MORAL NATURE OF THE DSM-IV CLUSTER B PERSONALITY DISORDERS

Louis C. Charland, PhD

Moral considerations do not appear to play a large role in discussions of the DSM-IV personality disorders and debates about their empirical validity. Yet philosophical analysis reveals that the Cluster B personality disorders, in particular, may in fact be moral rather than clinical conditions. This finding has serious consequences for how they should be treated and by whom.

MORAL CONSIDERATIONS

In a brief but original discussion, physician-philosopher Carl Elliott (1996) argued that we should hold persons with personality disorders morally responsible for their actions; he stated that “a person with a personality disorder who behaves badly ordinarily intends to behave badly, and people should generally be held accountable for what they have intended to do” (p. 70, emphasis in original). According to Elliott, a diagnosis of personality disorder is normally not sufficient for excusing a person’s actions, nor do disorders or defects of character excuse. As he argued, “judgments of responsibility are essentially judgments about a connection between an agent and an action, and these types of judgments must be distinguished from questions about a person’s character” (p. 58).

Elliott (1996) noted that “personality disorders test, in an especially acute way, our intuitions about character and responsibility” (p. 58). As is discussed below personality disorders also test our intuitions about what should count as a genuine clinical disorder. In the present article I build on Elliott’s discussion of personality disorders in order to explore its bearing on the question of what personality disorders are, a question he leaves relatively untouched. The topic bears directly on recent debates about the empirical validity of the current DSM-IV personality disorders (see e.g., Livesley, 1995); however, it addresses that question from an unusual angle: through the intermediary of moral responsibility and associated moral considerations. What is novel is the link between these moral ques-

From the Department of Philosophy & Faculty of Health Sciences, University of Western Ontario.

Address correspondence to Louis C. Charland, Ph.D., Associate Professor, Department of Philosophy & Faculty of Health Sciences, Talbot College 414, University of Western Ontario, London, Ontario, Canada N6A 3K7; E-mail: charland@uwo.ca
tions and traditional debates regarding the empirical validity of these categories.

EMPIRICAL VALIDITY WITHOUT CLINICAL VALIDITY

Discussions devoted to the empirical validity of the personality disorders tend to merge two quite different aspects, which for our purposes need to be distinguished. On the one hand, there is the question of whether the putative behavioral syndromes denoted by our current personality disorder categories are genuine discrete empirical entities. That is, do the behavioral syndromes denoted and grouped together by these categories actually exist as such? On the other hand, there is the further question of whether such syndromes, if they exist, are really clinical in nature. That is, assuming they exist, do these behavioral syndromes represent genuine clinical entities? The distinction is important, since even if the personality disorders represent genuine empirically valid syndromes, it does not necessarily follow that they also represent empirically valid clinical syndromes. Some could be empirically valid syndromes that are not specifically clinical in nature. This, in fact, is my main conclusion regarding one particular subset of the personality disorders, notably, those in Cluster B.

The central argument of this paper is that the DSM-IV personality disorders are actually comprised of two very different kinds of theoretical entities that denote two very different kinds of syndromes. Some denote genuine clinical disorders; these are the disorders in Clusters A and C. The others denote moral disorders; these are the disorders in Cluster B. The Cluster B disorders include the antisocial, borderline, histrionic, and narcissistic types. Thus, even if the Cluster B disorders are empirically valid theoretical categories, it does not necessarily follow that they are also necessarily empirically valid clinical categories. To the extent that they partake of both aspects, the two categories need to be distinguished. This is a conclusion with important consequences for how the Cluster B disorders should be treated and by whom. Indeed, one concern that emerges from this discussion is whether clinically trained therapists have the requisite skills and knowledge to conduct the sort of moral treatment required to treat Cluster B disorders—moral disorders would appear to require moral treatment and professional clinicians are not normally trained for that.

It will immediately be noticed that this argument takes the current DSM categorization at face value; it assumes it to be true. This is not to deny the many criticisms and challenges that this particular categorization faces, including its categorical nature; however, the purpose of the present discussion is to focus on what that categorization philosophically says and means. In addition, the claim that persons diagnosed with Cluster B disorders should be held morally responsible for their actions might also appear reactionary and reprehensible to some—a return to an era when clinical conditions were mistaken for moral conditions and sufferers had to bear the weight of moral stigma and blame. In response to this, it needs to be
stressed that the moral aspects of the Cluster B disorders are an integral part of the DSM conception of those disorders, not a fabrication or recommendation of this discussion. Indeed, the primary aim of this discussion is to uncover and expose these normative assumptions, which are philosophically concealed by the neutral clinical descriptive language of the DSM. That is quite different from endorsing or defending those assumptions.

