

PERSONALITY DISORDERS

1. Introduction

The concept of a personality disorder does not fit easily into the medical model of disease. Everyone has a personality and the definition of the end points between normal personality, personality problems and clinical personality disorders is necessarily arbitrary. The point at which personality problems become personality disorders is generally taken as the point at which the personality disturbance results in impaired relationships and reduced social and occupational functioning.

Personality disorders are widespread and present a major challenge in most areas of health care. They can be difficult to treat, complicate the management and adversely affect the outcome of other conditions. They can exert a disproportionate effect on the workload of staff dealing with them.

1.1 Classification of Personality Disorder

The classification systems currently used are described by:

1. The American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (4th edition) DSM-IV² and
2. The World Health Organisation in the International Classification of Mental and Behavioural Disorders (ICD-10)³

These are similar, however DSM-IV probably has more influence worldwide.

DSM-IV² defines personality disorder as '**an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has onset in adolescence or early childhood, is stable over time and leads to distress or impairment.**'

DSM-IV places personality disorders (along with mental retardation) on a separate axis (Axis II) to separate them from other mental disorders. (Axis I). It also groups the different disorders into three clusters.

Cluster A:	The odd and eccentric group	<ul style="list-style-type: none">• Paranoid Personality Disorder• Schizoid Personality Disorder• Schizotypal Personality Disorder
Cluster B	The flamboyant or dramatic group	<ul style="list-style-type: none">• Anti-Social Personality Disorder• Borderline• Histrionic• Narcissistic
Cluster C	The anxious and fearful group	<ul style="list-style-type: none">• Avoidant• Dependent• Obsessive Compulsive

Medical Services

ICD-10 defines personality disorders as '**deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations.**' ICD-10 does not include the concept of axis I and II disorders and divides personality disorders into 9 types.³

Appendix A contains the ICD-10 classification of Personality Disorders. Appendix B contains a comparison of the DSM-IV and the ICD-10 classifications.

1.2 Classification of Personality Disorders: Categorical *versus* Dimensional

DSM-IV and ICD-10 both use a **categorical** approach to the classification of personality disorder. This has attracted criticism as it uses a medical model. The categorical approach assumes the existence of distinct types of personality disorder with distinctive features. However, in reality, few patients fit neatly into any single category and individuals with severe personality disorder may satisfy the criteria in all categories. Hence, an alternative **dimensional** approach has been proposed which is gaining in popularity, although it is not yet standard clinical practice.^{1 4}

The dimensional system allows a number of traits to be mapped onto a grid-like representation of the individual's problem areas and strengths. This approach is proving useful in investigating the biochemical underpinnings of many of these disorders and it also facilitates a problem-orientated approach to treatment. Several different models have been proposed.⁴ One useful dimensional system that allows all personality abnormality assessed by categorical (ICD or DSM) criteria to be classified on a dimensional scale is included in Appendix C.¹

2. Description

2.1 Epidemiology

Historically, problems with the classification of personality disorders led epidemiological statistics for the prevalence of personality disorders to be unreliable.⁵

In Britain, the prevalence of personality disorder ranges from 2% to 13% in the general population.⁶ Studies have found a prevalence of 32% in primary care patients⁷, 30-40% amongst psychiatric outpatients and 40-70% in psychiatric inpatients.⁸ The prevalence is also high in institutional settings such as hospitals, prisons and residential homes.^{5 8} Some diagnoses are made more commonly in men (such as dissocial personality disorder) while others are more common in women (e.g. histrionic and borderline personality disorders).

Personality disorders are common among patients suffering from alcohol or substance misuse and eating disorders.^{6 8 9}

2.2 Aetiology

There are both biological and psychosocial theories of the aetiology of personality and behavioural disorders.⁵ These theories are not mutually exclusive, and many have contributed to treatment strategies.

