Psychological Medicine, 1974, **4**, 141–146

Personality disorder and the *International Classification of Diseases*[1]

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SYNOPSIS Despite diagnostic imprecision and terminological confusion, the concept of personality disorder remains indispensable to clinical psychiatric practice. In relation to the *International Classification of Diseases* the problems were examined at a seminar which formed part of the World Health Organization's programme on Psychiatric Diagnosis, Classification, and Statistics. The conclusions of the seminar are presented in this paper.

The foregoing review by Sir Aubrey Lewis (1974) clearly underlines Maughs's conclusion that 'after fifty years of sporadic investigation of psychopathy our understanding of the subject is still rudimentary, and our researches wretchedly inadequate' (Maughs, 1961). This verdict is upheld by recent work on the subject (Petrilowitsch, 1967; Schulsinger, 1972; Presly and Walton, 1973; Walker and McCabe, 1973). It is nonetheless indisputable that some working concept of psychopathic personality is essential for the practice of clinical psychiatry, a fact which is acknowledged by the inclusion of a separate category covering 'personality disorders' in the *International Classification of Diseases* (*I.C.D.*). The *Glossary of Mental Disorders* prepared by the Sub-Committee of Mental Disorders of the Registrar General's Advisory Committee on Medical Nomenclature and Statistics defines personality disorders as follows:

'This category refers to a group of more or less well-defined anomalies or deviations of personality which are not the result of psychosis or any other illness. The differentiation of these personalities is to some extent arbitrary and the reference to a given group will depend initially on the relative predominance of one or other group of character traits. This category includes what is sometimes called "Psychopathic Personality" (Subcommittee on Classification of Mental Disorders, 1968).

The draft glossary now being prepared by the World Health Organization is more explicit: personality disorder here includes

"deeply ingrained maladaptive patterns of behaviour generally recognizable by the time of adolescence or earlier and continuing throughout most of adult life, although often becoming less obvious in middle or old age. The personality is abnormal either in the balance of its components, their quality and expression or in its total aspect. Because of this deviation or psychopathy the patient suffers or others have to suffer and there is an adverse effect upon the individual or on society. It includes what is sometimes called psychopathic personality, but if this is determined primarily by malfunctioning of the brain, it should not be classified here but as one of the non-psychotic organic brain syndromes (309). When the patient exhibits an anomaly of personality directly related to his neurosis or psychosis, e.g. schizoid personality and schizophrenia or anankastic personality and obsessive compulsive neurosis, the relevant neurosis or psychosis which is in evidence should be diagnosed' (World Health Organization, 1971b).

The importance of this category has emerged

[1]This paper is based on the considerations of the Seventh Seminar on the Standardization of Psychiatric Diagnosis, Classification and Statistics: Personality Disorders and Drug Addiction. *Chairman of seminar:* Professor M. Kato; *vice chairman:* Professor J. Ewalt; *rapporteurs:* Dr. M. Rutter and Dr. E. S. Tan; *advisers:* Miss E. M. Brooke and Dr. T. C. N. Gibbens; *secretary:* Dr. N. Sartorius; *local secretary:* Dr. M. Meguro. A full list of participants is given in the *Report* of the Seminar. A limited number of copies of the *Report* is available to interested experts and can be obtained from Dr. N. Sartorius, Senior Medical Officer, Office of Mental Health, World Health Organization, Avenue Appia, Geneva, Switzerland.

clearly from the work of the World Health Organization programme on Psychiatric Diagnosis, Classification, and Statistics which has been in progress since 1964. A principal objective of this programme, which has been described in detail elsewhere (Shepherd *et al.*, 1968) consists in a systematic, detailed examination of the various categories of mental disorder in Section V of the *International Classification of Diseases*. The conclusions and recommendations of the expert groups have been based on consideration of the results of a selection of case-history and videotape exercises, each presented in the course of a series of annual seminars (Averbuch *et al.*, 1968; Rutter *et al.*, 1969; Astrup and Odegård, 1970; World Health Organization, 1972a). Personality disorders were specifically examined in this context in the seventh of these seminars, which was held in Japan in 1970 (World Health Organization, 1972b).

