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 introverted personalities, and avoidant and dependent personality disorders as 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 obsesive 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 preceding 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 homogenicity 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 preceding 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 tough 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 harmfull at least to have some attempts to prepare for the future.
Symptomatic and syndromal continuity in personality disorders: Can we establish a psycho-periodic table?

Figure 1: Symptomatic and Syndromal Continuity in Personality Disorders (Psyco-periodic Table)

References: