

Assessment of personality disorder

ARTICLE

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SUMMARY

In 2003 the Department of Health, in conjunction with the National Institute for Mental Health in England, outlined the government's plan for the provision of mental health services for people with a diagnosis of personality disorder. This emphasised the need for practitioners to have skills in identifying, assessing and treating these disorders. It is important that personality disorders are properly assessed as they are common conditions that have a significant impact on an individual's functioning in all areas of life. Individuals with personality disorder are more vulnerable to other psychiatric disorders, and personality disorders can complicate recovery from severe mental illness. This article reviews the classification of personality disorder and some common assessment instruments. It also offers a structure for the assessment of personality disorder.

DECLARATION OF INTEREST

None.

Historically, health professions have not always agreed on how best to conceptualise, categorise and define personality disorders. Although there are still many divergent views, there has been an increased consensus following the publication of definitions of personality disorder in ICD-10 (World Health Organization 1992) and DSM-IV (American Psychiatric Association 1994). In 2003 the Department of Health, in conjunction with the National Institute for Mental Health in England, produced *Personality Disorder: No Longer a Diagnosis of Exclusion* (National Institute for Mental Health in England 2003). This document outlined the government's plan for the provision of mental health services (both general and forensic) for people with a diagnosis of personality disorder, and emphasised the importance of practitioners having skills in identifying and assessing personality disorder in order to appropriately treat a person's difficulties.

Prevalence and comorbidity of personality disorders

Personality disorders are common conditions (Coid 2006a) that, by definition, run a prolonged course and are often associated with poor outcome (Stone 1993; Skodol 2005) and increased mortality (Harris 1998). In a general population study of

British households, Coid et al (2006a) found a weighted prevalence of 4.4% for a diagnosis of any personality disorder. The weighted prevalence for each individual personality disorder varied between 0.06 and 1.9%, with obsessive-compulsive, avoidant, schizoid and borderline personality disorders being the most common. Dependent and schizotypal personality disorders were the least prevalent (the study failed to identify any cases of histrionic or narcissistic personality disorder, suggesting that these disorders are particularly rare in the general population). Comorbidity within personality disorders is common; thus, patients with personality disorder are likely to fulfil diagnostic criteria for more than one subtype of personality disorder. In Coid et al's (2006a) sample, 54% had only one personality disorder, 22% had two personality disorders, 11% had three personality disorders and 14% had between four and eight personality disorders.

In a non-clinical sample, all personality disorders, except schizotypal, were more prevalent in men than women (Coid 2006a); however, in clinical samples, women with borderline personality disorder may be more likely to seek treatment (Tyrer 2000). There is an increased prevalence of personality disorder in people who are unemployed, divorced or separated, living in urban areas and from lower socioeconomic groups (Coid 2006a). Antisocial personality disorder is common in criminal justice settings. In the UK prison population, the prevalence of antisocial personality disorder has been estimated to be 63% in male remand prisoners, 49% in male sentenced prisoners and 31% in female prisoners (Singleton 1998).

Personality disorder is also frequently comorbid with other mental illness. There are strong associations between cluster B personality disorders (antisocial, borderline, histrionic and narcissistic) and psychotic, affective and anxiety disorders. There is also a strong association between cluster C personality disorders (dependent, obsessive-compulsive and avoidant) and affective and anxiety disorders (Coid 2006a). Both psychiatric in- and out-patients have a high prevalence of personality disorder – estimated to be of the order of 50%. In-patients with substance misuse and eating disorders have a particularly high prevalence of personality disorder, thought to be in the region of 70% (Moran 2002).

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The presence of more than one personality disorder in an individual is likely to result in a worse outcome for co-occurring mental illness (Tyrer 2000; Newton-Howes 2006) and may also increase the risk of violence in psychotic illness (Moran 2003). It is important that where personality disorder occurs in conjunction with mental illness this is recognised, as it may require adaptation of either the treatment, or the way in which this is delivered (Tyrer 2003; Dowsett 2007).

Classification of personality disorder

The ICD-10 definition of personality disorder is:

a severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption [World Health Organization 1992: p. 202].

In DSM-IV it is defined as:

an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment [American Psychiatric Association 1994: p. 629].

Despite minor differences, these two definitions are broadly similar and share several components: the disorder must be problematic for either the

individual or others; it is pervasive across a number of situations; it is persistent across the lifespan; and it involves a disturbance of both behaviour and emotion. In DSM-IV the disorders can be grouped into three clusters: cluster A (the odd or eccentric disorders); cluster B (the dramatic disorders); and cluster C (the anxious or fearful disorders). There are nine categories of personality disorder in ICD-10 and ten in the DSM-IV (Table 1).

Dimensional and categorical approaches to personality disorder

Two broad approaches to the classification of personality disorder exist: the categorical and the dimensional.

