Ministry of Defence

Synopsis of Causation

Personality Disorder

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Disclaimer

This synopsis has been completed by medical practitioners. It is based on a literature search at the standard of a textbook of medicine and generalist review articles. It is not intended to be a meta-analysis of the literature on the condition specified.

Every effort has been taken to ensure that the information contained in the synopsis is accurate and consistent with current knowledge and practice and to do this the synopsis has been subject to an external validation process by consultants in a relevant specialty nominated by the Royal Society of Medicine.

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1. Definition

1.1. **Overview.** The classification of personality and the diagnosis of personality disorders has been a contentious subject for many years. Whereas most mental disorders represent an alteration in the normal functioning of an individual (an abnormal "state"), personality disorders represent exaggerations of "traits" that are frequently present in the normal population. However, despite the difficulties that have arisen in classification, specific patterns of personality dysfunction appear to occur among certain people.

1.1.1. A significant minority of patients with mental health problems will be found to have comorbid personality disorder. Indeed, it can often be difficult to differentiate someone's premorbid personality traits from the effects of illness. For example, a depressed patient may seem morose, humourless, withdrawn, and irritable. Enduring mental illness from the late teens (e.g. psychotic illnesses or mood disorders) has the potential to affect an individual's personal and social development, frequently causing diagnostic difficulties. As a general rule, abnormal mental states represent a change from normal, but personality disorders are enduring and consistent patterns.

1.1.2. The diagnosis of personality disorder is fraught with procedural and classification difficulties.[1] One criticism of the concept as a whole has been that the collections of symptoms and behaviours thus described do not appear to fit easily into a disease framework. Certainly, there is no consistent model which explains the variety of supposed disorders of personality. From a practical point of view, the standard methods of assessment (such as structured interview and self-report questionnaire) have low consistency.[2] Furthermore, it is a frequent observation that the diagnosis of personality disorder is often made pejoratively.[3]

1.2. **Normal personality development**

1.2.1 **Psychodynamic theories.** Sigmund Freud believed that the personality has three main components: the *ego*, the *id*, and the *superego*. The id is totally unconscious and is made up of the basic inborn drives, and the sexual and aggressive impulses. The superego is the moral structure of personality and consists of conscience and ideals which are derived through the internalisation of parental or other authority figures. Freud believed that the superego is involved in the experience of guilt, perfectionism, indecision, and preoccupation with right or wrong. He argued that it was responsible for depression, obsessional disorders and sexual problems. The ego is the conscious part of the whole and uses reason to maintain a sense of reality. It is responsible for the control and regulation of instinctual drives.

In essence, Freud thought that our early childhood experiences were too threatening to be dealt with consciously and that via a variety of defence mechanisms (the main one being repression) we can reduce the anxiety of this conflict. Freud's theories have been developed and modified over the last hundred years or so by a variety of analysts but key concepts such as conscious and unconscious, and instinctual drives have persisted in common usage.

1.2.2 **Trait theories.** All trait theories make 3 assumptions. Firstly, traits are stable across time and, therefore, predictable. Secondly, traits are stable across different situations and can explain why people act in predictable ways in different settings. Finally, that individuals differ in how much of a particular trait they possess, resulting in an infinite variety of unique personalities.

One of the first prominent trait theories was developed by Raymond Cattell in 1965. He used factor analysis to calculate the degree to which various personality traits correlated with each other. He identified 16 "factors", such as shy versus bold and trusting versus suspicious, which he proposed are present in everyone.

Hans Eysenck used a dimensional approach to the categorisation of personality. He argued that personality can be described along 3 dimensions: psychoticism (consisting of cruelty, hostility, oddness); introversion-extraversion; and emotionality-stability, also known as neuroticism (characteristics such as worry, anxiety, and moodiness). His theories predicted that criminals tended to be emotional and extraverted, whilst anxious people score highly on emotionality and introversion.

One of the most robust trait theories is the "Big Five" model. Factor analysis has reduced the number of factors down to 5. The 5 factors are: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. Studies have demonstrated that these factors are present in a variety of different cultures from around the world.

