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Probable Association between Personality Patterns and Experiences of Passivity in Schizophrenia

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ABSTRACT

It is seen in different researches that personality disorders tend to prevail before a full blown clinically significant mental illness to occur. Kurt Schneider's first rank symptoms of schizophrenia assists in making the diagnosis and he believed that experiences of somatic passivity were particularly characteristic of schizophrenia and included them among his 'first rank' symptoms. In this present study it was attempted to study patterns of personality that were predominant in patients with schizophrenia with somatic passivity. After thorough interview and test findings it was found that patients with somatic passivity showed narcissistic and dependent personality traits predominant, where as patients without somatic passivity showed schizophrenia spectrum cluster A personality disorders as predominant.

Keywords: *Somatic Passivity, Personality, Schizophrenia, Narcissism, Dependent.*

Schizophrenia is a disorder characterised by abnormal thoughts, perception, behaviours and experiences. For many years, psychiatrists and researchers have attempted to understand mental illness and its relationship to the characteristics of the patients suffering from it, i.e., temperament, personality construct, attachment pattern. The association between predominant personality style and schizophrenia was first studied in the early years of 20th century. Some researchers proposed that previously present schizoid features deteriorates to schizophrenia[1,2] (Kraeplin, 1913; Bleuler, 1924; Kretschmer, 1925). Other authors suggested that schizophrenia was independent of the previous personality and that patients with schizophrenia could have previously had normal personalities or any other personality disorders apart from schizophrenia spectrum personality disorders [3] (Jaspers, 1948; Schneider, 1974). It has been suggested that personality disorders can be considered as intermediate points on a spectrum having mild traits at one extreme and serious symptomatic disorder at the other [4,5,6,7,8] (Krestchmer, 1925; Meehl 1962; Claridge, 1987; Siever and Davis, 1991;

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Stone, 1993). Schizophrenic disorders seem to exist on a spectrum with cluster A personality disorders [9] (Kety et al., 1968; Rosenthal et al., 1971; Kendler et al., 1981; Kendler and Walsh, 1995). Thus schizoid, schizotypal and paranoid disorders are made up by what are called 'Schizophrenia spectrum personality disorders. Few other researchers and authors agreed upon the ideas by Jaspers and Schneider, have found which are not in the spectrum associated with schizophrenia [10,11,12](Arieti, 1974; Bleuler, 1978; Hogg et al., 1990). But in spite of this notion, neurobiologists suggested compatible relationship between premorbid personality disorders and schizophrenia [13,14,15] (Murray and Lewis 1987; Weinberger, 1987; Lewis, 1989). As there is considerable ambiguity in the clinical symptomatology of schizophrenia, recent cognitive neuroscientific studies have sought to link specific symptom types to dysfunction in different neurocognitive networks [16,17](e.g, Frith, 1992; Spence et al., 1997).

Each and every symptoms found in specific disorders are influenced by particular personality pattern, again which was influenced by childhood experiences, psychosocial factors, biological, genetical and neurological factors. Volition is defined as 'the action of continuously willing or resolving; the exercise of the will', while the latter is the 'the power of choice in regard to action'. Clinical psychiatry accepts that the 'will' can be impaired in many mental disorders, whereby the capacity to choose, can be compromised. Individuals in such cases may then be considered not responsible for their behaviour. People with mental disorders may be fully aware of their behaviour but will nevertheless do something that is harmful to self or others. This leaves with the question about the capacity to resist. Kraepelin referred to impairments of self-awareness and self-regulation in schizophrenia as being part of the deficit in executive control. A defect in volition was central to his notion of dementia praecox, which he saw as being ultimately linked to a loss of will. It is now known that executive function is subserved at least in part by the prefrontal cortex and that there is prefrontal cortical dysfunction in schizophrenia. Patients with schizophrenia and affective psychosis experience phenomenon as not belonging to themselves, overwhelming and made from outside. According to Schneider, this is because of the 'loss of the very contours of the self'. Every human being has a structure of personality type, which leads the person to act accordingly. Because of the personality pattern, one becomes vulnerable to certain mental distresses. An example of a passivity experience in which a patient feels that his own actions are being created, not by himself, but by some outside force. The actions in question can be very trivial, such as picking up a cup or combing one's hair. Other examples of passivity include thoughts or emotions being made for the patient by outside forces. One hypothesis for passivity phenomena (or delusions of alien control) is that the inability to determine the agency of intentional movement may arise from the dysfunction of an internal self-monitoring system that normally permits distinctions between internally generated and external influences on intentional behaviour [18,19,20](Frith, 1997; Feinberg and Guazzelli, 1997; Frith

