ROCZNIKI PSYCHOLOGICZNE / ANNALS OF PSYCHOLOGY
2017, XX, 2, 241–245
DOI: http://dx.doi.org/10.18290/rpsych.2017.20.2-1en

AGNIESZKA POPIEL[a]
BOGDAN ZAWADZKI[b]
[a]SWPS University of Social Sciences and Humanities in Warsaw
Faculty of Psychology, Department of Behavior Analysis
[b]University of Warsaw
The Robert B. Zajonc Institute for Social Studies

DIAGNOSIS OF PERSONALITY DISORDERS: SELECTED METHODS AND MODELS OF ASSESSMENT

Both clinical and theoretical aspects of the problems of people suffering from personality disorders attract researchers' attention. An attempt to modify the current classification systems confronts scholars with the problems of the uncertain empirical status of the criteria for diagnosing this group of disorders and the imperfection of assessment instruments. The text is an introduction to a volume of articles devoted to personality disorders, particularly to historical and theoretical conceptions of personality disorders, instruments enabling the diagnosis of personality disorders and the assessment of cognitive schemas specific to personality disorders (in the light of both Beck's cognitive theory and the Young schema theory).

Keywords: personality disorders; prevalence; classifications; diagnosis; assessment instruments.

Issues of personality disorders have enjoyed considerable interest among both theorists and clinicians for a long time. Recently, however, it has become a subject of particularly intense debate. This is because the "eternal" problem that people suffering from personality disorders have with themselves and – in the case of some disorders – the problem that others have with their dysfunctional behaviors was understood as an additional difficulty in clinical practice. What was

Address for correspondence: AGNIESZKA POPIEL – SWPS University of Social Sciences and Humanities in Warsaw, Faculty of Psychology, Department of Behavior Analysis, ul. Chodakowska 19/31, 03–815 Warszawa; e-mail: apopiel@swps.edu.pl

particularly emphasized was the pervasive nature of the ailments, the influence of personality disorders on the effects of treatment for other co-occurring mental disorders, the increased risk of suicide, and generally worse individual and social functioning. While these observations appear to be valid – an attempt at empirical verification revealed areas of controversy, which concerned mainly definitional issues: the diagnostic criteria and the assessment instruments.

The year 1980 was important in the assessment of personality disorders due to significant changes in the classification system of mental disorders according to the American Psychiatric Association – DSM-III (*Diagnostic and statistical manual of mental disorders*, 1980). One of the changes was a proposal of systematizing the data obtained from interview and the conclusions from the examination of mental condition by means of the multiaxial system. Most mental disorders were coded on Axis I, personality disorders and mental retardation – on Axis II, somatic diseases and conditions – on Axis III, the assessment of general psychosocial stressors influencing the patient – on Axis IV, and the assessment of the patient's general functioning – on Axis V. The inclusion of personality disorders in Axis II and the remaining mental disorders in Axis I "forced" clinicians to consider the possibility of such disorders occurring in every patient diagnosed with any Axis-I disorder (e.g., anxiety, mood disorder, schizophrenia, addiction, or eating disorder). This also led to the assumption that personality disorders themselves may cause distress and impair functioning. The category of personality disorders was then divided into three clusters comprising 10 disorders: Cluster A – paranoid, schizotypal, and schizoid personality disorders; Cluster B – borderline, antisocial, narcissistic, and histrionic personality disorders; Cluster C – avoidant, dependent, and obsessive-compulsive personality disorders.

