

Defense Mechanisms and Personality Disorders



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Learning Objectives



- Understand personality, temperament and their neurobiologic, genetic and environmental influences.
- Identify the epidemiology, clinical presentation, diagnostic criteria, course, causality and treatment options for the major personality disorders
- Differentiate between personalities in similar pathology clusters.
- Differentiate between personality disorders and their similar Axis I disorders.
- Identify the major defense mechanisms
- Discuss how defense mechanisms can be seen in various psychopathologies and normal behavior

Pathological



- Denial
- Distortion
- Splitting

Immature Defenses

Acting Out

Externalization

Fantasy

Idealization

Omnipotent Control

Passive Aggressive

Projection

Projective Identification

Somatization

Neurotic Defenses



Displacement

Dissociation

Hypochondriasis

Intellectualization

Isolation

Rationalization

Reaction Formation

Regression

Repression/Blocking

Undoing

Higher Order (Mature) Defenses



Altruism

Anticipation

Humor

Identification

Introjection

Sublimation

Suppression

Defense Mechanisms

Displacement

Discharging pent-up feelings, usually of hostility, on objects less dangerous than those that initially aroused the emotion.

Examples:

After her new baby brother came home from the hospital the parents discovered Cheryl had dismembered her favorite doll.

Mark slams the door to the classroom after failing the exam.

Rationalization

Justifying one's failures with socially acceptable reasons instead of the real reasons.

Examples:

After Carla rejected him, Phil told friends he didn't think she was attractive, and he wasn't crazy about her anyway.

Jack told his parents he got a C in psychology because all the As and Bs went to students who cheated on tests.

Reaction formation

Transforming anxiety-producing thoughts into their opposites in consciousness.

Examples:

John has unconscious hostility toward his father but he acts very affectionate toward him.

Lucy dresses in provocative clothes although she fears she is unattractive.

Regression

Returning to more primitive levels of behavior.

Examples:

After Sue Ann's baby brother was born, she began to suck her thumb.

Mary was homesick and anxious when she started college. She slept with her favorite teddy bear again.

Repression

Blocking a threatening memory from consciousness.

Examples:

People held in concentration camps may not be able to remember what happened while there

Abuse victims sometimes don't recall events from their childhood

Denial

Refusing to admit that something unpleasant is happening, or that a taboo emotion is being experienced.

Examples:

16-year old Tom was using drugs, but his parents didn't believe the principal when told them about the problem.

50-year old Bill wears clothes that you'd see on teenagers and he drives a sports car.

Video



Psychopathology and Defense Mechanisms



- Depression – Introjection
- Psychosis/Paranoia – Projection
- Obsessive-Compulsive – Undoing
- Antisocial – Omnipotent Control
- Borderline Personality – Splitting and Projective Identification

Personality Disorders



Epidemiology



- Based on US data, about 6% to 9% of the population has a personality disorder (PD).
- PDs exist in several forms. Their influence on interpersonal functioning varies from mild to serious.
- Onset usually occurs during adolescence or in early adulthood.
- M > F: PPD, APD, NPD and OCPD; F > M: BPD

Personality



- Combination of stable, habitual patterns of behavior that are characteristic of a person and that develop over the first two decades of life and then change little
- Trait vs. State
 - Personality patterns are considered *traits* because they are longstanding and consistent (e.g., eye color, height).
 - *State* behavior refers to behaviors that come and go, such as a mood state and many DSM axis I conditions

