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PERSONALITY DISORDERS: A BRIEF HISTORICAL INTRODUCTION

In this paper we aim to portray the evolution of the understanding, classification and diagnosis of personality disorders. We analyze the characteristics of normal and abnormal personality in the light of the debate about the nature of mental disorders. A brief historical outline of the conceptualization of personality disorders is followed by a description of the evolution of contemporary diagnostic systems. The limitations and problems of these systems are analyzed.

Keywords: personality disorders; history; diagnosis; classification; DSM-5.

Personality, normality and pathology

Millon (2004) defined personality as a complex pattern of deeply embedded psychological characteristics that are expressed automatically in almost every area of psychological functioning. In this view, personality is conceived as the patterning of characteristics across the whole matrix of the person. Personality would be the result of the interaction of environmental factors (physical, social, cultural) and temperament, the biological disposition toward certain behaviors.

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According to Millon (1969), there are three pathological characteristics of personality disorders. Lack of resilience in the face of stress is the first of these pathological characteristics. While most people have various coping strategies to deal with stress, personality-disordered people tend to rigidly apply the same coping strategy, even when it is evident that this strategy is not successful or is even making matters worse. As a consequence, the level of stress keeps increasing, amplifying the vulnerability of the personality-disordered person, creating crisis situations and producing increasingly distorted perceptions of social reality.

The second characteristic clearly relates to the first one: personality--disordered people are inflexible. Normal personality functioning demands the flexibility to adapt to different roles – in other words, the wisdom to know when to try and change the environment and when to adapt to things as they are. When the constraints imposed by the environment are strong, most people will converge to similar behavior. Personality-disordered people, by contrast, have few alternative strategies, and they impose them rigidly on conditions for which they are not suited. The behavior of personality-disordered people imposes very powerful constraints on the course of social interaction. Because they cannot be flexible, the environment must become even more flexible. Crises arise when the environment cannot be modified to match the rigidity of the personality-disordered person. The opportunities for learning new, adaptive strategies are further reduced, and the person's life becomes less enjoyable.

Because the afflicted person fails to change, the pathological themes that dominate his/her life tend to repeat as vicious circles. This is the third pathological characteristic of personality disorders: self-perpetuation. In Millon's words, "life becomes a bad one-act play that repeats again and again" (Millon, 2004).

A brief history of the conceptualization of personality disorders

Clinical and scientific interests have contributed to the development of different research traditions in the field of personality. Academic psychologists typically focus on normative functioning, while psychiatrists and clinical psychologists are interested in treating dysfunctions.

In his famous *Traité*, Philippe Pinel (1801) introduced the concept of *manie sans délire*' (mania without delusion) and speculated that it might be originated by a deficient or ill-oriented upbringing of the child, or a perverse nature (Crocq, 2013). This inspired a disciple, Esquirol, to propose the construct of *monomanie raisonnante*, a concept he found akin to Prichard's "moral insanity" (Berrios,

1999; Crocq, 2013). Most of the cases commented on by these psychiatrists referred to the behavior of individuals in conflict with the law, reflecting a forensic interest for the psychiatric assessment and understanding of these problems.

By the beginning of the 20th century, Emil Kraepelin (1904) posited that the limit between pathological and normal personality is gradual and arbitrary, and determined by a faulty constitution. He described four types of "psychopathic personalities": the born criminal, the irresolute or weak-willed, the pathological liars and swindlers, and the pseudoquerulants. The concept of psychopathic personalities was elaborated upon by another German psychiatrist, Kurt Schneider, a researcher concerned about the reliability of psychiatric diagnoses. Schneider (1923/1950) introduced several key concepts related to personality disorders that are still considered valid. He defined "psychopathic" personalities as those individuals who suffer, or cause society to suffer, because of their personality traits. Abnormal personalities are thought to be largely inborn constitutions, but they can evolve as a result of personal development or outside influences (Crocq, 2013).

