality disorders are present, but the criteria for any specific personality disorder are not met; or 2) the individual's personality pattern meets the general criteria for a personality disorder, but the individual is considered to have a personality disorder that is not included in the DSM-5 classification (e.g., passive-aggressive personality disorder). (American Psychiatric Association, 2013, p. 645)

The DSM-V (2013), organizes personality disorders into three groups or clusters, with three or four disorders per group:

Cluster A - Eccentric Personality Disorders: Paranoid, Schizoid, Schizotypal:

People suffering from these disorders often appear odd or peculiar and begin to demonstrate these aspects of the disorder by early adulthood and in various contexts.

Cluster B - Dramatic Personality Disorders: Antisocial, Borderline, Histrionic, and Narcissistic:

People suffering from these disorders have intense, unstable emotions, distorted self-perception, and are often behave in impulsive ways.

Cluster C - Anxious Personality Disorders: Avoidant, Dependent, Obsessive-Compulsive: People suffering from these disorders are often anxious and fearful. They begin to demonstrate these aspects of the disorder by early adulthood and in various contexts.

Also included in Cluster C are the diagnoses of Personality Change Due to Another Medical Condition, Other Specified Personality Disorder and Unspecified Personality Disorder. The diagnosis of Personality Change Due to Another Medical Condition is related to severe personality changes that are caused by an underlying physical or medical condition. The DSM V includes eight types under this diagnosis: labile type, disinhibited, aggressive, apathetic, paranoid, other, combined, and unspecified. This diagnostic category should be a reminder for the clinician to make sure that any patients suspected of having a personality disorder be thoroughly screened for medical disorders.

The diagnoses for Other Specified Personality Disorder and Unspecified Personality Disorder would be given for disturbed personality functioning that does

not meet criteria for any specific personality disorder, but which leads to distress or harm in one or more important areas of functioning (e.g., social or work-related). Clinicians may also give these diagnoses if a specific symptom of a personality disorder that is not included in the DSM V classification seems to apply to an individual (e.g., depressive personality disorder, or passive-aggressive personality disorder). In practice, these catch-all diagnoses are often used even though guidelines for their application are not explicit (Verheul, Bartak, & Widiger, 2007).

[1] In fact, it is often difficult to separate the diagnoses of schizophrenia and personality disorder. The reported prevalence of personality disorders among people suffering from schizophrenia varies tremendously – from 4.5% to 100%. It has been suggested that type of care, country, study type, and diagnostic tools all bias prevalence rates. (Newton-Howes, et. al. 2008). Structural magnetic resonance imaging and computer tomography studies suggest that schizotypal personality disorder may in fact be a milder form of schizophrenia. Normal volume and perhaps functioning of the medial temporal lobes in those suffering from schizotypal personality disorder may explain why schizophrenics (who have abnormal medial temporal lobes) experience more severe psychotic symptoms Dickey, McCarley, & Shenton, 2002).

Co-Morbidity

Personality Disorders are among the least understood of the recognized psychological disorders. Unfortunately, they are also the most common severe mental disorders. Their severity is compounded because personality disordered persons often have other medical or mental illnesses. More specifically, people suffering from personality disorders are more likely than the general population to also suffer from a history of alcohol and/or substance abuse (Bowden-Jones, et. al., 2004; Morganstern & Miller, 1997; Thuo, et. al. 2008; Volkan, 1994.), sexual dysfunction (Bogaerts, et. al., 2006; Maina, et. al. 2007; Neeleman, 2007; Hill, Habermann, Berner, & Briken, P. 2006), generalized anxiety disorder (Brooks, Baltazar, & Munjack, 1989; Hansen, et. al., 2007; Massion, et. al., 2002; Mavissakalian, et. al., 1995), bipolar disorder (George, et. al., 2003; Maina, Albert, Pessina, & Bogetto, 2007; Wilson, et. al., 2007), body-dysmorphic disorder (Semiz, et. al. 2008), obsessive-compulsive disorder (Hansen, et. al., 2007; Maina, Albert, Pessina,

