14.10.2022

ICD-11 und Persönlichkeitsstörungen

Univ. Prof. Dr. Stephan Doering
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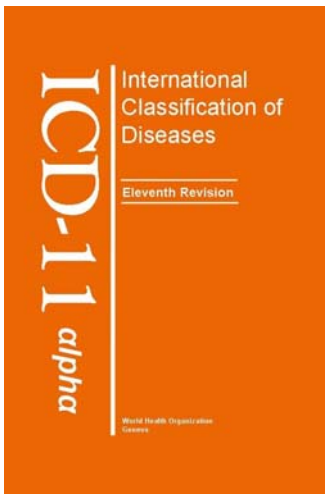


Verabschiedung Mai 2019

Gültigkeit ab 1.1.2022

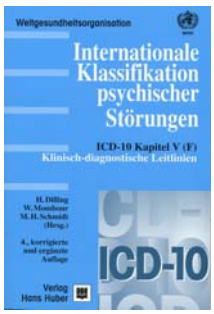
Paradigmenwechsel

Klassifikation der Persönlichkeitsstörungen

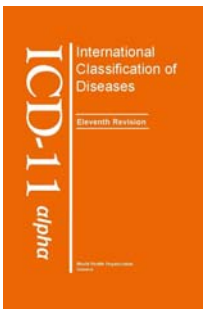
1992

2013

2022



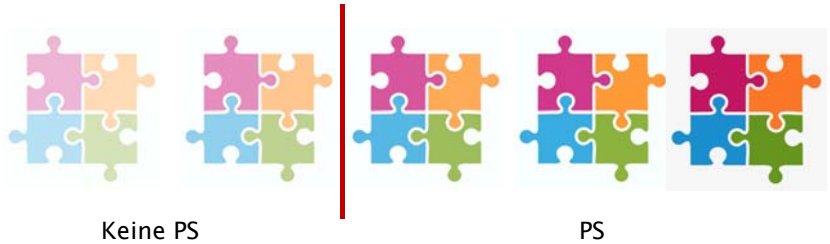
1991



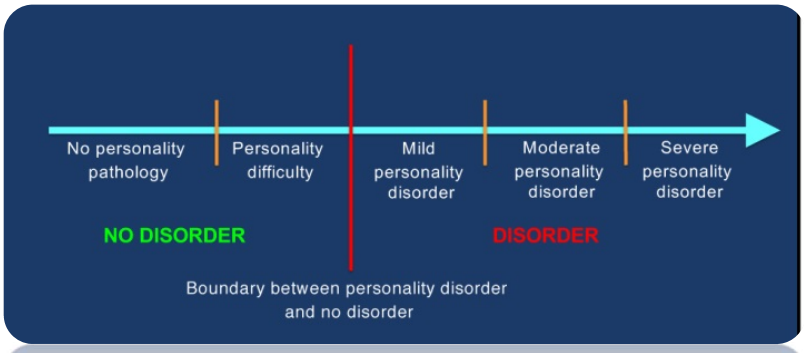
Ersetzung des kategorialen Systems durch ein Hybrid-System:

„Dimensionaler“ Anteil: „Severity“ oder „Personality Function“ -> 5 Stufen

Modularer Anteil: Persönlichkeitszüge



Keine PS PS



Reed 2018

REVIEW

CURRENT OPINION

Diagnosis and classification of personality disorders: novel approaches

Roger Mulder[a] *and Peter Tyrer*[b]

Purpose of review
To provide an update of the recent studies, which have evaluated the radical changes in personality disorder classification in *DSM-5* and *ICD-11*.

Recent findings
Although the *DSM-5* Committee rej
disorder classification, the model w
Disorders (AMPD) has been widely
evaluating its reliability and clinica
by the WHO and is also receiving
which most studies report is consist
descriptive domains, which appear
also be linked to disease extremes

Summary
The changes in *DSM-5* AMPD and
personality disorders. Early researc
researchers. The models more clos
of normal personality. The severity
personality disorder severity is a st
clinicians will use the classification

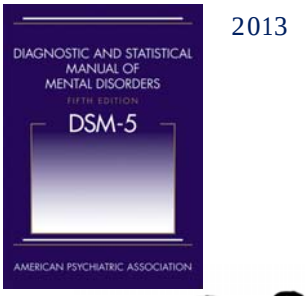
Keywords
classification, *Diagnostic and Statis*
of Diseases, 11th Edition, personal

2019

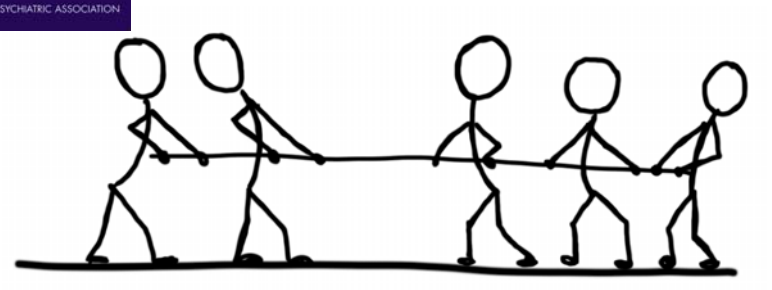
KEY POINTS

- Changes in the classification of personality disorders represent the beginning of a paradigm shift in diagnosis.
- Severity of personality disorder is the strongest predictor of impairment and prognosis.
- The *ICD-11* and *DSM-5* AMPD domains are largely consistent with each other and dimensional models of normal personality.

Paradigmenwechsel – oder doch nicht so ganz?

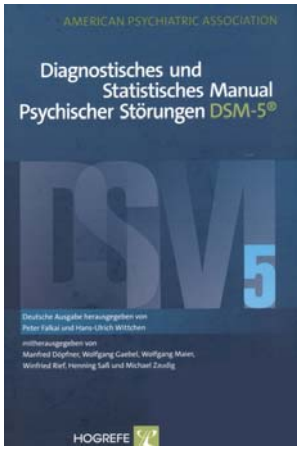


2013



Persönlichkeits-
psycholog*innen

Klinisch tätige
Psychiater*innen/
Psychotherapeut*innen



2013

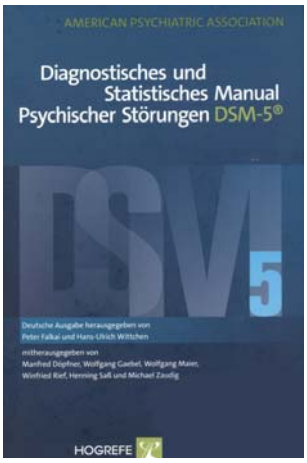
Allgemeine Persönlichkeitsstörung

Kriterien
A. Ein überdauerndes Muster von innerem Erleben und Verhalten, das merklich von den Erwartungen der soziokulturellen Umgebung abweicht. Dieses Muster manifestiert sich in mindestens zwei der folgenden Bereiche: 1. Kognition (d. h. die Art, sich selbst, andere Menschen und Ereignisse wahrzunehmen und zu interpretieren). 2. Affektivität (d. h. die Variationsbreite, Intensität, Labilität und Angemessenheit emotionaler Reaktionen). 3. Gestaltung zwischenmenschlicher Beziehungen. 4. Impulskontrolle. 5. Das überdauernde Muster ist unflexibel und tiefgreifend in einem weiten Bereich persönlicher und sozialer Situationen.
B. Das überdauernde Mus einträchtigungen in soz chen.
C. Das Muster ist stabil und Adoleszenz oder ins frü
D. Das überdauernde Must anderen psychischen St
E. Das überdauernde Mus stanz (z. B. Substanz mi schen Krankheitsfaktors

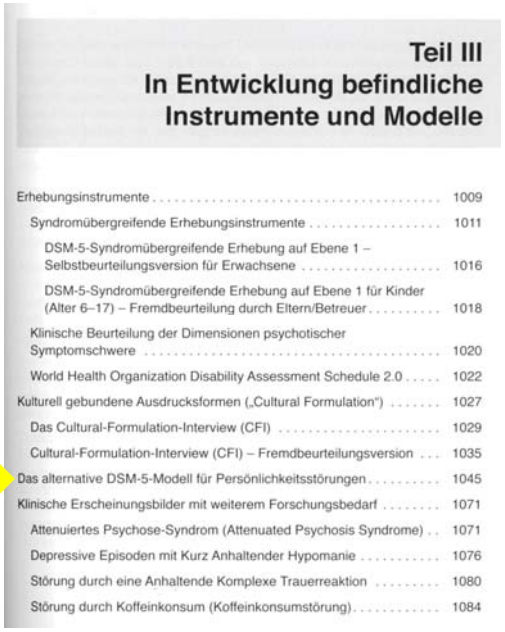
Borderline-Persönlichkeitsstörung

Diagnostische Kriterien	F60.3
A. Ein tiefgreifendes Muster von Instabilität in zwischenmenschlichen Beziehungen, im Selbstbild und in den Affekten sowie von deutlicher Impulsivität. Der Beginn liegt im frühen Erwachsenenalter, und das Muster zeigt sich in verschiedenen Situationen. Mindestens fünf der folgenden Kriterien müssen erfüllt sein:	
1. Verzweifeltes Bemühen, tatsächliches oder vermutetes Verlassenwerden zu vermeiden. (**Beachte:** Hier werden keine suizidalen oder selbstverletzenden Handlungen berücksichtigt, die in Kriterium 5 enthalten sind.)	
2. Ein Muster instabiler und intensiver zwischenmenschlicher Beziehungen, das durch einen Wechsel zwischen den Extremen der Idealisierung und Entwertung gekennzeichnet ist.	
3. Identitätsstörung: ausgeprägte und andauernde Instabilität des Selbstbildes oder der Selbstwahrnehmung.	
4. Impulsivität in mindestens zwei potenziell selbstschädigenden Bereichen (Geldausgaben, Sexualität, Substanzmissbrauch, rücksichtsloses Fahren, „Essanfälle"). (**Beachte:** Hier werden keine suizidalen oder selbstverletzenden Handlungen berücksichtigt, die in Kriterium 5 enthalten sind.)	
5. Wiederholte suizidale Handlungen, Selbstmordandeutungen oder -drohungen oder Selbstverletzungsverhalten.	
6. Affektive Instabilität infolge einer ausgeprägten Reaktivität der Stimmung (z. B. hochgradige episodische Dysphorie, Reizbarkeit oder Angst, wobei diese Verstimmungen gewöhnlich einige Stunden und nur selten mehr als einige Tage andauern).	
7. Chronische Gefühle von Leere.	
8. Unangemessene, heftige Wut oder Schwierigkeiten, die Wut zu kontrollieren (z. B. häufige Wutausbrüche, andauernde Wut, wiederholte körperliche Auseinandersetzungen).	
9. Vorübergehende, durch Belastungen ausgelöste paranoide Vorstellungen oder schwere dissoziative Symptome.	