Possible causes of personality disorder include:

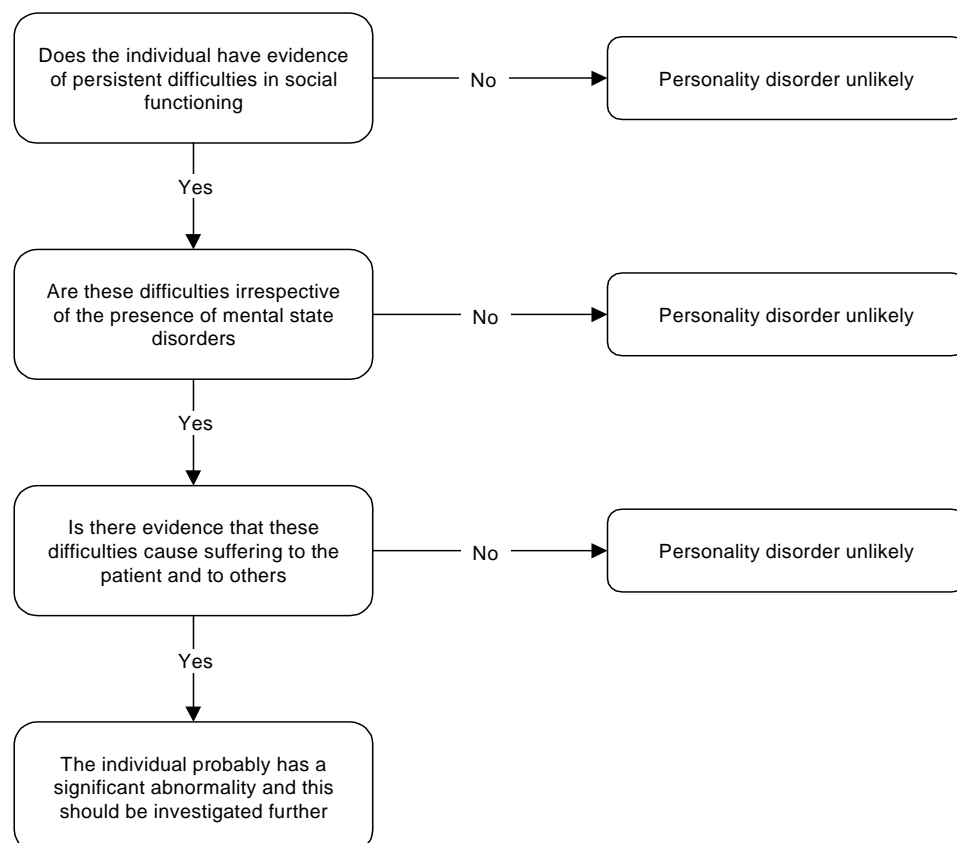
- There is increasing evidence of a genetic component for some behaviour (e.g. alcoholism of early onset in men).
- Neurochemical research has found serotonin metabolism to be related to abnormal impulsiveness and aggression.
- Some personality disorders can be considered as attenuated forms of mental illness, the strongest link being found between Cluster A and Schizophrenia.
- Psychological theories have focused on failure to progress through early developmental stages as a result of adverse conditions (e.g. abuse, neglect, and trauma), leading to problems in maintaining relationships later in life.

3. Diagnosis

The criteria for the diagnosis of a personality disorder are that:

- The person's characteristic and enduring patterns of behaviour deviate markedly from the cultural norm, with deviation in more than one area of cognition (i.e. attitudes and ways of perceiving and interpreting); affectivity, control of impulses and gratification, and ways of relating to others.
- The deviation is pervasive, and the behaviour is inflexible, maladaptive or dysfunctional in a broad range of situations.
- There is personal distress or an adverse impact on others.
- The deviation is stable and long-lasting, beginning usually in late childhood or adolescence.
- The deviant behaviour is not caused by brain injury, disease or dysfunction (e.g. depression, intoxication, organic brain disease).

The diagnostic process can be summarised as follows:



Derived from Tyrer 2002¹

3.1 Assessment of Personality Disorder

Assessment of personality disorder is difficult. The index of overall agreement between psychiatrists is lower for personality disorder than for any other major class of psychiatric disorder; they usually agree on the presence of a personality disorder, but disagree on the subtype.⁵ Value judgements may cloud clinical judgement.

Personality Disorder is best assessed as early in life as possible, ideally in adolescence. Disorders in childhood and adolescence are sometimes described as conduct disorders, but these do not inevitably lead to a personality disorder in adult life. Only persistent and maladaptive patterns of functioning sufficient to cause severe impairment would warrant a diagnosis of personality disorder in children and adolescents. Psychiatrists are often reluctant to contemplate a diagnosis of personality disorder, for fear of stigmatising a child. Problems presenting for the first time in adulthood may point to a functional or organic mental illness.