& Bogetto, 2007), depressive disorder (Wilson, et. al, 2007), post-partum depression (Akman, Uguz, & Kaya, 2007), eating disorders (Godt, 2002; Marañon, Echeburúa, & Grijalvo, 2004; Sansone, Levitt, & Sansone, 2005), post-traumatic stress disorder (Bollinger, et. al., 2000; Johnson, Sheahan, & Chard, 2003; Mclean & Gallop, 2003), self-mutilation (Andover, et. al., 2005; Dulit, et. al., 1994; Paris, 2005; Rollinick, 2001) and suicidal thoughts or acts (Pompili, Ruberto, Girardi, & Tatarelli, 2004).

Other maladaptive social consequences of personality disorders include decreased academic performance (King, 2000), domestic violence[2] (Berger-Jackson, 2003), child molestation and sexual offense (Bogaerts, et. al., 2008; Dudeck, et. al., 2007), incarceration (Lindsay, et. al., 2006; Narisco, 2007), poor work habits and performance (Furnham, 2007; Kyrios, et. al. 2007; Lynch & Horton, 2004), and pathological gambling (Bagby, et. al. 2008; Samuels, et. al., 1994).

People diagnosed with one personality disorder often suffer from other personality disorders. In one study the majority of patients meeting criteria for a diagnosis of a personality disorders also were diagnosed with an additional personality disorder. The most prevalent personality disorders for the first diagnosis were avoidant, borderline, and obsessive-compulsive personality disorders. The authors suggest that patients suffering from personality disorders should be evaluated for additional personality disorders because their presence can influence the course and treatment (Zimmerman, Rothschild, & Chelminski, 2005).

One of the most interesting things about personality disorders is that people around the one with disorder will be more distressed than the person manifesting the disorder. This distress may even be worse when the people close to the personality-disordered person are knowledgeable about the disorder (Hoffman, et. al., 2003; Scheirs & Bok, 2007). This fits in with many of our ideas about bizarre behaviors – they seem strange to us, but not the person exhibiting them.

[2] Interestingly enough it seems that being a victim of domestic violence rather than the perpetrator is not related to having a personality disorder. In fact, some personality disorders may be inversely related to being the victim of domestic violence (Manelski, 2005).

Prevalence

Understanding personality disorders is important, as

the prevalence of these disorders is quite high. For instance, a recent study found that 44% of volunteers for biomedical research studies suffered from a personality disorder (Bunce, et. al. 2005). Nevertheless the prevalence of personality disorders reported in the research is somewhat variable depending on the milieu and populations studied.

A good example of this variability can be seen in two studies conducted by the same first author. Moran et. al. (2000) examined the prevalence of personality disorder along with its relationship to sociodemographic status and common mental disorders in 300 primary care patients in the U.K.. They found a diagnosis of personality disorder in 24% of patients in the study. These personality-disordered patients were more likely to have past and present psychiatric problems, to be single, and to present to the surgery on an emergency basis when compared to non-personality disordered patients. Patients with cluster B personality disorders were particularly associated with psychiatric problems. The authors concluded that there is a high prevalence rate of personality disorders in the primary care setting and that this represents a significant source of burden.

However, two years later the same author reported relatively low rates for cluster B personality disorders in a similar population. Moran & Mann (2002) examined 303 primary care patients in southeast England for cluster B personality disorders. Using standardized assessment instruments they identified just 13 patients with personality disorders or a prevalence of 4% in their sample. The authors concluded that among primary care patients, cluster B personality disorders were uncommon.