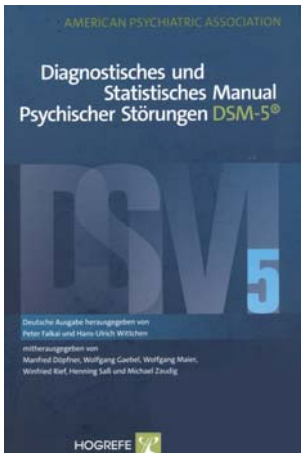
„Altes System"



„Alternatives System“



Teil III
In Entwicklung befindliche Instrumente und Modelle



„Alternatives System“

S. 1045

Das alternative DSM-5-Modell für Persönlichkeitsstörungen

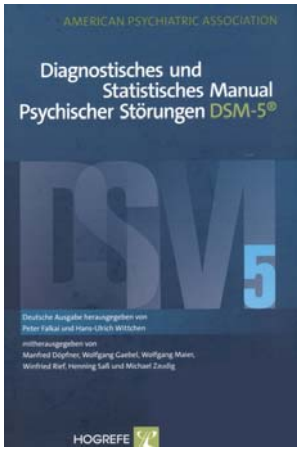
Koordination: Henning Saß, Michael Zaudig

Fachliche Beratung: Götz Berberich, Martin Bohus, Peter Fiedler, Sabine Herpertz, Daniel Leising, Johannes Zimmermann

Übersetzung: Götz Berberich, Dorothee Gescher, Haang Jeung

Der gegenwärtige Ansatz zur Diagnostik von Persönlichkeitsstörungen wird in Teil II des DSM-5 dargestellt. Zusätzlich wird hier in Teil III des Manuals ein alternatives Modell präsentiert, welches für DSM-5 entwickelt wurde. Die Aufnahme beider Modelle in das DSM-5 spiegelt die Entscheidung des APA Board of Trustees wider, einerseits Kontinuität in der gegenwärtigen klinischen Praxis zu gewährleisten, andererseits aber auch einen neuen Ansatz mit der Zielsetzung einzuführen, die zahlreichen Schwächen in der gegenwärtigen Herangehensweise an Persönlichkeitsstörungen zu überwinden. Zum Beispiel erfüllt der typische Patient, der die Kriterien für eine spezifische Persönlichkeitsstörung erfüllt, oft auch Kriterien für andere Persönlichkeitsstörungen. In ähnlicher Weise ist die Diagnose einer Anderen Näher Bezeichneten oder Nicht Näher Bezeichneten Persönlichkeitsstörung oft die korrekte (aber zumeist nicht aufschlussreiche) Diagnose in dem Sinne, dass Patienten in der Regel keine Muster von Symptomen zeigen, die nur einer einzigen Persönlichkeitsstörung zuordenbar sind.

Im folgenden alternativen DSM-5-Modell werden Persönlichkeitsstörungen durch Beeinträchtigungen im *Funktionsniveau* der Persönlichkeit und durch problematische *Persönlichkeitsmerkmale* charakterisiert. Die Diagnosen der spezifischen Persönlichkeitsstörungen, die aus diesem Modell abgeleitet werden können, sind die Antisoziale, Vermeidend-Selbstunsichere, Borderline-, Narzisstische, Zwanghafte und Schizotype Persönlichkeitsstörung. Dieser Ansatz erfasst auch die Möglichkeit, eine durch bestimmte Merkmale spezifizierte Persönlichkeitsstörung (PS, Merkmalsspezifiziert, PS-MS) zu diagnostizieren, wenn das Vorliegen einer Persönlichkeitsstörung angenommen wird, jedoch die Kriterien einer spezifischen Persönlichkeitsstörung nicht erfüllt werden.



2013

Allgemeine Kriterien für eine Persönlichkeitsstörung

Allgemeine Kriterien für eine Persönlichkeitsstörung
Die Hauptmerkmale einer Persönlichkeitsstörung sind
A. Mindestens mittelgradige Beeinträchtigungen im Funktionsniveau der Persönlichkeit (d. h. des Selbst und der interpersonellen Beziehungen).
B. Eines oder mehrere problematische Persönlichkeitsmerkmale.
C. Die Beeinträchtigungen im Funktionsniveau der Persönlichkeit und der Ausdruck der individuellen Persönlichkeitsmerkmale sind relativ unflexibel und durchgängig in einem weiten Bereich persönlicher und sozialer Situationen.
D. Die Beeinträchtigungen im Funktionsniveau der Persönlichkeit und der Ausdruck der individuellen Persönlichkeitsmerkmale sind relativ stabil über die Zeit, und ihr Beginn kann mindestens bis zur Adoleszenz oder bis zum frühen Erwachsenenalter zurückverfolgt werden.
E. Die Beeinträchtigungen im Funktionsniveau der Persönlichkeit und die Ausprägung der individuellen Persönlichkeitsmerkmale können nicht besser durch eine andere
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Tabelle 1: Elemente der Persönlichkeitsfunktion

Selbst	1. ***Identität:*** Erleben der eigenen Person als einzigartig, mit klaren Grenzen zwischen sich und anderen; Stabilität des Selbstwerts und Akkuratheit der Selbsteinschätzung; Fähigkeit, eine Reihe von Emotionen zu erleben und zu regulieren. 2. ***Selbststeuerung:*** Verfolgen von kohärenten und sinnhaften kurz- und langfristigen Zielen; Orientierung an konstruktiven und prosozialen Maßstäben des Verhaltens; Fähigkeit zur produktiven Selbstreflexion.
Interpersonelle Beziehungen	1. ***Empathie:*** Verständnis und Anerkennung des Erlebens und der Motive anderer; Toleranz gegenüber unterschiedlichen Sichtweisen; Verstehen der Wirkungen des eigenen Verhaltens auf andere. 2.

DOMÄNEN (polare Gegensätze) und Facetten	Definitionen
NEGATIVE AFFEKTIVITÄT (vs. Emotionale Stabilität)	Häufiges und intensives Erleben einer großen Bandbreite von starken negativen Emotionen und Affekten (z. B. Angst, Depression, Schuld/Scham, Besorgnis, Ärger) und ihrer behavioralen (z. B. Selbstverletzung) und zwischenmenschlichen (z. B. Abhängigkeit) Manifestationen.
Emotionale Labilität	Instabilität des emotionalen Erlebens und der Stimmung; heftige Emotionen bzw. Affekte sind leicht stimulierbar, hochgradig intensiv und/oder unangemessen hinsichtlich situativer Auslöser und Umstände.
Ängstlichkeit	Gefühle von Nervosität, Anspannung oder Panik als Reaktion auf verschiedene Situationen; häufige Sorge über negative Auswirkungen vergangener unangenehmer Erlebnisse und über mögliche negative Entwicklungen in der Zukunft; ängstliche Gefühle und Besorgnis bei Unsicherheit; Erwartung des schlechtmöglichsten Ausgangs.
Trennungsangst	Angst vor dem Alleinsein durch Zurückweisung und/oder Trennung von wichtigen Bezugspersonen, basierend auf einem Mangel an Vertrauen in die eigene Fähigkeit, für sich selbst physisch und emotional zu sorgen.

„Alternatives System“

Peter Tyrer

Peter Tyrer

Sabine Herpertz

Martin Bohus

PD-01 **Panel Discussion**
15:15 – 16:15 **Kammermusiksaal**

Personality Disorders in ICD-11 – a panel discussion on the current state of proposal

Chair: Wolfgang Gaebel, Germany

Discussants:
Geoffrey Reed, Switzerland
Martin Bohus, Germany
Lee Anna Clark, USA
Andrea Fossati, Italy
Sabine Herpertz, Germany
Steven Huprich, USA
Carla Sharp, USA

6D11.5 Borderline pattern

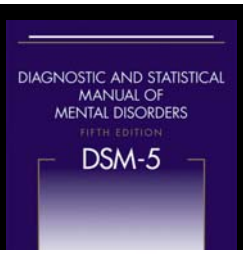
Note: The Borderline pattern specifier has been included to enhance the clinical utility of the classification of Personality Disorder. There is considerable overlap between this pattern and information contained in the trait domain specifiers (most typically Negative Affectivity, Dissociality and Disinhibition). However, use of this specifier may facilitate the identification of individuals who may respond to certain psychotherapeutic treatments.

The Borderline pattern specifier may be applied to individuals whose pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by five (or more) of the following:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships, which may be characterized by vacillations between idealization and devaluation, typically associated with both strong desire for and fear of closeness and intimacy.
- Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self.
- A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours (e.g., risky sexual behaviour, reckless driving, excessive alcohol or substance use, binge eating).
- Recurrent episodes of self-harm (e.g., suicide attempts or gestures, self-mutilation).
- Emotional instability due to marked reactivity of mood. Fluctuations of mood may be triggered either internally (e.g., by one's own thoughts) or by external events. As a consequence, the individual experiences intense dysphoric mood states, which typically last for a few hours but may last for up to several days.
- Chronic feelings of emptiness.
- Inappropriate intense anger or difficulty controlling anger manifested in frequent displays of temper (e.g., yelling or screaming, throwing or breaking things, getting into physical fights).
- Transient dissociative symptoms or psychotic-like features (e.g., brief hallucinations, paranoia) in situations of high affective arousal.

Other manifestations of Borderline pattern, not all of which may be present in a given individual at a given time, include the following:

- A view of the self as inadequate, bad, guilty, disgusting, and contemptible.
- An experience of the self as profoundly different and isolated from other people; a painful sense of alienation and pervasive loneliness.
- Proneness to rejection hypersensitivity; problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships; frequent misinterpretation of social signals.



Borderline Personality Disorder

Diagnostic Criteria **301.83** (F60.3)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

15

Progress in developing a classification of personality disorders for ICD-11

In appointing a Working Group charged with developing recommendations in the area of personality disorders (PDs) for the ICD-11, the World Health Organization (WHO) Department of Mental Health and Substance Abuse highlighted several problems with the classification of PDs in the ICD-10.

First, PDs appeared to be substantially underdiagnosed relative to their prevalence among individuals with other mental disorders. Second, of the ten specific PDs, only two (emotionally unstable personality disorder, borderline type and dissocial personality disorder) were recorded with any frequency in publicly available databases. Third, rates of co-occurrence were extremely high, with most individuals with severe disorders meeting the requirements for multiple PDs. Fourth, the typical de-

scription of PD as p
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The WHO, therefo
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At the same time, th
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The Working Grou
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ICD-11. PD was conc
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World Psychiatry 17:2 - June 2018

2018

Dr Geoffrey M. Reed
Senior Project Officer,
Revision of ICD-10
Mental Health and
Behavioural Disorders
World Health Organization
Geneva, Switzerland

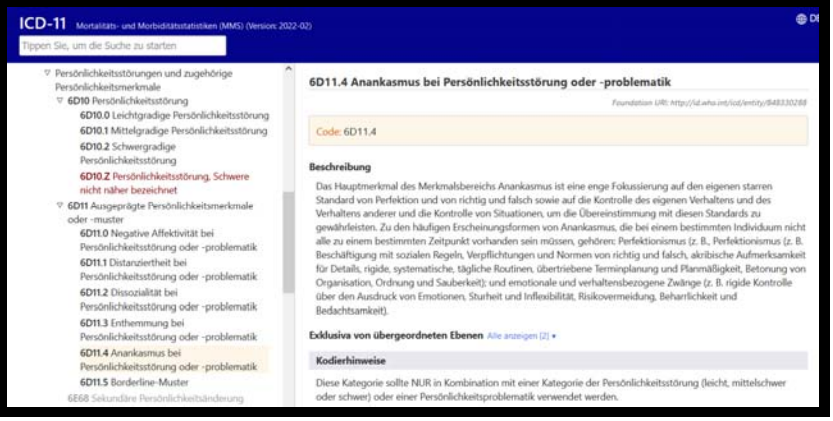
- *Systematic incorporation of self functioning in the core diagnostic guidelines for PD.* PD is conceptualized as an enduring disturbance characterized by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction) and/or interpersonal dysfunction.
- *A substantially richer and more clinically informative operationalization of PD severity.* The degree and pervasiveness of disturbances in functioning of aspects of the self; of interpersonal dysfunction across various contexts and relationships (e.g., romantic relationships, school/work, parent-child, family, friendships, peer contexts); of emotional, cognitive and behavioural manifestations of the personality dysfunction; as well as of associated distress or functional impairment should be considered in making a severity determination for individuals who meet the general diagnostic requirements for PD.
- *A substantially richer and more clinically informative operationalization of trait qualifiers.* Each should describe the core feature of the trait domain, followed by a description of the common manifestations of that domain in individuals with PD.
- *A complete description of PD includes the severity rating and the applicable trait domain qualifiers.* The WHO acknowledges that it will not be feasible to conduct such a complete evaluation in all settings.
- *Provision of an optional qualifier for "borderline pattern".* This qualifier may enhance clinical utility by facilitating the identification of individuals who may respond to certain psychotherapeutic treatments. Whether it will provide information that is non-redundant with the trait domain qualifiers is an empirical question.

