

1. Various attempts have been made to classify psychiatric disorders formally, the two major systems being:
 - 1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This appendix follows the common abbreviation of **ICD-10**. It is the international system used by the majority of clinical psychiatrists in Great Britain.
 - 1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA: however UK psychiatrists were consulted in its formulation.
2. The two systems above have been in existence for many years, but only in their current editions have they been closely comparable. This appendix is generally based on the ICD-10 system, with any major comparisons and distinctions with DSM-IV being discussed where relevant.
3. This appendix summarised the generally recognised clinical features of personality disorders.
 - 3.1. Section A describes the concept of the normal personality, including reactions and behaviours which are considered to be part of the normal range of functioning.
 - 3.2. Section B deals with personality disorders.
 - 3.3. Section C deals with the acquired personality changes.
 - 3.4. Section D deals with the development of the normal personality, some of the ways in which personality variables influence behaviour and the aetiology of the personality disorders.

SECTION A

THE NORMAL PERSONALITY

Definition

4. The term “personality” denotes a set of interrelated enduring habits, beliefs, attitudes and resulting behaviours which characterise a person and differentiate him from others.

Features

5. There are many identifiable traits which combine to constitute the personality, there being various methods of identifying them. Some questionnaires rate the degree to which a trait is present, such as Cattell’s “16 PF (personality factors) Questionnaire” which looks at groups of personality traits, a person being judged to lie somewhere along the continuum of traits, for example:
 - 5.1. guilt-proneness, insecure, worrying, self-reproaching –v- self-assured, confident, complacent, spirited.
 - 5.2. assertive, aggressive, dominant, competitive –v- submissive, mild, modest, accommodating.
 - 5.3. emotionally unstable, easily upset, immature –v- emotionally stable, calm, mature.
6. Another well recognised method of classifying personality has been devised by Eysenck, and includes a dimensional model of introversion / extroversion, neuroticism / stability, psychoticism / stability and intelligence. The high neuroticism score, for example is characterised by “an anxious worrying individual, moody and frequently depressed; he is likely to sleep badly and suffer from various psychosomatic disorders. He is overly emotional, reacting too strongly to all sorts of stimuli, and finds it difficult to get back on an even keel after each emotionally arousing experience”.
7. Other personality traits include whether a person is strict, easily irritated, sensitive, suspicious, prone to worry, impulsive, unpredictable, dependent, accepting, lacking self-confidence, indecisive, callous, ambitious, controlled, timid, dishonest, calm, naïve, easy going, tense, self confident, outgoing, self opinionated, etc. This list is by no means complete.
8. Behaviour which derives from personality traits may vary from one situation to another; for example someone may usually be very timid at work, arrogant and aggressive at home, and relaxed and easy going in the social setting. The personality should therefore be considered in the context in which the behaviour is observed.
9. There are some personality **types** in which a group of features form a recognisable cluster; however, it is stressed that these are **not disorders**, although there are equivalents in the personality disorder classification:

- 9.1. **Anankastic personality:** This is characterised by a cautious and careful attitude, with a desire for orderliness and precision. These people tend to have high standards and their mood tends to be stable; however, they can tend to get lost in detail, may find decision making difficult and are resistant to change.
 - 9.2. **Histrionic personality:** This person is characterised by being emotionally responsive, confident, lively and sociable: however they can sometimes tend to be vain and self-centred, with short-lived enthusiasms and prone to dramatic displays of emotion.
 - 9.3. **Cyclothymic personality:** This is characterised by changing periods of low mood, lack of energy and confidence, to bouts of great productivity, boundless energy and good spirits.
 - 9.4. **Eccentric personality:** Other more idiosyncratic personality types may be recognised, especially those which are characterised by odd or unusual behaviours.
10. The expression of the personality varies with the prevailing mood state at any one time, for example depressed mood, degree of arousal, anxiety, fatigue and intoxication. An angry or irritable demeanour is often thought to represent a personality type, whereas it is more probably a mood state. The personality however may have a direct bearing on the perception of situations which provoke anger in different individuals, the way in which it is expressed, and the degree of control over the emotion which the person has. Factors which are known to reduce this control are alcohol and benzodiazepines.
 11. None of these, however, are personality **disorders**, even though under certain circumstances some personality types find certain situations difficult, for example, when the anankastic personality type (who prefers to deal with things in a detailed and precise manner) is obliged or compelled to approach a task in a "broad brush" way.
 12. In this way, certain personality traits can create difficulties for short periods and may even lead people to seek medical help. However, these are still not mental disorders.

