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Immature Personality Disorder: Contribution to the Definition of this Personality

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Abstract

In clinical practice, psychiatrists, psychologists and other professionals claim, when appropriate, that an individual has an immature personality. Consulting the ICD-10 or the DSM-5, we found that IPD is not specifically referenced in the DSM-5 and, although it is referenced in the ICD-10, which includes, in Other Personality Disorders (F60.8), the "eccentric, haltlose type, immature, narcissistic, passive-aggressive and psychoneurotic personality (disorder)", there is no explanation of the criteria of any of the personality disorder (PD) included in F60.8. This paper describes the case studies of two patients and aims to help to fill a gap in the major classifications of mental disorders. Empirical studies are needed to better define the diagnostic criteria and the fundamental diagnostic criteria for a better structuring of immature personality disorder.

Growing up involves internalizing norms and values that allow the ego to adjust to the demands imposed by social norm. For this purpose, it is important that individuals internalize an attitudinal morality-impregnated with values-that fosters moral autonomy and leads them to adopt responsible behavior. It is common to affirm, regarding someone who displays childish or irresponsible behavior that this person is immature, or seems to be immature. Clinical experience shows that psychiatrists, psychologists, and other professionals also express that a certain individual has an immature personality. And this diagnosis is made, not in the sense that the individual has one or another characteristic that is immature, but rather as a whole, in the sense of what is understood as personality, the individual has an immature personality. More correctly, they have an immature personality disorder (IPD). In other words, the individual presents personality traits stable patterns of comprehension, relation, and thought regarding the surrounding environment and themselves which are expressed in a wide range of social and personal contexts. And, in this case, they determine the existence of a

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personality disorder in the individual: personality traits are inflexible and maladaptive, causing a significant functional deficit or subjective ill-being.

Keywords: Mental disorder; Immature personality; Immaturity; Personality disorder; Personality

Abbreviations: IPD: Immature Personality Disorder; PD: Personality Disorder; OSPD: Other Specified Personality Disorder; USPD: Unspecified Personality Disorder; ASPD: Antisocial Personality Disorder; BPD: Borderline Personality Disorder; HPD: Histrionic Personality Disorder; NPD: Narcissistic Personality Disorder; DD: Deserves Differential Diagnosis; AvPD: Avoidance Personality Disorder; DPD: Dependent Personality Disorder

Dynamic Perspective

A structural analysis of the personality of these individuals reveals a weakness of the ego, which results in the inability to model anxiety and contain the discharge of impulses, thus the individuals have difficulties in maintaining responsible behavior and being able to meet goals. The alternating expressions of contradicting behavior and attitudes are regarded by the individuals with lack of concern and, sometimes, denial. Often, they compartmentalize people as totally good and totally bad, with frequent oscillations for each individual. Contradictory visions and images of themselves (self-representations) coexist (inside them), which alternate in their dominance from one day to another or from one hour to another. They are unable to integrate the libidinal and aggressive aspects of others, which inhibits them in their ability to properly appreciate their own internal experiences [1-3]. Others may be idealized and devalued on a daily basis, which may be disturbing to anyone who relates to them [4]. Focused on a personality disorder that contained narcissistic traits, citing those characters who apparently function adequately, but with an inability for gratitude, frequently coupled with arrogance, as is often found in the psychopathological description of some patients with immature personality.

In another perspective, an IPD also suggests a failure in the process of forming a Psychosocial Identity: "being at home" in our own body, knowing where we are going and having the inner certainty of early recognition by significant others. Some patients with IPD display a severe confusion of identity, with consequent: a. Inability to concentrate; b. Excessive awareness of competition; c. Aversion to competitive fighting (1968) [5]. And this loss of sense of identity may be expressed by scornful hostility towards the roles offered to them as appropriate and desired in the family and in the community (such as Masculinity, Femininity, Nationality, Class Membership).

Clinical Perspective

On a clinical level, when someone is designated as immature, this means a person whose growth process is not yet complete and who may reveal some or all of the following characteristics:

- Frequently irresponsible behavior
- Propensity to not fulfill their commitments and obligations
- Proneness to act before thinking
- Susceptible to changing plans unexpectedly
- Easily seduced and manipulated by others
- Mood swings that have a more pronounced amplitude than normal and are often puerile;
- Emotional and behavioral manifestations that are unstable and inappropriate for their age and educational and cultural level, resulting in a level of functioning that is lower than expected (behavior, posture, that may consist of shyness, inconvenience of purposes and attitudes, negligent slights towards others, arrogance and vanity, expectation of compliance and overindulgence from others that is unsuited for their age, dependence on others, notwithstanding that they may be tyrannical within the family)
- Character levity resulting in genuine and fleeting repentance for acts committed, but soon forgotten, potentiating the repetition of the inappropriate behavior
- Ability to feel remorse and guilt without it necessarily meaning that it prevents the repetition of abnormal behavior (perversity and wickedness are often absent – these characteristics entail greater proximity to Antisocial Personality Disorder (ASPD) and, especially, to psychopathy
- Inability to adequately manage their assets
- Appetite for wonderment and consequent acquisition of goods even if it jeopardizes their own well-being or that of another
- Absence of a life project, putting the focus on instant gratification
- Inability to comply with a previously established plan;

- Propensity to lie – with devaluation of the given word and the lie itself –, and the lie frequently emerges in a puerile and often foolish way;
- Weakness of will, with consequent volubility and inconstancy, which can translate to abandoning an unfinished task or responsibility, difficulty in delaying a desire in time or resisting frustration, etc.
- puerile and/or absurd disinterest or devaluation of the opinions of others
- Lower interest/curiosity for the consumption of cultural goods appropriate to their age and educational and cultural level
- Often accompanies people with a development level significantly below the level that would be expected from that person. When they accompany people with a development level similar to the level that would be expected from that person, they almost always have a lower or signaled/stigmatized status
- Greater tendency to adopt risk behavior – substance use, pathological gambling, irresponsible sexual behavior, dangerous driving
- Instability in their relationships;
- Unpredictable behavior
- Sense of entitlement to rights they do not have
- Tyrannical in their demands from others
- Ungrateful, even if others comply with demands they have no right to make
- Excessive susceptibility to the non-fulfillment of their demands by others
- Dissatisfaction with others even if they fulfill the agreed obligations
- Avoidance of social situations or others that are anticipated as embarrassing
- Inadequate fear of the behavior of others
- May reveal excessive cowardice or reckless temerity
- Feeling of superiority that even causes "perplexity" (due to that person's limitations being very apparent, often with tunnel vision and an inability to understand others or the situation)
- Theatricality, looking to stand out even if it entails excessive or unjustified personal and financial cost
- Feelings of closeness or familiarity that are inexistent, with frequent invasion of the critical space of others
- Egotism that would be considered savage but often denied by the individual, despite being apparent;
- Fearful and suspicious character
- Feeling of inability to assume responsibilities that the individual would be expected to assume in different stages of their life, or indifference towards fulfilling those responsibilities
- Absence of mental disability
- History of infantile treatment, with foolish treatment of the individual, particularly by the parents, with task substitution and the parents undertaking responsibilities that should be assumed by the individual.

