

A Comparison Based on a Case Study

Classification of Personality Disorders in Adolescence: ICD-10 and ICD-11

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Abstract

The classification of personality disorders (PDs) has changed fundamentally from ICD-10 to ICD-11; the distinct diagnostic categories of ICD-10 are replaced by a dimensional approach in ICD-11. In ICD-11, various levels of severity are determined by impairments in self-related and interpersonal personality functioning. All ICD-10 subtypes have been eliminated except for borderline PD. Instead, five optional maladaptive personality traits are now used to characterize personality. Removing the age limit for a PD diagnosis is particularly significant for child and adolescent psychiatry, enabling early identification, treatment, and follow-up in children and adolescents. The clinical application of the new PD model will be illustrated using a case study.

Keywords: Child and adolescent psychiatry; ICD-11, maladaptive personality traits; personality disorders; personality functioning

Introduction

Personality disorders (PDs) are deeply ingrained, enduring behavioral patterns characterized by rigid reactions to various personal and social situations. They represent significant deviations from the majority of the population in terms of perception, thinking, feeling, and relationships with others. They are often associated with varying degrees of personal distress and impaired social functioning [1]. Newly defined in ICD-11, a PD is characterized by impairments in self-aspects (e.g., identity, self-esteem, accuracy of self-perception, self-control) and/or interpersonal dysfunction (e.g., ability to form and maintain satisfying relationships, understand others' perspectives, and manage conflict) persisting for an extended period (i.e., ≥ 2 years) [2]. Similar to the Alternative Model of PD in the research section of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), which defines "levels of personality functioning" (identity, self-direction, empathy, and in-

timacy), there is a paradigmatic shift from a categorical to a dimensional approach [3]. Instead of being categorized into separate types, PDs are now assessed along a spectrum of severity, with gradations ranging from mild to severe. The introduction of dimensional diagnostics is based on extensive research suggesting that a dimensional view better reflects reality compared to nosologically distinct categories [4].

The only PD that remains unchanged is borderline PD, which can be supplemented by a "trait qualifier." According to ICD-11, PD can be optionally characterized based on five maladaptive personality traits covering the following domains: Negative Affectivity, Dissociality, Detachment, Disinhibition, and Anankastia (Compulsivity) [2].

Negative Affectivity: Experiencing a wide range of negative emotions in a disproportionate way to the situation, emotional instability, poor emotion regulation, low self-esteem, negativistic attitudes, mistrust.

Dissociality: Disregard for the rights and feelings of others; self-centeredness; lack of empathy; and deceitful, manipulative, and exploitative behavior.

Disinhibition: Tendency toward unreflected, impulsive behavior that often leads to self- or other-endangerment; difficulties concentrating; irresponsibility; recklessness; and a lack of planning.

Detachment: Tendency to maintain interpersonal and emotional distance, avoid social interaction, lack of friendships and intimacy, and limited emotional expression.

Anankastia: Perfectionism (narrow focus on one's own rigid standard of perfection), emotional or behavioral compulsions, and emotional and behavioral restrictions.

The central change in the classification shift of PDs from the perspective of child and adolescent psychiatry has been the removal of the age limit for diagnosing a PD. For a detailed presentation and discussion of the change in the conceptualization of PDs, we refer to Schmeck & Birkhölzer (2020) [5]. The elimination of the age limit provides this classification system with the significant advantage of allowing early identification, follow-up, and disorder-specific therapies for children and adolescents with PD [6–9], for which there are now various approaches available, including Dialectical Behavior Therapy for Adolescents [10], Adolescent Identity Treatment [11], Mentalization-Based Therapy for Adolescents [12], and Schema Therapy for Adolescents [13]. The dimensional model of PD, with various levels of severity, also enables the identification of vulnerable individuals with subsyndromal disorders who could benefit from

therapy [14]. Early interventions may prevent severe impairment of the developing personality and a chronic course of the disorder [14]. Severity levels are also valuable for prognosis, treatment planning, and assessing the course of PD.

