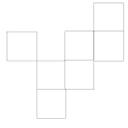


# Why we need a new classification of personality disorders

Professor Roger Mulder

Department of Psychological Medicine

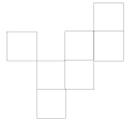
University of Otago, Christchurch



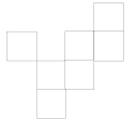
# Acknowledgements

Peter Tyrer  
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Lee Anna Clark





1. Problems with current classification system.
2. Evidence base for proposals to change.
3. ICD 11 proposal (DSM 5 proposal).
4. Ongoing challenges.

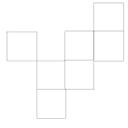


## Problems with current classification system

### 1. Erroneous Assumptions

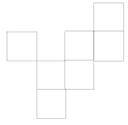
- The assumption that PDs are distinct from normal personality is wrong. The implication is that a classification should show continuity with normal personality and have a dimensional range of severity.
- The DSM IV assumption that the features of PD are organised into 10 diagnostic categories is wrong. We need a scientific classification that reflects the empirical structure of PD.

(Livesley, 2011)



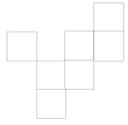
## Practical problems arising from these erroneous assumptions

- Extensive diagnostic overlap posing a serious challenge to validity and clinical utility (Mulder & Joyce, 1997; Widiger & Clark 2000).
- Most PD categories are ignored – PD diagnoses consist almost exclusively (97%+) of BPD, ASPR or PD NOS in Australia and New Zealand (MoH data).
- The high rates of PD NOS suggest the system cannot adequately classify up to 40% of cases.
- Criteria sets identify highly heterogenous samples even in the categories (BPD and ASPD that are used (Lyklen 2006; Stone 2010).



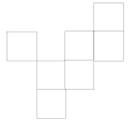
## Reaction to practical problems

- Dissatisfaction: 75% of experts dissatisfied with DSM IV (Berstein et al 2007).
- Ongoing use of selected unsatisfactory categories as if they were discrete homogenous entities.
- Resistance to change.



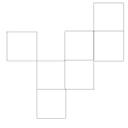
## How did this happen?

- Expert committee focused on opinion not evidence.
- Attracted by clinical descriptions of Schneider, Kernberg, Gunderson.
- Ignored evidence that there were no discrete categories.
- Ignored the work of trait psychologists.
- No attempt to link diagnosis to treatment.



## Step 1: Defining the severity of PDs

- Consistent evidence that PD symptoms are an example of dimensional diagnosis in psychiatry (Clark et al. 1990, Widiger et al. 1987, 2003).
- However because severity is rarely evaluated there is no good evidence that using it has clinical validity or reliability.
- Review of literature on severity and PDs.

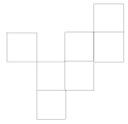


## Step 1: Defining the severity of personality disorders

Definitions of severe mental illness.

- **Diagnosis:** severe mental illnesses were restricted to psychoses, major affective disturbance and organic brain syndromes
- **Disability:** with a requirement that there was reduced functional capacity in three areas of daily life (such as economic self-sufficiency, interpersonal relationships and recreation)
- **Duration:** in order to be severe the illness needed to have persisted over at least three months and resulted in either prolonged or repeated short admissions to hospital.

Goldman et al. Hospital & Community Psychiatry, 1981;32:21-27

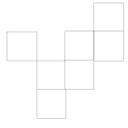


## Severity of personality disorder

Crawford et al. review all articles using the term 'severe PD' 5 main themes emerged.

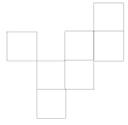
- Some categories of PD are considered more severe than others (notably cluster A and Cluster B are considered more severe than cluster C);
- The greater the number of features of a specific personality disorder the more severe the PD;
- The greater the number of specific categories of personality disorders a person has the greater the severity of PD;
- The greater the level of impairment of social functioning the more severe the personality is;
- Personality disorder is more severe when it is associated with a risk of harm to self or others.