The "somatic" conceptual world of Kraepelin's nosology was criticized by Karl Jaspers (1959, p. 853). "Faced with the various classifications of personality we get an impression of endlessness. Almost every fresh contributor thinks he has grasped the essentials of human nature"(p. 435). After almost a century of the publication of his *General psychopathology*, the opening statement of his chapter on character remains valid. In his analysis of different approaches to the study of personality, Jaspers distinguishes several kinds of classifications, based on ideal types, on systems of personality structure, or on the observation of real types. Based on those indicators, he distinguishes abnormal personalities that appear as "extreme variations of human nature" from personalities that are "genuinely ill, due to some additional process that has taken place" (p. 439). Among extreme variations of basic personality dispositions, he takes into consideration: (a) temperament (sanguine, phlegmatic, euphoric, depressive), will power, feeling, and drive (psychopath, fanatic), which constitute personality structure; (b) variations in "psychic energy" (neurasthenic, psychastenic) and variations in self-reflection (hypochondriacs, hysteric and self-insecure personalities).

Kraepelin's contemporary, Sigmund Freud, originated a new tradition in the understanding of personality disorders. Psychoanalysis gave a central role in the emergence of psychopathology to early life events that remained out of awareness and were kept unconscious. It was Sigmund Freud (with a 1908 paper on character and anal eroticism), Karl Abraham, and Wilhelm Reich who laid the foundation of the psychoanalytic character typology (Crocq, 2013). This was

followed by Franz Alexander's (1930) distinction between neurotic character and symptom neuroses and by Reich's (1945) psychoanalytic treatment of personality disorders.

Significant changes in psychoanalytic theory led to the development of the object relations approach, which emphasizes that the external world is known through mental representations or internal working models (Bowlby, 1969). These models are interpersonal in origin, being the result of early interactions with caregivers; they function as unconscious mental structures that organize experience and are only partially accessible to conscious reflection. The main exponent of this line of research in the field of personality is Otto Kernberg (1967, 1984, 1996), who proposed a threefold classification of personality pathology–neurotic, borderline, psychotic – representing varying degrees of organization or cohesiveness in personality.

A comprehensive alternative to psychodynamic approaches to personality was offered by cognitive-behavioral theories (Ellis, 1962; Beck & Freeman, 1990; Linehan, 1993; Young, 1990). The behavioral root in this understanding of personality emphasized the role of learning specific behaviors and emotional reactions and shaping them by their consequences. The cognitive part appreciates the role of learning, but considers the way people encode, transform, and retrieve information about themselves and others as central to personality (Heim & Westen, 2014). Cognitive-behavioral theories focus on the schemas (particularly those that reflect early traumatic experiences and become maladaptive) that lead people to attend to specific aspects of reality and to misinterpret information (Beck & Freeman, 1990; Beck, Freeman, and Associates, 2004; Young, Klosko, & Weishaar, 2003). They also emphasize skills and competencies, including emotion regulation (Linehan, 1993). According to the cognitive specificity hypothesis, a set of disorder-specific cognitions maintains the dysfunctional cycle of cognitions→emotions→behaviors (Beck et al., 2001). Such a cycle is reflected in the diagnostic criteria of the disorder. Cognitive and behavioral therapists share the beliefs about learning as the basis of personality but also about the need to measure and empirically test the hypothesized constructs. One of the most popular self-assessment tools designed for measuring schemas in personality disorders is the Personality Beliefs Questionnaire (PBQ; Beck et al., 2001) and the Young Schema Questionnaire (YSQ; Young, 1998). Both are described in detail in this volume (Zawadzki, Popiel, Pragłowska, & Newman, 2017, pp. 355–372; Staniszek & Popiel, 2017, pp. 401–427).

