



## Personality disorder 1

# Classification, assessment, prevalence, and effect of personality disorder

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Personality disorders are common and ubiquitous in all medical settings, so every medical practitioner will encounter them frequently. People with personality disorder have problems in interpersonal relationships but often attribute them wrongly to others. No clear threshold exists between types and degrees of personality dysfunction and its pathology is best classified by a single dimension, ranging from normal personality at one extreme through to severe personality disorder at the other. The description of personality disorders has been complicated over the years by undue adherence to overlapping and unvalidated categories that represent specific characteristics rather than the core components of personality disorder. Many people with personality disorder remain undetected in clinical practice and might be given treatments that are ineffective or harmful as a result. Comorbidity with other mental disorders is common, and the presence of personality disorder often has a negative effect on course and treatment outcome. Personality disorder is also associated with premature mortality and suicide, and needs to be identified more often in clinical practice than it is at present.

### Introduction

Personality disorder is important to all medical practitioners because it is very common, affects greatly the interaction between health professionals and patients, is a strong predictor of treatment outcome, a cause of premature mortality, and is a great cost to society. Personality disorder therefore should be an important part of every psychiatric assessment, whether done by a qualified expert in personality disorder or a family doctor in a low-income country. However, this disorder has largely been hidden in the undergrowth of practice. The term personality disorder has often been used in a pejorative sense as a diagnosis of exclusion;<sup>1</sup> a label applied to people who were regarded as difficult to help and probably untreatable. Attention to personality disorder in practice has therefore oscillated between attempts to dismiss it altogether as a non-diagnosis, or instead, to regard it as a specialist subject in psychiatry that could be parked outside the scope of mental illnesses that general and other medical practitioners would be expected to identify and treat. Part of the difficulty is that nobody doubts the existence of personality, but what constitutes its disordered form is difficult to specify. Moreover for several reasons, the diagnosis has developed an even more grossly pejorative reputation in the eyes of the public and the profession; it has now become more a term of abuse than a diagnosis.

Personality disorder was not properly regarded as a diagnosis until the 19th century, although Galen in 192 AD had much earlier linked the Hippocratic four humours to personality in his description of sanguine, phlegmatic, choleric, and melancholic types,<sup>2</sup> with only the sanguine one not having personality pathology. Much later, in the late 18th and 19th centuries, Bénédict Augustin Morel and Philippe Pinel in France, and Julius Koch in Germany, postulated that disorders

of personality were mainly neurodegenerative disorders. James Cowles Prichard<sup>3</sup> was a major influence in coining the term moral insanity: a disorder with no apparent illness but gross disturbance of behaviour. He described moral insanity as “a form of mental derangement in whom the moral and active principles of the mind are strongly perverted or depraved, the power of self-government is lost or greatly impaired, and the individual is found incapable, not of talking or reasoning on any subject proposed to him, but of conducting himself with decency and propriety in the business of life.”<sup>3</sup>

Formal classification of personality disorder did not begin to take shape until Kurt Schneider<sup>4</sup> described a group of what he termed, rather confusingly in view of the subsequent use of the term, psychopathic personalities in 1923. The central phrase Schneider used to describe people with personality disorder was that “those with personality disorders suffer because of their disorders and also cause society to suffer.”<sup>4</sup> Although this phrase is rather ambiguous (many mental illnesses could be included under this rubric), it nonetheless encapsulated an essential core of personality disorder: the inability to form and sustain satisfactory interpersonal relationships. The relational nature of the

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See [Editorial](#) page 664

This is the first in a [Series](#) of three papers about personality disorder

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### Search strategy and selection criteria

We searched on Medline, Web of Knowledge, and PubMed, and in textbooks of personality disorder to identify relevant data and references for this paper, using the search terms “epidemiology”, “personality disorder”, and “classification”.

We narrowed the search to articles published in English between Jan 1, 2000, and Aug 22, 2014, which were relevant to recent developments in the specialty.

disorder makes the diagnosis of personality disorder interactive and not solely dependent on individual symptoms or the phenomenology of mental illness. Although Schneider defined his nine personality types from his clinical experience only, they have generally persisted in slightly different forms in all subsequent classifications from the sixth revision of the International Classification of Diseases (ICD-6)<sup>5</sup> in 1948 to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013 (panel 1).