As can be seen from the abovementioned clinical characteristics, several other personality disorders present similar clinical characteristics to those mentioned above, particularly antisocial, borderline, narcissistic, histrionic personality disorders, but also others such as avoidant, dependent, and schizoid personality disorders [2]. Consulting the ICD-10 [1] or the DSM-5 [2], we found that IPD is not specifically referenced in the DSM-5 and although it is referenced in the ICD-10, which includes, in Other Personality Disorders (F60.8), the "eccentric, haltlose type, immature, narcissistic, passive-aggressive and psychoneurotic personality (disorder)", there is no explanation of the criteria of any of the personality disorder (PD) included in F60.8.

Regarding the DSM-5 [2], this integrates the Other Specified Personality Disorder (OSPD) 301.89 (F60.89), a category used in situations where the clinician chooses to communicate the specific reason for which the presentation does not fulfill the criteria for any specific personality disorder, which is done by registering "other specific PD", followed by the specific reason (for example, "mixed personality characteristics"). As for the Unspecified Personality Disorder (USPD) 301.9 (F60.9), it is a category that applies to presentations in which the characteristic symptoms of a personality disorder, which cause clinically significant ill-being and deficits in social and occupational functioning or in other important areas of functioning, are predominant, but do not meet all criteria for any of the disorders in the diagnostic category of personality disorders. The USPD is used in situations where the clinician chooses to not specify the reason for which the criteria are not fulfilled for a specific personality disorder and includes presentations in which there is insufficient information to make a more specific diagnosis.

Given the above, it begs the question: is there in fact a reason to speak of IPD? On the other hand, is it justified to speak of an autonomous entity IPD when the personality disorders included in the DSM-5 [2] may include IPD, for example, in OSPD? And how to constitute an autonomous entity (IPD) with a clinical specificity? How to autonomize an entity that can be presented as both shy and afraid or irresponsible, unpredictable and reckless? And, even if a cohesive body of clinical characteristics is found, will it be sufficiently distinctive from other PD? And is there some neurobiological, or other, substrate that would allow to identify IPD?

It is known that electroencephalographic brain studies reveal brain immaturity in individuals with pathologies as diverse as psychopathy, epilepsy, mental disability, substance abuse, schizophrenic psychosis [6-9].

But it is also known that some individuals with brain immaturity registered in the EEG display behaviors overlapping with those described above, while others do not have those behaviors. Therefore, there is no neurobiological etiology that we can present as an aggregator or identifier for example, brain immaturity –, to justify that this clinical entity is somehow autonomous and separate. Incidentally, we also know that individuals with normal brains, with no anomalies in the EEG, present clinical characteristics that reflect immaturity and that result from educational and environmental factors. Often, in the history of individuals with immature personality, we find an excessively condescending, or overprotective, mother (or father), who acted so that these individuals were granted everything and very little or nothing was demanded of them, whereas other parents of immature individuals were negligent, abandoning, and/or psychopathic-like. Other times, this immature behavior stems from a medical cause, including traumatic causes [10-12]. But, in this case, these are not the IPD of which we speak.

In summary, the individual can operate immature behavior because they were affected by brain immaturity that conditions them on a neurobiological level [11,12] or because they had an inadequate upbringing [13], or by a combination of both factors, or by a traumatic event, particularly, a traumatic brain injury, that conditions them [13]. Nonetheless, even with the difficulty of differentiating IPD and the inexistence of a biological or neurobiological substrate that underlies it, why not defend an autonomous IPD if it exists?

The existence of IPD will be demonstrated by presenting two clinical cases. Written informed consent was obtained from the participants for the publication of these case reports.

Clinical case 1

V. is a 29-year-old who lives in her parents house with husband (in reality they are not married) and son, and presented with propensity to not fulfill her commitments and obligations; lower interest/curiosity for the consumption of cultural goods appropriate to her age, educational and cultural level; tyrannical in her demands from others; ungrateful, even if others comply with demands she has no right to make; excessive susceptibility to the non-fulfillment of her demands by others; dissatisfaction with others even if they fulfill the agreed obligations; avoidance of social situations or others that are anticipated as embarrassing; inadequate fear of the behavior of others; may reveal cowardice or reckless temerity; egotism that would be considered savage but often denied by the individual, despite being apparent; fearful and suspicious character; feeling of inability to assume responsibilities that the individual would be expected to assume in different stages of their life, or indifference towards fulfilling those responsibilities; absence of mental disability; history of infantile treatment, with foolish treatment of the individual, particularly by the parents, with task substitution and the parents undertaking responsibilities that should be assumed by the individual, etc. As the only child of a lower-middle class family, she abandoned her studies at the age of 15 because her "head became too tired". Normal intelligence, not under-gifted. She does not work, not even at home, since it is her mother who does all the housework. She had always considered it normal to live off her parents', and now her husband's, income and wander around, doing nothing, not even claiming any complaint or disability, at her parents' or friends' houses. Her mood is almost always eutimic, but she sulks easily if her husband does not fulfill her whims or if he disturbs her with something that upsets her. In fact, similarly to her parents, who do not dare to not meet her demands because they know that, in that case, she will sulk like a child or be afflicted by many days of headaches, nausea, lack of appetite, and other related symptoms. The patient has a deceiving attitude of subalternity, because she is very imposing, if necessary, tyrannical. In all circumstances, she always upholds the primacy of her desire, not considering the interests and respect of others.

In the education of her six-month-old child, it is her mother who makes up for maternal childishness, since the patient behaves as if having made a delightful offering to her mother, who should care and protect him. If her parents are absent, which is rare, and despite knowing how to cook, she is incapable of preparing dinner. When her husband arrives, at the end of the day, he prepares dinner.

The contact is more appropriate to that of a shy pre-teenager, with one or another childish facial grimace. Resistant to any approach she deems threatening - she throws a few retracted looks announcing an escape in this event -, she consults the therapist as if was consulting a good friend, but with whom simply wants to address one or another irrelevant issue.

This woman, almost thirty years old, is immature and has her life conditioned by her disturbed personality.

However, if we try to fit her in the PD of the DSM-5 [2], where would we place her? Surely in none of the PD included in the respective chapter and integrating the groups A, B, and C. Only the two PD described above would remain 301.89 (F60.89) and 301.9 (F60.9) but neither would provide the exact dimension of what we want to explain when we speak of IPD.

Clinical case 2

A. is a 30-year-old man, a driver for a delivery company, married, with one child. He is described by his family as a good guy, but somewhat mischievous, as he is unpredictable and unable to rigorously fulfill his duties and commitments. His interest is easily captured by his friends and his path is diverted. For example, the last time he left home – he has done it twice, the first time he left for a month and the second time for a similar amount of time – he returned feeling sorry for having done it, imploring and humiliating himself in front of his wife for her to accept him again, guaranteeing, just as before, that he would not repeat the same behavior. Also like the first time, he had serious problems at his jobs because he was unexpectedly absent without justifying his absence. Despite being a young man, he has been fired several times, without it bothering him. He goes back to work only after finishing his unemployment benefits.