All these models were produced by clinical researchers, mostly psychiatrists. By contrast, academic personality psychologists traditionally studied nonclinical

populations. They were more interested in the "normal" personality and, consequently, devoted little attention in their theories to abnormal personality or personality pathology. Thus, for many years the worlds of normative personality theories and the theories personality pathology seemed to follow parallel paths. But it would be hard to believe that observations concerning normal behavior do not apply to psychopathology when a simple examination of the history of the biological roots of personality reveals that the concept of temperament was extensively used by a physician (Hippocrates) to explain and name the psychopathology of depression – *melancholia.*

Psychobiological approaches

Robert Cloninger's psychobiological model (2004) has been one of the most extensively researched views on personality. His model tries to account for the variety of psychopathological states. As is usually the case with conceptions born on the borders of disciplines, scholars may unwittingly rediscover the wheel or ignore a huge part of the accumulated knowledge. The 7-factor model of personality proposed by Cloninger consists of Temperament (**H**arm Avoidance, **N**ovelty Seeking, **R**eward Dependence, and **P**ersistence) and Character (Self--Directedness, Cooperativeness, Self-Transcendence). Some studies found that temperament dimensions differentiate subtypes of personality disorders – namely, that antisocial personality disorder is associated with high scores on Novelty Seeking (N) as well aslow scores on Harm Avoidance (h) and Reward Dependence (r) – and that some configurations of traits (NHr, nHr, Nhr, and NHR) increase the risk of immaturity (Cloninger, 2004, pp. 41–43).

Similar conclusions can be drawn from the study on temperamental traits measured according to the Regulatory Theory of Temperament (RTT; Strelau, 1983) and personality disorders (Zawadzki, Rozmysłowska, Nowocin, Popiel, & Pragłowska, 2012). According to that study, all personality disorders could be classified either into a "weak" type of temperament (characterized by low capacity for stimulation processing – involving Cluster A, Cluster C, and borderline personality disorders) or an into the "overstimulated" type (characterized by dysregulation of stimulation supply – Cluster B: antisocial, histrionic, and narcissistic personality disorders). However, the study could not identify the specific profile of relations of temperamental traits for each of the10 personality disorders described in DSM-IV. Nevertheless, clinical approaches underline the need to consider temperamental traits in the psychopathology of borderline personality disorder: either more specifically, as proposed by Marsha Linehan (1993, p. 79)

with reference to the RTT-based study by Eliasz, or as a mere "unmeasurable biological basis" (J. Young, 2006 – personal communication), or in personality psychopathology in general (Oldham, 2014).

The Big Five

One of the most common and mature models of personality structure isCosta and Mc Crae's Big Five (2005; see Zawadzki, 2009). Due to its popularity, an enormous amount of data in support of the model has been gathered. The analyses performed by Asendorpf, Borkenau, Ostendorf, and Van Aken (2001) led to the identification of three prototypic patterns of personality description (resilient, overcontrolled, and undercontrolled) and indicated an adaptive value of the configuration of traits characterizing the resilient type. The meta-analysis performed by Saulsman and Page (2004) on the relationship between personality traits and personality disorders led to the identification of characteristic profiles reflecting two clusters of personality disorders (in DSM-IV terms, Cluster A + C and Cluster B). In a synthesis of the abovementioned analyses and of his own studies, Zawadzki (2009) found that personality disorders show profiles opposite to the resilient type (oCEAn): either overcontrolled, as Clusters A and C (OceaN), or undercontrolled, as Cluster B (OcEaN). He concludes that studies on normative personality indicate both sides of the coin: the areas of good functioning defined as adaptation possibilities within specific cultural context, and the reverse: the profiles of traits characterizing dysfunction. However, it is too early to celebrate the integration of psychopathological and normative personality studies, mainly because the Big Five model does not capture the specificity of personality disorders.

An important contribution of clinical psychology to the history of personality and personality psychopathology was the development of psychological testing instruments and their application to the assessment of pathology in clinical settings (the "full-battery approach"). The focus of this traditional approach was, naturally, informed by the scientific context of the day – namely, the psychiatric diagnostic system of the time and psychodynamic treatment approaches.

In contrast to the full-battery approach, the Minnesota Multiphasic Personality Inventory (MMPI), a self-report instrument, was first published in 1943 by Hathaway and McKinley, with scales measuring salient clinical syndromes of the day, such as depression, hypochondriasis, schizophrenia, and others. The MMPI was called a personality test, reflecting an intertwining of conceptions of clinical syndromes and personality/personality pathology. Interestingly, only two of

the original nine clinical scales actually assessed constructs akin to personality traits or attributes (Scale 0, developed later, was designed to assess social introversion).