Temperament



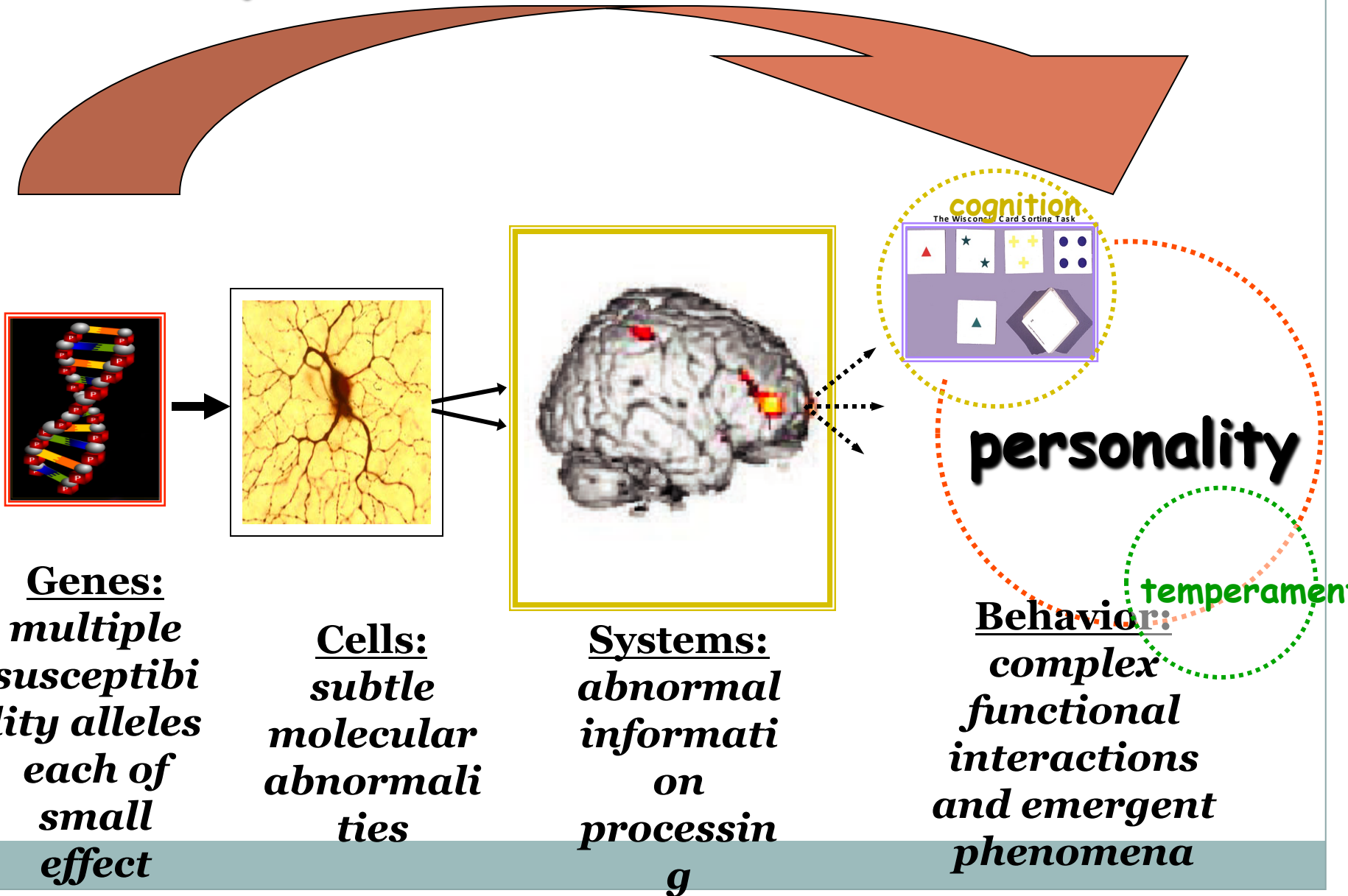
- **Infants and children manifest patterns of behavioral style (e.g., shy, fussy, calm, easy, etc.) that form the core of adolescent and adult personality.**
- **Examples of independent personality dimensions include novelty seeking, harm avoidance, conscientiousness, etc.**
- **Temperament is associated with psychiatric disorders, e.g. novelty seeking with drug taking, harm avoidance with anxiety and depression, and conscientiousness with obsessive-compulsive disorder, but also with impulsivity, psychopathy, and violence .**

Behavioral Traits with High Heritability



- Aggressiveness
- Altruism
- Assertiveness
- Constraint
- Empathy
- Harm avoidance
- Impulsivity
- Leadership
- Nurturance
- Persistence (stubbornness)
- Physicality
- Reward dependence
- Social closeness
- Sociability
- Traditionalism
- Well-being

The path from here to there...