Categorical classification is largely based on clinical psychiatry and uses clear operational criteria to define the behavioural elements of personality disorder, inferring that each personality disorder represents a qualitatively distinct clinical syndrome. This approach is used in both DSM-IV and ICD-10. Categorical classification has a number of fundamental problems. It focuses largely on the behavioural characteristics while ignoring the underlying psychopathology. As a number of different behavioural criteria can characterise a disorder, this system allows heterogeneity. Categorical systems have arbitrary cut-offs to

TABLE 1 ICD-10 and DSM-IV descriptions of personality disorders

Cluster	DSM-IV	ICD-10
A: Odd/eccentric	<p><i>Paranoid</i>: Interpretation of other's actions as deliberately demeaning or threatening</p> <p><i>Schizoid</i>: Indifference to social relationships and restricted range of emotional experiences and expression</p> <p><i>Schizotypal</i>: Deficit in interpersonal relatedness with peculiarities of ideation, odd beliefs and thinking, unusual appearance and behaviour</p>	<p><i>Paranoid</i>: Excessive sensitivity, preoccupation with conspiratorial explanations of events, persistent tendency to self-reference</p> <p><i>Schizoid</i>: Emotional coldness, detachment, lack of interest in others, eccentricity and introspective fantasy</p> <p>Categorised as a mental disorder (Schizotypal Disorder, F21) rather than a personality disorder</p>
B: Dramatic	<p><i>Antisocial</i>: Pervasive pattern of disregard for and violation of the rights of others</p> <p><i>Borderline</i>: Pervasive instability of mood, interpersonal relationships and self-image associated with marked impulsivity, fear of abandonment, identity disturbance and recurrent suicidal behaviour</p> <p>No direct equivalent</p> <p><i>Histrionic</i>: Excessive emotionality and attention-seeking, suggestibility and superficiality</p> <p><i>Narcissistic</i>: Pervasive grandiosity, lack of empathy, arrogance and requirement for excessive admiration</p>	<p><i>Dissocial</i>: Callous unconcern for others, irritability and aggression, and incapacity to make enduring relationships</p> <p><i>Emotionally unstable borderline type</i>: Impulsivity with uncertainty over self-image, liability to become involved in intense and unstable relationships, and recurrent threats of self-harm</p> <p><i>Emotionally unstable impulsive type</i>: Inability to control anger, to plan ahead or think before acts, with unpredictable mood and quarrelsome behaviour</p> <p><i>Histrionic</i>: Self-dramatisation, shallow mood, egocentricity and craving for excitement with persistent manipulative behaviour</p> <p>Not defined</p>
C: Anxious/fearful	<p><i>Avoidant</i>: Pervasive social discomfort, fear of negative evaluation and timidity, with feelings of inadequacy in social situations</p> <p><i>Dependent</i>: Persistent dependent and submissive behaviour</p> <p><i>Obsessive-compulsive</i>: Preoccupation with orderliness, perfectionism and inflexibility which leads to inefficiency</p>	<p><i>Anxious (avoidant)</i>: Persistent tension, self-consciousness, exaggeration of risks and dangers, hypersensitivity to rejection and restricted lifestyle because of insecurity</p> <p><i>Dependent</i>: Failure to take responsibility for actions, with subordination of personal needs to those of others, excessive dependence with need for constant reassurance and feelings of helplessness when a close relationship ends</p> <p><i>Anankastic</i>: Indecisiveness, doubt, excessive caution, pedantry, rigidity and need to plan in immaculate detail</p>

classify the disorder. Also, some of the information obtained through a personality profile is lost in a categorical system.

There is minimal empirical support for the perspective that disordered personalities can be captured by distinct categories, compared with the alternative perspective that there should be a quantitative distinction, with personality disorders on a continuum with one another, with mental disorders and with normal personality functioning. A dimensional approach reflects this perspective. It is based on personality traits and views personality along a continuum with normal variation at one end and personality disorder at the other.

Purpose of personality disorder assessment

Central to any discussion regarding the assessment of personality is the difficulty in describing, conceptualising and categorising any disturbance. Part of this difficulty arises from the disorder itself. For example, who is best placed to report on someone's personality: the person themselves, who may have no insight into how their personality interferes with their functioning, or an informant, who may experience the effects of an individual's adverse personality traits but has no insight into that person's inner subjective world? Another part of the difficulty arises from the definition of each of the personality disorders, in that some personality characteristics appear in the description of more than one personality disorder (e.g. avoidance of contact with others may be associated with both schizoid and avoidant personality disorders). Such overlap requires the assessor not only to describe the behaviour, but also to enquire about its meaning or purpose (e.g. a person with schizoid personality traits will avoid contact with others because they have no interest in engaging with them, whereas a person with avoidant personality traits will desire contact with others but avoid it because of feelings of inferiority and anxiety).

To add to the confusion, personality disorder is a highly comorbid condition, frequently occurring in combination with mental illnesses and substance use disorders (Coid 2006a). There may be particular problems in assessing personality disorder in people with intellectual disability (Alexander 2003; Mason 2007) or severe mental illness (Tyrer 1983; Moran 2003).

