5. More particularly, the 1983 Regulations should be amended s to require a prescribed seclusion register and forms to be kept[147];

6. Furthermore, any use of solitary confinement as a form of medical treatment for mental disorder should be regulated under Part IV;

7. The Code of Practice should abandon the term "seclusion" for "solitary confinement," defined as "the confinement of a patient alone in a room at any time of the day or night and a patient is confined to a room if he may not leave that room at will";

8. The circumstances in which a patient may be isolated in a room on the ground that his behaviour is putting the safety of others at immediate risk should in due course be defined and regulated by statute[148];

9. Nurses' and other professionals' powers of restraint, including the use of solitary confinement, should be put on a clearer statutory basis at that time.

147 The maintenance of a seclusion register was a legal requirement between 1845 and 1960. Article 94 of the Mental Treatment Rules 1930 required all institutions for mental patients to keep a "register of mechanical restraint and seclusion", the precise form of which was set out as Form 9 in the schedule to those rules. These provisions also applied to poor law establishments by Article 48(1) of the Public Assistance Order 1930, which was in the following terms: "Every case in which a person of unsound mind or a person alleged to be of unsound mind is placed in a padded room or is otherwise compulsorily secluded, shall be recorded in a book in the form 6 in the First Schedule, which may be included in the register of mechanical restraint, and the book shall be produced to every commissioner or inspector of the Board of Control visiting the institution." It is worth noting that section 32(2)(c) now provides that the regulations made under the Act may in particular make provision for requiring such bodies as may be prescribed to keep such registers or other records as may be prescribed in respect of patients who are liable to be detained or subject to guardianship or after-care under supervision.

148 For example, by enacting a section along the following lines: *Solitary confinement.* **134A.—(1)** A patient shall not be placed or kept in solitary confinement unless either— (a) his solitary confinement is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others; *or* (b) his being placed or kept in solitary confinement is a medical treatment which has been authorised by a certificate in writing given under section 58(3) above. **(2)** A member of the Mental Health Act Commission may at any time direct that a person who is being kept in solitary confinement otherwise than under subsection 1(b) above shall immediately cease to be so confined and, where he does so, he shall record his reasons for doing so in writing. **(3)** A full record in the form prescribed by regulations of every case of solitary confinement shall be kept from day to day and a copy of the records and certificates made under this section shall be sent to the Mental Health Act Commission at the end of every quarter. **(4)** In this section— "solitary confinement" means the confinement of a patient alone in a room at any time of the day or night and a patient is confined to a room if he may not leave that room at will; "patient" means a person suffering or appearing to be suffering from mental disorder. **(5)** This section applies to all hospitals and residential care homes in England and Wales. **(6)** Any person who wilfully acts in contravention of this section shall be guilty of an offence. **145(1)** In this Act, unless the context otherwise requires— ... "medical treatment" includes .... the solitary confinement of a patient whose solitary confinement has been authorised by a certificate in writing given under section 58(3) above and excludes all other instances of solitary confinement; "solitary confinement" has the meaning given in section 134A and the term includes seclusion and other cognate expressions.

21. Personality disorders

INTRODUCTION

Not all conditions characterised by abnormal mental functioning are conceived of as an illness. Certain forms of mental disorder are conceptualised and therefore categorised as disorders of the personality. The individual's mental state is here considered to represent his normal, although compared with other people abnormal, personality rather than the consequence of any disease or illness overlying and distorting that personality. The concept of personality implies a certain cohesion and "consistency of the personality as a backdrop upon which the vicissitudes of illness and other circumstances make transitory patterns, but the underlying features remain constant."[1] Whether or not an abnormality of personality actually manifests itself in the form of disordered behaviour, and is defined as a personality disorder, depends to a considerable extent on social circumstances.[2] Although this is so in practice, a particular kind of disturbed behaviour can be exhibited by more than one personality group with different mechanisms pertaining to each.[3]

PERSONALITY

Personality is what makes one individual different from another.[4] It is the unique quality of the individual, his feelings and personal goals; the sum of his traits, habits and experiences and the whole system of relatively permanent tendencies, physical and mental, which are distinctive of a given individual.[5] Alternatively, the ingrained patterns of thought, feeling, and behaviour which characterise an individual's unique lifestyle and mode of adaptation, and which result from constitutional factors, development, and social experience.[6] These personal characteristics are present since adolescence; stable over time despite fluctuations in mood; manifest in different environments; and recognisable to friends and acquaintances.[7] Personality has a genetic component and behaviour genetics is concerned with the pathway from genes to behaviour and the lifelong interactions between the genetic constitution of an individual and his environment. However, certain aspects of each individual's personality are generally considered to have been acquired through learning. An underlying biological assumption is that "if what is learnt at any one stage did not have some permanence, we would be endlessly open to change in response to events and circumstances."[8]

1 A. Sims, *Symptoms in the Mind* (Baillière Tindall, 1988), p.299.
2 *Ibid.*, p.285.
3 C.P.L. Freeman, "Personality disorders" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.592.
4 *Ibid.*, p.588.
5 K. Schneider, *Clinical Psychopathology* (5th ed., trans. M.W. Hamilton, Grune & Stratton, 1958).
6 *Lexicon of Psychiatric and Mental Health Terms* (World Health Organisation, 2nd ed., 1994), p.75.
7 C.P.L. Freeman, "Personality disorders," *supra*, p.588.
8 S. Wolff, "Personality development" in *Companion to psychiatric studies*, *supra*, p.61.

