Advances in psychiatric treatment (2012), vol. 18, 162–172 doi: 10.1192/apt.bp.109.006981

ARTICLE

The nature of personality disorder

Gwen Adshead & Jaydip Sarkar

Gwen Adshead is a consultant forensic psychotherapist at Broadmoor Hospital in Crowthorne, UK. **Jaydip Sarkar** is a consultant forensic psychiatrist with the Personality Disorder and Secure Women's Services, Leicester, UK. He is currently working as a forensic psychiatrist at the Institute of Mental Health, Singapore.
Correspondence Dr Gwen Adshead, Dadd Centre, Broadmoor Hospital, Crowthorne, Berkshire RG45 7EG, UK. Email: gwen.adshead@wlmht.nhs.uk

SUMMARY

The lack of a medically grounded approach to personality disorder and its management has led to its comparative neglect as a topic by many clinicians in the UK. In this article we present evidence that personality disorders are, like other mental disorders, the social manifestations of a pathological process. This process presents with characteristic clinical features that are developmental in nature. These cause disturbances in arousal, affect and reality testing that have an impact on interpersonal social functioning. Personality disorder may therefore be conceived of primarily as a socioemotional disability, not dissimilar to Axis I conditions.

DECLARATION OF INTEREST

None.

The term ‘personality’ derives from the Greek word *persona* or mask. It refers both to an individual's attitudes and ways of thinking, feeling and behaving, and to the social ways in which individuals interact with their environment. At an individual level, personality is not a single unitary entity, but a way to organise a number of different capacities that underpin one's sense of self (Allport 1961). At a social level, an individual personality profile allows one to be recognised over time by others, and is a powerful regulator of social relationships, which, as we are group animals, are crucial for our survival.

In evolutionary terms, personality is best understood as a regulation of biopsychosocial factors in the service of good-quality survival of the individual within the particular constraints of their habitat and environment (Box 1).

BOX 1 The function of the personality

Personality function involves regulation of:

- individual levels of arousal, impulsivity and emotions
- self-directness and self-soothing in response to survival challenges of stress and change
- reality testing
- maintaining an integrated sense of self over time
- social cooperativeness through verbal and non-verbal communications and predictability of behaviour

Theories of personality

In Ancient Greece, physicians attributed individual differences in personality to imbalances of bodily fluids or humors; other popular theories have included the influence of the stars' positions at birth, body build and skull shape (Knutson 2004). In the 20th century, research into personality moved to the level of the psychological, although still influenced by dominant social assumptions such as gender or racial difference. Freud emphasised the role of innate drives, an early account of what we might now understand as the genetic basis of stress responses. He is also attributed as being the first to describe the concept of ‘defences’ against stress and their effect on the expression of adult personality. Later theorists, such as Klein and Bowlby (in somewhat different ways), emphasised the importance of the interaction between the child's innate individual features and the environment in the development of normal personality functioning.

In the 1960s, Allport highlighted the role of ‘traits’ in the makeup of personality, which he defined as the ‘dynamic organization […] of those psychophysical systems that determine characteristics of behaviour and thought’ (Allport 1961: p. 28). Factor analysis enabled the description of personality in terms of dimensions such as dominance and affiliation (Freedman 1951).

Like Allport, some theorists see the self as an organising principle of a number of personality traits, some of which are inherited, and some of which develop in relation to early social experience with others. Others see the self as the subjective experience of personal identity (the ‘I’ of experience) and the personality as the objective aspect (the ‘me’ that others experience). More recent concepts of personality link it with related concepts such as the self and personal identity (McAdams 1992).

Personality and its disorders

The concepts of self, person and identity raise many complex questions for psychiatrists. Space does not permit an analysis of all of these, but an important one is the question of change and stability of the personality. Within general medicine, changes in function are usually associated with pathology. But, in relation to

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

personality function, it is not clear to what extent change can be expected over time or in response to different situations, nor whether such changes indicate pathology or are flexible responses to different demands. Similarly, personality disorder is defined in ICD-10 (World Health Organization 1992) and DSM-IV-TR (American Psychiatric Association 2000) as 'enduring' characteristics from early childhood; yet changes in personality after brain trauma have been recognised since the 19th century, and DSM-IV-TR recognises acquired personality disorder after exposure to traumatic stressors. If personality disorder can be acquired as a result of psychological or neurological change, then it can be the result of pathology, and not a permanent feature of a person.

Second, in everyday life, it is obvious that there are discrepancies between how people see themselves and how others see them: but it is not so clear what the discrepancies mean. This has implications for how disorders of personality are detected and assessed. Consider this example: three people experience a man as bullying, two see him as assertive and he sees himself as threatened. Each of these perspectives has some validity, which suggests that assessment of personality, or any presumed disorder of personality, requires not only self-report data but also other-report data. However, unlike other domains of medicine, where informants may have objective and valid information about a patient's symptoms, it is by no means clear whether informants can provide information that is not confounded by their personal experience of the patient and their interpersonal relationship.

Third, and related, individual emotional experience is probably not purely individual, or at least not purely internal. An individual who experiences a strong emotion is able to transmit that experience to others (and *vice versa*), probably through the operation of mirror neurons (Gallese 2001), which fire when another's emotional experience is witnessed. The closer the emotional tie, the more pronounced the experience: we do feel the pain of others, especially those with whom we are in close relationships (Singer 2004). Caregivers of infants, both human and non-human, regulate the stress responses of those infants through attachment relationships. This means that a well-functioning personality has to regulate and respond to another's feelings, not just to their own experience. Some disorders of personality have a greater impact on social relations than others, especially in relationships that involve the attachment system, such as parenting and intimate relationships.

