Overview and critique of the classification of personality disorders proposed for DSM-V

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Summary

This paper describes some of the concerns that motivated the committee developing the new classification of personality disorders for the DSM-V. They included the tension between empirical research on normal populations, on the one hand, and clinicians interested in the personality disorders constellations found in clinical settings, on the other. This tension was expressed in the controversies between categorical and dimensional approaches to the classification. There also was an effort to relate a dimensional system of concrete behavioural traits with neurobiological and genetic markers. In addition, there was also a tension between neurobiological and psychodynamic approaches.

A major compromise was reached in a “hybrid,” dimensional and categorical approach that maintained six of the ten categories of the DSM-IV systems, while developing a dimensional approach to a general level of personality function centered on the pathology of the experience of the self. This included the assessment of identity, the experience of oneself, self-esteem and self-appraisal, and emotional regulation; and self-direction. It also included the assessment of interpersonal functioning as reflected in the capacity for empathy and intimacy.

In a critical review of this proposal, the author expresses his general agreement with the main thrust of this proposal, the emphasis on identity and interpersonal functioning and their pathology, and points to the fact that this emphasis corresponds to central concerns of psychodynamic approaches to personality pathology. Regarding the selection of six of the ten personality prototypes of DSM-IV, the criteria for the elimination of the paranoid, schizoid, histrionic, and dependent personality disorder, and the depressive personality disorder (in the appendix of DSM-IV) may be questioned in terms of their prevalence and clinical significance. An underlying problem may be the fact that we do not yet have an integrated understanding of the interplay of neurobiological and psychodynamic structures in the development and psychopathology of the personality. In any case, the introduction of the pathology of identity and interpersonal relations in the proposed DSM-V system seems an important step forward.

Key words: personality disorders; DSM-V

Background

The committee developing the new classification of personality disorders for the forthcoming DSM-V started from several assumptions: (1.) that the DSM-IV classification had proved unsatisfactory because of the high comorbidity found regarding the various personality disorders, and the fact that the most frequent diagnostic conclusion, in clinical practice, was “personality disorder NOS” that is, “not otherwise specified”; (2.) within the committee there continued an old dynamic tension between empirical researchers interested in developing classification systems for the personality characteristics of normal populations, on the one hand, and clinicians who were concerned about developing a classification system that would do justice to the personality disorder constellations found in clinical settings.

Numerous factor analysis studies of large samples had demonstrated the consistent findings of the “five factor system” in describing the major dimensions that determine the differential profile of personality structures within a normal population. These five dimensions were openness, conscientiousness, extraversion, agreeableness, and neuroticism. Clinical psychiatry and psychology, in contrast, have consistently found certain predominant constellations of pathological personality traits that translated into differential categories of personality disorders, while mixed features of several of them might combine in certain patients. These clinical categories, it has been found, have differential prognostic and therapeutic implications. In short, competing dimensional and categorical systems of classification constituted a significant dynamic within the committees involved in DSM-III, IV, and V.

DSM-IV was a purely categorical system and the ten categories of personality disorders it described represented well differentiated entities, each of them characterised by a certain number of traits, which, in turn, signified that any particular diagnosis might be achieved by a particular combination of such respective traits. The underlying heterogeneity of at least some of these disorders was illustrated by the fact that different combinations of the traits representing one category could determine the same diagnostic conclusion about its presence.

The personality disorders work group of DSM-V operated under strong instructions from the overall leadership of the DSM-V to shift from the categorical system of DSM-IV into a dimensional system [1]. In addition to the dissatisfaction with the DSM-IV categorical classification system, other fundamental considerations also played a role here. First, the
search for a new classification system should link concrete behavioural traits with assumed underlying neurobiological dispositions and functions, and with the possibility of developing neurobiological and genetic markers to determine the disposition to a specific personality disorder [2]. In this regard, this effort corresponded to a major emphasis on “translational research”, relating psychopathology to neurobiological functioning and to pathology in the neurobiological realm. Second, less explicit, but as an underlying ideological influence, this orientation reflected a long ongoing struggle between neurobiological and psychodynamic disciplines, and the growing strength of neurobiological psychiatry in reducing the influence of clinical psychodynamic concepts and findings on the personality disorders classification system, bringing it in line with the dramatic growth in knowledge about the genetic and neurobiological basis of major domains of clinical psychiatry [3, 4].