Concerns about the validity of projective tests led to a decrease in their use for the assessment of personality. The focus moved towards the development of successors to the MMPI, reflecting the advances in psychometric development and more closely tied to the predominant diagnostic system of the time, which made a distinction between Axis I syndromes and Axis II personality pathology. An example of this kind of instruments is the Millon Clinical Multiaxial Inventory (MCMI; and subsequent versions, the MCMI-II and MCMI-III).

The historical role and importance attached to the clinical interview procedure in psychiatry and also the advances achieved in the design of structured interviews for other forms of psychopathology through the 1970s led to the development of semi-structured interviews that reliably assess personality disorders as described in the DSM and ICD systems, namely the SCID-II for DSM-IV (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and the International Personality Disorder Examination-ICD-10 (IPDE-ICD-10; Loranger, Janca, & Sartorius, 1997). The structured interview remains today the most accepted approach to the diagnosis of personality disorders, with a variety of reliable instruments to choose from (although, as Giesen-Bloo and Arntz underline further in this volume, there is a need for self- assessment tools that would be less demanding in terms of training required and time needed for examination, as well as more sensitive to change).

Theodore Millon's Model

Many of these traditions converged in the influential model that Theodore Millon began to develop in the 1960s. One of the salient aspects of this model is its integrative perspective, reflected in its attempt at accounting for both the structure and the dynamics of personality. Also, it tries to combine a nomothetic perspective (focusing on how needs, motives, traits, schemas, and defenses relate to one another) and an idiographic perspective (with a focus on individual differences). Thus, the model combines personality prototypes (a nomothetic perspective that would become very influential in the development of psychiatric diagnosis) and personality subtypes, a more idiographic attempt at characterizing personality (Millon, 1969; Cardenal, Sánchez, & Ortiz-Tallo, 2007).

Millon's model assumes a continuum between normality and personality pathology. What we take to be normal personality is the display of flexible, adap-

tive behavior in a given context. Based on an evolutionary perspective, personality is conceived as the more or less distinct style of adaptive functioning that a member of the species displays in his/her environment. But the question of the tipping point between the (still adaptive) personality *style* and personality *disorder* remains open (Oldham & Morris, 1994/2002; Popiel & Pragłowska, 2006).

As mentioned above, Millon's work would have a significant impact on the development of psychiatric diagnosis, as can be appreciated in the evolution of the *Diagnostic and statistical manual of mental disorders* of the American Psychiatric Association.

THE DSM AND ICD SYSTEMS

The first edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) was the result of a process that began with the military need for standardized psychiatric diagnoses in the context of World War II (Oldham, 2014). After the US War Department produced a psychoanalytically-oriented document for the classification of mental disorders in 1943, the American Psychiatric Association charged its Committee on Nomenclature and Statistics to develop a diagnostic manual. This first edition of the DSM manual (1952) provided four categories of psychiatric disorder: (a) disturbances of pattern; (b) disturbances of traits; (c) disturbances of drive, control, and relationships; and (d) sociopathic disturbances. Against common lore, this reflects the fact that personality pathology was taken into account from the very first edition of the DSM. Generally, personality disorders were viewed as rather permanent patterns of behavior and human interaction that were established by early adulthood and were unlikely to change throughout the life cycle. They were conceived as deficit conditions, reflecting partial arrests or distortions in development that were the consequence of pathological early caretaking (Oldham, 2014). Personality pattern disturbances were conceived as the less likely to change, while a more optimistic view was held for personality trait disturbances. The sociopathic category was generically destined to behaviors related to social deviation (from antisocial behavior to addiction).

The main reason for the development of the second edition of the manual was the publication of the 8th edition of the International Classification of Diseases (ICD) by the World Health Organization in 1967, with the American Psychiatric Association desiring to reconcile its diagnostic terminology with the

international system of the time. This led to an emphasis on trying to reach consensus on observable, measurable, enduring constellations of personality, moving away from theory-driven perspectives. Also, the idea that personality-disordered people do not experience emotional distress was abandoned, as were the four categories of DSM-I. The categories included in this second version of the manual were: inadequate, paranoid, cyclothymic, schizoid, hysterical, passive-aggressive, obsessive-compulsive, explosive, antisocial, and asthenic personality disorders. The last of these was an inclusion that would not be retained in the next edition of the manual.