As a father, he enjoys playing with his son and, if the child shows interest in having a toy, he is likely to buy the toy for his son in the middle of the month, run out of money and then borrow money from his parents, who, with all ease and indifference, he does not pay back (in fact, it is a topic that he never addresses again). On the other hand, and given the past occurrences, his wife would never leave him alone with his son for too long because she does not trust that he would responsibly care for the child.

In his own way, he is a friend to his wife but the relationship is not easy because he has difficulty in tolerating frustration, his mood and emotional expression are very unstable, and he is able to change from warm to angry, shaken and irritated with great ease. When he makes a mistake, he expects the victim to devalue the harmful act he committed. And the likelihood of him committing the same acts again is high. For example, his wife had two venereal infections because he is careless with his extramarital sexual behavior and never uses condoms.

His money management is chaotic, therefore, he hands over a large part of his salary, or his unemployment benefits, to his wife, who manages it responsibly. Most times, he reaches the middle of the month already without money for his personal expenses, and shamelessly asks his friends and family for money, who he obviously does not pay back, or does it very late. He has a group of friends who do not take him seriously – "they go easy on him" – because they never know how he will be, he might schedule something – for example, a meet up – but that does not mean he will attend.

While this type of behavior can be found in individuals with mild mental disability [2], A. is not intellectually under-gifted in any way. He also has no criminal or prison records. In fact, he has no history of illegal behavior.

This man has his life very conditioned by his disturbed personality. Nonetheless, similarly to the previous case, if we try to fit him in the PD of the DSM-5 [2], where would he be placed? Surely, in none of the ten PD included in the respective chapter and integrating groups A, B, and C. Only the two PD mentioned above would remain – 301.89 (F60.89) and 301.9 (F60.9) – but none of them provide an exact dimension of what we want to explain when we speak of IPD. And when ICD-10 [1] speaks about IPD is speaking about a personality disorder of this man or of the anterior woman we spoke about?

Diagnostic criteria

There is a vast clinical body common to IPD and other PD that apparently does not distinguish it from other PD, and a clinical body that is more restricted and specific to IPD (Table 1). IPD is divided into three clinical subtypes which symptoms will be discussed in item "IPD Subtypes" and Table 2.

Diagnostic Criteria for IPD	Explanation
1. Family, close friends, or community	Behavior changes can be present in family, close friends, and/or community.
2. Behavior that is frequently irresponsible or inadequate for the age or educational and cultural level the individual possesses	Consistent irresponsibility is typical of ASPD, in which individuals do not conform to social norms regarding legal behavior. Individuals with IPD may behave as if they do not conform because they function on an impulsive and childish register. It cannot be said that in IPD there is no conformity to social norms. Instead, there is immature self-control that encourages irresponsible behavior. The individual changes routes suddenly and unexpectedly, neglecting responsibilities. After making their mistakes,

	the immature person almost always displays regret, guilt, remorse, even if fleeting, whereas the person with ASPD tends to not exhibit that distress, on the contrary, they tend to show coldness, lack of remorse and lack of regret.
3. Propensity to act without thinking, not being too concerned about the consequences	Impulsivity or the inability to plan ahead is typical of ASPD. We cannot ignore that ASPD and psychopathy are not the same disorder. There are psychopaths who are cold, calculated, objective, determined, and very easily distinguishable, regarding this topic, from individuals with IPD. Some individuals with ASPD, Borderline Personality Disorder (BPD), Histrionic Personality Disorder (HPD), and less likely Narcissistic Personality Disorder (NPD) also have IPD.
4. Do not assume their tasks or responsibilities	This type of behavior, when individuals do not assume their tasks or responsibilities, can be present in the two subtypes of IPD. The shy subtype of IPD deserves differential diagnosis (DD) with DPD and Avoidance Personality Disorder (AvPD). In Dependent Personality Disorder (DPD), the individual has difficulty making decisions in their daily life without excessive counseling and reassurance from others, needing to transfer responsibilities to others in most important areas of their life. In the emotional and dramatic subtype of IPD, the individual often takes on responsibilities, for which they are not qualified, or does not fulfill the responsibilities they have assumed or behaves in a negligent and deserting way towards the situation. The dramatic and emotional subtype of IPD is not as obstinate as the shy subtype of IPD, when assuming tasks and responsibilities, but behaves as if they are not responsible, or transiently they are not, which may also occur in ASPD. In this latter PD, the individual may struggle to assume power and responsibilities, but often tends to not undertake their functions and responsibilities. Thus, in this sense, they may not differentiate, on this item, from the dramatic and emotional subtype of IPD. In the shy subtype, the individual may manifest behavior similar to what was explained here regarding DPD. Nonetheless, in IPD the individual does not renounce from asserting their authority in important areas of their life, does not need to volunteer themselves in order to obtain care and support from others, nor do they urgently seek another relationship as a source of support (in case of abandonment by a partner, their relationship with direct family members is enough support for them during a transitional period, or not). Regarding AvPD, the individual with the shy subtype of IPD does not display such pronounced interpersonal difficulties as the individual with AvPD. But there are other characteristics differentiating an individual with IPD from someone with AvPD.
5. Pronounced susceptibility to be seduced and manipulated by others	This item is very characteristic of IPD, though it also appears incorporated into the HPD of the DSM-5. It is also found in many individuals with ASPD, as well as in AvPD and DPD. The main feature of someone with IPD is that they can be seduced and manipulated by others with whom they previously had little contact, which does not happen in AvPD, nor in DPD, and they may be manipulated, in an easily visible way, against their own interests, which is harder to happen in ASPD, where pleasure is the main attraction. In HPD and NPD, the individual may be seduced and manipulated as a means of aggrandizement of the ego and eventually manifest some immaturity at this level, but what attracts them is of a qualitatively different dimension (less childish) than in IPD.
6. Pronounced mood swings	This item is very present in IPD, especially in the dramatic and emotional type, but also in the other subtypes of IPD. It also appears incorporated in HPD, BPD, and in some individuals with ASPD. In IPD, however, emotional and behavioral manifestations more often have features that are inappropriate for the age and educational and cultural levels of the individual, reflecting childishness, such as sulking, puerile quarrels, absurd ruptures.
7. Puerile expectation of complacency and overindulgence from others	This is very characteristic of IPD and does not appear so well integrated in the diagnostic criteria of any other PD of the DSM-5 although some ASPD individuals also manifest it. Many individuals with ASPD tend to give themselves a special status, which may somehow be related to the expectation of overindulgence from others.

