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Chapter 1

The Nosological Background

In this book the authors explore current issues in the conceptualisation, assessment and treatment of antisocial personality. Consideration of two related constructs, psychopathy and sociopathy, is unavoidable given overlap in their meanings. The *New Oxford Dictionary of English* offers the following definition of 'antisocial': contrary to the laws and customs of society; causing annoyance and disapproval in others, e.g., aggressive and antisocial behaviour [**1**]. A person with antisocial personality is therefore one who both acts unlawfully or contrary to social norms and customs, and behaves in ways that others find objectionable. The dictionary defines a 'sociopath' as one with a personality disorder manifesting itself in extreme antisocial attitudes and behaviour.[1] A 'psychopath' is defined as a person suffering from chronic mental disorder with abnormal or violent social behaviour. This latter definition perhaps reflects the common (layperson's) perception of the 'psychopath' as someone who is dangerous and mentally deranged. Implicit in these definitions is the idea that there exists a continuum of antisocial behaviour or 'antisociality', ranging from the obnoxious but relatively benign, through the more severe and disordered (sociopathy) to the extreme (psychopathy) characterised by abnormal or violent social behaviour. This idea of an antisociality continuum is reflected in contemporary usage of these terms.

Lykken, a pioneer of contemporary psychopathy research, drew a distinction between the sociopathic individual or 'sociopath' and the 'psychopath' [**2**]. While they were said to share a lack of the restraining influence of conscience and of empathic concern for other people, Lykken contended that sociopaths' unsocialised character is due primarily to parental failures rather than inherent peculiarities of temperament; they are 'the feral products of indifferent, incompetent or over-burdened parents' [2, p. viii]. In contrast, psychopaths' inherent peculiarities of temperament make them unusually intractable to socialization. Although subsequent research has not supported Lykken's distinction between these two types of antisociality in terms of their aetiology, subsequent research reviewed by Iacono has validated the existence of aetiologically distinct variants of antisociality – primary and secondary psychopathy – that are both appreciably heritable [**3**]. This distinction has stood the test of time and is considered in greater detail in Chapter 4. Iacono points out that parenting, especially from fathers, is important to the socialization of children, as we will see when, in Chapter 3, we consider family factors in the development of antisocial personality.

[1] The term 'sociopath' was introduced by the American sociologist George Partridge in the 1930s.

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All three terms – antisocial, sociopathic, psychopathic – have appeared in psychiatric nosologies, the most important of which are the various iterations of American Psychiatric Association's Diagnostic and Statistical Manual (DSM [**4**]) and the World Health Association's International Classification of Diseases (ICD [**5**]). The latter has adopted the term 'dissocial' to mean much the same as 'antisocial'. Below we will review how these various constructs have been treated in the various iterations of DSM and in ICD-11. Interesting to note at the outset is that 'psychopathy' and 'antisocial personality disorder' (ASPD) have been uneasy bedfellows, often diverging but at times merging together. Some psychiatrists (e.g., [**6**]) have been downright antipathetic toward the construct of 'psychopathy'. Conversely, some psychologists have been damning in their view of ASPD. Lykken, for example, stated: 'Identifying someone as "having" ASPD is about as nonspecific and scientifically unhelpful as diagnosing a sick patient as having a fever, or an infectious or neurological disorder' [**2**, p. 23]. Lykken considered that ASPD comprises a family of disorders, the largest and most important of which is the 'genus' of sociopaths. We return to psychopathy throughout book and will examine in greater detail the ASPD construct. We will first briefly review the historical development of the ASPD construct in the various iterations of DSM (here we draw heavily on the review by Crego and Widiger [**7**]).

