

Symptomatic and Syndromal Continuity in Personality Disorders: Can We Establish A Psycho-periodic Table?

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ÖZET:

Kişilik bozukluklarında semptomatolojik ve sendromal devamlılık: Bir psikoperiyodik cetvel oluşturabilir miyiz?

Bazı araştırmacılar kişilik bozukluklarıyla birinci eksen bozuklukları arasındaki sınırların yeterince belirgin olmadığını, dolayısıyla bu iki uçtaki bozuklukları birbirinin devamı olarak görmemiz gerektiğini söyler. Bu devamlılığın kolayca algılanabilmesi için de, bütün psikiyatrik bozuklukları bilişsellik/algısallık, dürtüsellik/saldırganlık, duygusal kararsızlık ve bunalı/baskılanma yönünden temel bir sınıflandırmaya indirgenebileceğini ifade ederler. Genel kabul olarak klinikte, bunalı/baskılanma içe dönüklük, dürtüsellik/saldırganlık ise dışa dönüklük belirtisi olarak kabul edilegelmiştir. Siever sınıflandırmasının üzerine oturtulan ve tarafımızdan yapılan buradaki yeni gruplandırma(sıralama) geçmiş kabullerimize ters olmakla birlikte, elimize psikopatolojik devamlılık çizelgesi oluşturmak için önemli bir olanak sağlamaktadır.

Buradaki temel düşünce, narsistik kişilik bozukluğunun, çekingen kişilik bozukluğuna göre daha içe dönük bir kişilik örgütlenmesi ve benzer şekilde ısrarcılığın utanmaya göre içe dönüklüğe daha fazla işaret eden bir belirti olduğu önkabullerine dayanır. Narsistik kişilik bozukluğu, erken dönem patolojisidir ki, bu bozuklukta nesne yatırımı azdır. Buna bağlı olarak kullandığı savunma mekanizmaları ilkel mekanizmalardır. Halbuki çekingen ve bağımlı kişilik bozukluğu gösteren hastalar, narsistik çekirdeklere daha az bağlılık gösterirler, bu kişilerde nesne yatırımı kuvvetlidir. Bunun doğal sonucu olarak son iki bozukluk, daha gelişmiş savunma mekanizmaları kullanır. Yani klinik olarak dışa dönüklük gösterdiği söylenen kişilik bozukluklarının(narsistik, antisosyal, paranoid vb) psikopatolojik olarak daha "içsel", klinik olarak içe dönüklük gösterdiği ifade edilen kişilik bozukluklarının(bağımlı, çekingen) da psikopatolojik olarak daha "dışsal" ve nesneye dönük bir yapı gösterdiklerini söyleyebiliriz.

Bu nokta öngörülerek yapılan cetvelde sıralanmış belirtiler, kişilik bozukluklarının tanısal değerlendirmede boyutsal profil çerçevesinde içe dönük-ağır/dışadönük-hafif boyutlarına uygun bir derecelendirme ile dizilmişlerdir. Yani hem kişilik bozuklukları hem de belirtiler, tek bir kriter göz önüne alınarak ortak olarak boyutlandırılmıştır. Başka boyutlarda(örneğin DSM-IV deki A, B, C grupları olarak kategorileştirmek) yapılan sıralama periyodik bir cetvel vermemektedir. Çünkü özellikle kişilik bozukluklarında temel patoloji belki de yeterince "dışlaşmamak"tır. Kişinin içini nesnelerle buluşturamadığı her durumda patolojiden bahsetmek mümkündür. Bu noktadan bakıldığında, narsistik çekirdeklerine olağanüstü bir sadakat gösteren ve fakat nesneyi o ölçüde değersizleştiren yapılanmaların içe en dönük(dolayısıyla patoloji derecesi en yüksek) kişilik örgütlenmeleri olduğunu kabul etmek dinamik bir çerçevede hatalı olmayacaktır.

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Siever and Davis (1991) describe that the borders between personality disorders and Axis I psychiatric disorders are not well-pronounced so that these disorders can be perceived as a continuation of each other on both ends. The authors also indicate that all psychiatric disorders can be reduced to dimensions in respect to cognitive/perceptual, impulsivity/aggression, affective instability and anxiety/inhibition in order to easily comprehend such a continuity.