Environmental Determinants



- Most of the non-genetic influences explaining personality differences are from non-shared (i.e., not shared) environmental influences:
 - Shared influences might include factors within a family; attachment behavior between infant/toddler and caregiver; the psychological fit between caretaker and infant's temperament
 - Whatever shared environment contributes to individual differences in personality development, it does so early on (preschool) and tends to be small. The genetic contribution is much more important at this time, assuming normal family life.
 - However, early trauma or loss (as an example) potentially has an important influence

Personality and Environment



- Non-shared environmental influences (other than intrauterine and illness-related childhood factors) begin to play an increasingly important role as the child has more and more unique experiences (e.g., with playground and school peers, going to school).
- Once past age 20-25, nonshared environment plays less of a role and neural development is substantially complete.

Personality Disorders: Definitions



- “An enduring pattern of inner experience and behavior 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 and impairment.”--DSM-IV

Personality Disorders: Definitions



- deeply ingrained, inflexible nature
- maladaptive, especially in interpersonal contexts
- relatively stable over time
- significantly impairs function
- egosyntonic: behaviors do not distress the person directly
- distresses those close to the person

Personality Disorders: DSM-IV



- An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual 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

Personality Disorders: DSM-IV



- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The enduring pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

Personality Disorders: DSM-IV



- The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
- The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Personality Disorders: Cluster A (weird)



- **Paranoid PD:** unwarranted suspiciousness and a tendency to misinterpret the actions of others as threatening, or deliberately harmful; stereotype of militia, hate group member, isolated bomber or killer
 - ✦ < 1% lifetime population risk; differential dx includes normal vigilance, delusional d/o, paranoid schizophrenia. Defense **Mechanisms: Projection**
- **Schizoid PD:** detachment from others, a restricted range of emotional expression and a lack of interest in activities; stereotype of socially awkward, isolated computer hacker
 - ✦ < 1% lifetime risk; maybe low-grade variant or pre-psychotic stage of schizophrenia (SCZ); differential dx might include autism and Asperger's syndrome

Personality Disorders: Cluster A (continued)



- **Schizotypal PD:** deficits in interpersonal relationships and distortions in both cognition and perception; the clairvoyant mystic
 - 2-3% lifetime risk; chronic low grade form of psychosis; considered part of the SCZ spectrum; shares common genetic diathesis and biological features of SCZ (e.g., ↑ homovanillic acid levels, aberrant eye tracking, cognitive deficits, electrophysiological abnormalities, brain abnormalities-- ↑ temporal horn size, ↑ CSF volume, temporal lobe and thalamic abnormalities, etc).
Defense Mechanism: Fantasy

Personality Disorders: Cluster B (continued)



- **Histrionic PD:** excessive emotional expression and attention-seeking behavior; Scarlett O'Hara in *Gone With the Wind*
 - 2-3% lifetime population risk; temperamental factors such as intensity, hypersensitivity, extroversion may predispose to HPD; associated with somatization d/o, drug abuse, conversion d/o, non-melancholic depression often with dysphoria. **Defense Mechanisms: Hypochondriasis, Somatization, Regression**
- **Narcissistic PD:** grandiosity, lack of empathy and a need for admiration; wealthy real estate tycoon who enjoys firing people
 - < 1% lifetime risk; men are 3x more likely than women to be dx; some overlap with HPD and a component of other disorders (e.g., hypomania, substance abuse). **Defense Mechanism: Omnipotent Control, Denial, Externalization**

Personality Disorders: Cluster B (Wild)