In order to make a diagnosis of personality disorder it is preferable to use more than one source of information and to interview both the patient and an informant (ideally someone who knows the patient well). The patient's own account of the disorder may be unreliable, as over-exaggeration (histrionic disorder) or lying (antisocial personality disorder) are features of the disorder itself. The patient's self-assessment of personality may be distorted by mood disorders.

In the diagnostic setting several checklists, questionnaires and interview schedules are available,^{1 5} however these are not applicable to the assessment of disability.

In addition to the routine psychiatric assessment, particular attention should be paid to the following:

- Presenting problems
- Childhood history and experiences, especially severe illness, abuse or behavioural disturbance
- Reactions to life events
- Violent outbursts and their precipitating factors
- Risk-taking behaviour
- Relationships (type and stability)
- History of relevant physical disorder (e.g. head injury, epilepsy)
- Substance abuse
- Co-morbid physical or mental disorders.

3.2 Presentation

Patients with personality disorders may present in various ways. The behaviour and attitude of someone with a personality disorder can cause considerable problems for the sufferer and for others. They may be particularly inflexible and have limited coping mechanisms.

Some behaviour may be overt (e.g. extreme aggression), but others may be subtle

Medical Services

(e.g. lack of assertiveness or avoidance behaviour). Temporary reactions to particular circumstances do not justify the diagnosis of a personality disorder.

Some of the most common presentations of personality disorders include aggression, alcohol or substance misuse, self-harm and eating disorders.

3.3 Common Presenting Symptoms

Certain features are characteristic of the different types of Personality Disorder:

3.3.1 Cluster A

Paranoid Personality Disorder

- Extremely sensitive to experiencing failure or rejection.
- Hold grudges against people and will refuse to forgive insults, injuries or slights.
- Very suspicious and will often misconstrue the friendly or neutral behaviour of other people as being unfriendly or hostile. Also, constantly suspicious about fidelity of sexual partners.
- A preoccupation with personal rights and a sense of these being infringed even when this is not so. Often self-centred and self-important.
- Prone to believing in conspiracy theories about events affecting their own lives and in the world at large.

Schizoid Personality Disorder

- Find pleasure in few, if any, aspects of life.
- Unemotional, seem to be cold and unfeeling and find it very difficult to express anger or warmth.
- Unaffected by the praise or criticism of others and noticeably insensitive to the norms and conventions held by society.
- Prefer to be on their own and have little interest in relationships. (Including close friendships or sexual partners).
- Very introspective and preoccupied with fantasy.

Schizotypal Disorder

- Behaviour is cold and aloof and in other respects is regarded as strange and eccentric.
- Experience difficulty in maintaining relationships and will tend to be socially withdrawn.
- Hold unusual beliefs such as magical thinking, which will influence the way they behave.
- Hold ideas that are paranoid and overly suspicious.
- Given to thinking obsessively about a subject without being able to let go. Often this will be of a sexual or violent nature.

Medical Services

- Unusual perceptions such as “voices,” “visions,” “bodily experiences.” Sometimes experienced as intense “psychotic” episodes.

3.3.2 Cluster B

Dissocial (Anti-Social) Personality Disorder – also known as Psychopathy

- Appear to be callous and unconcerned about how their behaviour makes other people feel; they do not feel guilt or profit from experience (for instance, punishment). On the other hand will tend to blame other people for their problems or to find a way of rationalising what they have done.
- Because of their disregard for social norms, rules and obligations, they act in ways that are regarded as unacceptable or grossly irresponsible.
- Cannot maintain a long-term relationship, although forming one is not problematic.
- Cannot tolerate frustration and are prone to outbursts of aggression and violence.

Emotionally Unstable

There are two kinds of this disorder known as ‘impulsive type’ and ‘borderline type’. They both share the following characteristics:

- A marked tendency to act impulsively without considering the consequences of these actions. For example, engaging in unprotected sex or substance abuse.
- An inability to plan is coupled with lack of self-control and outbursts of intense anger, which can lead to violence and other extreme behaviour, especially if impulsive acts are challenged or prevented by people around them.