	Something similar could be said regarding AvPD and, especially, DPD.
8. Settlement in the psychological or socioeconomic dependency on others, without being available, or being less available, for retribution to others	In ASPD, the individual is willing to make themselves dependent on others, exploiting them objectively and remorselessly, often adopting a threatening and aggressive stance. In IPD, the tone of this relationship is more childish and there is a distinct quality in this dependency. It is a dependency without distress, without significant gratitude or behavior reflecting gratitude, which also occurs in ASPD. In IPD, the individual behaves like an adolescent who feels entitled to ride on the rights of those they depend on, similar to what happens in ASPD, though the individual with ASPD is much colder and calculated in the exploitation of others than the individual with IPD. In DPD, individuals exhibit greater dependency, and in AvPD greater avoidance than in the shy subtype of IPD, but without the behavioral modifications typical of IPD and later considered in the DD between DPD, AvPD, and IPD.
9. Ability to feel and show genuine remorse, guilt, regret, shame of the anomalous behavior committed, without it reflecting in the non-repetition of the same behavior	In IPD, the individual is able to feel and show genuine regret, guilt, and remorse. Nonetheless, those feelings tend to be light and fleeting and do not result in a definitive interruption of the anomalous behavior: the individual with IPD, especially in the dramatic and emotional subtype, tends to repeat impulsive acts they come to regret. This repentance and desire for forgiveness is almost always exhibited in a puerile and childish tone, often inducing in the observer a feeling of compassion rather than desire for punishment, and not the desire for revenge caused by the individual with ASPD. In the latter, the demonstration of guilt, remorse, regret is mostly instrumental, with no ego-dystonia, or no significant ego-dystonia, regarding the behavior committed. In individuals with NPD, the demonstration of guilt, regret, remorse, has a closer character to that exhibited by ASPD, whereas in BPD or HPD, the individual may either be unyielding in the anger and aggression committed, or may come to show genuine regret for the anomalous behavior perpetrated.
10. Inability to properly manage their assets	This inability is different from the inability of the ASPD individual to comply with financial obligations, more associated, in the latter, to the disregard of others, the manipulation of others, indifference towards the financial health of others, optimism and sense of impunity associated with the willingness to commit illegal behavior that will bring the goods (e.g., money) they are now spending, or willingness to take risks (gambling, risky businesses, etc.) and spend the money they acquired. The inability of the IPD individual is seemed with the exhibited by ASPD, results especially from the wonderment, the seduction of here and now, of an Id that does not resist the neon emanating from an often unnecessary object that the individual cannot, however, resist acquiring, which may cause them to not meet their financial obligations. This inability to manage their assets may also result from the exploitation and manipulation that others do to the person with IPD, especially when the IPD person has a relationship of trust with the manipulator and the latter has some ascendant over the person with IPD, less likely in ASPD. In NPD or HPD, the individual may also reveal this difficulty, but their inability to adequately manage their assets is associated with the desire to presents themselves as greatly richer and powerful than they actually are, thus the individual is willing to spend their assets despite possibly jeopardizing their financial health or the health of the company they depend on/manage.
11. Difficulty or even inability to comply with a prescribed plan	It is not a unique feature of IPD, existing in other PD, especially in ASPD, but also in BPD and HPD. This difficulty is most visible in the dramatic and emotional subtype of IPD than in the shy subtype.
12. Propensity to lie, with devaluation of the given word and their own lie	It is not a unique feature of IPD and may exist in other PD, especially ASPD. However, the lying in ASPD is more instrumental and objectified than the lying in IPD. Lying in IPD is also frequently instrumental and objectified, but it often displays such a childishness and innocence – as it is easily uncovered – that baffles the observer. This difficulty is most visible in the dramatic and emotional subtype of IPD than in the shy subtype.
13. Pronounced difficulty in	It is not an exclusive feature of IPD and may exist in other PD, especially ASPD, but

delaying a desire	also in BPD, NPD, and HPD.
14. Significant difficulty in resisting frustration	It is not unique to IPD and may exist in other PD, especially in ASPD, NPD, and BPD (Cross, Coping, & Campbell, 2011).
15. Foolish and puerile devaluation of others, or their opinions	It is not an exclusive feature of IPD. Very present in other PD, especially in ASPD, but also in NPD, BPD or HPD.
16. Tendency to adopt risk behavior	It is not an exclusive feature of IPD and may exist in other PD, especially ASPD (Bickel & Johnson, 2003; Bickel & Marsch, 2001; Claus, Kiehl, & Hutchison, 2011; Conversano et al., 2012; Heil, Johnson, Higgins, & Bickel, 2006; Hoffman et al., 2006; Landes, Christensen, & Bickel, 2012; MacKillop, Anderson, Castelda, Mattson, & Donovick, 2006; Monterosso & Ainslie, 2007; Odum, Madden, Badger, & Bickel, 2000; Petry, 2001; Petry & Madden, 2010; Reynolds, 2006; Weller, Cook, Avsar, & Cox, 2008; White et al., 2014; Yi, Mitchell, & Bickel, 2010). Largely present in IPD, especially in the dramatic and emotional subtype. The levity or unexpectedness of the behavior is very common due to the behavioral instability of individuals with IPD, leading them to perpetrate behavior such as substance use, pathological gambling, irresponsible sexual behavior, dangerous driving, etc.
17. Instability in their relationships and behavior	It is not an exclusive feature of IPD and may exist in other PD, especially ASPD, BPD, NPD, and HPD.
18. Self with a sense of entitlement to rights it does not posses	It is not an exclusive feature of IPD and may exist in other PD, especially ASPD, BPD, NPD, and HPD. Most common in the dramatic and emotional type of IPD, but may also be present in the shy subtype. The individual often displays tyrannical behavior, and the compliance with their demands by others does not result in any or enough gratitude.
18. Self with a sense of incompetence and worthlessness	It is not exclusive to IPD and may exist in other PD, especially in AvPD and DPD. Most common in the shy subtype of IPD. However, in the latter, individuals often give themselves the right to be unacceptably demanding and even tyrannical and manipulative with those who are close to them, features that are not present in AvPD or DPD.
20. Propensity to want to stand out even if it entails excessive and unjustified personal or financial cost	It is not a unique feature of IPD and may exist in other PD, especially HPD, but also in ASPD, BPD, and NPD. The uniqueness of the individual with IPD, especially the dramatic type of IPD, is the higher childishness, levity and lack of introspection with which the immature person acts and that distinguishes them from individuals with other PD, although ASPD, especially this one, may have overlapping behavior with IPD.
21. Inadequate recklessness that can even be baffling	It is not a unique feature of IPD and may also exist in other PD, especially ASPD, but also BPD. The main difference is that, in ASPD, the recklessness is often accompanied by less fear, surprising (structural) courage, whereas in BPD this recklessness tends to occur in an explosive, angry context. On the other hand, in IPD, the individual displays recklessness in an impulsive context, most of the times. And sometimes without exactly being aware of what was at stake.
22. Inadequate shyness	It is not an exclusive feature of IPD, especially of the shy subtype. It is present in other PD, especially AvPD and DPD. Nevertheless, unlike DPD, the shy type of IPD often has a tyrannical facet, and has no difficulty in expressing disagreement with others for fear of losing support or approval. In addition, unlike DPD, often the individual does not avoid making decisions in everyday aspects of their life (they may even do it as a tantrum), although they are not willing to take on the work or responsibility it entails and tend to delegate that effort to others. It is also not typical of them to make excessive effort to obtain the care and support of others, to the point of volunteering to do unpleasant tasks, although they may do it occasionally, nor do they tend to unrealistically worry about fears of being left to fend for themselves, as occurs in DPD. In the differential diagnosis with AvPD, the IPD individual does not display the fear of