My thesis that the Cluster B disorders are moral and not clinical conditions is based on two arguments which form the subject of the next two sections. The first is the argument from identification; it is primarily a philosophical argument. The second is the argument from treatment; it is primarily an empirical argument. In the third section, I address the question of therapy and look more closely at the interface between clinical and moral factors in psychotherapy for the Cluster B disorders.

THE ARGUMENT FROM IDENTIFICATION
The current DSM depiction of the personality disorders conceals the fact that some of them are moral rather than clinical conditions. The difference remains hidden because it does not lend itself easily to description in clinical terms, which typically attempts to remain morally neutral. A philosophical analysis is therefore required to expose this difference among the personality disorders. The use of moral terms and notions to identify some of the personality disorders may not be immediately evident to the philosophically untrained eye. Nor, probably, are its implications. This is an area where the present paper hopes to make a special contribution.

The kind of philosophical method employed here analyzes the official language and terminology in which personality disorders are described. The language of the DSM is therefore the first line of evidence. From that evidence, one can then infer the logical character of the concepts involved and their interrelations. My task is to articulate what the language of personality disorders philosophically means, and what it logically implies and presupposes. This philosophical technique has already been successfully used in other branches of psychiatric inquiry (Fulford, 1999). Of course, this is meant to complement, not displace, empirical enquiry. What philosophy can do here is to elucidate and clarify the language of science, but it is no substitute for science itself. Yet it is clearly fundamental nonetheless, since scientific theories are largely expressed in language. If that language is not serving its intended purpose properly, then it needs to be changed. To start, the language in which the various personality disorders are described and classified must be examined. What kind of terms and notions are involved? What do these logically imply and presuppose? And what do these scientific theoretical concepts and their definitions really mean?

Like their predecessors, the DSM-IV personality disorders are identified using polythetic criteria sets. No one fixed list of features serves as the preferred list of necessary and sufficient conditions for identifying the
presence of a condition. Instead, there is flexibility to choose from various possible combinations of defining criteria. Ideally, in order to guarantee scientific objectivity, the criteria are stated in simple and unambiguous descriptive terms. This is crucial. For example, criteria for schizoid personality disorder include: "almost always chooses solitary activities," "lacks close friends or confidants other than first degree relatives," and "takes pleasure in few, if any, activities" (APA, 1994, p. 641). These descriptors are unlikely to generate much controversy when used in operational definitions. Reliable intersubjective agreement on when an instance of a condition has been identified is relatively easy to secure in such cases. At least, this is the hope and the reason behind the use of clear and simple uncontroversial descriptive terms.

Significantly, however, at times the language and defining criteria for the personality disorders invoke explicit moral terms and notions. This is especially true of the Cluster B disorders. For example, the criteria for antisocial and narcissistic personality disorder include, respectively, "deceitfulness, as indicated by repeated lying, uses of aliases, or conning others for personal profit or pleasure," as well as "lacks empathy: is unwilling to recognize or identify with the feelings of others" (APA, 1994, pp. 650, 651). Consider some of the associated moral implications and presuppositions of these notions. Normally, it is considered morally reprehensible to lie, and the desire to empathize is morally laudable. Most people would consider it morally wrong to ignore the feelings of others, or to try and con them. Clearly, the Cluster B criteria and definitions are philosophically morally loaded; moreover, their moral character is an integral part of the conditions they are designed to capture and it is not logically dispensable.

