Personality disorder

Paul Moran | Keeva Rooney | Peter Tyrer | Jeremy Coid
Summary

• Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. The self-completion Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) was used among 16–64 year old participants in the first phase interview to screen for antisocial personality disorder (ASPD) and borderline personality disorder (BPD).

• ASPD is characterised by a pervasive pattern of disregard for and violation of the rights of others in people aged at least 18, which has persisted since the age of 15. BPD is characterised by high levels of personal and emotional instability associated with significant impairment.

• 3.3% of people aged 18–64 screened positive for ASPD. It was more common in men (4.9%) than women (1.8%).

• 2.4% of people aged 16–64 screened positive for BPD, differences between men and women did not reach statistical significance.

• Personality disorder has also been seen as unitary, characterised by core interpersonal dysfunction and the presence of a range of adaptive and maladaptive traits. A general personality disorder screen (the SAPAS) was added to APMS 2014 to screen adults of all ages for ‘any personality disorder’ (PD).

• 13.7% of people aged 16 and over screened positive for any PD, with similar rates in men and women.

• Screening positive on all three measures of PD (ASPD, BPD, and any PD) was more common among younger people, and in those living alone, not in employment, or in receipt of benefits.

• 6.2% of people screening positive for ASPD and 13.2% of BPD screen positives, also believed that they have had a personality disorder. In comparison, about 1% of people who did not screen positive for these believed that they have had a personality disorder. Most people who believed that they have had a personality disorder, also had a diagnosis of this from a professional.
• Participants screening positively for PD, on any of the measures used, were more likely to be in receipt of mental health treatment than those who did not. 26.6% of people who screened positive for ASPD, 43.1% of screen positives for BPD, and 28.9% of screen positives for any PD reported receiving psychotropic medication, psychological therapy or both.

• 16.6% of screen positives for BPD, 9.1% of screen positives for ASPD, and 7.3% of screen positives for any PD had requested some kind of mental health treatment which they had not (yet) received, compared with 0.8% of people not screening positive for any PD.

7.1 Introduction

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Impairment in relational functioning is an enduring feature of personality disorder (Skodol et al. 2005). Along with substantial social difficulties (Yang et al. 2010), individuals with personality disorder also experience poor general health (Fok et al. 2014) and reduced life expectancy (Fok et al. 2012). Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance (Coid et al. 2006). They are associated with substantial burden on affected individuals, their families and wider society (Coid et al. 2009). Personality disorders often co-occur with mood and anxiety disorders (Grant et al. 2005). Yet prospective, population-based research shows that even after accounting for the effects of concurrent mood and anxiety disorder, personality disorder is an independent risk factor for poor future mental health, as well as serious relational difficulties (Moran et al. 2016). Mapping the prevalence and correlates of personality disorder in the general population is therefore important as the diagnosis identifies a subsection of the population who are at particularly high risk of future health problems.
**Antisocial personality disorder (ASPD)**

ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence (Goldstein et al. 2006). It is associated with increased morbidity and mortality, due, among other things, to increased rates of assaults, suicidal behaviour, road accidents, and sexually transmitted infections (Ellis et al. 1995; Shephard and Farrington 2003). The presence of ASPD may complicate treatment of comorbid conditions.

The estimated prevalence of ASPD in the wider general population varies with diagnostic classification system, method of assessment and place: for example the rate is higher in urban than rural areas (Coid et al. 2006). Despite these differences, there is great similarity in the estimates generated by community surveys of personality disorder based on full clinical assessment: 0.7% of 18–65 year olds in Oslo, Norway (Torgersen et al. 2001), 0.6% in the US (Lenzenweger et al. 2007), and 0.3% in England (McManus et al. 2009). ASPD is more prevalent in men than women.