#### Panel 1: Core features of the description of personality disorder since 1965

##### ICD-9 (approved 1975)<sup>6</sup>

"deeply ingrained maladaptive patterns of behaviour generally recognisable by the time of adolescence or earlier and continuing throughout most of adult life, although often becoming less obvious in middle or old age. The personality is abnormal either in the balance of its components, their quality and expression or in its total aspect. Because of this deviation or psychopathy the patient suffers or others have to suffer and there is an adverse effect upon the individual or on society."

##### DSM-III (1980)<sup>7</sup>

"It is only when personality traits (enduring patterns of perceiving, relating to, and thinking about the environment and oneself) are inflexible and maladaptive and cause either significant impairment in social or occupational functioning, or subjective distress, that they constitute personality disorders. The manifestations of personality disorders are generally recognisable by adolescence or earlier and continue throughout most of adult life, though they often become less obvious in middle or old age."

##### ICD-10 (approved 1990)<sup>8</sup>

"a severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of personality, and nearly always associated with considerable personal and social disruption. Personality disorder tends to appear in late childhood or adolescence and continues to be manifest into adulthood." Further characterised by "markedly disharmonious attitudes and behaviour, involving usually several areas of functioning" that is "pervasive and clearly maladaptive to a broad range of personal and social situations".

##### DSM-IV-TR (2000)<sup>9</sup>

"an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of an individual's culture. This pattern is manifested in two or more of the following areas—cognition, affectivity, interpersonal functioning, impulse control. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations, leads to clinically significant distress or impairment in social, occupational or other important areas of functioning, is stable and of long duration, and its onset can be traced back at least to childhood or early adulthood, and is not better accounted for by other mental disorder or effects of a substance."

##### ICD-11 (proposed, see full description in the text)

"a relatively enduring and pervasive disturbance in how individuals experience and interpret themselves, others, and the world that results in maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour. These maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships, manifested across a range of personal and social situations (ie, not limited to specific relationships or situations). Personality disorder is of long duration, typically lasting at least several years. Most commonly, it has its first manifestations in childhood and is clearly evident in adolescence."

Antisocial, borderline, narcissistic, and other qualifying adjectives have proved so enticing to clinicians describing patients that they have often led clinicians to bypass the general diagnostic requirements of personality disorder before applying labels corresponding to specific types. Although the general requirements for the diagnosis of personality disorder (a pervasive pattern of maladaptive traits and behaviours beginning in early adult life, leading to substantial personal distress or social dysfunction, or both, and disruption to others) captured its core features, the description of specific types of personality disorder always had a strong subjective element. Operational criteria were used to define ideal or prototypical manifestations that could be deemed as exemplars of each disorder. Two things were wrong with this approach. First, the approach assumed that personality disorders (disorders thought to persist over long periods) could be distinguished clearly from normal variation, cultural differences, and other mental disorders by this method, and second, the approach mistakenly assumed that the Schneiderian personality types were valid and homogeneous categories. The mistake was understandable, because people generally, and clinicians particularly, might seek to categorise people they find to be difficult into entities, in the hope of predicting their future behaviour.

#### Classification and diagnosis of personality disorder

Because of the complex issues regarding the classification of personality disorder, its assessment seems to be one of the most difficult tasks in clinical practice. The diagnosis has to be made of a disorder that is lifelong or at least of many years' duration, in which a main element of the disorder affects interaction with others, and in which no biological or other independent markers exist to assist in its identification. Another difficulty is that many people with personality disorders do not recognise that they, and not others, are defective in their interpersonal relations. Generally, one consequence of this difficulty in diagnosis is the tendency for classification to become recondite and complex over time, so that its nosology becomes a subject only for a specialist few. In the specialty of personality disorder, this complexity has also created division even within its own ranks of experts, with one group arguing for clearly defined disorders (the so-called categorical system of classification) and another putting forward a dimensional classification based on trait-based personality theory, well established in psychology,<sup>10</sup> in which the pathological effects show themselves increasingly as one moves across the severity of the dimension, so that severe personality disorder seems to be manifest as multiple pathologies.<sup>11</sup> Hence unsurprisingly, as of August, 2014, more than 5000 reports have been published on the subject of classification in personality disorder, many concerned with multiple pathology, and the specialty has struggled for many years to reach agreement.