BOX 2 Principal features of ICD-10 and DSM-IV-TR classification

Personality disorders are disorders that:

- begin early in development and last a lifetime
- tend to be inflexible and pervasive across different domains of functioning
- lead to clinically significant distress or impairment
- are not due to another mental disorder or the direct physiological effects of a substance or medical condition
- deviate markedly from the expectation of the person's culture

(World Health Organization 1992; American Psychiatric Association 2000)

The diagnosis of personality disorder

If personality is a property of human organisms, then there is no particular reason to suppose that it cannot become dysfunctional. The difficulty is with the conceptualisation of that dysfunction. If 'personality' is conceived as a limited number of traits in each individual, which are largely genetically driven, then a limited number of categories of disorder may seem appropriate. This categorical approach to diagnosis underpins the ICD and the DSM systems, both of which distinguish personality disorders from other psychiatric disorders. The principal features of personality disorders in both systems are summarised in Box 2.

There are a number of criticisms of the international classificatory systems. First, they do not address the primary aspects of personality pathology, namely social relationships with others. Second, a dimensional (rather than categorical) account of personality and its disorders might offer improved descriptions of the social and interpersonal dysfunctional aspects of personality disorder. On this account, personality disorder reflects the abnormal functioning of normal dimensions at different times and in different settings: individuals can develop degrees of severity of personality disorder (e.g. Yang 2010) or their personalities might become disordered for a period, then recover. Third, as has already been described above, there is now considerable evidence that personality disorder is not enduring (Seivewright 2002, 2004; Shea 2002).

Signs and symptoms of personality disorder

Like any other mental disorder, personality disorders have signs and symptoms. These constitute the three major components described in Box 3.

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

BOX 3 Major components of clinical features in personality disorder

- An intrapersonal component: marked individual dysregulation of arousal, impulse and affect systems in response to stress; individuals typically present as either hyperaroused or hypoaroused in unpredictable ways
- An interpersonal component: dysfunctional interpersonal attachment patterns that reduce healthy functioning and are a further source of stress; these may take the form of getting too close or being detached and uninvolved
- A social component: dysfunctions in social behaviours which bring individuals with personality disorders into conflict with others and sometimes into contact with statutory agencies such as mental health or criminal justice systems

At a general level, patients with personality disorders across all clusters find it hard to make and maintain relationships in any social domain. The more severe the personality disorder, the more socially isolated the individual is likely to be (Yang 2010). In broad terms, those with personality disorder demonstrate three distinct patterns of social engagement (or lack of it) with others. Although these patterns do not neatly map onto DSM clusters A, B and C (Box 4), people with cluster A disorders tend to move away from social attachments, either by taking up a frightened position with regard to others, or by flight into safety through isolation. Conversely, people with cluster C disorders move towards others as sources of support and dependence, and even if those sources of support become persecutory, individuals are relatively unable to disengage and assert themselves. Finally, people with cluster B disorders often tend to move against others. Ironically, to move against others, they have to first move towards them. Hence, their interactions are characterised by an ambivalence to social encounters that is most visible in those with borderline and narcissistic personality disorders.

BOX 4 DSM-IV clusters of personality disorders

Cluster A : Odd or eccentric behaviours (schizoid, paranoid and schizotypal)

Cluster B: Flamboyant to dramatic behaviours (antisocial, borderline, narcissistic and histrionic)

Cluster C: Fearful and anxious behaviours (avoidant, dependent and obsessive–compulsive)

Thus, a man with a mild degree of a cluster A (schizoid) disorder may still be able to form relationships in the workplace, or have some degree of emotional attachment to a friend or family member. A woman with a moderate degree of a cluster B borderline personality disorder is unlikely to be able to maintain emotionally intimate relationships with sexual partners, and may have complex relationships with carers, but may still be able to maintain work relationships. These two individuals will be quite unlike a man with a severe degree of cluster B antisocial personality disorder, who is unlikely to have ever been able to connect to any social group for work or social purposes, and close emotional relationships will be unknown to him (and he may indeed treat them with contempt). His chances of being both a criminal rule breaker and an exploiter of the vulnerable are much higher than for individuals with other types of personality disorder.

The symptoms of personality disorder are listed in Box 5. Symptoms of negative affect vary according to cluster, but include anxiety, irritability, low mood, intense distress, feelings of rage, fear of abandonment, the perception that others are threatening or attacking the individual, and dissociative experiences associated with stress. Individuals with emotionally impulsive borderline personality disorder frequently describe brief periods of pseudo-hallucinations that almost invariably take the form of voices telling them to harm themselves or others. People with antisocial personality disorder may report little distress, but complain of persecutory anxiety or anger with others whom they perceive to have let them down. They may also enjoy feelings of contempt for other people's distress, excitement in controlling others and hostility towards dependence and neediness.

The signs of personality disorder (Box 6) are manifested in disturbances of social relationships, i.e. at the interpersonal level, at the boundary between the individual and their social world. The signs include repeated behaviours that are socially rejecting, self-destructive or result in social exclusion, and more elaborate and enduring dysfunctional relationship styles. However, behaviours alone cannot determine the presence of a personality disorder; there must also be evidence of disturbance of affect and arousal regulation. It is also important to consider behaviours that do not attract attention, but are still pathological, such as social withdrawal.

In a particular subgroup of people who behave antisocially, lack of response to other's distress is noted to be a distinguishing feature (Cleckley 1964). Later researchers, principally Robert Hare, have confirmed the existence of a subgroup

Advances in psychiatric treatment (2012), vol. 18, 162–172 doi: 10.1192/apt.bp.109.006981

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

of individuals (mainly in the cluster B antisocial subgroup) who have both a pronounced lack of empathy for others and display predatory or cruel behaviours towards others. It has been suggested that these individuals do not recognise facial signals of distress in others and do not detect emotional tone, probably as a result of amygdala dysfunction (Blair 2003). In the most severe cases, this lack of response can be associated with extremes of cruelty and violence to others, and is captured by the clinical concept of 'psychopathy' (Hare 1991).

