Comparing the Psychological Effects of Different Psychiatric Labels: Borderline, Paranoid, and Antisocial Personality Disorder; Major Depression; Anxiety Disorder; and Posttraumatic Stress Disorder

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The psychological effects of six *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) psychiatric labels on respondents were evaluated, three of them being variants of "personality disorder" (PD). Self-selecting students from a university in London, United Kingdom, were invited to take part in a repeated-measures questionnaire study delivered online. One hundred and seventy-three participants completed the questionnaire, responding to 16 items for each of the six mental health labels. Results showed that respondents reported the greatest dysphoric reactions to the "paranoid personality disorder" label, followed by the "borderline" and "antisocial" personality disorder labels, with "major depression," "anxiety disorder," and "posttraumatic stress disorder" thereafter. Borderline personality disorder was designated as being least understandable of the six labels. It is evident that the PD psychiatric labels have greater iatrogenic effects than the others included here. From this, we conclude that PD labels produce greater dysphoric consequences because they can be construed as implying a fault in an individual's core and immutable sense of self, which in turn may cause significant stigma and distress in those to whom they have been applied. We conclude that given these adverse effects of PD labels and conceptual problems associated with the notion of personality disorder, that such labels at the very least should be replaced by more compassionate and self-explanatory terms, which reflect the chronic difficulties forming and maintaining attachments that underpin this group of presenting complaints.

Keywords: psychiatric labels; effects; posttraumatic stress disorder (PTSD); depression; personality disorder (PD)

Labeling theory, originating in the work of Tannebaum (1938), and later in that of Goffman (1963), argued that having an attribute that is discrediting is stigmatiz-ing, with stigmatized individuals being diminished in the minds of those perceiving

the negative attribute and being blamed as the source of the discrediting characteristic, resulting in observers distancing themselves. Although there is extensive research on

psychiatric stigma, less prevalent are studies examining the effects of psychiatric diagnostic labels on those to whom they are applied. Such labeling has been described by Brown (2002) as setting up expectations for deviant behavior. Although summary labels can be helpful in facilitating communication between professionals, they can be harmful when used by those who are unfamiliar with associated anchoring definitions. Scheff (1966) postulated that social attitudes are negatively influenced by the presence of psychiatric labels and that the mere presence of these negative terms causes patients to adopt problematic behavior, thereby exacerbating social rejection. Kirk (1974) has challenged these conclusions, arguing that it is the behavior of those with the mental illness, rather than the mental illness labeling per se that influences other peoples' responses. Nevertheless, Sirey et al. (2001), in a study of newly admitted adults for psychiatric treatments, found that medical adherence to pharmacological treatment for depression was significantly associated with self-perceived stigma. Where publically stigmatizing ideas are viewed as self-relevant, Corrigan, Kerr, and Knudsen (2005) call this "self-stigma." Such a tendency has been shown to be associated with significantly lower self-esteem among those with serious mental illnesses (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001) and as a barrier to recovery from affective disorder (Perlick et al., 2001). Furthermore, Corrigan and Watson (2006) note that as well as loss of self-esteem, some react with righteous anger in response to stigma, whereas others appear capable of ignoring the effects of public prejudice. However, the World Health Organization (2001) highlighted that the stigma associated with a psychiatric diagnosis can create "a vicious cycle of alienation and discrimination—leading to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalisation—which decreases the chance of recovery and normal life" (p. 99), assertions substantiated, for example, by the longitudinal work of Markowitz (1998). So, the designation and application of psychiatric labels can have deleterious material consequences for those to whom they are applied.

PERSONALITY DISORDER LABELS FROM *DSM-IV-TR* TO *DSM-5*

In the transition from *Diagnostic and Statistical Manual for Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*) to *DSM-5*, there was much debate about the methods by which personality disorders were diagnosed, with a hybrid dimensional-categorical model also included in *DSM-5* as an alternative for further study (which retains both borderline and antisocial personality disorder [PD] as subtypes). This inclusion perhaps signifies disquiet with the PDs as a diagnostic group. However, in *DSM-5*, the categorical approach was retained from *DSM-IV* with the same 10 PDs nominated therein (paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive), with disorders on the first three axes as in previous editions combined onto one. The original *DSM-IV* categorical model attracted criticism for high instances of comorbidity among PDs and arbitrary thresholds for diagnosis, thereby arguably bringing into question the existence of 10 discrete PDs (Skodol et al., 2005). In one study, 60% of individuals that met the criteria for a single PD also met the criteria for another (Skodol et al., 2011). In addition, the heterogeneity of PDs is illustrated given that there are at present 256 criteria combinations that can be used to justify a diagnosis of borderline personality disorder (BPD; Samuel et al., 2012). Skodol et al. (2011) argued that there is substantial empirical

support for antisocial, borderline, and schizotypal PDs, whereas there is limited evidence for paranoid personality disorder (PPD). Although PPD is not included in the hybrid model in *DSM-5*, and although its removal was flagged as a possibility, nevertheless, it remains in *DSM-5* as one of the 10 PDs specified therein.

