Can we do better in ICD-11?

We have got to make a clear distinction between personality traits, which are habitual long-lasting tendencies, and which are part of normal functioning (ego-syntonic), and symptoms, which are unpleasant and regarded as alien and undesirable (ego-dystonic).

The inter-situational, inter-rater and temporal reliability of a schedule for rating personality disorders is described. In an initial study with a simplified form of the schedule in patients from different wards of a psychiatric hospital inter-situational reliability between raters was higher for patients with personality disorders than with no personality disorder. Using the full schedule, inter-rater reliability, using audiotaped and separate interviews, and temporal reliability at interviews conducted a mean of 12.5 months apart all reached a satisfactory level, suggesting that the schedule may be a useful instrument for measuring deviant personality traits.
Classification of Personality Disorder

By PETER TYRER and JOHN ALEXANDER

SUMMARY An interview schedule was used to record the personality traits of 130 psychiatric patients, 65 with a primary clinical diagnosis of personality disorder and 65 with other diagnoses. The results were analysed by factor analysis and three types of cluster analysis. Factor analysis showed a similar structure of personality variables in both groups of patients, supporting the notion that personality disorders differ only in degree from the personalities of other psychiatric patients. Cluster analysis revealed five discrete categories; sociopathic, passive-dependent, anankastic, schizoid and a non-personality-disordered group. Of all the personality-disordered patients 63 per cent fell into the passive-dependent or sociopathic category. The results suggest that the current classification of personality disorder could be simplified.

Despite many criticisms the concept of personality disorder remains a useful one for psychiatrists (Lewis, 1974; Shepherd and Sartorius, 1974) and is included in formal classifications of illness (World Health Organization, 1965; American Psychiatric Association, 1968). Unfortunately it has not achieved the same diagnostic status as other psychiatric disorders because of major difficulties in establishing a valid and reliable classification (Walton et al, 1970; Walton and Presly, 1973). Current research is aimed at developing new methods for categorizing patients.

Patients and procedure

Over an 18 month period all patients attending PT’s out-patient clinic at the Department of Psychiatry, Southampton, were assessed provided that they satisfied one of the following criteria: (i) a relative or close friend of the patient who had known the patient for at least 10 years could be interviewed, or (ii) the assessor had seen the patient at least three times, one of which was at a time when the patient had no formal psychiatric disorder.
‘Although the numbers involved in the separate aspects of reliability were small the results suggest that abnormal personality can be assessed formally in the same way as mental state. If future work supports the findings, a bi-axial classification of psychiatric disorder in which both mental state and premorbid personality are recorded will become a distinct possibility.’
Summary of research from 1979-2009

- Four or five trait domains of personality persistently found in research studies.
- These are found in both normal and abnormal personalities (i.e., they have no specific pathological characteristics).
- When they create problems in interpersonal social functioning, they become more severe.
- When more severe, the domains tend to merge.
Preliminary ICD-11 recommendations

- Abolish all individual categories of personality disorder
- Replace by 4 severity levels
- Severity qualified by trait domains
- No age limits
Trait domains

- Internalising (neurotic)
- Externalising (sociopathic)
- Schizoid
- Anankastic
Not exactly new domains

- Externalising (choleric humour) (yellow bile humour)
- Internalising (black bile humour)
- Schizoid (phlegmatic humour)
- Anankastic (sanguine humour)

(After Hippocrates 422 BC & Galen 192AD)
How will the trait domains be defined?