	the AvPD individual of displeasing others, nor the fear of AvPD individual of being criticized or rejected in social situations, acting as if others are indebted to them. They do not tend to see themselves as socially or professionally inept, although they are arrogating to themselves desires or impositions that the individual with AvPD does not dare to exhibit. They may not take pleasure in knowing new people, but they are receptive of getting to know new people as long as they are treated with affection. However, their susceptibility may easily elicit an excessive and somewhat childlike response (e.g., sulking, anger), and they do not show any inhibition in giving this type of response. Given the above, they are people who do not meet the criteria for AvPD. On the other hand, they often adopt behavior in which they manifest suffering from multiple somatic complaints, or lead others to feel guilty for their malaise, causing increased infantilizing treatment by others. Some of IPD individuals have difficulties in social relationship and live closely with family and/or friends to whom show tyrannical and/or dependent behavior.
23. Behavior reflecting ingratitude and lack of respect for others	This type of behavior is not exclusive of IPD and occurs especially in ASPD, NPD, BPD, and HPD. The individual with IPD displays greatly increased susceptibility to others not promptly meeting their demands, which often causes rebellious, childish behavior. In fact, this behavior may occur even if others meet the demands of the person with IPD, but fail to do it with the brevity or in the way the IPD person demanded.
24. Feeling of proximity and familiarity that is inexistent	The IPD individual is often invasive, has difficulty in maintaining a good sense of distance and convenience and, thus, does not adopt the most appropriate behavior towards others. Undoubtedly, in ASPD, NPD, HPD, and BPD that may also happen. Nonetheless, the behavior of the IPD individual is more puerile than that of individuals with NPD, HPD and most individuals with ASPD. And, although it may be arrogant, it does not have the structure and density of the individual with NPD, nor is the anger as powerful, repetitive and consistent as that of BPD.
25. Absence of a credible life plan, putting the focus on here and now	This absence of a life plan is not characteristic of IPD and is often found also in ASPD. In IPD, this feeling that the individual is not capable of maintaining a consistent and adequate life plan is very pronounced. In ASPD, the individual does not want to but could, whereas in IPD the individual cannot, because they are immature and require prior substantive work to be able.
26. Substance use	Individuals suffering from IPD are more often involved in substance use (e.g., cannabis, cocaine, heroin), but are also more prone to excessive alcohol consumption. This behavior is very present in other PD, particularly ASPD and BPD.

Table 1: Diagnostic Criteria for Immature Personality Disorder.

Subtype 1 – Dramatic and emotional	Subtype 2 – Shy	Subtype 3 – Mixed type
1. Family and community		*
	1. Family and/or close friends	*
2. Behavior that **is often foolish**, irresponsible, not in accordance with the age or educational and cultural level the individual possesses	2. Behavior that **can be** irresponsible not in accordance with the age or educational and cultural level the individual possesses	*
3. **Propensity** to act without thinking, not being too concerned about the consequences	3. **Less propensity** to act without thinking, not being too concerned about the consequences	*
4. Not assuming their tasks or responsibilities	4. Not assuming their tasks or responsibilities	1. Not assuming their tasks or responsibilities
5. Pronounced susceptibility to be seduced and manipulated by others	5. Pronounced susceptibility to be seduced and manipulated by others	2. Pronounced susceptibility to be seduced and manipulated by others

6. Mood swings that are sudden, pronounced and often puerile	6. Mood swings that are sudden, pronounced and often puerile	3. Mood swings that are sudden, pronounced and often puerile
7. Excessive – often almost puerile – expectation of complacency and overindulgence from others, well above what is expected for the sociocultural environment	7. Excessive – often almost puerile – expectation of complacency and overindulgence from others, well above what is expected for the sociocultural environment	4. Excessive – often almost puerile – expectation of complacency and overindulgence from others, well above what is expected for the sociocultural environment
8. Settlement in the psychological or socioeconomic dependency on others, without being available, or being less available, for retribution to others	8. Settlement in the psychological or socioeconomic dependency on others, without being available, or being less available, for retribution to others	5. Settlement in the psychological or socioeconomic dependency on others, without being available, or being less available, for retribution to others
9. Ability to feel and show remorse, guilt, regret, shame of the anomalous behavior committed, without it reflecting in the non-repetition of said behavior	9. Ability to feel and show remorse, guilt, regret, shame of the anomalous behavior committed, without it reflecting in the non-repetition of said behavior	6. Ability to feel and show remorse, guilt, regret, shame of the anomalous behavior committed, without it reflecting in the non-repetition of said behavior
10. **Inability** to properly manage their assets	10. **Less inability** to properly manage their assets	*
11. **Difficulty or even inability** to comply with a prescribed plan	11. **Less difficulty** to comply with a prescribed plan	*
12. **Propensity** to lie, with devaluation of the given word and their own lie	12. **Less propensity** to lie, with devaluation of the given word and their own lie	*
13. Pronounced difficulty in delaying a desire	13. Pronounced difficulty in delaying a desire	7. Pronounced difficulty in delaying a desire
14. Significant difficulty in resisting frustration	14. Significant difficulty in resisting frustration	8. Significant difficulty in resisting frustration
15. Foolish and puerile devaluation of others, or their opinions	15. Foolish and puerile devaluation of others, or their opinions	9. Foolish and puerile devaluation of others, or their opinions
16. Tendency to adopt risk behavior		*
17. Instability in their relationships and behavior		*
18. Self with a sense of entitlement to rights it does not posses	16. Self with a sense of entitlement to rights it does not posses	10. Self with a sense of entitlement to rights it does not posses
19. Self with a sense of incompetence and worthlessness	17. Self with a sense of incompetence and worthlessness	11. Self with a sense of incompetence and worthlessness
20. Propensity to want to stand out even if it entails excessive and unjustified personal or financial cost		*
21. **Recklessness** that can even be baffling	18. **Less recklessness**	*
22. Behavior reflecting ingratitude, unfair judgment and lack of respect for others	19. Behavior reflecting ingratitude, unfair judgment and lack of respect for others	12. Behavior reflecting ingratitude, unfair judgment and lack of respect for others
23. **Feeling** of proximity and familiarity, which are inexistent	20. **Less feeling** of proximity and familiarity, which are inexistent	*

24. Absence of a credible life plan, putting the focus on here and now	21. Absence of a credible life plan, putting the focus on here and now	13. Absence of a credible life plan, putting the focus on here and now
25. Substance use		*
	22. Inadequate shyness	*

Table 2: Subtypes of IPD.
Note. Subtype 1 and 2 complies, respectively, 25 and 22 diagnostic criteria. Twenty-six diagnostic criteria are present in IPD, 13 of which are common to subtypes 1, 2, and 3; seven are similar (but not equal), four are exclusively to subtype 1 and two are exclusively to subtype 2.
* Subtype 3 comprises diagnostic criteria of subtypes 1 and 2 without filling all the specific diagnostic criteria, which differentiate subtypes 1 and 2.

