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Theoretical Background in Personality Disorders: Clinical Problems and their Projection in DSM-5/ICD-11

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Original Article

SUMMARY

Analyze in depth the theoretical background of this specialty, being necessary for the welfare efforts of any physician. Since new classifications for mental disorders are soon to be introduced, we will briefly examine the history of personality disorders and our interest will be directed to problems we might encounter using the current diagnostic criteria, i.e., DSM-IV/ICD-10.

Key words: Personality disorders, historical background, diagnostic criteria.

RESUMEN

Profundizar en los fundamentos teóricos de la propia especialidad es algo necesario para la labor asistencial de cualquier facultativo en Medicina. Ante las ya inminentes nuevas clasificaciones sobre las enfermedades mentales, hacemos un breve repaso de la historia de los trastornos de personalidad y nos planteamos las principales dificultades que se ponen de manifiesto al hacer el diagnóstico de trastorno de personalidad siguiendo los actuales criterios DSM–IV/ CIE–10.

Palabras clave: Trastornos de personalidad, antecedentes históricos, criterios diagnósticos.

The need to analyze in depth the theoretical background of the clinical practice is not the exclusive domain of psychiatry: any physician must regularly review the theoretical background of his/her specialty. Accordingly, it is important to consider the imminent danger of letting oneself be overcome by the care given to the patient disregarding conceptual issues, which, in the end, allow to successfully carrying out actions related to evaluation and treatment.

In this paper we, firstly, perform a brief review of the history of personality disorders, aimed at a better understanding of same from a welfare perspective. Secondly, we focus on the current diagnostic criteria[1,2] analyzing some aspects and their application in daily clinical practice.

The different studies related to the history of personality disorders agree on mentioning Hippocrates (5th century BC) as the first author of mandatory reference when analyzing the relations between the psychic and the corporeality. Through his description of the four types of temperaments (melancholic, sanguine, choleric and phlegmatic), according to the relative proportion of the four body humors (black bile, blood, yellow bile and phlegm, respectively), he was not far from the starting point of a scientific medicine. However, it should be recalled that Hippocratic medicine emphasizes health as a whole and the value of the patient's approach like a comprehensive human being.[3]

Although there are several typological systems —such as Sigaud's typology, representing the French school of biotypology, for which the body type would result from the footprint that the environment leaves on the soma, without the intervention of heredity nor constitutional factors; or the Viola and Pende's system, from the Italian school, which looks for the genesis of the body type in biological laws—,[4] today the Kretschmer and Sheldon body types are the most frequently used.

Ernst Kretschmer, when studying the relationship between the morphological characteristics and the psychological properties, points out three main body types: pyknic, leptosomic and athletic. Body types are related to the char-

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acter styles: cyclothymic, schizothymic and viscous temperaments.[5] His school proposes a transition relationship between personality and mental illness, as we state below when properly reviewing the history of personality disorders. His studies were a starting point for William Herbert Sheldon's research who heads the Anglo-Saxon school and, subsequently, Conrad and Janzarik's research.[4]

Apart from the constitutionalist hypotheses, which would group individuals about few types of characteristic physical and psychic features, the modern history of personality disorders starts at the beginning of the 19th century, when psychiatrists like Pinel, Morel or Pritchard, among others, described some types of personality with social adaptation problems found in clinical practice. This would apply to subjects affected by what was described as "mania without delirium" (Pinel), "insanity of degenerating people" (Morel) or "moral insanity" (Pritchard), who showed a perversion of feelings, moral habits and impulses, without experiencing any intelligence or reasoning capacity problem, and with no hallucinations. These types correspond to what we currently know as "psychopathic personalities", one of the large approaches of character pathology.

At the beginning of the 20th century, and from a psychogenic or psychodynamic conception, Janet and Freud (and Charcot earlier), studied the psychological model of hysteria, which comes before the histrionic personality disorder. In this context, the psychoanalytic school described with the name of "character neurosis" to personality organizations relating to the characteristic structure of a stage of the libidinal development (this is how the sadomasochistic or the obsessive compulsive-character is described). Subsequently, and already in the framework of object relations, the psychoanalytic theory enunciates that the personality is shaped mainly during the early childhood from the parental relationships.[6]

Within this context it bears mention, due to their clinical repercussions, the characteristics of the neurotic self. It is likely that we have clinical experience on assessment of patients, usually women, with an extreme emotional sensitivity and traits of evident insecurity, which hinders the therapeutic relationship (and the interpersonal relations in general).

As described by Henri Ey when referring to semiotics of personality disorders, the neurotic self is a self that cannot solve his internal conflict of identification: I am not "myself" but the identification of "a character" that constitutes the ideal of me. Then, the neurotic "does not manage to assume the role of his character, becoming identified and authenticate with oneself; and it is on a kind of artificial game, in a false sense, that the neurotic lives through his anguish".[7] While being unable to solve the internal problem of his identification, the relationships with himself and with others are affected: the discomfort of the individual regarding himself and others is experienced like an anguish in which feelings of guilt, the desire to be punished, the disappointment of frustrations, inferiority complexes, etc, are mixed. Also, despite appearances, the anguish of the neurotic patient does not depend on the circumstances but it is internal and unconscious. These are some of the clinical aspects that are often considered a primary characteristic of neurotic patients.