The two main classifications in psychiatry, DSM and ICD, have both attempted to acknowledge the need for a dimensional system and recognition of the potential for change in personality status, but have done this in very different ways. The DSM-5 Personality and Personality Disorder Work Group's proposal for the revision of the DSM-IV's classification of personality disorders was a hybrid model, which included the assessment of severity by assessment of impairments in personality functioning, a reduction from ten to six categories of disorder, and an assessment of five broad areas of pathological personality trait domains, composed of 25 trait facets. This was a bold change from the DSM-IV classification, which consisted of a categorical classification only. Impairment in personality functioning included deficiencies in self-functioning (self-awareness and self-directedness, as mentioned previously in Prichard's original comment<sup>3</sup>) or interpersonal functioning (empathy, intimacy, and mutual understanding), or both; essential elements in the capacity of an individual to form good relationships. The model also provided a framework for assessment of self and interpersonal pathological effects, and a new instrument, the Personality Inventory for DSM-5, to operationalise the DSM-5 trait model in both self-report and informant versions.<sup>12</sup>

The proposed model was based on empirical evidence that is quite at variance with the categorical system of DSM-IV and previous ICD classifications. The essentials of this hybrid model are sound and acknowledge both the severity of disorder (the best predictor of outcome) and the form or style of personality pathology, which are represented as personality traits that lie on dimensions ranging from normality to frank disorder.<sup>13</sup> However, the forced creation of specific categories from a dimensional classification system was unwieldy, and the American Psychiatric Association Board of Trustees felt that the model was not yet ready for general use.

As a result this alternative model was placed in a separate section of the DSM-5 entitled Emerging Measures and Models (Section III). The DSM-IV classification of personality disorders then, by default, was retained in the present DSM-5 classification, with modifications only to the text, not the criteria. This failure to move the science forward is regrettable. The DSM-IV classification (panel 1) identified ten categories of purportedly discrete personality disorders linked to the core definition,<sup>9</sup> a descriptive system that has overwhelmingly been shown to describe overlapping entities that blend into each other with no clear boundaries, and which only persist in practice through habitual usage. These categories are divided into three clusters.<sup>14</sup> Cluster A, including the paranoid, schizoid, and schizotypal categories (Galen's phlegmatic group, with additional links to thought disorder), Cluster B, including the antisocial, borderline, histrionic, and narcissistic categories (Galen's choleric group), and Cluster C, including the avoidant, dependent, and

	Schneider <sup>1</sup>	DSM-IV-TR <sup>9</sup>	ICD-6 <sup>5</sup>	ICD-10 <sup>8</sup>
Choleric	Emotionally unstable	Borderline	Emotional instability	Emotionally unstable, including borderline and impulsive
Choleric	Explosive	Antisocial	Antisocial	Dissocial
Choleric	Self-seeking	Narcissistic	..	..
Choleric	..	Histrionic	Immature	Histrionic
Melancholic	Depressive	Depressive*	Cyclothymic†	..
Melancholic	Asthenic	Avoidant	Passive dependency	Anxious (avoidant)
Melancholic	Weak-willed	Dependent	Inadequate	Dependent
Phlegmatic	Affectless	Schizoid	Schizoid	Schizoid
Phlegmatic	..	Schizotypal	Asocial	..
Not classified elsewhere	Insecure sensitive	Paranoid	Paranoid	Paranoid
Not classified elsewhere	Insecure anankastic	Obsessive-compulsive	Anankastic	Anankastic
Not classified elsewhere	Fanatical	..	..	..
Sanguine	Hyperthymic	..	..	..

DSM=Diagnostic and Statistical Manual of Mental Disorders. ICD=International Classification of Diseases. \*A diagnosis listed in earlier versions of DSM and recommended for further study in DSM-IV. †This category appeared in later revisions of ICD and DSM but was subsequently recoded under affective (mood) disorders.

**Table: Links between the classifications of Galen<sup>2</sup> with Schneider's and the more modern DSM and ICD classifications**

obsessive-compulsive categories (with affinities to Galen's melancholic group [table]). These cluster designations are not well substantiated empirically either, but are frequently used, partly because the comorbidity of individual categories make classification difficult and partly because of the simplicity for researchers dealing with only three clusters rather than ten disorders.