Case

We present the case of a 15.9-year-old unaccompanied asylum seeker accused of multiple attempted homicides, endangering life, grievous bodily harm, and simple assault. Additionally, there are allegations of criminal acts against freedom (threats, coercion, deprivation of liberty, and kidnapping) and property (including extortion, robbery, and vehicle theft).

Biography

The adolescent's childhood was marked by violence and escape; he was socialized in a conflictual household and experienced violence between his legal guardians and from his father toward him. At the age of 5 years, he fled with his father for several months to the neighboring country of Switzerland, resulting in an abrupt break in contact with his mother.

Despite initially unremarkable progress (as per medical records), escalating physical and psychological abuse by his father (including scalding with boiling water, stabbing with a red-hot knife, and beatings) led to increasingly borderline aggressive behavioral problems and apparent learning difficulties at the age of 9 years. This behavior, coupled with oppositional behavior at school and further violent escalations at home, resulted in frequent changes of school and interventions by child psychiatric crisis. At the age of 12 years, due to the threat of deportation from the country, the adolescent decided to leave his father and flee alone to Switzerland, where he was received as an unaccompanied minor asylum seeker. Over the following years, he was hospitalized in child and adolescent psychiatric clinics because of massive behavioral problems. At the age of 14 years, he was convicted of attempted grievous bodily harm (he attempted to rip out someone's eyeball with his fingers during an argument) and preparation of such an act. Two years later, the adolescent made a death threat, repeated suicide threats, and finally attempted murder with a bow and arrow, as well as grievous bodily harm.

Psychiatric diagnoses

During the adolescent forensic assessment, a significantly impaired personality structure indicative of a PD was diagnosed using the SCID II interview [15]. The diagnosis is classified below according to the ICD-10 and ICD-11 criteria.

The general entry criteria for the diagnosis of PD according to ICD-10 were fulfilled. However, at the next level of the defined categorical PDs, the adolescent did not sufficiently fulfill the relevant criteria. For example, certain features of paranoid, emotionally unstable, and narcissistic PD are present without reaching a cutoff. As a result, an ICD-10 diagnosis of unspecified PD (F60.9, PD-NOS) was made.

The diagnosis of PD according to ICD-11 is discussed below. The adolescent exhibited clear abnormalities in identity development (Who am I? What defines me as a human being?). Described as contradictory and elusive, he says of himself that he does not know who he really is. Even more striking was his inability to control himself: the adolescent had poor emotion regulation ability with impulsive behavior and extremely low frustration tolerance. In addition, the adolescent was highly incapable of setting meaningful goals and achieving them independently. He often overestimated himself and had marked deficits in structured action planning. Furthermore, he had low self-esteem, which was reflected in his avoidance of situations that are considered too difficult intellectually, socially, or physically. Low self-esteem is also associated with mistrust, leading to the interpretation of well-intentioned statements, in addition to criticism, as direct threats.

In addition to these impairments of self-aspects, the adolescent had pronounced interpersonal difficulties. His behavior in interpersonal relationships was very egocentric, often exerting pressure on others or acting manipulatively. His relationships also seemed to be rather superficial and not characterized by reciprocity, which is probably also related to his pronounced empathy deficit. As all areas of functioning were severely impaired as described, the adolescent's PD was classified as "severe" (6D10.2), with abnormalities in all personality traits except "Anankastia." Diagnosis was made using the Levels of Personality Functioning Questionnaire for Adolescents (LoPF-Q 12-18) and the Semi-Structured Interview for DSM-5 Personality Functions³ (StiP5.1) [16, 17].

Conclusion

This case study highlights the justification for removing the age limit for the diagnosis of a PD in the ICD-11, as corresponding abnormalities can already be sufficiently stable in adolescents [14, 18].