There is a second important thing which is pointed out by Siever; the clinicians have so far considered anxiety/inhibition as a trait of introversion and impulsivity/aggression as a trait of extroversion, which naturally resulted in interpretation of narcissistic and antisocial personality disorders as extroverted

personalities, and avoidant and dependent personality disorders as introverted personalities. Although our categorization, which is based on Siever's classification, is somewhat contradictory to what we knew so far, it provides us an important tool to establish a timeline for psychopathological continuity.

The following will help to set a basis for this argument: the narcissistic personality disorder is an early pathology with a poor object cathexis, and the individual displaying a pathology rather depending on narcissistic cores within his/her self. And, therefore, the defense mechanisms used are more primitive. On the other hand, individuals with an avoidant and dependent personality disorder are less dependent on narcissistic cores, and they have strong object cathexis. As a natural outcome, these

latter two disorders employ more developed defence mechanisms. In other words, we can state that the personality disorders, which are suggested to clinically demonstrate extroversion (narcissistic, antisocial, paranoid, etc.) have psychopathologically a more “intrinsic” nature, and the ones which are suggested to clinically demonstrate introversion (dependent, avoidant, insight obsessive compulsive, etc.) have psychopathologically a more “extrinsic”, basically extroverted and object oriented nature.

If the pathological dimensions are graded on the basis of this newly defined spectrum, it would be possible to list personality disorders from extroversion to introversion, from left to right on the upper line of the spectrum as follows: Dependent PD, avoidant PD, insight obsessive-compulsive PD, obsessive-compulsive PD without insight, paranoid PD, histrionic PD, antisocial PD, narcissistic PD.

As the schizoid and schizotypal personality disorders can be considered as a variant of schizophrenia, and the borderline personality disorder can be seen as a transitional form, they are excluded. The obsessive compulsive personality disorder can be divided into two; with strong insight and without insight based on the clinical experience (Phillips 2002). Therefore, the obsessive compulsive personality disorder is shown in two subgroups along the spectrum. We believe that the obsessive compulsive personality disorder without insight is closer to the paranoid personality disorder than the one with insight. The obsessive compulsive personality disorder with insight displays a psychopathology closer to the avoidant personality disorder.

Similarly, if we also classify the symptomatology of the individuals with personality disorders in terms of the introversion and extroversion dimension or in parallel in the form of mild and severe symptoms, then the left column of the table would be fulfilled top to bottom in the following order:

Fail to maintain independence, oversensitivity to negative criticism, embarrassment, social inhibition, avoidance from making new friends, decreased self-esteem, avoidance from group activities, preoccupation with details, preoccupation with rules, compulsivity, urge to control, discretion, fear of injury, fear of betrayal, interpreting wrongly, suspiciousness, desire to be center of attention, perseverance, being opponent, grandiosity,

overreacting, criminality, holding a grudge, hating intimate relations, lack of confidants/confidantes, bizarre (inappropriate) affect.

In this case, when they are arranged in order from extroversion toward introversion both from left to right and top to bottom of the spectrum, it can be clearly observed that personality disorders have a syndromal continuity, with each symptom placed in lower and higher degrees of the preceeding and following personality disorder as the grade of symptoms arranged to form a scale of the above mentioned personality disorders.

In addition, if the personality disorders closer to schizophrenia including schizoid PD and schizotypal PD as well as the borderline PD, an intermediate form, are excluded, the remaining personality disorders and symptoms displayed can be arranged to form a psycho-periodic table (which seems like Mendelyev's periodic table of elements) when they are organized based on their introversion and extroversion dimension. Each personality disorder shares one, two or three symptoms strongly, and a few other symptoms weakly with the preceeding and following disorders.

If various degrees of symptoms of the personality disorders are to be highlighted in colors as rated from darkest to lightest on a four-point scale, then there appears a line that we might call psychopathological vertebra linearly going down from upper left to lower right. This vertebra can be extended for some of the “Axis 1” disorders (if grading of introversion is properly dimensioned within the above mentioned framework with an appropriate positioning) to further down to the lower right, and the psycho-periodic spectrum can be expanded syndromally and symptomatologically on both sides of this line.