Problems related to life experiences

13. Both the ICD-10 and DSM-IV list several observable normal behaviours or situations which may lead the individual into contact with health and related services; however they are not considered to be illnesses, mental disorders or personality disorders, although they are often a reflection of the underlying personality.

Accentuation of personality traits

13.1. This refers to the more florid appearance of personality traits under certain circumstances. For example, when a shy, restrained and timid person is required to speak in public for the first time, anxiety builds as the day approaches and they are even more apprehensive than usual. This person is obviously not mentally ill, nor do they have a personality disorder. Situations have a direct influence on the expression of personality traits, in that if personal and social circumstances are harmonious to the individual, then certain personality traits may not be particularly apparent, and only at times of disruption of the equilibrium will the individual's reactions be seen to cause personal discomfort or difficulties.

Phase of life problem

13.2. Most people find difficulties in adjusting to various changes during life, including problems associated with starting school, changing jobs, starting a new career, marriage, divorce and retirement. Individuals with certain personality traits may have more difficulty than others; for example those with high dependency may find returning to work after a long break threatening. Similarly, those with a strong need for structure may find difficulties in adjusting to retirement or change of career.

Employment difficulties

13.3. Some may encounter problems more specifically relating to employment, this including job satisfaction or dissatisfaction, "burn-out" and unemployment. Personality traits such as a lack of initiative may hamper efficient resolution of employment difficulties.

SECTION B

PERSONALITY DISORDERS

14. The point at which a personality can be said to be disordered is difficult to define precisely; however the current definition of “personality disorder” is described by the World Health Organisation (ICD-10) as “deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and encompass multiple domains of behaviour and psychological functioning. They are frequently but not always associated with various degrees of subjective distress and problems in social functioning and performance. They are developmental conditions which appear in childhood or adolescence and continue into adulthood”.

Differentiation between normal personality and personality disorder

15. Various other definitions of personality disorder exist; however the concept common to all of them is that the patterns of behaviour are **maladaptive, enduring and pervasive**, and nearly always **cause clinically significant distress to the person themselves or they cause other people to suffer**. The distress caused to the individual may be defined as a subjective sense of misery, or that the personality disorder causes significant impairment in the person’s relationships or their social and occupational functioning. However, the distress may only become manifest at a very late stage. It is stressed that the presence of a few undesirable or discomfiting personality traits **does not** constitute a personality disorder.
16. Some workers have queried whether the criterion of “enduring” should be included as not all aspects of a personality disorder manifest to the same degree over the years, some features tending to improve. Some personality disorders show little variation with age, these being the “mature” personality disorders, i.e. anankastic, paranoid, schizoid and anxious types. However, there is a tendency for the “immature” types to improve with age, ie the antisocial, borderline, impulsive, histrionic, dependent and narcissistic types.
17. The specific term “psychopathy” has a long tradition of being used generally to indicate the presence of a personality disorder (and is still referred to in the Mental Health Act in this way). This may cause confusion as the term has also been used to describe a specific personality type, and therefore the more recent terms of “dissocial” (ICD) or “antisocial” (DSM) for this cluster of characteristics is preferable to avoid confusion.

