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From the Editor's Desk

Complex personality disorders

By Kamaldeep Bhui CBE, MD, FRCPsych

Personality disorders: still neglected?

Personality disorders continue to challenge clinicians and researchers. These diagnoses are still stigmatised and often present as complex mental states that include comorbid alcohol or substance misuse, depression, dissociative experiences and other mental disorders; cultural factors also complicate the assessment and therapeutic process.[1–5] In addition, people diagnosed with personality disorders may face social adversity, loss of social support, interpersonal distress and higher mortality.[6–8] Personality disorders are still underrecognised, especially among minorities, and in some socially excluded groups and service settings.[8–10] Volkert *et al* (pp. 709–715) provide an updated meta-analysis of the prevalence of categories of personality disorders, showing these to be common; they find that expert ratings produce a lower prevalence estimate than self-ratings.

New approaches to personality assessment

The ICD-11 and DSM5 propose a dimensional or trait model, alongside the assessment of severity and disrupted interpersonal function and relationships.[11,12] These new approaches may help to overcome some of the limitations of existing categories and the difficulties around recognition and overlapping diagnostic categories. Huprich *et al* (pp. 685–689) provide a compelling and thoughtful analysis of the implications of a dimensional model of personality functioning, arguing for a more dynamic assessment that considers defensive emotional states and behaviours. An idiographic assessment, they assert, may be more authentic and accurate, better capturing the person's experience and the complexities.

Traumatic events are thought to contribute to the likelihood of developing a personality disorder. Some argue that personality disorders are often confused with complex post-traumatic disorders.[13] These complex post-traumatic states may emerge from harsh early life influences that affect attachments.[7] Later traumatic events will then produce a different level of severity and symptoms compared with those with better earlier environments and attachment.

Post-traumatic stress

There is good evidence that childhood maltreatment is associated with later internalising and externalising behaviours (Kisley, pp. 698–703); the strongest associations are for anxiety and post-traumatic stress. By contrast, a study of natural disasters shows higher rates of post-traumatic stress disorder (PTSD) and depression (Beaglehole, pp. 716–722) but, surprisingly, not anxiety or alcohol misuse or dependence. Disaster-specific factors and variation in research methods explain some of the heterogeneity. The study by Stevelink *et al* study (pp. 690–697) of troops deployed to Iraq or Afghanistan shows that deployment and combat were associated with poorer mental health, for example, post-traumatic stress and common mental disorders, as well as alcohol misuse in ex-serving personnel but not in those actively deployed at the time of the study. These findings suggest that defensive functions and social supports are compromised on leaving the services.

Graham *et al* (pp. 704–708) report that early treatment responses for people with PTSD were as common with sertraline as prolonged exposure therapy. Early responders to sertraline have a better longer-term functional outcome. This may reflect expectations of treatments, or early response may be a marker of a subset of the sample that could be characterised to better target interventions in the future. The sample excluded those with comorbidities, and personality is not often assessed in studies of PTSD. We need trials that target complex post-traumatic states, including personality-related difficulties, dissociation, attachment problems and comorbidities.[7,13]

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