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# Editorial
# The classification of personality disorders in ICD-11: Implications for forensic psychiatry

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Twenty years ago, *Criminal Behaviour and Mental Health* carried an article from me entitled 'Flamboyant, erratic, dramatic, borderline, antisocial, sadistic, narcissistic, histrionic and impulsive personality disorder: who cares which?' (Tyrer, 1992). The many years since have confirmed the answer I gave in the article, the only ones who care are those with a vested interest in keeping these terms. The average clinician certainly does not seem to take much interest in these curious adjectives. When the International Classification of Diseases (11th edition) (ICD-11) working group for the revision of personality disorders met to review the use of the diagnostic categories in the ICD-10 (World Health Organisation, 1992) classification of personality disorders across different countries, we found that borderline, dissocial and mixed personality disorders were responsible for 95% of all personality disorder diagnoses, but more botheringly, they were diagnosed in well under 5% of all patients. When epidemiological studies show that the prevalence of personality disorders in the community is at or above 5% (Coid et al., 2006; Huang et al., 2009), there is clearly something wrong – this diagnostic system apparently leads to the 'Great Clinician Switch Off'.

Why is this? The classification clearly has no clinical utility, and possible reasons include (1) the stigmatic nature of the label, (2) the high comorbidity between different personality disorders, which is clearly a false separation as nobody is prepared to argue that this represents true comorbidity in the form of separate disorders (Livesley and Jackson, 1986) and (3) the very high proportion of what is called personality disorder not otherwise specified in the Diagnostic and Statistical Manual (DSM) classification (Verheul and Widiger, 2004), giving the clear message 'a plague on your classification, it does not represent what I see in my clinic'. The more damning criticism is that neither the current US DSM nor

ICD classifications have a satisfactory evidence base. Each of the adjectival labels for personality disorder, first described by Kurt Schneider in 1923 but added to sequentially since, has been created by 'expert evidence' (i.e. advisory committees and task forces). Eight of the original Schneiderian 'psychopathic types' have just been reformed under different names (Tyrer, 2004). So the famous sensitive personality (*der sensitive Beziehungswahn*) became paranoid personality disorder and insecure sensitive, insecure anankastic, self-assertive, emotionally unstable, explosive, affectless and asthenic became relabelled, respectively, as avoidant, obsessive compulsive, narcissistic, borderline, antisocial, schizoid and dependent personalities in DSM-III. Schneider was a clever man, and the continuation of these categories would not matter if these committees had good evidence to guide their discussions, but in general, they have not, so they have been guided by whim, and as expert opinion is the lowest level of the evidence hierarchy, it can be trumped by any data from a higher level.

These data exist. The best scientific evidence for personality disturbance comes from two lines of research, trait theory and dimensional structure. Trait theory has a long-established place in the assessment of personality (Matthews et al., 2003) and, until recently, has largely been ignored by clinicians and researchers interested in personality disorder. Everyone has a unique personality, but these are made up primarily from a combination of traits that act as a substrate for the rest of personality to develop upon. Some are more prominent than others (higher order traits), and the many others secondary to these can be used to define personality further. But the task of classifying these becomes unproductive if all these traits are taken into account, and it is usually wise to concentrate any classification on a limited number. Most evidence suggests that four or five will suffice (Mulder et al., 2011).

The dimensional structure has developed from a range of studies that have shown no meaningful qualitative differences between the so-called normal personalities and pathological ones (Tyrer and Alexander, 1979; Clark et al., 1997; Kushner et al., 2011), and this is supported by genetic evidence also (Jang and Livesley, 1999). Whilst the dimensional structure is also true for many other psychiatric disorders, it is particularly relevant for personality disturbance in view of the high negative valence of the diagnosis.

These two lines of evidence underlies the justification for the ICD-11 classification of personality disorders, a new, simplified system that is informed by evidence and does not go beyond it. The proposal, developed by a multinational cross-disciplinary group approved by the World Health Organisation, is now close to reaching its final stages. Its essential elements comprise diagnosis by severity with the main features at each level of severity subsumed into four domains. The names of the severity levels are still not fully decided, but there are four graded levels of severity beyond normal personality (Tyrer et al., 2011a). These are personality difficulty (classified as a Z-code and not qualifying as a disorder in the ICD classification but still very important), mild personality



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disorder, moderate personality disorder and severe personality disorder. The domains are close to being given their final names – many constituents, including service users, are commenting on the options – and the likely four domains are internalising (emotional), externalising (antagonistic), detached and anankastic (Mulder et al., 2011; Tyrer et al., 2011b). These domains have monothetic descriptions, and any number of them can be used to qualify the main level of severity if needed.

The antagonistic domain includes many of the features currently diagnosed as antisocial or dissocial personality disorder; the revision group was not sufficiently convinced to make any distinction between these in selecting the domains, although we recognise that it is a controversial area, not least as 'psychopathy' as a category has never been included in formal classifications despite having widespread use. We are continuing to receive advice on this in our work group and welcome comments. In the forthcoming ICD and DSM classifications, there is a merging of child and adult diagnoses, so there is no separate section on childhood disorders. This means that personality disorder can be diagnosed at any age, whereas previously, it was not permitted before the age of 18, even though most personality abnormality develops before this age. With the study of callous and unemotional states in childhood, a strong case has been made for the identification of psychopathy at a very early age (Dadds et al., 2012; Kumsta et al., 2012). Rutter (2012) and Viding and McCrory (2012) have argued for the diagnostic separation of antisocial personality disorder and psychopathy in classification, although they also recognise that the evidence is not yet strong enough to create separate categories here. We, and others in the World Health Organisation group, are not convinced that we have enough evidence to separate these two at the domain level, and some biological evidence suggests they are similar (Raine et al., 2010).

One other interesting consequence of the new classification that has relevance for forensic psychiatry is that severe personality disorder almost always affects more than one trait domain, manifesting most clearly in the very large number of personality disorder categories identified in the current classification when research studies are undertaken (Coid et al., 1999). Most of these in the new classification will be delineated as severe personality disorder with often many additional domain traits (Tyrer and Johnson, 1996) and a range of additional pathology (Yang et al., 2010), but by using a single dimension of severity, this category will eliminate the confusion of comorbidity. The ironical postscript to the highly criticised Dangerous and Severe Personality Disorder Programme, a condition that I renamed the 'Jack Straw Syndrome' at the time as it was a straw syndrome invented by a government minister (Home Secretary), not a task force, may have hit on the right way of classifying personality disorder (Duggan, 2011).

The consequence of the ICD-11 revision is that categories of personality disorder are now redundant. Indeed, they have always been so, and Livesley



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(2012) has made a devastating critique of the DSM-5 classification as a failed attempt to combine traits, categories and dimensions in an unwieldy and unmanageable classification that lacks all semblance of clinical utility. Indeed, the latest news is that even the American Psychiatric Association cannot tolerate it and will return to the old DSM-IV classification of personality disorders when the DSM-5 is published, with the DSM-5 proposal placed in a parking lot to be revisited by weary travellers at some time in the very distant future. A return to DSM-IV cannot be regarded as an advance, none of the DSM classifications have had good justification for inclusion and we hope that more people will now turn to a classification that we claim for the first time combines science, evidence and clinical utility.

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