By monothetic rather than polythetic criteria (ie all will apply – eg trait domain 2 – fearful, anxious, hypervigilant, cautious are all necessary)

Using the evidence from both normal and pathological personality disturbance
How will severity be defined

- By overlap of trait domains (the more severe the personality disorder the more domains are involved)
- By degree of social dysfunction
- By risk to self and others
Severity categories

- No personality disturbance
- Personality difficulty (not coded)
- Personality disorder
- Complex personality disorder
- Severe personality disorder
Long-term pattern of poor interpersonal functioning, self-awareness and relationships with others occurring at any age

The problems created by the personality features are closely linked to setting and are only present in some situations, and in other settings inter-personal and social functioning is adequate or good

The problems created by the personality features are well-circumscribed but are present all the time and are largely independent of situation, and there is a persistent lack of mutual understanding that impairs most relationships. The pattern of conflict and misunderstanding in personal interactions, lack of awareness of the needs and feelings of others, poor self concepts, and diminished mutuality and sharing are present in most relationships to some extent and create problems for others

There are persistent difficulties in inter-personal and social functioning and these may distress the sufferer but also creates problems for others. The lack of mutual understanding leads to overt conflict with others and prevents adjustment at work and at leisure. Many abnormal traits are frequently displayed

The problems created by the personality disturbance are as for complex personality disorder but in addition the manifestations of the personality disturbance are so disturbing or threatening that they lead to a significant risk to the self or others and action of some sort is necessary

Personality disturbance present

Personality difficulty

Personality disorder

Complex personality disorder

Severe personality disorder
Summary of personality domains

- **Schizoid domain**
  Traits characterised by social indifference, aloofness, introspection, reduced expression of affect, suspicion and lack of empathy.

- **Anankastic domain**
  Traits characterised by over-conscientious behaviour, excessive orderliness, perfectionism, inflexibility and cautiousness.

- **Externalising domain**
  Traits characterised by irresponsibility, antagonism and lack of regard for the needs of others, and by aggression and anger, insensitivity or callousness, deceit, and egocentricity.

- **Internalising domain**
  Traits characterised by anxiousness, lack of self-confidence, poor self-esteem and self-worth, shyness, timidity, dependence on others and reluctance to make decisions.
Illustration of overlap of domains as personality severity increases
Old borderline personality disorder

Where borderline fits into the new classification
Why is almost all treatment research in personality disorder concentrated on borderline personality disorder?

- Because the internalising and externalising domains are the most common

- Because the borderline concept is so heterogeneous anyone with a personality disorder is likely to qualify for trials

- Because only the borderline group has an excess of treatment-seeking personalities (Type S) (Tyrer et al, 2007)
Primary Article for Discussion
Why borderline personality disorder is neither borderline nor a personality disorder

PETER TYRER, Department of Psychological Medicine, Division of Neuroscience and Mental Health, Imperial College, London, UK

ABSTRACT
Objectives  Borderline personality disorder is the most well-studied personality disorder in psychiatry. Despite its great influence in the study of these conditions, it has not been properly recognized that borderline personality disorder is atypical.
Design  A critical analysis of the differences between borderline and other personality disorders is made.
Method  A comparison is made between borderline personality disorder and other personality disorders with respect to diagnostic criteria, relationship to normal personality variation and treatment options.
Results  Analysis of the operational criteria for borderline and schizotypal personality disorders shows that these are the only personality disorders that are dominated by discrete symptoms rather than traits. Cluster analysis of a data set of personality traits obtained between 1976 and 1978 (before borderline personality disorder became fashionable in the UK) could find no profile that supports the existence of a borderline personality disorder grouping, and the study of published papers on treatment in personality disorder shows a 3:1 ratio for borderline personality disorder compared with all other personality disorders combined, approaching 9:1 when unspecified (probably mainly borderline) conditions are taken into account.
Conclusions  Borderline personality disorder is incorrectly classified as a personality disorder and does an injustice to those who suffer from it. It is better classified as a condition of recurrent unstable mood and behaviour, or fluxithymia, which is better placed with the mood disorders than in odd isolation as a personality disorder. Copyright © 2009 John Wiley & Sons, Ltd.
How does pharmacotherapy of personality disorders fare?

Not very well, but many randomised trials have been carried out in the past 20 years, almost all in borderline personality disorder.

Most of the trials have been judged to be of low quality by NICE (NCCMH, 2009).