A major compromise

The dynamic tension between the researchers interested in the empirical studies of normal populations, relating them to the predominant prototypes of personality disorders, and clinical psychiatry trying to preserve what they saw as their confirmed experience of the validity of major categories described in DSM-IV evolved in the direction of a compromise, that included an important, major new development, namely, the agreement on a common basic factor of all personality disorders, a factor that represented a major criterion for the assessment of the severity of any personality disorder: the integration or lack of integration of the self, that is, of normal identity, and the degree of normality or pathology in the relations of the individual with others [5]. Here, what might be called the common sense observation that patients with personality disorders have difficulty in their comprehension and management of themselves and with their comprehension and management of the relationship with significant others was recognised, for the first time, as a basic characteristic of personality disorders. The fact that this dimension could be explicative, operationalised, and clinically evaluated in terms of the degree of its disturbance satisfied both empirical dimensionalists, and, particularly, psychodynamic psychotherapists, who, for over thirty years, have observed, described, and utilised this dimension in their assessment and therapeutic approaches to personality disordered patients [6, 7].

Regarding the differentiation of major personality prototypes, the struggle between the clinical experience of those interested in maintaining the categories of the DSM-IV system, and the researchers who wished to relate the five factor model to clinical prototypes of pathological personality structures led to a compromise. Of the ten DSM-IV personality prototypes, those would be retained that could evince significant empirical research carried out in recent years in support of their maintenance, and also were clinically important from the viewpoint of their frequency in clinical practice [4]. This led first to maintaining the schizotypal, antisocial, borderline, avoidant and obsessive-compulsive personality disorders – five of the original ten categories.

This decision, which in itself, already involved significant tensions and disagreements within the committee, evolved toward a minor temporal crisis of a sort, because of the proposed elimination of the narcissistic personality disorder, for which there is abundant recent empirical studies and is of high prevalence in clinical practice, and yet, was slated to be excluded! In all fairness, it may be said that this attempted exclusion manifested the anti-psychodynamic bias prevalent in the workgroup, because the clinical description, the study of the psychopathology, and empirical research on the features of this disorder had been carried out mostly by psychodynamically oriented researchers and clinicians [8]. In fact, the narcissistic personality disorder was “reinstated”, and became a sixth category within the proposed DSM-V nomenclature [9].

The excluded categories

The work group decided that the excluded DSM-IV personality disorders: the paranoid, schizoid, histrionic, and dependent personality disorders, and the personality disorders from the appendix of DSM-IV, that is, the depressive and the negativistic personality disorder, as well as the category of personality disorder NOS, would now be subsumed under the diagnosis of a “trait-specified personality disorder”, in practice meaning that the clinician would have the option of diagnosing a personality disorder on the basis of the pathology of self and relationships with others, and tailoring the description of the personality disorder to fit the specific patient, by using the specific features included by the corresponding pathological traits [4].

Needless to say, serious questions may be raised by the exclusion of personality disorders that have a long history of significant clinical observations and specific therapeutic interventions, such as, for example, the paranoid personality disorder and the histrionic personality disorder, the latter one corresponding to a broad spectrum of pathology described in psychodynamic literature, ranging from the hysterical to the histrionic or infantile personality disorders, and the depressive personality disorder, that has a prognostically favourable implication for psychodynamic psychotherapies. Also, the fact that no major research has been carried out, in recent years, regarding the paranoid personality disorder, seems a problematic reason for eliminating it. In any case, from the viewpoint of the psychodynamically oriented proponents of a categorical nomenclature, the reinstatement of the narcissistic personality disorder represented a significant positive development, corresponding to clinical reality. Clinicians may feel that the histrionic personality disorder may still be considered a less severe form of the borderline personality disorder, and the schizoid personality disorder a less severe form of the schizotypal one, and refer to them, in their practice, in that context.

