Chapter 1

History of Personality and Its Disorders

Historical chapters in scientific books are generally dull even though they do not intend to be. There is an understandable need to record what happened in the past even though it may be quite irrelevant to what is going on today. We are frequently asked to remember George Santayana's comment, made by many others, that 'those who cannot remember the past are condemned to repeat it' (Santayana, 1905). But this is hardly relevant for a textbook on The Wheel. Those who concentrate on wheel technology are not going to be particularly interested, except in a voyeuristic sense, in how Neolithic people might have been able to move large blocks of stone to Stonehenge for hundreds of miles using primitive garden rollers. But with personality disorder it is different. Without some knowledge of the history of personality disorder current descriptions cannot be placed in any sort of context.

This chapter highlights the split between the general notion of personality as a universal characteristic, a safe and acceptable subject, and the more focused history of personality disorder as a psychiatric condition, a highly stigmatised subject. We can divide this history into four ages.

1.1 Age 1. The Age of Discovery (460 BC–AD 1700)

Personality as a concept has been present almost since the dawn of civilisation. It is part of the mix that makes us human. All the primates are social animals and so personality is integral to their functioning, and as humankind has become more organised in its social structures the importance of personality has correspondingly increased. Nomenclature has changed from discussion of the four humours to categories and other groupings but personality has never lost its central importance.

Hippocrates (460 BC) begins the historical story; he often does. The importance of personality comes out in his teaching of the four humours. Essentially this presents the body as a combination of four substances (or humours): black bile, yellow bile, blood and phlegm. In order for a person to stay healthy, these humours have to be in balance. Sickness is the consequence when this balance is lost. It is easy to see how this view was created, as in most illnesses there are changes in the emanations of the body that are abnormal. The correct treatment of illness was to put these humours back into balance.

But it was his disciple, Galen, a Greek who, 500 years later, served as physician to many of the Roman emperors, who attached the humours to personality. Galen was impatient to apply the work of Hippocrates to medical practice, and in his work derived the first proper classification of personality types that has persisted in various forms to the present day. So personality became attached, almost indelibly, to the four humours:

- Black bile – melancholia and depressive personality

- Yellow bile – choleric personality with aggressive and explosive outbursts
- Blood – positive forceful (sanguine) personalities with great drive
- Phlegm – passive (negative) detached personalities.

It is easy to see how three of these could subsequently be attached to personality disorder. Don't worry – they were. This was too good an idea to fade into obscurity.

Another initiator of the notion of personality types was Aristotle's pupil Theophrastus, born in 371 BC. Theophrastus was a good observer, and he begins his description of each of his personality types (which he calls 'characters') with a brief account of the person concerned, followed by their personality foibles. In all he describes 30 characters, some of which when combined resemble modern descriptions of personality types, but others demonstrate only too well that they are poor ways of grouping people.

Theophrastus is bright and inquisitive and also very nosy (a useful quality in those who want to know more about personality), and starts off with the penetrating question about diversity: 'why it is that, while all Greece lies under the same sky and all the Greeks are educated alike, it has befallen us to have characters so variously constituted?' (Theophrastus, 1909). He then describes 30 of these characters in such a way that it constitutes a prototypical classification – descriptions that the reader can pigeonhole and recognise immediately. One of the best examples is the account of the 'distrustful man' who in many ways resembles the paranoid category of the International Classification of Diseases 10 (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV.

> The distrustful man is one who, having sent his slave to market, will send another to ascertain what price he gave. He will carry his money himself, and sit down every two-hundred yards to count it.
>
> (Theophrastus, 1909)

Similarly, the 'superstitious man' reflects some of the features of what is now called schizotypal personality, appearing to exhibit 'cowardice towards divine power'. Even when the soothsayer tells him that the mouse hole in his sack has no mystic significance and should be repaired by an ordinary cobbler, he proceeds to offer a sacrifice in expiation.

But then Theophrastus gets diverted into descriptions of his own personal prejudices. We read about the 'Ironical man', the 'Garrulous and the Chatty man' (obviously overlapping), the 'Gross man' (not gross in size but insensitive in behaviour), the 'Officious man' (one steeped in conventional authority) and the 'Late-learner' (one who engages in activities when too old), and it does not take much reflection to realise that these are not useful universal concepts. The 'Man of Petty Ambition' and the 'Boastful man' (an habitual liar who 'stands in the bazaar talking to foreigners of the great sums which he has at sea; about the vastness of his money-lending business and the extent of his personal gains and losses') can seem more accurate descriptions, but the 'Oligarch' (who loves authority and is covetous, not of gain, but of power), the 'Patron of Rascals' (who likes the company of those involved in 'criminal causes') and the 'Avaricious man' (who has 'excessive desire of base gain') are all obviously recognisable but not necessarily linked to personality pathology (Aldington, 1924).