and Done, 1989). The patient with delusions of control carries out the actions he intends. For example, he correctly carries out the actions requested by an experimenter. He recognises that these actions are successful and does not try to stop or correct them; and yet, at the same time, he experiences these actions as being made for him by alien forces.

In this present retrospective study, it was hoped to elucidate particular pattern of personality that might leads to somatic passivity in an individual having schizophrenia. Patients with schizophrenia show abnormalities on basic dimensions of personality [21,22] (Berenbaum and Fujita, 1994; Kentros et al., 1997;). These personality disturbances may be a manifestation of liability to schizophrenia [23,24,25] (Chapman et al., 1994; Claridge, 1987; Kendler et al., 1993; Lenzenweger and Loranger, 1989; Meehl, 1989). Comparing schizophrenia with experiences of passivity and schizophrenia without experiences of passivity may yield insights into which personality disturbances are common to which symptomatology, clinical severity, and which only occur with psychosis. For the development of symptoms of passivity, links can be drawn from many aspects like delusion of control, some form of suspiciousness, dependency and power. So the only association with schizophrenia spectrum personality disorder can get faded if finely investigated. Each form of symptoms has its own source and course and that is needed to be found out in order to understand the manifestations. Psychiatry deals with individuals of same disorder with variety of symptoms of different source and course and manifestations. Each individual is different from the other. Somatic experiences found in patients with schizophrenia is generally rare than other schizophrenia. What is the reason? Some individuals only show particular symptoms while others not. Is there a pattern of preformed personality that is influencing the symptoms?

Objectives of the research:

- ✓ To elucidate personality traits predominantly present in patients who later develop schizophrenia.
- ✓ To determine the relation, if any, between certain personality traits with the development of somatic passivity, in the patients with schizophrenia.

METHOD

Sample:

34 male indoor patients diagnosed with schizophrenia were taken, among which 13 patients had symptoms of somatic passivity and made volition along with other symptoms of schizophrenia and the rest 21 patients had no sign of somatic passivity and made volition. All patients were taken from indoor psychiatry department of Calcutta National Medical College and Hospital and Ranchi Institute of Neuroscience, Psychiatry and Allied Sciences.

Inclusion Criteria:

The patients were at least 18 years old in order to be able to make diagnoses of personality disorders with minimum of 8th grade education level. The patients were in remission of the acute stage of the illness so that the severe symptoms would not influence in the collaboration of the interviews. Cooperation during evaluation from the patient's side and informant's side was given preference as it is a retrospective study.

Tools used

a. PANSS: The Positive and Negative Syndrome Scale (PANSS) is a medical scale used for measuring symptom severity of patients with schizophrenia. It was published in 1987 by Stanley Kay, Lewis Opler, and Abraham Fiszbein. This was used in order to see the severity level of symptoms as only patients in remission were included.
b. CAPS: The 32-item CAPS measure is a reliable, self-report scale, which uses neutral language, demonstrates high content validity, and includes subscales that measure distress, intrusiveness, and frequency of anomalous experience. This was used to know and interview about the types and forms of somatic passivity one is experiencing.
c. MCMI-III: It is a psychological assessment tool intended to provide information on personality traits and psychopathology, including specific psychiatric disorders outlined in the DSM-5. It is intended for adults (18 and over) with at least a 5th grade reading level who are currently seeking mental health services.