"BORDERLINE PERSONALITY DISORDER" AS EXEMPLAR OF IATROGENIC EFFECTS

Research by Markham (2003) focused on whether people are viewed negatively and are rejected based on psychiatric labeling. In the study, mental health nurses completed questionnaires to indicate their attitudes and perceptions of patients with BPD, schizophrenia, and depression. Markham found that these respondents were less optimistic about individuals with BPD compared with those designated as having schizophrenia or depression. Markham suggests that clinicians hold strong negative perceptions of patients with a PD label, despite understanding the characteristics of a patient with PD. Clinicians have referred to clients with BPD as "more difficult," "manipulative," "less deserving of care," and "hateful," such terms reflecting a lack of empathy and the potential for unsympathetic treatment (Markham, 2003). Lewis and Appleby (1988) found that psychiatrists were inclined to feel less involved with their patients prior to seeing them once they realized they had been given a diagnosis of BPD. Similarly, psychiatric nurses in a study by Fraser and Gallop (1993) reported that they were more empathic to patients diagnosed as having affective disorder than they were with patients diagnosed with BPD. This response is particularly unfortunate for clients with BPD, given this group is especially sensitive to rejection and may perceive it as abandonment, thereafter resorting to self-harm or withdrawal from treatment (Brown, 2002). According to Gallop, Lancee, and Garfunkel (1989), the stigmatizing effects of BPD can independently contribute to such negative outcomes.

EFFECTS OF OTHER PERSONALITY DISORDER LABELS

Similarly, Birkeland (2011) has found those diagnosed as having PPD are also referred to as "difficult" and with whom it is "hard to form relationships." PPD is typified by a pattern of traits, which include suspiciousness, extreme sensitivity, and unwarranted doubt about the loyalty or trustworthiness of close friends and family, although research on PPD is limited, given that patients with paranoid thoughts and behavior are extraordinarily indisposed to seeking psychiatric help (Salvatore, Nicolo, & Dimaggio, 2005). Hinshelwood (1999) argues that patients with PD are seen as difficult because of their ability to evoke personal emotion from mental health workers, which essentially challenges their professionalism. We might expect similarly stigmatizing effects of other PD labels, in particular of antisocial personality disorder (ASPD), which includes a disregard for the rights of others from early teenage years and the presence of conduct disorder before the age of 15 years (including extensive "delinquent" behavior, such as theft, arson, law breaking, with lack of remorse). Left unexamined, according to Markham and Trower (2003), the diagnostic descriptors can become a justification for discrimination that leads to early termination of care as well as other possible negative outcomes.

PREVIOUS CALLS FOR DIFFERENT NAMES

Could a name change be enough for PDs and other mental health labels to reduce stigma? In support of this, Heller (as cited in Bogod, 2009) believes that the BPD label is inaccurate, explaining that it possesses negative judgemental connotations and pointing out that the suggestion that there is a fault with the whole person is an attack on an individual's personality. Heller argues that research on BPD indicates that the cause of the disorder is not a "flawed personality," but rather it is a biologically based brain disorder, with a dysfunction in the limbic system; he proposes thereby that BPD be relabeled "dyslimbia," with others suggesting it be called "emotional dysregulation disorder" (Porr, 2001).

THE CURRENT STUDY

In the literature discussed thus far, it is clear that further research is needed about the negative effects of psychiatric labels on people to whom they have been assigned. There is an absence of such work focusing on PPD and ASPD, whereas that on BPD is limited in scope. Furthermore, studies have not established the relative distressing effects of these diagnostic terms or compared their effects with ones used to denote more commonplace mental health difficulties, such as major depression, generalized anxiety disorder, and post-traumatic stress disorder. Using a repeated-measures design, this study seeks to redress this omission and extend the work of Markham (2003) by examining the relative iatrogenic effects of three PD labels (BPD, ASPD, PPD) and three more commonplace mental health disorder labels as listed earlier. It is hypothesized that the three PD labels will produce the greatest dysphoric responses to the six labels included, with the three more commonplace diagnostic labels being rated as least distressing and most understandable.

METHOD

Participants

Of 240 participants who logged onto SurveyGizmo and attempted to complete the online repeated-measures questionnaire, 173 did so. The age of the sample ranged from 18 to 75 years with a mean of 28.86 years, $SD = 9.46$. Most (99.4%) were 18–60 years old, with only one respondent older than this. Seventy-nine percent of the sample were aged 18–35 years. Eighty-one participants (46.8%) were male, and 92 (53.2%) were female. Ninety-eight (56.6%) self-designated as full-time students, 12 (7%) as part-time students, 43 (25%) as being in full-time employment, 3 (1.7%) as being in part-time employment, 5 (3%) as unemployed, 5 (3%) as a house-husband/wife, 1 (0.6%) as retired, and 6 (3.5%) self-classified as "other." Sixty-three percent of the sample were students attending a university in London, United Kingdom. Socioeconomically, modal income was £0–£5,000 per annum (31%), with 65% earning no more than £20,000 per annum. In terms of educational attainment, 38.7% ($n = 65$) of respondents had end-of-secondary school "A" level qualifications, whereas 26.2% ($n = 44$) had achieved an undergraduate education, and 17% ($n = 28$) at postgraduate level. The sample was ethnically inclusive and diverse, reflecting the intake of