There was undisputed agreement among the experts consulted that the present sub-division of personality disorders in the *I.C.D.* is inadequate for three principal reasons. First, the individual sub-categories are not comprehensive and do not make clear how far personality 'traits' are included in the various definitions. Secondly, it is unclear how far deviations of personality are related to mental disorder on the one hand—for example, 'schizoid' personality (301.2) to 'schizophrenia', or to an ill-defined notion of normality on the other—for example, 'asthenic' personality (301.6) which, according to the British glossary, 'is signalised by its negative rather than its positive characteristics'. Thirdly, no indication is given of the degree of severity necessary for the diagnosis of a personality disorder.

Several specific points were also emphasized at the WHO seminar, of which the more important were the following:

1. PERSONALITY DISORDER, MENTAL ILLNESS, AND CULTURE

The role played by cultural factors in the concepts of neurosis and personality disorder was apparent from discussion of several case-histories, for example:

Japanese male, aged 28, who sought psychiatric help because he was unable to meet people and had a tremor of his hands. He came from a middle-class rural family and had a protected childhood, graduating from university at the age of 22. He became a government official but had a fear of social contacts. On examination he was found to be unable to look the examiner in the eyes. This patient improved on Morita therapy and was able to function more effectively subsequently.

Most of the Japanese participants at the seminar regarded this patient as exemplifying the so-called 'Shinkeishitsu personality' (Kondo, 1971). The psychiatrists from other countries ranged in their diagnosis from frank neurotic illness to a wide variety of other personality disorders, principally of the anancastic variety. The response to indigenous treatment also highlights the question of the cultural specificity of this type of disorder.

2. PERSONALITY DISORDER AND PSYCHOSIS

The overlap between personality disorder and psychosis was well illustrated by another of the case-histories

Japanese male, aged 19, who was arrested for various forms of serious criminal behaviour. He alleged that his criminal behaviour was committed at the instigation of 'voices'. He came from a working-class family, which moved several times during his childhood. The patient was described as emotionally unstable in school and started to come into conflict with the law from the age of 16. He sniffed glue. It was the murder of a 7 year old girl that led to his arrest and examination. He was found to be prone to telling fantastic stories during interview and, although his death sentence was eventually commuted, he subsequently became quiet and withdrawn and never again mentioned his 'voices'.

There was again a striking difference in the diagnostic assessments of this patient: he was regarded as suffering from a personality disorder by most Japanese participants, but from some form of psychosis by the majority of psychiatrists from other countries. Here, again, the influence of cultural factors on the assessment of personality disorders and frank mental illness clearly requires clarification.

The first WHO seminar had shown that an estimate of a patient's personality is universally acknowledged to be an important factor in diagnostic formulations of the functional psychoses (Shepherd *et al.*, 1968). It was concluded from the findings:

'The clinical association of certain personality types with certain psychoses is integrated into the concept

of the psychotic diagnosis and does not need to be expressed separately. This correspondence does not obtain with the neuroses where more than one diagnostic category, with its corresponding *I.C.D.* number, may become necessary to describe the patient's condition.'

The results of the diagnostic exercises focused on personality disorders showed this generalization to be broadly sustained, and it was apparent that several advantages would accrue from the practice of coding personality separately from either neurosis or psychosis. In the first place, abnormal personality traits can occur in the presence of neurosis; secondly, a neurotic disorder can arise in middle life in a primarily normal personality or can supervene in an acute form in a long-standing personality disorder or after prolonged adversity; and, thirdly, a formal psychotic illness may be preceded or followed by a personality disorder.

3. PERSONALITY DISORDER AND ORGANIC DISEASE

The relationship of personality disorder to organic factors, including drugs, raises problems for classification which were well illustrated by the participants' responses to one of the case histories:

Japanese male, aged 23, who complained of ideas of reference and abnormal body sensations. He was also impulsively violent towards his family. His father was described as taller than average, as were a number of relations on his father's side. The patient had an average school record but started to complain of ideas of reference and abnormal bodily sensations since the age of 14. He had frequent job changes and stated that he had no interest in women. He complained of insomnia and anxiety and was reported to be obstinate and aggressive, with occasional violent reactions on the slightest provocation. He was found to be taller than the average Japanese male, and chromosome studies showed the presence of 47 chromosomes with an XYY constitution. The IQ performance score was 80, the verbal score 79. This patient, after discharge from hospital, continued to exhibit an unsteady employment record and displayed occasional violent reactions towards his family.