Personality types and personality traits

The observed behaviour of individuals is sufficiently similar in certain respects to suggest that it may be possible to formulate personality traits and personality types. In genetics, a trait is the characteristic observable expression of a hereditary predisposition, for example red hair. The trait is the outward manifestation so that, when the word is used to describe something characteristic about a person's behaviour, a personality trait is "a constant or persistent way of behaving,"[9] rather than the recurrent tendency towards such behaviour.[10] Nevertheless, the belief that observable behaviour patterns are the manifestations of unobservable dispositions within the individual's personality means that personality traits are most often defined in terms of these generalised predispositions. The underlying assumption is that "there are universal traits (such as hostility) present to different degrees in all people and which influence behaviour in the same ways in different situations and at different times, so that trait measures can be used predictively."[11] These traits vary in intensity and are usually regarded as abnormal when they pass beyond what is socially tolerable. Personality types considered to be abnormal are classified according to personality traits in various international classifications of mental disorders. The practical usefulness of these classifications can be tested by, and largely depends upon, their predictive accuracy. The trait and type approaches are therefore closely related to psychometrics, which uses standardised tests of personality to compare large numbers of individuals and groups or classes of individuals.[12] Unfortunately:

> "research has failed to show as much personality consistency as theorists would lead us to believe ... Studies which have looked at general traits such as anxiety or hostility have found that individual differences in the strength of a trait account for little of the variability of behaviour. What appears to matter most is the interaction of the differences in individuals with the differences in situations. In other words, it is not very useful to talk about general traits such as anxiety or hostility without considering the situation in which they may be exhibited. The importance of this in helping people with personality disorders is that one's efforts may be much more fruitfully directed towards finding situations in which the individual behaves less deviantly than in trying to change personality with psychotherapy."[13]

That being so, Powell has emphasised the importance of considering the underlying traits, stating clearly the specific behaviour causing concern, and describing the social context in which the personality problems exhibit themselves.[14] The underlying personality trait causing most difficulty, for example aggressiveness, can be rated by a single score on an appropriate psychometric test.

Personality trait ⟶ **Specific behaviour** ⟶ **Social context**

9 See G.W. Allport, *Personality: a psychological interpretation* (Holt, 1937).

10 G.L. Klerman and R.M.A. Hirschfield, "Personality as a vulnerability factor: with special attention to clinical depression" in *Handbook of social psychiatry* (ed. A.S. Henderson & G.D. Burrows, Elsevier, 1988), pp.41–53.

11 C.P.L. Freeman, "Personality disorders" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.588.

12 See R. Gross, *Psychology: The Science of Mind and Behaviour* (Hodder & Stoughton, 2nd ed., 1992), p.11.

13 C.P.L. Freeman, "Personality disorders," *supra*, p.591.

14 G.E. Powell, "Personality" in *Scientific principles of psychopathology* (ed. P. McGuffin *et al.*, Grune & Stratton).

Personality disorders

While acknowledging that the concept of personality disorder is an untidy concept and "an abstraction built upon several tenuous theories," Sims recently concluded that it is clinically useful.[15] What constitutes a disordered personality ultimately depends on how normality and abnormality are defined and so is partly determined by the social context (**1031**). Definitions of personality disorder are usually value-based. A person is considered to have an abnormal personality if he has to an excessive extent a personality trait which is considered to be undesirable (*e.g.* hostility) or possesses insufficiently a trait considered necessary for a person to be normal (*e.g.* empathy). More particularly:

- Schneider defined an abnormal personality as being a variation upon an accepted yet broadly conceived range of average personalities. It was immaterial whether the distinctive excess or deficiency of some personal quality which thereby rendered the individual markedly different from others was conceived of as good or bad, desirable or undesirable. The saint and the criminal both had abnormal personalities. A personality disorder was an abnormality of personality which caused the patient or other people, "the community," to suffer.[16]

- A personality and behaviour disorder is defined in the *Lexicon of Psychiatric and Mental Health Terms* as one of "a variety of conditions and behaviour patterns of clinical significance that tend to be persistent and appear to be the expression of the individual's lifestyle and mode of relating to self and others. Specific personality disorders, mixed personality disorders, and enduring personality change are deeply ingrained and persisting behaviour patterns, manifested as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels, and, particularly, relates to others."[17]

- The American DSM–IV classification defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."[18]

Enduring personality changes

Conventionally, an individual's personality may undergo enduring change during adulthood. This may be for the better, in terms of late maturation and the development of emotional sensitivity, or represent a deterioration in the individual's capacity to cope with his environment. An enduring personality change is defined in the *Lexicon of Psychiatric and Mental Health Terms* as "a disorder of adult personality and behaviour that has developed following catastrophic or excessive prolonged

15 A. Sims, *Symptoms in the Mind* (Baillière Tindall, 1988), p.284.

16 K. Schneider, *Psychopathic personalities, 9th ed.* (trans. M.W. Hamilton, Cassel, 1950).

17 *Lexicon of Psychiatric and Mental Health Terms* (World Health Organisation, 2nd ed., 1994), p.75.

18 *Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision (DSM–IV)* (American Psychiatric Association, 1994), p.629.

stress, or following severe psychiatric illness, in an individual with no ious personality disorder. There is a definite and enduring change in the individual's pattern of perceiving, relating to, or thinking about the environment and the self. The personality change is associated with inflexible and maladaptive behaviour that was not present before the pathogenic experience and is not a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder."[19]

PERSONALITY

• *Personality*	The unique quality of the individual, his feelings and personal goals; the sum of his traits, habits and experiences; the whole system of relatively permanent tendencies, physical and mental, which are distinctive of a given individual.
• *Personality trait*	A constant or persistent way of behaving.
• *Personality disorder*	A variety of conditions and behaviour patterns that tend to be persistent and appear to be the expression of the individual's lifestyle and mode of relating to self and others; they represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels, and, particularly, relates to others.

