Personality Disorders:
Problems of Classification
&
Ethical Considerations

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By

Dina Mohmaed Abdel Moniem El Gabry

M.B.B.Ch.

Supervised By

Prof. Abdel Naser Mahmoud Omar
Professor of Psychiatry
Department of Neuropsychiatry
Faculty of Medicine, Ain Shams University

Ass. Prof. Hisham Adel Sadek
Ass. Professor of Psychiatry
Department of Neuropsychiatry
Faculty of Medicine, Ain Shams University

Dr. Doaa Hamed Moustafa
Lecturer of Psychiatry
Department of Neuropsychiatry
Faculty of Medicine, Ain Shams University

Faculty of Medicine
Ain Shams University
Cairo ٢٠٠٩

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الطبيبة / دينا محمد عبد المنعم الجابرى

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تحت إشراف

الأستاذ الدكتور / عبد الناصر محمود عمر
أستاذ الأمراض النفسية
كلية الطب – جامعة عين شمس

الأستاذ المساعد / هشام عادل صادق
أستاذ مساعد الأمراض النفسية
كلية الطب – جامعة عين شمس

الدكتوره / دعـاء حامد مصطفى
مدرس الطب النفسي
كلية الطب – جامعة عين شمس

كلية الطب - جامعة عين شمس
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List of Abbreviations

٥-HIAA	:	٥-Hydroxy indoleacetic acid
٥-HT	:	٥-Hydroxy Tryptamine
٥-HTT	:	٥-Hydroxy Tryptamine (Serotonin) Transporter
APA	:	American Psychiatric Association
BPD	:	Borderline Personality Disorder
CO	:	Cooperativeness
DAPP-BQ	:	Dimensional Assessment of Personality Psychopathology-Basic Questionnaire
DRD٤	:	Dopamine Receptor D٤
DSM-I	:	Diagnostic and Statistical Manual of Mental Disorders, ١st edition
DSM-II	:	Diagnostic and Statistical Manual of Mental Disorders, ٢nd edition
DSM-III	:	Diagnostic and Statistical Manual of Mental Disorders, ٣rd edition
DSM-III-TR	:	Diagnostic and Statistical Manual of Mental Disorders, ٣rd edition, Text Revised.
DSM-IV	:	Diagnostic and Statistical Manual of Mental Disorders, ٤th edition
DSM-V	:	Diagnostic and Statistical Manual of Mental Disorders, ٥th edition
DSPD	:	Dangerous Severe Personality Disorder
EPP	:	Eysenck Personality Profile
EPQ	:	Eysenck Personality Questionnaire
FFM	:	Five-Factor Model
GABA	:	Gamma Amino Butyric Acid
GAD	:	Generalized Anxiety Disorder.
HA	:	Harm Avoidance

HPA	:	Hypothalamic Pituitary Axis
HVA	:	Homovanillic Acid
ICD-١٠	:	International Classification of Disease of mental and behavioural disorders, ١٠th edition.
ICD-٦	:	International Classification of Disease of mental and behavioural disorders, ٦th edition.
ICD-٧	:	International Classification of Disease of mental and behavioural disorders, ٧th edition.
ICD-٨	:	International Classification of Disease of mental and behavioural disorders, ٨th edition.
ICD-٩	:	International Classification of Disease of mental and behavioural disorders, ٩th edition.
IPC	:	Interpersonal Circumplex model
MAO-A	:	Mono amine oxidase A
MAO-B	:	Mono amine oxidase B
MCM-III	:	Millon Clinical Multiaxial Inventory ٣rd edition
MDD	:	Major Depressive Disorder.
MPQ	:	Multidimensional Personality Questionnaire
NEO-PI-R	:	Neuroticism-Extraversion-Openness Personality Inventory-Revised
NOS	:	Not Otherwise Specified
NS	:	Novelty Seeking
OCD	:	Obsessive Compulsive Disorder
PAS	:	Personality Assessment Schedule
PD	:	Panic Disorder
PDNOS	:	Personality Disorder Not Otherwise Specified
PET	:	Positron Emission Tomography
PS	:	Persistence
PSY-٥	:	Personality Psychopathology five

PTSD	:	Post Traumatic Stress Disorder
RD	:	Reward Dependence
SD	:	Self directedness
SNAP	:	Schedule for Non-adaptive and Adaptive Personality
ST	:	Self Transcendence
TCI	:	Temperament and Character Inventory
UK	:	United Kingdom
VTA	:	Ventral Tegmental Area of the midbrain
WHO	:	World Health Organization.
ZKPQ	:	Zuckerman-Kuhlman Personality Questionnaire

INTRODUCTION

ICD-١٠ defines personality disorders as 'deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations' *(ICD-١٠, ١٩٩٢)*. They can be understood as reflecting pathological amplifications of personality traits, and are considered to be significant deviations that persist through adult life and are evident in multiple domains of behaviour and functioning *(Paris, ٢٠٠٣)*.