Personality may be briefly assessed as part of a standard psychiatric assessment. However, an increasing number of instruments are being designed specifically for personality assessment. Several factors have contributed to this development. In the USA in 1980, the American Psychiatric Association officially recognised

personality disorder as a distinct and separate realm of psychopathology by giving it a separate axis within the DSM – Axis II. This resulted in increased clinical and research interest in personality disorder and the need for assessment instruments. In the field of psychology, the areas of personality and psychopathology developed along separate paths for decades, but in recent years their relationship has become the focus of much research. It began to be recognised that the knowledge accumulated about normal personality structure and personality measures could be used in the understanding of psychopathology. Assessment and classification of personality disorder are closely linked and therefore it is important to consider both areas before deciding how personality disorder may best be assessed.

In the UK in 1994, the Working Group on Psychopathic Disorder suggested that standardised assessments should be used (Reed 1994), recommending 'multi-method criteria' for the assessment of severe personality disorder. A postal survey was carried out to evaluate how severe personality disorder was assessed in secure services and how the assessments compared with these recommendations (Milton 2000). This survey revealed that only 40% of those who responded carried out a formal assessment. Assessments of personality structure and cognitive and emotional styles were more common than structured diagnostic instruments or ratings of interpersonal functioning. This suggests that, even in specialist centres, there is wide variation both in whether assessment of personality disorder occurs and in the assessment tools used.

A pragmatic approach to assessing personality disorder

Important factors in the assessment of personality disorder include the setting, purpose and time available for the assessment, as these will influence which of the several assessment methods are the most appropriate. Assessment to provide an accurate diagnosis requires a different emphasis from that used in assessing motivation to participate in treatment or of suitability for a particular treatment model. Assessment tools often allow more accurate diagnosis but give less information about other factors such as how an individual's interpersonal functioning actually affects them, the presence of comorbidity or response to previous treatments.

Assessment conducted in line with the principles of the National Health Service's care programme approach places an emphasis on the following areas (Bennett 2006: p. 284):

- risk of harm to self and others
- the presence of other mental health difficulties
- the complexity of a person's personality difficulties
- the level of burden and/or distress placed on other family members or agencies.

History-taking

A good psychiatric history provides the assessor with valuable information about the history of the problematic behaviour. Further understanding of problematic interpersonal functioning can be gained from education, employment and relationship histories. It is important to explore how long problems have been present, variations in the difficulties, any previous treatment and the efficacy of treatment. Other previous or current mental health problems and substance misuse should be explored.

Presentation

Part of the difficulty in assessing for personality disorder is that a person's presentation can vary greatly depending on their current affect or DSM Axis I (mental illness) symptomatology. It is therefore often helpful to carry out an assessment over several interviews. This allows the interviewer to be more confident that the patient's presentation reflects personality traits rather than their current mental state. It is also important to bear in mind that fluctuation in presentation may itself be a characteristic of personality disorder (e.g. emotional lability in borderline personality disorder).

Clinical interview

Clinical interview offers the opportunity to observe the patient's interaction with the interviewer. The interviewer has the opportunity to reflect not only on the content of the response but also on the emotional expression and any non-verbal communication. The patient's response to the assessor and the feelings evoked in the assessor also inform the assessor's understanding of the patient's interpersonal functioning and difficulties.

As well as developing an understanding of an individual's problems, it is important to allow them the opportunity to identify which part of their interpersonal functioning causes them most distress and what they wish to change or modify. A joint understanding of a patient's treatment goals helps to build a positive therapeutic alliance. It is important to enquire about high-risk behaviour directed against the self and others, as this affects treatment and management.

Clinical interview has some limitations in the assessment of personality disorder in comparison

with assessment of other mental disorders. The interviewer is interested not just in the standardised recording of symptoms and clinical features; in particular, they should assess maladaptive behaviour, its effect on the individual and others, attitudes and relationships with others, and social functioning in all areas of the person's life over a prolonged period of time. The interviewer must assess both the individual's current functioning and their normal functioning throughout their life. Some individuals, particularly those with cluster B personality disorders, exaggerate their difficulties; others minimise them. In our experience it is beneficial to supplement a clinical interview with a more structured assessment to gain a fuller understanding of a person's problems.

Other sources of information

In addition to information from clinical interview and structured assessment it is also advantageous to use information from sources other than the patient. Often a patient has difficulty recognising which aspects of themselves are most problematic and sometimes family or friends are more able to identify these personality traits. Of course, information from an informant is may also not be totally reliable; the informant's descriptions may be influenced by their relationship with the patient or their own personality traits. Also, informants will usually be able to provide information on the patient's behaviour, but not on their emotions. Sources such as previous records can add to the assessment and be beneficial in either supporting or refuting the problems identified.

Assessment instruments

Personality disorder can be assessed in a number of ways, including self-report, checklists and structured clinical interview. Numerous instruments are available to aid the clinician in making a diagnosis. These differ in terms of both reliability and validity. The validity of an instrument is the degree to which it measures the true concept which it purports to. This usually requires comparison with a gold-standard measure. As there is currently no accepted gold-standard measure of assessment of personality disorder it is difficult to assess the validity of a particular instrument. Reliability is the extent of agreement between assessors (interrater reliability) or with subsequent testing (test-retest reliability). Generally, the structured clinical interview is regarded as more robust than self-report questionnaires as the latter tend to overreport personality pathology compared with a more detailed structured clinical evaluation (Hunt 1992; Clark 2001).