1.2.3 **Social learning theories.** These view personality as the sum of all the cognitive and behavioural habits that individuals develop through learning from experience in the world. Social learning theorists argue that their approach provides a high degree of predictability of most people's behaviour in a variety of situations.

1.3. Common approaches to the diagnosis of personality disorder

1.3.1 The European and American classification of psychiatric disorders, i.e. the International Classification of Diseases 10 (ICD-10)[4] and the Diagnostic and Statistical Manual IV (DSM-IV)[5] respectively, differ slightly in their classification of personality disorders. Both systems are, however, non-aetiological classification systems; individual disorders are based on collections of symptoms rather than on distinct disease processes.

1.3.2 Personality disorder in both systems is characterised by the presence of abnormal traits which are maladaptive and which result in persistent dysfunction and/or personal distress in a number of areas, including social relationships, employment, self-image, and interpretation of the world.

1.3.3 ICD-10 identifies 9 main types of personality disorder, which are discussed later in more detail. The ICD-10 does not offer definitions of key terms or guidance on the extent to which a trait should be present in order to make a diagnosis. For example, it does not define "long duration" and does not indicate when "late childhood or adolescence" can be considered to start or end.

1.3.4 One of the key differences between ICD-10 and DSM-IV is the multi-axial approach of the US classification. Mental illness is classified on the first axis, whilst personality disorder, if present, is classified on the second axis. Axes III-V cover physical illness, social stressors, and level of functioning.

1.3.5 The DSM-IV organises personality disorders into one of three "clusters" which contain disorders that share similar groups of symptoms and personality dysfunction. Like the ICD-10, there are no definitions of key terms to assist in assigning the person to the appropriate cluster.

- Cluster A (odd/eccentric). This cluster contains paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder
- Cluster B (dramatic/emotional/impulsive). This group consists of antisocial personality disorder, borderline personality disorder, histrionic personality disorder, and narcissistic personality disorder
- Cluster C (anxious/fearful). This cluster contains avoidant personality disorder, dependent personality disorder, and obsessive-compulsive (anankastic) personality disorder

1.3.6 In terms of diagnostic criteria, for some personality disorders (histrionic, dissocial, and anxious/avoidant), ICD-10 has a slightly higher threshold, requiring more criteria to be met for diagnosis. It should also be noted that although most people with personality disorder will fit one specific type, some people with personality disorder have features of several different types.

1.4. ICD-10 criteria for personality disorder[4]

1.4.1 There is evidence that the individual's characteristic and enduring patterns of inner experience and behaviour as a whole deviate markedly from the culturally expected and accepted range. Such deviations must be manifest in more than one of the following areas:

- Cognition (i.e. ways of perceiving and interpreting things, people and events, forming attitudes, and images of self and others)
- Affectivity (range, intensity and appropriateness of emotional arousal and response)
- Control over impulses and gratification of needs
- Manner of relating to others and of handling interpersonal situations

1.4.2 The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations.

1.4.3 There is personal distress or adverse impact on the social environment, or both.

1.4.4 There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence.

1.4.5 The deviation cannot be explained as a manifestation or consequence of other adult mental disorders.

1.4.6 Organic brain disease, injury, or dysfunction must be excluded as the possible cause of the deviation.

1.5. **DSM-IV criteria for personality disorder**

1.5.1 An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in 2 (or more) of the following areas:

- Cognition (i.e. ways of perceiving and interpreting self, other people, and events)
- Affectivity (i.e. the range, intensity, lability, and appropriateness of emotional response)
- Interpersonal functioning
- Impulse control

1.5.2 The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

1.5.3 The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

1.5.4 The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

1.5.5 The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

1.5.6 The enduring pattern is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. head trauma).

2. Clinical Features

2.1. For each of the disorders below, the cardinal features required for diagnosis using ICD-10 are italicised under the heading "clinical features". Typically, 3-4 of these features should be present along with the core features of personality disorder described above.