The next 30 years brought many critical comments on this categorical perspective on personality disorders. Some of these comments stemmed from practice: because the clinical picture in many patients was complex, diagnosing several personality disorders simultaneously (but was it comorbidity?) became possible and probable. This led to the (over)use of the category labeled PDNOS (Personality Disorders Not Otherwise Specified; APA, 1980). Laborious categorical analysis frequently did not translate into the development of specific methods of help that would promise to ensure appropriate clinical effectiveness. This is because the clinical assessment of a personality disorder solely by means of structured interview (e.g., SCID-II – *Structured Clinical Interview for DSM-IV Axis II Disorders*; First, Spitzer, Gibbon, Williams, & Benjamin, 1997) requires 1 to 3 hours. Treatment recommendations based on empirical data pertain (with different power of data) to only three out of 10 disorders: borderline, antisocial,

and avoidant personality. The effort invested in the precise nosological diagnosis of the remaining disorders could therefore seem to be futile, but for the fact that these patients are encountered in practice. In their offices, psychotherapists (in therapy for personality disorders, pharmacotherapy alone has little to offer) often encounter patients whose abnormal way of functioning goes beyond the three disorders mentioned above. However, the intensity and configuration of symptoms varies, and – depending on the therapeutic school – different psychopathological mechanisms are regarded as fundamental to a given clinical picture. Taking into account the current condition – mental status and presenting problems (which may be reflected in the nosological diagnosis) and the mechanisms leading to its emergence (vulnerability factors and maintaining factors) results in an individualized conceptualization of the patient's problem. For this reason, clinicians turned in the direction of temperamental and personality determinants of personality disorders. There emerged a greater need for the empirical verification of theses concerning the mechanisms whose modification or inclusion in therapy could bring the desired changes.

Given the previously signaled problems with diagnosis, assessing the scale of the problem of personality disorders both in the general population and in clinical practice constitutes a great challenge for researchers. Clinicians' observations on this matter will certainly be a little misleading – on the one hand, they indicate the co-occurrence of disorders; on the other, the specificity of functioning defined by the personality disorder present in a person affects also that person's ability to recognize his or her own difficulties (egosyntonic *vs.* egodystonic symptoms: acceptable or desirable symptoms *vs* unacceptable or undesirable symptoms) as well as his or her tendency to seek therapeutic help. As a result, it is the people who are looking for help due to co-occurring mental disorders that report to clinicians more often. Epidemiological studies conducted in the last 10 years (based on the DSM-IV classification) report values of lifetime prevalence[1] that are three times higher compared to the prevalence diagnosed in a given period. Each of the ten specific types of personality disorders defined in DSM occurs in about 1.5% of the populations of Europe and the USA in a given period, and personality disorders (of any type) occur in about 11–12%. However, according to epidemiological data, the sum of the percentages of prevalence for particular disorders (comparable to 20%) is markedly higher than the percentage for

[1] **Prevalence** – more precisely, **prevalence rate** – the number of people in whom a given disorder is diagnosed in a particular group (e.g., per 100,000 inhabitants). Depending on the period analyzed, prevalence may refer to diagnosis at any time during the subject's lifetime (*lifetime prevalence*) of in the period of time chosen for the study, such as several years or days.

clear (unambiguous) diagnoses of particular disorders. These data therefore suggested relatively frequent co-occurrence of personality disorders (Torgersen, 2014), which in turn was one of the arguments in favor of reforming the system of classification and assessment of personality disorders. This drew scholars' attention to the need to include dimensional models in assessment. The needs of clinicians, epidemiologists, and researchers signaled above have a common denominator – namely, the call for instruments that would make it possible not only to confirm the diagnosis but also to monitor the changes occurring in therapy. The function performed by structured clinical interviews, as Bloo, Arntz, and Schouten (2017) rightly observe in this volume, is limited due to the large amount of time they require and to the low diagnostic sensitivity which does not allow them for identifying the changes occurring over a time shorter than the time assessed in an interview (e.g., during a therapy lasting a few months). It is these diagnostic issues that the current volume is devoted to.

The paper by Popiel and Keegan (2017) discusses the development of research and conceptions that led to changes in the understanding and classification of personality disorders. The publication of the recent changes in ICD-11[2] is planned for 2018, whereas the modifications to DSM-5 suggested before publication, preceded by heated debates, have still been presented as a proposal – an "alternative model" (APA, 2013).

