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Sam Vaknin
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Misdiagnosing Personality Disorders as Anxiety Disorders (Notes to the Therapist)

Sam Vaknin*

Visiting Professor of Psychology, Southern Federal University, Rostov-on-Don, Russia

***Corresponding author:** Sam Vaknin, Visiting Professor of Psychology, Southern Federal University, Rostov-on-Don, Russia

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Abstract

Generalized anxiety is often confused and conflated with the need to secure social approval or attention (Narcissistic Supply). This dependence on external feedback to regulate one's internal environment engenders apprehension and irritability, frustration, rage, and defiance whose adverse outcomes are met with anticipatory anxiety.

Subjects suffering from certain personality disorders (e.g., Histrionic, Borderline, Narcissistic, Avoidant, Schizotypal) resemble patients who suffer from Panic Attacks and Social Phobia (another anxiety disorder). They are terrified of being embarrassed or criticized in public. Consequently, they fail to function well in various settings (social, occupational, interpersonal, etc.).

What is Anxiety

Anxiety is uncontrollable and excessive apprehension, a kind of unpleasant (dysphoric), mild fear, with no apparent external reason. Anxiety is dread in anticipation of a future menace or an imminent but diffuse and unspecified danger, usually imagined or exaggerated [1]. The mental state of anxiety (and the concomitant hypervigilance) has physiological complements. It is accompanied by short-term dysphoria and physical symptoms of stress and tension, such as sweating, palpitations, tachycardia, hyperventilation, angina, tensed muscle tone, and elevated blood pressure (arousal). It is common for anxiety disorders to include obsessive thoughts, compulsive and ritualistic acts, restlessness, fatigue, irritability, and difficulty concentrating [2-4].

Personality Disorders and Anxiety

Patients with personality disorders are often anxious. Narcissists, for instance, are preoccupied with the need to secure social approval or attention (Narcissistic Supply) [5]. The narcissist cannot control this need and the attendant anxiety because he requires external feedback to regulate his labile sense of self-worth. This dependence makes most narcissists irritable. They fly into rages and have a very low threshold of frustration [6].

Subjects suffering from certain personality disorders (e.g., Histrionic, Borderline, Narcissistic, Avoidant, Schizotypal) resemble patients who suffer from Panic Attacks and Social Phobia (another anxiety disorder) [7]. They are terrified of being embarrassed or criticized in public. Consequently, they fail to function well in various settings (social, occupational, interpersonal, etc.) [8-11].

Narcissism, Obsession-Compulsion, and Anxiety

Anxiety Disorders - and especially Generalised Anxiety Disorder (GAD) - are often misdiagnosed as Narcissistic Personality Disorder (NPD).

Anxiety is uncontrollable and excessive apprehension. Anxiety disorders usually come replete with obsessive thoughts, compulsive and ritualistic acts, restlessness, fatigue, irritability, difficulty concentrating, and somatic manifestations (such as an increased heart rate, sweating, or, in Panic Attacks, chest pains) [12].

By definition, narcissists are anxious for social approval or attention (Narcissistic Supply). The narcissist cannot control this need and the attendant anxiety because he requires external feedback to regulate his labile sense of self-worth. This dependence makes most narcissists irritable [13]. They fly into rages and have a very low threshold of frustration [14-15].

Like patients who suffer from Panic Attacks and Social Phobia (another anxiety disorder), narcissists are terrified of being embarrassed or criticised in public [16]. Consequently, most narcissists fail to function well in various settings (social, occupational, romantic, etc.).

The personality disordered often develop obsessions and compulsions. Like sufferers of anxiety disorders, narcissists and compulsive-obsessives, for instance, are perfectionists and preoccupied with the quality of their performance and the level of their competence [17]. As the Diagnostic and Statistical Manual (DSM-IV-TR, p. 473) puts it, GAD (Generalized Anxiety Disorder) patients (especially children):

"… (A) re typically overzealous in seeking approval and require excessive reassurance about their performance and their other worries".