2.2. **General**

2.2.1 **Epidemiology.** Most studies show relatively consistent rates of personality disorders within the general population and among specific groups of individuals. Among community samples the prevalence rate of DSM-IV disorders is approximately 9%, with lower rates (5.1%) for ICD-10 disorders.[6] The prevalence of all personality disorders is raised in psychiatric patients and, among community mental health teams, the rates of comorbid personality disorder in patients with a psychotic illness may be as high as 92%.[7]

2.3 **Paranoid personality disorder**

2.3.1 **Epidemiology.** 0.7% of the general population has this disorder which is found in 4 times as many men than women.[8]

2.3.2 **Clinical features** (4 should be present). People with paranoid personality disorder tend to be overly *suspicious*, and misconstrue the neutral intentions of others as being hostile or threatening. They are *mistrustful*, interpreting events as being conspiratorial. They are *sensitive* to setbacks, and have a *tendency to bear grudges*. They are typically *argumentative* and their sense of personal rights is out of keeping with the situation. Their relationships are characterised by *jealousy*, repeatedly doubting the sexual fidelity of their partner. Most patients are *self-centred*, with a self-referential and self-important outlook.

2.4 **Schizoid personality disorder**

2.4.1 **Epidemiology.** Approximately 1% of the UK population has schizoid personality disorder.[8] It is more common in men than women.

2.4.2 **Clinical features** (4 should be present). These individuals are *humourless*, with few activities providing pleasure. They are seen by others as "loners", tending to be *emotionally cold*, with little expression of emotion. Indeed, they tend to be *detached* - having limited ability to express warmth, tenderness, or even anger towards other people. In social situations, they appear *indifferent* to praise or criticism. Their activities are *solitary* and they are *loveless*, showing minimal interest in having sexual relationships with other people. They have no desire for close friendships and most appear to be *friendless*. Many schizoid people are *introspective*, and preoccupied by fantasy. In keeping with their indifference to social relationships, they often appear to be *unconventional*, showing little sensitivity to social norms and conventions.

2.5 **Dissocial personality disorder**

2.5.1 **Epidemiology.** Dissocial personality disorder is much commoner in men than women with up to 3-5% of men in the general population having the disorder.[6]

Higher rates are found in younger adults, urban populations, the prison population, substance misuse programmes, and lower socio-economic groups.

2.5.2 **Clinical features** (3 should be present). The outdated name for people with this disorder was "psychopath". The disorder is characterised by a *callous* unconcern for other people's feelings. Individuals with antisocial PD tend to ignore social norms, behaviours, and rules. They are typically in trouble with the police. They have a *low tolerance to frustration* and will frequently resort to aggression and violence. Frequently presenting as being charming, they have no difficulty in establishing relationships, but have difficulty in maintaining them, resulting in *short relationships*. They display a *lack of guilt*, failing to respond to adverse experience such as punishment, and they tend to *blame others* for their behaviour.

2.6 Emotionally unstable personality disorder (Borderline personality disorder)

2.6.1 **Epidemiology.** This disorder is present in approximately 1% of the general population.[8] Three quarters of people with borderline personality disorder are women.

2.6.2 **Clinical features** (5 should be present). Individuals with borderline personality disorder tend to have unstable and *capricious* moods, combined with chronic *feelings of emptiness*. They have *poor self-image*, with longstanding disturbances of self-image, including sexual preference. They tend to have *relationship crises*, with a pattern of intense and unstable relationships. Most people with borderline personality disorder can be *unpredictable*, acting impulsively without thinking of the consequences. If others tend to criticise such impulsive acts, they can become *quarrelsome*. At times, their behaviour can be *explosive*, with an inability to control the outbursts of anger or violence. In the longer term, they are desultory – having difficulty in continuing courses of action which do not have immediate reward. Such individuals have a *fear of abandonment*, making excessive efforts to avoid being abandoned. *Self-harm* (either threats or acts) is common.

2.7 Histrionic personality disorder

2.7.1 **Epidemiology.** Histrionic personality disorder is estimated to be present in 2-3% of the general population. It is more common in women than men.