Crawford et al. *Journal of Personality Disorders*, 2011;25(3):321-330



## Empirical evidence

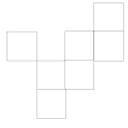
- The higher the numbers of BPD symptoms the greater the numbers of specific PD categories patients fulfil. (Dolan et al. *British Journal of Psychiatry*, 1997;171:274-279).
- Complex PD more likely to be unemployed. (Tyrer, *Clinical Medicine*, 2008;8:423-427).
- Complex PD associated with more self-harm. (Blasco-Fontecilla et al. *Acta Psychiatrica Scandinavica*, 2009;119:149-155).
- Complex PD associated with higher levels of mental disorder and substance abuse problems and more disability. (Pulay et al. *Journal of Personality Disorders*, 2008;22:405-417).
- Social dysfunction higher in people with PD (Tyrer et al. *Psychological Medicine*, 2004;34:1385-1394) and those with cluster A and B PDs compared to cluster C (Skodol et al. *Psychological Medicine*, 2005;35:443-451).



## Personality difficulty

A longstanding disturbance in an individual's way of viewing the self, others and the world, emotional experience and expression, and patterns of behaviour that impairs some aspects of social functioning and interpersonal relationships. However, impairment in functioning is not as severe as that found among people with PD and are seen only in social and interpersonal context.

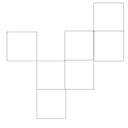
? Z code of 'factors influencing health status'.



## Personality disorders (definitions)

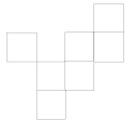
A longstanding pervasive disturbance in an individuals:

- a) way of viewing the self, others and the world.
- b) emotional experience.
- c) patterns of behaviour that impair social functioning and interpersonal relationships.



## Personality disorder: diagnostic guidelines

- A diagnosis of a PD requires evidence that the person's enduring patterns of inner experience and behaviour deviate from the culturally expected and accepted range. Such deviations is manifest in at least two of the following areas: cognition, emotional experience and expression and patterns of behaviour.



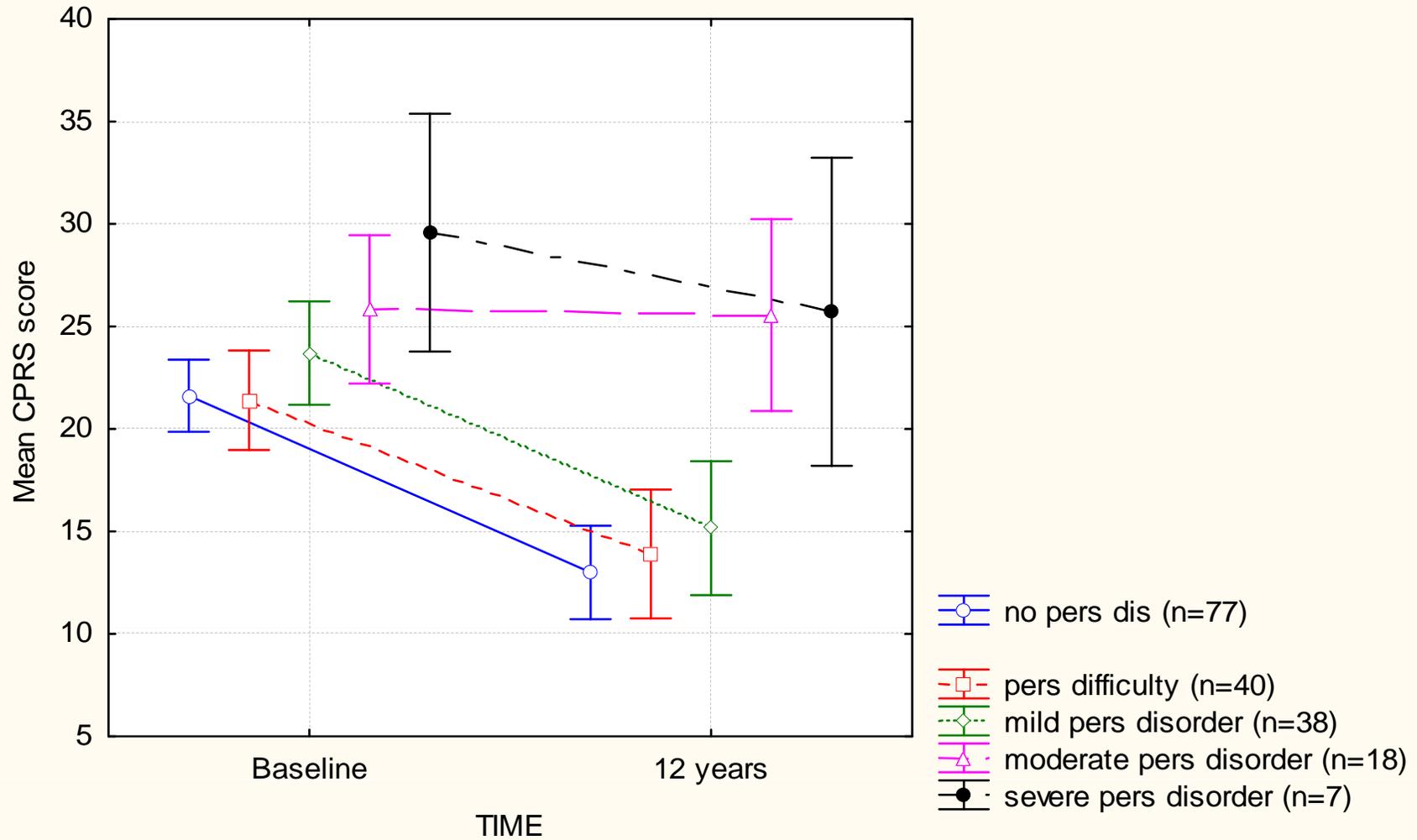
mild	moderate	severe
simple	Complex (more than one trait domain)	
Dysfunction present but limited	<b>Moderate dysfunction</b> The individual's ability to perform expected occupational and social roles is compromised and relationships are generally conflicted or absent.	<b>Severe dysfunction</b> Absence of successful occupational and social roles and relationships are which are conflicted or absent. <b>OR</b>
May involve risk of harm to self or others	Clear risk of harm to self or others	<b>Severe risk</b> sufficient to cause long term damage or endanger life.
-	Other comorbid mental disorders such as neuroses and/ or substance misuse problems are generally present	