The ICD-10 categories are very similar to the DSM-IV ones (panel 1). The main differences are that the schizotypal category is regarded as a part of the spectrum of schizophrenia<sup>8</sup> and not classified with the personality disorders, narcissistic personality disorder is not present in the classification, and borderline and impulsive personality disorders are subcategories of emotionally unstable personality disorder.

### Normal personality variation

Most people working in the specialty now accept, almost without demur, that personality abnormality is best viewed as a set of dimensional constructs, as the DSM-5 revision attempted to encompass.<sup>15,16</sup> Widiger and Simonsen<sup>17</sup> examined the components of personality disorder in dimensional terms, on the basis of the broad personality disorder literature, and concluded that four dimensions, emotional dysregulation (*vs* stability), extraversion (*vs* introversion), antagonism (*vs* compliance), and constraint (*vs* impulsivity), cover the range of personality disorder; this is one area that has consistent agreement. Similar dimensions of personality have been noted in the general population, which lends support to the argument that these components of normal and abnormal personality are consistent features.<sup>18</sup>

### Prevalence of personality disorder

The epidemiology of personality disorder is poorly described compared with that of other mental disorders; a natural result of accurate personality assessments being more difficult to obtain for personality disorders than other mental disorders in national surveys. Cross-sectional, community-based surveys<sup>19–21</sup> undertaken in North America and western Europe report a point prevalence of personality disorder of between 4% and 15%. At the time of writing, only one study<sup>22</sup> has examined the prevalence of personality disorder internationally. The study was done in seven countries spread between five continents and reported a point prevalence of 6.1%, with lowest prevalences in Europe and highest prevalences in North and South America.<sup>22</sup> In the general community, personality disorder is at least as common, if not more, in men than in women,<sup>21</sup> and at least as common in people from ethnic minorities<sup>23</sup> as in majority populations. Differences in prevalence across studies could be attributable to sampling methods, study instruments, and poor diagnostic reliability, especially when based on one interview.<sup>24</sup> Study setting also has an effect, with higher prevalence recorded in urban areas than in rural ones.<sup>20</sup>

The prevalence of personality disorder is higher in people in contact with health-care services than in those not in contact, with about a quarter of patients in primary care and 50% in psychiatric outpatient settings meeting criteria for the disorder.<sup>25,26</sup> The highest prevalence of personality disorder is noted in people in contact with the criminal justice system, with two-thirds of prisoners having personality disorder.<sup>27</sup> By contrast with community settings, the prevalence of personality disorder in clinical services is higher in women than in men, probably a result of higher rates of help seeking in women than in men for those who present with repeated self-harming behaviour.

### Implications of personality disorder

People with personality disorder have far higher morbidity and mortality than do those without.<sup>28,29</sup> Although similar international data are not available, data from the UK suggest that life expectancy at birth is shorter by 19 years for women and 18 years for men than it is in the general population. Increased mortality can be explained partly by increased incidence of suicide and homicide in people with personality disorder.<sup>30</sup> However, increased mortality from cardiovascular and respiratory diseases suggest that other factors are also important. Difficulties in interpersonal relationships, which lie at the heart of personality disorder, might have an effect on relationships with health-care professionals, resulting in misunderstandings, miscommunication, and poor quality care. Lifestyle factors are probably also important, with high prevalence of smoking, alcohol, and drug misuse in people with personality disorders.<sup>31</sup>

A reasonable question for practitioners to ask is why they should take special notice of personality disorder in their practice, when the disorder is difficult to assess and is associated with so many other disorders that seem to be of higher priority to both patient and therapist. The main reason is that if personality status is ignored then inappropriate treatment might be given, apparently acute disorders could become chronic, and important risks could go unrecognised. Thus, a patient with heart disease who has a personality disorder with anxiety proneness as the main feature, might achieve complete medical remission after insertion of a stent; however, if this outcome is insufficiently explained to the patient, a danger exists that the patient could become so preoccupied over possible recurrence that they become totally crippled by fear of recurrence. The cost of personality disorders is also very great, especially for those with severe personality disorder, who often pose a risk to themselves and the public, and need frequent institutional care.<sup>32,33</sup>