ASPD in DSM

When the first edition of DSM (DSM-I [**8**]) appeared in 1952 it included a category termed 'sociopathic personality disturbance' encompassing a range of problems including sexual deviations, addictions, and a condition referred to as 'sociopathic personality disturbance: antisocial reaction' marked by persistent aggression and criminal deviance. When the first revision of DSM (DSM-II) appeared in 1968, the term 'reaction' was eliminated; sexual deviations, addictions and delinquent personality types were grouped together under 'Personality Disorders and Other Non-Psychotic Mental Disorders', which included a condition referred to as 'antisocial personality' [**9**]. Aligning the ASPD construct more closely with Cleckley's psychopath prototype [**10**], a person with antisocial personality was said to be grossly selfish, callous, irresponsible, impulsive, unable to feel guilt or to learn from experience and punishment, and to have a low tolerance of frustration. Individuals with antisocial personality were said to repeatedly come into conflict with society, to have a low frustration tolerance and a tendency to blame others for their problems. It further specified that a mere history of repeated legal or social offences was not sufficient to justify this diagnosis. The third edition of DSM [**11**] and its revision (DSM-III-R) saw much greater emphasis being placed on overt behaviour in its definition of ASPD. The nine items in DSM-III were childhood conduct disorder (required), along with poor work history, irresponsible parenting behaviour, unlawful behaviour, relationship infidelity or instability, aggressiveness, financial irresponsibility, no regard for the truth, and recklessness [**12**]. Explicit criterion sets were stipulated, with each criterion having relatively specific requirements. For example, recklessness required the presence of 'driving while intoxicated or recurrent speeding'. The intention was to obtain greater diagnostic reliability, but in doing so, validity was sacrificed. From a psychological point of view this move toward behavioural criteria was a retrograde step, since it neglected the psychological factors such as motivational and emotional goals that may underlie these behaviours. Classifying people by their actions

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rather than by their psychological dispositions or traits may be suitable for purposes of criminal law, but it neglects the variety of reasons for any given action [**2**]. Speeding can have a variety of motivations, for example, fear of missing an urgent appointment or a desire for the thrill of driving fast, and may be accompanied by quite different emotions (anxiety or exhilaration). New to the DSM-III-R criterion set was the lack of remorse, along with impulsivity or failure to plan ahead [**12**]. DSM-III-R shifted all of the personality disorders to polythetic criterion sets, requiring the presence of only a subset of features for an ASPD diagnosis.

The appearance of DSM-IV in 1994 marked a move away from DSM-III's and DSM-III-R's emphasis on behavioural criteria, many of which were removed [**13**]. It was the intention of the authors of the DSM-IV ASPD to shift the diagnosis closer to the conceptualization of psychopathy embodied in the Psychopathy Checklist (PCL) developed by Robert Hare in the early 1980s and revised (PCL-R; see Box 1.1) in 1991 [**14**]. This revision deleted two items from the original 22-item checklist (drug and alcohol abuse, and a prior diagnosis of psychopathy) and broadened the irresponsibility item to involve behaviours beyond simply parenting. The items of the PCL-R fall conceptually and statistically into distinguishable sets, or factors [**15**]. Factor 1 ('interpersonal/ affective') comprises separate interpersonal and affective facets. Factor 2 ('unstable and antisocial lifestyle') comprises lifestyle and antisocial facets. Two items shown in Box 1.1, sexual promiscuity and having many short-term marital relationships, contribute to the total PCL-R score but not to any of the factors or facets.

The criteria for ASPD in DSM-IV (and retained in the main section of DSM-5 [**16**]) are shown in Box 1.2. At least three criteria are required for an ASPD diagnosis. An additional requirement is evidence of childhood conduct disorder (CD), but the number

Box 1.1 PCL-R Items

glib and superficial charm*
grandiose sense of self-worth*
need for stimulation
pathological lying*
conning/manipulative*
lack of remorse or guilt*
shallow affect*
callous/lack of empathy*
parasitic lifestyle
poor behavioural controls
sexual promiscuity
early behaviour problems
lack of realistic long-term goals
impulsivity
irresponsibility
failure to accept responsibility for own actions*
many short-term marital relationships
juvenile delinquency
revocation of conditional release
criminal versatility

(* indicates interpersonal/affective items)

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Box 1.2 DSM IV/5 ASPD Criteria

At least THREE of the following are required:

1. Failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
2. Deception, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure
3. Impulsivity or failure to plan ahead
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. Reckless disregard for safety of self or others
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another