It is almost impossible to draw a sharp dividing line between what constitutes a 'normal' and 'abnormal' personality. It is even difficult to decide what criterion should be used to make this distinction. Some have suggested statistical criterion, where abnormal personalities are seen as quantitative variations from the normal and the dividing line is decided by cut-off scores on an appropriate measure. While this has obvious value in research, it is of limited value in clinical practice with individual patients. Others have suggested a social criterion, where abnormal personalities are considered to be those that cause the individual to suffer or cause suffering to other people. While this may correspond well to the realities of clinical practice, it lacks precision and such a social approach is thought to be subjective. Given these conceptual problems, it is not surprising that it is

difficult to frame a satisfactory definition of abnormal personality *(Gelder et al., ٢٠٠١)*.

The current system of classification of personality disorders uses categories that require cut-off points which, although useful in epidemiological studies, are both arbitrary and imprecise. One problem is the inherent instability between raters when trying to diagnose personality disorders even when rating scales are used. This may reflect its somewhat artificial and theory-driven construct. This arises from the fact that their different types have their origins in different disciplines of psychiatry. For example, borderline personality disorder comes from dynamic therapy, anankastic from phenomenology, antisocial from follow-up studies and schizotypal from genetics. Another problem is that personality is not a stable entity over time and may also vary according to situation. Also, there is an overlap between the various types of personality disorders, suggesting that they exist on a dimension and not as a categorical diagnosis. In addition, people who just fall short of the criteria for caseness (sub-threshold cases) are frequent and often present with clinical problems similar to those of definite cases *(Tyrer et al., ١٩٩١)*.

An alternative approach to the current categorical classification of personality disorders is one based on traits and temperaments *(Kagan, ٢٠٠٥)*. These traits and temperaments are dimensional characteristics that are heritable and manifest early in life and underlie cognitive processes, interpersonal and social function, emotional and affective states, and biological stress response systems *(Buck, ١٩٩٩)*. Many researchers support the development of a dimensional model that can describe normal traits as well as personality disorders. However, there seems to be a lack of consensus as to which model should be adopted as there is some doubt as to whether dimensional models capture the clinical picture of certain well-researched categories such as borderline personality disorder *(Morey and Zanarini, ٢٠٠٠)*.

To describe a valid model of classification, we must identify the mechanisms underlying its phenomena. Research has failed to identify any consistent biological factors that correlate with the current categories of personality disorder on Axis II, whereas many studies have shown relationships between trait dimensions and many measures of brain function *(Paris, ٢٠٠٣)*. Even then, understanding these processes has led to greater complexity since many of them appear to be heterogeneous. Overt phenomena have multiple causes with separate pathways. The validity of each

phenomenon can be established by rooting each category in aetiology and pathogenesis *(Paris, ٢٠٠٠)*.

More recent developments include investigations of the genetics and neurobiology of personality traits and temperaments *(Bond, ٢٠٠١; Bouchard and Loehlin, ٢٠٠١)*, the interactions between genes and environment in the expression of various behavioural traits and their role in the development of disorders *(Kendler, ٢٠٠١)*. Recent behavioural genetics research has focused on the relative contributions of the co variation of personality disorder diagnoses and traits, which allows one to examine etiological relationships. Within the past several years, neuroimaging research on personality disorders has also begun to develop. These developments in brain imaging techniques have allowed researchers to examine the dysfunction in the neural integrity linked to specific neural circuits in personality-disordered individuals. Functional and structural neuroimaging studies in borderline personality disorder, antisocial personality disorder (including psychopathy) and schizotypal personality disorder provide support for dysfunction in fronto-limbic circuits in borderline and antisocial personality disorder, and temporal lobe and basal striatal-thalamic compromise is in schizotypal personality disorder. However, these dysfunctions are only likely to reflect certain features within each category rather than be

characteristic marker for the whole disorder *(McCloskey et al., ٢٠٠٥)*.

These new developments are already reflecting on the ongoing review of the classification of personality disorders. The American Psychiatric Association is currently sponsoring the research agenda for the next edition of the DSM classification in personality disorders (DSM-V) with a particular focus on the dimensional models, looking into phenomenology, aetiology, pathology, neurobiology and axis I and axis II continuity. It is hoped that this will reflect a more accurate description of personality disorders *(Widiger et al., ٢٠٠٥)*.

Psychiatrists are ambivalent whether to regard personality disorders as a mental illness and this has raised a number of ethical questions in dealing with this group of patients. A troubling issue is that the diagnosis is often applied to patients that psychiatrists don't like. It was found that where a diagnosis of personality disorder existed, psychiatrists were more likely to believe that the patient's behaviour was manipulative, attention-seeking, annoying and that such patients were in control of their suicidal urges *(Lewis and Appleby, ١٩٨٨)*.