Findings:

34 men were included in this work, of which 21 patients with no sign of somatic passivity and made phenomenon were given personality questionnaire with prolong interviews. It was found that 66% of them were found to have "avoidant" personality pattern. 19% has "schizoid" and rest were found with "schizotypal" pattern. On the other hand, when assessing personality pattern of the group of patients with symptoms of somatic passivity and made volition, one or two patterns together found of which most prominent were dependent, narcissistic and paranoid. 84% individuals found with narcissistic and paranoid pattern, 61% with dependent pattern, 23% schizotypal and 16% schizoid.

Table 1: This table showing kinds of personality patterns found in number of individual in both the groups

PATIENTS WITH SOMATIC PASSIVITY	
PERSONALITY PATTERNS	**NUMBER OF INDIVIDUALS**
Scale 1 SCHIZOID	2
Scale 2A AVOIDANT	2
Scale 2B DEPRESSIVE	
Scale 3 DEPENDENT	8
Scale 4 HISTRIONIC	
Scale 5 NARCISSISTIC	11
Scale 6A ANTISOCIAL	
Scale 6B SADISTIC	
Scale 7 COMPULSIVE	
Scale 8A NEGATIVISTIC	
Scale 8B MASOCHISTIC	
SEVERE PERSONALITY PATTERNS	**NUMBER OF INDIVIDUALS**
Scale S SCHIZOTYPAL	3
Scale C BORDERLINE	
Scale P PARANOID	11

PATIENTS WITHOUT SOMATIC PASSIVITY	
PERSONALITY PATTERNS	**NUMBER OF INDIVIDUALS**
Scale 1 SCHIZOID	4
Scale 2A AVOIDANT	14
Scale 2B DEPRESSIVE	
Scale 3 DEPENDENT	
Scale 4 HISTRIONIC	
Scale 5 NARCISSISTIC	
Scale 6A ANTISOCIAL	
Scale 6B SADISTIC	
Scale 7 COMPULSIVE	
Scale 8A NEGATIVISTIC	
Scale 8B MASOCHISTIC	
SEVERE PERSONALITY PATTERNS	**NUMBER OF INDIVIDUALS**
Scale S SCHIZOTYPAL	3
Scale C BORDERLINE	
Scale P PARANOID	14

DISCUSSION

Many early researches, including this study suggest that there is a predisposition to personality disorders in different clinical syndromes of axis I, and schizophrenia is no exception. Moreover, each disorder is more related to certain personality construct [26](Docherty et al., 1986; Fiester et al., 1990; Mors and Sorensen, 1994; Oldham et al., 1995). A clear predominance of 'eccentric' and 'fearful' group personality pattern was found, when assessing which of them occur in schizophrenia, it is found that the schizophrenia spectrum are quite frequent: schizoid, schizotypal and paranoid. In addition attention is driven to the fact that different other personality patterns are also frequent, like avoidant, dependent, narcissistic. From this point of view it could be thought as Meehl (1990)[27] stated that there are two forms of schizophrenia; one with genetic diasthesis previously expressed for the spectrum personality disorders, and another form, a non genetic copy of the previous one, which would appear without previous personality disorders or with personality disorders which are different from those of the spectrum. There is a strong association among the avoidant, schizoid and schizotypal

personality disorders which is supported by the correlation study. The association among these disorders, frequently demonstrated by different authors, suggests that they are elements of the same pathological continuum, with differences which are basically of degree, which range from minimum to maximum as follows: avoidant, schizoid and schizotypal personality disorders [28,29](Gunderson et al., 1983; Gunderson and Siever, 1985; Livesley et al., 1985; Widiger and Frances, 1985; Dhal, 1986; Widiger et al., 1988; Johnson, 1991; Schroeder and Livesley, 1991; Nurnberg et al., 1991).

In the current study, it was found that patients with somatic passivity showed predominance of narcissistic and dependent personality pattern with paranoid ideas. In narcissistic personality disorder, fear related to self-esteem regulation and risk of falling short can underlie and motivate a range of behaviour. [30] High achievements can be motivated by interpersonal ignorance and distancing by fear of humiliation, or being overpowered and lose control. Studies and observations raise several questions about the interaction between identifying, processing, and controlling fear from the perspective of narcissistic self-regulation. So in the present study, the result of Narcissistic personality pattern found in schizophrenia with somatic passivity, made volition, might finds its source in the fear of such personality where a person needs to be controlled by outside force to lose control or being over-powered.