The **impulsive** type is characterised by emotional instability and inability to control impulses, with episodes of threatening behaviour and violence occurring particularly in response to criticism.

A **borderline** type is also characterised by emotional instability and, in addition, severe doubts about their self-image, aims and sexual preferences, which cause upset and distress. It is common to experience a strong and debilitating sense of emptiness, and this can lead to self-harm and suicide threats. Liable to become involved in intense but unstable relationships, which can cause them continual emotional crises, but which they will endure to avoid being abandoned.

Histrionic Personality Disorder

- Given to theatricality, self-dramatisation and exaggerating the expression of emotions.
- Suggestible and easily influenced by others or circumstances.
- A need constantly to find activities offering excitement and the opportunity to be the centre of attention and a longing to be appreciated by other people.
- Over concern with physical attractiveness.
- A tendency to act or appear in an inappropriately seductive way.

Medical Services

- A tendency to be persistently manipulative to achieve what they want and to be easily hurt if obstructed.

Narcissistic Personality Disorder.

- Arrogant and self-important.
- Fantasise about unlimited successes and achievements.
- Believe that they are special and can only be understood by other special people.
- Constant need for attention and admiration.
- Exploit others to achieve own ends, lack empathy, and are unwilling to recognise or identify with the feelings and needs of others.
- Are often envious of others or believe that others are envious of them.

3.3.3 Cluster C

Avoidant (Anxious) Personality Disorder

- Persistent and pervasive feelings of shyness, insecurity, apprehension and tension leading to restrictions in lifestyle.
- Believing oneself to be unlikeable, undeserving, socially inept, and less important than other people, leading to a reluctance to get involved in relationships unless certain of being liked.
- Over-concerned by the fear of being criticised or rejected in social or work situations, leading to an avoidance of any activity that involves having to inter-relate with other people.

Dependant Personality Disorder

- Encouraging or allowing others to make important life decisions and a limited ability to make every day decisions unless given excessive reassurance and advice.
- Unwilling to make demands on people, especially those people who play an important part in their life.
- Are compliant and subordinate to other people's wishes.
- Feelings of helplessness and discomfort when alone and anxiety about being abandoned by loved ones due to fears of being unable to care for themselves.
- Appear unable to help themselves; need excessive help to make decisions.

Obsessive-Compulsive (Anankastic) Personality Disorder

- Feelings of excessive doubt and caution compensated by a need to adhere strictly to rules, lists and orders, although, paradoxically, this perfectionism often interferes with the successful completion of tasks.
- Close relationships and pleasurable activities are difficult to maintain in the face of the need to meet excessive standards of conscientiousness and productivity. This attitude is off-putting to other people, especially as they expect the same dedication from others or, conversely, will unreasonably seek to prevent others from doing things.

Medical Services

- Rigid and stubborn in outlook, whilst pedantic about doing the right thing.

Key points to remember:

- Personality disorder is often a diagnosis of exclusion.
- Most people diagnosed with a personality disorder fit the criteria for at least two different types of personality disorder.
- Most people diagnosed with a personality disorder are not dangerous.
- Danger (to self and others) is most often associated with a dissocial (i.e. psychopathic) disorder.
- People diagnosed as borderline or paranoid personality disorder may be at higher risk of self-harm and/or suicide.
- Dissocial personality disorder (i.e. psychopathic disorder) is included in the Mental Health Act 1983, and if thought to be treatable, can be the basis for compulsory admission to hospital.

3.4 Differential Diagnosis

It is important to differentiate Cluster A disorders from psychotic mental illness, and Cluster C disorders from anxiety and depression whenever possible. However, personality disorders commonly co-exist with mental disorders and the patient may exhibit symptoms of both.

Difficulty in diagnosis is common where symptoms may overlap e.g. with Asperger's Syndrome.¹⁰

People suffering from Cluster B personality disorders commonly present with aggressive behaviour. Any history of abuse or behavioural disturbance in childhood should be elicited, and details taken of:

- Episodes of violence in public or at home.
- Involvement with the police or prison services.