It is beyond the scope of this article to give a detailed description of all the available instruments, but Box 1 lists those most commonly used; a small number of these are described below in more depth. Readers seeking further information are also advised to consult Tyrer (2000) or Livesley (2001).

Minnesota Multiphasic Personality Inventory–II

The Minnesota Multiphasic Personality Inventory–II (Butcher 1989) is a self-report measure of global psychopathology consisting of 567 true/false items giving information about symptoms and interpersonal relationships. It does not strictly describe personality dimensions but describes different characteristics of personality, their coexistence and differing severity. This instrument takes about 60–90 min to complete.

Millon Clinical Multiaxial Inventory–III

This is a self-report instrument consisting of 175 items requiring a true/false response. It is designed to help practitioners assess the presence of DSM–IV Axis II disorders as well as a number of other clinical syndromes such as anxiety, alcohol dependence and post-traumatic stress disorder (Millon 1997). It takes approximately 25 min to complete.

International Personality Disorder Examination

The International Personality Disorder Examination (IPDE) (Loranger 1994) is a semi-structured clinical interview developed by the WHO and US National Institute of Health joint programme on psychiatric diagnosis and classification (World Health Organization 1995). The IPDE is arranged in a format that attempts to provide an optimum balance between a spontaneous, natural clinical interview and the requirements of objectivity. The questions are arranged under six headings: work, self, interpersonal relationships, affects, reality testing and impulse control. Each question assesses either a criterion or a partial criterion in the DSM–IV or ICD–10 classification system. This assessment tool examines for the presence or absence of a personality disorder and also results in a dimensional score on each disorder. The IPDE takes about 2–4 h to administer.

There is also a self-administered screening questionnaire version of the IPDE (World Health Organization 1995). This requires less time and expertise but produces a higher level of false positives. The use of such an instrument allows an interviewer to focus on highlighted areas and screen out cases of no personality disorder.

BOX 1 Structured personality disorder assessment instruments

Structured categorical (diagnostic) assessments

Observer-rated structured interview

- International Personality Disorder Examination (Loranger 1994)
- Diagnostic Interview for DSM–IV Personality Disorders (Zanarini 1996)
- Structured Interview for DSM–IV Personality Disorders (Pfohl 1997)
- Structured Clinical Interview for DSM–IV Axis I Disorders (First 1997)
- Personality Disorder Interview–IV (Widiger 1995)

Self-rated questionnaire

- Personality Diagnostic Questionnaire (Hylner 1994)

Structured interview – other sources

- Standardised Assessment of Personality (Mann 1981)
- Personality Assessment Schedule (Tyrer 1979)

Structured dimensional assessments

Observer-rated structured interview

- Schedule for Normal and Abnormal Personality (Clark 1990)

Self-rated questionnaire

- Personality Assessment Inventory (Morey 1991)
- Minnesota Multiphasic Personality Inventory–II (Butcher 1989)
- Millon Clinical Multiaxial Inventory–III (Millon 1997)
- Eysenck Inventory Questionnaire (Eysenck 1975)
- NEO Five-Factor Inventory (McCrae 1992)

Unstructured assessments

Interview based

- Clinical interview
- Psychodynamic formulation

Other

- Rorschach test (Rorschach 1964)
- Thematic Apperception Test (Morgan 1935)

NEO Five-Factor Inventory

This five-factor model of personality is the result of years of debate and research between scientists such as Cattell, Eysenck and Guildford, and psychometricians (McCrae 1992). The five factors are neuroticism, extraversion, openness to experience, agreeableness and conscientiousness. It is a dimensional model in which personality disorder can be interpreted as a maladaptive variant of personality. It has been argued that the dimensional approach to the assessment of personality disorder is theoretically superior. However, although this model offers a description of the various personality processes, it does not offer an explanation of the behaviour that a patient presents. The inventory is a self-report checklist, taking about 5–10 min to complete.

Personality Assessment Schedule

The Personality Assessment Schedule (Tyrer 1979) is another trait-based approach to the assessment of personality. It is a semi-structured assessment which also uses information from a collateral source and takes 30–40 min to complete. It assesses 24 traits, such as conscientiousness, aggression and impulsiveness, grouped together into five personality styles: normal, passive-dependent, sociopathic, anankastic (compulsive) and schizoid. Several studies have found good interrater

reliability (Tyrer 1984) and also validity when compared with other widely used instruments.

Assessment of comorbidity, severity and ability to benefit from treatment

Comorbidity

Patients with one diagnosed personality disorder often have further personality disorders and other dysfunctional personality traits and mental health problems. The presence of comorbidity should be explored in the psychiatric history, and additional assessment instruments should be administered to check for further personality disorders. A structured clinical assessment tool such as the Structured Clinical Interview for DSM–IV Axis I Disorders (First 1997) may increase the identification of comorbid mental health problems.