People with ASPD have often grown up in families where parenting was characterised by conflict and inconsistency, and care sometimes transferred to outside agencies (Black et al. 1995). Resultant truancy, delinquent peer groups and substance misuse contribute to low educational attainment, unemployment, unstable housing and inconsistency in relationships in adulthood (Martin et al. 1985). While ASPD is distinct from general antisocial behaviour, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA 1994) criteria do require childhood antisocial behaviour (to the level of conduct disorder) for the full diagnosis in adulthood. Interventions during childhood have, therefore, been identified as a priority by the Home Office in preventing the development of full adult ASPD (Moran and Hagell 2001).

Criminality is strongly associated with, but not essential for, the diagnosis of ASPD, which includes a broad range of antisocial behaviours and personality traits. The 1997 APMS prisoners’ survey identified ASPD in a very high proportion of inmates: 63% of male remand prisoners and 49% of male sentenced
prisoners (Singleton et al. 1998). People with the disorder account for a disproportionately large proportion of crime and violence committed.

The costs and extended harm associated with ASPD include high levels of personal injury and financial damage to victims, as well as increased costs of policing, and the impact on the criminal justice system and prison services (Welsh et al. 2008). Additional costs resulting from ASPD include increased use of healthcare, lost employment opportunities, and family breakdown.

**Borderline personality disorder (BPD)**

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties in sustaining relationships, and self-harm and suicidal behaviour is common (Paris and Zweig-Frank 2001). Most people with the disorder first show symptoms in late adolescence or early adult life. The symptoms fluctuate but generally improve over time (Newton-Howes et al. 2015). Among those receiving treatment, as many as half improve sufficiently not to meet the criteria for BPD 5–10 years after first diagnosis (Zanarini et al. 2003).

As with ASPD, the prevalence of BPD identified through community based surveys is sensitive to the diagnostic classification system used and the method of assessment. The rates identified have, however, been broadly similar across studies: 0.7% in the Oslo study (Torgersen et al. 2001), 1.4% in the US (Lenzenweger et al. 2007), and 0.5% in APMS 2007 (McManus et al. 2009). The rate has been found to be higher in women than men; in APMS 2007 it was identified in 0.7% of women and 0.3% of men (Skodol et al. 2005). A higher rate among women is consistently observed in clinical samples.

A considerable proportion of people with BPD are known to have experienced some form of physical, emotional or sexual abuse or neglect in childhood. Its association with past trauma and its similarities with posttraumatic stress disorder (PTSD) have led some to suggest that BPD should be regarded as a form of delayed PTSD (Cloitre et al. 2014). It is rare for a patient to have BPD without comorbid conditions (Coid et al. 2009), and because of this considerable overlap some have argued that BPD should not be classed as a personality disorder.
(NCCMH 2009). National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment and management of BPD, however, do regard BPD as a personality disorder.

**Personality disorder**
The categorical classification of personality disorder remains controversial. Population-based studies have failed to demonstrate a bimodal distribution of abnormal personality traits (Livesley et al. 1992). Furthermore, the diagnostic criteria for individual personality disorder subtypes considerably overlap. There is therefore substantial artefactual comorbidity among personality disorder subtypes. Given these limitations, it has been proposed that personality disorder should be classified as a unitary disorder, characterised by core interpersonal dysfunction (of varying degrees of severity), accompanied by the presence of a range of adaptive and maladaptive traits (Tyrer et al. 2015; Ellis et al. 1995). In light of these recent proposals, in APMS 2014 a general personality disorder screen was added to the assessment battery.

In this chapter, screen positive rates for ASPD, BPD and also for ‘any personality disorder’ for the household population in England are presented. Associations with age, sex, ethnicity, household structure, employment and benefit status, and region are examined, as well as levels of mental health service use and treatment among people screening positive. Comorbidity with personality disorder is covered in Chapter 13.