MEDIZINISCHE
UNIVERSITÄT WIEN

ICD-11 “Browser“

Diagnosenliste

https://www.bfarm.de/DE/Kodiersysteme/Klassifikationen/ICD/ICD-11/uebersetzung/_node.html



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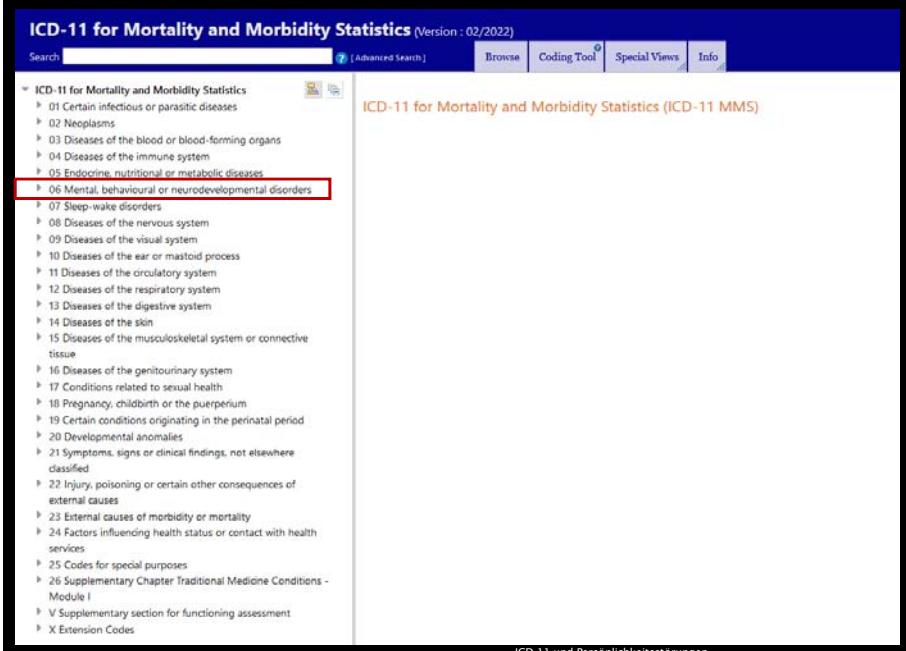


https://icd.who.int/browse11/l-m/en

ICD-11 “ICD-11 Clinical Descriptions and Diagnostic Guidelines (CDDG)“

Diagnostische Leitlinien

ICD-11 GUIDELINES

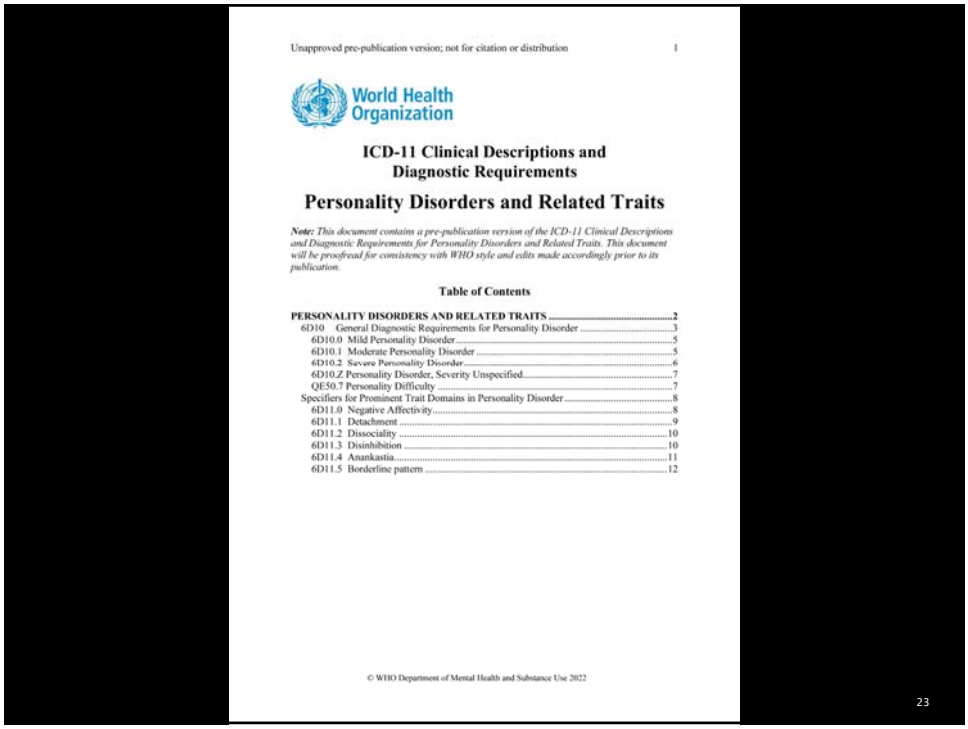
ICD-11 Clinical Descriptions and Diagnostic Guidelines for Mental, Behavioural and Neurodevelopmental Disorders

The following boxes correspond to the diagnostic groupings included the ICD-11 Clinical Descriptions and Diagnostic Requirements on Mental, Behavioural or Neurodevelopmental Disorders. After clicking on each box, you will have the option to download a copy of the guidelines for the corresponding diagnostic area.

Please note that these documents are made available to GCPNetwork members only and are to be used for educational purposes. Further edits may be made to the guidelines prior to their publication.

Neurodevelopmental Disorders	Schizophrenia or Other Primary Psychotic Disorders	Catatonia
Mood Disorders	Anxiety or Fear-Related Disorders	Obsessive-Compulsive or Related Disorders

https://gcp.network/icd-11-guidelines/grouping/



Unapproved pre-publication version; not for citation or distribution 1

World Health Organization

ICD-11 Clinical Descriptions and Diagnostic Requirements

Personality Disorders and Related Traits

Note: This document contains a pre-publication version of the ICD-11 Clinical Descriptions and Diagnostic Requirements for Personality Disorders and Related Traits. This document will be proofread for consistency with WHO style and edits made accordingly prior to its publication.

Table of Contents

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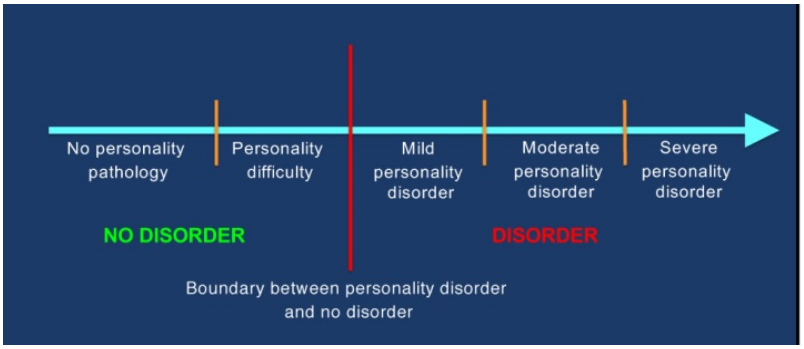
Allgemeine diagnostische Kriterien

6D10 General Diagnostic Requirements for Personality Disorder

Essential (Required) Features:

- An enduring disturbance characterized by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships).
- The disturbance has persisted over an extended period of time (e.g., lasting 2 years or more).
- The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated).
- The disturbance is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles), though it may be consistently evoked by particular types of circumstances and not others.
- The symptoms are not due to the direct effects of a medication or substance, including withdrawal effects, and are not better accounted for by another mental disorder, a Disease of the Nervous System, or another medical condition.
- The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- Personality Disorder should not be diagnosed if the patterns of behaviour characterizing the personality disturbance are developmentally appropriate (e.g., problems related to establishing an independent self-identity during adolescence) or can be explained primarily by social or cultural factors, including socio-political conflict.

Schweregrad



Reed 2018

Severity of Personality Disorder:

The areas of personality functioning shown in Table 6.18 should be considered in making a severity determination for individuals who meet the general diagnostic requirements for Personality Disorder.

Table 6.18. Aspects of Personality Functioning That Contribute to Severity Determination in Personality Disorder

- Degree and pervasiveness of disturbances in functioning of aspects of the self:
  - Stability and coherence of one's sense of identity (e.g., extent to which identity or sense of self is variable and inconsistent or overly rigid and fixed).
  - Ability to maintain an overall positive and stable sense of self-worth.
  - Accuracy of one's view of one's characteristics, strengths, limitations.
  - Capacity for self-direction (ability to plan, choose, and implement appropriate goals).
- Degree and pervasiveness of interpersonal dysfunction across various contexts and relationships (e.g., romantic relationships, school/work, parent-child, family, friendships, peer contexts):
  - Interest in engaging in relationships with others.
  - Ability to understand and appreciate others' perspectives.
  - Ability to develop and maintain close and mutually satisfying relationships.
  - Ability to manage conflict in relationships.
- Pervasiveness, severity, and chronicity of emotional, cognitive, and behavioural manifestations of the personality dysfunction:

Emotional manifestations:

  - Range and appropriateness of emotional experience and expression.
  - Tendency to be emotionally over- or underreactive.
  - Ability to recognize and acknowledge emotions that are difficult or unwanted by the individual (e.g., anger, sadness).

Cognitive manifestations:

  - Accuracy of situational and interpersonal appraisals, especially under stress.
  - Ability to make appropriate decisions in situations of uncertainty.
  - Appropriate stability and flexibility of belief systems.

Behavioural manifestations:

  - Flexibility in controlling impulses and modulating behaviour based on the situation and consideration of the consequences.
  - Appropriateness of behavioural responses to intense emotions and stressful circumstances (e.g., propensity to self-harm or violence).
- The extent to which the dysfunctions in the above areas are associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

Persönlichkeitsakzentuierung

QF40.7 Personality Difficulty

As noted, Personality Difficulty is not considered a mental disorder, but rather is listed in the grouping of Problems Associated with Interpersonal Interactions in the chapter on Factors Influencing Health Status or Contact with Health Services. Personality Difficulty refers to pronounced personality characteristics that may affect treatment or health services but do not rise to the level of severity to merit a diagnosis of Personality disorder.

Personality Difficulty is characterized by long-standing difficulties (e.g., at least 2 years), in the individual's way of experiencing and thinking about the self, others and the world. In contrast to Personality Disorder, Personality Difficulty is manifested in cognitive and emotional experience and expression only intermittently (e.g., during times of stress) or at low intensity. Personality Difficulty is typically associated with some problems in functioning, but these are insufficiently severe to cause notable disruption in social, occupational, and interpersonal relationships or may be limited to specific relationships or situations.

6D10.0 Mild Personality Disorder

Essential (Required) Features:

- All general diagnostic requirements for Personality Disorder are met.
- Disturbances affect some areas of functioning of the self but not others (e.g., problems with self-direction in the absence of problems with stability and coherence of identity or self-worth; see Table 6.18), or affect all areas but are of mild severity, and may not be apparent in some contexts.
- There are problems in many interpersonal relationships or in performance of expected occupational and social roles, but some relationships are maintained and/or some roles fulfilled.
- Specific manifestations of personality disturbances are generally of mild severity (see below for examples).
- Mild Personality Disorder is typically not associated with substantial harm to self or others.
- Mild Personality Disorder may be associated with substantial distress or with impairment in personal, family, social, educational, occupational or other important areas of functioning that is either limited to circumscribed areas (e.g., romantic relationships; employment) or present in more areas but of milder severity.