This could apply equally well to subjects with the Narcissistic or the Obsessive-Compulsive Personality Disorder. Both classes of patients - those suffering from anxiety disorders and those tormented by personality disorders - are paralyzed by the fear of being judged as imperfect or lacking [18-20]. Narcissists as well as patients with anxiety disorders constantly fail to measure up to an inner, harsh, and sadistic critic and a grandiose, inflated self-image.

From my book "Malignant Self Love - Narcissism Revisited".

"The narcissistic solution is to avoid comparison and competition altogether and to demand special treatment. The narcissist's sense of entitlement is incommensurate with the narcissist's true accomplishments. He withdraws from the rat race because he does not deem his opponents, colleagues, or peers worthy of his efforts [21].

As opposed to narcissists, patients with Anxiety Disorders are invested in their work and their profession. To be exact, they are over-invested [22]. Their preoccupation with perfection is counter-productive and, ironically, renders them underachievers.

It is easy to mistake the presenting symptoms of certain anxiety disorders with pathological narcissism. Both types of patients are worried about social approbation and seek it actively. Both present a haughty or impervious facade to the world. Both are dysfunctional and weighed down by a history of personal failure on the job and in the family. But the narcissist is ego-syntonic: he is proud and happy of who he is. The anxious patient is distressed and is looking for help and a way out of his or her predicament. Hence the differential diagnosis".

The Effects of Abuse

Repeated abuse has long lasting pernicious and traumatic effects such as panic attacks, hypervigilance, sleep disturbances, flashbacks (intrusive memories), suicidal ideation, and psychosomatic symptoms. The victims experience shame, depression, anxiety, embarrassment, guilt, humiliation, abandonment, and an enhanced sense of vulnerability [23].

C-PTSD (Complex PTSD) has been proposed as a new mental health diagnosis by Dr. Judith Herman of Harvard University to account for the impact of extended periods of trauma and abuse.

In **"Stalking - An Overview of the Problem"** [Can J Psychiatry 1998; 43:473–476], authors Karen M Abrams and Gail Erlick Robinson write: "Initially, there is often much denial by the victim. Over time, however, the stress begins to erode the victim's life and psychological brutalisation results. Sometimes the victim develops an almost fatal resolve that, inevitably, one day she will be murdered. Victims, unable to live a normal life, describe feeling stripped of self-worth and dignity. Personal control and resources, psychosocial development, social support, premorbid personality traits, and the severity of the stress may all influence how the victim experiences and responds to it Victims stalked by ex-lovers may experience additional guilt and lowered self-esteem for perceived poor judgement in their relationship choices [24]. Many victims become isolated and deprived of support when employers or friends withdraw after also being subjected to harassment or are cut off by the victim in order to protect them. Other tangible consequences include financial losses from quitting jobs, moving, and buying expensive security equipment in an attempt to gain privacy. Changing homes and jobs results in both material losses and loss of self-respect".

Surprisingly, verbal, psychological, and emotional abuse have the same effects as the physical variety [Psychology Today, September/October 2000 issue, p.24]. Abuse of all kinds also

interferes with the victim's ability to work. Abrams and Robinson wrote this [in "Occupational Effects of Stalking", Can J Psychiatry 2002;47:468–472].

"… (B) being stalked by a former partner may affect a victim's ability to work in 3 ways. First, the stalking behaviours often interfere directly with the ability to get to work (for example, flattening tires or other methods of preventing leaving the home). Second, the workplace may become an unsafe location if the offender decides to appear. Third, the mental health effects of such trauma may result in forgetfulness, fatigue, lowered concentration, and disorganisation. These factors may lead to the loss of employment, with accompanying loss of income, security, and status".

Still, it is hard to generalise. Victims are not a uniform lot. In some cultures, abuse is commonplace and accepted as a legitimate mode of communication, a sign of love and caring, and a boost to the abuser's self-image. In such circumstances, the victim is likely to adopt the norms of society and avoid serious trauma [25].

Deliberate, cold-blooded, and premeditated torture has worse and longer-lasting effects than abuse meted out by the abuser in rage and loss of self-control. The existence of a loving and accepting social support network is another mitigating factor. Finally, the ability to express negative emotions safely and to cope with them constructively is crucial to healing.

