Classifying and treating personality disorders: back to the future?

In his Keynote Lecture, Professor Tyrer detailed what he saw as the shortcomings of the proposed criteria for DSM-5 and ways in which he hoped the next version of the International Classification of Disease and Related Health Problems (ICD-11) would provide a more practically useful set of criteria for diagnosing personality disorder.

The current description of personality disorder in ICD-10 is: ‘ingrained patterns of behaviour indicated by inflexible and disabling responses that significantly differ from how the average person in the culture perceives, thinks and feels, particularly in relating to others.’ DSM-IV-TR is more precise, describing personality disorder as: ‘An enduring pattern of psychological experience and behavior that differs prominently from cultural expectations, as shown in two or more of: cognition (i.e. perceiving and interpreting the self, other people or events); affect (i.e. the range, intensity, lability, and appropriateness of emotional response); interpersonal functioning; or impulse control.

Both classification systems include additional criteria, which in ICD-10 comment on the time course of symptoms and detail the types of behaviour and impact on the individual and society typically seen in people with personality disorder. In DSM-IV-TR the additional criteria add context to situations in which symptoms are observed, detail time course again and mention the importance of identifying other possible causes including other mental disorders and substance abuse as well as other medical conditions such as head trauma.

Focus on symptom severity

Professor Tyrer explained that these are, however, merely the general criteria that need to be satisfied before a specific diagnosis can be arrived at. However, in reality, Professor Tyrer argued, clinicians do not use the general criteria, they tend to jump straight to the specific diagnoses. In DSM-IV-TR a person is determined to have a specific diagnosis if they fulfill a specific number of criteria. In other words, said Professor Tyrer, there is in effect a cut-off point between having the disorder and not having it, which just does not reflect the real world situation. The symptoms of personality disorder, like so many psychiatric disorders, exist on a continuum. It is the severity of symptoms that changes from individual to individual, not whether they exist or not: everyone exhibits some aspects of the symptoms of personality disorder.

Currently there are 11 different personality disorders in the DSM/ICD classification systems. Professor Tyrer argued that the criteria for arriving at these 11 different diagnoses are not supported by good empirical evidence. ‘They are committee diagnoses,’ he contested. It appears that DSM-5 will...
continue in this vein with criteria for six specific personality disorder types. But these will be qualified by 37 personality traits. Some clinicians feel it will take at least a three-hour interview to diagnose someone with personality disorder properly using this system. It would be preferable to have something that is easy to understand and that can be used fairly easily so it is clinically useful. Professor Tyrer hopes ICD-11 might do something to improve matters.

A key issue, particularly perhaps for British psychiatrists, is whether personality disorder should be regarded as a mental illness or not. Kendell noted in the British Journal of Psychiatry in 2002: ‘If personality disorders are not to be regarded as mental illnesses despite their undisputed relevance to psychiatric practice, the obvious alternative is to regard them as risk factors and complicating factors for a wide range of mental disorders, in much the same way that obesity is a risk factor for diabetes, myocardial infarction, breast cancer, gallstones and osteoarthritis, and complicates the management of an even wider range of conditions.’

Professor Tyrer argued, ‘We have to make a clear distinction between personality traits, which are habitual long-lasting tendencies, and which are part of normal functioning (ego-syntonic), and symptoms, which are unpleasant and regarded as alien and undesirable (ego-dystonic).’

Preliminary recommendations for ICD-11 are to abolish all individual categories of personality disorder and replace them with four severity levels. Severity should be qualified by trait domains and there should be no age limits. The trait domains should remain secondary and not be regarded as primary as they often seem to be currently.

Professor Tyrer commented that the proposed trait domains were not exactly new. They correspond by and large to those described by Hippocrates in 422BC and Galen in 192AD (see Table 1). Under the proposed system for ICD-11, trait domains would be defined by monothetic rather than polythetic criteria such that all criteria must be present for each specific trait (see Figure 1). Severity would be determined by the number of domains involved (the more domains involved the greater the severity), by the degree of social dysfunction and the risk to the individual and to others (see Table 2).

Borderline personality disorder
Professor Tyrer stressed he was keen to avoid including the classification borderline personality disorder under the proposed new diagnostic criteria. Under the current diagnostic criteria it is such an
amorphous, heterogeneous group that almost anyone diagnosed with personality disorder could be classified as borderline, he said. Under the proposed criteria for ICD-11 people currently classified as having borderline personality disorder would fulfil criteria for internalising and externalising trait domains.

Professor Tyrer has previously argued (although he admitted that his was a minority view) that borderline personality disorder would be ‘better classified as a condition of recurrent unstable mood and behaviour, or fluxi-thymia’. The other problem that besets researchers trying to discover whether treatment for personality disorder works or not is that there is a lack of consistency in outcomes used, which makes meta-analysis difficult, Professor Tyrer commented.

The lack of a strong evidence base may explain the current lack of consensus about the use of pharmacotherapy for personality disorder. So although the current NICE guideline does not recommend drug treatment, some evidence is emerging that mood stabilisers, for example, may have some benefits. However, that needs to be confirmed in trials with satisfactory long-term outcomes, Professor Tyrer concluded.

References

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