Although the international classificatory systems have yet to accept psychopathy as a 'disorder', its assessment is standard in most forensic psychiatric settings. The standard measure of psychopathy is useful for distinguishing 'milder' from more 'severe' or 'extreme' forms of antisocial personality disorder. However, clinicians not working with forensic patients are unlikely to see such individuals.

On the basis of the above, it may be argued that dysfunctional social relationships are a diagnostic feature of personality disorders that distinguish them from mental illnesses. The counterargument is that many serious mental disorders (especially chronic psychotic disorders and mood disorders) also have profound effects on social relationships. Social isolation is a common problem for many service users with severe mental illness and it is usually caused by relationship breakdown occasioned by aspects of the illness. The difference may be in degree, and the types of relationship breakdown, rather than an absolute difference.

Social difficulties in relationships with mental health professionals

These interpersonal and social difficulties are also inevitably manifest in relationships with healthcare professionals. Patients with personality disorder generally do not take on the conventional 'sick role', in which the patient is compliant, obedient and grateful. For these reasons, attempts to care for such patients on the basis of conventional therapeutic relationships are unlikely to succeed, and staff need particular competencies to provide a service for such individuals (Home Office 2005).

Individuals in the different clusters have different approaches to help-seeking from mental health professionals (Tyrer 2003). Those in clusters A and C and the more antisocial individuals may rebuff help, or (in the case of antisocial people) denigrate caregivers and therapies. Cluster C patients with dependent personality disorders, however, commonly form submissive, clinging relationships with clinicians rather than rebuffing help. In contrast, people with more borderline personality pathology have highly ambivalent attachment patterns, which mean that they may seek and then reject help. They are likely to be fearful of asking for help, and this fear can cause increasing arousal and ultimately hostility towards those they are approaching for help. There is evidence that help-seeking and care-seeking behaviours (including engagement in and adherence to therapy) are influenced by attachment experiences in childhood (Henderson 1974; Dozier 2001). This suggests that there is a link between personality disorder and attachment history.

BOX 5 Symptom subtypes in personality disorders

Arousal	Over- or underarousal, often self-medicated with drugs or alcohol; enhanced tendency to dissociate in cluster B; emotional indifference
Affect	Anger; suspicion; fearfulness; detachment; coldness or restricted emotion; resentfulness; anxiety about new activities; irritability; low mood; intense distress; feelings of rage and fear of abandonment; fear that others are threatening or attacking them; rapidly shifting emotions
Cognition	Poor reality testing in terms of dissociation; brief psychotic episodes; odd beliefs and magical thinking; cognitive distortions; preoccupations and ruminations in cluster C
Somatic self-identity	Somatic disorders, ranging from preoccupations with the somatic self to attacks on the physical body in the form of self-harm
Psychological self-identity	Disorders of sense of self; lack of sense of agency; exaggerated sense of self-importance; belief that the self is in danger from others; difficulty in distinguishing self from others

Prevalence and incidence

Prevalence data are similar worldwide and recent figures from the World Health Organization show no important or consistent differences across countries (Huang 2009). In the UK, the

BOX 6 Signs of personality disorder

Note: not all will be present in all disorders, nor do signs alone confirm the diagnosis

- Self-harming and suicidal behaviours
- Substance and alcohol misuse, dependence
- Eating disorders
- Unstable relationships and social isolation
- Persistent complaining and vexatious litigation
- Deceptive behaviour, such as duping, conning and factitious illnesses
- Attacks on attachment figures (partners, children, care staff, etc.)
- Persistent rule-breaking, violent attacks on others
- Clinging behaviours
- Compulsive behaviours

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

prevalence of any personality disorder is about 4% overall (Coid 2006) – considerably higher than the prevalence of psychotic disorders.

In primary care, the prevalence of personality disorder is around 10–12%, and it consists mainly of patients with depressive and somatising symptoms. However, the prevalence of personality disorder in general psychiatric out-patients is 33%, rising to about 40% in eating disorder services and 60% in substance misuse services (Herzog 1992; Sanderson 1994; Rounsaville 1998; Moran 2000; Torgersen 2001).

In forensic services and prisons, the prevalence of personality disorder is 70%, and the principal subtypes are antisocial, borderline and narcissistic (Singleton 1998). Prisoners' problems include lack of empathy, social hostility and contempt for weakness, as well as affect dysregulation. In specialist forensic personality disorder treatment settings, virtually all patients have comorbid psychiatric disorders such as substance misuse or depression, and most fulfil criteria for several personality disorders (Duggan 2007).

Prevalence data can be misleading because of selection bias. Services for behavioural conditions such as eating disorder, substance misuse or antisocial behaviour are likely to be 'selecting' for comorbid personality disorders that manifest in the particular behaviour. It is important for clinicians not to generalise about personality disorders as a whole on the basis only of the group they see in their service settings.

Pathogenesis

Social dysfunction in adulthood (including both self-harm and antisocial behaviour) is more likely when genetic vulnerability for arousal and affect dysregulation interacts with environmental adversity and negative life experiences during early development (National Scientific Council on the Developing Child 2010). Genetic studies suggest that personality disorder is strongly heritable (Jang 1996); one model hypothesises a vulnerability to the replication of genes for proteins that are relevant to neurophysiological processes such as arousal, response times and homeostatic mechanisms. However, it is also clear, from both retrospective and prospective studies, that early childhood adversity is highly relevant to the development of psychological signs and symptoms of personality disorder (Kessler 2010). Physical abuse and neglect appear to increase the risk of developing all types of psychiatric morbidity, especially substance misuse. Sexual abuse appears specifically to increase the risk of developing depression and borderline personality disorder.