### 7.2 Definition and assessment

**Antisocial, borderline and any personality disorders**
When this survey was in development DSM-IV was in place and the measures used relate to DSM-IV criteria. DSM-5 has since been released, and implications for the classification of PD are addressed in the discussion section of this chapter (see Section 7.4).
**Personality disorder**

DSM-IV defines a personality disorder as ‘an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment’.¹

Personality disorders were made a separate diagnostic axis under the DSM-III classification of mental disorders (APA 1980). DSM-IV identifies ten types of personality disorder grouped into three clusters (APA 1994):

- Cluster A includes the ‘odd or eccentric’ types
- Cluster B disorders are the ‘dramatic, emotional or erratic’ types, and
- Cluster C is the anxious-fearful group (Coid et al. 2006).
- ASPD and BPD are both cluster B disorders: the other ‘dramatic, emotional or erratic’ types (narcissistic and histrionic) yielded no positive cases when assessed in APMS 2000 and were not included in the 2007 or 2014 surveys.²

**ASPD**

DSM-IV characterises ASPD as a pervasive pattern of disregard for and violation of the rights of others that has persisted in the individual since the age of 15 or earlier, as indicated by three (or more) of seven criteria:

- Failure to conform to social norms
- Irresponsibility
- Deceitfulness
- Indifference to the welfare of others
- Recklessness
- Failure to plan ahead
- Irritability and aggressiveness (Millon and Davis 1993).

---

¹ NICE guidelines recommend the use of the DSM-IV diagnostic system for both antisocial and borderline personality disorder.
² Coid et al. examine reasons for the absence of histrionic and narcissistic personality disorder in the APMS 2000 sample: some studies have identified a higher rate of histrionic in particular, e.g. Torgersen et al. (2001) 2.0% histrionic, 0.8% narcissistic; and Samuels et al. (2002) 0.2% histrionic; 0.03% narcissistic.
A feature of ASPD in the DSM-IV is that it requires the individual to meet diagnostic criteria in childhood (presence of conduct disorder before age 15) as well as adulthood. Because particular behaviours must have persisted beyond the age of 18, people younger than this cannot be given the diagnosis. For this reason, participants aged 16 or 17 were excluded from the base for the ASPD analysis.

**BPD**

According to the DSM-IV diagnostic criteria for BPD, the key features are instability of interpersonal relationships, self-image and mood, combined with marked impulsivity, beginning in early adulthood. It is indicated by five (or more) of the following criteria:

- Frantic efforts to avoid real or imagined abandonment
- Pattern of unstable and intense personal relationships
- Unstable self image
- Impulsivity in more than one way that is self-damaging (e.g. spending, sex, substance abuse, binge eating, reckless driving)
- Suicidal or self-harming behaviour
- Affective instability
- Chronic feelings of emptiness
- Anger
- Paranoid thoughts or severe dissociative symptoms (quasi-psychotic).

Unlike ASPD, a DSM-IV diagnosis of BPD is possible before the age of 18, and the BPD analysis therefore included all APMS participants aged 16 and over.

---

3 The tenth International Classification of Disease (ICD-10, WHO 1992) does not have a directly equivalent category although ‘emotionally unstable personality disorder, borderline type’ (F60.31) shares some features.

4 Although some psychiatrists argue that a diagnosis of BPD should not be made before 18, as personality is still forming.
Assessment

Three methodologically rigorous surveys have covered all ten types of personality disorder,\(^5\) including APMS 2000 which used the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) (First et al. 1997; Singleton et al. 2002). There are issues with all the available screening tools,\(^6\) and no ‘gold standard’ has emerged (Zimmerman 1994; Guy et al. 2008). One common disadvantage is the large number of questions required to assess the full range of disordered personality types. In order to release capacity for new topics, the 2007 survey only measured ASPD and BPD. This was made possible by the modular structure of the SCID-II, which covers each personality disorder type separately.