PERSONALITY DISORDER TYPES

18. There are 9 major personality disorders listed in the ICD-10, and there is a core of criteria which is common to all of them. A summary of the individual features is given in this appendix, but for a full list criteria the classification system should be consulted.
19. The following diagnostic guidelines are common to all of the personality disorders and **must** be met in all cases:

- 19.1. the condition is not directly attributable to brain damage or disease or to another psychiatric disorder.
 - 19.2. there are marked abnormalities of functioning affecting such areas as affectivity, arousal, impulse control, ways of thinking and perceiving, and the style of relating to others.
 - 19.3. the abnormal behaviour pattern is enduring, of long standing and not limited to episodes of mental illness.
 - 19.4. the abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of social and personal situations.
 - 19.5. the above manifestations can be detected during childhood or adolescence and continue into adulthood.
 - 19.6. the disorder leads to considerable personal distress, but this may only become apparent late in its course.
 - 19.7. the disorder is usually but not invariably associated with significant problems in occupational and social performance.
20. In addition to the above core criteria, at least four of the characteristics listed in each individual disorder below should be present.

PARANOID PERSONALITY DISORDER

21. This is characterised by an excessive sensitivity to setbacks and rebuffs, a tendency to bear grudges, suspiciousness, and a tendency to misconstrue other people as hostile. They may also have an inappropriate sense of personal rights and often take on "causes" for other people.

SCHIZOID PERSONALITY DISORDER

22. This is characterised by an emotional coldness and detachment, with a limited capacity to express feelings towards others. These people appear unaffected by praise or criticism and prefer solitary activities. They may have difficulties in communicating freely with others and have little interest in sexual relationships.

DISSOCIAL (ANTISOCIAL) PERSONALITY DISORDER (Also termed antisocial, psychopathic, sociopathic)

23. In this disorder there is a gross disparity between the person's behaviour and the prevailing social norms. It is characterised by callous unconcern for others, marked irresponsibility and a disregard for rules and obligations. They are unable to sustain relationships and have a very low tolerance to frustration, with aggressive and violent acts being performed with little thought of the consequence. They do not learn from experience, and punishment has little effect. They do not feel guilt and often blame others for disasters of their own making.

IMPULSIVE PERSONALITY DISORDER

(Emotionally unstable personality disorder, impulsive type)

24. This type includes “explosive” and “aggressive” personality disorders. The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others, and outbursts of intense anger may often lead to violence or “behavioural explosions”; these are easily precipitated when impulsive acts are criticised or thwarted by others.

BORDERLINE PERSONALITY DISORDER

(Emotionally unstable personality disorder, borderline type)

25. Several of the characteristics of emotional instability (above) are present, with outbursts of violence and lack of impulse control. In addition the person’s own self image is disturbed and they have chronic feelings of emptiness and boredom. They are unable to control angry feelings; relationships are intense and unstable, characterised by alternating between idealisation and devaluation of the other person, this leading to repeated emotional crises and excessive efforts to avoid being abandoned. They also may mutilate themselves or make repeated suicidal threats.

HISTRIONIC PERSONALITY DISORDER

26. This is characterised by a need to be the centre of attention: the person plays the role of “the life and soul of the party” including overdramatisation and the production of elaborate stories to increase their own self image. They often express emotions in a dramatic way, with sobbing at minor upsets, or display temper tantrums. They are easily influenced by other people and are suggestible, often following fads. They are often flirtatious and over concerned with appearance, about which they seek approving comments, being easily upset by adverse ones.

ANXIOUS (AVOIDANT) PERSONALITY DISORDER

27. This personality disorder is characterised by persistent and pervasive feelings of tension and apprehension. They believe they are socially inept, personally unappealing, or inferior to others. They are often unwilling to become involved in case they will be disliked and are preoccupied with being criticised or rejected, and consequently their lifestyle may become restricted.

ANANKASTIC PERSONALITY DISORDER

(syn: obsessive compulsive and obsessional personality disorders)

28. This must be differentiated from obsessive compulsive disorder. Anankastic personality disorder is characterised by a preoccupation with orderliness, perfectionism, and mental and interpersonal control, which is at the expense of flexibility, openness, and efficiency. People with this disorder are excessively conscientious, being preoccupied with rules and regulations which hinder the completion of tasks. They find decision making difficult and are full of doubt. They often pursue productivity in work to the exclusion of leisure activities and relationships. They are often very pedantic and inflexible and their relationships may consequently suffer. Other traits sometimes found are hoarding (being unable to get rid of worthless objects, in case they are “needed” in the future), extreme parsimony and poor allocation of time with important tasks often being left to the last minute.