There are three major theoretical approaches to explaining how early childhood relationships and maltreatment result in the adult interpersonal dysfunction found in personality disorder.

Approach 1: The impact of external events on neurobiological development and gene–environment interaction

Humans are unique among animals in their long period of total dependence on others for survival after birth. The key outcome of an optimal experience of care and nurture is the development of the neuroarchitecture that is necessary for two essential capacities: first, the activation and regulation of affects in the task of self-survival; and second, the regulation of affects in social relationships to produce positive environments.

Being raised in a hostile or abusive environment is posited to increase the risk of developing personality disorder because of the direct effect of chronic stress on the developing cytoarchitecture of the autonomic nervous system, limbic system, amygdala and the right orbitofrontal cortex (Schore 2001). A distressed infant experiences high degrees of arousal, mediated by the sympathetic division of the autonomic nervous system. Being a catabolic system, the autonomic nervous system makes available large amounts of energy to prepare the infant for a self-preservative action repertoire of 'fight or flight'. The infant experiences the peripheral and central effects of noradrenaline (e.g. more rapid heart and pulse rate, increased blood pressure, dilated pupils), which are uncomfortable. The amygdala is activated by a whole range of stimuli that represent unexpected or unfamiliar/novel events, which may be negatively (fear/threat) or positively (reward/pleasure) valenced. During periods of high stress, the amygdala and limbic system are activated, leading to enhanced learning of fear and stress cues, both external (loud voice, pain, etc.) and internal (rapid heart beat, dryness of mouth, etc.) (Makino 1994), i.e. there is hypersensitisation to effects of stress. When soothed by the carer, the infant's parasympathetic system, which has opposite effects, is activated and restores homeostasis. The autonomic system then returns to its normal rate and rhythm (Sarkar 2006).

The basic task of child care consists in responding sensitively to episodes of interactive signals produced by the autonomic nervous system in both infant and carer. These episodes emerge when the infant reaches about 2 months of age, and they are highly arousing, affect-laden and short interpersonal events that expose the infant to high levels of cognitive and social information (Feldman

Advances in psychiatric treatment (2012), vol. 18, 162–172 doi: 10.1192/apt.bp.109.006981

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

1999). As the infant grows, it is the memory of the relationship, rather than the particular caregiver, that becomes the (accessory) affect regulator, allowing attachment to develop with others on the basis of this template.

A good-quality affect regulatory system, based on secure bonding between carer and infant, leads to optimal maturation of the right hemisphere of the brain at a critical period during the first 2–3 years of life (Schore 2003). The right orbitofrontal cortex (ROFC) acts as a regulator and modulator both of amygdala responses to fear and distress and of autonomic nervous system response (LeDoux 1996; National Scientific Council on the Developing Child 2011). Any measurable damage to cytoarchitecture of the developing ROFC results in failure to develop a top-down regulatory system (Taylor 1997; Schore 2003).

Any adverse experience during childhood risks some degree of ROFC neuronal disorganisation and is likely to lead to impaired emotional regulation throughout the individual's lifetime. This in turn has an impact on the ability to optimally organise an integrated sense of self (Sarkar 2006). The degree of disorganisation arises from an interaction between genetic vulnerability and the degree, nature and duration of the environmental insult (National Scientific Council on the Developing Child 2010). For example, monkeys with a genetic marker for reduced serotonin metabolism are more at risk of developing impulsive behaviours that increase the likelihood of social exclusion and early death. This risk is greatly enhanced if these genetically vulnerable monkeys are exposed to poor maternal rearing (Suomi 1999, 2003). Among boys, it has been shown that genetically determined low monoamine oxidase A (MAOA) activity, leading to dysregulation of the 5-HT system, moderates the association between childhood maltreatment and later vulnerability to the effects of environmental stress, thus causing mental health problems (Kim-Cohen 2006).

Such data suggest an evolutionary aspect to personality development. Individuals who exhibit antisocial behaviour are moving away from the more adaptive species-preservative behaviour seen in higher mammals towards a more ancient self-preservative reptilian behaviour. As the name suggests, species-preservative behaviour has evolved to improve the chances of survival of a species (Henry 1998). When trauma results in a stressful loss of control, the self-preservative fight/flight catecholamine coping response takes priority. Problems arise when this becomes the default coping response to a wide range of events, people and circumstances.

Approach 2: Theories that address social attachment over time

Longitudinal studies of attachment styles suggest that individuals with insecure attachment to caregivers in childhood tend to grow up into adults who form insecure attachments with peers and who become insecure parents to their own offspring (Grossman 2000; Waters 2000). Although there is some flexibility in the system, the more insecure the attachment organisation in childhood, the more likely the individual is to remain insecure in adulthood.

Many of the features of insecure attachment in adulthood resemble the signs and symptoms of personality disorder, and it has been suggested that insecure attachment should be seen as a dimension of personality disorder (Livesley 1998). There have been numerous studies of attachment patterns in people with personality disorders, all of which indicate that such individuals show higher rates of insecure attachment than the general population (Cassidy 2008). Specifically, the pathology of borderline personality disorder is associated with a subtype of insecure attachment called preoccupied or enmeshed attachment, whereby the individual is highly ambivalent about those to whom they are attached (either in a passive or angry way, or both). Individuals who display antisocial violent behaviour towards others are more likely to exhibit a dismissing attachment pattern, in which weakness or vulnerability are denied and attachment to others is seen as unnecessary or contemptible (Pfafflin 2003; van IJzendoorn 2009).