2.7.2 **Clinical features** (4 should be present). Individuals with histrionic personality disorder are characteristically *dramatic*, with theatrical or exaggerated displays of emotion. Their prevailing mood is typically *shallow and labile*, and they are *stimulus seeking* – constantly trying to be the centre of attention. They may appear to live in a fantasy world, often becoming bored with routine. Such people tend to be *suggestible*, easily influenced by other people or by the circumstances. Their behaviour may be flirtatious or *seductive* at times but they are emotionally shallow. Individuals are often *vain*, and overly concerned about their attractiveness.

2.8 Anankastic personality disorder

2.8.1 **Epidemiology.** About 2% of the general population has obsessive-compulsive personality disorder with twice as many men than women having this disorder.[8] Rates are higher in those with anxiety and depressive disorders.

2.8.2 **Clinical features** (4 should be present). Such individuals are excessively *cautious*, expressing doubt about most of their activities. They are obsessed by *orderliness*, and are preoccupied with rules, lists, order, and organisation. They are *conscientious*, but this conscientiousness is excessive. They are typically *perfectionist* in what they do, but such perfectionism interferes with the completion of tasks and activities. Indeed, their *preoccupation with productivity* excludes other pleasurable activities and social relationships. They can also be *pedantic* and *rigid*, appearing stubborn in their manner and beliefs. They will often adhere excessively to social conventions, and may be reluctant to allow others to do things their way. Such people find it difficult to relax and may appear to be 'workaholics'. Because of their stiffness and formality, they may have problems in the workplace or in interpersonal relationships.

2.9 Anxious (avoidant) personality disorder

2.9.1 **Epidemiology.** Among the general population, 0.5-1% of people has this disorder.

2.9.2 **Clinical features** (4 should be present). People with anxious personality disorder exhibit a high degree of *anxiety*, feeling tense and apprehensive in most situations. They are preoccupied with being criticised or rejected in social situations. Often they will *feel inferior*, unattractive, or socially inept. As a result, they will frequently *avoid social* or occupational situations which involve personal contact for fear of criticism or *fear of rejection*. They are often *afraid to trust* people, and will avoid social contact unless they are certain of being liked. Due to their anxiety and need for physical security, they tend to lead a *restricted lifestyle*. These people may also have features of dependent personality disorder and many will meet criteria for social phobia.

2.10 Dependent personality disorder

2.10.1 **Epidemiology.** The prevalence in the general population tends to be lower than other personality disorders, with rates typically being lower than 0.5%.

2.10.2 **Clinical features** (4 should be present). People with dependent personality disorder are *dependent on others for* making most of life's decisions. They *need reassurance* and cannot make decisions without excessive amounts of advice and reassurance from others. They will *subordinate* their own needs to those that they are dependent on, and will be very compliant with their wishes. They are *undemanding*, finding it difficult to make demands on the people that they depend on. They have *a fear of not coping*, and when left alone they feel *helpless* because they fear that they cannot look after themselves. Typically, they will have problems questioning authority, and ask others for guidance.

3. Aetiology

3.1. Introduction

3.1.1. The aetiology of personality disorder is largely unknown. Indeed, whilst certain associations have been described between specific life experiences and later personality disorder(s), the mechanism by which this influences behaviour is not known. Similarly, the development of most personality disorders is believed to have a genetic component, but the precise mechanism of interaction between a genetic predisposition and later experience is yet poorly understood.

3.1.2. Most theories of abnormal personality development reflect psychodynamic theories of the self. Such theories focus on early childhood experiences and how these affect the development of a person's relationships with the world and other people. Most psychodynamic theories relate to early life (typically childhood) and such theories predicate that the effects of adverse experience as a teenager will be very different to that of an infant. There is no evidence that adverse experience in an individual over the age of 16 can cause personality disorder by itself. Indeed, in most cases there is evidence of disturbance of functioning prior to this, and such a diagnosis would be extremely rare in someone with normal personality functioning prior to the late teens.

3.1.3. It should be noted that most personality disorders research is conducted on relatively small numbers of patients, and it is difficult to confidently extrapolate findings to all cases of personality disorder.