3.5 Co-morbidity

Personality disorders are commonly co-morbid with other psychiatric illnesses.

Medical Services

Mental State Disorder	Personality Disorder	Extent of Association (%)
Substance Misuse (Drugs and Alcohol)	Cluster B (and Cluster C to a lesser extent)	Strong (50-80%)
Schizophrenia	Cluster A (and B to a lesser extent)	Moderate (30-50%)
Bipolar Disorders	No consistent evidence	
Stress Disorders	Clusters B and C	Moderate (30-50%)
Neurotic Disorders	Cluster C	Strong (>50%)
Eating Disorder	Clusters B and C	Moderate (30-50%)
Somatoform Disorder	Cluster C	Very strong (>60%)

Derived from Duggan and Tyrer (2002)¹²

4. Treatment

The tendency to withdraw all treatment and support once a personality disorder is suspected should be resisted.

Patients with personality disorders may be difficult to treat as the condition involves lifelong pervasive attitudes and behaviours, and because patients often have other mental health problems.¹¹ However, while the condition is not curable, the patient can be helped, and general support can improve behaviour.

The best principles of intervention and treatment include a clear consistent approach, with offers of help being made and delivered within realistic limits. The aim is one of helping patients with their problems without the physician being cast into extreme positions (often either “the best” doctor or “useless”). It is important to encourage patients to assume responsibility for their actions, and to minimise avoidance and dependence behaviour patterns.^{6 9 13}

Establishing a therapeutic relationship may be very difficult when the patient has difficulty in forming relationships. The patient must be aware of the particular responsibilities of members of the care team.

Ultimately, developing a working relationship and enhancing the motivation for change are the main foundations of any specific intervention to change behaviour.

General principles of treatment include:

- Be realistic about what can be delivered, by whom, and in what period
- Avoid being cast as angel or tyrant
- Communicate clearly with the patient and other professionals involved
- Aim to improve the patient's:
 - a) Self worth
 - b) Problem solving abilities in the short term
 - c) Motivation for change in the long term
- Treat co-morbid mental or physical illness.

Both drug treatment and specific psychological treatments are appropriate in some cases (e.g. avoidant and anankastic disorders).

When another disorder co-exists, the intervention should initially be directed at this.

Self-help organisations such as befriending services or voluntary agencies may support patients with Cluster C disorders and reduce their need for protracted involvement with health services.

Patients with habit disorders may benefit from involvement with organisations such as Gamblers Anonymous or Narcotics Anonymous.

Medical Services

4.1 Drug Treatment

Short-term treatment may include anxiolytic or neuroleptic drugs given for limited periods or at times of severe stress.^{6 13 14} Long-term treatments may involve the use of neuroleptics, which can be helpful in cases of paranoid and schizotypal disorders.¹⁴

Depot anti-psychotic drugs have been reported to benefit patients who harm themselves impulsively, and those who display symptoms of frank psychotic illness.^{6 13 14}

Selective serotonin reuptake inhibitors have been used in patients with borderline personality disorders to reported good effect.¹¹

Carbamazepine has been reported to have some success in the treatment of aggressive behaviour.⁶

All drug interventions, however, are not supported by much research evidence. It is possible that the medication is being used to control risk and stress, rather than having any long-term impact on the personality disorder itself. The benefits must be weighed against the risk of side effects and toxicity in overdose. Full discussion with the patient is essential.

4.2 Psychosocial Intervention

The principal psychological treatments and their indications include:

- Cognitive behavioural therapy which has been found to be effective in several personality disorders (mainly Cluster B)
- Assertiveness training and anxiety management for dependent and anxious patients (Cluster C disorders)
- Techniques for managing anger in patients with aggressive behaviour
- Group psychotherapy may help in Cluster B disorders, but individual cognitive or behaviour therapy is more usual.^{6 13 15}

The aim of treatment is to provide insight for patients, allowing them to understand their emotions and to find more appropriate coping mechanisms.

Occupational and vocational therapy can be very beneficial.