Box 1.3 DSM-IV/5 PDs

Cluster A Odd and eccentric	**Paranoid**: Distrust; suspiciousness **Schizoid**: Socially and emotionally detached **Schizotypal**: Social and interpersonal deficits; cognitive or perceptual distortions
Cluster B Dramatic, emotional and erratic	**Antisocial**: Violation of the rights of others **Borderline**: Instability of relationships, self-image and mood **Histrionic**: Excessive emotionality and attention-seeking **Narcissistic**: Grandiose; lack of empathy; need for admiration
Cluster C Anxious and fearful	**Avoidant** : Socially inhibited; feelings of inadequacy **Dependent**: Clinging; submissive **Obsessive-compulsive**: Perfectionist; inflexible

of CD criteria which had to be fulfilled was not specified. The chief difference between ASPD as defined in DSM and psychopathy as defined by PCL-R is inclusion in the latter of the interpersonal/affective features asterisked in Box 1.1. Hence ASPD is more closely related to PCL-R Factor 2 than to Factor 1. Psychopathy can be considered a more severe variant of antisociality than ASPD; thus, while about 75% of prison inmates were said to meet criteria for ASPD, only 15–25% were said to meet criteria for psychopathy [**17**]. These figures need to be qualified by recent results from a large database of US prison inmates [**18**]. Of 1,000 prison inmates, 42% met criteria for ASPD, and of 4,600 inmates, 22% met the criterion for PCL-R psychopathy (total score $\geq$ 30). Compared with offenders with ASPD only, those whose ASPD co-occurs with psychopathy show more severe criminal behaviour [**19**]. Those showing a triple comorbidity (ASPD comorbid with both psychopathy and borderline PD, characterized by a pervasive pattern of instability; see Box 1.3) were reported to show especially severe violence in their criminal history [**20**]. Thus although psychopathy appears to lie toward the high antisocial end of

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the prosocial-antisocial continuum, it gives rise to a more severe manifestation of antisociality when combined with ASPD and borderline PD.

By the time DSM-5 appeared in 2013, there was considerably more research concerning psychopathy than ASPD. This was due to the large impetus to psychopathy research resulting from development of the PCL-R, which, while requiring special training, did not require expertise or training in psychiatry. It again appeared to be the intention of the DSM-5 work group to shift the diagnosis of ASPD toward PCL-R and/or Cleckley psychopathy. This was explicitly evident in the proposed (but subsequently rejected) change in name from 'antisocial' to 'antisocial psychopathic'. Despite increasing indications that the features of PD are continually distributed and do not form discrete categories in nature, the APA Board of Trustees voted to retain the DSM-IV diagnostic system for personality disorders virtually unchanged in the main section of DSM-5. A brief description of each of these PDs is given in Box 1.3.

Among the many shortcomings acknowledged to attach to diagnostic categories of PD are their excessive comorbidity, their heterogeneity and their limited clinical utility. To this list may be added their impoverished and limited criteria. For example, hostility, sadism, lack of empathy, lack of insight, self-importance and power-seeking are arguably defining features of antisocial personality disorder, yet these aspects of mental life are absent from the DSM description. Contrast the truncated criteria for ASPD offered by DSM-IV/5 with the far more comprehensive description offered by Shedler and Westen [**21**]:

> Patients with this personality syndrome tend to take advantage of others, are 'out for number one,' and have little investment in moral values. They tend to be deceitful, to lie or mislead, and to engage in unlawful or criminal behavior. They have little empathy, appear to experience no remorse for harm or injury caused to others, and may show reckless disregard for the rights, property, or safety of others. They tend to act impulsively, without regard for consequences. They seem unconcerned with consequences and appear to feel immune or invulnerable. They tend to be unreliable and irresponsible (e.g., they may fail to meet work obligations or honor financial commitments). Patients with this syndrome try to manipulate others' emotions to get what they want. They tend to be angry or hostile, to seek power or influence over others, and to be critical of others. They appear to gain pleasure or satisfaction by being sadistic or aggressive. They may abuse alcohol. They tend to be conflicted about authority and are prone to get into power struggles. They blame others for their own failures or shortcomings and appear to believe that their problems are caused entirely by external factors. They have little psychological insight into their motives and behavior. They may have an exaggerated sense of self-importance.

Despite retaining the DSM-IV PD categories in the main section of DSM-5, it was decided to include an 'alternative DSM-5 model for personality disorders' in Section 3 of DSM-5, the section referred to as 'Emerging Measures and Models'. This alternative, hybrid model will be described below.