The following symptoms are nuclear in the definition of this personality disorder:

- Behavior changes in family, close friends, or community
- Behavior that is often irresponsible or not in accordance with the age or educational and cultural level the individual possesses
- Propensity to act without thinking, not being too concerned about the consequences
- Not assuming their tasks or responsibilities
- Pronounced susceptibility to be seduced and manipulated by others
- Mood swings that are sudden, pronounced and often puerile
- Excessive – often almost puerile – expectation of complacency and overindulgence from others, well above what is expected for the sociocultural environment
- Settlement in the psychological or socioeconomic dependency on others, without being available, or being less available, for retribution to others
- Ability to feel and show remorse, guilt, regret, shame of the anomalous behavior committed, without it reflecting in the non-repetition of said behavior
- Inability to properly manage their assets
- Difficulty or even inability to comply with a prescribed plan
- Propensity to lie, with devaluation of the given word and their own lie
- Pronounced difficulty in delaying a desire
- Significant difficulty in resisting frustration
- Foolish and puerile devaluation of others, or their opinions
- Tendency to adopt risk behavior
- Instability in their relationships and behavior
- Hypertrophied self with a feeling of self-worth and entitlement to rights it does not have
- Hypotrophied self with a sense of incompetence and worthlessness
- Propensity to want to stand out even if it entails excessive and unjustified personal or financial cost
- Inadequate recklessness that can even be baffling
- Inadequate shyness
- Behavior reflecting ingratitude, unfair judgment and lack of respect for others
- Feeling of proximity and familiarity that is inexistent
- Absence of a credible life plan, putting the focus on here and now
- Substance use

Differential Diagnosis

Considering Case 1, and accordingly to DSM-5 [2], the Avoidant PD (301.82) and Dependent PD (301.6) must be considered. To diagnose Avoidant PD, the following criteria must be met: a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of following:

- Avoids occupational activities that involve significance interpersonal contact because the fears of criticism, disapproval, or rejection
- Is unwilling to get involved with people unless certain of being liked
- Shows restraint with intimate relationship because of the fear of being shamed or ridiculed
- Is preoccupied with being criticized or rejected in social situations
- Is inhibited in new interpersonal situations because of feelings of inadequacy
- Views self as socially inept, personally unappealing, or inferior to others
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

- V. never could be a AVPD because she has no social inhibition: although most part of time she stays at home, V. visits friends and walks daily with them. If a different person appears to walk she puts no problem; she never spoke about feelings of inadequacy and, if

present, it seems not to be oppressive; hypersensivity to negative evaluation is present: if criticized, V. becomes furious and cuts off the relationship with that person. She has no occupation because she is a "princess" that has no need to work – never worked; is available to relate to other and doesn't inhibited in new interpersonal situations because of feelings of inadequacy, doesn't view herself as socially inept or personally unappealing. When asked, she never said she considered inferior to others but we have doubts about this point. In a superficial perspective, perhaps we could fit it into the AVPD but she has a IPD: above all, she functions has a girl much younger whose main objective is to exist for the joy of those who are close to her, without culpability or feeling of social maladjustment.

To diagnose Dependent PD (DPD), the following criteria must be met: a pervasive and excessive need to be taken care of that leads to submissive and viscous clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- Needs others to assume responsibility for most major areas of his or her life
- Has difficulty expressing disagreement with others because of fear of loss of support or approval
- Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
- Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
- Urgently seeks another relationship as a source of care and support when a close relationship ends
- Is unrealistically preoccupied with fears of being left to take care of himself or herself.

V. is not a DPD because she has no submissive and viscous but tyrannical behavior although fears of separation are present. Criteria explicated in 1, 3, 4 and 5 above are not present in V.

Considering Case 2, and accordingly to DSM-5 [2], the ASPD (301.7) and Borderline PD (BPD) (301.83) must be considered. To diagnose ASPD, the following criteria must be met: A**.** A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

- Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are ground for arrest
- Deceitfulness, as indicated by repeated lying, use aliases, or conning others for personal profit or pleasure; **3.** Impulsivity or failure to plan ahead
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults
- Reckless disregard for safety of self or others
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another. B. The individual is at age 18 years. C. There is evidence of conduct disorder with onset before 15 years. D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

To diagnose BPD, the following criteria must be met: a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the followings:

- Franc efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: do not include suicidal or self-mutilating behavior covered in Criterion 5.)
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

In general, the diagnosis of IPD requires differential diagnosis (DD) with ASPD, in the sense that many clinical characteristics of IPD may be present in ASPD. Though there is nothing preventing the diagnosis of both IPD and ASPD.

In what differs A from someone with ASPD? In the ability of guilt regret and remorse in the childish behavior in which he asks for forgiveness and for others to not abandon them behavior that is not typical of ASPD [13]. In A is present disregarding towards others, particularly in the sense of commitments and duties towards others, however, the pleasure in humiliating or harming others is not present. It is a lack of respect that is childish and generally not perverse, foolish and not sadistic, without the pleasure of the suffering of others. In IPD can be seen a genuine desire of regeneration, when discovered or confronted with their behavior, whereas in ASPD, and especially in a psychopath, the aforesaid regeneration is simply a scam with which the individual wants to manipulate others. In ASPD, there is greater consistency and robust determination for crime and delinquency: the crime does not occur as a consequence of the appeal of the moment, or due to vulnerability to manipulation: it happens with total adherence by the individual. On the other hand, in ASPD, there is no pronounced susceptibility to be seduced and manipulated by others, nor such a puerile expectation of overindulgence and excessive complacency from others, and well above the amount expected for the sociocultural environment.

In ASPD, as in A, the individual settles in the dependency on others, whether psychological or socioeconomic, without being willing, or being poorly willing, for retribution to others. But in ASPD, the individual tends to be an aggressive and perverse tyrant, whereas A is puerile and childish, even some IPD are childish tyrant.

Regarding the inability to comply with financial obligations, in ASPD the individual exploits others objectively, in a calculating way and without remorse. But usually it does not exhibit the childish tone of A. This incapacity in A results mainly from the wonderment, seduction of here and now, of an Id that cannot resist the neon emanated from an object the individual cannot resist to acquire, potentially causing them to not meet their financial obligations. The lying of A is often instrumental and objectified, but it frequently presents a puerility and innocence that leaves us perplexed, due to being easily uncovered, what is absent or much less frequent in ASPD. As for pacifying behavior towards others: in A there is often a genuine desire to be forgiven, to ingratiate himself, with genuine regret and remorse. In ASPD, that pacifying behavior is essentially manipulative, instrumental, destined to be verbalized without being forgotten because it never was remembered. IPD is different even in terms of prognosis and it allows more hope of normative behavior than ASPD or psychopathy.