These descriptions make amusing reading (see www.eudaemonist.com/biblion/characters), but their main interest is to show that the gossip in the Athenian marketplace of 2500 years ago is little different from the gossip of boardrooms, production lines and offices of today. We all like to gossip about others' personalities, usually sotto voce with selected

people. It gives us a little thrill and puts us into special coteries of understanding. Despite the curious paradox of modern science largely ignoring disorders of personality and valiant attempts of others to suppress the term altogether, it is always with us.

George Stein has made an exhaustive and penetrating study of the psychiatric aspects of the writings revealed in the Old Testament of the Bible (Stein, 2018). The book of Proverbs (800–500 BC) is a guide to success in leading a contented and moral life. It is expressed as a series of teachings in the form of proverbs from fathers to their sons on how to achieve wisdom in life. The opposite of wisdom is folly, and the text describes a number of different fools who should not be emulated and should be avoided at all costs. The word fool in the English is a translation for several different character types found in the Hebrew text, and although these are described as bad characters, it is not difficult to detect that the 'bad character' types show many of the known features of modern day personality disorders, especially antisocial personality disorder (Stein, 2018, p. 386).

One character in particular chimes with personality disorder; the *Belial* or Scoundrel, who is described as having a perverted mind, devises evil schemes and goes around sowing discord. He is haughty and lies and spreads strife. He testifies falsely, sows discord in his family and he sounds just like a textbook example of an aggressive psychopath (Stein, 2018, p. 437). There are several other malevolent characters described in this text: the *pithy* combines antisocial behaviours with stupidity; the *ceil* is an immoral fool and is also not very bright but not as stupid as the *pithy*; the '*ewil* is an immoral antisocial type but of normal or above average intelligence; the *les* is a narcissist with arrogance and contempt for others and is also an antisocial person but of normal intelligence. The book of Proverbs also has verses which contain 21 out of the 22 antisocial character traits that comprise the Hare Psychopathy Check List (PCL-R) (see Chapter 2). The only trait that cannot be located is 'parasitic existence', but this is hardly surprising as there were few opportunities to be parasitic in society in ancient Israel.

Finally, unusual females are described in the book of Proverbs, the *essa zarah,* or the strange women, often mistranslated in English Bibles as 'the loose women'. Each of these has seductive speech, is adulterous and can dress up like a prostitute. They are loud and wayward, have itchy feet and lack any sense of identity. They can also be bitter and angry and are emotionally unstable. Stein suggests this description shows some resemblance to current Cluster B personality disorders, particularly borderline and histrionic disorder, and fulfils diagnostic criteria for both. It is quite possible that Kurt Schneider had read about these before deciding to make his own assessments of personality disorder with the prostitutes in Hamburg (see 1.3, Age 3. The Age of Investigation and Intervention).

Some would argue that it is too much of a leap into the dark to equate an immoral character of the Bible, from a rural society of the first millennium BC, with a twenty-first-century Western medical category such as a personality disorder. But the language of personality crosses millennia and cannot easily be ignored.

But although Stein equates this with psychopathy and antisocial personality disorder, the descriptions in Proverbs are basically no different from those of Theophrastus. They are character descriptions of personality and not defined in terms that naturally allow conversion to descriptions of disorder.

But these examples illustrate that personality types (i.e. descriptions of dominant features of personality) have been well described for centuries. Robert Burton, in his comprehensive account of depression and associated disorders, *The Anatomy of*

Melancholy, describes the typical melancholic as having 'a calm, quiet and patient personality' (Burton, 1621; republished 1927).

1.2 Age 2. The Age of Personality as a Substrate (1750–1950)

This title may seem odd to modern readers. But in the eighteenth and nineteenth centuries, personality and its disorder was seen as an underlying substrate to all mental illness. It is common to refer to James Prichard (1837) as a key definer of personality disorder in his description of moral insanity, but his descriptions are more those of mood (hypomania) rather than personality disorder. The same applies to Philippe Pinel's description of 'manie sans délire' (Pinel, 1809), often wrongly referred to as a description of personality pathology. 'Manie', at the time of Pinel, referred to almost all serious mental illness and did not embrace personality.