Another study from a nearby geographical area, but situated in a community mental health clinic demonstrated much higher prevalence of personality disorders among their patients. This team of researchers from South London assessed personality disorders, as well as psychotic and affective disorders in their patient population. They found 52% of their patients met the criteria for one or more personality disorders, while 67 % of patients had a psychotic illness and 23 % had a diagnosis of a depressive disorder. Non-psychotic patients seen by nursing staff had extremely high rates of personality disorder, when compared to patients seen by psychiatrists and psychologists (Keown, Holloway, & Kuipers, 2002).

Using data from the *2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions*, Grant et. al. (2004) report that 14.79% of adults in the United States (approximately 30.8 million people) met the criterion for diagnosis of at least one personality

disorder. The study did not include diagnoses for borderline, schizotypal and narcissistic personality disorders, which would have likely increased the incidence of personality order diagnoses. Of the personality disorders studied the most prevalent disorder was obsessive-compulsive personality disorder (7.9%), followed by paranoid personality disorder (4.4%), antisocial personality disorder (3.6%), schizoid personality disorder (3.1%), avoidant personality disorder (2.4%), histrionic personality disorder (1.8%), and dependent personality disorder (0.5%). Women had a significantly higher risk of avoidant, dependent, and paranoid personality disorders while men were at greater risk for antisocial personality disorder. No gender differences were seen for risk of obsessive-compulsive, schizoid, or histrionic personality disorders. Other risk factors for the personality disorders studied included being Native American, black, young adulthood, low socioeconomic status, and not having a significant other. Avoidant, dependent, schizoid, paranoid, and antisocial personality disorders were significant predictors of disability, while obsessive-compulsive personality disorder had an inconsistent relationship to disability. Individuals with histrionic personality disorder did not have any disability when compared with those without the disorder.

Bowden-Jones, et. al. (2004) found 37% of substance abusers and 53% of alcohol abusers in their sample also suffered from a personality disorder.

It is estimated that up to 50% of prisoners in the United States have antisocial personality disorder. This is likely due to the fact that behavioral characteristics associated with antisocial personality disorder, such as substance abuse, aggression, violence and vagrancy, are often related to criminal behavior. (Lindsay, et. al. 2006). In the U.K. the number of prisoners with antisocial personality disorder is 26%, less than the prevalence rates in the U.S., but still a substantial number (Hobson & Shine, 1998).

Clinical History & Treatment

Personality typically refers to those aspects of a person's character that are not transient, i.e. 'traits', and opposed to 'states'. According to Millon, Blaney, & Davis (1999):

Personality is seen today as a complex pattern of deeply imbedded psychological characteristics that are largely non-conscious and not easily altered, which express themselves automatically in almost every area

of functioning. (pg. 510)

From this definition of personality the expectation is that traits associated with personality disorders would be stable over time. Recent studies support this idea (McGlashan, et. al. 2005). Therefore we can understand personality disorders (PDs) to be long-term, maladaptive patterns that pervade all aspects of a person's life. These patterns include problems related to: perception (viewing and understanding the external world), ability to regulate emotions, high levels of anxiety, and poor impulse control. These patterns can lead to significant costs to both the person suffering from a personality disorder and the society he or she functions within. These costs, include lost productivity, increased interaction with law enforcement, imprisonment, a pattern of hospitalization, significant unhappiness, and suicide.

Personality disorders are notoriously difficult to treat. Long-term intensive psychotherapy has been shown to be effective for some personality-disordered patients (Bond, & Perry, 2004, 2006; Chatham, 1989). As Chatham puts it in regards to patients with borderline personality disorder:

I have observed that towards the end of the change process, patients often realize with surprise that early in psychotherapy certain things upset or traumatized them strongly enough to trigger various degrees of aberrant behavior. Basically, genuine improvement in borderline patients can begin only when primitive defenses and internalized pathological object relations have been uncovered and discarded. The patients must recognize that they can get on in the world without this pathology, because they now have moved forward in psychological development. But to get to this point sometimes requires a very long period of intensive psychotherapy (1989, p. 420).