The DD can be done with BPD: the instability that is typical of BPD is also present in A. However, there are pronounced differences between A and BPD. For example, the feeling of boredom, of emptiness, is not present in A although it can be present in IPD. In IPD, pronounced anger modifications may occur. A does not present them, but they are more exuberant in BPD. And the anger is more brutal in BPD. Self-harming behavior may happen in IPD. A does not present it, but they are less common in IPD and more typical of BPD, particularly skin cutting. These emerge as a discharge of anger and cause relief in the individual with BPD, whereas in IPD, when the individual self-harms, this relief is rarely present. Harming oneself appears more in a context of impulse or despair, which the IPD individual tends to regret immediately, while the BPD individual assumes the relief this tension discharge brings them and most times does not regret the subsequent behavior caused by it. On the other hand, in BPD, alternating between idealization and devaluation is very pronounced, whereas in IPD, when present it is more related to a frustration determined by the individual who caused it, even if the individual with IPD may have improperly inflated this feeling of frustration, because the fact did not justify such distress. Mainly the individual with IPD allows us to understand that they do not have a sufficiently mature personality, they cannot outline a goal and if they have they are not given the credibility that they will pursue it, which is a feature that is not typical, nor integrates the diagnostic criteria of BPD. The DD can be done with HPD, but the HPD individual is more consistent in the orchestration of their life than the IPD person. In HPD, the individual evolves as if they were always onstage, feeling discomfort in situations in which they are not the center of attention. In IPD, the individual emotional and dramatic subtype may present similar behavior, but they do not tend to be as consistent and willing to always be onstage, and their speech is usually not as impressive as in HPD. The IPD individual tends to treat themselves less well, to be less consistent in the projects that guide them, to be more inconsiderate in their histrionic component. The greatest difference between HPD and IPD can be thusly summarized: the individual with HPD knows what their role is, they play it and enjoy taking the stage, whereas the IPD individual may be irresponsibly absent from a show that is playing, or throw a childish tantrum for a puerile reason, even if it creates difficulties for the entire theatre company. And, even though the individual with HPD may do this every now and then, the IPD individual tends to

repeat it, even due to a futility, as if they have never learned from the lessons they were given.

In the DD with NPD, the narcissist shows less instability, less frequent and unmotivated emotional changes, is less likely to be manipulated or feel regret than the IPD individual. The NPD individual is more consistent and presents themselves as consisting of a less porous cement and is less unpredictable, less prone to unexpected and self-harming behavior. The grandiose feeling of self-importance, the concern with fantasies of unlimited success, the belief that they are special, the need for excessive admiration, are cornerstones of NPD, but not of IPD. In IPD the individual behaves as if they are entitled to special rights, without necessarily having a grandiose feeling of self-importance. The IPD individual is much more the inability to tolerate frustration or to delay a desire in time that motivates the IPD individual, than fantasies of unlimited success, although the IPD individual may also eventually develop them.

In some immature individuals of the shy subtype, it may be difficult to perform a DD with AvPD. In AvPD, individuals show greater responsibility, greater stability in their avoidance condition, less unexpected and surprising behavior. On a family level, the AvPD individual tends to be more predictable and adequate, allowing other members of the family a greater sense of security and predictability, without displaying the childish behavior typical of IPD.

The DD with DPD demonstrates that, in DPD, individuals exhibit greater dependency than in the shy type of IPD, but without the behavioral modifications typical of IPD. Individuals with IPD are more demanding, more capricious, more imposing of their selfish demeanor, more aggressively reactive towards any frustration, they have less difficulty in making decisions, though they tend to burden others with their decisions – like a child who wants a dog at all costs, promises to care for it, but if the mother does not care the dog, the animal will not have a bright future. The immature person, as a rule, does not have difficulty in expressing disagreement with family members. In the immature person, the urgent need to substitute one intimate relationship for another is not as present as in DPD, however, they may remain focused in the relationship with their family of origin, or fancifully focus on a lost relationship that is going nowhere. They also do not display such a pronounced need to make excessive effort in order to obtain care and support from others, although they may adopt childish behavior in order to request/capture that support. But they do not have such a pronounced need as the DPD individual to volunteer themselves for unpleasant tasks. They tend to feel helpless, as does the DPD individual, when they are alone. They do not display as much concern as DPD individuals do, regarding unrealistically worrying about the fear of being left to fend for themselves. Both IPD individuals and DPD individuals may function with more or less pronounced limitations. But DPD does not entail the childish behavior typical of IPD.

The DD must also be done with Schizoid Personality Disorder (SPD). SPD individuals exhibit greater disinterest in relationships with others than individuals with the shy type of IPD. In fact, in SPD, the individual does not derive pleasure from close relationships. The IPD individual, even those of the shy subtype, does not have such a pronounced tendency as the SPD individual to isolate themselves. Indeed, the isolation of the IPD individual may emerge or worsen suddenly and temporarily (for example, when they sulk), as opposed to the isolation in SPD, which is stable and constant. On the other hand, whereas the SPD individual usually has little interest in sexuality, as a rule, that is far from happening in the IPD individual. In addition, unlike SPD individuals, IPD individuals are more likely to derive pleasure from more activities than SPD individuals, particularly those that require interaction with people, which is not characteristic of SPD individuals. Moreover, the IPD individual, unlike the SPD individual, tends to, sooner or later, confide in or open up to someone, often being incapable to keep a secret they were asked to keep. And, unlike the SPD individual, the IPD individual is not indifferent to compliments or criticism from others, on the contrary. Finally, the IPD individual rarely exhibits the emotional coldness, affective detachment or leveling of the SPD individual.

IPD Subtypes

As is apparent from the clinical cases presented, IPD is not presented as a single clinical type. IPD is a PD distinguishable from other PD and it is reasonable to subdivide it into three subtypes:

I. A more dramatic, emotional, and unstable subtype, with connotations of group B – the individual mixes characteristics of PD from group B of the DSM-5, but without sufficiently overlapping any of those PD (there may be, however, room to diagnose more than one PD).

II. A more shy subtype, closer to group C of the PD, especially Avoidant PD and Dependent PD, without forgetting that some immature individuals may display schizoid and even paranoid behavior. These individuals are more shy, more anxious and fearful in interactions with others than those from group 1, and may eventually isolate themselves or live in a small

circle. But they do not fulfill the criteria for AvPD or DPD. Some of these IPD individuals, however, besides displaying childish behavior, they also display a posture that is tyrannical and/or excessively demanding towards others.

III. A subtype, which we call a mixed type, integrating characteristics from type 1 and type 2.

Concerning the etiological factors of IPD, IPD is almost always a permissive education, notwithstanding the possibility of other factors, such as those of traumatic or infectious nature. Nourished by excessive and unhealthy indulgence, the individuals sometimes develop a feeling of uniqueness, of entitlement to a special status, not only within their family, but often in the world [14], other times they develop the inability to have autonomous, independent, assertive functioning, to be able to face the challenges of a mature individual. And, even if they intellectually do not possess that right, they act as if it were legitimate to benefit from a special, less responsible status [2].