Approach 3: Theories of personality disorder as persistence of childhood thinking/feeling patterns

A number of different theorists have suggested that it is maladaptive for immature patterns of thought, belief or value to persist into adulthood, especially those immature cognitions and emotions that have occurred in response to childhood stress (Young 2002). Work in the field of post-traumatic stress disorders suggest that in response to high arousal and distress, cognitions, images and emotions can remain stored in situationally accessible memory (Brewin 1996). Other theorists have emphasised the importance of thoughts, feelings and beliefs as organised 'defences' against distress, and suggested that personality disorder may be best understood as a collection of immature defences (Vaillant 1993, 1994; Bond 2004; Cramer 2006).

Psychological defences (Box 7) are those personality traits, cognitions and beliefs that help an individual regulate their own sense of distress.

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

BOX 7 Examples of psychological defences in everyday use

- Mature: humour, altruism, sublimation, suppression
- Neurotic: idealisation, intellectualisation
- Immature: denial, displacement, dissociation, somatisation

Defences have conscious and unconscious aspects, both of which are mediated through memory, and which may be expressed physically. Defences develop in childhood but are used continually throughout life. Every single person uses a mixture of mature, neurotic and immature defences, and optimal social and personal functioning is associated with maximal use of mature and minimal use of immature defences.

Longitudinal studies have shown that people can and do change the characteristic pattern of defences that they use, particularly at times of stress (Vaillant 1993; Soldz 1998). Most people utilise immature defences under stress, but most healthy people go back to using mature defences when the stress is over. In adulthood, persistent use of immature defences in general social relationships leads to problems (Vaillant 1993; Kernberg 2005).

Studies of people with personality disorder indicate that they almost exclusively use immature defences, and do not use mature defences (Vaillant 1994). However, there is no specific pattern of defences that maps onto any specific personality disorder diagnosis. There may be an interaction with attachment style, in that insecure and disorganised attachment strategies may in turn affect the profile of defences that an individual will preferentially use at times of stress. Most psychological therapies for personality disorder address the cognitive and emotional aspects of psychological defences. There is evidence that individuals can learn to use more mature defences, and thereby improve their psychosocial function (Vaillant 1997; Bond 2004).

Course of the disorder

Personality disorders are long-term, chronic disorders, with varying degrees of severity (Tyrer 1996; Yang 2010). Some forms have a relapsing and remitting nature, depending on environmental factors and comorbidity. There is evidence that a proportion of individuals gradually experience remission of the disorder over time (Paris 2003). Given the link with affect and arousal regulation, one would expect patients with personality disorder to exhibit more signs and symptoms when they are distressed, aroused or depressed. This may explain why psychotropic mood-stabilising or sedating medication is helpful for some individuals with personality disorder.

A rule of thumb is that symptoms of personality disorder will be exacerbated during periods of stress, particularly if the stress is linked to relationships with partners, parents or dependants. As a result, people with personality disorders may behave in socially alienating ways at times of stress – ironically, at the time of their greatest need. Patients with the disorder may consequently be excluded from help or they may reject help, without realising that they are doing so. Appropriate clinical skills are therefore of paramount importance in terms of acknowledging such features as signs of a disorder rather than an expressed view that the person is rejecting services or trying to manipulate professionals.

Severe personality disorder

Personality disorders have not typically been graded in terms of severity, partly because of the tradition of using categorical descriptions. However, it has long been recognised that not all personality disorders cause the same degree of dysfunction. Millon (1981) suggests that borderline, paranoid and schizotypal personality disorders are the most severe types within a social system, because these personality styles characteristically produce significant social incompetence and isolation. Blackburn (2000) suggests that individuals with dependent, histrionic, narcissistic and antisocial personality disorders are deemed to be the least severely disordered in terms of social adaptation. However, if severity is defined by the degree of disorganisation caused by a personality disorder within a society, then antisocial and narcissistic personality disorders may both be defined as 'severe'. Here the meaning of the word 'severe' depends on whether one understands it in terms of individual social adaptation or the impact of the individual on a social group.

Severity of personality disorder implies something quite different if the categorical approach of the international classificatory systems is employed. There is some disagreement between the ICD and DSM systems on the types and number of personality disorders that they respectively recognise as existing. It has been suggested that the threshold for making a diagnosis of personality disorder is lower in ICD-10 (Tyrer 1996), although DSM-IV recognises eleven different types of the disorder, compared with the eight endorsed by ICD-10. The two systems also differ in their

Advances in psychiatric treatment (2012), vol. 18, 162–172 doi: 10.1192/apt.bp.109.006981

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

respective recommended guidelines for diagnosing personality disorder. The DSM-IV is a more rigid system that advocates a checklist approach to diagnosis, in that a specific number of observable behaviours have to be present for a diagnosis (even though the preamble to DSM-IV warns against a 'cook book' approach). The ICD-10, a trait-based system, allows the clinician a greater degree of flexibility in establishing a diagnosis.

Tyrer & Johnson (1996) suggest a five-point rating of severity: 0, 'no personality disorder'; 1, 'personality difficulty' (any subthreshold criterion of a personality disorder); 2, 'simple personality disorder' (one or more personality disorders within the same cluster); 3, 'complex personality disorder' (personality abnormalities spanning more than one cluster as diagnosed by the international classificatory systems); and 4, 'severe personality disorder' (two or more personality disorders in more than one DSM cluster with one being antisocial personality disorder). A recent study using this rating found different prevalences of personality disorders of different severity: the most severe cases were seen in specialist services and milder conditions were seen in primary care (Yang 2010).