3.2. Paranoid personality disorder

3.2.1. Some have found that the incidence of schizophrenia-like personality disorders is higher in first-degree relatives of those with schizophrenia.[9] The nature of this link is not established. Others have proposed that deficits in childhood care might account for the development of paranoia and hostility in adulthood, but such ideas are largely theoretical and unsupported by evidence.

3.2.2. Other theories suggest that abnormalities of the dopaminergic system in the brain (which shows abnormalities in schizophrenia) may account for dysfunctional patterns of thinking which are reflected in distorted interpretations of the world.[10]

3.3. Schizoid personality disorder

3.3.1. The dopaminergic system in the brain is involved with behavioural adaptation to rewarding stimuli. Associations have been reported with polymorphisms of the dopamine D2 receptor and schizoid/avoidant behaviours,[11] suggesting that common abnormalities of dopamine function may contribute to disorders on the schizophrenic spectrum. Such findings have yet to be replicated by other genetic studies and remain associations only.

3.4. Dissocial personality disorder

3.4.1. The causes of this disorder, as other personality disorders, are likely to involve a complex interaction between genetic influences, developmental factors, and social behaviour.

3.4.2. Family studies would support a genetic component to antisocial behaviour, with twins sharing a greater number of antisocial characteristics.[12] This, together with similar findings from adoption studies, supports the view that genetic factors account for some degree of antisocial behaviour.[13,14]

3.4.3. Reduced central serotonergic activity has been associated with impulsive aggression in a subset of patients with personality disorder.[15] A common finding in other studies supports a relationship between violent suicide attempts and low metabolites of serotonin in the cerebrospinal fluid.[16] However, the evidence would not support the conclusion that serotonergic abnormalities underlie antisocial behaviour in all cases of dissocial personality disorder.

3.4.4. The evidence for structural and functional brain abnormality is weak. Reported findings include: frontal lobe hypoperfusion in some cases of antisocial behaviour;[17] reduced activity in the limbic system when processing emotional information in criminal psychopaths;[18] and reduced volume of the prefrontal cortex in antisocial personality disorder.[19] Neuroimaging studies tend to be small (typically 15-20 individuals) and such findings, however interesting, should not be seen as underpinning all cases of dissocial behaviour.

3.4.5. In terms of developmental factors, growing up with an alcoholic or psychopathic father is reported to be associated with adult antisocial behaviour.[20] Some studies have found further associations with a history of physical abuse[21] and low parental care with maternal overprotection.[22] However, such studies are small scale and such putative associations cannot be assumed to reflect common factors in causation.

3.5 Borderline personality disorder (BPD)

3.5.1 Over 85% of people with BPD will have experienced childhood trauma, either physical or sexual.[23,24] Psychodynamic theories posit that such trauma impacts on the development of the self, and it is probable that the earlier the abuse occurs the more damaging to the personality it tends to be.

3.5.2 Psychodynamic theories go on to develop the idea that early abuse or neglect affects the individual's ability to think about their own feelings, as well as those of others. A lack of sense of self has been proposed as the core pathology in BPD. In order to deal with childhood trauma, it is postulated that the individual resorts to "defence mechanisms" which often include dissociation (separation of cognitive and emotional functions) and "splitting" (conflicting yet simultaneous emotions/thoughts), the latter of which is frequently encountered in patient care.

3.6 Histrionic personality disorder

3.6.1 Some researchers have suggested that a similar core pathology underlies histrionic personality disorder in women and dissocial personality disorder in

men,[25] but empirical evidence for this is lacking. Indeed, there is little research into the aetiology of histrionic personality disorder but as with other personality disorders, it is assumed to have developmental, social, and genetic contributory factors.

3.6.2 Individuals with histrionic or antisocial personality disorders will often share common features in terms of a history of childhood abuse, and lack of emotional care.

3.7 Anankastic personality disorder

3.7.1 Twin studies suggest a degree of heritability to obsessive-compulsive traits.[26,27] Many authors argue for the existence of an obsessive-compulsive spectrum, which also includes other disorders such as Tourette's syndrome and body dysmorphic disorder.[28,29] However, only 6% of patients with obsessive-compulsive disorder have obsessive-compulsive personality disorder,[30] and the relationship between the two is not clear.