6D10.1 Moderate Personality Disorder

Essential (Required) Features:

- All general diagnostic requirements for Personality Disorder are met.
- Disturbances affect multiple areas of functioning of the self (e.g., stability and coherence of identity, self-worth, self-direction; see Table 6.18) and are of moderate severity.
- There are marked problems in most interpersonal relationships and the performance of most expected social and occupational roles is compromised to some degree.
- Relationships are likely to be characterized by conflict, avoidance, withdrawal, or extreme dependency (e.g., few friendships maintained, persistent conflict in work relationships and consequent occupational problems, romantic relationships characterized by serious disruption or inappropriate submissiveness).
- Specific manifestations of personality disturbance are generally of moderate severity (see below for examples).
- Moderate Personality Disorder is sometimes associated with harm to self or others.
- Moderate Personality Disorder is associated with marked impairment in personal, family, social, educational, occupational or other important areas of functioning, although functioning in circumscribed areas may be maintained.

6D10.2 Severe Personality Disorder

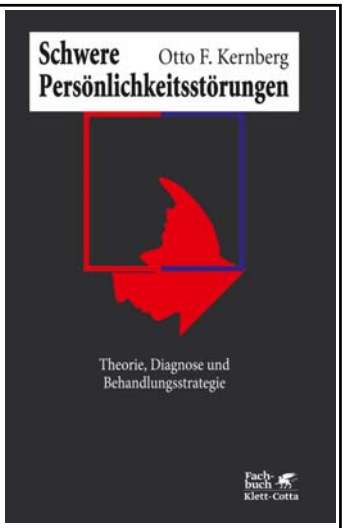
Essential (Required) Features:

- All general diagnostic requirements for Personality Disorder are met.
- There are severe disturbances in multiple areas of functioning of the self (e.g., sense of self may be so unstable that individuals report not having a sense of who they are or so rigid that they refuse to participate in any but an extremely narrow range of situations; self view may be characterized by self-contempt or be grandiose or highly eccentric; See Table 6.18).
- Problems in interpersonal functioning seriously affect virtually all relationships and the ability and willingness to perform expected social and occupational roles is severely compromised or absent.
- Specific manifestations of personality disturbance are severe (see below for examples) and affect most, if not all, areas of personality functioning.
- Severe Personality Disorder is often associated with harm to self or others.
- Severe Personality Disorder is associated with severe impairment in all or nearly all areas of life, including personal, family, social, educational, occupational, and other important areas of functioning.

Die psychoanalytische Strukturdiagnostik hat in den psychiatrischen Mainstream Einzug gehalten

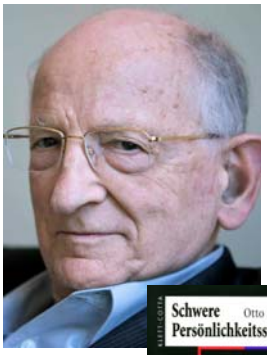
Tabelle 1: Differenzierung der Persönlichkeitsorganisation

Strukturelle Kriterien	Neurotische Organisation	Borderline-Organisation	Psychotische Organisation
	Selbst- und Objektvorstellungen sind scharf voneinander abgegrenzt.	Identitätsdiffusion: widersprüchliche Aspekte vom Selbst und von anderen sind schwach integriert und werden getrennt gehalten.	
Identitätsintegration	Integrierte Identität: widersprüchliche Selbst- und Objektbilder sind in umfassende Konzepte integriert.		Selbst- und Objektvorstellungen sind schwach voneinander abgegrenzt, oder es besteht eine phantasierte Identität.
Abwehrmechanismen	Verdrängung und Abwehrmechanismen höherer Ebene: Reaktionsbildung, Isolierung, Ungeschehenmachen, Rationalisierung, Intellektualisierung.	Hauptsächlich Spaltung und Abwehrmechanismen niederer Ebene: primitive Idealisierung, projektive Identifizierung, Leugnung, Omnipotenz, Entwertung.	
	Abwehrmechanismen schützen den Patienten vor intrapsychischem Konflikt. Interpretation verbessert das Funktionieren.		Abwehrmechanismen schützen den Patienten vor Desintegration und Verschmelzung von Selbst und Objekt. Interpretation führt zu Regression.
	Fähigkeit zur Realitätsprüfung ist erhalten: Differenzierung von Selbst und Nicht-Selbst sowie von intrapsychischen und äußeren Ursprüngen der Wahrnehmungen und Reize.	Veränderungen in der Beziehung zur Realität und in Gefühlen hinsichtlich der Realität treten auf.	
Realitätsprüfung	Fähigkeit zur realistischen und tiefgehenden Einschätzung des Selbst und anderer ist vorhanden.		Fähigkeit zur Realitätsprüfung ist verlorengegangen.



1992

Das Strukturelle Interview von Otto F. Kernberg



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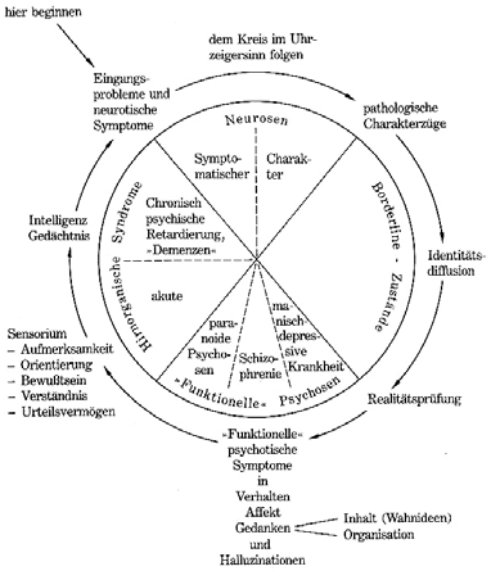

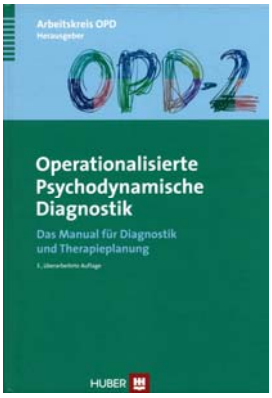

(Semi-)strukturierte Interviews

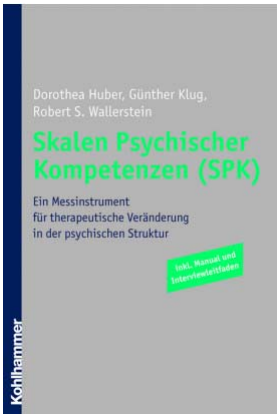

Tabelle 2: Skala zur Erfassung des Funktionsniveaus der Persönlichkeit (SEFP)

Ausmaß der Beeinträchtigung	Selbst		Interpersonelle Beziehungen	
	Identität	Selbststeuerung	Empathie	Nähe
0 – Keine oder geringfügige Beeinträchtigung	• Durchgängiges Bewusstsein eines eigenständigen Selbst; hält rollenadäquate Grenzen ein. • Stabiler und selbstregulierter positiver Selbstwert mit akkurater Selbsteinschätzung. • Ist in der Lage, eine ganze Bandbreite von Emotionen zu erleben, auszuhalten und zu regulieren.	• Setzt sich Ziele und verfolgt diese vernünftig, basierend auf einer realistischen Einschätzung der eigenen Fähigkeiten. • Orientiert sich an angemessenen Verhaltensmaßstäben und erreicht in vielen Bereichen persönliche Erfüllung. • Kann eigenes Erleben reflektieren und auf konstruktive Weise interpretieren.	• Ist in der Lage, das Erleben und die Motive anderer in den meisten Situationen richtig zu verstehen. • Versteht und würdigt die Sichtweisen anderer, auch wenn er/sie diese nicht teilt. • Ist sich der Wirkung des eigenen Verhaltens auf andere bewusst.	• Unterhält im privaten und gesellschaftlichen Umfeld zahlreiche stabile und befriedigende Beziehungen. • Hat den Wunsch nach und widmet sich einer Reihe von liebevollen, engen und auf Gegenseitigkeit beruhenden Beziehungen. • Strebt nach Kooperation und gegenseitigem Nutzen und reagiert flexibel auf verschiedene Ideen, Gefühle und Verhaltensweisen anderer.
1 – Leichte Beeinträchtigung	• Relativ intaktes Selbstgefühl, wobei die Klarheit von Grenzen etwas eingeschränkt ist, wenn starke Emotionen und psychische Belastung erlebt werden. • Selbstwert ist zeitweise reduziert, mit übermäßig kritischer oder etwas verzerrter Selbsteinschätzung. • Starke Emotionen können belastend sein, verbunden mit einer eingeschränkten Bandbreite des emotionalen Erlebens.	• Übermäßig zielstrebig, etwas blockiert im Setzen und Verfolgen eigener Ziele oder konfliktharter Umgang mit Zielen. • Kann unrealistische oder sozial unangemessene persönliche Maßstäbe haben, was die persönliche Erfüllung in einigen Bereichen einschränkt. • Kann eigenes Erleben reflektieren, überbetont aber möglicherweise einen bestimmten (z. B. intellektuellen, emotionalen) Aspekt der Selbstwahrnehmung	• Etwas eingeschränkte Fähigkeit, das Erleben anderer zu würdigen und zu verstehen; kann dazu tendieren, anderen unangemessene Erwartungen oder einen Wunsch nach Kontrolle zuzuschreiben. • Ist zwar in der Lage, andere Sichtweisen zu berücksichtigen und zu verstehen, tut dies aber nur widerwillig. • Ist sich der Wirkung des eigenen Verhaltens auf andere nicht durchgängig bewusst.	• Ist in der Lage, im privaten und gesellschaftlichen Umfeld stabile Beziehungen einzugehen, jedoch mit einigen Einschränkungen bezüglich Tiefe und erlebter Zufriedenheit. • Hat die Fähigkeit und den Wunsch, enge und auf Gegenseitigkeit beruhende Beziehungen aufzubauen, kann aber Schwierigkeiten haben, dies auszudrücken, und mitunter gehemmt sein, wenn starke Emotionen oder Konflikte auftreten. • Kooperation kann durch unrealistische Maßstäbe erschwert sein; etwas eingeschränkte Fähigkeit, die Ideen, Gefühle und Verhaltensweisen anderer zu respektieren oder darauf einzugehen.