From a different perspective, in the 1920's authors of the German school, headed by Kretschmer, described the types of personality like forms of transition of the paranoid and affective psychoses.5 These personality changes would match current paranoid, schizotypal or cyclothymic disorder of personality, according to criteria of DSM-IV (the ICD-10 neither include the schizotypal nor the cyclothymic disorder in the "Personality Disorders" section but in the "Schizophrenia, Schizotypal Disorder and Delusions Disorders" and in the "Mood Disorders" subsections, respectively). The interconnection between psychopathological personality and psychopathological disorder is one of the fields of maximum interest that is still open to research.[8]

German phenomenologist Kurt Schneider, on the contrary, considered that personality disorders represented deviations that exceeded the limits of personal variants average types, giving rise to well-defined clinical types. Therefore, he did not consider personality disorders as precursors of other, even more severe, mental disorders but as coexisting models (in this respect the American classifications from the DSM-III, published in 1980, place personality disorders on an axis different than the mental illnesses). Moreover, he developed a wide category system of personality disorders that established the model for many disorders considered in current classifications. Nevertheless, Schneider himself also pointed out the difficulty for making a plastic description of the psychopathic types.[9]

In any case, despite the dichotomy between the categorial and the dimensional is still open, the theoretical foundation of diagnostic categories for personality disorders has been gradually changed, and current descriptions try to represent a synthesis between clinical tradition and empirical findings.[10,11]

It is good that clinicians analyze in depth the theoretical background of our specialty, because reflection and discussion on the nature of the psychopathological disorders benefit clinical practice and facilitates the development of research.

Patients suffering personality disorders represent one of the main challenges for clinicians, since they force the therapist to implement, with the highest intensity, his own personal resources: how to treat patients that, usually, have the same difficulty to interact appropriately with others, and whose normal way to respond to the demands of the environment often aggravates even more such difficulties? Likewise, they may not recognize that the origin of their

problems lies in their own personality, thus they tend to hold others accountable for their situation, and they could even deny during a certain time the existence of any problem. The complexity of all these cases is increased because what is noted of patients with personality disorders is not only a problem of the person but something affecting the axis of what such person is. Thus, the mental pathology —and specifically personality disorders, unlike the general pathology— appears before us "not as a pathology of organic life that is more or less fatally threatening 'life', but as a pathology of psychic life that is threatening man in his humanity".[7]

When carrying out the diagnostic approach in the clinical practice we found a series of aspects that need to be addressed. For example, the ICD-10 considers that these disorders cover both lasting and deeply entrenched forms of behaviors on the patient, which manifest as stable modes of response to a wide range of individual and social situations.[2] On the other hand, the DSM-IV considers personality disorders as patterns of inflexible and maladaptive traits causing subjective discomfort, significant social or labor impairment—or both things.1 Then, considering personality disorders as chronic and steady patterns involves certain limitations. Actually, to what extent a personality trait may be considered inflexible? We all have experience on how some personality traits that we considered hardly subject to change can be modified. In this regard, it is possible to speak about a "personal development of character" or "development of personality" as for what we want to become, if such development does not occur automatically or spontaneously: it requires the assistance of our freedom. Also, if such traits are unchangeable or invariable, why do we try to modify them in the therapeutic relationship? Therefore, it is logical that in personality disorders as well there is an inner space more or less accessible to the therapist's guidance and to the external demands. The personality disorder concept is not equivalent to the impossibility for attaining a personal maturation.

Then, we may speak about "invariable" personality traits in the sense that they are stable enough to identify the habit and the reactivity style of each, but without forgetting that the personality system is precisely the self while being "owner of his nature, actor of his character, craftsman of his world and subject of his knowledge",[7] and, in this regard, we always may make changes modifying such reaction style that is hindering an appropriate development of the self.

These traits —still according to the ICD-10—[2] represent extreme or at least significant deviations of the way the normal individual of certain culture perceives, thinks, feels and, especially, relates to others, or must markedly keep away from the cultural expectations or standard, in accordance with the DSM-IV.[1] This last classification also states that the deviation must become apparent in more than one of the following areas: cognitive, affective, of impulse control, of the need for gratification and of the way of relating to others.[1]

It should be noted that the "extreme or significant deviation" or the "standard" to which the Manuals refer is not to be interpreted in terms of quantity (deviations of the statistical average): a person shall not have a personality disorder according to the intensity of his/her intellective, affective, among others, personal experiences. It is not about a quantitative matter but assessing to what extent there is a real difficulty in such individual so that he behaves appropriately. This can be noticed through the interpersonal relationship established in the clinical interview, which is the key tool for the diagnosis and for the conceptualization of the mental disorder. Thus, what we have to ask ourselves is not to what extent the behavior of a certain person is extreme from the quantitative point of view, but to what extent his/her behavior is a consequence of a previous limitation in the personality that compromises the possibilities to satisfactorily complete his/her development as a person.