Severity could be defined in terms of the harm done to others, even if this would apply only to small subgroup of people with personality disorders. In 1999, a Royal College of Psychiatrists' working party reviewed the diagnosis of psychopathic and antisocial personality disorders (Royal College of Psychiatrists 1999), and proposed an additional category, defined as those who manifest 'gross societal disturbance'. A 'gross' disturbance was defined as having one cluster B diagnosis and a personality disorder in at least one other cluster also. No detailed rationale was provided for such a grouping, nor did the document explain further what might constitute 'gross societal disturbance'. However, that same year the UK Home Office and the Department of Health identified a subgroup of offenders with personality disorders who were violent and defined them as having 'dangerous and severe personality disorder' or DSPD (Home Office 1999). The DSPD condition, perhaps extrapolating from the recommendations of the College, was defined as the presence of (a) two or more personality disorders, (b) a Psychopathy Checklist score (Hare 1991) of over 30, and (c) a functional link between the disorder and the violence. The link between severity of personality disorder and severity of risk to others is made quite explicit. This makes sense for a public protection agenda, but has clinical limitations. One objection is that there are many individuals who are dangerous to others as a result of having a single personality disorder, but who do not fulfil criteria (a) or (b). The most obvious group in this category are perpetrators of child and partner abuse.

If personality disorder were to be rated in terms of severity, then this would make it more like depressive disorders and intellectual disability, and less like schizophrenia and bipolar affective disorders, which are described in terms of categorical types rather than dimensional severity. One advantage of a severity rating is that it might help determine workforce competencies and other resource allocation requirements. It might also lay the foundation for research into prognosis and outcomes. For example, several new community services for personality disorder have taken a 'complex needs' approach to determining the service configuration and skills mix appropriate for each individual. They categorise a personality disorder as severe if the individual's problems involve several areas of care. Thus, a patient might have attachment difficulties and also require containment in a secure unit. Such patients typically fulfil criteria for several personality disorders and also have comorbid Axis I conditions.

Personality disorder and mental illness

It is commonly argued that personality disorder is not a mental illness, and/or that it is qualitatively different from mental disorders such as schizophrenia. One argument seems to be principally that people with personality disorders do not lose their capacity for reality testing (e.g. do not have symptoms such as hallucinations and delusions). However, there are a number of counterarguments to this. First, loss of reality testing is not the sole test of whether someone has a mental illness or not. Addiction disorders and neurotic disorders such as depression are still classified as mental illnesses. Further, the presence of psychotic symptoms does not determine mental illness status, since psychotic symptoms occur in many physical disorders, such as delirium or the encephalitides. Finally, even if one does use psychotic symptoms as a defining diagnostic test for mental illness, there is plenty of evidence that some types of personality disorder do involve psychotic symptoms, albeit usually of brief duration.

There are other good reasons to think that personality disorder has more in common with the Axis I conditions than traditionally supposed. First, it has an aetiology that brings about pathology and, like many medical conditions, it afflicts only a minority of the population, who are consequently quantitatively different from the

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

norm. Second, personality disorder produces a pattern of symptoms and signs that are common to a group, and make group members resemble each other. There is evidence of abnormal brain structure and function in personality disorders, and overlap of psychopathology between Axis I and II disorders in terms of cognitive/perceptual organisation, impulse control, affect regulation and anxiety modulation (Sarkar 2012).

Third, there is the issue of comorbidity or co-occurrence of Axis I and Axis II disorders, which suggests at least a close relationship between them. For example, at least one cluster A disorder (schizotypal personality disorder) lies on a continuum with schizophrenia; cluster B disorders, especially borderline and antisocial personality disorders, co-occur with substance misuse (Knutson 2004); and cluster C disorders preferentially co-occur with increased rates of somatoform disorders (Tyrer 1997). People with either cluster B or C disorders have a higher risk of comorbidity with all types of Axis I disorders (Dolan-Sewell 2001). Conversely, the coexistence of personality disorder with an Axis I disorder can lead to poorer outcomes (Newton-Howes 2006). In one study of patients with mental disorders managed by community teams, 40% fulfilled criteria for at least one personality disorder (Newton Howes 2010). There seems to be an interaction between two or more mental health conditions such that there is an additive (if not multiplicative) effect in terms of 'load' of clinical symptomatology and socioclinical outcomes.

In contrast to the expanding evidence base that there is at least a complex relationship between Axis I and Axis II disorders, there is no new evidence in support of the assertion that (a) personality disorder is fundamentally different from mental illness, or (b) that Axis I and Axis II disorders are alternatives that cannot coexist. Although the multiaxial nature of the DSM should make it obvious that disorders can coexist, it is still common to hear clinicians refer to these conditions as if they were alternatives.

Conclusions

There is a great deal more to know about personality disorder. At present, there is still theoretical debate about how to classify it, which in turn makes consensus on how best to assess and diagnose it difficult to achieve. Intriguing ethical questions arise as we rethink old ideas about the disorder: if it is an acquired disorder, how can we justify not providing services for its treatment? Should we concentrate resources on that very small group of individuals with the most severe form that makes them dangerous to others, even if they are probably the least treatable group? Or should we focus resources on the larger, much more treatable group, where the benefits of treatment have been proven in terms of cost-offset (Dolan 1996)? Or should we concentrate resources on the prevention of the development of personality disorders? We can currently do little to alter genetic vulnerability, but we could offer treatment to parents who frighten and maltreat their children, and spend more money on improving the environments in which vulnerable children grow up. These, and other questions, were unthinkable 20 years ago: who knows what we will think about personality disorder 20 years from now?

References

Allport GW (1961) *Pattern and Growth in Personality*. Rinehart & Winston.

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders (4th edn, Text Revision) (DSM-IV-TR)*. APA.

Blackburn R (2000) Treatment or incapacitation? Implications of research on personality disorders for the management of dangerous offenders. *Legal and Criminological Psychology* **5**: 1–21.

Blair RJR (2003) Neurobiological basis of psychopathy. *British Journal of Psychiatry* **182**: 5–7.

Bond M (2004) Empirical studies of defence style. *Harvard Review of Psychiatry* **12**: 263–78.

Brewin CR, Dalgleish T, Joseph S (1996) A dual representation theory of posttraumatic stress disorder. *Psychology Review* **103**: 670–86.