4.3 Management of Deliberate Self-Harm

There is no consensus as to the best management of deliberate self-harm in patients with personality disorders. Admission to hospital may actually worsen self-harm, particularly if the admission is unfocused and not part of an overall plan.^{6 13}

Medical Services

Managing deliberate self-harm will include:

- Hospital admission only as part of a prepared treatment plan.
- Relative indications for admission are assessment of co-existing illness or risk of suicide.
- Contracts, agreed and signed by staff and patient, may help provide a structure within which help can be offered and received.
- The contents of a contract must be constructive and not punitive.
- Specialist inpatient units may allow a better opportunity for changing recurrent self-harm behaviour than general psychiatric units.

4.4 Management of Aggressive Behaviour

Aggressive behaviour has been shown to respond to carbamazepine therapy,⁶ particularly if associated with:

- History of head injury
- Genuine amnesia for assaults
- Déjà vu phenomena
- Olfactory hallucinations

Psychological techniques for managing anger are useful for patients who can tolerate a therapeutic environment and can discuss their own behaviour.

The main issues are to identify triggering situations and modify the reactive pattern of aggressive behaviour.

The key points in dealing with aggressive patients are:

- Be supportive to patients – explain their options and choices positively
- Take a forgiving attitude to rudeness
- Do not keep agitated patients waiting
- Do not see patients in isolated areas
- Do not be patronising or scold patients

Examining doctors should take basic safety precautions and ensure that alarm systems are available. Patients should not be criticised, and the doctor should always appear to be relaxed. The boundaries of acceptable and unacceptable behaviour should be clearly explained to patients in the context of helping them to avoid further difficulties.

Further advice on dealing with potentially aggressive situations is contained in the protocol of that name.

5. Prognosis

Accurate personality assessment helps to predict subsequent behaviour, e.g. a patient's reaction to physical illness, and will help in giving a prognosis.

Personality disorders are lifelong conditions, so no major change is likely. Some disorders, especially emotional disorders, can improve with age and maturation. This is less so for anankastic, schizoid and paranoid disorders.^{10 13} Normal individuals become less emotional and impulsive and more cautious and careful with age; a patient with personality disorders much less so. Patients with dissocial personality disorders are usually most destructive in their early life. They are diagnosed most frequently between the ages of 30 and 35 and can "burn out" later in life, becoming less anti-social. Family difficulties such as wife battering, child abuse and alcohol abuse may persist.^{10 13}

There is also a higher incidence of death by violence and suicide; between 30 and 60% of completed suicides retrospectively showed evidence of a personality disorder.⁶

Obsessional personality disorders are at a high risk of progression to an actual Obsessive Compulsive Disorder, or to depression. A patient suffering from an Obsessive Compulsive Disorder is usually distressed and functionally restricted by the condition, whereas someone with an obsessive personality disorder is not usually bothered or upset by the condition (see protocol on Obsessive Compulsive Disorders).

Paranoid and schizotypal disorders may progress to schizophrenia, but schizoid disorder does not.¹³

Borderline personality disorder carries a relatively favourable prognosis with clinical recovery in over 50% at 10-25 year follow up.^{10 13}

The presence of a personality disorder also influences the course and response to treatment of mental illnesses. The prognosis is improved if the patient establishes a stable relationship with another person.

Recently, a group of patients compulsorily detained in hospital for the purposes of treatment challenged the legality of their detention. The courts found that although the conditions were not curable, the patients could still be helped by several non-specific measures ("treatment"), and so their detention was deemed legal. [Personal communication, Dr. and Dr.]

6. Main Disabling Effects

The actual handicap in society experienced by a patient with a personality disorder depends both on the type of disorder and the degree to which it is exhibited.¹⁶ There is a continuum of behaviour from the exhibition of particular personality traits to the actual diagnosis of a personality disorder.¹⁷ Some of these traits may be desirable attributes in particular occupations (e.g. dissocial personality traits in the Armed Forces and obsessional traits in the legal profession). However, difficulties in society can be caused by overt personality attributes. This may be no more than someone being regarded as “different” or “a bit odd” while still being able to carry on a relatively normal existence. More marked difficulties with everyday life can occur, and each case needs to be assessed on an individual basis.

Everyone is an individual with particular personality characteristics, and a personality disorder is only diagnosed when the behaviour becomes maladaptive and causes an adverse impact.