Experience of passivity, delusion of control in narcissistic individual with paranoid and dependant personality pattern has a strong connection among them. Psychoanalytic studies have primarily attended to the intrapsychic aspects of decision making in narcissistic personality patterns. Fear can influence decision-making by engulfing either an individual's sense of agency or sense of identity, or both. The former can affect competence, while the latter can cause self-confusion and uncertainty about who one really is. Although not currently acknowledged as a diagnostic or clinical indicator of narcissistic personality, nevertheless, remarkable lapses in some narcissistic individuals' decisions can force them into unbearable situations and life crises that call for urgent need of intensive treatment. In clinical settings, therapists can face a paradoxical discrepancy between such patients' consistent self-control and proactive competence, and their sudden disparate decision strategies that seem ruled by immediate short-term gain and mis-judgment, or by ignorance of salient negative or even destructive consequences, especially in interpersonal areas. Usually referred to either as narcissistic crises or trauma motivated by urgent, defensive push for protection and enhancement of self-esteem, or by avoidance of perceived inevitable ultimatums, many of the roots and underpinnings for such decision-making are still relatively unknown.

In other words, narcissistic patients do not depend on others like dependent ones do, but need other’s approval and admiration, most of all when there is a risk of approval and

admiration by the world disappearing. Nothing should challenge these grandiose aspects, as patients can feel invalidated and hurt, or a fragile self can surface and feel threatened [31] (Dimaggio et al., 2007). In both situations patients may react angrily for self defensive purposes, or become depressed which further can lead to malfunctioned way to fulfil the self-needs.

[32] Unhealthy dependency can manifest itself with periods of vindictive rage towards the significant other and self. In narcissists the rage is a transition state [33](Dimaggio et al., 2002), which gets activated when they see others as rejecting or hindering their goals, and serves to avoid the shift towards the empty depressive state, in which, instead of blaming others, narcissists collapse under their own perception of limited personal worth. Moreover, a narcissist's joy is essentially 'about and for self' and only apparently linked to the state of a relationship. In the dependent patient, on the other hand, maintaining the other's presence and attention remains necessary for maintaining the joyful mental state [34] (Carcione & Conti, 2007).

In narcissists, a lack of events capable of feeding the grandiose self-image; for example, after the joy for an earlier success has deflated and self-esteem [35] (Dimaggio et al., 2002). All this studies also hypothesises the concept that somatic passivity, delusion of control, made phenomenon can be the result of repeated lack in feeding of self esteem which is simultaneously giving origin to vindictive rage and hopelessness of not controlling the situation. When these are guided by paranoid ideas, full blown delusion can be lead.

Table 2: Percentage of personality patterns found in two respective groups

Schizophrenia without somatic passivity and made volition	**Schizophrenia with somatic passivity and made volition**
Avoidant + Paranoid - 66%	Paranoid+ Dependent + Narcissistic – 61%
Schizoid- 19%	Narcissistic + Paranoid+ Schizotypal- 23%
Schizotypal- 14%	Schizoid + Avoidant- 16%

CONCLUSION

We are aware of several weaknesses in the present study due to the retrospective method of gathering data. Also in the remission phase, negative symptoms can affect the data, though with thorough interview was done to avoid contamination of information. Personality disorders in schizophrenia are a generally neglected area of research, probably due to the methodological difficulties. We propose future prospective studies of

personality disorders in subjects at high risk of developing schizophrenia, such as the children of schizophrenic parents, focusing on the presence of these personality traits found to be frequent in schizophrenia in the present study. In this research gender differences were not considered because of the variable 'somatic passivity, as this seemed quite rare in schizophrenic population, so further study can be done to see personality construct differences among males and females. Also it can be compared in future the differences in personality patterns leading to somatic passivity among different psychiatric disorders. Further comparison of cognitive and experiential study can be done with somatic passivity in schizophrenia, conversion, and the alien-hand syndrome (associated with damage to the supplementary motor area and/or the anterior corpus callosum)

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Conflict of Interests
The author declared no conflict of interests.

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