PERGAMON

Personality and Individual Differences 30 (2001) 311–320

PERSONALITY AND INDIVIDUAL DIFFERENCES

www.elsevier.com/locate/paid

Personality disorders in the general population: DSM-IV and ICD-10 defined prevalence as related to sociodemographic profile

Lisa Ekselius [a,*], Maria Tillfors [b], Tomas Furmark [b], Mats Fredrikson [b]

[a] *Department of Neuroscience, Psychiatry, University Hospital, 751 85 Uppsala, Sweden*
[b] *Department of Psychology, Uppsala University, Uppsala, Sweden*

Received 17 September 1999; received in revised form 14 February 2000

Abstract

Prevalence and sociodemographic characteristics of DSM-IV and ICD-10 defined personality disorders were examined in a Swedish community sample. Data were obtained by means of the DSM-IV and ICD-10 personality questionnaire (DIP-Q) postal survey administered to 1000 randomly selected adults from the Isle of Gotland. A total of 557 individuals responded to the questionnaire. The prevalence of any ICD-10 defined personality disorder was 11.0% and 11.1% when using DSM-IV criteria. Comorbidity between personality disorders were common. Prevalence similarities between DSM and ICD definitions were obtained for paranoid, schizotypal, borderline/emotionally unstable, histrionic, avoidant, dependent, and obsessive-compulsive/anancastic but not schizoid and antisocial/dissocial personality disorders. Personality disorders were significantly more often diagnosed in the younger subjects, students and unemployed/homemakers had the highest rates. Individuals with personality disorders more often received psychiatric treatment and lacked social support. In addition, they reported significantly more psychosocial and environmental problems in the past year. Thus, personality disorders are relatively common in the community and affected individuals are more impaired than subjects without personality disorders.

Keywords: Personality disorders; Epidemiology; ICD-10; DSM-IV; Prevalence

* Corresponding author. Tel.: +46-18-66-52-27; fax: +46-18-51-58-10.
E-mail address: lisa.ekselius@uaspsyk.uu.se (L. Ekselius).

0191-8869/00/$ - see front matter
PII: S0191-8869(00)00048-9

1. Introduction

Personality disorders may be significant causes of psychiatric morbidity and can be major sources of long-term disability. They relate to a poor outcome in patients with other major psychiatric disorders and general medical conditions (Reich & Vasile, 1993; Sato, Sakado, Sato & Morikawa, 1994; Ekselius, von Knorring, Enskog & Ordeberg, 1996). However, it is necessary to investigate personality disorders in the population to estimate their prevalence in the community, understand their consequences in individuals who do not seek treatment, in order to plan and evaluate the delivery of psychiatric services (Samuels, Nestadt, Romanoski, Folstein & McHugh, 1994). Two areas of great concern with high societal costs and great individual suffering for example are substance abuse and suicide.

Epidemiological studies in North America and Europe conducted between 1951 and 1963 suggest a personality disorder prevalence rate of 6–10% of the total population (Bremer, 1951; Essen-Möller, 1956; Leighton, 1959; Langner & Michael, 1963). The overall lifetime community rates or in nonreferred samples according to DSM-III/DSM-III-R criteria are 6–14% (Casey & Tyrer, 1986; Reich, Yates & Nduaguba, 1989a; Zimmerman & Coryell, 1990; Maier, Lichtermann, Klingler & Heun, 1992; Samuels et al., 1994).

Reich et al. (1989a), ascertained DSM-III personality disorders by sending the self-completed Personality Diagnostic Questionnaire (Hyler et al., 1988) to a random sample of households in Iowa City. Reich et al. (1989a) estimated that 11.1% of the 235 adults who completed the questionnaire had personality disorders. Subjects with personality disorders were less educated and reported more alcohol problems. Of those married, individuals with personality disorders reported more marital difficulties than subjects without personality disorders. In addition, there was a significant association between the number of disordered personality traits and medical resource utilisation (Reich, Boerstler, Yates & Nduaguba, 1989b).

Samuels et al. (1994) reported an adult personality disorder prevalence rate of 5.9% (9.3% when provisional cases were included) using a semistructured method to interview 810 adults in the Eastern Baltimore Mental Health Survey. Men had higher rates than women and separated or divorced subjects had the highest rates. Individuals with personality disorders were more likely to have a history of sexual dysfunctions, alcohol and drug use disorders as well as suicidal thoughts and attempts. In addition, they reported significantly more life events in the past year. Only one fifth of the individuals who qualified for diagnoses of personality disorder in the community sample received treatment.

In 1992, the tenth revision of the international statistical classification of diseases and related health problems (ICD-10) (WHO, 1992) was introduced, and separate diagnostic criteria for personality disorders research purposes are now available (WHO, 1993). In the fourth version of the diagnostic manual of mental disorders (DSM-IV) (American Psychiatric Association, 1994) stringent efforts were made to increase concordance with the ICD-10. The two upgraded versions of the DSM and ICD have great similarities. DSM-IV covers ten personality disorders whereas the ICD-10 diagnostic criteria for research cover eight personality disorders. Narcissistic personality disorder is not specified in the ICD-10. Furthermore, the DSM-IV schizotypal personality disorder is a ''schizophrenia spectrum disorder'' classified under ''Schizophrenia, schizotypal and delusional disorders'' in the ICD-10. During the past years the DSM-IV and ICD-10 Personality–Questionnaire (DIP-Q) has been developed and validated (Ottosson et al., 1995; Ottosson et al.,