According to Kernberg, (1985) for this long-term intensive psychotherapy to be effective for people suffering from borderline personality disorders (or low ego strength - a defining characteristic of most personality disorders) the psychotherapy needs to be conducted by a skilled therapist who is in control of his or her own hostility and is not narcissistic. Therefore, while long-term psychotherapy for personality disorders is recommended there are many barriers to this type of treatment. Even if patients could afford and tolerate or afford this kind of treatment, finding the right therapist is crucial for a positive treatment prognosis. Short-term and supportive psychotherapy doesn't seem to work as well as long-term intensive

psychotherapy (Hoglund, 1993; Kernberg, 1985). Caligor, Kernberg, & Clarkin (2007) report on a transference-based object relations psychotherapy specifically designed for the treatment of personality disorders that appears to be effective.

Newer kinds of therapeutic techniques such as Cognitive-Behavior therapy and Dialectic Behavior Therapy (or DBT, which was specifically designed to treat personality disorders) show promise in effectively treating personality disorders[3] (Davidson, et. al., 2007; Fruzzetti, 2002; Linehan, 1993; Linehan, et. al., 2007; Lynch, et. al., 2007; Salsman & Linehan, 2006; Sperry, 2006). Some question the long-term efficacy of these treatments, which seem to be measuring rather simple outcomes when compared to long-term psychodynamic treatment (Kernberg, 1985). Indeed, some research suggests that Cognitive-Behavior therapy works less well for personality disorders than for other types of mental problems (Luk, et. al., 1991). Another study indicates that the psychodynamic approaches may yield better long-term therapeutic results than Cognitive-Behavioral therapy with personality disordered patients (Leichsenring & Leibing, 2003). Nevertheless, Cognitive-Behavior therapy and Dialectic Behavior Therapy have shown efficacy in reducing acting out behaviors such as suicide attempts while being accessible (Davidson, et. al., 2006; Linehan, et. al., 2007). In fact, in one study the four major approaches to treating borderline personality disorders were all found to be successful in reducing behavioral acting out and affective instability, while not eliminating the underlying personality disorder (Lopez, et. al., 2007).

One of the dirty secrets of the psychotherapy profession is that many if not most therapists either consciously or unconsciously screen out patients with personality disorders (Hartman, 1999), or take on a 'removed' scientific attitude towards them (Hinshelwood, 1999). A UK study found that registered mental health nurses perceived patients with a diagnosis of borderline personality disorder more negatively than patients with a diagnosis of schizophrenia. Patients diagnosed with borderline personality disorder were perceived as more dangerous and were subject to more social rejection than those with a diagnosis of schizophrenia (Markham, 2003). Rothschild and Rand (2006) make the case that psychotherapists take on the emotional states of their patients through unconscious mirroring. This can cause vicarious trauma for psychotherapists, especially when they are unaware of their autonomic arousal. Since personality disordered patients have

much more unstable emotional states it stands to reason that the psychotherapist will take on a much greater burden and a higher level of vicarious trauma when working with this patient population. As Fonagy says:

Why are these patients designated as difficult? Part of the difficulty undoubtedly arises out of the obligation we quickly feel as clinicians to enact that which is projected onto us. We are forced to be as our patients wish us to be, because we sense that without this, prolonged contact with us might be intolerable. They behave "unreasonably" toward us to elicit the reaction that they require, one which confirms for them that they have successfully externalized the alien part of the self. Because we try not to react in these directions in response to mild provocation, we unwittingly force our patients to become "more difficult." They get under our skin and eventually discover what will make us react with anger, or what will cause us to neglect them, reject them, or feel excited by them, in all instances forgoing our therapeutic identity. (Fonagy, 1998, p. 1)