1.1 Kognitive Fähigkeit: Selbstwahrnehmung

OPD-2	Gut integriert	Mäßig integriert	Gering integriert	Desintegriert
1.1 Selbstreflexion	Patient verfügt über die Fähigkeit, den Blick auf die eigene Person und die eigene Innenwelt zu richten. Patient kann realitätsgerecht wahrnehmen, was für ein Mensch er ist und was in ihm vorgeht, und kann dies in sprachliche Begriffe fassen.	Patient hat wenig Interesse, über sich nachzudenken. Selbstreflexion richtet sich vor allem auf das handelnde Selbst (was Patient gesagt und getan hat); Selbstbild wirkt vergröbert. Es fällt schwer, treffende sprachliche Begriffe zu finden.	Selbstreflexive Wahrnehmung ist kaum möglich; Patient kann auch mit Unterstützung kein kohärentes Bild von sich und seiner inneren Situation entwerfen; widersprüchliche Selbstaspekte stehen nebeneinander. Keine Begriffssprache für innere Vorgänge.	Selbstschilderung erzeugt das Gefühl der Beliebigkeit, fehlende Realitätsbezogenheit, Unverständlichkeit; Selbstbild wirkt wenig authentisch, u. U. entliehen, abwegig. Sprachlich befremdliche, widersprüchliche Formulierungen.
1.2 Affektdifferenzierung	Affekte können trotz konflikthafter Einschränkungen differenziert wahrgenommen werden und sind handlungssteuernd. Im Erleben überwiegen positive Affekte wie Freude, Neugier und Stolz. Negative Affekte wie Angst, Verachtung, Ärger, Ekel, Trauer, Schuld und Scham haben große Variabilität.	Affekte werden nur eingeschränkt wahrgenommen und in schwierigen Situationen zur Wahrung der Stabilität auch vermieden. Sie sind daher auch nur begrenzt handlungssteuernd. Im affektiven Erleben überwiegen negative Affekte wie Wut, Angst, Enttäuschung, Selbstentwertung und Depression.	Affekte können nicht differenziert wahrgenommen oder nachvollziehbar geschildert werden. Sie äußern sich entweder in Erregung oder in Entfremdung, Affektleere, Depression und manischer Gestimmtheit. Sie können von daher auch nicht zur gezielten Verhaltenssteuerung eingesetzt werden. Im affektiven Ausdruck dominieren chronische Verachtung, Ekel und Wut.	Kein innerer Abstand zu den eigenen Gefühlen und keine introspektive Wahrnehmung von Affekten. Zwischen Handlungen und Affekterleben ist nur sehr wenig steuernde Instanz geschaltet. Ausgeliefertsein an heftige, nicht ausgestaltete emotionale Zustände, die nicht in Worten benannt werden können.
1.3 Identität	Patient verfügt über ein Selbstbild, das über die Zeit hinweg konstant und kohärent erscheint und eine eindeutige psychosexuelle Identität erkennen lässt.	Situations- und stimmungsabhängige Einbrüche und Wechsel im Selbstbild.	In unterschiedlichen Zeiten und Situationen treten unterschiedliche Selbstaspekte in den Vordergrund; das Gefühl einer konstanten psychosexuellen und sozialen Ausrichtung im Sinne einer Identität ist nicht verfügbar.	Weitgehendes Fehlen einer differenzierten psychosozialen und sexuellen Identität zugunsten verzerrter oder klischeehafter Eigenschaftszuschreibungen, u. U. wahnhafte Identitätsaspekte.

SELBST	OBJEKT/ BEZIEHUNGEN
Selbstwahrnehmung	**Objektwahrnehmung**
ST1.1 Selbstreflexion	ST1.4 Selbst-Objekt-Differenzierung
ST1.2 Affektdifferenzierung	ST1.5 Objektbezogene Affektdifferenzierung
ST1.3 Identität	ST1.6 Integrierte Objektwahrnehmung
Selbstregulation	**Beziehungsregulation**
ST2.1 Impulssteuerung	ST2.4 Beziehungen schützen
ST2.2 Affekttoleranz	ST2.5 Antizipation
ST2.3 Selbstwertregulierung	ST2.6 Interessenausgleich
Abwehr	
ST3.1 Lebens- und Erlebensmöglichkeit	
ST3.2 Interpersonalität	
ST3.3 Mechanismen	
Kommunikation nach innen	**Kommunikation na**
ST4.1 Affekte und Fantasien erleben	ST4.4 Emotionale K
ST4.2 Lustvolles Erleben	ST4.5 Intimität
ST4.3 Körperselbst	ST4.6 Empathie
Bindung an innere Objekte	**Bindung an äußere Objekte**
ST5.1 Internalisierung	ST5.4 Bindungsfähigkeit
ST5.2 Introjekte nutzen	ST5.5 Vertrauen
ST5.3 Variabilität	ST5.6 Bindung lösen

Abbildung 1: Übersicht der Dimensionen und Facetten

Tabelle 1: Elemente der Persönlichkeitsfunktion

Selbst	1. ***Identität:*** Erleben der eigenen Person als einzigartig, mit klaren Grenzen zwischen sich und anderen; Stabilität des Selbstwerts und Akkuratheit der Selbsteinschätzung; Fähigkeit, eine Reihe von Emotionen zu erleben und zu regulieren. 2. ***Selbststeuerung:*** Verfolgen von kohärenten und sinnhaften kurz- und langfristigen Zielen; Orientierung an konstruktiven und prosozialen Maßstäben des Verhaltens; Fähigkeit zur produktiven Selbstreflexion.
Interpersonelle Beziehungen	1. ***Empathie:*** Verständnis und Anerkennung des Erlebens und der Motive anderer; Toleranz gegenüber unterschiedlichen Sichtweisen; Verstehen der Wirkungen des eigenen Verhaltens auf andere. 2. ***Nähe:*** Tiefe und Dauer von (positiven) Beziehungen mit anderen; Wunsch und Fähigkeit, anderen Menschen nahe zu sein; gegenseitiger Respekt, der sich im interpersonellen Verhalten zeigt.

OPD-3 Achse IV
und
DSM-5 LPFS

11 von 27 Facetten

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Trait Domain Specifiers

Persönlichkeitszüge

Personality Disorder and Personality Difficulty can be further described using five trait domain specifiers. These trait domains describe the characteristics of the individual's personality that are most prominent and that contribute to personality disturbance. As many as necessary to describe personality functioning should be applied.

Trait domain specifiers that may be recorded include the following:

6D11.0 Negative Affectivity
6D11.1 Detachment
6D11.2 Dissociality
6D11.3 Disinhibition
6D11.4 Anankastia

5 Domain Specifiers

6D11.0 Negative Affectivity	6D11.1 Detachment	6D11.2 Dissociality	6D11.3 Disinhibition	6D11.4 Anankastia
Negative emotions	Social detachment	Self-centeredness	Impulsivity	Perfectionism
Emotional lability	Emotional detachment	Lack of empathy	Distractibility	Emotional and behavioral constraint
Negativistic attitudes			Irresponsibility	
Low self-esteem			Recklessness	
Mistrustfulness			Lack of planning	

16 Facetten (DSM-5 hat 29)

6D11.0 Negative Affectivity

The core feature of the Negative Affectivity trait domain (sometimes referred to as Neuroticism) is the tendency to experience a broad range of negative emotions. Common manifestations of Negative Affectivity, not all of which may be present in a given individual at a given time, include the following:

- ***Experiencing a broad range of negative emotions with a frequency and intensity out of proportion to the situation.*** Common negative emotions include but are not limited to anxiety, worry, depression, vulnerability, fear, anger, hostility, guilt, and shame. The particular negative emotions that are most characteristic of any particular person vary across individuals and are largely dependent on the presence or degree of other trait domains. For example, individuals high on Dissociality are more likely to experience 'externalizing' negative emotions (e.g., anger, hostility, contempt), whereas those high on Detachment are more likely to experience 'internalizing' negative emotions (e.g., anxiety, depression, pessimism, guilt).
- ***Emotional lability and poor emotion regulation.*** Individuals high on Negative Affectivity are overreactive to both their own negative cognitions and to external events. They can become overwrought through their own thought processes, such as by ruminating over their shortcomings or past mistakes, over real or perceived threats, slights, or insults; or over potential future problems. They are overreactive to external threats or criticism, problems, and setbacks. They have low frustration tolerance and easily become visibly upset over even minor issues. They often experience and display multiple emotions simultaneously or vacillate among a range of emotions in a short period of time. Once upset, they have difficulty regaining their composure and must rely on others or on leaving the situation to calm down.
- ***Negativistic attitudes.*** Individuals high on Negative Affectivity typically reject others' suggestions or advice, arguing that enacting others' ideas would be too complicated or difficult; or that the suggested actions would not lead to the desired outcomes or have a high likelihood of negative consequences. The manner of rejection is largely dependent on the individual's other traits. For example, those high on Detachment are most likely to blame themselves for the likely difficulties or poor outcomes, whereas those high on Dissociality are most likely to blame others for offering such bad ideas.
- ***Low self-esteem and self-confidence.*** Individuals high on Negative Affectivity may exhibit low self-esteem and self-confidence in several different ways. These include: *avoidance of situations and activities* that either are judged to be too difficult (e.g., intellectually, physically, socially, interpersonally, emotionally, etc.), even despite evidence to the contrary; *dependency*, which may be manifested in frequent reliance on others for advice, direction, and other kinds of help; *envy* of others' abilities and indicators of success; and, in more severe cases of low self-esteem, believing themselves to be useless, to have lived a worthless less, to be incapable of accomplishing anything of value, which may be associated with *suicidal ideation or behaviours*.
- ***Mistrustfulness.*** Interpersonally, this is typically manifested as suspicion that others have ill intent, and that neutral or even benign remarks and positive behaviours are hidden threats, slights, or insults. Individuals high on Negative Affectivity tend to hold grudges and be unforgiving even over long time periods. In non-interpersonal situations, this mistrustfulness typically takes the form of bitterness and cynicism (e.g., the belief that the 'system is rigged').

VER
DEP

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BPS

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PAR

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6D31.1 Detachment

The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of Detachment, not all of which may be present in a given individual at a given time, include the following:

- ***Social detachment***. Social detachment is characterized by avoidance of social interactions, lack of friendships, and avoidance of intimacy. Individuals high on Detachment do not enjoy social interactions and avoid all kinds of social contact and social situations to the extent possible. They engage in little to no 'small talk' even if initiated by others (e.g., at store check-out counters), seek out employment that does not involve interactions with others, and even refuse promotions if it would entail more interaction with others. They have few to no friendships or even casual acquaintances. Their interactions with family members tend to be minimal and superficial. They rarely, if ever, engage in any intimate relationships and are not particularly interested in sexual relations.
- ***Emotional detachment.*** Emotional detachment is characterized by reserve, aloofness, and limited emotional expression and experience. Individuals high on Detachment keep to themselves to the extent possible, even in obligatory social situations. They are typically aloof and respond to direct attempts at social engagement only briefly and in ways that discourage further conversation. Emotional detachment also encompasses emotional unexpressiveness, both verbally and non-verbally. Individuals high on Detachment do not talk about their feelings and it is difficult to discern what they might be feeling from their behaviours. In extreme cases, there is a lack of emotional experience itself and they are non-reactive to either negative or positive events, with a limited capacity for enjoyment.

SCH

VER

PAR

6D31.2 Dissociality

The core feature of the Dissociality trait domain is disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy. Common manifestations of Dissociality, not all of which may be present in a given individual at a given time, include the following:

- ***Self-centeredness.*** Self-centeredness in individuals high on Dissociality is manifested in a sense of entitlement, believing and acting as if they deserve—without further justification—whatever they want, preferentially above what others may want or need, and that this 'fact' should be obvious to others. Self-centeredness is manifested both actively and passively. Active manifestations of self-centeredness include expectation of others' admiration, attention-seeking behaviours to ensure being the center of others' focus, and negative behaviours (e.g., anger, 'temper tantrums,' denigrating others) when the admiration and attention that the individual expects are not granted. Typically, such individuals believe that they have many admirable qualities, that their accomplishments are outstanding, that they have or will achieve greatness, and that others should admire them. Passive manifestations of self-centeredness reflect a kind of obliviousness that other individuals matter as much as oneself. In this aspect of Dissociality, the individuals' concern is with their own needs, desires, and comfort, and those of others simply are not considered.
- ***Lack of empathy.*** Lack of empathy is manifested as indifference to whether one's actions inconvenience others or hurt them in any way (e.g., emotionally, socially, financially, physically, etc.). As a result, individuals high on Dissociality are often deceptive and manipulative, exploiting people and situations to get what they want and think they deserve. This may include being mean and physically aggressive. In the extreme, this aspect of Dissociality can be manifested as callousness with regard to others' suffering, and ruthlessness in obtaining one's goals, such that such individuals may be physically violent with little to no provocation and may even take pleasure in inflicting pain and harm. Note that this aspect of Dissociality does not necessarily imply that individuals high on Dissociality do not cognitively understand the feelings of others, only that they are not concerned about them and instead are likely to use this understanding to exploit others.