Typically, by the time the abuse reaches critical and all-pervasive proportions, the abuser had already, spider-like, isolated his victim from family, friends, and colleagues. She is catapulted into a nether land, cult-like setting where reality itself dissolves into a continuing nightmare.

When she emerges on the other end of this wormhole, the abused woman (or, more rarely, man) feels helpless, self-doubting, worthless, stupid, and a guilty failure for having botched her relationship and "abandoned" her "family". In an effort to regain perspective and avoid embarrassment, the victim denies the abuse or minimises it.

No wonder that survivors of abuse tend to be clinically depressed, neglect their health and personal appearance, and succumb to boredom, rage, and impatience. Many end up abusing prescription drugs or drinking or otherwise behaving recklessly.

Some victims even develop Post-Traumatic Stress Disorder (PTSD).

Contrary to popular misconceptions, Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (or Reaction) are not typical responses to prolonged abuse. They are the outcomes of sudden exposure to severe or extreme stressors (stressful events). Yet, some victims whose life or body have been directly and unequivocally threatened by an abuser react by developing these syndromes. PTSD is, therefore, typically associated with the aftermath of physical and sexual abuse in both children and adults.

This is why another mental health diagnosis, C-PTSD (Complex PTSD) has been proposed by Dr. Judith Herman of Harvard University to account for the impact of extended periods of trauma and abuse.

One's (or someone else's) looming death, violation, personal injury, or powerful pain are sufficient to provoke the behaviours, cognitions, and emotions that together are known as PTSD [26]. Even learning about such mishaps may be enough to trigger massive anxiety responses.

The first phase of PTSD involves incapacitating and overwhelming fear. The victim feels like she has been thrust into a nightmare or a horror movie. She is rendered helpless by her own terror. She keeps re-living the experience through recurrent and intrusive visual and auditory hallucinations ("flashbacks") or dreams. In some flashbacks, the victim completely lapses into a dissociative state and physically re-enacts the event while being thoroughly oblivious to her whereabouts.

In an attempt to suppress this constant playback and the attendant exaggerated startle response (jumpiness), the victim tries to avoid all stimuli associated, however indirectly, with the traumatic event. Many develop full-scale phobias (agoraphobia, claustrophobia, fear of heights, aversion to specific animals, objects, modes of transportation, neighbourhoods, buildings, occupations, weather, and so on) [27].

Most PTSD victims are especially vulnerable on the anniversaries of their abuse. They try to avoid thoughts, feelings, conversations, activities, situations, or people who remind them of the traumatic occurrence ("triggers").

This constant hypervigilance and arousal, sleep disorders (mainly insomnia), the irritability ("short fuse"), and the inability to concentrate and complete even relatively simple tasks erode the victim's resilience. Utterly fatigued, most patients manifest protracted periods of numbness, automatism, and, in radical cases, near-catatonic posture. Response times to verbal cues increase dramatically. Awareness of the environment decreases, sometimes dangerously so. The victims are described by their nearest and dearest as "zombies", "machines", or "automata".

The victims appear to be sleepwalking, depressed, dysphoric, anhedonic (not interested in anything and find pleasure in nothing).

They report feeling detached, emotionally absent, estranged, and alienated. Many victims say that their "life is over" and expect to have no career, family, or otherwise meaningful future.

The victim's family and friends complain that she is no longer capable of showing intimacy, tenderness, compassion, empathy, and of having sex (due to her post-traumatic "frigidity"). Many victims become paranoid, impulsive, reckless, and self-destructive. Others somatise their mental problems and complain of numerous physical ailments. They all feel guilty, shameful, humiliated, desperate, hopeless, and hostile.

PTSD need not appear immediately after the harrowing experience. It can – and often is – delayed by days or even months. It lasts more than one month (usually much longer). Sufferers of PTSD report subjective distress (the manifestations of PTSD are ego-dystonic). Their functioning in various settings – job performance, grades at school, sociability – deteriorates markedly.

The DSM-IV-TR (Diagnostic and Statistical Manual) criteria for diagnosing PTSD are far too restrictive. PTSD seems to also develop in the wake of verbal and emotional abuse and in the aftermath of drawn out traumatic situations (such a nasty divorce). Hopefully, the text will be adapted to reflect this sad reality.