Indeed, we find that psychotherapists report personality-disordered patients as their most difficult (Davidtz, 2008; Reimer, 1991). This is not only true in individual therapy but for group therapy as well (Liebenberg, 1990; Roth, Stone, & Kibel, 1990). Psychotherapists quickly learn that the amount of progress these patients make in therapy is disproportional to the amount of distress they inflict on the therapist. This sentiment has been born out on research studies that have shown that patients with personality disorders may have a propensity to engage in litigation with their therapist (Gutheil, 2005; Gutheil & Alexander, 1992), or their workplace (McDonald, 2002). This makes sense when examining the relationship between personality disorder-related phenomena such as suicide attempts and memories of child abuse which produce a good deal of the litigation directed towards mental health professionals (Gutheil, 2004). In the defense of psychotherapists, many are not trained to treat people with personality disorders, or only offer therapies that clearly do not work with these kinds of patients. In this way the screening of personality-disordered patients is justified as being better for both the therapist and the patient.

There are currently no drugs that directly treat personality disorders. Instead a number of different kinds of drugs are used to treat the symptoms associated with the personality disorder (Quante, et. al., 2008).

The onset of personality disorders is usually in adolescents or early adulthood. However, a careful observer may be able to identify children who are likely to express these disorders later on. People who suffer from personality disorders, particularly Hysterical, Borderline, or Paranoid, end up with a greater chance of being hospitalized throughout their lives. This is due to a good deal of suicidal behaviors, depression, alcohol/drug abuse, obsessive compulsive behaviors, eating disorders, domestic violence and other types of drama which are co-morbid with these personality disorders.

[3] DBT combines Cognitive Behavior Therapy with mindfulness techniques from Buddhist psychology.

Origins of Personality Disorders

The cause of personality disorders is unknown. However, we do know that personality disorders are highly related to early childhood trauma, which can take the form of emotional, physical or sexual abuse, inconsistent parenting, and/or parental neglect (Dudeck, et. al., 2007; Griffin, 2004; Grover, et. al. 2007; Johnson, Sheahan, & Chard, 2003; Mclean & Gallop, 2003; Minzenberg, Poole, & Vinogradov, 2006; Modestin, 2006; Narisco, 2007; Seese, 1997; Semiz, Basoglu, Ebrinc, & Cetin, 2007)[4]. A study of personality disordered outpatients (who tend to have less severe symptoms) by Bierer, et. al. (2003) found only modest relationships between specific trauma dimensions and personality disorder diagnoses, though the general relationship between trauma and personality disorders was high. Sexual and physical abuse were specific predictors of paranoid and antisocial personality disorders, while emotional abuse predicted borderline personality disorder.

Interestingly enough, childhood sexual abuse does not seem to cause neuro-biological changes in people suffering from borderline personality disorder (Zweig-Frank, et. al., 2006), though numerous studies have now demonstrated neurological differences in personality disordered patients compared to normal controls (see section below).

Genetic and other environmental factors play important roles in the characteristics of some personality disorders. For instance, borderline personality disorder itself does not seem to be genetically determined and research has shown that most people with borderline personality disorder have

suffered from abuse as children and that memories of this abuse are stable (Kremers, et. al. 2007). Nevertheless, some the key characteristics of this disorder, such as aggressiveness, impulsivity, suicidal tendencies, and emotional instability have been shown to be heritable (Coccaro, Bergman & McLean 1993; Bohman, et. al., 1984; Bouchard, 1994; Machizawa-Summers, 2007; Silverman, et. al., 1991; Torgersen, et al, 1994; Torgersen, 2000).

A rule of thumb is 'the worse the childhood the worse the personality disorder', (Modestin, 2006; Vizard, Hickey, & McCrory, 2007) with more severe personality disorders being co-morbid with dissociative disorders (Sar, et. al., 2006). In another study childhood trauma and dissociative experience among patients with borderline personality disorder was related to emotional and physical abuse, and emotional neglect. Patients labeled as 'high dissociators' reported significantly greater levels of emotional/physical abuse, and emotional/physical neglect than low dissociators. Sexual abuse was not significantly related to dissociative experiences (Watson, et. al. 2006). In fact one study has demonstrated that people diagnosed with borderline personality disorder who do not report childhood sexual abuse are likely to achieve remission of the disorder in a relatively short amount of time Zanarini, et. al., 2006)[5].