PERSONALITY AND MENTAL ILLNESS

The way in which a human's genetic potential expresses itself is largely determined by his environment and the state of any biological organism is the result of the interplay of genes with their environment. When the environment is less than perfect, as it always is, the way in which the brain develops represents a response to the environmental stimuli which it receives. Certain potentials and responses are stimulated while others are discouraged. By analogy, the soil within which an acorn is planted, and amount and distribution of light in the immediate environment, affect the way in which it develops into an oak — the extent of the root system, the height of the tree, the shape of its bole, the distribution of its leaves and the direction in which they incline. Planted in a different place, the same acorn would develop differently and only rarely is the appearance of an oak so markedly different from its neighbours that its profile represents the expression of innate defects in the acorn's structure. Likewise, although limited development of the personality in a human being may occasionally be caused by an innate structural defect, such as mental retardation, this is relatively rare. The manner in which an organism such as a brain or tree develops from its seed in order to survive is therefore characterised by a high degree of adaptability which includes a capacity to compensate for some degree of environmental deprivation. However, once the growth of an organic structure such as a tree or brain is complete, and their roots and branches have been developed and shaped according to the stimuli received during the formative period, the capacity for further change is usually limited. This reflects the fact that structure and

[19] *Lexicon of Psychiatric and Mental Health Terms* (World Health Organisation, 2nd ed., 1994), p.75.

functioning virtually always and in hand, the established structure of an organism limiting and defining the way in which it can function. Certain kinds of environment, whether soil types or domestic and social conditions, are particularly common in any particular country, as therefore are particular structural patterns of human and plant adaptation. As concerns human development, the ingrained patterns of thought, feeling, and behaviour which characterise these different modes of adaptation are often referred to as personality types. Because the capacity for further structural change is limited once the formative period is over, the form taken by the structure may be such that it is poorly-equipped to function adequately in certain kinds of environment encountered by members of the species. The way in which the structure has evolved may then be viewed as abnormal if these situations are relatively common — notwithstanding that, in the brain's case, it refers by habit to its habitual responses to environmental stimuli as constituting its mind or personality. Thinking is a form of activity engaged in by a biological organism whenever habitual patterns of action are disrupted and the function of thought is to solve the problems that give rise to it. Various outcomes are possible when an environmental event requires a thoughtful response. If a person's environment produces no food because of a drought, he will starve unless the environment fortuitously changes and produces food, or he can modify his environment (by introducing an irrigation system), or he can change himself biologically (so that he requires little or no food). However, there are strict limits as to how far an individual's biological system can adapt to survive devastating environmental change. Sometimes the response is only partially effective, limiting rather than eliminating the threat. Thus, the bacteria causing leprosy often provoke such a severe inflammation that the blood supply around infected areas is cut off and large areas of tissue are damaged or destroyed. The position is similar with "mental" events since these are received and stored by the brain in biological form, the brain being a biological instrument. If an individual's brain is challenged by environmental events, resolving the disturbance requires modifying one of the two factors at variance, the environment or the brain's habitual ways of dealing with and making sense of its surroundings — what we call the individual's personality. However, it is often not possible to change the environment at an objective level and, after events such as bereavement, such modification is impossible. Likewise, because the habitual dispositions of the brain and nervous system correspond to their established structures, the brain's capacity to add to or modify its established range of "natural" responses is limited. Consequently, its natural responses, which comprise its various established habitual responses, become increasingly pronounced and exaggerated when the necessary equilibrium is still not restored. Under severe conditions, the brain which is disposed to interpret events in a paranoid manner no longer merely has that disposition but actually engages in paranoid misinterpretations of environmental events. The resulting mental state is then regarded as a form of mental illness (specifically, a "delusional disorder"). The individual's personality therefore shapes his mental state during everyday life and determines the unique adjustment which he makes to the environment, including therefore the way he becomes mentally ill. As with a crystal, the structure gives way along the well-defined lines of cleavage which constitute its weakest plane so that it is artificial to draw an absolute distinction between personality and mental illness or to view the onset of mental illness as unrelated to any pre-existing personality disorder. The clinical picture is profoundly coloured by the individual's personality in the same way that a gem's structure determines how it shatters and the impurities within it give it its colour.

EPIDEMIOLOGY

The number of persons in any given population who have a disordered personality depends upon how normality and abnormality are defined and, more specifically, the precise criteria used to determine what constitutes abnormal behaviour. Historically, definitions within a given society have been based on that society's values. Necessarily, this requires periodically revising what is considered to be abnormal or deviant as the values and conduct of people change over time. The tendency has been to restrict the designation to a small proportion of the population whose behaviour grossly deviates from accepted norms. The alternative approach, to base the criteria on standards of mental functioning and behaviour which contravene certain relatively fixed value-norms ("ideals") without taking account of how many people violate those norms, has not been acceptable. To categorise behaviour indulged in by the majority of the population as a manifestation of their abnormal personalities would be unacceptable to that majority. Nevertheless, basing notions of normal and abnormal conduct on patterns of behaviour which are normal in the sense of being commonplace also has its problems. Given that some 30–40 per cent. of young men now have at least one criminal conviction, so that criminal behaviour is statistically approaching the norm, the tendency is to revise ideas about what constitutes an abnormal personality and abnormal behaviour in order to avoid vast numbers of people, perhaps even the majority eventually, being categorised as "abnormal." If enough people infringe the law by engaging in anti-social behaviour, the effect of this may be only that such behaviour is no longer considered to be abnormal or the expression of an abnormal personality — even though the undesirability of that behaviour, and the personality traits giving rise to it, remain the same and no less damaging to society.[20] Estimates of how many people have an abnormal personality or behave abnormally must therefore always be carefully scrutinised and often have fairly limited usefulness. All that can be said is that a lifetime prevalence of personality disorder of between 2.1 and 18 per cent. has been found depending on the population and the criteria used and that about 7–8 per cent. of the in-patient hospital population has a diagnosed personality disorder.[21]

CLASSIFYING PERSONALITY DISORDERS

The classification of mental disorders in official usage in England and Wales is the World Health Organisation's International Classification of Diseases, now in its tenth revision (ICD–10); and, more particularly, that part of it dealing with mental and behavioural disorders. One section or "block" of the classification is concerned with "disorders of adult personality and behaviour" (block F60–F69) and, within this block, each type and sub-type of disorder is separately listed and coded. For example, specific personality disorders are given the code F60.0 and a further digit is used to record its various sub-types such as paranoid personality disorder (F60.0) and schizoid personality disorder (F60.1). Operational definitions (diagnostic guidelines or criteria) are used to specify which combinations of symptoms are adequate to substantiate a diagnosis. They define what a clinician means when he uses the term "paranoid personality disorder" and represent an attempt to standardise

[20] It is, of course, true that as more criminal law is passed so there is more law for people to infringe. Consequently, even if a people's behaviour remains unchanged over a generation, more of them will today be "convicted criminals" and fewer remain of good character. The quickest way to reduce the crime rate is to reduce the number of crimes.