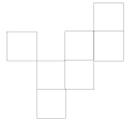


Influence of baseline personality severity (imputed ICD-11 levels) on clinical outcome after 12 years (Nottingham study)

$F(df\ 4, 173)=2.67, p=.034$

Vertical bars denote 0.95 confidence intervals

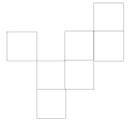




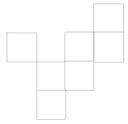
# The central domains of personality pathology in psychiatric patients

(Mulder RT, Newton-Howes G, Crawford MJ, Tyrer P.  
Journal of Personality Disorders, 2011;25(3):364-377)

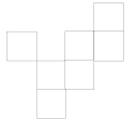
- Subclassifying PD symptoms into broad prototypes of behavioural disturbance.
- Comprehensive review of all papers analysing patterns of PD symptoms in an attempt to create simpler, less overlapping categories.



- Methods
- search using key word terms
  - 1408 papers – title and abstract
  - 32 included
  - 22 in final synthesis

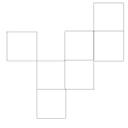


- Commonest number of factors was 3
  - Internalising
  - Externalising
  - Schizoid / aloof factors
- Next most common – obsessive-compulsive factors which splits off the internalising factor.



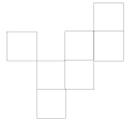
## ■ Externalising Factor

- Incorporates histrionic, narcissistic, borderline, antisocial (cluster B) and often paranoid PD.
- May be separate factor incorporating callousness, lack of remorse and antisocial behaviours.



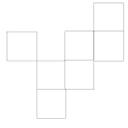
## ■ Internalising Factor

- Avoidant/dependant/borderline PD traits – shyness, timidity, passivity and anxiety, emotionality.
- All studies report high correlations between avoidant and dependent traits.



## ■ Schizoid Factor

- Social indifference, restricted expression of affect, aloofness.
- Sometimes overlaps with eccentric and odd behaviour.
- Sometimes overlaps with paranoia.



## ■ Obsessive-Compulsive

- Aligns most with avoidant and dependent traits.
- Generally separates out as a coherent factor relatively independent of all other PDs.

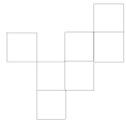
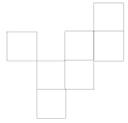


Table 2: Synonyms for the Big Four higher order traits that make up the fundamental structure of personality