The Roles of Therapy

Victims of abuse in all its forms – verbal, emotional, financial, physical, and sexual – are often disorientated. They require not only therapy to heal their emotional wounds, but also practical guidance and topical education. At first, the victim is, naturally, distrustful and even hostile. The therapist or case worker must establish confidence and rapport painstakingly and patiently.

The therapeutic alliance requires constant reassurance that the environment and treatment modalities chosen are safe and supportive. This is not easy to do, partly because of objective factors such as the fact that the records and notes of the therapist are not confidential. The offender can force their disclosure in a court of law simply by filing a civil lawsuit against the survivor.

The first task is to legitimise and validate the victim's fears. This is done by making clear to her that she is not responsible for her abuse or guilty for what happened. Victimisation is the abuser's fault – it is not the victim's choice. Victims do not seek abuse – although, admittedly some of them keep finding abusive partners and forming relationships of co-dependence. Facing, reconstructing, and reframing the traumatic experiences is a crucial and indispensable first phase.

The therapist should present the victim with her own ambivalence and the ambiguity of her messages – but this ought to be done gently, non-judgementally, and without condemnation. The more willing and able the abuse survivor is to confront the reality of her mistreatment (and the offender), the stronger she would feel and the less guilty.

Typically, the patient's helplessness decreases together with her self-denial. Her self-esteem as well as her sense of self-worth stabilise. The therapist should emphasise the survivor's strengths and demonstrate how they can save her from a recurrence of the abuse or help her cope with it and with her abuser.

Education is an a important tool in this process of recovery. The patient should be made aware of the prevalence and nature of violence against women and stalking, their emotional and physical effects, warning signs and red flags, legal redresses, coping strategies, and safety precautions.

The therapist or social worker should provide the victim with lists of contacts – help organisations, law enforcement agencies, other women in her condition, domestic violence shelters, and victims' support groups both online and in her neighbourhood or city. Knowledge empowers and reduces the victim's sense of isolation and worthlessness.

Helping the survivor regain control of her life is the over-riding goal of the entire therapeutic process. With this aim in mind, she should be encouraged to re-establish contact with family, friends, colleagues, and the community at large. The importance of a tightly-knit social support network cannot be exaggerated.

Ideally, after a period of combined tutoring, talk therapy, and (anti-anxiety or antidepressant) medications, the survivor will self-mobilise and emerge from the experience more resilient and assertive and less gullible and self-deprecating.

Statistically, the majority of abuse victims are female and most abusers are male. Still, we should bear in mind that there are male victims and female offenders as well.

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But therapy is not always a smooth ride. Victims of abuse are saddled with emotional baggage which often provokes even in the most experienced therapists reactions of helplessness, rage, fear and guilt. Countertransference is common: therapists of both genders identify with the victim and resent her for making them feel impotent and inadequate (for instance, in their role as "social protectors").

Reportedly, to fend off anxiety and a sense of vulnerability ("it could have been me, sitting there!"), female therapists involuntarily blame the "spineless" victim and her poor judgement for causing the abuse. Some female therapists concentrate on the victim's childhood (rather than her harrowing present) or accuse her of overreacting.

Male therapists may assume the mantle of the "chivalrous rescuer", the "knight in the shining armour" – thus, inadvertently upholding the victim's view of herself as immature, helpless, in need of protection, vulnerable, weak, and ignorant. The male therapist may be driven to prove to the victim that not all men are "beasts", that there are "good" specimen (like himself). If his (conscious or unconscious) overtures are rejected, the therapist may identify with the abuser and re-victimise or pathologise his patient.

Many therapists tend to over identify with the victim and rage at the abuser, at the police, and at "the system". They expect the victim to be equally aggressive even as they broadcast to her how powerless, unjustly treated, and discriminated against she is. If she "fails" to externalise aggression and show assertiveness, they feel betrayed and disappointed.

Most therapists react impatiently to the victim's perceived co-dependence, unclear messages, and on-off relationship with her tormentor. Such rejection by the therapist may lead to a premature termination of the therapy, well before the victim learned how to process anger and cope with her low self-esteem and learned helplessness.

