Georges Canguilhem and the Diagnosis of Personality Disorder

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Psychiatric participation, actual and anticipated, in the detention of "sexually violent predators" in the United States and "dangerous severe personality disordered" people in the United Kingdom provokes controversy. Much of this controversy concerns the proper roles of doctors and other mental health professionals. And since existing and proposed legislation requires that a person have a mental disorder or mental abnormality before he can be detained,[1,2] debate has focused also on criteria for diagnosing personality disorders and some paraphilias.[3]

As a diagnostic category, personality disorder has a long and controversial history. In the past 20 years, the debate has included disagreement about the degree to which an Axis II diagnosis is a valid indicator of mental disorder.[4–6] Current psychiatric classifications adopt a descriptive approach[7–11] and list as signs of personality disorder particular personality traits.[12]

But those traits are not restricted to the personality disordered.[13] No criterion has been identified for which there is a "zone of rarity,"[6] in terms of its statistical distribution in the population, between those who can be reliably diagnosed as personality disordered and those who cannot. Diagnoses elsewhere in psychiatry and medicine often derive validity from evidence of "dysfunction."[14–16] The concept of dysfunction, however, has proved difficult to apply consistently to personality disorders.[15,17] A person's performance in the activities of daily living, for instance, seems peripheral to whether he has a personality disorder.

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Canguilhem and Disease

Georges Canguilhem was born in Castelnaudary, near Toulouse in southwest France, in 1904. He entered medical training at 32, and his thesis, *Essais sur Quelques Problèmes Concernant le Normal et le Pathologique*, earned him his medical degree in 1943. While much of the text concerned physiology, what he was later to call his "interrogation" of the normal and the pathological led him to cite the psychiatrists Karl Jaspers, Eugene Minkowski, and Henri Ey. During the Second World War he worked as a doctor in the French resistance in the Auvergne. In 1955, he became the Professor of History and Philosophy of Sciences at the Sorbonne. He died in 1995.

Canguilhem identified a tension between those conceptions of disease that emerged in the 17th and 18th centuries and others of longer standing. The more longstanding conceptions he identified as, first, the Hippocratic tradition, whereby disease is defined as a dynamic disturbance of the four humors, and, second, the "ontological" drive to localize disease and, hence, to identify the means by which that disease augments or diminishes the individual. Canguilhem believed that Pasteur's germ theory of contagion, for instance, owed the rapidity of its acceptance to its embodiment of the desire to "see" and drive out the agent of ill health. Both the Hippocratic and ontological approaches share an assumption that disease differs from health in qualitative terms, either

through the lack of a "definite principle" or by an alteration of the "total organism."[18]

By the time of Sydenham, however, a desire to govern disease, and hence to understand the relation of disease to the healthy state, had spawned a conception of pathology that was linked to physiology. It was this desire that had led Sydenham, Saint-Hilaire, Pinel, and, particularly, Morgagni to their systems of classification. Pathology had come to be seen as a quantitative phenomenon, "departing from the normal not so much by a or dys as by hyper or hypo" (Ref. 18, p 13). Health and sickness were no longer qualitatively opposed. In the approach of his contemporaries Auguste Comte and Claude Bernard he identified an assumption that science could advance best by establishing continuities between health and sickness. This, to Canguilhem, raised the prospect that the concept of disease could be subsumed into a continuous scale of normality. Three of his arguments seem germane to the current debate about the diagnosis of personality disorder.

First, anomaly is not abnormality. Canguilhem was concerned that qualitative differences, such as that between health and illness, had been obscured by the identification of continua. The qualitative difference between colors, he argued, was not diminished by the fact that each could be positioned on a spectrum of wavelengths. He was concerned that, "to introduce terms into the relationships of composition and dependence, the homogeneity of these terms should be obtained first" (Ref. 18, p 58). He contrasted his views with those of Bernard, arguing that a healthy man and a man with diabetes differ by more than just the quantity of glucose in the bloodstream. A pathological state was not simply a greater or lesser version of a physiological one.[18]