DEPENDENT PERSONALITY DISORDER

(includes asthenic, inadequate, passive, self-defeating)

29. This disorder is characterised by difficulties in making everyday decisions without an excessive amount of advice and reassurance from others. They prefer other people to make important decisions for them and become dependent on this subordinate relationship, letting the other person take the lead in many areas of life. However, they are unwilling to make even reasonable demands of others, often being afraid of asking for too much and thus risking rejection. They find disagreeing with other people difficult and feel unable to completely care for themselves, being afraid of abandonment.

NARCISSISTIC PERSONALITY DISORDER

30. This is characterised by a sense of extreme self importance and need for admiration. They often exaggerate their achievements and talents and expect to be recognised as superior without any basis. They are preoccupied with fantasies of unlimited success, power or intellectualism. They believe that they are “special” and unique and can only be understood by, or should associate with, other special or high-status people.

DEPRESSIVE PERSONALITY DISORDER

31. The position of this disorder is not clear in the classification systems. Although it is a clinically well recognised personality disorder, it is not clearly specified as a personality disorder, being mentioned in the “not otherwise specified” category of DSM-IV and as a category suitable for further research. In the ICD-10, it now lies with the affective disorders under the nomenclatures of cyclothymia and dysthymia.
32. The features of depressive personality include “a persistent and pervasive feeling of dejection, gloominess, cheerlessness and unhappiness. These individuals are overly serious, incapable of enjoyment or relaxation and lack a sense of humour. They also tend to brood and worry, dwelling persistently on their negative and unhappy thoughts. Such individuals view the future as negatively as they view the present; they doubt that things will ever improve, anticipate the worse and, whilst priding themselves on being realistic, are considered by others to be pessimistic.”

33. **Equivalents in DSM-IV and ICD-10**

ICD-10	DSM-IV
Paranoid	Paranoid
Schizoid	Schizoid
Dissocial	Antisocial
Emotionally unstable - Impulsive type	No equivalent
Borderline	Borderline
Histrionic	Histrionic
Anankastic	Obsessive-Compulsive
Anxious	Avoidant
Dependent	Dependent
Narcissistic (unspecified)	Narcissistic

34. ICD-10 also includes “Other specific personality disorders”, but in fact the criteria are not specified. They include eccentric, immature, passive-aggressive, psychoneurotic.
35. The specific diagnostic criteria for each personality disorder vary slightly between classification systems. However at least four or five different symptoms are required by both systems to make a diagnosis, and the presence of one or two criteria alone does not indicate a personality disorder.
36. The personality disorders in the classification systems of ICD and DSM are synthetic groupings based on clusters of maladaptive behaviours; however many people do not fit neatly into these categories. The recommended method of classifying these is to use two concurrent diagnoses, or to use the term “personality disorder not otherwise specified” with a description of the personality traits found.

ENDURING PERSONALITY CHANGE AFTER CATASTROPHIC EXPERIENCE

37. Occasionally a profound **change** in personality may occur as a late consequence of exposure to extreme and prolonged stress, which may manifest decades after the event. Examples of the types of stressor are the most extreme and existential types of stressor such as torture, concentration camp experience, disasters, prolonged exposure to what is felt to be almost certain death, eg a prolonged hostage situation.
38. The personality change must be clearly obvious, of significant degree and associated with maladaptive behaviour which was not present prior to the experience. These changes are enduring, inflexible and maladaptive, and cause long-standing problems in interpersonal, social or occupational functioning and cause subjective distress. The change is characterised by a hostile or mistrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, estrangement and a chronic feeling of being on edge as if constantly threatened. The change must have been present for at least two years and should not be attributable to another psychiatric disorder (except post-traumatic stress disorder), and there should be no history of a pre-existing personality disorder or accentuation of personality traits.
39. Personality disorders differ from these personality changes in both their timing and mode of emergence: the ICD-10 makes a clear distinction between these two groups of conditions, the personality disorders being developmental conditions and the personality changes being acquired in adult life.