3.8 Anxious (avoidant) personality disorder

3.8.1 Since the core feature of this disorder is avoidance of social situations, it is thought that such individuals may be on a spectrum that includes anxiety disorders such as social phobia.[31] As with most personality disorders, a degree of inheritance of biological vulnerability is assumed and those with reduced self-esteem from overly-critical parenting tend to be socially avoidant, which will perpetuate the problem throughout schooling. Little is otherwise known about the causes of this personality disorder.

3.9 Dependent personality disorder

3.9.1 Most theories about the aetiology of this disorder focus on psychodynamic theories of personality development. For example, Sigmund Freud believed that dependent personality was due to fixation on the oral phase of psychosexual development. However, there is little empirical evidence to support such theories and very little is known about the aetiology of this disorder.

3.10 Relationship between military service and personality disorders

3.10.1 Due to the way that personality disorder is defined (i.e. evidence of enduring patterns of behaviour from late childhood or adolescence onwards), the strength of association between personality disorder and military service reduces with advancing age of military experience. A diagnosis of personality disorder is extremely unlikely in someone with no disturbance of function or social relationships during their second decade of life. There is no evidence to suggest that specific experiences associated with military service have any causal link with the development of personality disorder.

3.10.2 There is evidence that premorbid personality factors may act as vulnerability factors for the development of specific mental disorders. For example, Axelrod et al report that features of pre-war borderline personality disorder accounted for variability in post-combat symptoms of post-traumatic stress disorder (PTSD).[32] Other studies have identified that individuals with PTSD are more

likely to have personality dysfunction of a number of types: paranoid, borderline, and avoidant.[33,34] However, these studies cannot support the conclusion that PTSD or trauma causes the personality disorder, and the extent to which personality disorder predisposes to PTSD is largely unknown. Whilst the presence of personality disorder tends to be a risk factor for mental disorders such as depression[35] and drug misuse,[36] the nature and extent of this vulnerability is not yet understood.

3.10.3 In terms of antisocial behaviour, associations have been identified between combat exposure and adult antisocial behaviour. Within studies performed in Vietnam veterans, it has been suggested that trauma may perpetuate adult antisocial behaviour in some individuals.[37] These findings have not been replicated in larger studies, or within combat veterans from different theatres of conflict, so the strength of association is uncertain and conclusions cannot be drawn.

3.10.4 Among US veterans of the Persian Gulf War in 1991, lower rates of hospitalisation for personality disorder have been reported.[38] The study lacked detailed assessments of pre-combat mental health and a greater rate of outpatient treatment for personality disorders might account for such findings. It would be fallacious to conclude that combat exposure reduces prevalence rates of personality disorder or that individuals with personality disorder are somehow directed away from combat duties.

4. Treatment and Prognosis

4.1 General principles

4.1.1 By their nature, personality disorders tend to be lifelong patterns of malfunction and distress which are not readily amenable to treatment. In addition, people with personality disorder of any type are generally more vulnerable to other psychiatric disorders which, if present, should be treated. In some individuals, effects of personality disorder diminish with ageing, perhaps due to adoption of more effective coping behaviours. In addition, for those individuals who do experience improvements in functioning with treatment, the goal will often be one of managing to cope with, or adapt to, the distressing problems associated with the diagnosis.[40,41]

4.1.2 **Psychodynamic psychotherapy.** Only certain types of personality disorder may respond to "insight-oriented" treatments such as psychodynamic psychotherapy. Such disorders include anankastic, anxious (avoidant), and dependent types. Such treatment may require as long as 5 years to show any benefit. The number of studies is small, but psychodynamic psychotherapy appears to have reasonable effect sizes.[39]

4.1.3 Psychotherapy is generally not recommended for paranoid or dissocial personality disorders since the individual may resent the therapist, whom they may view as trying to control them.

4.1.4 **Cognitive behavioural therapy (CBT).** A CBT-based approach may be helpful for individuals with avoidant or dependent personality disorders.