If ASPD is defined, at least in part, in terms of doing things that could result in arrest (criterion 1 in Box 1.2), then naturally a large number of incarcerated persons will appear to suffer from the disorder. A sharper focus on the individual symptoms listed in Box 1.2 reveals particular problems with ASPD as a diagnostic category. Thus in a study by Schnittker and colleagues, the presence and symptoms of ASPD were explored among people with varying degrees of contact with the American criminal justice system (CJS) [**22**]. Overall, nearly half of all respondents, who comprised 5,001 adults resident in the

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community, had some exposure to the CJS. Results indicated that contact with the CJS appeared to exert a disproportionate influence on an ASPD diagnosis. The prevalence of ASPD using the standard criteria (three or more of the symptoms listed in Box 1.2) was 14%. When symptom 1, failure to conform to social norms as indicated by having been arrested, was eliminated from the diagnosis, the prevalence of ASPD was reduced by more than 50%, even among formerly incarcerated persons. Some symptoms, in particular irritability/aggressiveness and irresponsibility, appeared to be linked to the presence and length of incarceration. This led the authors to suggest that the symptoms of those previously incarcerated might have been driven by their circumstance rather than by their personality. Last, and perhaps most important, criterion 7, lack of remorse, was met by only 5% of the overall sample and did not distinguish those receiving an ASPD diagnosis from those not receiving this diagnosis. Of the ASPD criteria listed in Box 1.2, only criteria 2 and 3 (deceitfulness and impulsivity) appeared to differentiate, to any substantial degree, those with from those without an ASPD diagnosis. We should note that assessment of ASPD in this study was carried out by lay interviewers rather than by mental health professionals. This might have led to the prevalence of an ASPD diagnosis in the sample being inflated. Despite its limitations, this study clearly indicates the need for a sharper focus on individual ASPD criteria so that criminality can be disaggregated from personality symptoms. Importantly, ASPD as specified in DSM does not appear to adequately capture the construct of insensitivity that, according to Tyrer [**23**], is one of its key features (see Box 1.4 below).

Gender Differences in ASPD

ASPD is three times more prevalent in men than in women, less than 1% of whom are reported to receive this diagnosis [**24**]. We should note that many gender differences have been observed in ASPD with regard to its prevalence, risk factors, aetiology, genetic underpinnings, comorbid disorders, prognosis, key traits and symptoms, and its overall presentation (summarised in Table 1 in [**24**]). Males and females with ASPD differ in predisposing factors, offending behaviours, deceitfulness and impulsivity (more likely in females), aggression and recklessness (more likely in males), relationship problems (more promiscuity in males, greater marital separation in females), substance misuse (common in females, but highly prevalent in males), comorbid internalising disorders (more common in females) and narcissistic PD (more common in males). These authors point out that there is still a dearth of research carried out on women with ASPD, and very little is understood about why these gender differences occur. There is a significant

Box 1.4 The Three I's of ASPD (after Tyrer [23])

- **Insensitivity**: the ability of some to disregard the humanity of others; to commit execrable acts against a person without any remorse. Insensitivity, lack of empathy and callousness all describe the central features of antisociality and is a prime factor in psychopathy. This insensitivity extends to insensitivity about oneself, the lack of awareness of who you are.
- **Infringement**: the violation of basic rights of others.
- **Injury**: injury and unjustified physical and mental aggression, used as a means of control.

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proportion (somewhere between 30% and 50%) of female offenders with the disorder who would benefit from specific interventions and treatment programs, as well as customized assessment tools. We will consider gender differences in ASPD in greater detail when we examine its epidemiology in Chapter 5. In Chapter 3 we consider the possibility that developmental pathways to adult antisociality are gender-linked.

DSM-5 Alternative Model for Personality Disorders (AMPD)