ENDURING PERSONALITY CHANGE AFTER PSYCHIATRIC ILLNESS

40. This change is listed in ICD-10 as a personality change which can be attributable to the trauma of suffering from a severe mental illness. Although it is stated that it should be distinguished from a preceding mental illness, it is not clear where the borders of the mental illness and this personality change lie, many of the symptoms of the latter appearing to be very similar to residual effects of the mental illness. The condition is characterised by excessive dependence on others, passivity, reduced interests and involvement in activities, complaints of being ill with illness behaviour, significant impairment in social and occupational functioning and dysphoric mood, although ICD-10 states that the last symptom must not be due to a current or previous mental disorder. The use of this must therefore be extremely circumspect.

ORGANIC PERSONALITY DISORDER

41. This is the change which may occasionally occur following a severe head injury or brain disease and, although termed a “personality disorder” it is more properly considered to be a **personality change**. It is characterised by a significant alteration of the habitual patterns of behaviour which were in evidence prior to the disease or head injury. The expression of emotion, needs and impulses is particularly affected. Cognitive function may be specifically affected especially in the areas of planning and anticipation, this having been formerly thought of as damage restricted to the frontal lobe area of the brain, but now shown to be a result of damage in almost any area of the brain. A fairly common feature is a lack of concern about any injury which may have occurred. The condition may be seen after psychosurgery, severe head injury, and in certain types of limbic epilepsy.

Diagnostic guidelines

42. The presence of frank brain damage or disease must be established.
- 42.1. There is inability to persevere with goal-directed activity (especially tasks which need to be maintained over a long period of time).
- 42.2. Mood changes include emotional lability, unwarranted cheerfulness easily changing to irritability, or brief explosions of anger.
- 42.3. The patient is apathetic.
- 42.4. There is inappropriate expression of impulses such as stealing, sexual advances, voracious eating and a disregard for personal hygiene.
- 42.5. Abnormal patterns of thinking with suspicious or paranoid ideation or preoccupation with a single abstract theme e.g. “right and wrong”.
- 42.6. Some may show altered sexual behaviour e.g. hyposexuality or change of sexual preference.

Genetics

43. Studies of the personalities of adult monozygotic twins reared apart compared with monozygous twins reared together, and dizygous twins reared together, show that monozygous twins reared apart are more alike than dizygous twins, the correlation coefficient being +.61 in the monozygous twins and +.17 in the dizygous twins.
44. The Louisville twin study (begun in 1957 and reported in 1983) followed the development of 500 pairs of twins and their siblings. The timing of the monozygous twins' development (which normally occurs in spurts, determined by genetics) was almost identical when compared with dizygous twins (which were much less synchronised). A further very large study of 2600 adolescents and adults (including 400 pairs of twins) showed remarkably close resemblance between attitudes and various fears between monozygous twins which was not apparent in the dizygous twins. This similarity between the monozygous twins increased with age throughout adolescence.
45. **Temperament.** This refers to preconceptual personality traits which do not alter qualitatively after the pre-school years and are generally recognisable from a very early age. Genetic studies have shown novelty seeking, harm avoidance and reward dependence to be heritable temperament factors. Other temperament factors which have been identified are emotionality, activity, impulsivity and sociability, the first three of these together relating to aggressivity.
 - 45.1. **novelty seeking** is the activation of behaviours such as frequent exploratory behaviour, impulsive decision making, extravagance in approach to cues of reward, quick loss of temper and active avoidance of frustration.
 - 45.2. **harm avoidance** is a bias towards the inhibition of behaviours such as pessimistic worry about future problems, passive avoidance, fear of uncertainty, avoidance of strangers and rapid fatigability.
 - 45.3. **reward dependence** is the maintenance of ongoing behaviours manifest as sentimentality, social attachment and dependence on the approval of others.
46. Temperament traits remain stable over time; however the way in which they are manifest (as behaviour) changes, depending on the situation. For example, behavioural inhibition may be revealed in infancy as clinging to the mother, at school age it may manifest as a cautious approach to new tasks, and later as a particular style of social interaction.
47. **Intelligence.** The degree of intelligence limits the rate at which learning can take place at the various stages of development and thus directly influences the development of the full personality. It also dictates levels of achievement and is a determining factor in the development of coping styles and the resolution of problems. Intelligence itself is determined by genetic, antenatal, perinatal and neonatal factors and early life experience.