### Assessment of personality disorder

In clinical practice, personality disorder is seldom diagnosed and accounts for less than 5% of all hospital admissions. Those who are diagnosed are almost always assigned the categories of borderline, antisocial, or not otherwise specified. These factors expose the complex nature of the diagnostic system, which results in few clinicians taking the trouble to assess personality status in all its components. But these factors also probably show stereotyped thinking, wherein those who repeatedly self-harm are automatically given a diagnosis of borderline personality disorder and those who are aggressive and have a history of offending behaviour are given a diagnosis of antisocial personality disorder, irrespective of the complexity of their issues. What is clear is that practitioners identify the disturbances associated with personality disorder quite accurately, but only record the diagnosis in a few cases.<sup>34</sup>

One of the great difficulties in the assessment of personality disorder is the absence of quick and reliable instruments. Several reasons for this scarcity exist, including, in the DSM-IV, the complexity of reviewing 79, often highly inferential, criteria in ten disorders (plus the 15 criteria of conduct disorder), and the difficulty in separating personality from mental state assessment at a single timepoint. Furthermore, most rating instruments focus on the assessment of many facets of specific personality types rather than the core features of personality disorder. A review of assessment instruments<sup>35</sup> identified 23 “validated” questionnaires and interview schedules for the assessment of personality disorder, with many more if measures for types of individual personality disorder are included. Semi-structured interviews typically take from 1 h to 2 h to do,<sup>36</sup> and even self-rating instruments can take a long time to complete; for example, the Personality Inventory

for DSM-5<sup>12</sup> has 220 items, and other widely used instruments vary from 85 to 390 items.<sup>35,36</sup> So although self-report questionnaires are quicker and need less clinician time than structured interviews, they are still deemed too long to be used in general clinical settings and their valid use still depends on clinical knowledge and judgment. In the past two decades attempts have been made to develop interviews and questionnaires, which are reduced in length and screen for the presence of probable personality disorder. The simplest and best known are the Standardised Assessment of Personality—Abbreviated Scale<sup>37</sup> and the Iowa Personality Disorder Screen,<sup>38</sup> but, similarly to all screening questionnaires, these tend to overdiagnose.<sup>36</sup>

Clinicians also have trouble interpreting and assessing comorbidity within personality disorders because substantial comorbidity usually suggests increased dysfunction and interpersonal difficulties, but the option of listing several diagnoses is rarely used.<sup>11,32</sup> Informant and patient reports often have discrepancies, which complicate interpretation.<sup>39,40</sup> A simplified diagnostic system could incite the development of new instruments that can be used in both primary care and specialised mental health settings. Instrument availability at both settings is important because patients with personality disorder attend primary care more frequently than any other service and have much higher rates of consultation in all settings than the general population.<sup>25,41,42</sup>

### Difficulty of comorbidity

A prominent concern related to the present classification of types of personality disorder is comorbidity. For the classification of comorbidity of disease, diagnosis should ideally show the presence of two or more independent diseases existing in the same person,<sup>43</sup> but when patients are identified as having between three and ten personality disorders (as is often the case in research assessments), that these are not separate disorders is clear to everyone.<sup>44</sup> Comorbidity also extends to other mental disorders. Personality disorders, especially when more severe, are very often associated with one or more other mental health disorders.<sup>34,45–49</sup> At times, these other disorders (eg, recurrent depressive disorder and generalised anxiety disorder) can be more prominent than the personality disturbance and dominate the clinical picture.

However, in these situations, to regard the personality disturbance as a secondary and unimportant component of the clinical picture would be a mistake. Personality disorder could be one of the strongest explanations for recurrence in common mental disorders.<sup>50</sup> Developmental data suggest that a single general factor accounts for almost all mental pathology,<sup>51</sup> but good personality data are not available for this population. Personality function is quite possibly the, or at least one, important general factor because personality is set early in life. Personality status has been shown to be a strong

predictor of poor outcome,<sup>52–54</sup> especially for psychological treatments.<sup>55,56</sup> Personality disturbance also quite often contributes to difficulties in treatment of other mental disorders. However, personality disorder is often forgotten as a target of treatment, particularly since most people who have the disorder present requesting relief from their clinical symptoms and not requesting treatment for their personality difficulties.<sup>57,58</sup> This was one of the reasons that the 1980 edition of the US classification, DSM-III, introduced a second axis of classification devoted to personality function only.<sup>7,9</sup> But in DSM-5 the second axis has been abandoned because in practice, clinicians were quite clearly not using the multiaxial classification, and no fundamental distinction exists between personality disorder and other mental disorders. Some practitioners are concerned that with the loss of the second axis, the diagnosis of personality disorder might be forgotten, although notably ICD has never been multiaxial and has included a classification of personality disorders since the first edition published by WHO in 1948.<sup>5</sup> Irrespective of whether they are represented on a single or multiple axes, strong arguments exist that personality assessment should be part of every psychiatric assessment.