What was happening around this time was the recognition that personality problems were somewhat separate from mental illness but could also influence them. Henry Maudsley described people who would now be regarded as unequivocally antisocial:

> They display no trace of affection for their parents, or of feelings for others; the only care they evince is to contrive the means of indulging their passions and vicious propensities.
>
> (Maudsley, 1868, p. 329)

Bénédict Morel was born in Vienna but practised all his life in France, and he created a classification system that included the notion of hereditary insanity – that some individuals had congenitally nervous temperaments that made them more prone to insanity (Morel, 1852). This notion of hereditary disposition in personality disorder was a pernicious one and has persisted unfairly. It was followed by the notion of 'psychopathic inferiorities' introduced by Julius Koch in 1888, who summarised the condition as some having it from birth, some acquiring the condition and the worst group showing degenerative features (Shorter, 2005, p. 213). This was when stigma developed in earnest.

But the notion of personality as an underlying substrate influencing or creating predisposition to mental illness had taken root. Here we had a condition that was on the fringe of mental illness but could not be ignored as at the time it could prod you unwillingly into the realm of other mental disorders.

In the early twentieth century four figures dominated the study of personality: Sigmund Freud, Adolf Meyer, David Henderson and Gordon Allport. Freud's description of oral, anal and phallic phases of sexual development are too well known to go into detail here, but his description of what happens when these phases are arrested brought him into discussion of underlying personality (although he described this as character rather than personality) (Freud, 1916; republished 1963). This had a major influence on psychiatric thinking. Adolf Meyer is much less known nowadays, although he was at least is as well known as Freud in the early years of the twentieth century (Meyer, 1950). He was a German-speaking Swiss who emigrated to the USA at an early age and quickly made a name for himself as an all-round psychiatrist with an eclectic view of the subject. He accepted that psychoanalysis had something to offer but rejected its theory-based approach and much preferred one based on common sense. Unfortunately, despite being an excellent teacher, his writings are almost impossible to follow, and none of them are really quotable.

This is unfortunate because there is much that can be learned from Adolf Meyer's approach. He regarded the personality of a person as integral to the manifestation of mental

illness. Put simply, something Meyer seemed incapable of doing, except in lectures, the personality of a person is the foremost mental feature and any subsequent illness was regarded as a reaction to this. This led to a somewhat confusing idea of diagnosis in which each psychiatric diagnosis, now regarded as a disorder, was described as a 'reaction type'. For the average psychiatrist this was confusing, but in making a psychiatric assessment Meyer emphasised the importance of getting to know each aspect of that person's life, their thinking and their goals. In teaching medical students, he asked each of them to assess a colleague's personality in this way in order to get what would now be described as 'whole person thinking'. He was especially concerned about a diagnostic label being given to a patient prematurely as this would inhibit further enquiry and thought. He would certainly have reinforced the concerns about over-diagnosis in psychiatry, perhaps best expressed by Allen Frances (2013), and might well have agreed that DSM really stood for 'Diagnosis for Simple Minds' (Tyrer, 2012).

The reason why Meyer became the most important figure in US psychiatry was because he bridged the different disciplines and theories swirling around the subject at the beginning of the twentieth century. He accepted the principles of psychoanalysis but felt they were overstated; he felt psychiatry should be linked to medicine but not absorbed into it, and he was very supportive of a multidisciplinary approach to treatment (his wife was a social worker).

Adolf Meyer inspired others, including Rolv Gjessing in Norway (who identified the cause of periodic catatonia) and David Henderson in Edinburgh. (Gjessing had a notice on his office door 'In the long run it all depends on personality'.) Henderson worked with Adolf Meyer early in his career and subsequently became one of the foremost psychiatrists in the United Kingdom, writing the standard textbook on the subject in 1927 (Henderson and Gillespie, 1927), with revised editions until 1961. He too referred to reaction types throughout these books, but he also developed Meyer's interest in personality further.