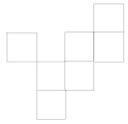
Source	Sociopathic group	Neurotic or negative affectivity group	Withdrawn or eccentric group	Inhibited or obsessional group	Other factors
Galen (190)	Choleric	Melancholic	Phlegmatic	Sanguine	
Eysenck and Eysenck (1964)	Extroversion	Neuroticism	Psychoticism		
Tyrer and Alexander (1979)	Sociopathic	Passive-dependent	Schizoid	Anankastic	
McCrae and Costa (1987)	Disagreeable	Neurotic	Introverted	Conscientiousness	Openness
Goldberg (1990)	Surgency	Emotional stability	(Low) agreeableness	Conscientiousness	Intellect
Cloninger, Svrakic, and Pryzbeck (1993)	Novelty-seeking	Harm avoidance	(Low) reward dependence	Persistence	Self-directedness cooperativeness self-transcendence
Current cluster model (DSM-IV) (American Psychiatric Association, 1994)	Cluster B	Cluster C	Cluster A		
Mulder and Joyce (1997)	Antisocial	Asthenic	Asocial	Anankastic	
Livesley et al. (1998)	Dissocial	Emotional dysregulation	Inhibitedness	Compulsivity	
Proposed cluster model (Tyrer et al., 2007)	Cluster B (dissocial)	Cluster C (dysthymic)	Cluster A (detached)	Cluster D (dutiful)	

DSM-IV, Diagnostic and Statistical Manual of Mental Disorders-IV.



## Method

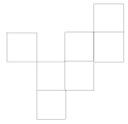
- Sample: 598 outpatients with major depression completed a SCID-PQ and were interviewed using SCID-II interview.
- All interviewers received training using videos and observational interviews.
- Reliability was checked using a subsample of patients.



# Reliability

Every tenth SCID-II interview was videotaped, and the subject re-interviewed by another clinician who rated personality disorder symptoms and diagnoses

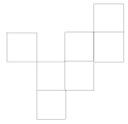
	Test-retest reliability	Kappa
Diagnoses	Total diagnoses	.67
	Cluster A	.62
	Cluster B	.47
	Cluster C	.60
Symptoms	Correlation	
	Total symptoms	.87
	Cluster A	.86
	Cluster B	.63
	Cluster C	.93



## Data Restrictions

- Six symptoms were dropped because they were not measured under DSM-III-R (AV6, OC8, HIS7, HIS8, NAR9, BOR9).
- OC7 was dropped because it appeared to be uncorrelated with all other symptoms.
- In the case of duplicate symptoms e.g. SZO5, SZT8 (lacks close friends) one of the duplicates was dropped.
- In some instances items with very low base rates were combined to avoid unstable correlations e.g. SZT6 (inappropriate affect) with SZT7 (odd behaviour/appearance).

This resulted in a reduction of the potential pool of 79 DSM-IV PD symptoms to a total of 63 symptoms included in the analyses.

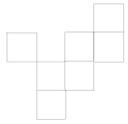


## Exploratory Factor Analysis (EFA)

The data were analysed using Principal Components Analysis with direct oblimin rotation to allow the underlying factors to be correlated.

Selection of the number of factors was guided by Cattell's scree test. This suggested a 4 or 5 factor solution was probably optimal.

However, a range of solutions was explored over the range from 4-10 factors to examine the stability of the factor solution with increasing dimensionality.



## Items and Factor Loadings (>.25)

**Factor 1: Generalized/Histrionic/Narcissistic/Borderline - Emotional**

HIS 1–6; NAR 1-8; BOR 1-3, 6–8; PAR 2, 6, 7; SZT 5; DE 2, 6-8

**Factor 2: Antisocial/Borderline - Antagonistic**

ASPD 1–7; BOR 2–5, 8

**Factor 3: Schizoid/Paranoid - Detached**

SZO 1–7; SZT 1, 5-7, 9; PAR 1-7; BOR 7

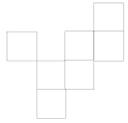
**Factor 4: Avoidant/Dependent - Emotional**

AV 1-5, 7; DE 1-5, 7, 8; SZT 9

**Factor 5: Obsessive/Compulsive - Anankastic**

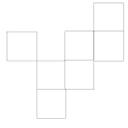
OC 1-6; PAR 3, 5

(Mulder et al. in preparation)



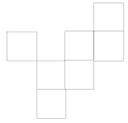
## Current domain names and definitions

1. **Anankastic**
2. **Detached**
3. **Antagonistic**
4. **Emotional**



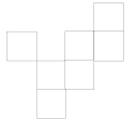
## Definition of Anankastic

The core of the anankastic trait domain is concern over the control and regulation of behaviour. Traits in the anankastic domain include perfectionism, constraint, stubbornness, dutifulness, conscientiousness, deliberation and order.