In the current survey, personality disorders were not assessed in two phases (as they had been in previous surveys in the series). Instead APMS 2014 screened for personality disorders based only on phase one self-report data. The rates presented in this chapter, therefore, are not comparable with the two-phase rates in the 2007 report. A positive screen for personality disorder only indicates that someone may have sufficient traits to warrant further and fuller investigation. Screen positive rates tend to be higher than actual rates of disorder. It should also be noted that the term ‘screen’ is used as a convention, and does not indicate that the screening tests used in the survey are used as part of any national screening programme in England.

Screening positive for ASPD or BPD on the SCID-II

SCID-II is available as both a self-completion screen and as a semi-structured clinician administered face to face interview. In APMS 2014, the modules of the self-completion SCID-II covering BPD and ASPD were included in the Computer Assisted Self Interview (CASI) at phase one. They were asked of participants aged between 16 and 64 (in 2007, the SCID-II was asked of everyone).

The ASPD module covered childhood conduct disorder and adult antisocial personality, as a diagnosis of ASPD requires both to be present. The questions

\(^{5}\) DSM-III listed 12 types of personality disorder, but passive-aggressive and self-defeating were not included in DSM-IV. ICD-10 lists nine categories of personality disorder.

\(^{6}\) These include relying on respondent self-report in response to a structured interview, the way in which other disorders can mimic symptoms of borderline personality disorder, and the absence of an informant account of a patient’s personality. (Zimmerman 1994).
used to assess these disorders are listed in the questionnaire in Appendix D. Each question asked the participant to indicate whether or not they had a particular personality characteristic, for example: ‘Are you the kind of person who…’. All questions had three response categories: yes, no, and ‘don’t know/does not apply’. A score of one was given for each item endorsed.

Screening positive for any personality disorder on the SAPAS
In APMS 2014, the Standardised Assessment of Personality: Abbreviated Scale (SAPAS) (Moran et al. 2003) was added to measure the likelihood that an individual has a personality disorder in a more general sense, as opposed to screening for specific types of personality disorder (Hesse and Moran 2010). The SAPAS was chosen on the grounds that it is currently the best performing rapid screen for personality disorder (Germans et al. 2012). Each of the eight questions on the SAPAS asked participants to indicate whether or not they had a particular personality characteristic, for example “Are you normally an impulsive sort of person?” Participants could answer either ‘yes’ or ‘no’. A score of one was given for each item endorsed, generating a score of 0–8. Those scoring four or more were defined as screening positive for possible personality disorder. This cut-point was chosen as it provides the best balance between sensitivity and specificity in a general population sample (Lenzenweger et al. 2007; Fok et al. 2015). Participants with more than two SAPAS items missing were not given a SAPAS score.

In summary, in this chapter:

- Screen positive for ASPD and BPD always draws on the SCID-II
- Screen positive for ‘any PD’ always draws on the SAPAS.

7.3 Results

Screening positive for ASPD, BPD and any PD by age and sex
Overall, 3.3% of participants aged 18 to 64 screened positive for ASPD on the SCID-II. If everyone in the population had been screened, it is likely
(95% probability) that between 2.8% and 4.0% of 18 to 64 year olds would screen positive. The ASPD rate was higher in men (4.9%, 95% confidence interval (CI): 3.9% to 6.0%) than women (1.8%, 95% CI: 1.4% to 2.4%). Screening positive for ASPD was associated with age. Positive screens for ASPD were more common in men aged 18–24 (6.4%) and 25–34 (6.6%) than in men in older age groups (4.1% of men aged 55–64). A similar pattern was observed among women: 3.3% of women aged 18–24 screened positive for ASPD, compared with 0.4% of women aged 55–64.

2.4% of adults aged 16 to 64 screened positive for BPD on the SCID-II, it is likely that the rate in the wider population of 16 to 64 year olds is between 2.0% and 2.9%. An apparent difference in rate by sex did not achieve statistical significance, with 1.9% (95% CI 1.3% to 2.7%) of men screening positive and 2.9% (95% CI 2.3% to 3.7%) of women. Younger people were more likely to screen positive for BPD than older people, this pattern was more evident in women than men.

