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Commentary

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Arjan C. Videler

Keywords
Personality disorders; complex emotional needs; stigma.

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Response

This editorial letter[1] is on an important issue that primarily resonates in the UK and Commonwealth countries. As I reside outside of these countries, the discussion in the UK on the potential flaws of replacing the term personality disorder with 'complex emotional needs' is both interesting and confusing. In the rest of the world, professionals, researchers and patients recognise the stigma associated with the diagnosis, which is part of a general mental illness stigma.[2] However, this 'British solution' to rename personality disorder as complex emotional needs seems somewhat awkward and out of bounds to me. In other countries, efforts are aimed at reducing stigma by emphasising the recovery possibilities of people with personality disorders and by educating them about the biological and psychological underpinnings of personality disorders.[2] This editorial is all the more interesting as it was written from a lived experience perspective. This has become routine practice in the field of autism and in my opinion the field of personality disorders is way behind. As such, I am very sympathetic to this editorial.

The authors describe how terms such as 'emerging personality disorder' are often used for children and young people, acknowledging that a person's personality continues to develop into early adulthood. However, research has shown that (emerging) personality disorder in young people is associated with severe and detrimental outcomes later in life, and personality disorder in adolescence usually persists into adulthood and even late life, with a waxing and waning course.[3–5] I feel, therefore, both as a clinician and a researcher, that a proper personality disorder diagnosis does matter. I agree that clinicians and researchers need to be aware of the stigma associated with the term. Just using another term will not do the job.

The case for viewing people with personality disorders as not having complex emotional needs is strong as it might contribute to 'blaming the patient' for having complex needs. People with adversity in early life do not have 'complex emotional needs'. Instead, they had the same human needs as all people in childhood, but these needs were not met sufficiently. Because of this, they developed maladaptive personality patterns, and have difficulty with emotion regulation. Therefore, for instance in schema therapy, unmet core emotional needs are at the centre of the model.[6] The core feature of schema therapy is the construct of Early Maladaptive Schemas, which develop when human core emotional needs (such as connection and acceptance, healthy autonomy, reasonable limits and realistic standards and reciprocity) are not met in childhood. As needs are so central to healthy development, in schema therapy Early Adaptive Schemas (or positive schemas) have recently been introduced as positive constructs.[7,8] Positive schemas develop during childhood or adolescence, when the family and sociocultural context adequately meets someone's core emotional needs. Jeffrey Young[6] hesitated to speak of personality disorder, as he developed schema therapy from lived experience himself. In an interview, Young disclosed that he was dissatisfied while receiving cognitive behaviour therapy himself, as he could not get to the bottom of where his issues of loneliness and intimacy were coming from. Young preferred to speak of 'characterological issues' instead of personality disorder.

I fully agree with the authors that reframing the personality disorder diagnosis as 'complex emotional needs' does not address the issue of inappropriate diagnosis or misdiagnosis. More importantly, it broadens the scope of the label, and as a consequence this language may worsen the prevalence of inappropriate diagnoses. The 'complex emotional needs' construct may increase the likelihood that people with unmet needs in childhood will continue to have their core emotional needs unmet throughout life, even by mental health services.

The alternative that the authors propose is 'people diagnosed with a personality disorder' instead of personality as a noun. This reminds me of the discussion on the language used to refer to autism, which has been a topic of ongoing debate.[9] The words used to describe autism and people with autism tends to shape the way we think about autism. These words may unintentionally contribute to stigmatisation, just like people diagnosed with a personality disorder tend to be stigmatised. Research in the UK and Australia indicated an overall preference for identity-first language ('autistic person') among autistic adults rather than person-first language ('person with autism').[9] In the Netherlands, however, a person-first language preference prevails.[10] There are large differences in the words that people prefer, and researchers, clinicians and people who are diagnosed with autism therefore use both person-first and identity-first language, to emphasise respect for both perspectives. Maybe we should to do the same in the field of personality disorder. Just ask people what term they prefer themselves to refer to the difficulties they face in life. Everyone experiences anxiety and fluctuations in their mood, and when tremendous anxiety or a severe depressed mood interferes with daily life and has a detrimental effect on quality of life, the term 'anxiety disorder' or 'mood disorder' usually feels appropriate to people. I think the same holds for personality: we all have a personality, and when one's core emotional needs were not met sufficiently in early life, people tend to struggle with the challenges they face in life. Being diagnosed with a personality disorder opens the way for helpful treatment, whatever term we use. But please discuss with the persons involved which language they prefer. Some may prefer 'personality disorder', while others prefer 'being diagnosed with a personality disorder'. Jeffrey Young[6] opted for 'characterological issues'.

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Declaration of interest

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