Cassidy J, Shaver P (2008) *Handbook of Attachment (2nd edn)*. Guilford Press.

Cleckley H (1964) *The Mask of Sanity (4th edn)*. C. V. Mosby.

Coid J, Yang M, Tyrer P, et al (2006) Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry* **188**: 423–31.

Cramer P (2006) *Protecting the Self: Defense Mechanisms in Action*. Guilford Press.

Dolan BM, Warren FM, Menzies D, et al (1996) Cost-offset following specialist treatment of severe personality disorders. *Psychiatric Bulletin* **20**: 413–7.

Dolan-Sewell RT, Krueger RF, Shea MT (2001) Co-occurrence with syndrome disorders. In *Handbook of Personality Disorders: Theory, Research and Treatment* (ed WJ Livesley): 84–103. Guilford Press.

Dozier M, Lomax L, Tyrrell CL, et al (2001) The challenge of treatment for clients with a dismissing states of mind. *Attachment and Human Development* **3**: 62–76.

Duggan C, Mason L, Banerjee P, et al (2007) Value of standard personality assessments in informing clinical decision-making in a medium secure unit. *British Journal of Psychiatry* **190** (suppl 49): s15–9.

Feldman R, Greenbaum CW, Yirmiya N (1999) Mother–infant affect synchrony as an antecedent of the emergence of self-control. *Developmental Psychology* **35**: 223–31.

Freedman HB, Leary TF, Ossorio AG, et al (1951) The interpersonal dimension of personality. *Journal of Personality* **20**: 143–61.

Gallese V (2001) The 'shared manifold' hypothesis: from mirror neurons to empathy. *Journal of Consciousness Studies* **8**: 33–50.

Grossman KE, Grossman K, Waters E (2000) *Attachment from Infancy to Adulthood: The Major Longitudinal Studies*. Guilford Press.

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

Hare RD (1991) *The Hare Psychopathy Checklist – Revised*. Multi-Health Systems.

Henderson S (1974) Care eliciting behaviour in man. *Journal of Nervous and Mental Disease* **159**: 172–81.

Henry JP, Wang S (1998) Effects of early stress on adult affiliative behaviour. *Psychoneuroendocrinology* **23**: 863–75.

Herzog D, Keller M, Lavori P, et al (1992) The prevalence of personality disorders in 210 women with eating disorders. *Journal of Clinical Psychiatry* **53**: 147–52.

Home Office, Department of Health (1999) *Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development*. Home Office & Department of Health.

Home Office, Department of Health (2005) *Personality Disorder Capacity Plans*. Home Office & Department of Health.

Huang Y, Kotov R, de Girolamo G, et al (2009) DSM-IV personality disorders in the WHO World Mental Health Surveys. *British Journal of Psychiatry* **195**: 46–53.

Jang KL, Livesley WJ, Vernon PA, et al (1996) Heritability of personality disorder traits: a twin study. *Acta Psychiatrica Scandinavica* **94**: 438–44.

Kernberg OF, Caligor E (2005) A psychoanalytic theory of personality disorders. In *Major Theories of Personality Disorder* (2nd edn) (eds MF Lenzenweger, JF Clarkin): 114–56. Guilford Press.

Kessler RC, McLaughlin KA, Greif Green J, et al (2010) Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *British Journal of Psychiatry* **197**: 378–85.

Kim-Cohen J, Caspi A, Taylor A, et al (2006) MAOA, maltreatment and gene-environment interaction predicting children's mental health: new evidence and a meta-analysis. *Molecular Psychiatry* **11**: 903–13.

Knutson B, Heinz A (2004) Psychobiology of personality disorders. In *Textbook of Biological Psychiatry* (ed J Panksepp): 145–66. Wiley-Liss.

LeDoux J (1996) *The Emotional Brain: The Mysterious Underpinnings of Emotional Life*. Simon & Schuster.

Livesley J (1998) Suggestions for a framework for empirically based classification of personality disorder. *Canadian Journal of Psychiatry* **43**: 137–47.

Makino S, Gold PW, Shulkin J (1994) Corticosterone effects on corticotrophin-releasing hormone mRNA in the central nucleus of the amygdala and the parvocellular region of the paraventricular nucleus of the hypothalamus. *Brain Research* **640**: 105–12.

McAdams D (1992) The five-factor model of personality: a critical appraisal. *Journal of Personality* **60**: 329–61.

Millon T (1981) *Disorders of Personality: DSM III Axis II*. John Wiley & Sons.

Moran P, Jenkins R, Tylee A, et al (2000) The prevalence of personality disorder among primary care attenders. *Acta Psychiatrica Scandinavica* **102**: 52–7.

National Scientific Council on the Developing Child (2010) *Early Experiences Can Alter Gene Expression and Affect Long Term Development: Working Paper No 10*. Center on the Developing Child, Harvard University.

National Scientific Council on the Developing Child, National Forum on Early Childhood Policy and Programs (2011) *Building the Brain's "Air Traffic Control" System: How Early Experiences Shape the Development of Executive Function: Working Paper No 11*. Center on the Developing Child, Harvard University.

Newton-Howes G, Tyrer P, Johnson T (2006) Personality disorder and outcome of depression: meta-analysis of published studies. *British Journal of Psychiatry* **188**: 13–20.

Newton-Howes G, Tyrer P, Anagnostakis K, et al (2010) The prevalence of personality disorder, its co-morbidity with mental state disorders and its clinical significance in community mental health teams. *Social Psychiatry and Psychiatric Epidemiology* **45**: 453–60.

Paris J (2003) *Personality Disorders Over Time: Precursors, Course and Outcome*. American Psychiatric Press.

Pfafflin F, Adshead G (2003) *A Matter of Security: Attachment Theory in Forensic Psychiatry and Psychotherapy*. Jessica Kingsley.