The 1970s were marked by a strong concern for the reliability of psychiatric diagnoses. The neo-Kraepelinian revolution in American psychiatry led to an "atheoretical approach" – one that was supposed to be above parochial interests and closely linked to explicit criteria, often in terms of observable behavior that could be reliably assessed. Some critics (Lezenweger & Clarkin, 2005) remarked that the issue of reliability was conflated with that of the atheoretical approach, but clearly the focus was on generating a diagnostic system that would be both reliable and useful for all theoretical approaches and mental health professionals.

A multiaxial evaluation system was introduced that would survive many editions to be dropped in the last version of the DSM. Axis I included disorders conceived of as "episodic," whereas Axis II was reserved for personality disorders (considered to have a psychological origin) and specific developmental problems (considered to be biologically caused).

These changes to the diagnostic system led to an increase in the interest and research in the field of personality disorders. The *Journal of Personality Disorders* and the International Society for the Study of Personality Disorders were established in this fertile period (Lezenweger & Clarkin, 2005). The explosive personality disorder and the cyclothymic personality disorders of the previous edition were renamed and moved to Axis I, while asthenic personality disorder was removed, as mentioned above. The schizoid category was split into three more specific categories, and two new categories were added: borderline personality disorder and narcissistic personality disorder.

In 1987, a revised edition of the DSM-III was published, with input from researchers and clinicians, upholding the same principles as the original version, identifying reliable diagnostic categories that were both clinically-useful and consistent with research. There were no significant changes in the personality disorders section. All of them were defined by polythetic criteria sets. Two provisional categories were included: sadistic personality disorder and self-defeating personality disorder, but none of them would survive the next revision of the DSM.

The significant increase in research in the field led to a considerable amount of empirical data that was used for the revision of the section in DSM-IV, published in 1994. General diagnostic criteria for any personality disorder were included in the manual for the first time, including early onset, pervasiveness, inflexibility and long duration, albeit as a result of expert consensus rather than empirical research. The categories and dimensional organization of the personality disorders of DSM-III-R were maintained, with the exception of passive-aggressive personality disorder, which was included in Appendix B, where categories for further study were listed. It was renamed "negativistic personality disorder" and its criteria were revised because their previous definitions were considered too generic. A rather controversial depressive personality disorder was also included in Appendix B and presented as different from either passive--aggressive personality disorder or Axis I dysthymic disorder.

The next revision took place in 2000, but it was mostly aimed at updating information and revising the texts accompanying the diagnoses, as indicated by the acronym DSM-IV-TR (text revision).

Although the empirical support of DSM-IV was considerably stronger than that of previous editions, a number of problems with the categorical approach became evident from the very publication of the system. A number of important questions remained unanswered, and many important problems were not solved. The issues of dimensions versus categories led to a heated debate, mostly presented as a matter of choice between incompatible systems. Of course, the categorical approach, based on the idea of discontinuity, is central to the neo-Kraepelinian perspective, but certainly not without its problems, and these were probably the most evident in the field of personality disorders. The three clusters of DSM-IV – A (odd and eccentric personalities), B (dramatic, emotional, and erratic personalities), and C (anxious and fearful personalities) – were certainly dimensional in nature.

Also, clinical practice revealed a clear tendency in clinicians to give single diagnoses of personality disorder, while research based on semi-structured interviews shows that clients normally meet criteria for two or three personality disorders (Oldham, Skodal, & Kellman, 1992; Shedler & Westen, 2004; Widiger et al., 1991).