The diagnosis of a personality disorder does not necessarily prevent someone from gaining useful employment, however certain occupations which require the continued application of judgement and self-discipline (e.g. civil aviation) are generally not compatible with a personality disorder.¹⁶

6.1 Assessing the Claimant

Certain personality disorders will affect the individual's functional capacity in different ways.

Coping with tasks is likely to be affected by avoidant, dependent and emotionally unstable disorders. Anankastic disorders may cause difficulty with the completion of tasks in both an acceptable manner and within a reasonable period. For example, agitation may be so severe as to have caused accidents, or avoidance behaviour may have caused problems in opening letters or paying bills.

Daily living is affected mainly in disorders such as schizoid personality as well as cluster B and C disorders such as narcissistic, avoidant, dependent, histrionic and emotionally unstable. There may be extreme emotional lability in borderline disorders or an abnormal obsession with appearance in narcissistic disorders.

Coping with pressure is again affected mainly by Cluster B and C disorders i.e. dissocial, emotionally unstable, avoidant, dependent and anankastic. The claimant may have been unable to sustain employment due to difficulties with coping or due to excessive anxiety, and their general lifestyle may be severely restricted by the inability to face up to new situations.

Social interaction is affected by all disorders to a greater or lesser extent. The conditions exerting the maximal effect are mainly cluster A disorders such as paranoid, schizoid and schizotypal disorders. The client may lead a solitary existence without the normal family or social contact, or interactions with others may be characterised by bizarre behaviour.

Medical Services

6.1.1 IB-PCA Considerations

In the IB-PCA, it is unlikely that claimants presenting for assessment will fall exactly into neatly defined categories, as there is such an overlap between the different disorders. It is important for the examining doctor to assess the claimant's actual functional capabilities and not to assume that particular difficulties exist purely on the basis of the diagnosis.

It may become apparent during the interview that the claimant's condition has a severe and detrimental effect on their behaviour, and that either their social functioning or awareness of the immediate environment is severely affected. The personal safety of potential work colleagues or members of the public may also need to be taken into account. Under these circumstances, exemption should be considered. Further advice can be obtained in the training module, "Exemption Advice at the Examination Stage."

6.2 Disability Discrimination Act

A mental impairment is defined in the Act as a mental illness that is "Clinically well recognised." Any illness within the DSM or ICD would probably be accepted. The definition of "Mental Impairment" is particularly sensitive. The Meaning of Disability Regulations 1996(SI 1996/1455) exclude the following conditions even though they are recognised as dissocial or psychopathic disorders:

- Pyromania
- Kleptomania
- Tendency to physical or sexual abuse of others
- Exhibitionism
- Voyeurism.

A patient with a personality disorder that causes a substantial and long-term adverse effect upon his or her ability to carry out normal everyday activities may qualify for the Act's protection. The type of activities likely to be affected include:

- Perception of risk of physical danger
- The ability to concentrate, learn and understand.

"Long term" means that the impairment must have lasted for, or is likely to last for, twelve months or longer. This criterion will apply in all cases of personality disorder.

Appendix A - WHO Classification of Personality Disorders

ICD-10 (International Classification of Disease, 10th edition)

F60 Specific Personality Disorders

Paranoid	- Includes formerly used categories of sensitive and querulent personality
Schizoid	- Distinct from schizotypal disorder, which is related to schizophrenia
Dissocial	- Formerly called antisocial, asocial, psychopathic, or sociopathic personality
Emotionally Unstable	- Includes impulsive (explosive) and borderline types.
Histrionic	- Formerly hysterical personality.
Anankastic	- Formerly obsessional personality.
Anxious	- Also called avoidant personality.
Dependent	- Formerly asthenic, inadequate, or passive personality.

F61 Mixed Personality Disorders

F62 Enduring Personality Changes

Includes permanent changes after catastrophic experiences (such as being taken hostage, torture, or other disaster) or severe mental illness, but excludes changes due to brain damage.

F63 Habit and Impulse Disorders

Includes pathological gambling, fire setting (pyromania), stealing (kleptomania), hair pulling (trichotillomania) and others.

F68 Other Disorders of Personality

A mixed category including elaboration of physical symptoms for psychological reasons and intentional production of symptoms (factitious disorder).