He published a book, *Psychopathic States* (Henderson, 1939), in which he defined three types of psychopaths. The first, equivalent to what is now commonly known as psychopathic personality was aggressive and dangerous. The second was the inadequate psychopath, a person who lived off society by swindling and cheating, was frequently in prison for minor offences, but who was not violent, and the third group, the most controversial, being eccentric people who went against social norms. He included individuals such as Lawrence of Arabia in this group, but most would not consider many of these examples to be psychopathic in the same way as the other two groups. His book was a major influence in the UK in the mid-twentieth century, and his advocacy of psychopathy as an important condition for psychiatrists to recognise led to the first hospital to treat this condition in the form of a therapeutic community. It was named the Henderson Hospital.

Gordon Allport added much more rigour to the study of personality than Meyer and Henderson. He rejected the psychoanalytic approach to personality, which he viewed as interpreting beyond the data, but was equally rejecting of the behavioural approach, which he considered did not interpret enough. In their place he developed a trait theory of personality. Before his theory was described, the word 'trait' was very liberally used to cover different types of behaviour, belief systems and habits, and was generally reviled as a scientific concept.

Allport (1927), together with his brother, Henry, the originator of social psychology (Allport and Allport, 1921), made trait theory respectable by defining it more tightly with five key elements:

(1) the recognition of 'trait' as the unit of personality,
(2) the admission of a probable hierarchy of traits, certainly of unit tendencies higher than the level of specific habits,
(3) an approach to the problem of the limits of generalization in the most comprehensive traits,
(4) the admission of both a major synthesis in personality as well as minor syntheses and dissociated acts,
(5) the tentative admission of subjective values as the core of such syntheses, but the exclusion of objective evaluation (character judgments) from purely psychological method.

(Allport, 1927)

The first two of these are the most significant. Traits were persistent; other features (unless they were linked to traits) were not, and so it was reasonable to regard the measurement of traits as a true record of personality. The second acknowledged that all trait measures were only a guide to underlying personality and that although relatively few 'higher order' traits might be identified, there were many other 'lower order' ones that could be measured too (covered by points 3 and 4 above). The fifth point allowed for the subjective expression of relevant traits to be more dominant than objective measures alone (e.g. the fact that you hit somebody after an argument did not necessarily mean you had an aggressive trait).

A single sentence tried to cover all these points:

> A trait is a dynamic trend of behavior which results from the integration of numerous specific habits of adjustment, and which expresses a characteristic mode of the individual's reaction to his surroundings.
>
> (Allport, 1927, p. 288).

But of course this chapter would be remiss if it pretended that the range of personality can be completely encapsulated by a single description or a set of traits. The best personality descriptions come from books, both fictional and biographical. Here is an excellent dissection of the differences in the writings of Charles Dickens and Leo Tolstoy that illustrates the subtleties of personality description:

> Except in a rather roundabout way, one cannot learn very much from Dickens. And to say this is to think almost immediately of the great Russian novelists of the nineteenth century. Why is it that Tolstoy's grasp seems to be so much larger than Dickens's – why is it that he seems able to tell you so much more about yourself? It is not that he is more gifted, or even, in the last analysis, more intelligent. It is because he is writing about people who are growing. His characters are struggling to make their souls, whereas Dickens's are already finished and perfect. In my own mind Dickens's people are present far more often and far more vividly than Tolstoy's, but always in a single unchangeable attitude, like pictures or pieces of furniture. You cannot hold an imaginary conversation with a Dickens character as you can with, say, Peter Bezoukhov. [Note that Orwell hated using foreign words, so Pierre became Peter.]
>
> (Orwell, 1940)

This is where descriptions of personality types can never do their subjects justice, and even traits go only part of the way to understanding. We need to assess personality abnormality, even within the bounds of a limited classification system, in a way that allows for considerable variation, rather than a stock display of characters that only appear to be

cartoons. This shows the attraction of Dickens as a character builder but not as a developer. We need a classification of personality and personality disorder that allows people to grow or even shrink, like Tolstoy's, a daunting challenge.

1.3 Age 3. The Age of Investigation and Intervention

By the middle of the twentieth century there was a reasonable level of agreement between psychologists, psychiatrists and the lay public about personality. 'Habit is the fly-wheel of society', said William James (1890), and a tighter definition of 'habits' in the form of traits, and a general understanding that personality was a measurable entity helped research and discourse.

But since the time of Koch, paradoxically, the more personality disorder was studied, the more it was rejected. The main reason was that stigma had added its own carriage on the train of personality disorder and has been there ever since, waving furiously at bystanders to stay away. Pierre Janet added a little more by his description of the hysterical personality in 1893, essentially a fuller development of his idea of hysteria as dissociation. Kraepelin also described psychopathic personalities but was eclipsed by Kurt Schneider, who in 1923 attempted to synthesise previous descriptions in his book, *Die Psychopathischen Persönlichkeiten* (Schneider, 1923).

