CHALLENGES IN MAKING DIFFERENTIAL DIAGNOSIS OF PERSONALITY DISORDERS WITH ONSET IN ADOLESCENCE -CASE PRESENTATION-

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ABSTRACT

The topic of diagnosing personality disorders (PDs) in adolescence has been and still is fraught with controversy. Despite the fact that the Diagnostic and Statistical Manual of Mental Disorders [1], 5th Edition states that PDs may be applied to adolescents, it remains a diagnosis seldom given at this age. In part this may be due to the fact that adolescence is seen as a period of profound change, with behaviors that ebb and flow. In addition, the presence of other psychiatric diagnoses and comorbidities and the lack of clear limitations of the psychopathologies present in adolescence, are some other elements that question the validity of a PD diagnosis at this age. Nevertheless, there are studies [2] which showed that the stability coefficients for PDs in adolescence were comparable to stability correlations observed in adults. Given that PDs often have their debut in adolescence, and given their long-term consequences, it is important for clinicians to be able to identify these disorders as early as possible. In line with that, this article focuses on presenting the case of a young person diagnosed with depressive disorder and portraying mixed traits of the narcissistic, histrionic and borderline personality disorders.

Keywords: personality disorder, adolescence, narcissistic, borderline, histrionic.

INTRODUCTION

Mental health care professionals have traditionally been reluctant to diagnose personality disorders (PDs) in adolescents because of their supposed transient nature and because of stigmatizing effects [3]. More generally, PDs can be diagnosed reliably in adolescents [3], and are highly prevalent; prevalence rates range from 10 to 15% in this age group [4]. Furthermore, PDs in adolescents are extremely invalidating and may cause serious current and future distress in young people and their environment [5].

For this reason, Chanen and colleagues [6] proposed early detection and intervention of PDs in adolescence. In line with these developments, recent treatment guidelines support diagnosing PDs in adolescents starting at age 13 (e.g., NICE) [7]. However, it remains unclear to what extent scientific evidence and practice guidelines concerning PDs in adolescence have found their way into actual clinical practice. The hesitation of clinicians to diagnose PDs in adolescents may be delaying the development of treatment models for this group. Currently, there is relatively little research on effective treatments for adolescents with PDs [8]. More research on effective treatments for this group of patients is warranted because adolescents with PDs are at greater risk for having a broad range of problems than adolescents without PDs. Furthermore, these adolescents have a greater risk of developing problems in adulthood [3].
CASE PRESENTATION

We report the case of a 14-year-old boy, diagnosed with Major Depressive Episode (MDE) and under observation for narcissistic PD.

The patient M.M., accompanied by his mother, referred to our clinic in March 2015, for: fatigue, loss of energy (“I have no energy, physically or mentally”), refusal to attend school (“he hasn’t been to school in the last 3 weeks”), diminished ability to concentrate (“I stopped going to school because if I go, I can’t focus in class, I am too sad to focus, sometimes I even cry during classes”), irritable mood (“he is very easily disturbed and becomes mad if things do not go his way, he is a little tyrant”), insomnia (“I can’t go to sleep until 2 or 3 AM”), refusal to bathe (“he hasn’t had a shower in a week I think”), recurrent suicidal thoughts (“I want to kill myself and I will, if I have the chance”) and self-harm acts (“he has multiple cuts on his forearm and he has written the name of the one he is in love with on his forearm, with a blade of a pencil sharpener”).

His family history reveals:
- the mother – age 45, economist, hyperprotective, has always highly praised her child for all of his accomplishments, especially his literary creations and other illustrations of his multiple talents (“ever since he was little, he has been a very talented boy, I’ve read some of his stories and they are great”)
- the father – age 46, engineer is not very involved in the life and education of the patient, spending most of the time at work or, when he is at home, alone in his room, playing the guitar or listening to music.

His personal history reveals: only child, pregnancy and delivery had physiological evolution, normal psychomotor development in different stages of age, with no documented history of mental or somatic illness. He lives with his parents and his maternal grandmother, in an urban area and he is in the 8th grade, having mediocre school results.