48. **Motivation.** Certain innate drives have been identified, including food-seeking, gregariousness, acquisitiveness and pugnacity. Other motivational factors are culturally acquired and include religiosity, the conscience, career seeking and employment and all are present to very differing degrees in individuals. The interplay of motivating factors, intelligence and temperament has a profound influence on behaviour, the personality evolving as each person, as a thinking being, develops a way of dealing with the temperamental traits with which he is endowed.

Psychological theories

49. Various models have been described to attempt to link the variables relating to personality development.
- 49.1. The psychoanalytical model described by Freud, in which the person is seen as a being driven by innate instincts (the id), with different levels of control being imposed, (the ego and superego), these motivating factors being unconscious.
- 49.2. Various other psychodynamic theories in which the emphasis is on the child's interpretation of experiences in infancy, rather than instincts e.g. Horney, Fromm, Sullivan.
- 49.3. The type models, including the concept that physical characteristics determine types, for example Sheldon's ideas on body types (obsolete) and Jung's concepts of introversion and extroversion.
50. These are all just viewpoints or ways of looking at personalities but they can help the understanding of how a personality actually develops. The new born infant can be seen as having the same basic drives or needs, but also having differing "innate" characteristics or differences in temperament which can be detected from the days of life. The way in which these needs are responded to is thought to influence the way in which the infant perceives the world, for example the amount of time he is consistently left waiting for food, whether the supply is enough, etc., these perceptions forming the basis of all future actions. As the child grows, the relationships within the family become the testing ground for how he relates to other people in the wider sphere outside.
51. At the same time it is thought that there are inner conflicts of needs, with the accompanying emotions which shape how a person views the world. This in turn influences how they behave in reality.
52. The personality is therefore determined primarily from the moment of conception (the genetic endowment): the individual's repertoire of behaviour patterns are established in childhood. Experiences in late childhood and adolescence may have an influence on the personality but, beyond early adolescence, patterns become less malleable and increasingly fixed.
53. Certain traits may be attenuated in later life as ageing and experience temper the personality, for example impulsivity may be restrained. Some traits may occasionally become more obvious as the ageing process imposes physical limits and cognitive abilities decline leading to accentuation of the expression of anger and frustration.

AETIOLOGY OF PERSONALITY DISORDERS

54. Personality disorders are **maladaptive** personality traits which arise from the interplay between inherited genetic tendencies, drives, temperament, intelligence, pre- and perinatal factors and early life experiences as described above. A personality disorder arises as a result of inherited and constitutional factors and disordered early life experiences.
55. By definition a personality disorder is generally recognisable by the time of adolescence, or earlier if a full investigation of the individual is made. A cursory examination which does not base its conclusions on detailed investigations cannot properly comment on the presence or absence of a personality disorder.
56. In addition to those effects it is well recognised that certain drugs have teratogenic effects of the foetus; however some drugs (notably heroin and methadone) taken during pregnancy may have subtle effects on the nervous system, causing enduring personality distortion in the offspring without any apparent physical abnormalities. Children whose mothers took these drugs during pregnancy have been shown to have irritability, sleep disturbance and unusually strong reflexes; in later childhood they have a short attention span and hyperactivity. Other teratogens may also affect the foetus by causing hypoglycaemia, hypothermia or by interfering with the placental transport of nutrients. Alcohol has long been recognised as affecting the foetus (even in the absence of physical abnormalities) and subsequently the behaviour of the child, including hyperactivity, poor motor skills, sleep disturbance and disturbed language development.

SPECIFIC AETIOLOGICAL FACTORS

Borderline personality disorder

57. Psychodynamic theory suggests that maternal inconsistency together with over-involvement may be aetiologically important in this personality disorder. Other studies have suggested that a history of childhood sexual abuse is more prevalent, the personality disorder developing as a coping response to the trauma. Other studies have suggested that social disintegration reduces the threshold at which impulse behaviours are expressed.