At the more severe end of the personality disorder spectrum the patient may experience transient psychotic states. For patients at the severe end of this spectrum the distinction between a personality disorder and a psychosis can become a bit academic (Newton-Howes, et. al. 2008).

[4] Literally hundreds of studies could have been listed here to support this statement. I have chosen to list only a few recent examples.

[5] This also calls into question the reliability of the methods used for determining a diagnosis of borderline personality syndrome and would suggest that the predictors found in this study be used to rule out diagnosis of this disorder.

Neurobiology of Personality Disorders

There is quite a bit of promising research on personality disorders that examines the development of the brain. Traumatic events and/or inconsistent

parenting are theorized to cause changes in the nerve pathways from the part of the brain where emotions are generated through the cerebral cortex where the emotions are regulated. As people with personality disorders have difficulty regulating emotions it is thought that areas of the brain related to emotional regulation may be dysfunctional. Using state of the art imaging technologies such as fMRI (functional magnetic resonance imaging) researchers have been able to show difference in brain function between people diagnosed with personality disorders and normal volunteers. This research not only gives hope for the development of new kinds of medication that may help personality disordered people better regulate their emotional states, but also may clarify the role of emotional regulation in human beings.

One interesting line of research theorizes that neurological mechanisms underlying personality disorders may have evolved to help a person (really a child) adapt to a chaotic external environment. Lack of various types of empathy may have had survival value at different times in human evolution (Smith, 2006). In a chaotic, unstable, environment – say for instance a war zone – being in 'fight or flight' mode, labile emotional states and the ability to dissociate from one's emotions, may have survival value (Austin, Riniolo, & Porges, 2007, Troisi, 2007). These kinds of chaotic and uncertain environments have characterized much of human and primate history. The deep and inherent nature of these mechanisms would also help explain why personality disorders are so very difficult to work with.

The idea that personality disorders have at least a partially neurological genesis is not new. As early as 1946, Estabrooks theorized that strong emotional shocks, especially in childhood could 'sensitize' the brain causing personality disorders:

It matters little if the photographic plate of the brain, to use a very crude analogy, is exposed once in blinding light or 100 times in to the same object in dim light. The impression is, in the long run, just as definite and just as permanent (204).

Modern views of personality disorders hypothesize that genetics, childhood trauma (and other environmental factors) are related to the characteristics of personality disorders such as emotional instability, impulsivity, aggression, and possibly cognitive and perceptual problems. These views have been arrived at not only through psychological studies, but increasingly through research on brain chemistry and structure (Goyer, Konicki, & Schultz, 1994).

One of the personality disorders most often studied is borderline personality disorder. Besides the obvious importance for understanding this destructive disorder the characteristics of the disorder lend themselves to better operational definition than the characteristics of other personality disorders. Typically, researchers have looked at impulsivity, aggression, (as well impulsive aggression), emotional instability, self-mutilation, and suicidal behaviors as indicators of borderline personality disorder. It may be that reduced serotonin transmission capacity in the brain may contribute to these negative traits among people suffering from borderline personality disorder. There is also research that suggests that the cholinergic system may be related to emotional instability, but that more work needs to be done to understand the physiology of this phenomenon. (Leyton, et. al. 2001; New & Siever, 2002; Zaboli, et. al., 2006).

A recent review of the research in this area conclude that impulsive aggression may involve deficits in central serotonin function as well as changes in the cingulate and medial and orbital prefrontal cortex. While these changes are hypothesized to be caused by early childhood trauma, this has not yet been definitively demonstrated. Borderline personality disorder has been shown to be biologically distinct from post-traumatic stress so the role of specific trauma is not yet known. Nevertheless, people with borderline personality disorder typically suffer from high rates of childhood abuse and neglect. It may be that the contribution of specific instances of trauma are less important than an overall long-term pattern of abuse in childhood. Studies of gene alterations that cause a reduction in serotonin have been shown to moderately affect impulsive and aggressive behavior and indicate that these aspects of borderline personality disorder may be inherited traits (Goodman, New & Seiver, 2004).