The central premise of my philosophical argument from identification can now be stated: The identification of Cluster B disorders involves the explicit use of moral terms and notions while the language of Cluster A and C disorders does not. This is not an accident. The reason is that Cluster B disorders are fundamentally moral in nature while Cluster A and C disorders are not. Indeed, one could argue that it is logically impossible to properly identify the Cluster B disorders without presupposing moral terms and notions or using descriptions that imply such moral terms. By definition, a Cluster B diagnosis logically implies and presupposes that a person has engaged in some form of morally reprehensible behavior, of the sort specific for that category. Because the Cluster B categories manage to capture a significant amount of regularities in human behavior, they are quite probably empirically valid. In other words, not only can instances of these behaviors be reliably identified, the conditions themselves really exist as such. This is why one can often predict how such a person will behave. Typically, they will behave in specific immoral kinds of ways, as specified by the defining criteria for a particular Cluster B disorder. But note that none of this means or implies that the disorders in question are clinical in nature; on the contrary, by definition these appear to be moral and not clinical conditions.
Could the Cluster B personality disorders possibly be both moral and clinical conditions or are the two sorts of categories mutually exclusive? The answer is that moral and clinical categories are not mutually exclusive. A person can be a cardiac patient but also a thief and a liar. In the case of the Cluster B disorders, the relevant point is simply that the alleged clinical character of the disorder is totally unspecified. Given the manner in which the DSM is constructed, there is no clinical reason or evidence to think that the Cluster B disorders are more than moral categories. Of course, they may cause clinical distress, but that is hardly sufficient to consider a disorder clinical in nature and, therefore, subject to and amenable to clinical treatment and therapy. There is also the possibility that a dimensional analysis might provide such clinical evidence, but presently the DSM personality disorders are organized and understood categorically, not dimensionally.

Many of the key terms in the defining operational criteria employed for the identification of the Cluster B disorders are explicitly moral in nature, and the manner in which those terms figure in the various operational definitions for the application of those categories logically implies that the categories themselves are moral categories. This moral aspect of the Cluster B disorders is not explicitly stated in the DSM, but it is implicit. It is a logical consequence of the manner in which moral terms and notions are used in stating the central defining criteria for those categories.

Apparently, the use of a moral vocabulary is constitutive of the Cluster B disorders and is logically required for their identification. This becomes eminently clear when one moves from the “thin” vocabulary stated in the DSM-IV to the “thick” vocabulary of case descriptions in the DSM IV Casebook (APA, 1994). Those thick descriptions often explicitly refer to moral terms or imply them. The Casebook descriptions are more personalized and narrative in form. They provide a more concrete meaning and interpretation of the DSM criteria. According to philosopher Ian Hacking (1995), those case descriptions are not simply pedagogical afterthoughts but rather central ingredients of the DSM system. They provide the best means for identifying what the various mental disorders refer to and what their more technical descriptions really mean. The claim that appeal to a thick vocabulary often reveals moral presuppositions that under a thin description are otherwise absent or less obvious is an important element of Fulford’s argument that our concept of physical disease is a heavily value-laden notion (Fulford, 1999; see also Agich, 1994). Other excellent examples of that general line of argument can be found in the work of thinkers like Elliott (1999).

THE ARGUMENT FROM TREATMENT

Elliott (1996) is skeptical about the clinical status of the personality disorders; however, he does not appear to doubt their existence as genuine behavioral syndromes. What he questions is whether they are clinical condi-
tions. He notes that, “the idea that personality disorders are illnesses should give us pause” (p. 62). The notion of treatment plays a central role in his doubts because he believes that the personality disorders do not appear to have any effective clinical treatments. The reason for this, he suspects, is that they are not genuine clinical conditions. He writes:

First, when the diagnosis of an illness is made, it is usually for the purpose of treatment, be it cure, control, or palliation. For personality disorders there is often no effective treatment. Second, for many (but not all) illnesses there is (or is suspected to be) an underlying organic, physiological abnormality. For most personality disorders there appears to be none. Third, most illnesses are unwanted, and this could not be said of many personality disorders. Finally, most medical diagnoses are not made solely on the basis of behavioral signs, as is the case with most personality disorders. (p. 62, emphasis in original).

In this argument, Elliott asserts that “there is often no effective treatment” for the personality disorders. As a general argument meant to cover all the personality disorders, this argument may be exaggerated (but as an argument specifically directed at the Cluster B disorders, it is very revealing). This becomes evident when one considers the most recent edition of Treatments of Psychiatric Disorders (APA, 2001). In the introduction to Treatments of Psychiatric Disorders, the claim is made that “advances in the diagnostic understanding and treatment of the personality disorders have been substantial;” indeed, some personality disorders are now held to be “eminently treatable with psychotherapy” (APA, 2001, p. 2223). This suggests that at least some personality disorders may be illnesses after all. That, in turn, suggests that they may in fact be genuine clinical conditions. The controversial premise here is nicely captured by Fulford’s claim that “medical interventions require medical grounds” (1999, p. 164, 182, emphasis in original).