When they are born into families of some wealth but not only some of these individuals integrate a conviction of superiority often fueled by their own parents, and they acquire behavior that is of unbearable boastfulness, arrogance, haughtiness, intemperate and abusive devaluation of others, which is underlined by a monstrous, given its excess, feeling of self-worth and inability to understand their own limitations, with the individuals revealing the most incredible lack of common sense and manners - a housemaid patient told us that the daughter of her mistress, a rude, immature girl, once told her: but you have an opinion? How can you have an opinion if you are nobody? This feeling that the individual has the right to offend others purposely or aimlessly, and often allow themselves to invade others beyond reasonable limits, is not a result of biological determination, but rather an educational process. Arrogant and vain, the individual will wander around as if the world owes them something, in which they mix characteristics from the B category of the DSM-5, but without sufficiently overlapping with any of those PD. Because, indeed, what they have is an IPD. Having discussed the etiological and clinical issues, how can one, therefore, support the existence of an IPD? How can one integrate it as an autonomous entity that stands out and differs from others? This difficulty is all the greater since, if there is a PD that deserves to be analyzed in a dimensional, and not categorical, perspective, it is IPD. Because the maturing process never stops occurring throughout life and it is not always easy to discern between behaviors that reflect immaturity and those that do not, and even if they reflect immaturity, knowing if it is sufficiently intense and comprehensive to be considered a PD. Furthermore, how many times does a mature individual behave inappropriately and immaturely? And does it make sense to consider them immature solely because they had that behavior? Almost always, it does not. Many characteristics of IPD will be found in many people who are healthy and adequately functioning. This work pretends to open a new light in this personality disorder being conscientiousness that much work will be needed to know how many diagnosis criteria will be necessary to make diagnosis of IPD. In a dimensional perspective the diagnosis of IPD will depend on clinical experience and the functional disturb that must be continuously presented by the individual.

Given the above, it seems essential to create, similarly to other PD, diagnostic criteria for IPD (Table 1) and subtypes of IPD (Table 2).

Discussion

Analysis of clinical case 1 and differential diagnosis allows to conclude that V., although has many features similar to AVPD and DPD, thus not present a AVPD, a DPD or any other specific personality disorder of DSM-5. However, she has a personality disorder because V. has a global pattern of inner experience that deviates markedly from the expected in the culture of the individual. And this pattern is manifested in 2 (or more) of the following areas: cognition, affectivity, interpersonal functioning, impulse control – in the case of V. about everything cognition and interpersonal functioning, but also affectivity. The global standard is inflexible and global in a wide range of personal and social situations and is long lasting and causes clinically significant malaise or deficits in social, occupational, or other important areas of functioning. The pattern is stable, long lasting and its onset occurred at the latest in adolescence or early.

Analysis of clinical case 2 and differential diagnosis allows to conclude that A., although fills criteria compatible with ASPD, does not present a ASPD or any other specific personality disorder of DSM-5. However, he has a personality disorder because he meets the criteria necessary to that diagnosis: a global pattern of inner experience that deviates markedly from the expected in the culture of the individual. And this pattern is manifested in 2 (or more) of the following areas: cognition, affectivity, interpersonal functioning, impulse control – in the case of A. about everything cognition, interpersonal functioning and impulse control, but also affectivity. The global standard is inflexible and global in a wide range of personal and social situations and is long lasting and causes clinically significant malaise or deficits

in social, occupational, or other important areas of functioning. The pattern is stable, long lasting and its onset occurred at the latest in adolescence or early.

Considering the criteria that we explained, V and A have IPD. However, V. and A. are very different from one another. This finding led us to consider that IPD must be divide in subtype shy, and a subtype more dramatic, emotional, unstable. Some individuals don't belong to subtypes shy or dramatic but have symptomatology of one and other subtypes and must be considered a mixed subtype. Criteria to diagnose IPD were advanced by our team. However much more study must be done on prevalence, development and course, diagnostic aspects related to culture, diagnostic aspects related to gender, associated characteristics that support the diagnosis, a better definition of the diagnostic criteria. Studies that help define the diagnostic criteria are fundamental for a better structuring of this personality type disorder. Similarity of some individuals with IPD subtype instable and some individuals with ASPD can originate diagnosis of ASPD and not of IPD. But they are not the same branch of the same tree, although they can overlapping some ASPD are also IPD - and have different prognosis and different risk of criminality and of violence.

Prognosis seems to us better in IPD than in ASPD but studies are necessary in this subject. Considering this, and because therapists often unleash in the treatment of ASPD, differential diagnosis can be very important to make distinction between these two types of personality.

Assessment of criminal individuals would benefit if IPD was considered a personality disorder. In forensic area (e.g., in jail, court penalty) it is important to separate IPD from ASPD. In jail because individuals with IPD considered ASPD by the judicial and prison system will be placed in situations in which they can be manipulated and abused by ASPD and other individuals with whom they are mixed in the jail; in court penalty because judges can have a different vision of the prognosis of IPD individuals who were confused with ASPD and consider them in a different way.

Studies are needed to understand if individuals with immature personality are diagnosed with behavioral disturbance (in adulthood) and with hyperactivity and attention deficit disorder (in adulthood).

References

1. World Health Organization (2011) Classificação de Transtornos Mentais e de Comportamento da CID-10. Porto Alegre, Artmed.
2. American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5th edn), Arlington, VA: American Psychiatric Publishing.
3. Zabala A (1998) A prática educativa: como ensinar. Porto Alegre: Artes Médicas Sul.
4. Cortesão E (1990) Narcisismo e Relações de Objecto: Os Trabalhos de H. Kohut e a Investigação das Relações de Objecto [Narcissism and Object Relations: H Kohut's Studies and the Investigation on Object Relations]. Revista da Sociedade Portuguesa de Psicanálise 8: 31-42.
5. Erikson E (1976) Identidade, Juventude e Crise. Rio de Janeiro: Zahar Editores.
6. Blair K, Newman C, Mitchell D, Richell R, Leonard A, et al. (2006) Differentiating Among Prefrontal Substrates in Psychopathy: neuropsychological Test Findings. Neuropsychology 20(2) 153-165.
7. Marion B, Sellbom M (2011) an Examination of Gender-Moderated Test Bias on the Levenson Self-Report Psychopathy Scale. J Per Ass 93(3): 235-243.
8. Moreira D, Almeida F, Pinto M, Barros S, Barbosa F (2015). Psychopathy in Women: A Brief Review of its Assessment and Subtypes. Psiquiatria, Psicologia & Justiça, 7: 49-64.
9. Wright J, Boisvert D, Vaske J (2009) Blood Lead Levels in Early Childhood Predict Adulthood Psychopathy. Youth Violence and Juvenile Justice 7(3): 208-222.
10. Anderson S, Bechara A, Damásio H, Tranel D, Damásio A (1999) Impairment of social and moral behavior related to early damage in human prefrontal cortex. Nat Neurosci 2(11): 1032-1037.
11. Damásio A (1994) Descartes' error*:* emotions, reason, and the human brain, Avon Books, New York.
12. Damásio A (2005) O Erro de Decartes. Emoção, razão e cérebro humano. Portugal: Publicações Europa-América.
13. Moreira D, Almeida F, Pinto M, Fávero M (2014) Psychopathy: A Comprehensive Review of its Assessment and Intervention. Aggre and Violent Beha 19(3):191-195.
14. Almeida F (1999) Homicidas em Portugal. Maia: Instituto Superior da Maia.