Severity

The type of personality disorder diagnosed and an understanding of its impact on functioning gives an indication of the severity of the disorder. The notion of severe personality disorder is particularly pertinent in specialised personality disorder services and the field of forensic psychiatry. However, there is no standard way of recording this from DSM–IV or ICD–10. It has been noticed in many studies that patients with more severe personality disorder tend to have a greater number of personality disorder diagnoses than those with a less severe disorder (Dolan 1995). Disorder severity is also considered greater in those with disorders in more than one cluster. Some individuals have problematic personality traits but do not reach the threshold for a diagnosis of a particular disorder. Nevertheless, they can still experience marked interpersonal dysfunction and often show increased vulnerability under stress.

Tyrer & Johnson (1996) proposed a system for classifying the severity of personality disorder into five levels, ranging from 0 (no personality disorder) to 4 (severe personality disorder) (Table 2). They

define severe personality disorder as the presence of widespread personality abnormalities in more than one cluster and leading to gross societal disturbance.

Treatability

Assessment of personality disorder often precedes decisions about treatability and whether an individual is suitable for a particular intervention. Interventions such as cognitive–behavioural programmes require a certain level of intellectual ability. If a programme or treatment intervention is too intellectually challenging for an individual, they may not be able to benefit from it. It is also likely to have a negative impact on their confidence and self-esteem and possibly exacerbate problem behaviours. Often the clinical interview will give some indication of level of intellectual functioning. It should be borne in mind that this can be influenced by many factors, including current mental state, education and cultural influences. A formal assessment is valuable for predicting whether an individual can potentially benefit from a particular treatment.

Many patients with a diagnosis of personality disorder disengage from treatment and services. This has a number of consequences. Studies looking at non-completion of treatment programmes in offender populations, both in the community and in institutions, revealed that non-completers were more likely to reoffend than those who had received no treatment (McMurran 2007). A number of explanations have been offered, including low motivation, resistance and low responsiveness. Howells & Day (2007) proposed the term ‘readiness for treatment’, which they defined as:

the presence of characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to promote engagement in therapy and which, thereby, promote therapeutic change.

They suggested that readiness is a function of both internal (patient) and external (context) factors. Internal factors include cognition, affect,

TABLE 2 Classification of personality disorder severity

Level	Diagnosis	Characteristics
0	No personality abnormality	No personality abnormality
1	Personality difficulty	Meeting a probable diagnosis (DSM–IV) and three diagnostic criteria for paranoid, schizoid, histrionic, anankastic and/or anxious personality disorder and two criteria for dissociative, impulsive and/or borderline personality disorder (ICD–10)
2	Simple personality disorder	Either a single personality disorder or if more than one, all personality disorders are within the same cluster
3	Complex personality disorder	Two or more personality disorders from different clusters
4	Severe personality disorder	Two or more personality disorders from different clusters, which causes gross societal disturbance

Adapted from Tyrer & Johnson (1996).

volition, behaviour and identity. External factors include circumstances, location, opportunity, resources, support and available treatment. Internal factors that suggest a greater level of readiness for treatment include: a positive appraisal of the treatment intervention offered; ability to trust others; a capacity to express emotions and reflect on emotional states; moderate (but not overwhelming) distress; experiencing guilt rather than shame; and a belief that change is possible.

The diagnosis of personality disorder is often seen as pejorative, so an important part of assessment should be the identification of the individual's strengths and protective factors. These can be revealed in the clinical history and by some of the assessment instruments, and they need to be emphasised by both patient and clinician: successful treatment requires the management of problematic functioning, and the building and enhancing of the individual's positive qualities.

Assessment of risk to self and others

Patients with personality disorder are at increased risk of harming themselves and others (Stone 1993; National Institute for Mental Health in England 2003). Although the magnitude and causes of this increased risk are unclear, it should be acknowledged that only a minority represent a risk to others. Patients with cluster B personality disorders are at greater risk of criminal offending than the general population, but this increased risk is not found in those with cluster A and C personality disorders (Coid 2006a). There is a particularly strong association between antisocial (dissocial) personality disorder and violent offending (Coid 2006b), but given that features of this disorder include anger outbursts, failure to conform to social norms and lack of concern for others, perhaps this is not surprising. Despite the association between cluster B personality disorders and violence, most people with personality disorders, including half of those with antisocial personality disorder, have no history of violent behaviour (Coid 2006b).

Risk assessment[†] is an important part of any psychiatric assessment and should include an assessment of risk to both self and others. The depth and breadth of the risk assessment when assessing a person with possible personality disorder will depend on the particular clinical circumstances, but the factors in Box 2 should be considered. Many different risk assessment tools are available to help the process of assessing risk to others, although there is increasing evidence that structured clinical judgement, using, for example, the Historical, Clinical and Risk Management scale (HCR-20; Webster 1997) may have particular clinical utility (Doyle 2006; Maden 2007).