It followed that no list of symptoms and signs or measurement of deviation from a statistical norm could form the basis of a definition of disease. Such a definition had to be based on the abnormalities of the mechanisms involved, rather than the effects of those mechanisms. Each of these mechanisms, in turn, was unlikely to be affected on its own. He again used the example of diabetes to point to the relationships between different biological functions and argued that it is their contribution to the malfunctioning of the living organism as a whole that justifies the label of disease. He quoted Henry Ey's arguments with reference to mental disease: that the normal is not a mean correlative to a social concept, nor a judgment of reality, but rather a value judgment.[18]

Second, being healthy means being able to adapt to and overcome obstacles.[19] It allowed "a margin of tolerance for the inconsistencies of the environment." Canguilhem described health as a "regulatory flywheel of the possibilities of reaction" (Ref. 18, pp 115–6). Third, this process of adaptation is active, not passive. What characterizes health is the possibility of transcending a norm, of tolerating infractions and of instituting new norms in response. This quality he called "normativity."[18] Normative beings are able to deal with conflicts in a way that leaves open the possibility of future correction. Any normality limited to maintaining itself, hostile to any variation in the themes that express it, and incapable of adapting to new situations does not represent health, because it is devoid of "normative intention."[20]

Even a sick organism exhibits biological norms. In the presence of an infection, a higher level of antibody is normal. An organism is healthy to the extent that it is capable of adjusting these norms in the face of changing circumstances. When the infection resolves, the white cell count should change. The pathological condition is one in which the new norm is incapable of this type of adjustment. The normative condition he labeled impulsive and the norm of pathology repulsive, in the sense of "driving back." He quoted with approval Cassirer's metaphor, that disease throws the sick person "a step backward on the roads mankind [has] to clear slowly by means of constant effort" (Ref. 21, p 565).

Active Adaptation and Current Practice

That inflexibility is a mark of personality dysfunction is not a new idea.[22] Vaillant and Perry[23] regarded an "inflexible" response to stress as characteristic of all types of personality disorder. Curran and Mallinson described among their three categories of abnormal personality one made up of people with "a small margin of reserve" who, "when pinched by circumstances," are likely to manifest psychological symptoms (Ref. 24, p 282). Psychodynamic formulations of personality, in particular, make frequent reference to patients' failures to adapt. Partridge[25] referred to poverty of "adjustment" and Rado to "disturbances of psychodynamic integration that significantly affect . . . adaptive life performance" (Ref. 26, p 406).

The references in diagnostic manuals to the capacity for adaptation are not consistent, however. The International Classification of Diseases[27] refers to "inflexible responses to a broad range of personal and social situations." The term maladaptive is also used, but the emphasis is on the longstanding and enduring nature of the traits rather than on the sufferer's ability, or otherwise, to respond appropriately to different circumstances. DSM-III-R[28] similarly concludes that personality traits amount to disorders when they are "inflexible and maladaptive," and DSM-IV uses the same wording in both its original[29] and revised[30] versions. Elsewhere in the revised version of DSM-IV, however, inflexible again seems to be used as a synonym for enduring and assumes less prominence when describing individual disorders, particularly borderline personality disorder.

In addition to this inconsistency, the capacity for adaptation referred to in diagnostic manuals is not usually "active" in Canguilhem's sense. Emphasis is usually placed on a person's ability to function in the circumstances in which he finds himself and less often on his history of being able to respond to change, to function effectively in a range of roles, and to continue to do so when circumstances require those roles to change. One testable hypothesis arising from Canguilhem's work is that a failure actively to adapt to one's surroundings represents the final common pathway by which narcissistic, borderline, schizoid, or other traits prevent someone from achieving his or her potential in a range of social and occupational spheres.

Conclusion

It may be that, in the future, a diagnosis of personality disorder will continue to be seen in the light that it has always been seen by some, as a category developed by doctors and psychologists to describe some of the patients who come to see them. If, as recent legislative proposals suggest, it is also to be used as a marker of a real boundary between health and disease, further work is needed to define that boundary. Functional criteria have fulfilled this role elsewhere in medicine.

Canguilhem wrote that an impaired ability actively to adapt distinguished health from disease. Canguilhem can be difficult to interpret. One reviewer described his work as having the "density of Kryptonite" (Ref. 31, p 15). Further, producing an operational definition of "active adaptation" is likely to present a formidable challenge. The task of distinguishing "disordered" from other personalities has proved formidable also, however. Any meaningful distinction based on function, in addition to informing the debate over recent legislation, would bring psychiatry more closely into line with diagnostic practice elsewhere in medicine.

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