Schizotypal

58. Many studies have shown a genetic link to schizophrenia, particularly when lack of emotional reactivity is prominent. Study of the concept of "schizophrenia spectrum" disorders (including schizophrenia, schizoaffective disorders, schizotypal personality disorder, other non-affective psychoses and psychotic affective illness) shows a conclusive genetic vulnerability to these disorders.

Dependent Personality Disorder

59. Studies have suggested that this disorder runs in families but it is too early to say whether it is a genetic effect or whether it is due to a family style repeated through social learning.

Antisocial Personality Disorder

60. Genetic research and linkage analysis have shown a strong genetic component to this type of personality disorder. Studies have also shown an excess of alcoholism and criminality in fathers of probands. Other studies have suggested that perinatal factors (including birth difficulties) may be associated with later antisocial **behaviours**; some studies have replicated this but have shown no evidence of a link with the full criteria of antisocial personality disorder. Antisocial behaviour in the form of a conduct disorder may be an antecedent of adult antisocial personality disorder.

Enduring personality change following catastrophic experience

61. Exposure to a prolonged intolerable situation such as in concentration camps or where people have been held in prison and tortured, is easily understood as such a severe stress that most people would not fail to be affected by it. The length of exposure to the situation and the degree of suffering determine the change in personality. This is discussed more fully in the appendix on post-traumatic stress disorder.

Organic personality disorder

62. The condition is a direct result of severe and permanent damage to brain tissue. The presence of a pre-existing personality disorder does not preclude the diagnosis.

ASSOCIATION BETWEEN PERSONALITY TRAITS, PERSONALITY DISORDERS AND OTHER MENTAL ILLNESS.

63. Personality disorders and mental illness may accompany each other and can share similarities, for example feelings of anxiety, mood disturbance, fearfulness or preoccupation. The presence of some personality disorders may be more likely to lead to psychiatric illness in response to stressors, notably the avoidant, dependent and anxious types, whereas some studies show other personality disorders (in particular the dissocial) may have a protective effect. However in the former example such psychiatric illnesses are highly unlikely to affect the course of the underlying personality disorder.
64. It is well recognised however that the converse applies, that is that presentation of a mental illness will often be coloured by the personality or a pre-existing personality disorder (the "pathoplastic effect").
65. The main differentiating factor between personality disorder and an episode of mental illness is that in a mental disorder the symptoms are new and relatively temporary, whereas personality disorders are by definition longstanding, persistent and pervasive. For example the individual with a paranoid personality disorder may develop an adjustment disorder in response to a stressful event and become depressed. The separation of the conditions therefore takes into account such factors as the current symptoms compared to the previous symptoms, past history and response to treatment.

66. Personality disorders and neurotic disorders are on a continuum with the normal and in this way some personality disorders and some neuroses are not distinct entities. As previously stated, cyclothymia was formerly classified as a personality disorder but now is being thought of as primarily a genetically determined mood disorder. Similarly, schizotypal disorder was formerly classified with personality disorders; however genetic research has prompted its reclassification in ICD-10 to the spectrum of schizophrenia and related disorders. There is also some evidence that schizoid personality disorder may be similarly linked with the psychoses. This is not a universal move however and schizotypal personality disorder remains classified with the personality disorders in DSM-IV.

CONCLUSION

67. The personality is a set of interrelated enduring habits, attitudes and resulting behaviours which have their origins in genetic factors and childhood experience. The personality disorders are maladaptive attitudes and behaviours which have their origin in genetic factors and abnormal early experiences. Once the personality has been established, only in very specific circumstances can it be altered after adulthood is reached, these being for example the enduring personality change following catastrophic experience and the organic personality changes which may follow serious and permanent damage to brain tissue.
68. Certain circumstances may lead to an accentuation of personality traits; this accentuation however must not be classified as a personality disorder, cardinal features of the latter being the significant distress caused to the individual (or to others) or, in some cases, the gross deviation from the normal pattern of behaviour expected by the individual's culture. The traits which define the personality disorder must also be distinguished from symptoms that emerge in response to specific situational stressors, or transient mood states that are classified as separate conditions.

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