It may be true that people with the serotonin reducing genes may be more highly susceptible to traumatic childhood environment. A study by Reif, et. al. (2007) also found that genetic polymorphisms related to reduced serotonergic neurotransmission were related to violent behavior. The authors found that 45% of subjects carrying the low serotonin activity allele were prone to violent behavior compared to 30% with the normal serotonin activity allele. Subjects with the low serotonin activity allele who had experienced a highly adverse childhood environment were more likely to be violent later in life.

Brendel, Stern, & Silbersweig (2005) examined the interaction between negative emotion and lack of behavioral control. The authors report that abnormal

frontolimbic circuitry is a likely suspect that explains the major clinical features of borderline personality disorder. These neuroimaging findings are integrated with developmental perspectives to explain the pathology associated with borderline personality syndrome, including the ways in which early childhood experience may interact with the developing brain.

The research on structural aspects of the brain also has demonstrated key differences in the brain of borderline personality sufferers when compared to normal people. One recent study by Silbersweig, et. al. (2007) examined impulse control in people with borderline personality disorder using functional magnetic resonance imaging technology. In order to assess impulse control the researchers asked subjects not to push a button when negative words were displayed. Normal subjects showed increased activity in the areas of the brain associated with emotional regulation and inhibition of limbic regions including the amygdala (orbitofrontal and cingulate cortices). These increases did not occur in people who suffered from borderline personality disorder. Also those with borderline personality disorder demonstrated increased activity in areas of the brain (dorsal anterior cingulate cortex) related to detection of conflict related to deciding on a response, suggesting that while they were unable to exercise impulse control, they had some awareness of the conflict inherent in the experimental situation. The research leads us to

...infer that when individuals with borderline personality disorder display decreased impulse control, this loss of impulse control may reflect a deficit in recruitment of brain mechanism of emotional regulation, and this process may be potentiated by context. Particularly stressful or negative contexts could lead to more impaired impulse control (Siegle, 2007, p. 1778).

Interestingly, the brain regions related to borderline personality disorder are also implicated in depression. Not surprisingly, borderline personality disorder and depression are often co-morbid. This suggests that treatment that works for some affective disorders may also help in borderline personality disorder. This may especially be true if contextual factors related to impulse control are included in the therapeutic regime (Brendel, Stern, & Silbersweig, 2005), and may explain why treatment such as Dialectic Behavior Therapy has proven successful with people suffering from borderline personality disorder (Siegle, 2007).

Conclusion - Culture & Personality Disorders

As we saw in the definition of personality disorders presented by the DSM-5 above, cultural norms play a role in the diagnosis of personality disorders. So how do we understand the influence of culture to personality disorders? One thing we can try to do is to understand the relative influence of cultural characteristics in the different personality disorders. Alarcon & Foulks have attempted this in their 1995 paper. They list the personality disorders in a rank from the most 'biologically based' to the most 'psychosocialculturally based'. This kind of ranking may make it easier to understand the influence of culture on each type of personality disorder. Alarcon & Foulks (1995, p. 84) also list each personality disorder in this ranking scheme with the characteristics of each disorder:

Schizotypal (Eccentric): Individualism, hyperintellectualization, hyperstimulation leading to excessive fantasy, self-affirmation, insociability.

Paranoid (Suspicious): Individualism, distrustfulness, rigidity, sense of oppressiveness, anger, adversarialism / antagonism, distorted sociability.

Schizoid (Asocial): Individualism, indifference, distorted self-sufficiency, hypostimulation, limited sociability.