For the neurobiologically oriented, and dimensional trait system committed members of the work group, the influence of the five factor theory seems to be relatively assured by the relationship of the factors of conscientiousness, extraversion, agreeableness, and neuroticism, respectively, to the obsessive compulsive personality, the avoidant personality
The diagnostic criteria for the six selected specific categories of personality disorders are described in terms of predominantly subjective experiences, a very important aspect in the evaluation of the personality, which complements the analysis of the actual interpersonal and social functioning. The research on attachment has provided the objective evidence for the intimate connection between the earliest relations with significant others and the build-up of internal models of those relationships as reciprocal, dyadic constellations of self and object representations, and psychoanalytic theory has provided an explanatory theory of how these early intrapsychic structures become integrated, respectively, into an integrated concept of self and of significant others.

The maintenance of the six major diagnostic categories of personality disorders, be it within an effort to link them to a predominantly trait oriented psychology (with an expectation of direct, linear relationships to neurobiological functioning and to underlying genetic predispositions), does, indeed, reflect clinically predominant categories of personality disorders, and, these categories are justified, it seems to this author, to have been retained. The elimination of the other four categories from DSM-IV, however, raises questions. The fact that there has not been empirical research in recent years regarding these other personality types does not seem to be reason enough to eliminate them if they are clinically relevant, and, again, reconfirmed in clinical practice, and, therefore, important in the general differential diagnostic and therapeutic approach to personality disorders. The paranoid personality disorder, for example, would be easily recognised by most clinicians, and has been described in the psychiatric literature of many countries. But even if their diagnostic utilisation in clinical practice is less frequent than the personality disorders that have been

**Some critical reflections**

From the viewpoint of this author, the major innovative contribution and strength of the DSM-V proposal resides in the belated recognition of the essential nature of the experience of the self and of relationships with significant others in the assessment of normality or degree of pathology of the personality. The concept of an integrated self, in contrast to severe lack of integration that characterizes what, in psychoanalytic literature, Erik Erickson introduced many years back as the concept of identity diffusion, is the central issue in the evaluation of a personality disorder, a fundamental structure of the personality, the pathology which defines, more than anything else, the nature and degree of severity of personality disorders. The criteria of identity and self-direction now proposed reflect that aspect of the self accurately. The relationship with others, as DSM-V has recognised, intimately relates to the degree of integration of the self, and reflects, I would add, the integration of the representations of significant others that are reflected in the actual capability of empathy and intimacy as now defined in the DSM-V model.

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retained, the wisdom of including only the most frequent conditions, while discarding less frequent, yet clinically discriminant conditions is questionable. Would we exclude relatively rare types of illness in other medical fields just because of few cases where the diagnosis has been established?

Another issue with regard to the excluded personality disorders is that some represent milder forms of underlying pathologies, the elimination of which does not quite do justice to the spectrum of certain related personality disorders. Thus, as mentioned before, the histrionic personality may represent a less severe form of the borderline personality disorder, but, by the same token, presents a different prognosis and indication for therapeutic management. The same may be stated regarding the schizoid personality disorder, reasonably considered a less severe form of the schizotypal personality disorder, with important implications regarding genetic predisposition to schizophrenia in the latter, but less likely so in the former. Here we touch upon an area not explored by the DSM-IV nor by the DSM-V Committees: the dimensional aspect of relationships between groups of personality disorders, such as, the schizoid and schizotypal, the histrionic and borderline, and the unacknowledged relationship between the narcissistic personality disorder and the antisocial personality disorder, the latter an extremely severe form of pathological narcissism that presents the symptoms of a narcissistic personality as an important aspect of its features. What I am suggesting here is that there exists a dimensional aspect of relationships between various personality disorders that, by itself, justifies, it seems to me, a classification of personality disorders that combines categorical and dimensional features [12]. From this very general viewpoint, the adoption, in DSM-V, of such a combined, “hybrid” model seems appropriate.