Table 7.1

Figure 7A: Screen positive for antisocial and borderline personality disorder in past year (SCID-II)
Base: 18–64 (ASPD); aged 16–64 (BPD)
Using the SAPAS, 13.7% of adults screened positive for any PD, at a cut-point of 4. The proportion of the population as a whole is likely to be between 12.7% and 14.6%. The prevalence among men (13.2%, CI 95% 11.9% to 14.7%) and women (14.0%, CI 95% 12.8% to 15.4%) was very similar. There was a strong, linear association between age and screening positive for any PD: 22.4% of 16–24 year olds screened positive compared with 8.0% of adults aged 75 and over. Table 7.2

**Figure 7B: Screen positive for any personality disorder (SAPAS), by age and sex**

*Base: all adults*

![Graph showing screen positive for any PD](image)

**ASPD and BPD screens by any PD screen**

The SAPAS identifies about one person in eight aged 16 or over as screen positive for ‘any PD’ (covering all ten types of PD), while the SCID-II screen detects specifically ASPD in about one person in thirty (aged 18–64) and BPD in one in forty (aged 16–64). As expected therefore, while most participants identified with ASPD or BPD also screened positive on the SAPAS, most SAPAS screen positives did not also screen positive on the SCID-II. Table 7.3
**Self-diagnosis and professional diagnosis of PD**

Participants were asked whether or not they thought that they had ever had any of a list of mental disorders, including ‘a personality disorder’. Those who responded positively to this were also asked whether a professional had confirmed that diagnosis.

6.2% of people screening positive for ASPD and 13.2% of BPD screen positives, also believed that they have had a personality disorder. In comparison, less than 1% of people who did not screen positive on the SCID-II believed that they have had a personality disorder. Most people who thought that they have had a personality disorder, also had a diagnosis of this from a professional.

3.4% of people who screened positive for any PD also believed that they have had a personality disorder. Again, most of these people had been diagnosed by a professional. **Table 7.4**

**Screening positive for PD by other characteristics**

*Ethnic group*

There was no significant association between any measure of PD and ethnic group. This was the case both when the analysis was age-standardised and when the analysis was run without adjusting for the different age-profiles of the ethnic groups. It should be noted that the APMS sample is underpowered for looking at variation by ethnic group. **Tables 7.5, 7.6**

*Household type*

Participants aged less than 60 and living in lone person households had higher rates of PD than those living in other types of household, for all measures of PD. **Tables 7.7, 7.8**

*Employment status*

Employment status was associated with all measures of PD. Screen positive rates were highest among the unemployed for ASPD and any PD, and in people who were economically inactive for BPD. **Tables 7.9, 7.10**

---

7 Age-standardisation allows for comparisons to be made between groups after adjusting for the effects of any differences in age distribution. Observed results refer to those which have not been age-standardised.
Figure 7C: Screen positive for antisocial, borderline personality disorder and any personality disorder, by employment status

*Base: 18-64 (ASPD); aged 16-64 (BPD and any PD)*

**Benefit status**

Benefit status was looked at in relation to three groupings: being in receipt of any out-of-work benefit (including Jobseeker’s Allowance and Employment and Support Allowance (ESA)), receiving an out-of-work benefit specifically related to disability (ESA), and living in a household that received housing benefit support with rent. These categories are further described in the Glossary.

Screening positive for PD – across all three PD indicators – was higher among those who received benefits than among those who did not. The strength of association was greatest for those receiving ESA. About half of the people in this group (40.1% of men and 57.9% of women) screened positive for any PD, compared with one in eight (13.5% of men and 14.5% of women) not receiving an out-of-work disability benefit. **Tables 7.11, 7.12**
Figure 7D: Screen positive for antisocial, borderline personality disorder and any personality disorder, by type of benefit received

*Base: 18-64 (ASPD); aged 16-64 (BPD and any PD)*

Region

Screening positive for PD did not vary by region, using any of the PD measures.  *Tables 7.13, 7.14*