DIS

NAR

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6D31.3 Disinhibition

The core feature of the Disinhibition trait domain is the tendency to act rashly based on immediate external or internal stimuli (i.e., sensations, emotions, thoughts), without consideration of potential negative consequences. Common manifestations of Disinhibition, not all of which may be present in a given individual at a given time, include the following:

- ***Impulsivity.*** Individuals high on Disinhibition tend to act rashly based on whatever is attractive at the moment, without consideration of negative consequences for oneself or others, including putting oneself or others at physical risk. They have difficulty delaying reward or satisfaction and tend to pursue immediately available short-term pleasures or potential benefits. In this way, the trait is strongly associated with such behaviours as substance use, gambling, and unplanned sexual activity.
- ***Distractibility.*** Individuals high on Disinhibition also have difficulty staying focused on important and necessary tasks that require sustained effort. They quickly become bored or frustrated with difficult, routine, or tedious tasks, and are easily distracted by extraneous stimuli, such as others' conversations. Even in the absence of distractions, they have difficulty keeping their attention focused and persisting on tasks, and tend to scan the environment for more enjoyable options.
- ***Irresponsibility.*** Individuals high on Disinhibition are unreliable and lack a sense of accountability for their actions. As a result, they often do not complete work assignments or perform expected duties; they fail to meet deadlines, do not follow through on commitments and promises, and are late to or miss formal and informal appointments and meetings because they allow themselves to become engaged in something more attractive that has caught their attention.
- ***Recklessness.*** Individuals high on Disinhibition lack an appropriate sense of caution. They tend to overestimate their abilities and thus frequently do things that are beyond their skill level, without considering potential safety risks. Individuals high on Disinhibition may engage in reckless driving or dangerous sports, or perform other activities that put them or others in physical danger without sufficient preparation or training.
- ***Lack of planning.*** Individuals high on Disinhibition prefer spontaneous over planned activities, leaving their options open should an attractive opportunity arise. They tend to focus on immediate feelings, sensations, and thoughts, with relatively little attention paid to longer term or even short-term goals. When they do make plans, they often fail to follow through on them, thus they seldom are able to reach long-term goals and often fail to achieve even short-term goals.

HIS

BPS

DIS

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6D31.4 Anankastia

The core feature of the Anankastia trait domain is a narrow focus on one's rigid standard of perfection and of right and wrong, and on controlling one's own and others' behaviour and controlling situations to ensure conformity to these standards. Common manifestations of Anankastia, not all of which may be present in a given individual at a given time, include:

- ***Perfectionism.*** Perfectionism is manifested in concern with social rules, obligations, norms of right and wrong; scrupulous attention to detail; rigid, systematic, day-to-day routines; hyper-scheduling and planfulness; and an emphasis on organization, orderliness, and neatness. Individuals high on Anankastia have a very clear and detailed personal sense of perfection and imperfection that also extends beyond community standards to encompass the individual's idiosyncratic notions of what is perfect and right. They believe strongly that everyone should follow all rules exactly and meet all obligations. Individuals with high on Anankastia may redo the work of others because it does not meet their perfectionistic standards. They have difficulty in interpersonal relationships because they hold others to the same standards as themselves and are inflexible in their views.
- ***Emotional and behavioural constraint.*** Emotional and behavioural constraint is manifested in rigid control over emotional expression, stubbornness and inflexibility, risk-avoidance, perseveration, and deliberativeness. Individuals with prominent anankastic traits tightly control their own emotional expression and disapprove of others' displays of emotion. They are inflexible and lack spontaneity, stubbornly insisting on following set schedules and adhering to plans. Their risk-avoidance includes both refusal to engage in obviously risky activities and a more general over-concern about avoiding potential negative consequences of any activity. They often perseverate and have difficulty disengaging from tasks because they are not yet perfect down to the last detail. They are highly deliberative and have difficulty making decisions due to concern that they have not considered every aspect and all alternatives to ensure that the right decision is made.

ZWA

Diskussion
Thieme

Neue Wege der Klassifikation von Persönlichkeitsstörungen in ICD-11

A new approach to classifying Personality Disorders

Autoren
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Schlüsselwörter
Persönlichkeitsstörungen, Kategorien, Dimensionen, Schweregrade, Funktionsbeeinträchtigungen

Key words
personality disorders, categories, dimensions, severity levels, functional impairments

eingereicht 03.01.2018
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ZUSAMMENFASSUNG

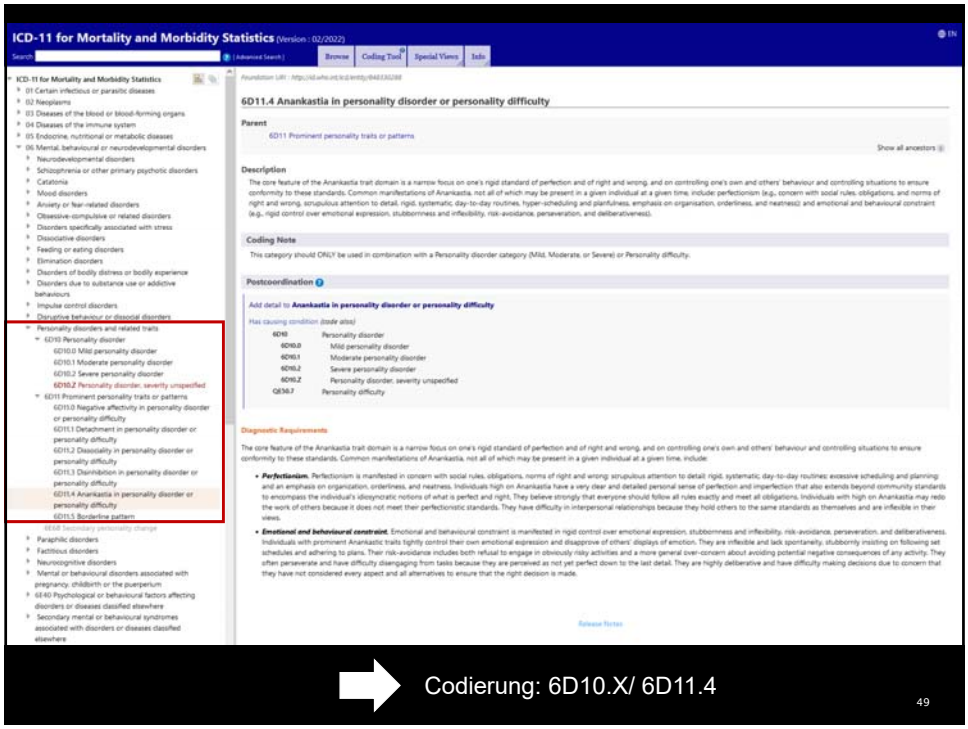
Ausgehend von der derzeit noch gültigen ICD-10-Klas
der Persönlichkeitsstörungen wird der von der WHO
und geführte Entwicklungsprozess hin zu einer grunds
Neukonzeptionierung von Persönlichkeitsstörun
gestellt. Aus einer kategorialen Klassifikation von Diff

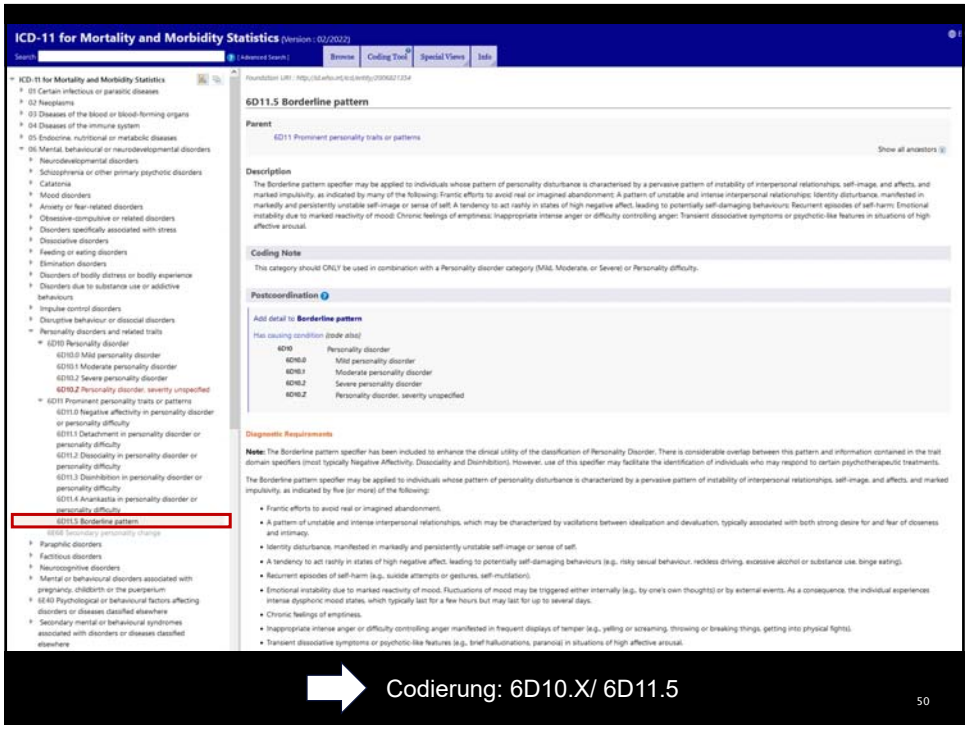
typen auf der Basis polythetischer Kriterienlisten wird eine weitgehend dimensionale Klassifikation werden, die im Falle der Erfüllung der Allgemeinen Kriterien einer Persönlichkeitsstörung drei Schweregrade unterscheidet und zur näheren Beschreibung fünf Persönlichkeitsdomänen heranzieht. Nach einem ersten Entwurf, der von der ICD-11 Arbeitsgruppe zu Persönlichkeitsstörungen ausgearbeitet wurde, liegt inzwischen ein zweiter Entwurf vor, der Anregungen der Internationalen Gesellschaften zur Beforschung von Persönlichkeitsstörungen aufgenommen hat. Dieser beschreibt die Schweregrade mit einem höheren Systematisierungsgrad, indem er sich an Funktionsbeeinträchtigungen des Selbst und der interpersonellen Beziehungsgestaltung orientiert, Symptome bezüglich der Emotionalität, der Kognition und des Verhaltens spezifiziert und schließlich die psychosozialen Auswirkungen, also in welchem Maße die Probleme die verschiedenen situativen Kontexte durchzieht, bewertet.

▸ **Abb. 1** Beispiel für ein Profil einer Persönlichkeitsstörung basierend auf Persönlichkeitsdomänen

evaluating the psychosocial impacts.

2018


ICD-11 for Mortality and Morbidity Statistics (Version : 02/2022)
6D11.4 Anankastia in personality disorder or personality difficulty
Parent
Description
Coding Note
Postcoordination
Diagnostic Requirements
Codierung: 6D10.X/ 6D11.4
49


ICD-11 for Mortality and Morbidity Statistics (Version : 02/2022)
6D11.5 Borderline pattern
Parent
Description
Coding Note
Postcoordination
Diagnostic Requirements
Codierung: 6D10.X/ 6D11.5
50

Thieme

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ABSTRA

symptoms concerning emotions, cognitions and behaviors and evaluating the psychosocial impacts.

2018

FAZIT BETREFFEND DES VON DER PROJEKTGRUPPE VORGESCHLAGENEN REVIDIERTEN ENTWURFS ZUR ICD-11 KLASSIFIKATION

1. Erhebung der allgemeinen diagnostischen Kriterien; **wenn erfüllt, dann**
2. Erhebung des Schweregrades **und**
3. Erhebung der klinisch relevanten Persönlichkeitsmerkmalsdomänen
4. **optional**: Feststellung des Borderline Qualifizierungsmerkmals

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Borderline Pattern

6D11.5 Borderline pattern

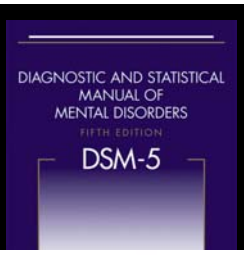
Note: The Borderline pattern specifier has been included to enhance the clinical utility of the classification of Personality Disorder. There is considerable overlap between this pattern and information contained in the trait domain specifiers (most typically Negative Affectivity, Dissociality and Disinhibition). However, use of this specifier may facilitate the identification of individuals who may respond to certain psychotherapeutic treatments.