In the Section 3 alternative model, the essential criteria to define any personality disorder are, first, moderate or greater impairment in personality functioning (criterion A) and, second, the presence of pathological personality traits (criterion B). As defined in this model, personality functioning consists of the degree to which there is an intact sense of self (involving a clear, coherent identity and effective self-directedness) and interpersonal functioning (reflecting a good capacity for empathy and for mature, mutually rewarding intimacy with others). This hybrid model requires assessment of the level of impairment in relation to six specific personality disorder types (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal) with the option for a diagnosis that is trait specified. Pathological personality traits are organized into five trait domains (negative affectivity, detachment, antagonism, disinhibition and psychoticism), each of which is further explicated by a set of trait facets reflecting aspects of the domain itself. A self-report instrument, the Personality Inventory for DSM-5 (PID-5), has been developed to measure these traits and their facets [25]. This trait system has been shown to correlate well with the Five-Factor Model, as shown in Figure 1.1. Watson and Clark [**26**] showed that the AMPD could be realigned to enhance its convergence with the Five-Factor Model of personality. A principal factor analysis based on these authors' revised PID-5 yielded a clear and well-defined 'Big Four' structure comprising neuroticism/negative affectivity**,** antagonism (vs agreeableness), extraversion (vs detachment) and conscientiousness (vs disinhibition). Watson and colleagues have shown that some, especially agentic, aspects of extraversion have important links to personality pathology, for example, recklessness and exhibitionism [**26**, **27**].

The trait facets that are diagnostic for an ASPD diagnosis (criterion B) in the alternative model, together with criteria for impairment (criterion A), are shown in Box 1.5. The trait domains and facets can be measured either using the PID-5 [**25**] or by clinician ratings, for example, using the DSM-5 Clinicians' Personality Trait Rating Form (PTRF [**28**]). An interview-based instrument, the Semi-Structured Interview for Personality Functioning DSM-5 (STiP-5.1), has been developed to determine the severity of personality impairment [**29**]. Wygant and colleagues developed an interview-based instrument, the DSM-5 ASPD Impairment Criteria Interview, to assess impairments in identity, self-direction, empathy and intimacy in ASPD and psychopathy [**30**]. However, results indicated that only the measure of self-direction significantly predicted ASPD. It therefore remains to be seen whether impairments in identity/self associated with ASPD can be reliably identified and measured. We return to this question in the final section of this chapter and in the following chapter.

The AMPD includes a psychopathic features specifier for the diagnosis of ASPD associated with interpersonal/affective features of psychopathy. These features are indicated by low scores on anxiousness (from the negative affectivity domain) and withdrawal (from the detachment domain) together with a high score on attention seeking

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DSMS Domain	Description	Core facets used to score the domain	Big Five/FFM counterpart
Negative affectivity	More frequent and intense experiences of negative emotions including depression, anxiety, and anger	Anxiousness; emotional lability; separation insecurity	Neuroticism
Detachment	Diminished interest and emotional responsivity to social intractions; diminished positive emotionality more generally	Anhedonia; intimacy avoidance; withdrawal	Low extraversion
Antagonism	Emotional, cognitive and behavioral styles that are self-focused rather than other-focused; involve willingness to take advantage of others and interpret others' behavior through negative and hostile lens	Deceitfulness; grandiosity; manipulativeness	Low Agreeableness
Disinhibition	Emphasis on short-term reward; difficulty delaying gratification and considering long-term implications of behavior	Distractibility; impulsivity; irresponsibility	Low conscientiousness
Psychoticism	Presence of cognitions, emotions, and behaviors that are non-normative, unusual, and idiosyncratic.	Eccentricity; perceptual dysregulation; unusual beliefs and experiences	High openness (?)

Figure 1.1 DSM-5 Section 3 domains and their Five-Factor Model counterparts. From [**31**].

(from antagonism). There seems little doubt that this alternative model represents a much closer alignment of ASPD with psychopathy. However, there is limited representation of PCL-R psychopathy traits in the alternative DSM-5 Section 3 model [**31**]. For example, grandiosity was not included within the dimensional trait description of ASPD nor even within the eventually added psychopathy specifier. Wygant and colleagues [**30**, **32**] examined whether, in male and female offender samples, the DSM-5 alternative model of ASPD had moved closer to the traditional construct of psychopathy relative to the behaviourally oriented Section 2 model. While indicating a resounding affirmative response to this question, their results suggested that two additional trait facets, namely, grandiosity and restricted affectivity, might usefully be added to the trait facets listed in Box 1.5. Wygant and colleagues' results indicated that the psychopathy specifier facets (low anxiousness, low withdrawal and high attention seeking) aligned more clearly with interpersonal/affective features of psychopathy than did the Section 2 model of ASPD. When assessed by a self-report measure, the Minnesota Multiphasic Personality Inventory (MMPI), ASPD was associated with a broad spectrum of maladaptive personality traits and overlapped considerably with other PDs [**33**]. This points in the direction of a general severity dimension of PD, an aspect that is emphasised in the revised ICD assessment of PD which we consider below.