Antisocial (Aggressive): Individualism, antagonism, conflict-proness, rigidity, need to prove self, anger, demonstrativeness.

Borderline (Unstable): Ambiguity, unpredictability, inconsistency, need to prove self, distorted sociability.

Obsessive-Compulsive (Conforming): Self-doubts, uncertainty, inconsistency, rigidity, frugalism.

Avoidant (Withdrawn): Inconsistency, sense of personal inferiority, no risk-taking, limited sociability.

Dependent (Submissive): Opaqueness, distorted sociability, unconditional rule following, search for paternalism.

Narcissistic (Egotistic): Individualism / selfishness, self-affirmation, grandiosity, emptiness, hypersociability.

Histrionic (Gregarious): Social, instability, overstimulation, self-affirmation, demonstrativeness,

materialism.

And lastly Alarcon and Foulks include an 11th characterization which, is not strictly a personality disorder:

Passive-Aggressive (Negativistic): Inconsistency, conflict-proness, distorted sociability, punitiveness.

This is an interesting way to understand the different personality disorders as each set of traits in the above descriptions may reflect characteristics of a patient's cultural group and

"...it would be incumbent upon the clinician to sort them out...and assign to them a diagnostic, as well as a therapeutic value. An analysis of the "symptoms" present in the above sets, from the perspective provided by different ethnic and cultural groups...might prove helpful to the clinician in differentiating PDs from non-pathological, culturally determined behavior." (Alarcon & Foulks, 1995, p.84-85)

And in fact, this type of approach (similarly proposed by Paniagua, 2000) can be used to examine the 'pathology' of all culturally influenced behaviors, not just those that resemble personality disorders.

However, in reality it is often difficult to make a differential diagnosis as many key cultural features are common in many of the personality disorders. Diagnosis often becomes an impression of the predominant features of the personality disorder rather than excluding one set of diagnostic criterion for another. Some of the traits that are common to all personality disorders include: self centeredness, lack of individual accountability, lack of perspective, lack of empathy, superficial understanding of themselves, a lack of insight into how objectionable their behavior is to others, lack of hallucinations and overt thought disorders (except during brief psychotic episodes), vulnerability to other mental problems, and difficulty abiding by societal rules and conventions. There are gender differences in the prevalence of types of personality disorders. Antisocial personality disorder is more common among males, while borderline, dependent, and hysterical personality disorders are more common among females. Labeling biases among health professionals may explain some of these gender differences (Ussher, (2013). All these characteristics are subject to being influenced by culture.

Nevertheless, personality disorders tend to resemble

many of the bizarre syndromes, disorders, and behaviors found in cultures from all around the world. For instance, the culture-bound syndrome taijin kyofusho (which literally means fear of interpersonal relations) typically found in Japan and other parts of Asia, shares many of the features of avoidant and dependent personality disorders. The phenomena of latah, found primarily in Southeast Asia, carries echoes of borderline and histrionic personality disorders, while people who suffer from amok may show symptoms of antisocial and narcissistic personality disorders. It is easy to see the relationship between obsessive-compulsive personality disorder and the salaryman culture in Japan, just as it is difficult not to notice the schizotypal thinking present in koro. While these are just a few examples from around the world, we can also find similarities with personality disorders in our own Western culture. For example, it is hard to miss the flavor of narcissistic and borderline personality disorders among some of the people who practice vampirism. Likewise, we see characteristics of antisocial, narcissistic, paranoid, and schizotypal disorders in the phenomena of school shooters – perhaps a Western version of the Southeast Asian cultural disorder amok. The connection between various culture bound syndromes and personality disorders deserves further study. While not everything defined as a culture bound syndrome is related to personality disorders, the prevalence of similarities suggests more than a coincidental connection. Personality disorders are indeed a world-wide phenomenon. Our lack of understanding the etiology of personality disorders and the difficulty in treating them, suggests that the study of these serious disorders should be a priority for clinical psychology research.

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