The ICD-10 classification system can be criticized for the fact that "PD Not Otherwise Specified," one of the most common PD diagnoses (as in the case described), does not describe specific characteristics or allow conclusions to be drawn about the severity of the

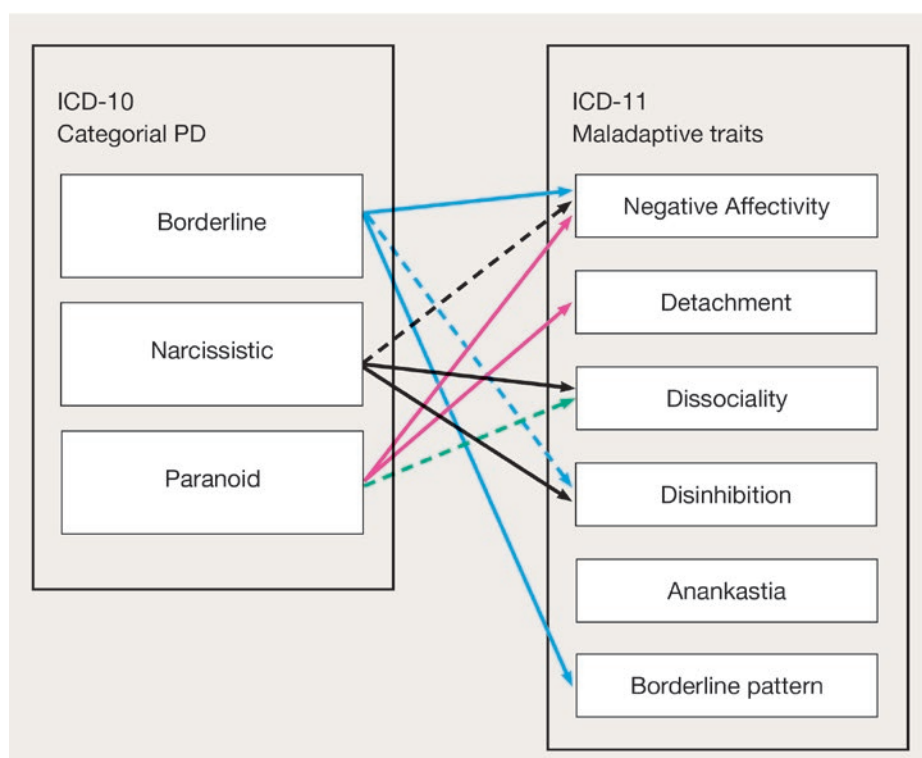


Figure 1: The changes in the classification system are illustrated based on the described case. Abnormalities in categories such as "borderline," "narcissistic," and "paranoid" in ICD-10 are replaced in ICD-11 by the five listed maladaptive traits and the "Borderline" pattern. The arrows depict how categorical diagnoses can be "translated" into the maladaptive personality traits.

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impairment or the treatment plan [19]. In contrast, the ICD-11 definition of impaired personality functions allows not only for an assessment of the severity of the impairment but also for the recording of the central areas of life. This fosters a shared understanding of the problem and the development of common therapy goals, demonstrating clinically relevant benefits. In addition, the dimensional model of PD with different levels of severity allows for the identification and treatment of individuals at risk with subsyndromal disorder symptoms. This allows for early intervention and prevention of chronic progression [14].

In the forensic context of assessment and treatment, ICD-11 provides a more differentiated presentation of both the severity and qualitative manifestation of PDs. This is extremely important in communication with legal practitioners (such as youth advocates and juvenile courts), especially concerning court-ordered measures.

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Conflict of Interest Statement

The authors have no potential conflicts of interest to declare.

Author Contributions

Nicole Geiger: First author, conceptualization, writing of the first draft, refinement, final approval;
Marc Birkhölzer: Supervisor, conceptualization, review and refinement, final approval;
Marc Graf: Review and refinement, final approval.

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