Finally, there is the issue of personal security. Some ex-lovers and ex-spouses are paranoid stalkers and, therefore, dangerous. The therapist may even be required to testify against the offender in a court of law. Therapists are human and fear for their own safety and the security of their loved ones. This affects their ability to help the victim.

This is not to say that therapy invariably fails. On the contrary, most therapeutic alliances succeed to teach the victim to accept and transform her negative emotions into positive energy and to competently draw and implement realistic plans of action while avoiding the pitfalls of the past. Good therapy is empowering and restores the victim's sense of control over her life.

References

1. Stomberg D, Roningstam E, Gunderson J, Tohen M (1998) Pathological Narcissism in Bipolar Disorder Patients. Journal of Personality Disorders 12: 179-185.
2. Roningstam E (1996) Pathological Narcissism and Narcissistic Personality Disorder in Axis I Disorders. Harvard Review of Psychiatry 3: 326-340.
3. Alford C (1988) Fred - Narcissism: Socrates, the Frankfurt School and Psychoanalytic Theory.
4. Fairbairn WRD (1954) An Object Relations Theory of the Personality Basic Books.
5. Freud S (1964) Three Essays on the Theory of Sexuality (1905) - Standard Edition of the Complete Psychological Works of Sigmund Freud 7.
6. Freud S (1914) On Narcissism - Standard Edition 14: 73-107.
7. Golomb Elan (1995) Trapped in the Mirror: Adult Children of Narcissists in Their Struggle for Self .
8. Greenberg Jay R, Mitchell Stephen A (1983) Object Relations in Psychoanalytic Theory.
9. Burness Moore E (1979) Narcissism: Psychoanalytic Essays by Bela Grunberger- New York, International Universities Press 311.
10. Guntrip Harry (1961) Personality Structure and Human Interaction - New York International Universities Press.
11. Horowitz MJ (1975) Sliding Meanings: A defense against threat in narcissistic personalities 4: 167-180.
12. Russell Anderson A (1965) The Self and the Object World By Jacobson Edith New York International Universities Press 34: 584-613.
13. Kernberg O (1975) Borderline Conditions and Pathological Narcissism - New York Jason Aronson.
14. Klein Melanie (1964-75) The Writings of Melanie Klein - Ed. Roger Money-Kyrle New York Free Press 4.
15. Kohut H (1971) The Analysis of the Self - New York International Universities Press.
16. Lasch Christopher (1979) The Culture of Narcissism - New York Warner Books.
17. Lowen Alexander (1984) Narcissism : Denial of the True Self - Touchstone Books.
18. Millon Theodore, Roger Davis D (1996) Disorders of Personality: DSM IV and Beyond - 2nd ed - New York John Wiley and Sons.
19. Millon Theodore, Carrie Millon M, Sarah Meagher E, Seth Grossman D, Rowena Ramnath (2004) Personality Disorders in Modern Life - New York John Wiley and Sons.
20. Ronningstam Elsa F (1998) Disorders of Narcissism: Diagnostic Clinical and Empirical Implications - American Psychiatric Press 175: 497.
21. Roningstam E (1996) Pathological Narcissism and Narcissistic Personality Disorder in Axis I Disorders. Harvard Review of Psychiatry 3: 326-340.
22. Rothstein Arnold (1984) The Narcissistic Pursuit of Reflection - 2nd revised ed New York International Universities Press.
23. Schwartz Lester (1974) Narcissistic Personality Disorders A Clinical Discussion 22 : 292-305.
24. Stern Daniel (1985) The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology - New York Basic Books.
25. Stormberg D, Roningstam E, Gunderson J, Tohen M (1998) Pathological Narcissism in Bipolar Disorder Patients. Journal of Personality Disorders 12: 179-185.
26. Vaknin Sam (2015) Malignant Self Love - Narcissism Revisited 10th revised impression - Skopje and Prague Narcissus Publications.
27. Zweig Paul (1968) The Heresy of Self-Love: A Study of Subversive Individualism - New York Basic Books.