This described ten different personalities, not formally called disorders but certainly interpreted as such. It is often believed that he garnered his ideas from his clinical experience but he had already published a book on *The Personality and Fate of Registered Prostitutes* in 1921 (Schneider, 1921) when he described 12 different personality types. These types were all called 'psychopathic' and they have dominated the nomenclature for a century with no good justification (see Table 1.1). They had the asset of not being value laden and so were not prejudiced like Koch, but whether a classification based on clinical impressions alone, especially if they were primarily obtained in brothels in Hamburg, should dominate the field for a century is hard to understand. It is sometimes said that the eminence of a scientist can be measured by the number of years he or she holds up progress. On this basis Schneider is a gold medallist. If he had produced his classification of prostitutes today, the reception of his ideas would have been very different; he would have been macerated on Twitter.

Either because of Schneider, or simply because he wrote his book when the tide was at the flood, personality disorder research has steadily deviated from general personality research in the past century. Psychologists in the main, but many others too, have continued to study personality in accordance with trait theory as well as other models, and the development of the so-called Big Five (Table 1.2) is an example of this.

Psychiatrists in clinical practice have gone in a different direction down the Schneiderian path. Rather than carry out research to test the value and utility of this clinical/prostitution-derived classification, it has embraced it uncritically, changed a few names here and there, described each category as though it was unique and definitive when in fact it is swamped by comorbidity of other personality disorders, and then wonder why mixed personality disorder or PD-NOS (personality disorder – not otherwise specified) is so commonly used in practice (Verheul and Widiger, 2004). They have also introduced a gremlin into the system called borderline personality disorder. Here we cannot really blame Schneider alone, despite his adjective 'emotionally unstable' being attached to the condition. The circuitous route by which this was introduced to the classification is discussed in Chapter 4.

The influence of the psychoanalysts was considerable in denying empirical research into the personality disorder concept. Whereas Meyer had managed to straddle psychoanalysis

Table 1.1 The influence of Galen and Kurt Schneider on current classifications of personality disorder

Galen[a]	Schneider	DSM-IV-TR	ICD-6	ICD-10
Choleric	Emotionally unstable	Borderline	Emotional instability	Emotionally unstable, including borderline and impulsive
Choleric	Explosive	Antisocial	Antisocial	Dissocial
Choleric	Self-seeking	Narcissistic	. . .	. . .
Choleric	. . .	Histrionic	Immature	Histrionic
Melancholic	Depressive	Depressive[b]	Cyclothymic[cb]	. . .
Melancholic	Asthenic	Avoidant	Passive dependency	Anxious (avoidant)
Melancholic	Weak-willed	Dependent	Inadequate	Dependent
Phlegmatic	Affectless	Schizoid	Schizoid	Schizoid
Phlegmatic	. . .	Schizotypal	Asocial	. . .
Not classified elsewhere	Insecure sensitive	Paranoid	Paranoid	Paranoid
Not classified elsewhere	Insecure anankastic	Obsessive–compulsive	Anankastic	Anankastic
Not classified elsewhere	Fanatical	. . .	. . .	. . .
Sanguine	Hyperthymic	. . .	. . .	. . .

DSM=Diagnostic and Statistical Manual of Mental Disorders. ICD=International Classification of Diseases. [a] Galen produced *De Temperamentis* in AD 192; *De Temperamentis*. Edited and translated by P. N. Singer, P. J van der Eijk & P. Tassinari, 2019. Cambridge: Cambridge University Press. [b] A diagnosis listed in earlier versions of DSM and recommended for further study in DSM-IV. [c] This category appeared in later revisions of ICD and DSM but was subsequently recoded under affective (mood) disorders.

and biological psychiatry with some success, he still aimed for a scientific psychiatry that found out the causes, diagnosis and treatment of all mental illnesses. But after he died, the psychoanalysts, coming from a completely different tradition, abhorred the notion of any form of diagnostic labelling. In the end, in order to get their agreement to support DSM-III, Bob Spitzer, as we describe later, had, in effect, to buy them off by giving them personality disorder to do with as they pleased. This was realpolitik – it had nothing to do with science.