The treatments for personality disorders referred to in Treatments of Psychiatric Disorders include both pharmacological and psychological therapies. Sometimes pharmacological therapies are recommended because of concurrent Axis I comorbid conditions. In practice, pharmacological treatments might also be administered even though they are not therapeutically specific to the conditions they are applied to (APA, 2001, p. 2225). For example, antidepressants or anxiolytics might form part of the recommended treatment for some personality disorders, even though there is no full-fledged Axis I indication for them (Healy, 2002, p. 346). In that respect, they resemble and function like the pharmacological tonics of earlier eras (Healy, 1997, p. 257; 2002, pp. 65–67). On the psychotherapeutic side, a variety of approaches are possible. Virtually all are said to require the establishment of a therapeutic alliance and empathy. Pharmacological and psychotherapeutic treatment recommendations are not divided equally across the different personality disorders. As might be expected, pharmacotherapies tend to be favored in the case of disorders that are suspected to have strong biological determinants; for example, the schizotypal and
avoidant types (APA, 2001, p. 2223). In other cases, pharmacological interventions are prescribed on a creative basis depending on the individual details of the case (APA, 2001).

Let us now turn to see how these empirical considerations regarding treatment relate to our second argument, the argument from treatment. To start, recall the central role of moral terms and notions in the defining criteria for the Cluster B disorders. Think especially of what these might imply regarding the proper goals and objectives for treatment of those disorders. The relevant point in this case is that it is impossible to imagine a successful treatment or cure for those conditions that does not involve some sort of conversion or change in moral character. Successful treatment in this case is tantamount to a moral conversion (Charland, 2004).

To see why, consider very briefly the nature of the individual Cluster B disorders. Antisocial personality disorder is said to involve a “pervasive pattern of disregard for and violation of the rights of others” (APA, 1994, p. 649), and narcissistic personality disorder is said to involve a “lack of empathy” (p. 661). The moral nature of histrionic personality is more implied than explicit but is clear nonetheless; here the “excessive attention seeking” and “inappropriate sexually seductive and provocative behavior” is flatly inconsistent with a pattern of empathy and regard for others (APA, 1994, p. 657–658). Finally, the “inappropriate, intense anger” and “instability in interpersonal relationships” cited in the diagnostic criteria for borderline personality disorder again imply clear moral deficits in empathy and regard for others.

There is therefore no escaping the conclusion that, either by explicit mention or by implication, persons diagnosed with Cluster B personality disorders exhibit morally objectionable and reprehensible behavior toward others. That moral aspect of their condition is logically inseparable from their having the condition. Without it, the diagnosis cannot be applied. Therefore, moral shortcomings of some sort appear to be logically necessary conditions for the presence of these DSM-IV Cluster B personality disorders. This is a logical point. But it has empirical implications.

What emerges from these considerations is that, unless the moral problems and behaviors associated with the Cluster B disorders can be overcome or eliminated, successful treatment and cure is impossible. Someone who is empathic and caring of others cannot logically be said to suffer from antisocial or narcissistic personality disorder in the way these are presently characterized in the DSM. Likewise, someone who is morally committed to being more respectful and considerate of others can plausibly be said to be improving and recovering from histrionic personality disorder. The case of borderline disorder is more difficult, but here as well it is plausible to imagine that a moral commitment to being patient and loving with both others and oneself is an essential ingredient of any serious treatment and cure.

Note that the same cannot be said of psychotherapeutic interventions for many other sorts of conditions. There are no such moral presupposi-
tions for desensitization behavioral therapy for phobias or even cognitive therapy for depression. Willingness, commitment, and effort are of course required for therapy to succeed in these and many other cases. But moral willingness, commitment, and effort of the sort I have been discussing is not required. In addition, successful pharmacological interventions to reduce conditions like depression and anxiety for the Cluster B disorders may well help foster positive growth and development, but without a moral commitment to change, those interventions are doomed to remain insufficient and will elude any thorough cure.