The effort to link the five factor model as representative of descriptive studies of large normal populations with the prototypes of clinically observed personality disorders may be questioned from the standpoint of the particular structure of an individual personality disorder: regardless of their neurobiological or psychosocial dispositions, the nature of personality disorders may reflect an organisation of constellations of personality traits that may not have any psychopathological relevance regarding the statistically predominant constellations of traits of normal populations (the five factor system). The assumed relationship between the five factor system and the nature of the retained personality disorders seems rather forced, with the factor of “openness” not relevant at all, and the need to establish a new factor, “psychoticism”, to find a possible connection with the schizotypal personality disorder seemingly well illustrating this point.

**The double layer of neurobiological and subjective, intrapsychic structures**

The most important critique, in my view, of the conceptual underpinning of the proposed DSM-V personality disorders model relates to the underlying assumption that a trait psychology, in contrast to a categorical one, may permit a direct relationship between concrete personality traits and underlying neurobiological mechanisms. There are, of course, underlying neurobiological mechanisms related to all psychological functioning: subjectivity and intentionality, as we know by now, are clearly dependent on complex structural arrangements of the central nervous system, and there are concrete linkages between the functioning of different areas of the brain and subjective and behavioural aspects of human psychology. The function of neurotransmitters, such as oxytocin, in activating the attachment system and being influential in the passionate aspects of erotic life illustrate one such relationship; that the orientation of the self-regarding its immediate psychological environment and its influence on affect control relate to functions of the medial prefrontal cortex and the anterior part of the cingulum has been clearly established. In our own research on borderline personality disorder we have found that the hyperactivity of the amygdala, combined with a primary inhibition of the prefrontal and pre-orbital cortex differentiates these patients from normal controls, and there is an abundant literature in this regard, that has confirmed these findings [13], in recent years.

But we have also learned that the central nervous system operates not through the isolated activation of particular structures or neurotransmitters but, rather, through the integrated activation of multiple structures.

For example, emotional dysregulation depends on a complex interaction between the activation of limbic areas, the hippocampus and amygdala, cortical areas, particularly the prefrontal and pre-orbital cortex and the anterior cingular region, and even broader areas including insula, and aspects of the parietal, temporal and occipital cortices. By the same token, we also have evidence that certain key psychological functions, in turn, derive from the organisation of underlying psychological structures, such as the very concept of the self, derived from the integration of centres of self-reflection that provide information about the location of the body in space and time, the information from the linguistic self, the status of the historical self, the assessment of the perception of self by others. In other words, while all these psychological functions derive from a neurobiological basis, they, in turn, become organised at a psychological level. The study of subjective intentionality of behaviour, I believe, has to consider two levels of organismic organisation: a basic neurobiological one, and a derived, secondary, symbolic or psychological one that, as recent research also has shown, in turn may influence the functioning of the underlying neurobiological structures.

This conceptualisation of the double layer of neuropsychological organisation raises serious questions about the organisation of our nomenclature of personality disorders in terms of the linear concept of interaction of isolated multiple traits, practically considered as almost equivalent in their liberality. This problem, it seems to me, is clearly reflected in the main dimension rightly proposed for personality disorders, namely the integration of the self, reflected by identity and self-direction on the one hand, and the capacity for empathy and intimacy on the other.
Conclusions

In conclusion, my view is that the proposed DSM-V model for classification of personality disorders represents a significant improvement over DSM-IV, by adding, as central criteria, the severity of pathology of the self and of relations with others, incorporating, in this regard, the findings and clinical contributions from psychoanalytic object relations theory. The decision to maintain six of the ten categories of DSM-IV is wise, and will permit continuity in the research regarding those respective areas. The elimination of the four categories that have been excluded seems to me questionable, but perhaps may be compensated in practice by signalling the constellation of the corresponding, predominant traits in those personality disorders that also fulfil criterion A, (regarding identity), but cannot be classified within the six categories that remain. The main problem with the new classification lies not, it seems to me, in the decisions regarding its shape, to the point at which it has been agreed upon until now, but in the untouched conceptual and methodological problem of dealing with the disposition to personality disorders stemming from two interrelated levels of organisation of the mind, a basic neurobiological one, and a symbolic or psychological level [14]. The achievement of such an integration implies tasks for future research.

References