[21] P. Casey, "The epidemiology of personality disorder" in *Personality Disorders: Diagnosis, Management and Course* (ed. P. Tyrer, Wright, 1988), pp.77, 79.

clinical practice and understa ıg. Inevitably, the classification represents "compromises between scientists with the most influential theories and the practice of senior clinicians at national and international level."[22]

Other classifications

The ICD–10 classification, and the diagnostic guidelines which form part of it, comprise one of many medical classifications of mental disorder. Although a core of typical patients meet all definitions, there are significant differences in the populations of patients covered by each of them. Each operational definition generates different values for the incidence of a disorder, its heritability, its responsiveness to therapeutic agents, and its prognosis. Because defining what constitutes a disordered personality is profoundly difficult, and has significant consequences for any individual so categorised, the operational criteria used in the other main international classification (DSM–IV) are set out below, before considering the ICD–10 scheme is in greater detail.

DSM–IV General diagnostic criteria for a personality disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in one (or more) of the following areas:

(1) cognition (*i.e.* ways of perceiving and interpreting self, other people, and events)

(2) affectivity (*i.e.* the range, intensity, lability, and appropriateness of emotional response)

(3) interpersonal functioning

(4) impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early childhood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (*e.g.*, a drug of abuse, a medication) or a general medical condition (*e.g.*, head trauma).

[22] J.K. Wing, "Differential diagnosis of schizophrenia" in *Schizophrenia — An overview and practical handbook* (ed. D.J. Kavanagh, Chapman & Hall, 1992), p.17.

THE ICD–10 CLASSIFICATION

The section of the International Classification of Mental and Behavioural Disorders (ICD–10) which deals with "disorders of adult personality and behaviour" (Block F60–F69) sub-divides them into various types —

- specific personality disorders (F60)
- other personality disorders (F61)
- enduring personality changes (F62)
- habit and impulse disorders, such as pyromania (F63)
- sexual behaviour, orientation and development (F64–66).

PERSONALITY DISORDERS AND PERSONALITY CHANGE

The "specific" personality disorders differ from enduring personality changes in two major respects—

- in their timing and the mode of their emergence — personality disorders are developmental conditions, which appear in late childhood or adolescence and continue into adulthood; it is therefore unlikely that the diagnosis of personality disorder will be appropriate before the age of 16 or 17 years.[23]
- in that they are not secondary to another mental disorder or brain disease, although they may precede and coexist with other disorders. In contrast, personality change is acquired, usually during adult life, following severe or prolonged stress, extreme environmental deprivation, serious psychiatric disorder, or brain disease or injury.[24]

SPECIFIC PERSONALITY DISORDERS (F60)

A specific personality disorder is described as "a severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption."[25] Such conditions comprise deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations, and they represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and, in particular, relates to others. These behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychosocial functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance.

23 *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), pp.200, 202.
24 *Ibid.*, p.200.
25 *Ibid.*, p.202.

Specific personality disorders iagnostic guidelines

The ICD–10 diagnostic guidelines for specific personality disorders are set out in table below.

Specific personality disorders — Diagnostic guidelines (ICD–10)

Conditions not directly attributable to gross brain damage or disease, or to another psychiatric disorder, meeting the following criteria—

a. markedly dysharmonious attitudes and behaviour, involving usually several areas of functioning, *e.g.* affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others;

b. the abnormal behaviour pattern is enduring, long standing, and not limited to episodes of mental illness;

c. the abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social conditions;

d. the above manifestations always appear during childhood or adolescence and continue into adulthood;

e. the disorder leads to considerable personal distress but this may only become apparent late in its course;

f. the disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

In making a diagnosis of personality disorder, the clinician should consider all aspects of personal functioning, although the diagnostic formulation, to be simple and efficient, will refer to only those dimensions or traits for which the suggested thresholds for severity are reached ... If a personality condition precedes or follows a time-limited or chronic psychiatric disorder, both should be diagnosed.

Source: The ICD–10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines, World Health Organisation, Geneva, 1992, p.202.

SPECIFIC PERSONALITY DISORDERS — SUB-TYPES

Specific personality disorders are sub-divided in the ICD–10 classification according to clusters of traits that correspond to the most frequent or conspicuous behavioural manifestations. These sub-types are considered by the World Health Organisation to be "widely recognised" as major forms of personality deviation.[26] For the diagnosis of "most of the subtypes listed, clear evidence is usually required of the presence of *at least three* of the traits or behaviours given in the clinical description."[27] The different sub-types are listed in the following table.

