

THIS ISSUE:

Personality Disorders

David Bienenfeld, MD

Guest Editor



When the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., (DSM-III) was published in 1980, it revolutionized — and polarized — psychiatric nosology. Two innovations raised issues that are active a quarter century later. These items relate to personality disorders and are addressed in this edition of *Psychiatric Annals*.

First, the new schema introduced multi-axial diagnosis. By separating syndrome diagnoses on Axis I and personality diagnoses on Axis II, the manual freed clinicians from either-or thinking that was an implicit hindrance previously. The practitioner was now not only permitted but encouraged to discard questions such as, “Does this person have depression or a narcissistic personality?” Instead personality was — and is — now viewed as a parallel construct, upon which various syndromic disorders may occur.

Second, the manual became deliberately atheoretical, abandoning abstract and unprovable constructs in making psychiatric diagnoses and substituting objective and verifiable observations about mood, thought, perception, and behavior. Although this formula yielded unprecedented reliability for the diagnoses on Axis

I, the Chairperson of the American Psychiatric Task Force that developed the DSM-III acknowledged, “For some disorders, however, particularly the Personality Disorders, a much higher order of inference is necessary.”¹

Also, because the descriptive approach was independent of theories of causality, it dictated no particular therapeutic method. One aim of the objective set of defining criteria was that by increasing reliability of diagnosis, more accurate prognostic implications could be derived.

This month’s issue of *Psychiatric Annals* looks to bring the reader up to date on several issues related to these ambiguities:

1. How reliable are the Axis II diagnoses and the methodology used in defining them? Are there systems that better achieve the goals of the DSM series?
2. There is a wealth of literature about the anatomy and neurochemistry of most Axis I disorders. What, if any, such data correlate with personality dysfunction?
3. The Diagnostic and Statistical Manual is deliberately cross-sectional in its observations. What precursors in childhood correlate with adult personality disorders? What is the evolution of these traits and disorders over the lifespan?

4. In an era of therapeutic accountability, what treatment interventions have been proven useful for Axis II conditions?

IN THIS ISSUE

Thomas A. Widiger, PhD, has examined the nosological constructs of personality disorders for most of his career. This month he reviews for us the methodology of personality diagnosis and makes recommendations for future categorizations. He points out the scientific weakness of the DSM-III and DSM-IV structure, and the artificiality of current descriptive diagnoses. Particularly, he criticizes the extensive diagnostic overlap and co-occurrence of multiple disorders and the lack of verification for the currently defined conditions. He finds significantly more support for a dimensional model that identifies certain aspects of personality function and rates them for the individual, rather than a categorical model, which seeks to define personality disorders that may not really exist.

Marianne Goodman, MD; Joseph Triebwasser, MD; Sweta Shah, BA; and Antonia S. New, MD, address the biological underpinnings of personality function from one important perspective. They present an

overview of neuroimaging findings in personality disorders. It is notable that, consistent with Dr. Widiger's criticisms, there are no consistent findings on functional or structural neuroimaging studies that correlate with straightforward DSM-IV Axis II diagnoses. There are, however, robust findings that support the biological verifiability of dimensional constructs, such as aggressive impulse control and emotional reactivity.

Christina G. Weston, MD, and Stephanie Riolo, MD, MPH, look at precursors of adult personality disorders in childhood and adolescence. They define the childhood variables that frequently lie behind later personality dysfunction, including family function and traumatic childhood experiences. Specifically, attachment disorders, childhood abuse, and identifiable Axis I disorders predict personality

dysfunction. Although there is some support for adult personality diagnoses, empirical data tends to sort along dimensional lines.

Robert C. Abrams, MD, and Chaim E. Bromberg, PhD, look at the opposite end of the developmental spectrum. DSM criteria for all diagnoses tend to be based on the function of modal adults. Particularly for the elderly, the yardstick of "normality" becomes unreliable, even more so for Axis II disorders than for syndrome diagnoses. The authors review the course of personality disorders over the lifespan, and the overlap with Axis I conditions in late life. They provide guidelines for assessment of personality in elderly patients.

Finally, your Guest Editor offers a look at one avenue towards treatment. Classically, because personality disorders were regarded

as manifestations of unchangeable temperaments and/or the result of dysfunction in very early experiences, psychotherapy was regarded as a lengthy and complicated undertaking. Psychodynamic therapy sought to identify and correct early sources of contemporary maladaptation. Cognitive therapy, initially designed for Axis I disorders of moderate severity, has been expanded to include much more ambitious goals, including the treatment of individuals with personality disorders. The author reviews the cognitive model of personality dysfunction and strategies for implementing cognitive therapy with these individuals.

REFERENCES

1. Spitzer RL. Introduction. In: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, DC: American Psychiatric Publishing; 1980: 1-12.

about the guest editor



David Bienenfeld, MD, is Professor and Vice Chair of the Department of Psychiatry in the Wright State University School of Medicine, where he serves as Director of the Residency Training

Program. He received his BA from the University of Pennsylvania and his MD from the University of Cincinnati. He also completed his residency training in psychiatry and his fellowship in geriatric psychiatry at the University of Cincinnati. Dr. Bienenfeld is the author of a number of papers and book chapters on depression, dementia and psychotherapy in the elderly. He is also the editor of a major textbook in the field of geriatric psychiatry, *Verwoerd's Clinical Geropsychiatry*. 3rd edition, and the author of an important psychotherapy text, *Psychodynamic Theory for Clinicians*.

TABLE 1.

**Age at First Hospitalization of Patients
Suffering from Periodic Catatonia: Analysis of Samples
Assessed During Different Periods**

Author	Leonhard (1999)	Stöber et al (1998)	Stober et al (2002)
Period of Recruitment	Before 1985	1991/1992	10/1995 to 12/2005
Sample Patients (Total/Males/Females)	136/67/69	83/42/41	209/118/91
Age at First Hospitalization	24.8/23.0/26.5	24.8/23.2/26.5	25.4/24.1/27.1
Years \pm Standard Deviation	*	$\pm 9.6/\pm 8.0/\pm 10.8$	$\pm 10.0/\pm 9.4/\pm 10.6$

*SD not available

CORRECTION

This table at left, originally published in the January 2007 issue in the article “Genetic Correlates of the Nosology of Catatonia” (pages 37-44), was published with some incorrect data. The correct table appears here. *Psychiatric Annals* regrets these errors.