### Changes in ICD-11

A radical change in the classification of personality disorder has been proposed for ICD-11. At first sight the proposed ICD-11 classification seems very different from the model originally proposed for DSM-5 and is now included as an alternative model, but the classification is conceptually compatible in many ways and differs mainly in that it emphasises the severity of personality disturbance and does not attempt to preserve traditional personality disorder categories. The proposed ICD-11 classification abolishes all type-specific categories of personality disorder apart from the main one, the presence of personality disorder itself. Because of the near universal recognition that personality dysfunction is best represented on a continuum or dimension, different degrees of severity are defined to show what point on the continuum best represents the person's personality functioning at the time of the assessment, including the recent past.<sup>59–62</sup> Although personality disorder is widely assumed to be a lifelong diagnosis, abundant evidence exists that the severity and form of the disorder fluctuates over time<sup>63–65</sup> depending on many factors. For the profession and the public to acknowledge the fluctuating nature of the disorder would be a major help in the de-stigmatisation of its diagnosis and alleviate the tendency to regard the disorder as a reason for non-intervention. The acknowledgment would also reassure the practitioner when making the diagnosis during adolescence, when the disorder is typically first apparent, because any diagnosis given could be seen as subject to change rather than as a lifelong label (see Newton-Howes and colleagues,<sup>66</sup> a paper in this series,

### Panel 2: Proposed category names and essential features of personality disorders in International Classification of Diseases (ICD)-11

#### Personality disorder

- A pervasive disturbance in how an individual experiences and thinks about the self, others, and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour.
- The maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships.
- The disturbance is manifest across a range of personal and social situations (ie, is not limited to specific relationships or situations).
- The disturbance is relatively stable over time and is of long duration. Most commonly, personality disorder has its first manifestations in childhood and is clearly evident in adolescence.

#### Late onset qualifier

- If the disturbance has its origin in adulthood, the qualifier for "late onset" may be added. The "late onset" qualifier should be used for cases in which, by history, there is no evidence of personality disorder or its early manifestations prior to age 25 years.

#### Mild personality disorder

There are notable problems in many interpersonal relationships and the performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out.

- Examples: Able to maintain, and has some interest in maintaining, a few friends. Intermittent or frequent, minor conflicts with peers, co-workers and/or supervisors or, alternatively, exhibits withdrawn, isolative behaviour but, in either case, is capable of sustaining and willing to sustain employment, given appropriate employment opportunities. Has meaningful relationships with some family members but typically avoids or has conflict with others.

Mild personality disorder is typically not associated with substantial harm to self or others.

#### Moderate personality disorder

There are marked problems in most interpersonal relationships and in the performance of expected occupational and social roles across a wide range of situations that are sufficiently extensive that most are compromised to some degree.

- Examples: Able to maintain very few friends or has little interest in maintaining friendships. Regular conflict with

peers, coworkers and/or supervisors or marked withdrawal and isolative behaviour that interferes with the ability to function constructively at work or with others. May exhibit little interest in and/or efforts toward sustained employment when appropriate employment opportunities are available. May have a history of frequently changing employment as a result. Has conflicted, or a marked absence of, relationships with many family members.

Moderate personality disorder often is associated with a past history and future expectation of harm to self or others, but not to a degree that causes long-term damage or has endangered life.

- Examples: Recurrent suicidal ideation or suicide attempts without clear expectation of death, recurrent episodes of self-harm without clear lethality, recurrent hostile and confrontational behaviour, or occasional violent episodes that involve only minor destruction of property (eg, breaking things) or interpersonal aggression such as pushing, shoving, or slapping that is not sufficient to cause lasting injury to others.