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Box 1.5

BOX 1.5. Criteria for ASPD in DSM-5 Alternative Model

CRITERION A	CRITERION B
At least moderate impairment in at least TWO of the following areas:	Elevations on at least SIX of the ASPD-specified traits from domains of:
IDENTITY/SELF-DIRECTION • Egocentricity • Absence of internal prosocial standards • Failure to conform to lawful behaviour	**ANTAGONISM** • Manipulativeness • Deceitfulness • Callousness • Hostility
EMPATHY/INTIMACY • Lack of concern for others • Lack of remorse • Exploitativeness • Use of deceit • Coercion, dominance and intimidation to fulfill interpersonal needs	AND **DISINHIBITION** • Irresponsibility • Impulsivity • Risk-taking

Zimmerman and colleagues [**34**] highlight an important question with regard to the AMPD, namely, whether impairments in personality functioning (criterion A) and maladaptive personality traits (criterion B) provide distinct or overlapping information. Empirical findings reviewed by these authors indicated that measures of criterion A (including similar measures of personality functioning) and criterion B were highly correlated. A review by Widiger and colleagues [**35**] indicated considerable overlap between criterion A deficits and criterion B traits, and that criterion A may be largely redundant in the assessment of PD. However, other authors support the idea that criterion A (self/other deficits) adds importantly to the assessment of PD. Most clinicians would argue that intrapersonal and interpersonal problems are core features of personality pathology, with evidence suggesting that they co-exist and are reciprocally interrelated in PD patients [**36**]. It can be argued that the way self/other deficits are formulated in AMPD criterion A does not adequately capture all there is to know about the individual's sense of self and interpersonal relatedness or offer ideas on how to improve self and relational functioning. Two separate questions arise in relation to

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ASPD. First, do the self and interpersonal descriptions contained in DSM-5 criterion A adequately capture the intrapsychic and interpersonal deficits shown by individuals with ASPD? Second, does a description of ASPD in terms of the trait domains and facets as captured by AMPD measures (see Box 1.5) adequately cover core features of their interpersonal deficits? In the chapter that follows we will examine in greater detail the question of what exactly are the interpersonal deficits of antisocial individuals.

ICD-11

Compared with DSM-5, ICD-11 represents a more radical departure from the categorical system of assessing PD. ICD-11 has jettisoned all PD categories in favour of assessing the level of PD severity, ranging from mild to severe, with each level of severity qualified by five trait domains (negative affectivity, disinhibition, dissociality, anankastia and detachment). One exception to ICD-11's eschewal of PD categories has been its retention of a 'borderline pattern specifier'. The definition of PD in ICD-11 is shown in Box 1.6. DSM-5 Section 3 and ICD-11 share a twofold conceptualization of severity and style, but there are noteworthy differences. First, ICD-11 does not include the possibility to assign specific PD diagnoses (except borderline PD). Second, in ICD-11 the assessment of trait domains is not a necessary part of the diagnosis; for a diagnosis of PD in AMPD, at least one maladaptive personality trait domain or facet must be in the clinically significant range. Third, the trait domain of psychoticism and its trait facets are absent from ICD-11.

Both DSM-5 AMPD and ICD-11 emphasize, in broadly similar ways, severity as an important factor in assessment of PD. While DSM-5 and ICD-11 both emphasise interpersonal dysfunction as critical to a diagnosis of PD in general, ICD-11 gives this rather more emphasis than does DSM-5. For ICD-11, the severity of interpersonal problems is a key factor in defining overall severity of PD. A classification as mildly severe requires that there should be notable problems in *many* interpersonal relationships. For a classification as moderately severe there should be marked problems in *most* interpersonal relationships. A classification as severe requires that there should be severe problems in interpersonal functioning *affecting all areas of life*.

It should be noted, however, that other features are important in defining severity of personality dysfunction in ICD-11, namely: degree and pervasiveness of disturbances in functioning of aspects of the self; pervasiveness, severity and chronicity of emotional,

Box 1.6 The ICD-11 Definition of Personality Disorder

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

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