What this philosophical analysis shows is that the Cluster B personality disorders are fundamentally moral conditions. Consequently, their treatment requires a sort of moral treatment. None of this should be taken to imply that Cluster B disorders cannot or do not admit of treatment using other means. Rather, the point is simply that those other treatment interventions can never be sufficient for complete treatment or recovery. There is a moral line in the sand that pharmacology apparently cannot cross. Only moral treatment can assure a full cure. Such a cure requires moral willingness, moral change, and moral effort. Of course, these moral desiderata are not mentioned in most standard psychotherapeutic interventions recommended for the treatment of personality disorders. Scientific tradition and protocol in the area does not permit it, yet those desiderata are ultimately required for successful treatment and cure. They actually do appear to be present in one of the most successful treatments for borderline personality disorder: Dialectical Behavioral Therapy (DBT; Linehan, 1993).

THE MORAL INTERFACE

There is a moral aspect present in DBT that is adroitly concealed beneath its clinical description. It has to do with the initial contract that the therapist must establish with the client if therapy is to be successful. Often that contract revolves around setting limits to manipulative threats of suicidal or other self injurious behavior. Establishing mutual respect between the therapist and the client is a major goal of this sort of contract and its special alliance. The two must agree to be moral allies—to treat each other morally, with all that this implies—in order to confront an agreed upon problem.

It is interesting that the therapeutic contract in DBT falls squarely within the parameters of standard bioethical moral obligations which are often said to obtain between a professional clinician and his or her client. These include veracity, privacy, confidentiality, and fidelity (Beauchamp & Childress, 2001, pp. 283–336). In many therapeutic contexts, these moral aspects of the professional-client relationship can be taken for granted, and some may be irrelevant. But in the case of borderline patients, for example, these moral desiderata actually count as goals that need to be achieved in therapy. Note, that they are moral goals. Among other things,
the therapist’s aim in this case is to convince the client to try and be more honest, more truthful, less manipulative, and less resentful and vindictive. These are deeply human matters, where success probably hinges largely, if not entirely, on the therapist’s ability as a moral being rather than a professional clinician.

The contract that must be negotiated at the start of DBT therapy is therefore really a moral contract and the therapy is moral treatment. Of course, once the moral contract is established, therapy can move on to more clinical matters, where the clinician’s professional skills and expertise are paramount. Yet nothing in the professional clinician’s training arsenal seems designed to prepare them to be a moral being, which is the starting point of their professional therapeutic relationship with their client. Some sort of moral authority or guiding role is required for this aspect of therapy, but standard clinical training does not usually provide anything of the sort.

There are interesting historical precedents to build on in exploring the nature and goals of moral treatment for the personality disorders (Charland, 2003, 2004; Lilleleht, 2003), but for the moment I will stop with the empirical claim that there exists a significant moral interface in at least one highly promising therapy for a paradigm Cluster B disorder; namely, borderline personality disorder. The problem is that the moral nature of this interface is normally not acknowledged for what it really is. Strictly speaking, it is not clinical and it is misleading to consider it a professional clinical skill or intervention; rather, it is a moral initiative, undertaken between two moral beings, in the quest for moral consensus on how to behave morally with respect to one another.

I have only considered the case of borderline personality disorder; however, it should be clear that many of the same moral issues arise in the case of the remaining Cluster B disorders, where the basic goals of moral treatment are essentially the same. This is not surprising, since they are all fundamentally moral conditions. The fact that the moral treatment covertly practiced in DBT is apparently so appropriate and successful for treating borderline personality disorder is a good empirical indication that the borderline syndrome is at least partly a moral condition. It can only be hoped that this clue leads to other equally promising moral approaches to the other Cluster B disorders. Sensitive and properly clinically informed management is clearly indicated for these disorders (Livesely, 2003), but we should not ignore their moral aspects and the need to accommodate them in therapy.

CONCLUSION
Moral considerations do not appear to play a large role in discussions of the DSM-IV personality disorders and debates about their empirical validity, yet philosophical analysis reveals that the Cluster B personality disorders, in particular, may in fact be moral rather than clinical conditions.
This finding has serious consequences for how they should be treated and by whom.

Clinical therapy may be recommended and helpful in treating the Cluster B disorders, but without some form of moral treatment specifically designed to target their underlying moral aspects, full recovery is likely to prove elusive. Such moral interventions are already surreptitiously incorporated in some contemporary varieties of therapy for the personality disorders, notably, Dialectical Behavioral Therapy; however, to fully appreciate the real reasons for these interventions and their distinct moral character, the moral aspects of the *DSM-IV* Cluster B disorders need to be discussed and scrutinized more openly and explicitly. This is a task where philosophy can help.

**REFERENCES**