26 *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), pp.200–201.
27 *Ibid.*

F60.0	*Paranoid*	A personality disorder characterised by excessive sensitivity to setbacks and rebuffs; a tendency to bear grudges; suspiciousness; a pervasive tendency to misconstrue the neutral or friendly actions of others as hostile or contemptuous; and preoccupation with unsubstantiated "conspiratorial" explanations of events.
F60.1	*Schizoid*	A personality disorder characterised by emotional coldness and detachment; limited capacity to express warmth; preference for solitary activities; excessive preoccupation with fantasy and introspection; lack of conflicting relationships; marked insensitivity to prevailing social norms and conventions.
F60.2	*Dissocial (psychopathic)*	A personality disorder characterised by callousness; gross and persistent irresponsibility and disregard for social norms, rules and obligations; incapacity to maintain enduring relationships; very low tolerance to frustration and a low threshold for discharge of aggression; incapacity to experience guilt and to profit from experience; marked proneness to blame others.
F60.3	*Emotionally unstable*	A personality disorder characterised by a marked tendency to act impulsively without consideration of the consequences, together with affective instability. Outbursts of intense anger may often lead to violence or behavioural explosions, which are easily precipitated when impulsive acts are criticised or thwarted by others.
F60.4	*Histrionic*	A personality disorder characterised by theatricality and exaggerated displays of emotions; suggestibility; shallow, liable affect; continual seeking for excitement and being the centre of attention; inappropriate seductiveness and concern with physical attractiveness.
F60.5	*Anankastic*	A personality disorder characterised by excessive doubt and caution; preoccupation with rules, lists, order, organisation; perfectionism that interferes with task completion; excessive conscientiousness and undue preoccupation with productivity to the exclusion of pleasure and relationships; excessive pedantry and rigidity; intrusion of insistent and unwelcome thoughts or impulses.
F60.6	*Anxious (avoidant)*	A personality disorder characterised by persistent and pervasive feelings of tension and apprehension; belief that one is socially inept, unappealing or inferior; excessive preoccupation with being criticised or rejected; avoidance of situations that involve significant personal contact because of fear of criticism, disapproval, or rejection.
F60.7	*Dependent*	A personality disorder characterised by encouraging or allowing others to make most of one's important life decisions; subordination of one's own needs to those of others on whom one is dependent and undue compliance with their wishes; preoccupations with fear of being abandoned; limited capacity to make everyday decisions without excessive advice and assurance.

PARANOID PERSONALITY DISORDER (F60.0)

A paranoid personality disorder is characterised by excessive sensitivity to setbacks and rebuffs; a tendency to bear grudges; suspiciousness and a pervasive tendency to misconstrue the neutral or friendly actions of others as hostile or contemptuous; a combative and tenacious sense of personal rights; recurrent unjustified suspicion regarding sexual fidelity; a tendency to experience excessive self-importance, manifest in a persistent self-referential attitude; preoccupation with unsubstantiated "conspiratorial" explanations of events.[28] Fixed delusions are absent. The prevalence of paranoid personality disorder is variously estimated as being between 0.5 and 2.5 per cent and more common in men than women.

Management and treatment

The prognosis is unclear but the very concept of personality implies that the particular traits will be resistant to change. In some cases, the paranoid traits may be a harbinger of a paranoid delusional disorder or of paranoid schizophrenia. Psychotherapy may be offered although the patient's suspicious attitude and tendency to misinterpret the actions of others may make progress difficult. Antipsychotics may be employed if there is evidence of quasi-delusional thinking.

SCHIZOID PERSONALITY DISORDER (F60.1)

Schizoid personality disorders have usually been linked to the presence of schizophrenia and, for this reason, they are considered in the chapter dealing with that form of illness (**1243**).

DISSOCIAL ("PSYCHOPATHIC") PERSONALITY DISORDER (F60.2)

Dissocial personality disorder includes conditions previously or elsewhere described as amoral, antisocial, psychopathic, or sociopathic personality disorders. A dissocial personality disorder is a personality disorder which usually comes to attention because of a gross disparity between behaviour and the prevailing social norms and is characterised by callous unconcern for the feelings of others; gross and persistent irresponsibility and disregard for social norms, rules and obligations; incapacity to maintain enduring relationships, though having no difficulty in establishing them; very low tolerance to frustration and a low threshold for discharge of aggression, including violence; incapacity to experience guilt and to profit from experience, particularly punishment; marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society. A conduct disorder during childhood and adolescence may further support the diagnosis.[29]

Psychopathic disorder

The term "dissocial personality disorder" is synonymous with psychopathic disorder. There has never been any consensus about whether "psychopathic disorder is an illness with social consequences which can be treated medically or a social condition

[28] *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), pp.202–203.

[29] *Ibid.*, p.204.

which needs to be managed or addressed in a non-medical environment."[30] ... differences of opinion are linked to different ideas about responsibility and free will and the extent to which the personalities of some people do not enable them to resist or to refrain from anti-social conduct.

Historical development of the concept

In 1801, Phillippe Pinel described a condition which he called "manie sans délire", the specific features of which were a pronounced disorder of the affective functions and a blind impulse to acts of violence in the absence of any specific alteration in the intellectual functions, perception, judgment, imagination and memory.[31] In 1812, Rush described a condition of "moral derangement" which was characterised by innate, constitutional, moral depravities and was suitable for medical treatment.[32] In 1818, Gröhmann wrote of "moral diseases of the mind", including "moral dullness", "congenital brutality" and "moral imbecility." In 1835, James Pritchard referred to moral insanity as a "morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions and natural impulses, without any remarkable disorder or defect of the intellect or knowing or reasoning faculties and particularly without any insane illusion or hallucination."[33] In 1839, Morel then distinguished four types of degeneratives: idiots, imbeciles, the feeble-minded and "degeneres superieurs," persons who were of average or superior intellects but morally defective. In 1885, Maudsley wrote that "as there are persons who cannot distinguish certain colours ... so there are some who are congenitally deprived of moral sense."[34] The term "psychopathic inferiorities" was introduced by Koch in 1891, to denote all those mental irregularities which influence a man and cause him to seem not fully in possession of normal mental capacity but which do not amount to psychoses. These variations in personality from the norm constituted an abnormal deviation from normal mental life.[35] Kraepelin, describing psychopathic personalities in 1915, believed that they represented a form of degenerative disorder quite separate from neuroses and psychoses.[36] In 1927, Schneider defined psychopathic personalities as abnormal personalities, that is persons deviating from the norm of a variety of traits, who either suffer themselves or cause society to suffer.[37] Partridge introduced the concept of the "sociopath" in 1930, his use of the term emphasising the effects of life-long anti-social behaviour on society, behaviour which was difficult to influence by social, penal or medical means. The notion of "sociopathy" therefore denotes a propensity for behaviour which is regarded as criminal or anti-social. In 1939, Henderson and Gillespie described psychopaths as "individualistic, rebellious, emotionally immature, lacking foresight and behaving like dangerous children; they fail to learn from their mistakes and the stupidity of their actions is appalling."[38] This inadequacy, or deviation, or failure to adjust to ordinary social life was not mere wilfulness or badness which could be threatened or "thrashed out" of the individual but