Further articles address strictly diagnostic issues. Bloo, Arntz, and Schouten (2017) describe an instrument making it possible to assess the complex psychopathology of borderline personality disorder and to monitor the changes that occur over time. Two other texts (Zawadzki, Popiel, Prągłowska, & Newman, 2017; Staniaszek & Popiel, 2017) present instruments rooted in cognitive conceptions focused on the role of schemas in the psychopathology of personality disorders. Schemas understood as core beliefs characteristic for particular personality disorders are measured by means of the *Personality Beliefs Questionnaire* (PBQ) by A. T. Beck and colleagues, and the Polish versions of this instrument are described by Zawadzki, Popiel, Prągłowska, and Newman (2017).

The specific "early maladaptive schemas" that, according to J. Young, play a significant role in the development and maintenance of pathological functioning in people with personality disorders are measured by the *Young Schema Questionnaire* (YSQ), whose short Polish experimental version is presented by

[2] ICD-11 (International Classification of Diseases) – the next version of the classification of diseases, injuries, and causes of death, issued by the World Health Organization, in which one of the chapters is devoted to mental disorders, including personality disorders; it is planned to be issued in 2018.

Staniaszek and Popiel (2017). The series of texts devoted to instruments concludes with an article about a questionnaire enabling the assessment of personality disorders from the perspective of DSM-5 proposals (Strus, Rowiński, Cieciuch, Kowalska-Dąbrowska, Czuma, & Żechowski, 2017). The last article in the present volume is Zawadzki's (2017) paper devoted to the model of personality metatraits and its potential usefulness in the understanding of personality disorders.

In conclusion, presenting these papers to the reader, we would like to note that the preparation of the whole volume, the present text, and several other articles was financed by Grant 2012/06/A/HS6/00340 "PTSD: Diagnosis, Therapy, Prevention" from the National Science Centre (NCN).

REFERENCES

American Psychiatric Association, APA (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, D.C.: Author.

American Psychiatric Association, APA (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D.C.: Author.

Bloo, J., Arntz, A., & Schouten, E. (2017). The Borderline Personality Disorder Checklist: Psychometric evaluation and factorial structure in clinical and nonclinical samples. *Roczniki Psychologiczne, 2*(20), 311–336.

First, M., Spitzer, R., Gibbon, M., Williams, J., & Benjamin, L. (1997). *Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II)*. Washington, D.C.: American Psychiatric Press.

Popiel, A., & Keegan, E. (2017). Personality disorders: A brief historical introduction. *Roczniki Psychologiczne, 2*(20), 265–280.

Staniaszek, K., & Popiel, A. (2017). Development and validation of the Polish experimental short version of the Young Schema Questionnaire (YSQ-ES-PL). *Roczniki Psychologiczne, 2*(20), 401–427.

Strus, W., Rowiński, T., Cieciuch, J., Kowalska-Dąbrowska, M., Czuma, I., & Żechowski, C. (2017). The Pathological Big Five: An attempt to build a bridge between the psychiatric classification of personality disorders and the trait model of normal personality. *Roczniki Psychologiczne, 2*(20), 451–472.

Torgersen, J. (2005). Epidemiology. In J. Oldham, A. E. Skodol, & D. S. Bender (Eds.), *Textbook of personality disorders* (pp. 129–141). Washington, D.C.: American Psychiatric Publishing.

Zawadzki, B. (2017). The location of personality disorders in the Circumplex of Personality Metatraits. *Roczniki Psychologiczne, 2*(20), 493–512.

Zawadzki, B., Popiel, A., Pragłowska, E., & Newman, C. (2017). Specificity of dysfunctional beliefs in personality disorders: Psychometric characteristics of the Polish translation and modified version of the Personality Beliefs Questionnaire (PBQ). *Roczniki Psychologiczne, 2*(20), 355–372.