Rounsaville B, Kranzler H, Ball S, et al (1998) Personality disorders in substance abusers: relation to substance use. *Journal of Nervous and Mental Disease* **186**: 87–95.

Royal College of Psychiatrists (1999) *Offenders with Personality Disorder (Council Report CR71)*. Gaskell.

Sanderson W, Wetzler S, Beck A, et al (1994) Prevalence of personality disorders among patients with anxiety disorders. *Psychiatry Research* **51**: 167–74.

Sarkar J, Adshead G (2006) Personality disorders as disorganisation of attachment and affect regulation. *Advances in Psychiatric Treatment* **12**: 297–305.

Sarkar J, Duggan C (2012) Diagnosis and classification of personality disorder: difficulties, their resolution and implications for practice. In *Clinical Topics in Personality Disorder* (eds J Sarkar, G Adshead): in press. RCPsych Publications.

Schore A (2001) The effect of early relational trauma on right brain development, affect regulation and infant mental health. *Infant Mental Health Journal* **22**: 201–49.

Schore A (2003) *Affect Dysregulation and Disorders of the Self*. W. W. Norton.

Seivewright H, Tyrer P, Johnson T (2002) Changes in personality status in neurotic disorder. *Lancet* **359**: 2253–4.

Seivewright H, Tyrer P, Johnson T (2004) Persistent social dysfunction in anxious and depressed patients with personality disorder. *Acta Psychiatrica Scandinavica* **109**: 104–9.

Shea M, Stout R, Gunderson J, et al (2002) Short-term diagnostic stability of schizotypal, borderline, avoidant and obsessive-compulsive personality disorders. *American Journal of Psychiatry* **159**: 2036–41.

Singer T, Seymour B, O'Doherty J, et al (2004) Empathy for pain involves the affective but not sensory components of pain. *Science* **303**: 1157–62.

Singleton N, Gatwood R, Meltzer H (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. TSO (The Stationery Office).

Soldz S, Vaillant G (1998) A 50-year longitudinal study of defense use among inner city men: a validation of the DSM-IV defense axis. *Journal of Nervous and Mental Disease* **186**: 104–11.

Suomi S (1999) Attachment in rhesus monkeys. In *Handbook of Attachment* (eds J Cassidy, P Shaver): 181–97. Guilford Press.

Suomi SJ (2003) Gene–environment interactions and the neurobiology of social conflict. *Annals of the New York Academy of Science* **1008**: 132–9.

Taylor GJ, Bagby M, Parker JD (1997) *Disorders of Affect Regulation*. Cambridge University Press.

Torgersen S, Kringlen E, Cramer V (2001) The prevalence of personality disorders in a community sample. *Archives of General Psychiatry* **58**: 590–6.

Tyrer P, Johnson T (1996) Establishing the severity of personality disorder. *American Journal of Psychiatry* **153**: 1593–97.

Tyrer P, Gunderson JG, Lyons M, et al (1997) Extent of comorbidity between mental state and personality disorders. *Journal of Personality Disorders* **11**: 242–59.

Tyrer P, Milchard S, Methuen C, et al (2003) Treatment rejecting and treatment seeking personality disorders: Type R and Type S. *Journal of Personality Disorders* **17**: 263–8.

Vaillant G (1993) *The Wisdom of the Ego*. Harvard University Press.

Vaillant G (1994) Ego mechanisms of defence and personality psychopathology. *Journal of Abnormal Psychology* **103**: 44–50.

Vaillant LM (1997) *Changing Character: Short Term Anxiety Regulating Psychotherapy for Affects, Attachment and Defenses*. Basic Books.

van IJzendoorn M, Bakermans-Kranenburg M (2009) The first 10 000 Adult Attachment Interviews: distribution of adult attachment representations in clinical and non-clinical groups. *Attachment & Human Development* **11**: 223–63.

MCQ answers

1 a 2 d 3 a 4 a 5 a

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press

Waters E, Merrick S, Treboux D, et al (2000) Attachment security in infancy and early adulthood: a twenty-year longitudinal study. *Child Development* **71**: 684–9.

World Health Organization (1992) *The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)*. WHO.

Yang M, Coid J, Tyrer P (2010) Personality pathology recorded by severity: national survey. *British Journal of Psychiatry* **197**: 193–9.

Young JE (2002) Schema-focused therapy for personality disorders. In *Cognitive Behavior Therapy: A Guide for the Practicing Clinician* (vol 1) (ed G Simos): 201–22. Brunner Routledge.

MCQs

Select the single best option for each question stem

1 Personality function includes:
- a regulation of individual levels of arousal, impulsivity and affect
- b ability to carry out activities of daily living
- c being able to relate adversely to others
- d ability to manage financial responsibilities
- e absence of mental illness.

2 ICD-10 and DSM-IV state that personality disorders:
- a begin in adulthood
- b are not developmental in nature
- c are not mental disorders
- d are not due to other mental disorders
- e do not deviate markedly from sociocultural norms.

3 The clinical components of personality disorders include:
- a disturbed relationships with caregivers
- b individual regulation of drug and alcohol consumption
- c lack of socially appropriate behaviours
- d lack of cognitive and reality distortions
- e onset in adulthood.

4 Clinical features of personality disorders include:
- a abnormalities in somatic self-identity
- b normal psychological self-identity
- c lack of attacks on self and others
- d absence of psychotic episodes
- e absence of major affective episodes.

5 Personality disorders are:
- a valid and legitimate clinical syndromes
- b not mental disorders
- c untreatable
- d significantly different from mental illnesses
- e abnormal illness behaviours, not genuine illnesses.

Advances in psychiatric treatment (2012), vol. 18, 162–172 doi: 10.1192/apt.bp.109.006981

https://doi.org/10.1192/apt.bp.109.006981 Published online by Cambridge University Press