Additionally, when making a diagnosis of personality disorder, not only we have proven a socially inappropriate behavior, but also a clinically significant discomfort, or social or labor functioning impairment or other important areas of the subject's activity.[1,2] Actually, if there were a lack of functional impairment one could speak of a set of symptoms but the term "disorder" should not be used (a different issue would be how to measure the functional impairment).[11]

Finally, both the ICD-10 and the DSM-IV also coincide in the temporary criterion: the deviation should have established chronically from adolescence or the beginning of adulthood and be persistent. That is to say, it should occur on a wide variety of situations rather than in a specific trigger situation or in response to a particular stimulus. Likewise, it is necessary that the alteration of the personality is not attributable to a brain damage or brain disease or to other psychiatric disorders.

These brief reflections, and many others that could be made, lead us, yet again, to Henri Ey's thought, which after mentioning that for the clinical psychiatrist theories have remained in the background of his concerns, he insists that —in any case— it is unavoidable to refer to a theoretical approach that compels him —even to his own regret— to determine his position in the light of the difficult problems in which he necessarily puts into question his conception and his therapeutics of the mental illness. Therefore, he is definitely "compelled to adopt a certain way of judging or prejudging the relations between physical and moral aspects, between brain and thought, between the constitution of the person and the environment, etc".[7] The theoretical position of each one shall be determined by the school to which he belongs or to which he is most identified, either psychodynamic, biomedical o sociocultural.

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The definitions and criteria on personality disorders may be more or less useful, but what is important is the fact that we —as clinicians— are capable of identifying such disorders in our patients. In the first place, because they are people who need specialized help (unlike other mental health problems that may be attended in the field of primary health care), an "individualized treatment plan", which we would refer to using today's language of public health care systems; secondly, because having a personality disorder not only creates particular problems on the person suffering from such a disease but within the family, labor and social environment (even with legal implications); thirdly, because they are disorders that often interfere in the evolution of another coexisting mental disorder, either of an affective, food or addictive nature, etc. As a matter of fact, it is found that affective disorders are common on personality disorders, thus it would be interesting to explore the possible comorbidity, since it has several implications on the treatment and on the global results of any therapeutic approach.[12]

Regarding future international classifications of illnesses and trends appearing on their approaches, the current debate is revolving around the possibility to improve the representation of personality disorders in the DSM-5 and in the ICD-11. As previously mentioned, the discussion on whether personality disorders are better classified as dimensions or as categories is still open: are personality disorders better described as dimensional representations of diagnostic categories or dimensional ends of the overall functioning of personality, or as categorial representations in themselves?

Although, certainly, the categorial models applied to the personality disorders have facilitated a common language and have been of widespread use in research, also their limitations are known: the overlapping among diagnoses, the great heterogeneity in patients who receive the same diagnosis, the arbitrary limits between the normal and pathological functioning of personality, and the difficulty to cover the different psychopathological conditions, so that the diagnosis of the "non-specified" personality disorder is the most common.

Such difficulties make it necessary to clarify whether mental disorders in general, and personality disorders in particular, would not be better represented in the form of psychopathological dimensions than through multiple categories.[13] Actually, some authors do not hesitate to assert the necessity to develop dimensional models of diagnosis,[14] and several dimensional models are offered as a solution to problems that the categorial diagnosis poses.[11]

Most of the clinicians, however, are not familiar with the dimensional models but with the medical model, where a single diagnosis may convey a great deal of information about the problems of the patient, the treatment and the most likely forecast. At all events, the dimensional model advocates state that some clinical phenomena in medicine, such as blood pressure, have a continuous distribution although they lead to a categorial diagnosis (for example, hypertension), once cut-off points compatible with illness and with need for treatment are established.

The bibliography published in relation to the future of the personality disorders classifications does not exclude that the next diagnosis manuals are based on a hybrid model including the following aspects: 1. an overall assessment of the functioning of the personality covering from what is considered normal to what is seriously deteriorated; 2. prototype descriptions of the main personality disorders; 3. an exam of personality traits based on prototypes, but that may be also used to describe the main characteristics of patients who, either do not have a personality disorder or have a personality disorder that does not fit into any of the prototypes; 4. general criteria of personality disorder that providing for the deficit in the differentiation and integration of the self and in the capacity to establish interpersonal relations; 5. measures of an adaptive or appropriate functioning of the person.[15]

Regardless of whether the research on these topics may modify —to a greater or lesser extent— the forecasts, a trend is discernible for the substitution of current classifying categorial models (DSM-IV, CIE-10), based on a descriptive psychopathology of mental illnesses (lists of symptoms), for dimensional or combined models including, among other measures, assessments of the normal personality traits, thus leading to wider approaches that may allow a better understanding of the personality psychopathology.

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