The various diagnostic formulations of this case exhibited the problems of relating a diagnosis of 'personality disorder' to such varied categories as XYY syndrome, mental retardation, and schizophrenia.

A video-taped case-history of a man who underwent a deterioration of personality after a prefrontal lobotomy raised an issue of a different type. According to the Eighth Revision of the *I.C.D.* the logical categorization of this case, and the one adopted by most of the participants, should be code no. 309, 'non-psychotic disorder associated with a physical condition'. However, as the sub-categories of 309 are grouped according to physical cause and the clinical syndromes can vary a great deal, much essential information is inevitably lost by coding a case in this way. The abolition of combination categories recommended for *I.C.D.* 9 should go some way towards rectifying this weakness.

4. PERSONALITY DISORDER, ANTI-SOCIAL BEHAVIOUR, AND FORENSIC PSYCHIATRY

The relationship of personality disorders to criminality and anti-social behaviour raises special problems. Most of these are related to the term, 'anti-social personality disorder' (301.7), an unsatisfactory ragbag which is peculiarly susceptible to misunderstanding and misuse. The forensic aspects were clearly illustrated by one of the case-histories:

Japanese male, aged 19, who was referred by a district court for psychiatric assessment after being accused of repeated threats and indecent acts. There was a strong family history of psychiatric abnormality. He was raised by his mother who had neglected him. His conflict with the law started from the second grade in school and the patient had been through a series of correctional institutions. At interview, he was found to be emotionally labile, complaining bitterly about various people. His EEG showed irregular low-voltage activity. The patient was given an indeterminate sentence and stayed four years in a juvenile prison, during which time he was punished for violent behaviour. He was subsequently discharged after a period in an adult prison and continued to come into conflict with the law.

It was generally agreed that when an individual without evidence of personality disorder commits an anti-social act he or she should not be allocated to *I.C.D.* category 301.7. Here the potential advantages of being able to categorize conduct separately from personality are apparent; the examples of 'sexual deviation' or 'excessive drinking', both already in separate *I.C.D.* categories, can be taken as useful precedents.

CONCLUSION

As Lewis points out, it is evident that the fundamental problems associated with personality disorder cannot be resolved without further research. This conclusion was one of the major reasons for retaining the manifestly unsatisfactory fourth digit subdivisions of category 301 in the recommendations for the forthcoming Ninth Revision of the *International Classification of Diseases*.

In terms of future activities there are two that appear to be particularly important and would seem to be logical further steps in WHO's programme on standardization of psychiatric diagnosis, classification, and statistics. The first of these consists in the construction of sharper and more precise definitions which would command general acceptance. The second step would be to devote serious consideration to the possibility of introducing a multiaxial or multidimensional system of recording personality disorders, along the lines of the schema introduced experimentally for the psychiatric disorders of childhood (Rutter *et al.*, 1973). The items on the axes would be necessarily different in the adult sphere, but the allocation of a separate axis to personality would undoubtedly add to the coded information for disease and behaviour. The advantages accruing from an experimental programme with this objective would be considerable.

APPENDIX

Recommendations of the Seventh WHO Seminar on Standardization of Psychiatric Diagnosis, Classification and Statistics of Personality Disorders and Drug Dependence, 1971a

1. GENERAL

i. The standardization of diagnosis, classification and statistics of personality disorder is severely hampered by the lack of scientific data. More research into this problem is essential. It was strongly recommended that WHO should strengthen and/or initiate research in this area. The problems particularly requiring attention are:

a. A more precise delineation of how personality disorders may be differentiated from normal variants of personality. Epidemiological research should be conducted in the light of the sociocultural, and particularly the cross-cultural and comparative aspects of this problem and its public health implications. Particular attention should be paid to the distinguishing of personality traits from personality disorder.

b. The possibility of introducing a multiaxial or multidimensional system of recording personality disorders. Experimental investigations along the lines of those conducted for psychiatric disorders in childhood seem to be indicated. The question of which axes are applicable to adult disorders requires further consideration.