30 *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder* (Department of Health/Home Office, 1994), p.9.
31 P. Pinel, *A Treatise on Insanity in Which Are Contained the Principles of a New and More Practical Nosology of Mental Disorders*, 1801.
32 B. Rush, *Medical Inquiries and Observations upon the Diseases of the Mind*, 1812.
33 J. Pritchard, *A Treatise on Insanity and other Disorders affecting the mind* (London, 1835).
34 H. Maudsley, *Responsibility in Mental Disease* (Kegan Paul, Trench & Co., 1885).
35 J.L.A. Koch, *Die Psychopathischen Minderwertigkeiten* (Ravensburg, 1891).
36 E. Kraepelin, Der Verfolgungswahn der Schwerhorigen Psychiatrie, Vol. 8 Part IV, (Barth, 1915).
37 K. Schneider, *Psychopathic personalities* (9th ed., trans. M.W. Hamilton, Cassel, 1950).
38 D.K. Henderson, *Psychopathic States* (Norson, 1939).

a true illness for which there was no specific explanation. Such psychopaths were of three types — aggressive, inadequate and creative. In 1941, Cleckley conceived of psychopathic disorder as a "moral psychosis; such persons were chameleons, suiting their conversation and behaviour to what they considered others wished it to be, rather than by reference to any internalised values.[39] The Percy Commission of 1954–57, which reviewed the existing mental health legislation, described "mentally abnormal patients whose daily behaviour shows a want of social responsibility and of consideration for others, of prudence and foresight, and of ability to act in their own best interests and whose persistent anti-social mode of conduct may include inefficiency and lack of interest in any form of occupation, pathological lying, swindling, slandering, alcoholism, drug addiction, sexual offences, violent acts with little motivation and an entire absence of self-restraint which may go as far as homicide ... Punishment or the threat of punishment influences their behaviour only momentarily and its more lasting effect is to intensify their vindictiveness and anti-social attitude."[40] Reviewing the literature in 1960, Scott considered that the major definitions of psychopathic disorder shared four common elements: an absence of any psychiatric disease or defect; anti-social behaviour, whether aggressive or inadequate; persistence of the behaviour from an early age; and the need for a specialised form of handling by society.[41] In 1966, Robins demonstrated the persistence of the disorder from childhood to adulthood, showing that it ran in families and carried a poor prognosis with death commonly resulting from self-neglect, suicide, fighting, careless accidents, and the effects of too much alcohol or other drugs.[42] More recently, in 1975, Whiteley defined a "psychopath" as an individual who persistently behaves in a way which is not in accordance with the accepted social norms of the culture or times in which he lives; who appears to be unaware that his behaviour is seriously at fault; and whose abnormality cannot be readily explained as resulting from "madness" or "badness" alone.[43] During the previous year, Sir Aubrey Lewis had summarised the historical development of the concept in the following terms:

> "Psychopathic personality is one of a cluster of terms which have been used, interchangeably or successively, in the last 150 years to denote a life-long propensity to behaviour which falls midway between normality and psychosis. Mania sine delirio, moral insanity, moral imbecility, psychopathy, degenerate constitution, congenital delinquency, constitutional inferiority — these and other semantic variations on a dubious theme have been bandied about by psychiatrists and lawyers in a prodigious output of repetitious articles."[44]

Management and treatment

Various treatment strategies have been suggested although none of them has been shown to be effective in a controlled evaluation.[45] The options include individual

39 H. Cleckley, *The Mask of Sanity* (Henry Kimpton, 1941).
40 *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, Cmnd. 169 (1957).
41 P.D. Scott, "The treatment of psychopaths" *British Medical Journal* (1960) i, 1641–1646.
42 L. Robins, *Deviant Children Grow Up* (Livingstone Press, 1966). See E. Fottrell, "Violent behaviour by psychiatric patients" in *Contemporary Psychiatry* (ed. S. Crown, Butterworths, 1984), p.21.
43 J.S. Whiteley, "The psychopath and his treatment" in *Contemporary Psychiatry* (ed. T. Silverstone and B. Barraclough, Headley Brothers, 1975).
44 Sir A. Lewis, "Psychopathic disorder: A most elusive category" *Psychological Medicine* 4, 133.
45 M. Gelder, *et al.*, *Oxford Textbook of Psychiatry* (Oxford University Press, 3rd ed., 1996), p.130; Quality Assurance Project, "Treatment outlines for borderline, narcissistic and histrionic personal-

psychotherapy, small-group therapy and treatment in a therapeutic com ity, such as that provided at the Henderson Hospital in Surrey. Seriously disturbed behaviour which is the manifestation of a psychopathic disorder may be managed by legal or medical means, or by a combination of the two in the case of detention under the Mental Health Act 1983. Whether detention in a psychiatric hospital has any therapeutic advantage over imprisonment in more than a small minority of cases has still to be established. Most often, the greatest hope lies in the possibility of late maturation, perhaps after forming an understanding relationship with someone, and the fact that anti-social behaviour tends to become less frequent as individuals get older. The main motivation for dealing with dangerous anti-social offenders by committal to hospital under a restriction order may lie in the fact that it provides a mechanism for indefinite preventative detention in cases where a discretionary life sentence is inappropriate, rather than any hope that treatment received there will be efficacious.