Treatment and service use

Participants screening positively for PD, on any of the measures used, were more likely to be in receipt of mental health treatment than those who did not. 26.6% of 18 to 64 year olds who screened positive for ASPD, 43.1% of screen positives for BPD, and 28.9% of screen positives for any PD reported receiving psychotropic (mental health) medication, psychological therapy or both.  *Tables 7.15, 7.16*

People screening positive were more likely to be in receipt of medication than counselling. Psychotropic medication was being taken by about a quarter of individuals screening positive for ASPD (24.5%) and any PD (25.6%), and more than a third of those screening positive for BPD (38.3%). As in the general population, drugs
used in the treatment of anxiety or depression were the most commonly prescribed to people screening positive for PD, although a notably high proportion of BPD cases were taking antipsychotics (7.5%) or medication indicated for bipolar disorder (9.5%).

As well as psychotropic medication, substance dependence medication was being taken by 8.0% of ASPD and 8.0% of BPD screen positives, and 4.0% of screen positives for any PD. **Table 7.17, 7.18**

Counselling or other psychological therapy was currently being received by one in five (20.2%) people screening positive for BPD (aged 16 to 64), one in seven (13.6%) with ASPD (aged 18 to 64), and one in ten (9.7%) screen positive for any PD. For ASPD, the most common form was alcohol or drug therapy (6.2%), and for BPD it was psychotherapy or psychoanalysis (7.5%) and cognitive behavioural therapy (6.9%). **Table 7.19, 7.20**

Along with the finding that people screening positive for PD are more likely to be in receipt of mental health treatment, it was also the case that they were more likely to have requested a particular treatment which they then did not receive. 16.6% of screen positives for BPD, 9.1% of screen positives for ASPD, and 7.3% of screen positives for any PD had requested some kind of mental health treatment in the past 12 months which they had not (yet) received, compared with 0.8% of people not screening positive for any PD. **Table 7.21**

**Figure 7E: Requested but did not receive a particular mental health treatment, by personality disorder screens**
*Base: 18–64 (ASPD); aged 16–64 (BPD); all adults (PD)*
7.4 Discussion

The epidemiological data generated from this survey has limitations, chiefly in terms of the reliance on self-reported cross-sectional data. Although the numbers of people who screened positive for ASPD and BPD were relatively small (164 and 121 respectively), a number of clear patterns are evident.

People at high risk of personality disorder are more likely to live alone and not be in employment compared with those who do not screen positively for personality disorder. ASPD is more common in men than women. All the measures of personality disorder included in the survey showed strong associations with age: with rates higher in younger age groups than older.

Since this study was carried out there have been significant changes in the classification of personality disorder. The DSM-5 approach was rejected by the American Psychiatric Association (detailed reasons can be found in Zachar et al. (2016)) and so the classification has reverted to the DSM-IV criteria, at least for the next few years. This former classification includes the definitions of antisocial and borderline personality disorder described in this chapter.

The ICD classification has changed radically in that all categorical diagnoses of personality disorder have been abandoned (Tyrer et al. 2015). In its place a single dimensional classification has been proposed, which extends from no personality dysfunction through to severe personality disorder, with personality difficulty, and mild and moderate personality disorder as intermediate levels. A recent population-based longitudinal study has provided some empirical support for this new severity-based classification scheme (Moran et al. 2016). There are five trait domains that qualify the level of severity but are not diagnoses in their own right. These are dissocial, anankastic, detached, negative affective and disinhibited domains that relate directly to normal personality variation. People with personality disorder can have disturbance in more than one domain, and in recent research using the ICD-11 criteria those currently diagnosed as borderline tend to cluster together across the negative affective and dissocial domains (Mulder et al. 2016).