An interesting point of the spectrum is that all personality disorders display scepticism, compulsivity, misjudgment, fear of betrayal, fear of injury, perseverance and, urge to control in various degrees ranging from the mildest to the most severe. These symptoms constitute sort of a symptomatological body common to all personality disorders.

On the other hand, although there exists no personality disorder which manifests each of these symptoms, the disorder groups which are almost near to manifest all symptoms to some extent are paranoid PD and obsessive and compulsive PD without insight, located in the middle

of the scale. It is worth to have further comments by authors interested in this field. Until more comments are provided, we content ourselves with an explanation saying that “probably development of personality advances embodying a paranoid and obsessive core within its natural course.” In this spectrum, the borderline PD is not consistent with the periodicity. For example, wherever the “sense of emptiness,” a characteristic symptom of the borderline PD, is placed, it is not equally shared by the preceeding or following entity morbid. Therefore, the spectrum excludes the borderline PD when the symptomatological continuity is taken into account. This excluded disorder may be an “assembled” disorder, with different personality disorders being equally comorbid. In fact, it is already known that such patients take syndromal elements from schizophrenia in developing psychosis from time to time, from bipolar disorder in affective instability, from depression in suicidal behavior, and from some other disorders in some symptoms not necessary to be listed here.

For schizoid and schizotypal PDs, there is another case for exclusion from the spectrum. In the introversion/extroversion dimensioning, these two disorders should be placed at the very end of the introversion dimension according to this newly suggested arrangement. In that case, both disorders should have symptoms specific to personality disorders with poor object cathexis such as criminality, overreacting and holding a grudge. However, we know that both disorders do not possess enough homogeneity to manifest these symptoms. Thus, the spectrum cannot integrate neither of these disorders.

We consider the eight personality disorders included in the spectrum as the basic disorders since these disorders do not disrupt the psychopathological continuity, displaying characteristics of climbing up for a symptom while climbing down for another one like the steps of a ladder in terms of the severity of the symptom. In case new personality disorders are to be defined, they will fit in a place among others by narrowing the values on the color scale. It is always possible to fit for a group of already being defined or previously defined disorders among others, however what is most important is to accommodate new nosologic categories in the spectrum by ensuring that they share at least one symptom with the preceeding and following categories to a great extent.

The symptoms in the spectrum have a grading

arranged in accordance with the introverted-severe/extroverted-mild dimension in the dimensional profile resulted from the diagnostic assessment of the personality disorders. This arrangement was made considering the distance-proximity axis to the object in parallel to the object cathexis developed during the psychopathological development, for example; bizarre affect, which never underwent any correction by objects, was selected as a most extreme (severe) sign of introversion at the level of personality disorders. With a similar methodology, fail to maintain independence, dependence on the object (dependency) even at the puerile level, was also selected as the most extreme (mild) sign of extroversion.

The key to the spectrum is the introversion and extroversion dimension for both personality disorders and symptoms, which is very important because the grading in other dimensions (e.g. categorization of groups A, B and C in DSM-IV) do not provide a spectrum including periodicity. It is interesting as well as being important because the underlying pathology, particularly in personality disorders (perhaps in all psychiatric disorders) is the “inability to externalize” adequately. The pathology may occur in any case where the individual fails to associate his/her inner self with objects adequately. From this point of view, I guess it will not be wrong to accept the narcissistic personality disorder, which has an extraordinary loyalty to his/her inner self (narcissistic cores) while devaluing the object to the same extent, as the most introverted personality disorder. The “inability to externalize” adequately may be the most significant determinant of the pathological depth in any of the psychiatric disorders. From an existentialistic view, we need to accept that our ontogenic history is based on adapting to the outer world, and embracing and internalizing the objects. We believe that the most convenient term, which combines each of these elements without any exclusion, would be “to externalize.”

Even though it is possible to expand the spectrum to the right side, to Axis I disorders following the personality disorders, it is challenging to have a consistency. Dimensional grading of Axis I disorders present some difficulties and furthermore the available nosological categorization is subject to definition of new disorders. Even so, it would not be harmful at least to have some attempts to prepare for the future.



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