BOX 2 Factors to be considered during assessment

- Demographic factors
- Current social situation
- Current presentation
- Psychosocial stressors
- Previous history of violence and self-harm
- Previous response to treatment/supervision
- Level of social support
- Anger
- Impulsivity
- Substance misuse
- Presence or absence of mental illness

(Doyle 2006)

Psychopathy

Of particular relevance to the assessment of risk of harm to others in people with personality disorder is the Psychopathy Checklist – Revised (PCL-R; Hare 2003). This rating instrument aims to operationalise a clinical concept of psychopathy based on Hare's modification of Cleckley's (1976) description of psychopathy. Compared with offenders without psychopathy, those with psychopathy (as assessed by the PCL-R) begin offending at an earlier age, commit more criminal offences, commit more types of offence and are more likely to reoffend (Harris 1991; Hart 1998).

Psychopathy is a clinical concept that, although not included as a category of personality disorder in ICD-10 or DSM-IV, meets the general DSM-IV criteria for personality disorder. It may be thought of as a more severe form of antisocial/dissocial personality disorder in which antisocial behaviour is accompanied by emotional deficits such as callousness and lack of empathy (Hare 1996). There is increasing evidence that psychopathy may have a particular neurobiological basis (Blair 2003).

The PCL-R assesses traits of psychopathic personality on the basis of patient interview and review of previous records. Although clinical judgement is required, trained raters yield reliable scores and the test-retest reliability is also high (Hare 2003). The result of a PCL-R assessment may have negative implications for the individual, such as exclusion from treatment programmes or harsher disposal by the criminal justice system. It is therefore important that assessment is carried out for a specific purpose and that the full implications of an assessment are shared with the individual before it is undertaken. One of the benefits of the identification of high-risk behaviour is that it helps in setting treatment goals.

[†]This topic is discussed in *Advances* by: Carroll A (2009) How to make good-enough risk decisions. **15**: 192–8; Undrill G (2007) The risks of risk assessment. **13**: 291–7. Ed.

Dangerous and severe personality disorder

The criminal justice system in England and Wales has shown increased interest in personality disorder as a result of the government's Dangerous and Severe Personality Disorder (DSPD) programme[†] (www.dspdprogramme.gov.uk). The DSPD programme was set up after a number of high-profile cases in England focused public opinion on the potential risk that individuals with personality disorder present to the public (Feeney 2003). 'Dangerous and severe personality disorder' is not a clinical diagnosis. Rather, it is a descriptive term, embodying both psychiatric and social references, that is applied to a small number of individuals who are thought to be potentially suitable for this treatment programme. The Department of Health has defined this group as '[people over 18] who have an identifiable personality disorder to a severe degree, who pose a high risk to other people because of serious antisocial behaviour resulting from their disorder' (Department of Health 2004).

Being classified as having a personality disorder and being at high risk of harming others may have significant consequences, such as long-term incarceration (Morris 2007).

Although the aim of formal risk assessment is to provide a means of identifying and predicting any potential risk that an individual poses to both themselves and others, it should be used in tandem with risk management. This involves the interpretation of assessment tools in monitoring both dynamic and static risk factors and identifying appropriate treatment and/or supervision for the individual.

Conclusions

Personality disorders are common conditions that have an impact on all areas of an individual's functioning and on other mental health problems. It is important to make a detailed diagnosis specifying both the personality disorder(s) diagnosed and the maladaptive traits displayed, together with the evidence on which this is based. An accurate description of the disorder is an essential prerequisite to providing appropriate treatment.

Personality disorder is a highly comorbid condition and it is important that a systematic attempt is made to evaluate the patient for other personality disorders, mental illnesses and substance use disorders.

The eventual aim of assessment is to arrive at a shared understanding with the patient about their difficulties so that patient and professional can work collaboratively on shared treatment goals. Part of this assessment should focus on the patient's strengths and protective factors.