ii. The participants indicated their interest in research and training to ensure better and more widespread use of the *International Classification*. It was recommended that WHO, in continuing activities in this field, should provide opportunities for participants interested in collaborating with WHO in this field.

iii. The glossary on psychiatric disorders that should accompany the Ninth Revision of the *I.C.D.* is of crucial importance for its better use. Further refinement in the glossary should be undertaken in order to minimize incorrect coding and facilitate use of the *I.C.D.* It is suggested that this recommendation regarding the glossary should be brought to the attention of the WHO working group considering revision of the glossary.

iv. In revision of the *I.C.D.*, attention should be paid to the recording of culture-specific entities that might be discovered on further research in the different cultures concerned.

v. For more effective use of the existing classification, it may be necessary to consider the possibility of recording the severity of the abnormality, particularly in personality disorders. This would be of particular use in forensic psychiatry. Investigations into this possibility should be encouraged by WHO.

2. SPECIFIC

i. Category 309 is not satisfactory and it may be useful to consider changing the description of the fourth digit in this category to describe the type of disorder. The underlying organic condition could be coded separately, giving its full *I.C.D.* number. The same applies to categories 292, 293, and 294.

ii. Category 301.7 antisocial personality disorder, needs a very precise description in the glossary because at present it seems to be utilized for the classification of a wide variety of conditions. A new coding should be provided for antisocial disorder not associated with personality disorder or any other psychiatric condition.

iii. The subdivision of the various personality disorders requires reconsideration. Subcategories such

as 'passive-aggressive', 'sensitive', and 'anxious' personality disorders, which were mentioned by some participants and are recognized in some countries, are not satisfactorily described in the glossary and do not have a separate rubric at present. Adequate instructions on how to assign these should be provided and consideration should be given to the question whether any of them merit separate subcategories. In addition, these categories seem to have a different content in different countries.

iv. The glossary should contain instructions on how to code a personality disorder when it occurs after the onset of psychosis or drug dependence or when it is present in association with an acute neurosis. Some modifications of the general description of personality disorders may also be necessary—for example, it may be desirable to modify the statement that in personality disorders the abnormality is permanent.

v. There is some ambiguity about whether 301 concerns personality traits or personality disorders. Thus, 301.0 includes paranoid traits, whereas the other subheadings of 301 seem to suggest that a disorder of personality must be present. It was recommended that the glossary should make explicit which is intended.

vi. Personality is more logically considered in terms of a continuum than of a disease state that is present or absent. The glossary must therefore be explicit on how severe an abnormality of personality must be present for 301 to be coded. Some participants suggested that only extreme departures from normality should be coded, as the diagnosis of minor abnormalities is likely to be quite unreliable, but there was no unanimity on this point. Nevertheless, it was recommended that the working group concerned with the glossary should decide what degree of abnormality is needed and that this should be included in the glossary.

vii. This discussion led to a consideration of the value of noting the degree of abnormality of personality, especially for forensic work, where some studies have shown the predictive value of such a note. It was agreed that severity is an important parameter in any diagnostic formulation and that it is desirable to include severity in the *I.C.D.* coding. In view of the lack of knowledge at present on how to measure this, WHO should undertake research into this topic. It was appreciated that this is a task for the future and that it is impossible to code severity at the present time.

viii. It was recommended that the *I.C.D.* should be amended to bring the drug dependence and alcoholism sections in line with one another. The same applies to the glossary. Withdrawal symptoms should not form a necessary part of the definition of drug dependence and where dependence (including alcoholism) occurs in association with some other psychiatric condition both should be coded. There should also be a coding for tobacco dependence and the subcategories of 304 should be brought in line with the recommendations of the WHO Expert Committee Reports on this topic. The term 'dependence' should replace the term 'addiction' in the *I.C.D.* The coding of multiple drug dependence needs further consideration, as it is unsatisfactory at present.

ix. The instructions in the glossary should be amended so that both neurosis and personality disorder can be coded when both are present.

x. In order to provide adequate data on therapeutic misadventures resulting in psychiatric disorder, it is essential that psychiatrists should be aware of the possibility of using the E code for therapeutic misadventures as an additional category. A note should be inserted in the glossary to this effect.

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