EMOTIONALLY UNSTABLE PERSONALITY DISORDER (F60.3)

Emotionally unstable personality disorders are those in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or behavioural explosions, which are easily precipitated when impulsive acts are criticised or thwarted by others. The classification specifies two variants —

- *Emotionally unstable personality disorder, impulsive type* is characterised by emotional instability and lack of impulse control; outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.
- *Emotionally unstable personality disorder, borderline type* is characterised by emotional instability, disturbed self-image, chronic feelings of emptiness, and a liability to become involved in intense and unstable relationships, which may cause repeated emotional crises and be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm.

HABIT AND IMPULSE DISORDERS (F63)

The legal definition of what constitutes a psychopathic disorder (**082**) is not confined to specific personality disorders, such as dissocial personality disorders. Certain other psychiatric conditions are not uncommonly legally classified as psychopathic disorders. In particular, habit and impulse disorders and certain kinds of sexual behaviour (**089**) may in practice be so classified. The habit and impulse disorders are characterised by repeated acts that have no clear rational motivation and generally harm the patient's own interests and those of other people.[46]

[46] *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), p.212.

PATHOLOGICAL FIRE-SE. G (PYROMANIA) (F63.1)

Pyromania is characterised by "multiple acts of, or attempts at, setting fire to property or other objects, without apparent motive, and by a persistent preoccupation with subjects related to fire and burning. There may also be an abnormal interest in fire-engines, in other associations of fire, and in calling out the fire service."[47] The essential features incorporated in the diagnostic guidelines are (a) repeated fire-setting without any obvious motive such as monetary gain, revenge, or political extremism; (b) an intense interest in watching fires burn; and (c) reported feelings of increasing tension before the act, and intense excitement immediately after it has been carried out.[48]

DSM–IV Classification

According to the DSM–IV classification, the essential feature of pyromania is "the presence of multiple episodes of deliberate and purposeful fire setting (Criterion A). Individuals with this disorder experience tension or affective arousal before setting a fire (Criterion B). There is a fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (*e.g.*, paraphernalia, uses, consequences) (Criterion C). Individuals with this disorder are often regular 'watchers' at fires in their neighbourhoods, may set off false alarms, and derive pleasure from institutions, equipment, and personnel associated with fire ... (They) experience pleasure, gratification, or a relief of tension when setting the fire, witnessing its effects, or participating in its aftermath (Criterion D). The fire setting is not done for monetary gain, as an expression of socio-political ideology, to conceal criminal activity, to express anger of vengeance, to improve one's living circumstances, or in response to a delusion or a hallucination (Criterion E). The fire setting does not result from impaired judgment (*e.g.*, in dementia, mental retardation, or substance intoxication). The diagnosis is not made if the fire setting is better accounted for by a conduct disorder, a manic episode, or an antisocial personality disorder (Criterion F)."[49]

Alternative explanations

Pyromania should be distinguished from criminal conduct where there is an obvious motive; fire-setting as part of a general conduct disorder or personality disorder including theft, aggression, truancy, and a lack of concern for others; schizophrenia, when fires are started in response to delusional ideas or auditory hallucinations; organic mental disorder, when fires are started accidentally as a result of confusion, poor memory, or a lack of awareness of the consequences of the act.

INTERMITTENT EXPLOSIVE DISORDER

The category "Other habit and impulse disorders (F63.8)" is used in the ICD–10 classification for persistently maladaptive behaviour which is not attributable to a recognised psychiatric syndrome but in which there is repeated failure to resist impulses to carry out the behaviour. This includes conditions classified in the DSM–IV classification under the rubric of "intermittent explosive disorder," the essential features of which are—

[47] *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), p.212.

[48] *Ibid.*, p.213.

[49] *Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision (DSM–IV)* (American Psychiatric Association, 1994), p.614.

- the occurrence of discrete episodes of failure to resist aggress impulses that result in serious assaultative acts or destruction of property (criterion A)
- the degree of aggressiveness expressed during an episode is grossly out of proportion to any provocation or precipitating psychosocial stressor (Criterion B)
- other mental disorders or general medical conditions that might account for the episodes of aggressive behaviour have been ruled out and the aggressive episodes are not drug-induced (Criterion C).

DISORDERS OF SEXUAL BEHAVIOUR (F64–F66)

These disorders are divided into three types, only two of which have any relevance to legal proceedings—

- Gender identity disorders, *e.g.*, transsexualism (F64)
- Disorders of sexual preference, *e.g.* fetishism, exhibitionism, voyeurism, paedophilia, sadomasochism (F65)

The most important of these "disorders" are described below. It should, however, be noted that section 1(3) of the Mental Health Act 1983 provides that no person shall be dealt with under the Act by reason only of "promiscuity, other immoral conduct (or) sexual deviancy." Nevertheless, the limits of this prohibition have not been firmly established, and tribunals and courts have tended to deal with paedophilia on the basis that it is the expression of a psychopathic disorder. The problem is considered in greater detail in chapter 2 (**089**).

Transsexualism (F64.0)

Transsexualism is a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or the inappropriateness of, one's anatomic sex and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with the preferred sex.[50]

Fetishism (F65.0)

Fetishism is a "reliance on some non-living object as a stimulus for sexual arousal and sexual gratification. Many fetishes are extensions of the human body, such as articles of clothing or footware."[51]

50 *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), p.215.

51 *Ibid.*, p.218.