In order to address this state of affairs, the American Psychiatric Association (APA) and the National Institute of Mental Health (NIMH) convened a series of research conferences to develop an agenda for another revision of the DSM, which would become DSM-5. Distinguished researchers raised a number of important criticisms, highlighting that the DSM-IV system failed to fulfill the basic

objectives of facilitating communication between clinicians and researchers and of fostering advances in the management of these conditions. The benefits of dimensional approaches for characterizing personality traits were also highlighted and backed by a systematic revision of all the existing dimensional models of personality pathology (notably the five domains of the Big Five; Cloninger's psychobiological seven-dimensional model; Livesley's four-factor model, consisting of emotional dysregulation, dissocial behavior, inhibitedness, and compulsivity; Clark and Watson's three-factor model, comprising negative affectivity, positive affectivity, and constraint; the interpersonal circumplex dimensions of agency and communion; and the three polarities – i.e., self-other, active--passive, and pleasure-pain, proposed by Millon; Trull & Widiger, 2013). A workgroup on the topic was established by the APA. After prolonged debate, a hybrid dimensional and categorical system was proposed for DSM-5.

The original categories of DSM-IV were maintained in Section II of the new manual, while the dimensional system was placed in Section III. This model comprises six specific personality disorders (schizotypal, antisocial, borderline, narcissistic, avoidant, and obsessive-compulsive), plus a seventh diagnosis, that of personality disorder-trait specific. This category allows for the description of individual trait profiles of clients who do not have any of the six disorders. Pathological personality traits are grouped into five domains that reflect the existing dimensional approaches. The new system also includes another dimensional aspect, that of level of impairment in functioning, which is of obvious clinical relevance in two areas: self and interpersonal. The main areas of personality assessment according to DSM-5 are depicted in Figure 1 (a more detailed description of DSM-5 model as well as the proposal of the questionnaire designed for the assessment of the traits according to DSM-5 has been provided by Strus et al., 2017, further on in this volume).

Regardless of the diagnostic system, patients with borderline personality disorder (BPD) tend to be the most problematic for mental health professionals. This is due to the complexity of clinical picture, chronic course and suicidality, and high comorbidity with other disorders, which means reliable diagnosis enabling sensitive assessment of changes (in the course of treatment) seems essential. The checklist for BPD is described by Bloo, Arntz, and Schouten in this volume, and the DSM-5 approach to the BPD diagnosis is illustrated in Figure 2.

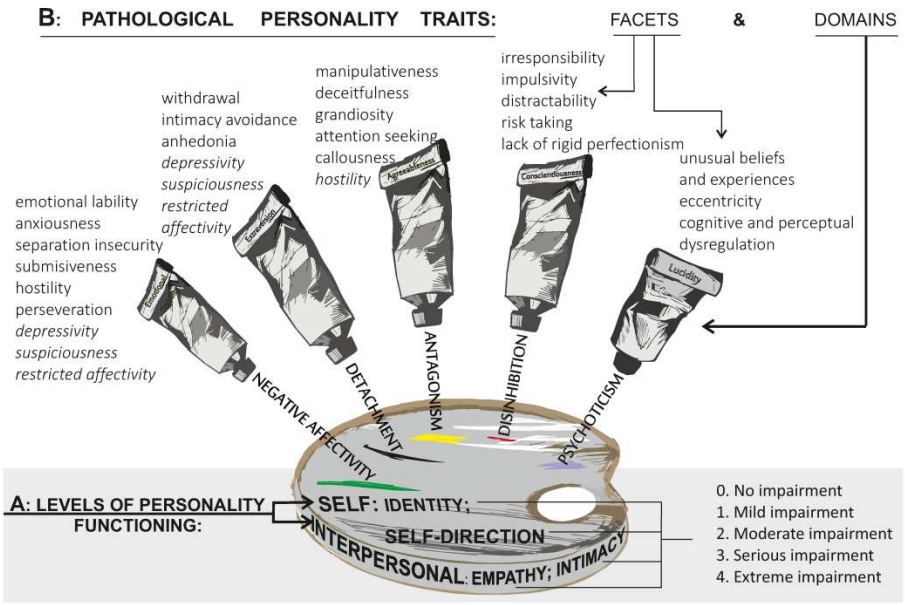

Figure 1. DSM-5 alternative model of personality disorders.