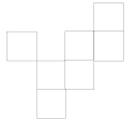
## Definition of Detached

The core of the detached domain is social indifference and impaired capacity to experience pleasure. Traits in the detached domain include aloofness, preference for solitary activities, unassertiveness, avoidance of close relationships, and reduced expression of emotions.



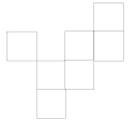
## Definition of Antagonistic

The core of the antagonistic domain is disregard for social obligations and conventions and the rights of others. Traits in the antagonistic domain include insensitivity, lack of empathy, hostility and aggression, ruthlessness, and inability to maintain prosocial, goal-oriented behaviour.



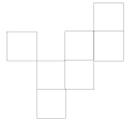
## Definition of Emotional

The core of the emotional trait domain is a persistent tendency to evaluate and respond negatively to the self, the world and others. Traits in the negative emotional domain include sensitivity to scrutiny by others, self-consciousness, vigilance, fearfulness, pessimism, and emotional dysregulation.



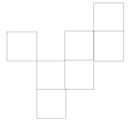
## Feedback: Anankastic

- Generally supportive.
- Some argue that obsessive a better term.
- Very similar to DSM 5 obsessive.



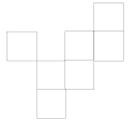
## Feedback: Detached

- Obscure name – social avoidance, schizoid preferred (patients strongly supported detached).
- Should positive “pseudo-psychotic symptoms” be included?
- Overlaps but very different to DSM 5 schizotypal.



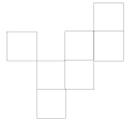
## Feedback: Antagonistic

- Not related to clinical concepts.
- Word means “competing” or “acting in opposition” (OED).
- “Dissocial” a better word.
- Callousness should be specifically added as should impulsivity, sensation seeking and recklessness.
- Aspects of narcissism – particularly grandiosity could be added.
- Similar to DSM 5 antisocial.



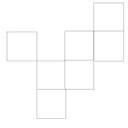
## Feedback: Emotional

- Seriously under described.
- Covers a broad constellation of traits in factor analyses.
- Should be called “emotional dysregulation”, “negative emotionality”.
- Not enough about insecure attachment or dependency.
- Some overlap with DSM 5 borderline, narcissistic.



## Summary: Basic structures

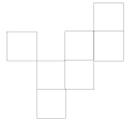
- Adopting a two-component structure for the classifications based on severity and domains of individual differences often a parsimonious and straightforward way to classify PDs.
- Defining PDs independently of traits gets around the problems of defining pathology on the basis of elevated levels of individual traits (which may or may not indicate a disorder) or maladaptive traits (which are difficult and cumbersome to define).



## Domains

Reasons to adopt this structure include:

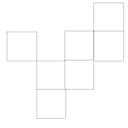
1. Robust evidence of stability across measures and samples differing with respect to the presence of personality disorder, age (it is found in adolescent samples), and culture.
2. Compatibility with five factor and big five models of normal personality.
3. Congruence with the structure of genetic influences.
4. Genetic continuity with normal personality traits.
5. Parsimony.



## Clinical relevance

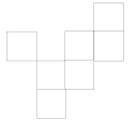
### Severity will guide treatment

- Mild - reassurance, brief cognitive interventions.
- Moderate - brief cognitive interventions, less intensive structured psychotherapies.
- Severe - structured intense psychotherapies  
- medications.



## Domains will guide type of treatment

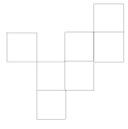
- Anankastic – CBT, serotonergic antidepressants.
- Detached – nidotherapy.
- Antagonistic – containment, CBT, anti-androgens.
- Emotional – MBT, DBT, CAT, etc.



We welcome:

- Suggestions.
- Names.
- Criticisms.
- Money

Remember you will be stuck with this from 2014.



## Articles

Tyrer P, Crawford M, Mulder R et al. (2011). The rationale for the reclassification of personality disorder in the 11<sup>th</sup> revision of the International Classification of Diseases (ICD-11). *Personality and Mental Health*, 5(4): 246-259.

Mulder RT, Newton-Howes G, Crawford MJ, Tyrer PJ. (2011). The central domains of personality pathology in psychiatric patients. *Journal of Personality Disorders*, 25(3): 364-377.

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Tyrer P, Crawford M, Mulder R. (2011). Reclassifying personality disorders. *The Lancet*, 377(9780):1814-1815.

Tyrer P, Mulder R, Crawford M et al. (2010). Personality disorder: A new global perspective. *World Psychiatry*, 9(1):56-60.