Exhibitionism (F65.2)

Exhibitionism is "a recurrent or persistent tendency to expose the genitalia to strangers (usually of the opposite sex) or to people in public places, without inviting or intending closer contact."[52] So defined, men who expose themselves on a single occasion do not come within the operational criteria. Exhibitionists make up about one-third of sexual offenders referred for psychiatric treatment and about a quarter of sexual offenders dealt with in the courts.[53] The reconviction rate is low after a first conviction but high after a second conviction. It is not correct that all exhibitionists are inadequate and passive. In terms of risk assessment, the circumstances of the index offence are paramount, in particular the age of the victim, the degree of aggression, and any pleasure taken in causing distress. As "a broad generalization, two groups of exhibitionists can be described. The first group includes men of inhibited temperament who struggle against their urges and feel much guilt after the act; they sometimes expose a flaccid penis. The second group includes men who have aggressive traits, sometimes accompanied by features of antisocial personality disorder. They usually expose an erect penis, often while masturbating. They gain pleasure from any distress they cause and often feel little guilt."[54] Apart from treating any underlying mental illness, such as depression, various psychological treatments may be employed — including psychoanalysis, individual and group psychotherapy, and aversion therapy — but their effectiveness has yet to be established.[55] According to Gelder, a practical approach combines counselling and behavioural techniques.[56]

Voyeurism (F65.3)

Voyeurism is a recurrent or persistent tendency to look at people engaging in sexual or intimate behaviour such as undressing.[57] Again, there is no reliable information about prognosis or the benefits of particular psychological treatments.

Paedophilia (F65.4)

Paedophilia is defined as "a sexual preference for children, usually of prepubertal or early pubertal age. Some paedophiles are attracted only to girls, others only to boys, and others again are interested in both sexes."[58] The prognosis has been summarised by Gelder: "In the absence of reliable information from follow-up studies, prognosis has to be judged in individual patients by the length of the history, the frequency of the behaviour, the absence of other social and sexual relationships, and the strengths and weaknesses of the personality. Behaviour that has been frequently repeated is

52 *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), p.219.

53 I. Rosen, "Exhibitionism, scotophilia and voyeurism" in *Sexual deviations* (ed. I. Rosen, Oxford University Press, 2nd ed., 1979); M. Gelder, *et al.*, *Oxford Textbook of Psychiatry* (Oxford University Press, 3rd ed., 1996), p.501.

54 M. Gelder, *et al.*, *Oxford Textbook of Psychiatry*, *supra*, p.501.

55 *Ibid.*, p.502; J.S. Witzig, "The group treatment of male exhibitionists" *American Journal of Psychiatry* (1968) 125, 179–185; F.G. Rooth & I.M. Marks, "Persistent exhibitionism: short-term response to aversion self-regulation and relaxation treatment" *Archives of Sexual Behaviour* (1974) 3, 227–243.

56 M. Gelder, *et al.*, *Oxford Textbook of Psychiatry*, *supra*, p.501.

57 *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), p.219.

58 *Ibid.*

likely to persist despite efforts at treatment."[59] There is no convincing evidence that group treatment or behaviour therapy leads to good results in the majority of cases.[60]

Sadomasochism (F65.5)

The term "sadomasochism" denotes "a preference for sexual activity that involves bondage or the infliction of pain or humiliation ... Sexual sadism is sometimes difficult to distinguish from cruelty in sexual situations or anger unrelated to eroticism. Where violence is necessary for erotic arousal, the diagnosis can be clearly established."[61] There is no reliable information about prognosis and no evidence that any particular form of treatment is effective.

59 M. Gelder, *et al.*, *Oxford Textbook of Psychiatry* (Oxford University Press, 3rd ed., 1996), p.500.

60 *Ibid.*; V. Hartmann, "Notes on group therapy with paedophiles" *Canadian Psychiatric Association Journal* (1965) 10, 283–288; H.R. Beech, *et al.*, "Classical conditioning of a sexual deviation: a preliminary note" *Behaviour Therapy* (1971) 2, 400–402.

61 *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), p.220.

22. Mood disorders

INTRODUCTION

In mood disorders, the fundamental disturbance is a change of mood to depression (with or without associated anxiety) or elation. This mood change is normally accompanied by a change in the overall level of activity and most other symptoms are either secondary to, or easily understood in the context of, such changes. Most of these disorders tend to be recurrent and the onset of individual episodes is often related to stressful events or situations.[1] Mood disorders tend to be cyclic in nature, with stable seasonal fluctuations in the incidence of suicide, and many depressed people experience diurnal variation of mood.

ASSESSMENT, DIAGNOSIS AND CLASSIFICATION

When a patient is examined prior to admission, or immediately following admission, the first task is to assess the kind of disorder (if any) which is troubling him so that, having identified it, conclusions can be reached about its causes, probable course, and treatment. Assessment is the process of collecting information relevant to the diagnosis, management, and treatment of a patient's clinical condition, including therefore this art of distinguishing the presence of a particular disorder, for example mania or depression, from the existence of a characteristic pattern of symptoms or manifestations. A diagnosis is a "short-hand way of describing what is wrong with the patient"[2] and involves assigning the patient's case to a predesignated diagnostic class according to some reliable medical classification of mental disorders.

Classifying mood disorders and using operational criteria

Because some symptoms are commonly features of a number of different conditions — for example, they may occur as symptoms of both schizophrenia and mood disorders — operational definitions specify which combinations of symptoms are adequate to substantiate a diagnosis. They define what a clinician or researcher means when he uses the term "depression" and hence represent a pragmatic approach to the problems of syndromes and an attempt to standardise clinical practice and understanding. Over the past two decades there has been a multiplication of classifications and diagnostic criteria to cope with the different conceptions of mood disorders.[3] Although a core of typical patients meet all of the definitions, there are significant differences in the populations of patients covered by each of them, and each generates

1 *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD–10): Clinical descriptions and diagnostic guidelines* (World Health Organisation, 1992), p.112.

2 J.M. Pfeffer and G. Waldron, *Psychiatric Differential Diagnoses* (Churchill Livingstone, 1987), p.4.

3 C. Thompson, *The Instruments of Psychiatric Research* (John Wiley & Sons, 1989), p.4.