Personality disorder diagnosis

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Every person has a characteristic manner of thinking, feeling, and relating to others. Some of these personality traits can be so dysfunctional as to warrant a diagnosis of personality disorder. The World Health Organization's International Classification of Diseases (ICD-10) includes ten personality disorder diagnoses. Three issues of particular importance for the diagnosis of personality disorders are their differentiation from other mental disorders, from general personality functioning, and from each other. Each of these issues is discussed in turn, and it is suggested that personality disorders are more accurately and effectively diagnosed as maladaptive variants of common personality traits.

Key words: Personality, personality disorder, antisocial, borderline, diagnosis

Every person has a characteristic manner of thinking, feeling, behaving, and relating to others (1). Some persons are typically introverted and withdrawn, others are extraverted and outgoing. Some are invariably conscientious and organized, whereas others are consistently carefree. Many of these traits, however, can be problematic and even maladaptive. If one or more of them result in a clinically significant level of impairment to social or occupational functioning or personal distress, it would be appropriate to suggest that a disorder of personality is present. The World Health Organization's International Classification of Diseases (ICD-10) (2) includes ten personality disorder diagnoses, as does the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (3). However, there are important differences between these two prominent nomenclatures (Table 1). For example, ICD-10 does not include narcissistic personality disorder, DSM-IV does not include enduring personality change after catastrophic experience or enduring personality change after psychiatric illness, and ICD-10 classifies the DSM-IV schizotypal personality disorder as a form of schizophrenia rather than a personality disorder (4).

No section of ICD-10 or DSM-IV lacks a diagnostic issue or controversy. Three issues of particular importance for the diagnosis of personality disorders are their differentiation from other mental disorders, from general personality functioning, and from each other. Each will be discussed in turn.

AXIS I AND II

In DSM-IV (3), personality disorders (along with mental retardation) are diagnosed on a separate axis (Axis II). ICD-10 (2) does not include a multiaxial system. There are compelling reasons for the separate axis placement. Personality disorders can provide a disposition for the onset of many of the Axis I disorders, as well as have a significant effect on their course and treatment (5,6). The reason that the authors of the multiaxial system of DSM-III wanted to draw attention to personality disorders was precisely because of the "accumulating evidence that the quality and quantity of preexisting personality disturbance may… influence the predisposition, manifestation, course, and response to treatment of various Axis I conditions" (7).

In addition, "personality features are typically ego-syntonic and involve characteristics that the person has come to accept as an integral part of the self" (8). Personality traits are integral to each person's sense of self, as they include what people value, how they view themselves, and how they act most every day throughout much of their lives. Most Axis I disorders, like most medical disorders, are experienced by persons as conditions or syndromes that come upon them. Personality disorders, in contrast, will often concern the way persons consider themselves to be.

Finally, personality disorders can be related conceptually to the general personality functioning evident in all persons, the assessment of which would be of potential relevance to virtually every psychiatric patient. Some of these personality traits will be problematic to treatment, and others will be facilitative. Much of the research on the contribution of personality to the etiology of Axis I disorders has in fact concerned personality traits, such as neuroticism, introversion, and sociotropy, that are evident within general personality functioning (5,6).

The placement of personality disorders on a separate axis has been effective in increasing their recognition in clinical settings, but perhaps the pendulum has swung so far that clinicians and researchers are now confusing Axis I disorders with personality disorders (9). The boundaries of the anxiety, mood, and other Axis I disorders have also been expanding with each edition of the diagnostic manual. Axis I now includes diagnoses that shade imperceptibly into normal personality functioning and have an age of onset and course that are virtually indistinguishable from

a personality disorder (e.g., generalized social anxiety and early onset dysthymia). Some clinicians and researchers have therefore suggested that the multiaxial system be abandoned and others have even proposed that the personality disorders be deleted altogether from the diagnostic manual and replaced by early onset and chronic variants of existing Axis I disorders (10). A precedent for this proposal is the ICD-10 classification of DSM-IV schizotypal personality disorder as a variant of schizophrenia (2).

Many of the existing personality disorders could not be replaced meaningfully by an early onset variant of an Axis I disorder, notably the narcissistic, dependent, and histrionic. One potential solution might be to simply delete them. The loss of the narcissistic personality disorder might not be missed internationally, as it is already excluded from ICD-10 (2). Clinicians with a neurophysiological orientation may also fail to miss the dependent and histrionic diagnoses, as they lack any meaningful understanding from this theoretical perspective (11). Another potential solution would be to include a new section of the diagnostic manual for disorders of interpersonal relatedness (12). DSM-IV and ICD-10 currently have sections devoted to disorders of mood, anxiety, impulse dyscontrol, eating, somatization, sleep, substance use, cognition, sex, learning, and communication but, surprisingly, no section devoted to disorders of interpersonal relatedness. Interpersonal relatedness is a fundamental component of healthy and unhealthy psychological functioning that is as important to well being as the existing sections of the diagnostic manual. A new section devoted to disorders of interpersonal relatedness would provide marital and family clinicians with a section of the manual that is more compatible with the focus of their clinical interventions (10) and would account for much of the personality disorder symptomatology that is not well accounted for by existing Axis I diagnoses (12,13).