The Borderline pattern specifier may be applied to individuals whose pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by five (or more) of the following:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships, which may be characterized by vacillations between idealization and devaluation, typically associated with both strong desire for and fear of closeness and intimacy.
- Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self.
- A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours (e.g., risky sexual behaviour, reckless driving, excessive alcohol or substance use, binge eating).
- Recurrent episodes of self-harm (e.g., suicide attempts or gestures, self-mutilation).
- Emotional instability due to marked reactivity of mood. Fluctuations of mood may be triggered either internally (e.g., by one's own thoughts) or by external events. As a consequence, the individual experiences intense dysphoric mood states, which typically last for a few hours but may last for up to several days.
- Chronic feelings of emptiness.
- Inappropriate intense anger or difficulty controlling anger manifested in frequent displays of temper (e.g., yelling or screaming, throwing or breaking things, getting into physical fights).
- Transient dissociative symptoms or psychotic-like features (e.g., brief hallucinations, paranoia) in situations of high affective arousal.

Other manifestations of Borderline pattern, not all of which may be present in a given individual at a given time, include the following:

- A view of the self as inadequate, bad, guilty, disgusting, and contemptible.
- An experience of the self as profoundly different and isolated from other people; a painful sense of alienation and pervasive loneliness.
- Proneness to rejection hypersensitivity; problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships; frequent misinterpretation of social signals.



Borderline Personality Disorder

Diagnostic Criteria **301.83** (F60.3)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

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Einfaches Codierungssystem

Bach and First *BMC Psychiatry* (2018) 18:351
https://doi.org/10.1186/s12888-018-1908-3

BMC Psychiatry

CASE REPORT Open Access

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Bo Bach[1*] and Michael B First[2]

Abstract

Background: The ICD-11 classification of Personality Disorders focuses on core personality dysfunction, while allowing the practitioner to classify three levels of severity (Mild Personality Disorder, Moderate Personality Disorder, and Severe Personality Disorder) and the option of specifying one or more prominent trait domain qualifiers (Negative Affectivity, Detachment, Disinhibition, Dissociality, and Anankastia). Additionally, the practitioner is also allowed to specify a Borderline Pattern qualifier. This article presents how the ICD-11 Personality Disorder classification may be applied in clinical practice using five brief cases.

Case presentation: (1) a 29-year-old woman with Severe Personality Disorder, Borderline Pattern, and prominent traits of Negative Affectivity, Disinhibition, and Dissociality; (2) a 36-year-old man with Mild Personality Disorder, and prominent traits of Negative Affectivity and Detachment; (3) a 26-year-old man with Severe Personality Disorder, and prominent traits of Dissociality, Disinhibition, and Detachment; (4) a 19-year-old woman with Personality Difficulty, and prominent traits of Negative Affectivity and Anankastia; (5) a 53-year-old man with Moderate Personality Disorder, and prominent traits of Anankastia and Dissociality.

Conclusions: The ICD-11 Personality Disorder classification was applicable to five clinical cases, which were classified according to Personaity Disorder severity and trait domain qualifiers. We propose that the classification of severity may help inform clinical prognosis and intensity of treatment, whereas the coding of trait qualifiers may help inform the focus and style of treatment. Empirical investigation of such important aspects of clinical utility are warranted.

Keywords: ICD-11, Classification, Personality disorder, Severity, Trait

Beispiel 1

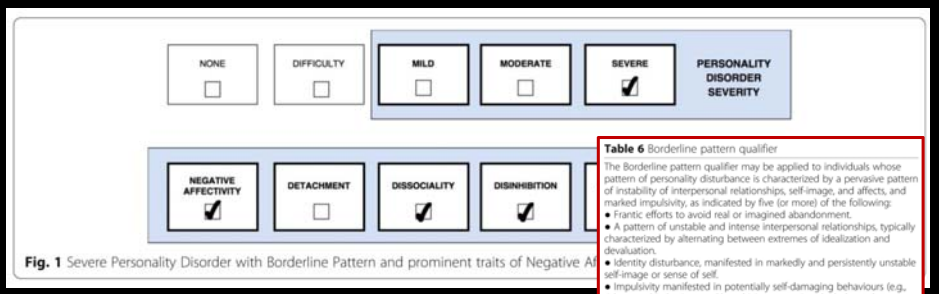

Fig. 1 Severe Personality Disorder with Borderline Pattern and prominent traits of Negative Af

Table 6 Borderline pattern qualifier

The Borderline pattern qualifier may be applied to individuals whose pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by five (or more) of the following:

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- A pattern of unstable and intense interpersonal relationships, typically characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self.
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- Recurrent episodes of self-harm (e.g., suicide attempts or gestures, self-mutilation).
- Emotional instability due to marked reactivity of mood. Fluctuations of mood may be triggered either internally (e.g., by one's own thoughts) or by external events. As a consequence, the individual experiences intense dysphoric mood states, which typically last for a few hours but may last for up to several days.
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- Proneness to rejection hypersensitivity; problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships; frequent misinterpretation of social signals.

Note. Adapted from the ICD-11 Clinical Descriptions and Diagnostic Guidelines for Personality Disorder

Beispiele 2 & 3

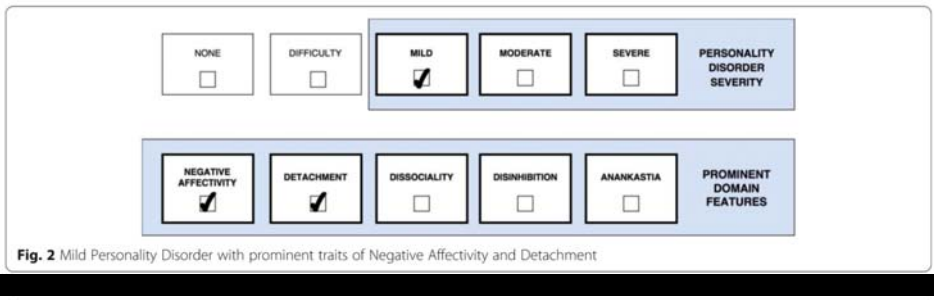

Fig. 2 Mild Personality Disorder with prominent traits of Negative Affectivity and Detachment

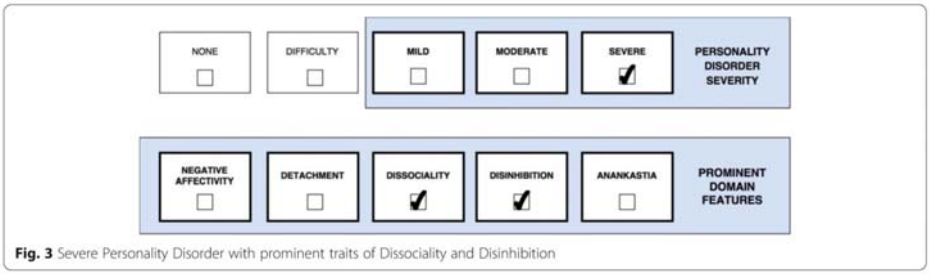

Fig. 3 Severe Personality Disorder with prominent traits of Dissociality and Disinhibition

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Beispiel 4 & 5

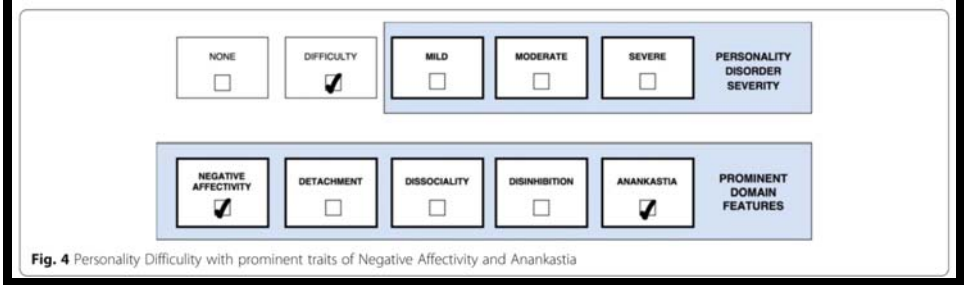

Fig. 4 Personality Difficulty with prominent traits of Negative Affectivity and Anankastia

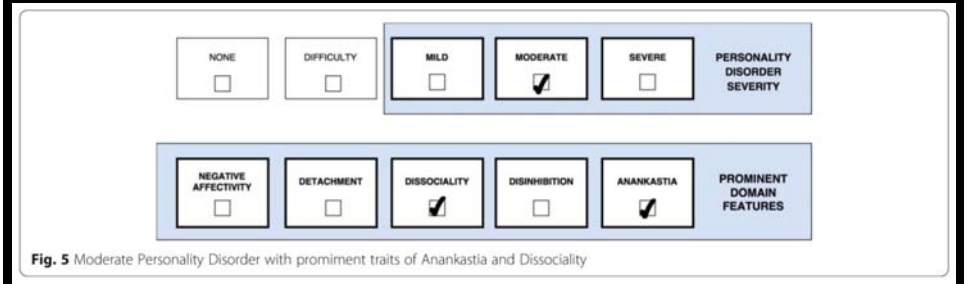

Fig. 5 Moderate Personality Disorder with prominent traits of Anankastia and Dissociality

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Beziehung zum DSM-5 AMPD

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Keywords: ICD-11, Classification, Personality disorder, Severity, Trait

Table 7 ICD-11 "Cross Walk" for DSM-5 Alternative Model of Personality Disorders

ICD-11 Severity of Personality Dysfunction	DSM-5 Criterion A: Level of Personality Functioning
None	0) No impairment (Healthy Functioning)
Personality Difficulty	1) Some impairment
Mild Personality Disorder	2) Moderate impairment
Moderate Personality Disorder	3) Severe impairment
Severe Personality Disorder	4) Extreme impairment
ICD-11 Trait Domain Qualifiers	DSM-5 Criterion B: Trait Domains
Negative Affectivity	Negative Affectivity
Detachment	Detachment
Disinhibition	Disinhibition
Dissociality	Antagonism
Anankastia	[Rigid Perfectionism and Perseveration][a]

Note. The threshold for a Personality Disorder diagnosis is a t least Mild Personality Disorder (ICD-11) or Moderate impairment of personality functioning (DSM-5)
[a]These are facets from the domains of (low) Disinhibition and (high) Negative Affectivity, respectively

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Big Five	Neuroticism	Openness to experience	Agreeable-ness	Extra-version	Conscien-tiousness
DSM-5	Negative Affectivity	Detachment	Antagonism	Disinhibition	Psychoti-cism
ICD-11	Negative Affectivity	Detachment	Dissociality	Disinhibition	Anankastia

Beziehung zur ICD-10

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Table 8 Tentative ICD-10 "Cross Walk" for ICD-11 Trait Domain Qualifiers