Using GRADE ratings of 124 outcomes in over 40 trials, 78 (63%) were ‘very low’, 11 (9%) were ‘low’, 33 (27%) were ‘moderate’ and only 2 (1.6%) ‘high’.
Differing conclusions

- APA (2001) “pharmacotherapy often has an important adjunctive role, especially for diminution of symptoms such as affective instability, impulsivity, psychotic-like symptoms, and self-destructive behavior”

- NICE (2009) “antipsychotic drugs should not be used for the medium- and long-term treatment of borderline personality disorder” - and in general drug treatment should be avoided except in an emergency; ‘short-term use of sedative medication may be considered cautiously as part of the overall treatment plan for people with borderline personality disorder in a crisis’, ‘but for no longer than 1 week’

- Lieb et al (2010) “pharmacotherapy should be targeted at specific symptoms”
Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials

Klaus Lieb, Birgit Völlm, Gerta Rücker, Antje Timmer and Jutta M. Stoffers

Background
Many patients with borderline personality disorder receive pharmacological treatment, but there is uncertainty about the usefulness of such therapies.

Aims
To evaluate the evidence of effectiveness of pharmacotherapy in treating different facets of the psychopathology of borderline personality disorder.

Method
A Cochrane Collaboration systematic review and meta-analysis of randomised comparisons of drug v. placebo, drug v. drug, or single drug v. combined drug treatment in adult patients with borderline personality disorder was conducted. Primary outcomes were overall disorder severity as well as specific core symptoms. Secondary outcomes comprised associated psychiatric pathology and drug tolerability.

Results
Twenty-seven trials were included in which first- and second-generation antipsychotics, mood stabilisers, antidepressants and omega-3 fatty acids were tested. Most beneficial effects were found for the mood stabilisers topiramate, lamotrigine and valproate semisodium, and the second-generation antipsychotics aripiprazole and olanzapine. However, the robustness of findings is low, since they are based mostly on single, small studies. Selective serotonin reuptake inhibitors so far lack high-level evidence of effectiveness.

Conclusions
The current evidence from randomised controlled trials suggests that drug treatment, especially with mood stabilisers and second-generation antipsychotics, may be effective for treating a number of core symptoms and associated psychopathology, but the evidence does not currently support effectiveness for overall severity of borderline personality disorder. Pharmacotherapy should therefore be targeted at specific symptoms.

Declaration of interest
None.
Effect of removing four outlying studies from analysis (as in NICE)

None of the pharmacological studies suggest that antipsychotic drugs, topiramate or selective serotonin reuptake inhibitors have any value in the treatment of borderline personality disorder.

The position of mood stabilisers is less clear.
Section B: Project Details

HTA Priority Area: 10/103 Use of mood stabiliser in borderline personality disorder

Full title of project (expand any abbreviations):
The clinical and cost effectiveness of lamotrigine for people with borderline personality disorder: Randomised controlled trial

Relevance to commissioning brief:
Recent national guidance on the treatment for people with borderline personality disorder highlighted the potential value of mood stabilisers but concluded that there is currently insufficient evidence to recommend the use of any drug in the treatment of this condition. By conducting a properly powered placebo-controlled randomised trial of lamotrigine for people with borderline personality disorder we will directly address the commissioning brief and generate high-quality evidence on the clinical and cost effectiveness of a mood stabiliser that may benefit people with this distressing disorder. We have selected lamotrigine because available evidence suggests that it could reduce core features of borderline personality disorder while being relatively safe in overdose and less harmful to those exposed to this drug in utero than valproate.

Strategic HA: London
Country if not UK: 
No. of applicants: 12

Start date: 01/03/2012
End date: 30/11/2014

Research grant: £1,441,000
Research grant inc. NHS costs: £1,539,000

☐ Is a Clinical Trials Unit (CTU) involved with this application?
☐ If Yes, does the unit hold an UK CRC reg.? 
If Yes, please specify the CTU registration number: 26
☐ Is the unit receiving Clinical Evaluation and Trial support funding from the NETSCC?
The classification of personality disorder is in need of repair and resuscitation.

We have a way forward that is simple and straightforward.

Drug treatment may have a place but we need satisfactory long-term outcomes.