There are, however, significant problems with both options. Both would remove from the diagnostic manual any meaningful reference to or recognition of the existence of personality functioning, for which there is substantial and compelling empirical support (1). In addition, reformulating personality disorders as early onset and chronic variants of existing (or new) Axis I disorders may simply create more diagnostic problems than it solves. For example, persons have constellations of maladaptive personality traits that are not well described by just one or even multiple personality disorder diagnoses (9,13). These constellations of maladaptive personality traits will be even less well described by multiple diagnoses of 'comorbid' mood, anxiety, impulse dyscontrol, delusional, disruptive behavior, and interpersonal disorders (12).

DIFFERENTIATION FROM GENERAL PERSONALITY FUNCTIONING

Researchers have been unable to identify a qualitative distinction between normal personality functioning and personality disorder (9,10,13). DSM-IV and ICD-10 provide specific and explicit rules for distinguishing the presence versus absence of each of the personality disorders, but the basis for these thresholds are largely unexplained and are weakly justified (14). The DSM-III schizotypal and borderline personality disorders are the only two for which a published rationale has ever been provided (4).

The heritability and structure of personality disorder symptomatology is as evident within general community samples of persons lacking the personality disorders as it is in persons who have been diagnosed with these disorders (15). All of the fundamental symptomatology of the personality disorders can be understood as maladaptive variants of personality traits evident within the normal population (16). For example, much of the symptomatology of borderline personality disorder can be understood

Table 1 Personality disorders in ICD-10 and DSM-IV

ICD-10	DSM-IV[a]
Paranoid	Paranoid
Schizoid	Schizoid
Schizotypal[b]	Schizotypal
Dyssocial	Antisocial
Emotionally unstable, borderline type	Borderline
Emotionally unstable, impulsive type	
Histrionic	Histrionic
	Narcissistic
Anxious	Avoidant
Dependent	Dependent
Anankastic	Obsessive-compulsive
Enduring personality change after catastrophic experience	
Enduring personality change after psychiatric illness	
Organic personality disorder[c]	Personality change due to general medical condition[d]
Other specific personality disorders and Mixed and other personality disorders	Personality disorder not otherwise specified

[a] Included within an appendix to DSM-IV are proposed criteria sets for passive-aggressive (negativistic) personality disorder and depressive personality disorder.
[b] ICD-10 schizotypal disorder is consistent with DSM-IV schizotypal personality disorder but included within the section of Schizophrenia, schizotypal, and delusional disorders.
[c] Included within section of Organic mental disorders.
[d] Included within section of Mental disorders due to a general medical condition not elsewhere classified.

as extreme variants of the angry hostility, vulnerability, anxiousness, depressiveness, and impulsivity included within the broad domain of neuroticism (17). Similarly, much of the symptomatology of antisocial or dyssocial personality disorder appears to be extreme variants of low conscientiousness (rashness, negligence, hedonism, immorality, undependability, irresponsibility) and high antagonism (manipulative, deceptive, exploitative, aggressive, callous, ruthless) that are evident within the general population (18,19).

PERSONALITY DISORDER DIAGNOSTIC CO-OCCURRENCE

Patients often meet diagnostic criteria for more than one personality disorder (20,21). Some patients may even meet criteria for five or more personality disorders (22,23). Comorbidity is a pervasive phenomenon across both axes of DSM-IV that has substantial importance to clinical research and treatment (21,24), yet comorbidity may be grossly under-recognized in general clinical practice (25). Clinicians tend to diagnose personality disorders hierarchically. Once a patient is identified as having a particular personality disorder (e.g., borderline), they often fail to assess whether additional personality traits are present (26). Multiple diagnoses are not provided by practicing clinicians, perhaps because they are problematic to the "categorical perspective that personality disorders are qualitatively distinct clinical syndromes" (3).

The intention of ICD-10 and DSM-IV is to help the clinician determine which particular mental disorder is present, the selection of which would purportedly indicate the presence of a specific pathology that will explain the occurrence of the symptoms and suggest a specific treatment that will ameliorate the patient's suffering (8). It is evident, however, that DSM-IV routinely fails in the goal of guiding the clinician to the presence of one specific disorder (27). Despite the best efforts of the leading clinicians and researchers who have been the primary authors of each revision of the diagnostic manual, diagnostic comorbidity rather than the presence of one particular mental disorder is the norm (24).