4.2 Paranoid personality disorder

4.2.1 **Treatment.** Psychological approaches are unlikely to be fruitful for the reasons given above. If comorbid anxiety or depression is present, then anxiolytics or antidepressants may be useful. Low-dose antipsychotics might have a role if psychotic symptoms become evident.

4.2.2 **Outcome.** Paranoid individuals are likely to generate hostility and social anxiety in peers, which might contribute to continued paranoid interpretations of the world. Some people will undoubtedly develop frank delusional thinking in late adolescence together with hallucinations and thought disorder, and go on to develop schizophrenia. Others may harbour longstanding fixed paranoid interpretations without other psychotic symptoms and attract a diagnosis of delusional disorder.

4.3 Dissocial personality disorder

4.3.1 **Treatment.** There is some suggestion that group therapy is more effective than individual therapy but large, randomised trials have not been performed. Groups tend to be small, with insufficient numbers of therapists. Self-help groups may be beneficial for some. Traditionally, the therapeutic community has been a popular form of treatment but such resources are inevitably limited.

4.3.2 A variety of pharmacological treatments for impulsivity and aggressive behaviour have been suggested, although large, randomised controlled trials are lacking. Lithium has been shown to reduce aggression in prisoners,[42] and other drugs used to treat aggression include phenytoin, carbamazepine, propranolol and the antipsychotic drugs.[43,44]

4.3.3 **Outcome.** Antisocial behaviour is frequently a lifelong pattern, in most cases developing before the age of 15. Adolescent problem behaviour appears to be a predictor of adult antisocial behaviour,[45] although antisocial behaviour tends to decrease with increasing age. This may be due to maturation of the personality, or the presence of a supportive and compensatory relationship.

4.3 Borderline personality disorder (BPD)

4.4.1 **Treatment.** Dialectical behaviour therapy (DBT) is a novel treatment method which has been designed for the treatment of BPD. It is based on the belief that individuals with BPD have difficulties in self-regulation and interpersonal skills, and it assumes that these can be learnt in therapy. It incorporates a variety of techniques including individual therapy, group skills training, telephone contact, and therapist consultation. DBT has been shown (including in some randomised controlled trials) to reduce self-harming behaviour and reduce hospitalisation of those undergoing therapy.[46]

4.4.2 Psychoanalytic approaches have been the most commonly used treatment for some time, and have demonstrated effectiveness over 18 months.[47] It seems likely that for many people, a stable therapeutic relationship might be helpful in allowing a more functional psychological development.

4.4.3 A variety of pharmacological treatments have been trialled for the treatment of BPD. Olanzapine, an antipsychotic, has been found to improve the mood symptoms and behavioural disturbance associated with BPD, although the numbers involved were small.[49,50] SSRIs have also been used to treat the emotional instability and dysphoria of BPD.

4.4.4 **Outcome.** The long-term outcome of BPD may not be as pessimistic as many psychiatrists believe. Whilst 3-9% of patients will have committed suicide at 10-25 year follow-up, 50-60% will have shown a clinical recovery.[51]

4.5 Histrionic personality disorder

4.5.1 **Treatment.** Individuals with histrionic personality disorder will often present with depressive symptoms, and treatment with antidepressants and/or psychological approaches is necessary.

4.5.2 For the disorder itself, psychotherapy is probably the treatment of choice with the goals being the prevention of depressive episodes, and stability of mood.

4.5.3 **Outcome.** Like many of the personality disorders, histrionic personality disorder may become less problematic with advancing age, as the individual matures and learns more constructive coping behaviours. Many people with histrionic personality disorder will have depressive episodes, and self-harming behaviour is not uncommon.

4.6 **Anankastic personality disorder**

4.6.1 **Treatment.** Those individuals who experience a high degree of anxiety as a result of doubt and indecision may respond to trials of antidepressants with serotonergic activity. The SSRIs and clomipramine are the preferred drugs. Antidepressants should be considered where the individual has comorbid depressive disorder.

4.6.2 Psychological treatment focuses on the cognitions associated with perceived failure – a cognitive behavioural approach would be the intervention of choice.