References

- Alexander R, Cooray S (2003) Diagnosis of personality disorders in learning disability. *British Journal of Psychiatry*; **182** (suppl 44): s28–31.
- American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders (3rd edn) (DSM-III)*. APA.
- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders (4th edn) (DSM-IV)*. APA.
- Bennett L (2006) Community mental health teams and the assessment of personality functioning. In *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide* (eds MJ Sampson, RA McCubbin, P Tyrer). John Wiley & Sons.
- Blair RJR (2003) Neurobiological basis of psychopathy. *British Journal of Psychiatry*; **182**: 5–7.
- Butcher JN, Dahlstrom WG, Graham JR, et al (1989) *Manual for the Restandardized Minnesota Multiphasic Personality Inventory: MMPI-2*. University of Minnesota Press.
- Clark LA (1990) Toward a consensual set of symptom clusters for assessment of personality disorder. In *Advances in Personality Assessment, Vol. 8* (eds J Butcher, C Spielberger): 243–66. Erlbaum.
- Clark L, Harrison J (2001) Assessment instruments. In *Handbook of Personality Disorders: Theory Research and Treatment* (ed WJ Livesley): 277–306. Guilford Press.
- Cleckley H (1976) *The Mask of Sanity (5th edn)*. Mosby.
- Coid J, Yang M, Tyrer P, et al (2006a) Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry*; **188**: 423–31.
- Coid J, Yang M, Roberts A, et al (2006b) Violence and psychiatric morbidity in the national household population of Britain: public health implications. *British Journal of Psychiatry*; **189**: 12–9.
- Department of Health, Home Office, HM Prison Service (2004) *Dangerous and Severe Personality Disorder (DSPD) High Security Services: Planning and Delivery Guide*. Home Office.
- Dolan B, Evans C, Norton K (1995) Multiple axis-II diagnoses of personality disorder. *British Journal of Psychiatry*; **166**: 107–12.
- Dowsett J, Craissati J (2007) *Managing Personality Disordered Offenders in the Community: A Psychological Approach*. Routledge.
- Doyle M, Dolan B (2006) Predicting community violence from patients discharged from mental health services. *British Journal of Psychiatry*; **189**: 520–6.
- Eysenck HJ, Eysenck SGB (1975) *Manual of the Eysenck Personality Questionnaire*. Hodder & Stoughton.
- Feeney A (2003) Dangerous severe personality disorder. *Advances in Psychiatric Treatment*; **9**: 349–58.
- First MB, Spitzer RL, Williams JBW, et al (1997) *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)*. American Psychiatric Association.
- Hare RD (1996) Psychopathy and antisocial personality disorder: a case of diagnostic confusion. *Psychiatric Times*; **13**(2): 1 February (<http://www.psychiatrictimes.com/display/article/10168/51816>).
- Hare RD (2003) *The Hare Psychopathy Checklist – Revised (2nd edn)*. Multi-Health Systems.
- Harris EC, Barraclough B (1998) Excess mortality of mental disorder. *British Journal of Psychiatry*; **173**: 11–53.
- Harris GT, Rice MT, Cormier CA (1991) Psychopathy and violent recidivism. *Law and Human Behaviour*; **15**: 625–37.
- Hart SD (1998) Psychopathy and risk for violence. In *Psychopathy: Theory, Research and Implications for Society* (eds D Cooke, AE Forth, RD Hare). Kluwer.
- Hunt C, Andrews G (1992) Measuring personality disorder: the use of self-report questionnaires. *Journal of Personality Disorders*; **6**: 125–33.
- Howells K, Day A (2007) Readiness for treatment in high risk offenders with personality disorders. *Psychology, Crime and Law*; **13**: 47–56.
- Hyler SE (1994) *Personality Diagnostic Questionnaire-4 (PDQ-4)*. New York Psychiatric Institute.
- Livesley J (ed) (2001) *Handbook of Personality Disorders: Theory, Research and Treatment*. Guilford Publications.

[†]For a discussion in *Advances* of treatment within the DSPD programme and of the concept of DSPD see: Howells K, Krishnan G, Daffern M (2007) Challenges in the treatment of dangerous and severe personality disorder. **13**: 325–32; Kingdon D (2007) DSPD or 'Don't Stigmatise People in Distress'. **13**: 333–5. Ed.

Loranger AW, Sartorius N, Andreoli A, et al (1994) The International Personality Disorder Examination. The World Health Organization/Alcohol, Drug Abuse, and Mental Health Administration international pilot study of personality disorders. *Archives of General Psychiatry*; **51**: 215–24.

Maden A (2007) *Treating Violence – A Guide to Risk Management in Mental Health*. Oxford University Press.

Mann AH, Jenkins R, Cutting JC, et al (1981) The development and use of standardized assessment of abnormal personality. *Psychological Medicine*; **11**: 839–47.

Mason J (2007) Personality assessment in offenders with mild and moderate intellectual disabilities. *British Journal of Forensic Practice*; **9**: 31–9.

McCrae RM, John OP (1992) An introduction to the five-factor model and its applications. *Journal of Personality*; **60**: 175–215.

McMurrin M, Theodosi E (2007) Is offender treatment non-completion associated with increased reconviction over no treatment? *Psychology, Crime and Law*; **13**: 333–43.

Millon T, Davis RD (1997) The MCMI–III: present and future directions. *Journal of Personality Assessment*; **68**: 69–85.

Milton J (2000) A postal survey of the assessment procedure for personality disorder in forensic settings. *Psychiatric Bulletin*; **24**: 254–7.

Moran P (2002) *The Epidemiology of Personality Disorders*. Department of Health.

Moran P, Walsh E, Tyrer P, et al (2003) Impact of comorbid personality disorder on violence in psychosis. Report form the UK700 trial. *British Journal of Psychiatry*; **182**: 129–34.

Morey LC (1991) *Personality Assessment Inventory – Professional Manual*. Psychological Assessment Resources.

Morgan CD, Murray HA (1935) A method for investigating fantasies: the Thematic Apperception Test. *Archives of Neurology and Psychiatry*; **34**: 298–306.