So personality disorder did not enter the mainstream of day-to-day psychiatric practice and classification principles have not caught up. What happens now is that only the most severe disorders are diagnosed, assessment becomes highly specialised, treatment becomes focused more on exclusion than inclusion, and the many people who at first feel heartened by the recognition of their problems are disillusioned by the limited interventions offered.

Table 1.2 Neuroticism, extraversion, agreeableness, conscientiousness, and openness
The Big Five (higher order) personality traits.

Personality feature	Essential elements at each extreme
Neuroticism	Calm and confident versus anxious, pessimistic and fearful
Extraversion	Sociable and fun-loving versus reserved and thoughtful
Agreeableness	Trusting, helpful and affable versus suspicious, uncooperative and hostile
Conscientiousness	Disciplined and careful versus impulsive and disorganised
Openness to experience	Likes routine, practical and predictable events versus imaginative and spontaneous ones

Although the epidemiologists have shown the size of the problems created by personality disorder (see Chapter 5), the subject remains seriously neglected. This particularly applies to research. Only a tiny proportion of funded research is allocated to personality disorder, the vast majority of it to the borderline condition. The antisocial group, despite incurring massive costs, remains stuck in a risk assessment time warp. It is sad to read the words of a distinguished author in the area: 'because there are no standard treatments of antisocial personality, it is essential to identify coexisting problems that *can* respond' (Black, 2013, p. 169). How many randomised trials have been mounted to investigate the value of new treatments in this condition? Read Chapter 8 to find out, and prepare to be shocked.

1.4 Age 4. The Age of Acceptance and Understanding

We hope this age is just about to start. Our hope is that the new ways of looking at personality disorder, especially the new ICD-11 classification and a broader awareness of the ubiquity of personality dysfunction, offer a way of bringing personality disorder back into the mainstream, as Adolf Meyer would have wanted. The recent history of personality disorder, if it tells us anything of value, informs us that the current road travelled has a dead end. We have to change course and come back together with our psychological colleagues. We need to make personality disorder respectable by emphasising we are all on the same spectrum of disturbance, embrace good trait theory, abolish useless categories that only confuse and mislead, and tread forward with a secure footing on the route outlined in this book. So we expect that all clinicians of the future will ask themselves the question, 'what about the personality', whenever they are assessing and planning the care of the patients they meet in their working lives.

Chapter 2

Assessment of Personality
From Normal to Disorder

The two main reasons, we suspect, why most health professionals shy away from assessing personality status is that it is considered both too complicated and too risky. The risky aspect is discussed in Chapter 9 in dealing with stigma. In this chapter, the process of assessment is taken in stages in a form that everybody can appreciate without prior knowledge of the subject. Throughout the book we will be putting the main focus on the new ICD-11 classification of personality disorder, but the general principles of assessment apply to all ways of looking at personality disorder.

We are also assuming in this chapter that the reader has a fair knowledge of psychiatric assessment, but the first stages apply to all health professionals, including general practitioners, who are involved in patient care. The main message here is to emphasise that personality assessment is not just a task for the specialist.

2.1 Preliminary Stage

Six elements are essential when assessing personality (Table 2.1).

These six areas are covered in any good clinical assessment, and once the ancillary questions are answered the assessor should be able to at least make a rough impression of personality status. Please note that this assessment can be completed in a 20–30-minute clinical interview.

From this interview, it is relatively easy to place the person's current personality status on the scale above. Some will baulk at the idea that after a short interview it is possible to make an assessment of personality status, still less to disclose this to the patient. To use a comment on the MIND website: 'being given a diagnosis or label of personality disorder can feel as if you're being told there's something wrong with who you are' (MIND, 2020). The important two words here are 'can feel'. If the information is conveyed in the right way, it can be construed as valuable and positive.

The first task is to use the personality spectrum in Figure 2.1 to place the person at an approximate point. It will be extremely rare for anyone with severe personality disorder to be seen without clear evidence of serious dysfunction already being known, so the clinician is likely to be looking at placing the person somewhere on one of the three lower levels of severity, or in the no personality dysfunction group. One difficulty here will be in separating the problems created by current mental state symptoms from the difficulties of personality function. This is best clarified by checking on timescales. If the problems posed by personality difficulties are long-lasting (which they usually will be) and the mental state ones have clear beginnings and ends, then it is possible to conclude that the personality problems are likely to be independent. But in some instances (e.g. in chronic anxiety disorders beginning