4.6.3 **Outcome.** In most western societies conscientiousness and perfectionism are valued personality traits and individuals with this disorder may find occupational roles in which such traits offer an advantage. They may be able to sustain relationships in which their partner tends to be submissive.

4.6.4 Due to their rigidity, they often have difficulty in adjusting to changes in circumstances, and depressive episodes are not uncommon in later life.

5. Summary

5.1. Personality disorders are a heterogeneous group of diagnoses which are united by the impact that a particular set of personality traits has upon an individual's life. Prevalence rates for all personality disorders combined are approximately 10% in the general population but the rate increases among psychiatric inpatients and other populations.

5.2. The causes of each disorder are relatively poorly understood but, for a diagnosis to be made, the dysfunctional patterns of behaviour must be stable, present since late adolescence and not due to any other mental illness or disease. Personality disorders are likely to be caused by a combination of inherited vulnerability and early life experience. Whilst an individual may experience greater difficulties due to the disorder at times of stress, specific life events in adulthood are unlikely to have a role in the causation of the disorder.

5.3. Historically, it was believed that personality disorders would not respond well to treatment and that there was little to offer. However, there is some evidence that symptomatic improvements can be obtained from psychotherapy, although there is uncertainty as to which form of therapy is best and which group of patients will respond. Whatever the answer, for many individuals the improvements from treatment will be modest at best.

6. Related Synopses

Post-Traumatic Stress Disorder

Adjustment Disorder

Generalised Anxiety Disorder

Alcohol Dependence/Alcohol Abuse Syndrome

Bipolar Affective Disorder

Obsessive Compulsive Disorder

7. Glossary

aetiology	The study of the causes, e.g. of a disorder.
anankastic	Compulsive nature.
antipsychotic	A medication (or another measure) that is believed to be effective in the treatment of psychosis.
anxiolytic	Anxiety-reducing. The term is used to describe a class of drugs which includes the benzodiazepines.
body dysmorphic disorder	A condition in which the individual is preoccupied with a perceived physical defect. This preoccupation becomes consuming and results in significant impairment in the individual's life and social functioning, typically avoiding social contact. The individual may consult multiple doctors and surgeons, looking for surgical intervention.
clomipramine	A tricyclic antidepressant drug used to treat depression and obsessive-compulsive disorder (OCD).
comorbid	The presence of one or more disorders (or diseases) in addition to a primary disorder or disease.
cognition	The process of knowing and, more precisely, the process of being aware, knowing, thinking, learning and judging.
dopaminergic system	Relating to dopamine (a neurotransmitter).
dysphoria	Lowered mood, typically experienced as "unhappiness" but not of a severity which would be associated with depressive illness.
heterogeneous	Derived from a different source or species. Also called heterogenic.
hypoperfusion	Reduced perfusion, i.e. blood flow, and by inference, reduced activity.
neuroimaging	A range of methods, including magnetic resonance scanning (MRI), used to investigate and study the functioning of the central nervous system.
polymorphism	A variation in the DNA that is too common to be due merely to new mutation. A polymorphism must have a frequency of at least 1% in the population.

post-traumatic stress disorder (PTSD)	A common anxiety disorder that develops after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened.
psychodynamic psychotherapy	A type of psychotherapy that draws on psychoanalytic theory to help people understand the roots of emotional distress, often by exploring unconscious motives, needs, and defences.
schizophrenia	One of several brain diseases with symptoms that may include psychosis, disturbance of behaviour, social withdrawal and impairment of normal functioning, and abnormal emotional responses. It may also include catatonia.
serotonergic	Relating to serotonin (a neurotransmitter also known as 5-HT).
SSRI	Abbreviation for selective serotonin reuptake inhibitors, commonly prescribed drugs for treating depression, OCD and anxiety disorders.
Tourette syndrome	Gilles de la Tourette syndrome/Tourette Syndrome is a neurological disorder characterised by persistent motor and/or vocal tics. It usually presents in childhood.
trait	In genetics, a trait refers to any genetically determined characteristic. In personality, it refers to a distinguishing characteristic. There is insufficient evidence to conclude that specific personality traits are genetically determined.

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