#### Severe personality disorder

There are severe problems in interpersonal functioning affecting all areas of life. The individual's general social dysfunction is profound and the ability and/or willingness to perform expected occupational and social roles is absent or severely compromised.

- Examples: Has no friends but may have some associates. Unwilling or unable to sustain regular work due to lack of interest or effort, interpersonal difficulties, or inappropriate behaviour (eg, irresponsibility, fits of temper, insubordination), even when appropriate employment opportunities are available. Conflict with or withdrawal from peers and coworkers. Family relationships are absent (despite having living relatives) or marred by significant conflict.

Severe personality disorder usually is associated with a past history and future expectation of severe harm to self or others that has caused long-term damage or has endangered life.

- Examples: Suicide attempts with a clear expectation of death, episodes of self-harm that permanently injure, disfigure or deform the individual, episodes of serious property destruction such as burning down someone's house in anger, or episodes of violence sufficient to cause lasting injury to others.

for further discussion of this topic). In the proposed ICD-11 system, the first step in the diagnosis of personality disorder is to establish whether the patient satisfies the general definition of personality disorder (panel 2). This definition does not greatly differ from previous diagnoses of personality disorder, but because

categorical diagnosis no longer exists in the classification, the practitioner has no choice but to assess personality disorder itself rather than being distracted by categories.

The second step is to identify the severity of personality disturbance. For ICD-11, a subthreshold degree of disorder called personality difficulty has been

proposed. Personality difficulty is not deemed to be a disorder, but instead would be placed in the part of the classification that relates to non-disease entities that constitute factors influencing health status and encounters with health services (Z codes in ICD-10). The category of personality difficulty can be assigned if it is relevant to the provision of health services, and refers to a disturbance that might be manifest only intermittently, in specific circumstances (eg, when under stress), or in particular environmental settings. Panel 2 shows the proposed ICD-11 definitions for personality disorder at different degrees of severity. One of the advantages of the new ICD-11 classification is that it removes the confusing comorbidity of different categories of personality disorder. Consequently, the proportion of patients with unspecified personality disorder (a very common, but unsatisfactory diagnosis in the present diagnostic systems)<sup>67,68</sup> should be substantially reduced.

The degree of severity can be qualified by a description of domain traits. These traits show which of the main facets of personality are most prominent in the individual. An important point to recognise is that these are not categories, but rather represent a set of dimensions that correspond to the underlying structure of personality dysfunction. The domain traits proposed in ICD-11 have been distilled from studies of psychiatric patients and in populations of participants both with or without personality disorders and will be subject to field testing.<sup>69-72</sup> However, four of the traits are essentially the same as four of those identified by the DSM-5 Personality and Personality Disorders Work Group<sup>12</sup> but with slightly different nomenclature (negative affective, dissocial, disinhibited, and detached domain traits; panel 3).<sup>12</sup> The traits of the ICD-11 model differ from those of the DSM-5 alternative model in that they include an anankastic domain and not a psychoticism domain. These four domains are not coincidentally very similar to four of the so-called Big Five traits identified in normal personality variation—neuroticism, low agreeableness, low conscientiousness, and low extraversion<sup>73</sup>—and represent the higher order domains that subsume the facets of normal personality variation.<sup>12</sup> The domain traits are not inherently pathological, but rather represent a profile of underlying personality structure. They apply equally to individuals without any personality disorder and to those with severe disorder, but in personality disorder they show where the focus of the disorder is manifest. In severe disorder, several domain traits are likely to be associated with the disorder.<sup>42</sup>

The ICD-11 classification also allows the practitioner the option of rapid assessment of personality. Although personality dysfunction can rightly be defended as multitudinously variable, it generally needs abbreviated diagnosis in practice. As such, a clinician should be able first to identify the presence or absence of personality

### Panel 3: Domain traits in the proposed International Classification of Diseases (ICD)-11 classification of personality disorders

#### Negative affective features

The negative affectivity trait domain is characterised primarily by the tendency to manifest a broad range of distressing emotions including anxiety, anger, self-loathing, irritability, vulnerability, depression, and other negative emotional states, often in response to even relatively minor actual or perceived stressors.

#### Dissocial features

The core of the dissocial trait domain is disregard for social obligations and conventions and the rights and feelings of others. Traits in this domain include callousness, lack of empathy, hostility and aggression, ruthlessness, and inability or unwillingness to maintain prosocial behaviour, often manifested in an overly positive view of the self, entitlement, and a tendency to be manipulative and exploitative of others.