The ICD-11 revision group was also impressed with the evidence that personality disorder is not stable over time (Seivewright et al. 2002; Zanarini et al. 2003),
a finding which is also tentatively supported by the age distribution associated with personality disorder found in this study. For this reason it has included two additional diagnoses; late-onset personality disorder and personality disorder in development, that allow personality disorder to be diagnosed at different ages (Tyrer et al. 2015).

Stability is a defining feature of both the ICD-10 (WHO 1992) and DSM definitions of personality disorder (NICE 2003). The cross-sectional association with age is therefore interesting as it raises a prospective research question about whether the condition truly persists across the life course. Certainly there is evidence of fluctuation over time in the presence of criteria within individuals (Livesley et al. 1992), and the course of the disorder also seems to be susceptible to treatment (NCCMH 2013; Marcus et al. 2006). Moreover, clinical trials have shown that some talking therapies can be effective in the treatment of a number of personality disorders, although the results of pharmacological trials have been less conclusive (Paris 2008).

Most people screening positive for personality disorder in the APMS sample were not receiving treatment although it is noteworthy that the prevalence of reported therapy was higher among those with personality disorder, compared to those without any personality disorder. Of those that were receiving treatment, more cited medication than psychological therapies. It is also noteworthy that screening positive for personality disorder was also associated with requesting but not receiving specific treatment.

As noted previously, the sample size and cross-sectional nature of these data requires us to treat these findings with some caution. Nevertheless, they also suggest that further improvements in treatment provision may be required in order to achieve satisfactory levels of therapeutic help for people with personality disorder as recommended by NICE. For example, NICE quality standards for people with BPD include being offered a choice of psychological therapy.
7.5 Tables

**Prevalence and trends**
Table 7.1  Screen positive for antisocial and borderline personality disorder, by age and sex
Table 7.2  Standardised Assessment of Personality – Abbreviated Scale (SAPAS) personality disorder screen, by age and sex
Table 7.3  Antisocial and borderline personality disorder (SCID-II) screen by screen for any personality disorder (SAPAS)
Table 7.4  Self-diagnosis and professional diagnosis of personality disorder, by screen positive for personality disorder

**Characteristics**
Table 7.5  Screen positive for antisocial and borderline personality disorder (observed and age-standardised), by ethnic group and sex
Table 7.6  Screen positive for any personality disorder (observed and age-standardised), by ethnic group and sex
Table 7.7  Screen positive for antisocial and borderline personality disorder, by household type and sex
Table 7.8  Screen positive for any personality disorder, by household type and sex
Table 7.9  Screen positive for antisocial and borderline personality disorder, by employment status and sex
Table 7.10  Screen positive for any personality disorder, by employment status and sex
Table 7.11  Screen positive for antisocial and borderline personality disorder, by benefit status and sex
Table 7.12  Screen positive for any personality disorder, by benefit status and sex
Table 7.13  Screen positive for antisocial and borderline personality disorder (observed and age-standardised), by region and sex

Table 7.14  Screen positive for any personality disorder (observed and age-standardised), by region and sex

Treatment and service use
Table 7.15  Treatment currently received for a mental or emotional problem, by screen positive for antisocial or borderline personality disorder

Table 7.16  Treatment currently received for a mental or emotional problem, by screen positive for any personality disorder

Table 7.17  Psychotropic medication currently taken, by screen positive for antisocial or borderline personality disorder

Table 7.18  Psychotropic medication currently taken, by screen positive for any personality disorder in past year

Table 7.19  Current counselling or therapy for a mental or emotional problem, by screen positive for antisocial and borderline personality disorder

Table 7.20  Current counselling or therapy for a mental or emotional problem, by screen positive for any personality disorder

Table 7.21  Requested but not received a particular mental health treatment in the past 12 months, by personality disorder screens

7.6 References


American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV).*


Goldstein RB, Grant BF and Ruan WI. Antisocial personality disorder with childhood vs adolescence onset conduct disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. The Journal of Nervous and Mental Disease, 2006; 194(9): 667–675.


*This chapter should be cited as:*