Medical Services

F21 Schizotypal Disorder

This category is included for completeness, but it is best avoided as its status as a variant of schizophrenia or of personality disorder is not clear.

Appendix B - Classification of Personality Disorders

Comparison of DSM and ICD Classification Systems for Personality Disorders		
Diagnostic Criteria	DSM	ICD
	Diagnostic criteria for personality disorder refer to behaviours or traits that are characteristic of the person's recent and long term functioning since early childhood. Personality disorder describes a constellation of behaviours or traits that cause either significant impairment in social or occupational functioning or subjective distress.	Diagnostic criteria include a variety of conditions, which indicate a person's characteristic, and enduring patterns of inner experience (cognition and affect) and behaviour(s) that differ markedly from a culturally expected and accepted range.
Classification of Personality Disorder	Three Main Clusters	Nine Main Types
	Cluster A <ul style="list-style-type: none"> Paranoid Personality Disorder Schizoid Personality Disorder Schizotypal Personality Disorder 	<ul style="list-style-type: none"> Paranoid Schizoid
	Cluster B <ul style="list-style-type: none"> Anti-Social Personality Disorder Borderline Histrionic Narcissistic 	<ul style="list-style-type: none"> Dissocial Emotionally Unstable Impulsive Type Borderline Type Histrionic
	Cluster C <ul style="list-style-type: none"> Avoidant Dependent Obsessive Compulsive 	<ul style="list-style-type: none"> Anxious (avoidant) Dependent Anankastic

Appendix C - Simple Dimensional System of Classifying Personality Disorders¹

Level of Severity	Description	Definition by Categorical System
0	No personality Disorder	Does not meet actual or sub-threshold criteria for any personality disorder
1	Personality Difficulty	Meets sub-threshold criteria for any or several personality disorders
2	Simple Personality Disorder	Meets actual criteria for one or more personality disorders within the same cluster
3	Complex (diffuse)	Meets actual criteria for one or more personality disorders within more than one cluster
4	Severe Personality Disorder	Meets criteria for creation of severe disruption both to the individual and to many in society

7. Bibliography and References

1. Tyrer P, Garraalda E, Rangel L. Assessment of personality disorders. *Psychiatry* 2002;1(1):4-7.
2. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington DC: The American Psychiatric Association, 1994.
3. World Health Organisation. *The ICD-10 Classification of mental health and behavioural disorders*. Geneva: World Health Organisation, 1993.
4. Suryanarayan. The history of the concept of personality disorder and its classification. *Psychiatry* 2002;1(1):1-4.
5. Casey P. Personality Disorders. In: Stein G, Wilkinson G, editors. *Seminars in General Adult Psychiatry*. Royal College of Psychiatrists, 1998:753-814.
6. Davies T, Craig T. *ABC of Mental Health*. BMJ Publishing, 2001.
7. Hueston W, Werth J, Mainous A. Personality disorder traits: prevalence and effects on health status in primary care patients. *Int J of Psych Med* 1999;29(1):63-74.
8. Moran P. Epidemiology of Personality Disorders. *Psychiatry* 2002;1(1):8-14.
9. Puri B, Laking P, Treasden I. *Textbook of Psychiatry*, 1996.
10. Robertson M. *Psychiatry at a glance*. Second ed: Cornelius Catona, 2000.
11. Higgins E. Obsessive Compulsive Spectrum Disorders in Primary Care: the Possibilities and the Pitfalls. *Journal of Clinical Psychiatry* 1996;57.
12. Duggan C, Tyrer P. Co-morbid personality disorder in the treatment and outcome of common mental disorders. *Psychiatry* 2002;1(1):26-29.
13. Gelder M, Mayou R, Cowen P. *Shorter Oxford Textbook of Psychiatry*. Oxford: Oxford University Press, 2001.
14. O'Rourke M, Hammond S. *Personality Disorders*: The Mental Health Foundation, 2001.
15. Becker P. A Multi Facet Circumplex Model of Personality as a Basis for the Description and Therapy of Personality Disorders. *Journal of Personality Disorders* 1998;12(3):213-225.
16. *Fitness for Work*. Third edition ed, 2000.
17. Cloninger C. Temperament and Personality. *Current Opinion in Neurobiology* 1994;4:266-273