ICD-10 Category	ICD-11 Qualifier	Specific ICD-11 Trait Features
F60.0 Paranoid	Negative Affectivity	Mistrustfulness, anger, bitterness, tendency to hold grudges; may become overwrought over real or perceived slights or insults from others.
	Detachment	Emotional and interpersonal distance; avoidance of close friendships.
F60.1 Schizoid	Detachment	Do not enjoy intimacy or social interactions and are not particularly interested in sexual relations; aloofness, emotional unexpressiveness, non-reactive to negative and positive events, with a limited capacity for enjoyment.
	low Negative Affectivity	Absence of emotional intensity and sensitivity.
F60.2 Dissocial	Dissociality	Lack of empathy including callous, deceptive, manipulative, exploiting, mean, ruthless, and physically aggressive behavior, and may sometimes take pleasure in inflicting pain or harm.
	Disinhibition	Impulsivity, irresponsibility, recklessness, and lack of planning without regard for risks or consequences.
	low Negative Affectivity	Absence of vulnerability, shame, and anxiety.
F60.3 Emotionally unstable	Negative Affectivity	Poor emotion regulation including being overreactive to criticism, problems, and setbacks; low frustration tolerance; often experiencing and displaying multiple emotions simultaneously or vacillate among a range of emotions in a short period of time. Once upset, it is difficult to regain composure.
	Disinhibition	Impulsivity associated with e.g., substance use, unplanned sexual activity, and sometimes deliberate self-harm; lack of planning.
	Dissociality	Sometimes being mean and physically aggressive.
F60.4 Histrionic	Dissociality	Expectation of others' admiration and attention-seeking behaviours to ensure being the center of others' focus.
	Disinhibition	Easily distracted by extraneous stimuli, such as others' conversations and tend to scan the environment for more enjoyable options. Acts rashly based on whatever is attractive at the moment. Focus on immediate feelings and sensations.
	Negative Affectivity	Emotional lability including being overreactive to external events; often experiences and displays multiple emotions simultaneously.
	low Detachment	Reversed emotional and social detachment including avoidance of social interactions, limited emotional expression and experience.
F60.5 Anankastic	Anankastia	Perfectionism including hyper-scheduling, planfulness, orderliness, and neatness. Behavioral constraint including control over emotional expression, stubbornness, risk-avoidance, perseveration, and deliberativeness.
	low Disinhibition	Reversed Irresponsibility, lack of Planning, and Impulsivity.
	Negative Affectivity	Worry, anxiety, and negativistic attitudes involving rejection of other's suggestions or advice.
F60.6 Anxious (avoidant)	Negative Affectivity	Anxiety, vulnerability, fear, shame, and low self-esteem/confidence including avoidance of situations and activities that are judged too difficult.
	Detachment	Avoidance of social interactions and intimacy, seek out employment that does not involve interactions with others, and even refuse promotions if it would entail more interaction with others.
	low Dissociality	Reversed self-centeredness: attention-seeking behaviours to ensure being the center of others' focus; believing that one has have many admirable qualities, that one's accomplishments are outstanding, that one will achieve greatness, and that others should admire one.
F60.7 Dependent	Negative Affectivity	Anxiety, vulnerability, and low self-confidence including dependency, which may be manifested in frequent reliance on others for advice, direction, and other kinds of help.
	low Dissociality	Excessive prosocial behavior and absence of self-centeredness: lack of concern about own needs, desires, and comfort, while those of others are overly considered.
F60.8 Other: Narcissistic	Dissociality	Grandiosity, a sense of entitlement, believing that they have many admirable qualities, that they have or will achieve greatness, and that others should admire them.
	Negative affectivity	Dysregulated self-esteem, which may involve envy of others' abilities and indicators of success; the individual can become overwrought over real or perceived slights or insults.

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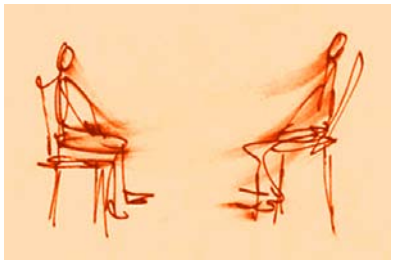
Praktische Anwendung



NONE	DIFFICULTY	MILD	MODERATE	SEVERE	PERSONALITY DISORDER SEVERITY

NEGATIVE AFFECTIVITY	DETACHMENT	DISSOCIALITY	DISINHIBITION	ANANKASTIA	PROMINENT DOMAIN FEATURES

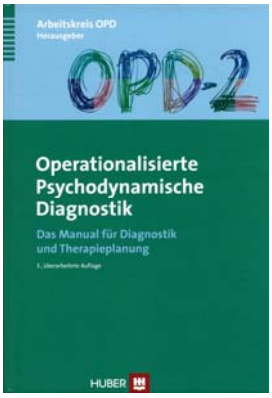


Tabelle 4-12: Kriterien für die Einschätzung des Strukturniveaus

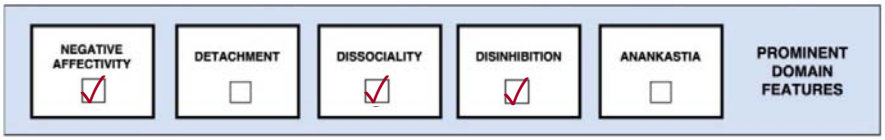
①	gut integriert	Relativ autonomes Selbst; strukturierter psychischer Binnenraum, in dem sich intrapsychische Konflikte abspielen können; Fähigkeit zur Selbstreflexion und realitätsgerechten Wahrnehmung des anderen; Fähigkeit zur Selbststeuerung; Empathiefähigkeit; ausreichend gute innere Objekte; zentrale Angst: die Zuneigung des Objekts zu verlieren.
	1,5	gut bis mäßig.
②	mäßig int.	Die intrapsychischen Konflikte sind destruktiver; selbstentwertende und autodestruktive Tendenzen; Schwierigkeit, Selbstbild und Identität zu gewinnen; Übersteuerung und eingeschränkte Selbstwertregulierung; Objektbilder sind auf wenige Muster eingeengt; wenig empathiefähig; dyadische Beziehungen sind vorherrschend; zentrale Angst: das wichtige Objekt zu verlieren.
	2,5	mäßig bis gering
③	gering integriert	Wenig entwickelter psychischer Binnenraum und geringe Differenzierung psychischer Substrukturen; Konflikte sind interpersonell statt intrapsychisch; Selbstreflexion fehlt; Identitätsdiffusion; Intoleranz für negative Affekte; Impulsdurchbrüche und große Kränkbarkeit; Abwehr: Spaltung, Idealisierung, Entwertung; fehlende Empathie und eingeschränkte Kommunikationsfähigkeit; innere Objekte sind vorwiegend verfolgend und strafend; zentrale Angst: Zerstörung des Selbst durch den Verlust des guten Objekts oder durch das böse Objekt
	3,5	gering bis desintegriert
④	desintegriert	Die fehlende Kohärenz des Selbst und die überflutende Emotionalität werden durch Abwehrmuster im Sinne postpsychotischer, posttraumatischer, perverser Organisationsformen überdeckt. Selbst- und Objektbilder erscheinen konfundiert. Empathisches Objektwahrnehmen so gut wie unmöglich. Verantwortung für eigenes impulsives Handeln wird nicht erlebt (die Dinge geschehen einfach). Zentrale Angst: symbiotische Verschmelzung von Selbst und Objektrepräsentanzen mit der Folge des Selbstverlustes.

NONE	DIFFICULTY	MILD	MODERATE	SEVERE	PERSONALITY DISORDER SEVERITY

CAVE: Neurotische PS

Table 8 Tentative ICD-10 "Cross Walk" for ICD-11 Trait Domain Qualifiers

ICD-10 Category	ICD-11 Qualifier	Specific ICD-11 Trait Features
F60.4 Histrionic	Dissociality	Expectation of others' admiration and attention-seeking behaviours to ensure being the center of others' focus.
	Disinhibition	Easily distracted by extraneous stimuli, such as others' conversations and tend to scan the environment for more enjoyable options. Acts rashly based on whatever is attractive at the moment. Focus on immediate feelings and sensations.
	Negative Affectivity	Emotional lability including being overreactive to external events; often experiences and displays multiple emotions simultaneously.
	low Detachment	Reversed emotional and social detachment including avoidance of social interactions, limited emotional expression and experience.



Codierung: 6D10.1/ 6D.11.0/ 6D11.2/6D11.3

ICD-10	ICD-11
F60.0 - Paranoid	6D10.X/6D11.0/6D11.1
F60.1 - Schizoid	6D10.X/6D11.1
F60.2 - Dissozial	6D10.X/6D11.2/6D11.3
F60.3 – Borderline	6D10.X/6D11.5
F60.4 - Histrionic	6D10.X/6D11.0/6D11.2/6D11.3
F60.5 - Zwanghaft	6D10.X/6D11.4/6D11.0
F60.6 – Ängstlich-vermeidend	6D10.X/6D11.0/6D11.1
F60.7 - Dependent	6D10.X/6D11.0
F60.8 - Narzisstisch	6D10.X/6D11.0/6D11.2

Mittelgradige Persönlichkeitsstörung mit negativer Affektivität, Dissozialität und Enthemmung
ICD-11: 6D10.1/ 6D.11.0/ 6D11.2/6D11.3

oder doch lieber

Histrionische Persönlichkeitsstörung
mit ödipalem Konflikt auf mäßig bis geringem Strukturniveau (2,5) nach OPD-2?

Resumée

- Strukturdiagnostik!
- Tribut an die empirische Messung von Persönlichkeitszügen
- Absage an die klinische Evidenz und Notwendigkeit

Epistemologische Kritik

Auch die Traits folgen der Klassifikationslogik von ICD-10 und DSM-IV: phänomenologisch-deskriptiv.

Black-box-Prinzip hinsichtlich der psycho-dynamischen und ätiologischen Muster

6D31.1 Detachment

The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of Detachment, not all of which may be present in a given individual at a given time, include the following:

- ***Social detachment***. Social detachment is characterized by avoidance of social interactions, lack of friendships, and avoidance of intimacy. Individuals high on Detachment do not enjoy social interactions and avoid all kinds of social contact and social situations to the extent possible. They engage in little to no 'small talk' even if initiated by others (e.g., at store check-out counters), seek out employment that does not involve interactions with others, and even refuse promotions if it would entail more interaction with others. They have few to no friendships or even casual acquaintances. Their interactions with family members tend to be minimal and superficial. They rarely, if ever, engage in any intimate relationships and are not particularly interested in sexual relations.
- ***Emotional detachment.*** Emotional detachment is characterized by reserve, aloofness, and limited emotional expression and experience. Individuals high on Detachment keep to themselves to the extent possible, even in obligatory social situations. They are typically aloof and respond to direct attempts at social engagement only briefly and in ways that discourage further conversation. Emotional detachment also encompasses emotional unexpressiveness, both verbally and non-verbally. Individuals high on Detachment do not talk about their feelings and it is difficult to discern what they might be feeling from their behaviours. In extreme cases, there is a lack of emotional experience itself and they are non-reactive to either negative or positive events, with a limited capacity for enjoyment.

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Resumée - Klinik

- Strukturdiagnostik!
- Tribut an die empirische Messung von Persönlichkeitszügen
- Absage an die klinische Evidenz und Notwendigkeit
- Keine Hilfe für die Psychotherapieplanung und -durchführung
  - Im Idealfall: Ordentliche Strukturdiagnostik und klinische Verwendung der alten Kategorien (mit „Übersetzungstabellen“)
  - Das System der Persönlichkeitszüge ist zu grobmaschig und nicht an klinischen Bedürfnissen orientiert
  - Die Kassenlogik wird sich einzig am Schwergrad der PS orientieren (z.B.: Analytische Psychotherapie nur für mittel- und schwergradige PS)

Resumée – Forschung?

- Forschung???
  - Verlust von mehreren Jahrzehnten an Forschung zu den PS
  - Freude für die Strukturdiagnostik und psychopathologische Forschung
  - Schon die Social Cognition Forscher*innen können nur mit Mühe an ihre früheren Arbeiten anknüpfen
  - Therapieforschung wird sich erst neue Wege bahnen müssen:
    Mittel- und schwergradige PS mit dissozialen Zügen und negativer Affektivität ist nicht das Gleiche wir die narzisstische Persönlichkeitsstörung!

    ➡ „Abkoppelung“ der klinischen Forschung?

Vielen Dank für Ihre Aufmerksamkeit!