- **Antisocial PD:** guiltless, exploitative and irresponsible behavior with the hallmark being conscious deceit of others; stereotype of the cold and callus criminal
 - ✦ lifetime risk 3% of males, 1 % of females, but 90% of patients male; associated with drug abuse, criminality, violence, and the use of weapons in fights; spouse and child abuse; sexual crime; somatization d/o; conversion d/o; ADHD; conduct d/o; IQ in 70-90 range; biologic: strong evidence for genetic factors in heritability; non-localizing neurological signs; lower reactivity of the autonomic nervous system; low cortical arousal and reduced level of inhibitory anxiety; lowered levels of 5-HIAA found in impulsive/aggressive patients. **Defense Mechanisms: Acting Out, Denial, Externalization**



- **Borderline PD:** pervasive instability in moods, interpersonal relationships, self-image, and behavior; often disrupts family and work life, long-term planning, and the individual's sense of self-identity. Originally thought to be at the "borderline" of psychosis, people with BPD suffer from a disorder of emotion regulation; Glenn Close in *Fatal Attraction*
- 2% lifetime risk; heterogeneous group; associated with mood d/o; impaired impulse control leading to behaviors (e.g., high rate of self injury without suicide intent, significant rate of suicide attempts and completed suicide in severe cases, domestic violence, assault, drug abuse); higher rates of childhood sexual abuse; relationship between impulsive aggression and serotonin; affective instability or emotional dysregulation correlated with imbalances in cholinergic, noradrenergic and GABAergic neurotx; genetics--prominent features of impulsivity, suicidality, affective instability. **Defense Mechanisms: Acting Out, Splitting, Projective Identification, Dissociation**

Personality Disorders: Cluster C (Wacky)



- **Obsessive-compulsive PD:** rigidity, perfectionism, orderliness, indecisiveness, interpersonal control and emotional constriction; Felix Unger in the *Odd Couple*
 - ✦ 1% lifetime risk; M > F; assoc. with OCD, anxiety d/o, non-melancholic depression. **Defense Mechanisms: Undoing**
- **Avoidant PD:** inhibition, introversion and anxiety in social situations; the Cowardly Lion in *The Wizard of Oz* (“If I only had the nerve.”)
 - ✦ 1% lifetime risk; assoc. with anxiety d/o’s, eating d/o, dissociative d/o, benzodiazepine abuse, non-melancholic depression; introversion found to be a hereditary factor
- **Dependent PD:** submissive behavior and excessive needs for emotional support; Dr. Watson in *Sherlock Holmes*
 - ✦ < 1% lifetime risk; assoc. with same conditions as avoidant; temperamental features c/w DPD are submissiveness and low activity levels; children born with or develop serious illnesses can become overly dependent. **Defense Mechanism: Idealization**

Co-Morbidities



- PDs often co-occur with other psychiatric disorders, so it is important to understand the interactions between “Axis I and Axis II” conditions and how to respond to deviant personality behaviors.
 - Examples:
 - ✦ Axis I: PTSD; Axis II: Borderline PD
 - ✦ Axis I: ADHD; Substance Dependence; Axis II: Antisocial PD
 - ✦ Axis I: Bipolar, mania; Axis II: Narcissistic PD
 - ✦ Axis I: Social phobia; Axis II: Avoidant PD

Rule-Outs



Head injury	Large right hemisphere or frontal injuries	Irritable and coarsening, respectively
Stroke	Large or multiple anterior strokes	Avolitional or disinhibited frontal lobe syndromes
Drug abuse	Chronic use of cannabis, inhalants, cocaine	Avolitional, irritable and paranoid
Degenerative brain disease	White matter dementias, Pick's disease, basal ganglia dementias, chronic metabolic disorders	Avolitional or disinhibited frontal lobe syndromes

Treatment



- Differential approaches for different PDs
- Long-term v. short-term
- Psychoanalytic v. cognitive-behavioral v. dialectical behavioral therapies
- Individual v. group psychotherapy
- Medications

Treatment



- Open-ended approach and not systematic review of diagnostic criteria
- Description of patient's relationships looking for repeated themes, attitudes and behaviors
- Encourage patient to elaborate on behavioral patterns that suggest various PDs
- Be aware of counter-transference reactions