#### Features of disinhibition

The disinhibition trait domain is characterised by a persistent tendency to act impulsively in response to immediate internal or environmental stimuli without consideration of longer term consequences. Traits in this domain include irresponsibility, impulsivity without regard for risks or consequences, distractibility, and recklessness.

#### Anankastic features

The core of the anankastic trait domain is a narrow focus on the control and regulation of one's own and others' behaviour to ensure that things conform to the individual's particularistic ideal. Traits in this domain include perfectionism, perseveration, emotional and behavioural constraint, stubbornness, deliberativeness, orderliness, and concern with following rules and meeting obligations.

#### Features of detachment

The core of the detachment trait domain is emotional and interpersonal distance, manifested in marked social withdrawal and/or indifference to people, isolation with very few or no attachment figures, including avoidance of not only intimate relationships but also close friendships. Traits in the detachment domain include aloofness or coldness in relation to other people, reserve, passivity and lack of assertiveness, and reduced experience and expression of emotion, especially positive emotions, to the point of a diminished capacity to experience pleasure.

disorder, then its degree of severity, and, if relevant, its domain trait features. Thus, the domain trait features might be expected to be used mainly in specialist practice and not in general care or in low-resource settings. Unlike the DSM-5 proposal, the ICD-11 classification contains no assessment of self-pathology, mainly because an accurate assessment of self-pathology of personality is highly complex and beyond the expectations of most practitioners. This has been a point of criticism of the ICD-11 proposal and clearly is an important subject for further study.

ICD has never included an age restriction for diagnosis of personality disorder, so in theory the disorder could be diagnosed in childhood. Although some maintain strongly that personality disorder can be identified in adolescence,<sup>74</sup> many are concerned about the potential dangers of the patient being affixed with a long-term diagnosis at an early age, even though good evidence exists that those diagnosed as having

personality disorder in adolescence are more likely than others to have not only a personality disorder but also other disorders in adult life.<sup>75,76</sup> ICD-11 will include the instruction that the diagnosis can be applied, but only with caution, to young people. However, in view of the difficulty for practitioners to distinguish interpersonal difficulties from normal adolescent development and the mutability of personality pathology over time, the non-disorder category of personality difficulty could be, at least initially, the most appropriate way to note problems in this area.<sup>34</sup>

The medical community is also increasingly aware that personality problems can arise later in life than late adolescence and might even arise in old age. A qualifier for late-onset personality disorder—arising after the age of 25 years and persisting for at least 2 years—could be used in such cases. This addition is necessary because many people with personality problems might only show the features of disorder when other factors that have protected them (eg, family support and occupational status) have been withdrawn.<sup>40,77</sup> This addition might increase the prevalence of personality disorder in ICD-11 compared with ICD-10.<sup>78</sup>

WHO will field test the proposals for the ICD-11 classification of personality disorders in the coming months and will access a wide range of information regarding their clinical usefulness and applicability across countries, languages, and disciplines, using both internet-based and clinic-based methods. The diagnostic guidance described in this Series paper will be modified on the basis of the results of the field testing. Internet-based field testing in many languages will be done through WHO's Global Clinical Practice Network. Clinicians who are interested in participating are invited to register at the multilingual website.

The other papers<sup>66,79</sup> in this Series will examine the many treatments that are available for personality disorder and their efficacy, and also draw attention to the wide variation in personality status that can occur throughout the lifespan. This variation will show that the old idea of personality disorder as a permanent label, which puts individuals with it beyond the sphere of concern of conventional psychiatric care, could not be further from the truth. The message these papers convey also shows that personality disturbance should not be deemed to be an esoteric specialty, walled off from the rest of medicine, but should be embraced by all clinicians, if only to a basic degree. The importance of personality disorders has been under recognised and ignored for far too long.

#### Contributors

PT wrote the first draft, which was added to by GMR and MJC. All three authors contributed to revisions of the paper.

#### Declaration of interests

PT and MJC are members of the WHO International Classification of Diseases, Revision 11, Working Group on the Classification of Personality Disorders, and GMR is a member of the Secretariat, Department of Mental Health and Substance Abuse, WHO.

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