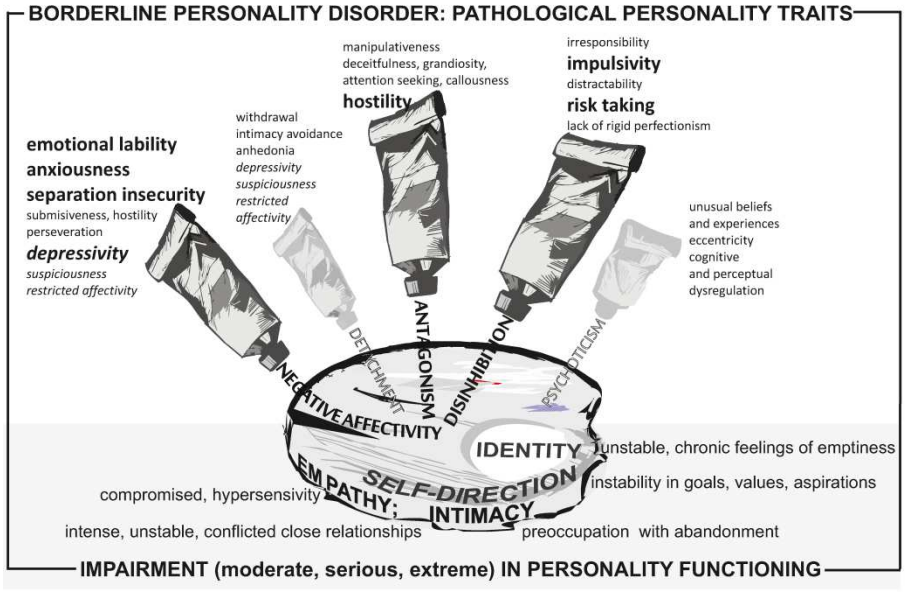

Figure 2. Borderline personality disorder according to DSM-5 alternative model.

The diagnosis of personality disorder according to DSM-IV and ICD-10 was very similar, except for the way of coding personality disorders on Axis II in the multiaxial DSM system, which "forced" psychologists to consider personality disorder in each patient with an Axis I problem. But empirical evidence would not support the polythetic categorical system. Moreover, according to Tyrer (Tyrer et al., 2011; Tyrer, Reed, & Crawford, 2013), only borderline, antisocial, and mixed personality disorders were responsible for 95% of PD diagnoses, and specific categorical diagnoses other than borderline personality disorder and personality disorder 'NOS' (not otherwise specified) were very rarely used.

This led not only to the abandonment of the multiaxial system in DSM-5, but also to radical changes in the proposed ICD-11 (Tyrer et al., 2011; Tyrer et al., 2015). The ICD-11 proposal emphasizes the severity of personality disturbance and does not attempt to preserve the traditional personality disorder categories. Consequently, the only category is personality disorder as such, described by three degrees of severity, in the recent past: mild, moderate, and severe personality disorder. According to the ICD-11 proposal described by Tyrer et al. (2015) the diagnosis starts with establishing whether the patient satisfies the general definition of personality disorder (no significant changes compared to previous diagnoses of personality disorder). The second step is to identify the severity of personality disturbance. The third step is a description of severity according to five domain traits. These traits show which of the main facets of personality are the most prominent in the individual. Only one domain (anancastic features) is different from DSM-5). ICD-11 proposal is planned to be published in 2017. It tends to be a "practitioner friendly"diagnostic system that enables to quickly assess the presence of PD, leaving the assessment of domains to specialists (Tyrer et. al., 2015). The future will show whether it will be published in the proposed way and to what extent it will be an improvement.

However, the problems and limitations of the DSM system led some researchers (Insel et al., 2010) to search for alternative classification systems that would be better based in biology and less dependent on clinical judgment (the Research Domain Criteria). The main assumption of this approach – that mental disorders are essentially disorders of the brain – would make them more compatible with neurobiological perspectives on personality such as those proposed by Cloninger (Cloninger, Svrakic, & Przybeck, 1993) and Siever (Siever & Davies, 1991), but also at odds with more psychological or integrative approaches. Some researchers (Hofmann, 2014) have proposed a combined system of classification, one that would be the result of empirical data emerging from both the advances in the understanding of neurobiology and empirically-based cognitive-behavioral

psychopathology. The future will tell how productive and influential this research paradigm and classification systems prove to be.

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