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Editorial

Why we need to take personality disorder out of the doghouse

Peter Tyrer

Summary

The diagnosis of personality disorder is sometimes tolerated but often reviled as a label to attach to people we do not like. This is hardly surprising when we consider that problems in interpersonal relationships constitute the main feature of the disorder. But we cannot escape the fact that personality problems are extremely common and rejection on grounds of perceived undesirability is doltish. Both the DSM-5 (2013) alternative model and new ICD-11 classification of personality may help understanding as they are more in tune with science. Most of the previous classifications have failed to help practitioners or patients.

Declaration of interest

The author was the chair of the ICD-11 Revision Group for the Classification of Personality Disorders of the World Health Organization between 2010 and 2017.

Keywords

Stigma and discrimination; social functioning; personality disorders; epidemiology; nosology.

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Some highly personality disordered people are my best friends. This statement should be made more often. I know a singer who reboots as a male Florence Foster Jenkins (pushing to the front and singing loudly and out of key, yet insisting he is the only one in tune); am amused by the self-important actress who cannot stop talking about herself and is always promoting her limited talents; and tolerate the angry young man who makes dark threats at those who annoy him, but his menacing mien is never followed up by action and really is a sham. They all have great difficulty in understanding how others feel and act, but it does not make them unlikeable as they have other qualities that are endearing.

In common parlance we might consider these people as oddballs or eccentrics as the words 'personality disorder' are too stigmatising to utter. In psychiatry we take the same stance, rarely using the term unless we are forced to do so or work in forensic services where it is standard nomenclature. But this is taking diagnostic sensitivity too far. We now have abundant evidence from across the world that personality disorder is present in 6–12% of the population,[1] with much greater prevalence in psychiatric patients. Of course, these figures immediately give rise to allegations of inappropriately medicalising normal human variation, but this criticism needs to be paused, even though it at first seems incomprehensible. Recent findings have shown that relatively mild personality disorder is associated with higher psychopathology, more frequent use of health services[2] and greater costs compared with those without personality pathology, all of which steadily increase over time. Even if further research suggests the boundaries of diagnosis have been set too low, at least the subject will not have been ignored.

So how do we proceed? Some want to abolish the term personality disorder altogether, whereas others want to give it a new – more fragrant – title, hoping that it can rise from the swamp of stigma. But however we deal with it, the term will not go away and it would be utterly asinine to ignore it or dismiss it as prejudicial or unscientific. There are now two new lexicons of personality disorder. The first is the DSM-5 alternative models classification which was placed in Section 3 (for further study) by the American Psychiatric Association but has now achieved general support, particularly in the form of the DSM-5 personality model whose operation is linked to a valuable scale, the Personality Inventory for DSM-5[3] that scores 25 personality traits. The second is the ICD-11 classification[4] that essentially puts personality status into five groups. At one end we have 'normal personality', which might be possessed by a minority of the population and which is apparently a desired state. Next we have personality difficulty, a term which most people seem to readily accept, that covers problems in interpersonal function confined to certain situations only. It is very common. We then have the standard adjectives of mild, moderate and severe that we apply to depression, but in this case are attached to personality disorder. At each level, five trait domains that describe the form of the personality disorder can be attributed: negative affectivity, anankastia, dissociality, detachment and disinhibition. Although the DSM-5 and ICD-11 models appear to be very different, they are surprisingly similar because the five higher order traits in DSM-5 are almost exactly the same as the ICD-11 domain traits, with only schizotypal traits – regarded as part of the schizophrenia spectrum in ICD but as a personality dimension in DSM – differing in the two systems. Recent studies show the two classifications fit in well[5] and that the alternative DSM-5 model is becoming the option of choice in most countries that use DSM.

We also need to address the words personality disorder, which many would like to dispense with altogether. This could be done at the stroke of the pen. 'Dispositional disorder' and 'social incongruity disorder' come to mind, but as they describe the same condition there would just be a short delay before stigma was attached again.

But the stigma can be removed, first of all by psychiatrists. Nearly half of all psychiatric out-patients or people served by community mental health teams have personality disorders, almost all in the mild and moderate group, but we ignore this diagnosis and treat them no differently from all the others, even though in private we mutter about their foibles. Where we have been stigmatising is in our casual use of adjectival labels such as narcissistic, histrionic and schizoid. These have been taken up with gusto by journalists and other commentators. They are dispensed like confetti at every personal quarrel, particularly when politicians are involved. As a consequence the existing classifications have been grossly undermined. We have also been late to appreciate that those whose personality problems are a direct consequence of trauma and abuse

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might be better classified as complex post-traumatic stress disorder, a new diagnosis in ICD-11 that should help greatly in understanding the relationship between trauma and personality.[3] In particular it should help the diagnosis of borderline personality disorder to become less heterogeneous and at last to give it a name that is not just a blurred edge of the diagnostic jigsaw. A borderline personality pattern is still permitted as a qualifier in ICD-11 but only after severity of personality status has been coded.

One of the advantages of classifying personality disorder on a single spectrum is that one of the main bugbears of existing classifications, comorbidity, is instantly abolished. We are where we are on the personality scale; we cannot be on two places at once. The problem of comorbidity is best illustrated by the extensive use of 'personality disorder not otherwise specified' or 'mixed personality disorder' in current practice. Practitioners cannot fit their patients' personalities into clear diagnostic boxes and so abandon any effort to be specific. We can also record progress in treatment much better as the five-item disorder scale is so much more sensitive than the brutal dichotomy of 'no disorder' versus 'disorder'.

With easier diagnosis the position of personality disorder in the general scheme of classification should become clearer. For far too long personality status has been an also-ran in the diagnostic system. It is now becoming clearer that common disorders such as depression and anxiety persist because of personality difficulties, not because they are resistant or in some way different from others. If we spent a fraction of the time and effort into improving the personality elements of the disorder than we do to the pathological symptoms we would serve the cause of recovery much better.

Above all, we must not be timid about acknowledging the presence of personality disorder to all those who suffer from it. By using the term widely and openly there is bound to be abuse and criticism at first[5] but this will slowly attenuate with the accumulated advantages of greater understanding. It may also be premature to ask for a formal personality assessment to be made of people whenever they are seen for any form of psychiatric assessment. But it aids understanding and management greatly, and the extra time needed to do this – only about 15 min in total – pays off in the longer term. Some may scoff at the notion that personality can be assessed in only a few minutes of interview, but a good psychiatric formulation identifies many personality features and these can be reinforced by short screening questionnaires that take only a few minutes to complete. We certainly need easier methods of assessing personality disturbance but the new classification is already leading to simpler forms of assessment. This diagnostic approach can also be used by people with relatively little psychiatric training because the central core of disturbance, persistent difficulties in interpersonal social function, is not difficult to identify. But much of this is conjecture at present as the new system of looking at personality disorder has only just been introduced and is becoming more closely linked to the revised DSM system. The new kid on the block is demanding attention; please listen and note.

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