Mental State Examination

The patient is cooperative, self-conscious, oriented, visual and psychic contacts are easily obtained. He is dressed in black clothes, with multiple metallic accessories on them and has a particular hairdo (his long, curly hair is half braided half loose). His hygiene is somewhat improper, having a particular odor, greasy hair and dirty fingernails. His mimics and gestures are mobile, consistent with his sad disposition and avoidant look. The patient doesn’t have qualitative perception disorders at the present examination. However, he describes sometimes hearing “a voice that tells me I should kill myself”. He has a normally spontaneous speech, which is centered on his feelings of sadness, tiredness and lack of will to do anything. Information gathered from his mother reveals that he has been spending most of the days of the last few weeks in bed, listening to “loud, disturbing” music (the patient describes himself as a heavy-metal music fan), without taking into consideration that the high volume of that music disturbs the members of his family and his neighbors (“I don’t care if it’s too loud, it is the only thing that gives me pleasure these days”). When asked about his social life, the patient states that, at the moment, he doesn’t have any friends to go out or have fun with; his only friends are those he chats with on social media groups destined to heavy-metal fans (“I don’t have any real friends, they have all abandoned me, my only friends are online and they are the ones that matter, because they appreciate me the way I am, without judging me”; “I can’t stand to be around people who are close-minded and ignorant”). When asked about his interests, the patient says that he is “a lover of nature and all its magical creatures” and a “dead-on-
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the-inside being that gives birth to life and beauty through the art I create”, “a skilled writer who can transform his ugly feelings into lyrical works of art”. When talking about her child, the patient’s mother uses words like “very talented”, “a gifted writer and poet”, saying that ever since he was little, her boy “had multiple talents and succeeded in some writing contests, but did not get the highest prizes, although he deserved them”.

Clinical somatic and neurological examinations were normal, except from multiple superficial linear cuts on his forearms and some apparent dirt marks on his feet and abdomen. Laboratory tests (CBC, transaminases, blood calcium and sugar levels, ESR, CRP, fecal exam, pharyngeal exudate, EKG) were normal. EEG line performed while the patient was awake had no pathological graphic elements. The patient performed cerebral imaging (brain MRI) which did not detect any space replacement process or abnormalities.

In order to assess the severity of the symptoms indicating a depressive episode, we applied the Beck Depression Inventory, which revealed a total score of 29 points (>16 points = severe depressive state). The patient also benefited from a psychological evaluation with the KID-SCID (Structured Clinical Interview for DSM, edition for children) revealing a major depressive episode.

All this considered, the positive first axis diagnosis was set to Major Depressive Episode.

Due to the age of the patient, the challenge for the clinician was to determine whether or not this patient should be kept under observation for a PD diagnosis and establishing which of the PDs is the most relevant since, as the DSM-5 observes, an individual can have personality features that meet the criteria for one or more personality disorders and, therefore, diagnosis can be difficult. For this reason, careful attention must be paid to distinguishing among these disorders according to the differences in their characteristic features.

The three PDs that we focused on where disorders from Cluster B, namely narcissistic, histrionic and borderline personality disorder.

Narcissistic personality disorder (NPD)

The essential feature of NPD is a pervasive pattern of grandiosity and need for admiration [1], which could be observed in our patient, as he talks a lot about his “artistic power” and his ability to “heal the souls of others through my creations”. The patient also portrays the characteristic lack of empathy of the narcissistic PD, since he is the center of attention in his home, the only child, being taken care of by a loving mother and grandmother, who “would do anything for him, he is such a special boy”, although he is also described as “a little tyrant, who doesn’t care if others are deeply disturbed by his actions and behavior, who doesn’t care if he hurts his parents when he says or does different things”. The patient also typically overestimates his writing abilities, having no proof of the artistic value of his creations, other than the appreciations of the women in his family. His mother talks about how surprised they were when, after entering some writing contests at school, the boy did not get the greatest prize, “as he deserved”. These feelings of being special, unique and the lack of others (except from family members) recognizing his superiority led to the patient’s isolating himself from “the ignorant, close-minded people at school” and befriending people online, whom he considers to be of a special status, with similar interests and talent, people whom he idolatrizes. The patient also exhibits a constant need of admiration and appreciation, which can be observed in some of the things he says (“I need a lot of love in order to get better”) and, during the time he
spent in the clinic, in the way he expects to be congratulated for the poems he writes or the drawings he makes. Expecting to be given everything he wants at the exact moment he wants it, no matter what it might mean to others, the patient has difficulties in respecting different rules at the clinic and the time each patient is granted to spend with the doctors. In an article for Psychology Today [9], Susan Heitler, PhD, author and Harvard graduate, describes emotionally healthy functioning in the absence of BPD or NPD: “Emotionally healthy functioning is characterized by ability to hear your own concerns, thoughts, and feelings and also to be responsive to others’ concerns. “In the world of the narcissist, that second part just isn’t present. Narcissists are unable to step outside of themselves to imagine any weight behind someone else’s opinion.

Whereas NPD is a distinct entity, it shares many similarities with other cluster B disorders, which can be concomitantly diagnosed if the appropriate diagnostic criteria are met. It is therefore important to be aware of the salient differences among cluster B personality disorders. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to narcissistic personality disorder, all can be diagnosed. The most useful feature in discriminating narcissistic personality disorder from histrionic and borderline personality disorders, in which the interactive styles are coquettish, callous, and needy, respectively, is the grandiosity characteristic of narcissistic personality disorder. Excessive pride in achievements, a relative lack of emotional display, and disdain for others’ sensitivities help distinguish narcissistic personality disorder from histrionic personality disorder. Although individuals with borderline, histrionic, and narcissistic personality disorders may require much attention, those with narcissistic personality disorder specifically need that attention to be admiring [1], [10].