Morris A, Gibbon S, Duggan C (2007) Sentenced to hospital – a cause for concern? *Personality and Mental Health*; **1**: 74–9.

National Institute for Mental Health in England (2003) *Personality Disorder: No Longer a Diagnosis of Exclusion*. Department of Health.

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

Pfohl B, Blum N, Zimmerman M (1997) *Structured Interview for DSM–IV Personality (SIDP–IV)*. American Psychiatric Press.

Reed J (1994) *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder*. Home Office.

Rorschach H (1964) *Psychodiagnostics*. Grune & Stratton.

Singleton N, Meltzer H, Gatward R (1998) *Psychiatric Morbidity among Prisoners in England and Wales: A Survey Carried out in 1997 by the Social Survey Division of ONS on Behalf of the Department of Health*. TSO (The Stationery Office).

Skodol AE, Gunderson JG, Shea TM, et al (2005) The collaborative longitudinal personality disorders study (CLPS): overview and implications. *Journal of Personality Disorders*; **19**: 487–504.

Stone MH (1993) Long-term outcome in personality disorders. *British Journal of Psychiatry*; **162**: 299–313.

Tyrer P, Alexander MS, Cicchetti D, et al (1979) Reliability of a schedule for rating personality disorders. *British Journal of Psychiatry*; **135**: 168–74.

Tyrer P, Strauss J, Cicchetti D (1983) Temporal reliability of personality in psychiatric patients. *Psychological Medicine*; **13**: 393–8.

Tyrer P, Cicchetti D, Casey P, et al (1984) Cross-national reliability of a schedule for assessing personality disorders. *Journal of Nervous and Mental Diseases*; **172**: 718–21.

Tyrer P, Johnson T (1996) Establishing the severity of personality disorder. *American Journal of Psychiatry*; **153**: 1593–7.

Tyrer P, Seivewright H (2000) Outcome of personality disorder. In *Personality Disorders: Diagnosis, Management, and Course (2nd edn)* (ed P Tyrer): 105–25. Butterworth-Heinemann.

Tyrer P, Simmonds S (2003) Treatment models for those with severe mental illness and comorbid personality disorder. *British Journal of Psychiatry*; **182** (suppl 44): s15–8.

Webster CD, Douglas KS, Eaves D, et al (1997) *HCR–20. Assessing Risk for Violence, Version 2*. Mental Health, Law and Policy Institute, Simon Fraser University.

Widiger TA, Mangine S, Corbitt EM, et al (1995) *Personality Disorder Interview–IV: A Semistructured interview for the Assessment of Personality Disorders*. Psychological Assessment Resources.

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

World Health Organization (1995) *International Personality Disorder Examination (IPDE Manual)*. American Psychiatric Publishing.

Zanarini MC, Frankenburg FR, Sickel AE, et al (1996) *The Diagnostic Interview for DSM–IV Personality Disorders (DIPD–IV)*. McLean Hospital.

MCQ answers				
1	2	3	4	5
a	t	a	f	a
b	f	b	f	b
c	f	c	f	c
d	f	d	f	d
e	f	e	f	e

<p>MCQs</p> <p>1 Patients with a diagnosis of personality disorder:</p> <p>a often have more than one personality disorder</p> <p>b rarely have evidence of mental illness</p> <p>c recover more quickly from major mental illnesses such as schizophrenia</p> <p>d are less likely to misuse drugs and alcohol than the general population</p> <p>e have decreased all-cause mortality.</p> <p>2 Regarding the use of assessment instruments:</p> <p>a self-report instruments tend to produce a higher rate of false negatives than structured clinical interviews</p> <p>b reliability refers to the extent to which an instrument actually measures the characteristic it purports to measure</p>	<p>c validity refers to whether an instrument uses questions that can be easily understood by the patient</p> <p>d a good assessment instrument should have both good reliability and validity</p> <p>e structured clinical interview can only be used if an informant is also present.</p> <p>3 Regarding the diagnosis of personality disorder:</p> <p>a ICD–10 and DSM–IV use a dimensional approach</p> <p>b narcissistic personality disorder appears in ICD–10 but not DSM–IV</p> <p>c since personality cannot be reliably diagnosed and personality disorder is a pejorative label, it is an unhelpful diagnosis to make</p> <p>d dangerous and severe personality disorder is an ICD–10 diagnosis</p>	<p>e in terms of validity and reliability, structured clinical interview is the most robust way of assessing personality disorder.</p> <p>4 Examples of structured categorical personality assessment instruments are the:</p> <p>a International Personality Disorder Examination</p> <p>b NEO Five-Factor Inventory</p> <p>c Thematic Apperception Test</p> <p>d Global Assessment of Functioning scale</p> <p>e Adult Attachment Interview.</p> <p>5 Factors indicating a more favourable engagement in treatment include:</p> <p>a feelings of shame</p> <p>b negative view of the treatment available</p> <p>c severe distress</p> <p>d feelings of guilt</p> <p>e difficulty trusting others.</p>
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