Personality and personality disorders appear to be the result of a complex interaction of biogenetic dispositions and environmental experiences that result in a wide array of adaptive and maladaptive personality traits. Providing a

Table 2 Description of the five factor model of general personality functioning (adapted from Widiger et al [33])

Neuroticism versus emotional stability		
	Anxiousness:	wary, apprehensive, tense, fearful *versus* relaxed, unconcerned, cool
	Angry hostility:	hypersensitive, bitter, angry, rageful *versus* even-tempered, good-natured
	Depressiveness:	worried, pessimistic, despondent *versus* not easily discouraged, optimistic
	Self-consciousness:	timid, embarrassed, ashamed *versus* self-assured, glib, shameless
	Impulsivity:	tempted, urgent, dyscontrolled *versus* controlled, restrained
	Vulnerability:	fragile, helpless, panicked *versus* stalwart, unflappable, brave, fearless
Extraversion versus introversion		
	Warmth:	warm, cordial, attached, affectionate, loving *versus* cold, aloof, indifferent
	Gregariousness:	sociable, outgoing, can't tolerate aloneness *versus* withdrawn, isolated
	Assertiveness:	forceful, dominant, bossy *versus* unassuming, quiet, resigned
	Activity:	active, energetic, frantic *versus* inactive, passive, lethargic
	Excitement-seeking:	daring, reckless, foolhardy *versus* cautious, monotonous, dull
	Positive emotions:	high-spirited, giddy, euphoric *versus* serious, austere, placid, anhedonic
Openness versus closedness to experience		
	Fantasy:	imaginative, unrealistic, dreamer *versus* practical, concrete, sterile
	Aesthetic:	aesthetic, aberrant, preoccupied *versus* unappreciative, no interests
	Feelings:	aware, responsive, preoccupied *versus* constricted, alexythymic
	Actions:	open, exotic, unconventional *versus* routine, repetitive, monotonous
	Ideas:	creative, odd, peculiar, aberrant *versus* pragmatic, realistic, closed-minded
	Values:	broad-minded, permissive *versus* traditional, inflexible, dogmatic
Agreeableness versus antagonism		
	Trust:	trusting, naive, gullible *versus* skeptical, cynical, suspicious, paranoid
	Straightforwardness:	honest, open, confiding *versus* shrewd, cunning, manipulative, deceptive
	Altruism:	generous, self-sacrificing *versus* stingy, selfish, greedy, exploitative
	Compliance:	cooperative, docile, meek *versus* oppositional, combative, aggressive
	Modesty:	humble, self-effacing, self-denigrating *versus* confident, boastful, arrogant
	Tender-mindedness:	kind, empathic, gentle, soft-hearted *versus* tough, callous, ruthless
Conscientiousness versus undependability		
	Competence:	able, efficient, perfectionistic *versus* relaxed, carefree, lax, negligent
	Order:	organized, ordered, methodical *versus* intuitive, haphazard, sloppy
	Dutifulness:	dependable, principled, rigid *versus* casual, undependable, unethical
	Achievement:	ambitious, diligent, workaholic *versus* relaxed, aimless, desultory
	Self-discipline:	devoted, dogged, single-minded *versus* indulgent, hedonistic, negligent
	Deliberation:	reflective, circumspect, ruminative *versus* intuitive, hasty, careless, rash

diagnosis that refers to a particular constellation of traits can be useful in highlighting features that would be evident within a prototypic case (e.g., 19), but a categorical diagnosis will suggest the presence of features that are not in fact present and will fail to identify important features that are present (13). A single DSM-IV personality disorder diagnosis will fail to adequately describe the complexity and individuality of any particular person's personality profile.

CONCLUSIONS

"Personality disorders are now at a crossroads with respect to theory, research, and conceptualization" (28). The diagnosis of personality disorders should perhaps follow the lead taken by its brethren on Axis II, mental retardation (29). Mental retardation, like personality disorders, is diagnosed at an arbitrary but meaningful point of demarcation along a multivariate and continuous distribution that shades imperceptibly into normal psychological functioning.

A number of alternative dimensional models of personality disorder have been developed, many of which were outlined in the Journal of Personality Disorders' first two issues of the 21st century (29-32). Table 2 provides a brief description of the five factor model of general personality functioning, including illustrations of both the adaptive and maladaptive aspects of each of the two poles for each of its 30 facets (33).

An important question for the eventual clinical application of a dimensional model is how it would be used by a clinician to render a personality disorder diagnosis. It remains unclear if simply an elevation on a particular personality scale would warrant a diagnosis (e.g., self-directedness or neuroticism), whether a disorder could be suggested instead by particular constellations of maladaptive personality traits (e.g., high antagonism and low conscientiousness), and whether a separate, independent assessment of social and occupational functioning or personal distress should be required. Several approaches have been taken to try to delineate personality disorder from normal personality traits using a dimensional system. For example, Cloninger (30) suggests that the presence of a personality disorder would be diagnosed by levels of cooperativeness, self-transcendence, and, most importantly, self-directedness (the ability to control, regulate, and adapt behavior); the specific variants of personality disorder would be determined by the temperaments of novelty seeking, harm avoidance, reward dependence, and persistence. Livesley and Jang (31) propose an assessment of self-pathology as a fundamental distinction between personality and other mental disorders. Widiger et al (33) provide a four step procedure. The first step is a description of an individual's personality structure in terms of the five-factor model; the second is the identification of problems and impairments associated with these personality traits (a comprehensive list of problems and impairments associated with each of the 30 facets of the five factor model is provided); the third is a determination of whether these impairments reach a specified level of clinical significance (modeled after Axis V of DSM-IV); and the fourth is a matching of the personality profile to prototypic cases to determine whether a single, parsimonious diagnostic label could or should be applied.

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