**Histrionic personality disorder (HPD)**

Some of the features that are required for diagnosing HPD that were portrayed by our patient were self-dramatization and an exaggerated expression of emotion (as his mother states - “he feels everything to the extreme, he is very sensitive”), with shallow and rapidly shifting emotional expression (“one minute he says he hates us all and would like for us to die to leave him be, the other he says he is sorry and he loves me more than anything in the world”). He is also very theatrical, having a style of speech that is excessively impressionistic and lacking in detail (“my story is the classical fairytale – a princess in search of her beautiful prince”). His physical appearance is an important element to him and he spends an excessive amount of time, energy, and money on clothes and grooming: “I like to wear different clothes every day and I spend a lot of time in front of the wardrobe before I decide what to wear; I like to wear many accessories and special rocker boots, which are very expensive, but that doesn’t matter”.

Individuals with histrionic personality disorder have a high degree of suggestibility, their opinions being influenced by others and by current fads. In our patient, we can see this portrayed as his incline to listen to a specific type of music that his online friends, a group of people that he considers “special and open-minded” are fond of and describe as “cool”. Histrionics resemble narcissists: both seek attention compulsively and are markedly dysphoric and uncomfortable when not at the center of attention. If they fail in achieving this pivotal role, they act out, create hysterical scenes, or confabulate. While the characteristic distinguishing

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feature of Histrionic Personality Disorder (HPD) is coquettishness that of NPD is grandiosity [1].

Both personality types tend towards the demonstrative, exhibitionistic, dramatic and seductive in their behavior. What distinguishes these qualities in the person with NPD are the person's haughty, cold, and exploitative attitudes. In contrast, the person with HPD is warm and playful and can be dependent on others; moreover, these individuals are capable of love, empathy and concern whereas those with NPD are not. Finally, the behavior of the person with NPD has the qualities of being controlled, calculated and relentless in its objectives, while that of the person with HPD is more spontaneous and without ulterior motives [11].

Borderline Personality Disorder (BPD)

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that is present in a variety of contexts. Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment. The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. They may believe that this "abandonment" implies they are "bad" [1]. Our patient describes an event that occurred at school, when he declared his long-lasting love and appreciation to a classmate, who dismissed him in an aggressive and disdainful manner, as the patient describes it: “my fairytale had a lovely and beloved prince, but now, I don’t know who that prince is anymore; I only know I cry rivers of tears for what happened”.

Like other individuals with borderline personality disorder, our patient was troubled by chronic feelings of emptiness – “after flying in love for so long, my wings are tired and I am now falling in a river of tears, with a permanent empty soul”.

The impulsivity characteristic to the BPD, as well as the recurrent suicidal threats and self-mutilating behavior could be seen in the way our patient superficially cut his forearms on multiple occasions and in the way he speaks about death and suicide – “I sometimes think about killing myself with a knife, in the bathtub, and let rivers of blood flow, like the pain I am feeling inside”, “I only cut myself for my love”.

Based on overlapping symptoms, Borderline Personality Disorder (BPD) and Narcissistic Personality Disorder (NPD) are often mistaken for one another. The two personality disorders even have a rate of co-occurrence of about 25 percent, according to the National Alliance on Mental Illness (NAMI). Both persons with NPDs and BPDs place great importance on attention; however, unlike borderlines, who “seek nurturing attention because they need it, narcissists feel they deserve admiring attention because of their superiority” [11].

Persons with either Narcissistic Personality Disorder or Borderline Personality Disorder have weak interpersonal relationships, are unable to love others, have difficulty empathizing, are egocentric in their perceptions of reality, and have a great need for attention. Unlike the borderline personality, however, because the personality of someone with NPD is more well-integrated, people with NPD are less likely to have episodes of psychotic states, especially when under stress.

A key distinguishing feature of BPD is neediness; in contrast, for NPD an important discriminator is grandiosity. Likewise, persons with NPD are less self-destructive, have better impulse control, a higher tolerance for anxiety, and are less preoccupied with dependency and abandonment issues than are BPDs [11].
CONCLUSIONS

Adolescence is a phase during which vulnerable young people may find themselves in a sea of fluctuating emotions, including a fluctuating sense of self. Their previous means of coping may be in danger of collapsing. They may be fearful of being alone but equally terrified of anxieties evoked when in relationships. In this stormy sea, people don’t make sense and cannot be trusted.

Due to the commonly held belief among mental health professionals that personality is still evolving during adolescence, there has been a reluctance to diagnose personality disorders among this age group. Nevertheless, clinical experience and some of the current scientific works unveil the need for mental health professionals to reconsider this issue, since many adolescents may not receive specific treatment for their dysfunctional behaviors, or worse, receive inappropriate treatments.

REFERENCES