the university and of the London metropolitan area. As an example of this, 36% ($n = 62$) self-designated as Black African, Black British, or Black Caribbean, whereas 29% self-designated as White British/English or White, with the remaining 35% self-designating as either Asian, Bangladeshi, Chinese, British Mauritian, Hispanic, Irish, Italian, Moroccan, Pakistani, Portuguese, or Swedish. Most of the sample were single (60.1%; $n = 104$), with 29 (16.8%) married, 27 (15.6%) cohabiting, and 11 (6.4%) divorced.

Materials

Participants completed an online survey in which they were asked to consider in turn six mental health labels in the following order: posttraumatic stress disorder, borderline personality disorder, major depression, paranoid personality disorder, anxiety disorder, and antisocial personality disorder. For each label, they were asked the following: "If you were diagnosed as having [*name of disorder*] by a psychiatrist, clinical psychologist, or a GP, how would that make you feel?" Thereafter, for each label, in a repeated-measures format, participants indicated their responses to 15 emotion terms, specifically: upset, embarrassed, misunderstood, confused, determined, uncomfortable, burdened, anxious, enlightened, afraid, interested, distressed, ashamed, angry, and vulnerable. For each emotion term, participants were presented with a 1–7 Likert scale, wherein 1 was anchored as *not at all* and 7 as *extremely*, to indicate how application of the mental health label made them feel. For each label, participants also responded to a 16th item ("To what extent is the label [*name of disorder*] understandable to you?") with a 1–7 Likert scale again provided, wherein 1 = *not all understandable* and 7 = *very understandable*. Following these six sections of the survey, which contained in all 96 items, a further seven questions solicited demographic information (for gender, age, ethnicity, occupation, partnership status, highest level of educational attainment, and annual earnings before tax).

Notably, four of the emotion terms (distressed, upset, ashamed, afraid) load significantly onto the negative affect factor in the Positive and Negative Affect Schedule, whereas two (interested, determined) load significantly onto the positive affect factor, as after Crawford and Henry (2004). The remaining nine terms were author-selected to reflect the range of possible affective and cognitive responses to psychiatric diagnostic labels and are considered here appropriate for this purpose.

Procedure

Prospective participants were sent a link to the questionnaire as hosted on SurveyGizmo. The link remained active for 3 months (November 2012 to January 2013 inclusive). After a participant had activated the online link, a letter of invitation was presented in which it was explained that the purpose of the study was to "investigate the effect of mental health labels on people." Participants were informed that they would be asked 16 questions in relation to each of six mental health labels and that they would be asked for some additional information about themselves thereafter. Participants were informed that responses would be held confidentially, that respondent's anonymity would be assured, and that they had the right to withdraw and have their data withdrawn without consequence at any point. It was explained that by continuing to the first question, participants would be indicating that their free and informed consent was being given. At the end of the study, all respondents were given access to additional debriefing information and another opportunity to contact the researchers to ask any questions or to address any residual concerns.

RESULTS

Data from the 173 participants who completed the online questionnaire were exported from SurveyGizmo to the Statistical Package for the Social Sciences (SPSS) version 20 for analysis. Given the questionnaire was administered online wherein progression only occurs if all preceding items have been completed, there were no missing values in the data set. Scores for the three positive affect items (determined, enlightened, interested) were reversed ($1 = 7$, $2 = 6$, $3 = 5$; $7 = 1$, $6 = 2$, $5 = 3$) to align them with the scoring of the 12 negative affect items. Repeated-measures analyses of variance (ANOVAs) of mean scores were computed for each of the 16 questionnaire items, with type of psychiatric label as the independent variable—the within-participants factor. Assumptions of homogeneity and normality of variance were met using the Greenhouse-Geisser correction. The results of these analyses of the means are shown in Table 1, wherein associated F ratios and post hoc pairwise comparisons are provided (for the latter, with significance at $p < .05$ and for also when employing Bonferroni adjustment). Two such additional analyses were also computed for scores composed of a summation of the 12 negative affect terms and of the 3 positive affect terms. These are also included in Table 1.

Notably, the "paranoid personality disorder" label was rated as the most upsetting ($M = 5.62$) and distressing ($M = 5.29$) of all of the labels, followed by "borderline personality disorder" and "antisocial personality disorder" in that order. This ordering of dysphoric effect is confirmed in the analysis of the summed means for the 12 negative affect terms ($F = 83.62$, $p < .001$). Of the six named mental health labels, "paranoid personality disorder," "borderline personality disorder," and "antisocial personality disorder" elicit the most embarrassment, confusion, discomfort, sense of burden, sense of being misunderstood, of anxiety, fear, shame, anger, and vulnerability. By contrast, anxiety disorder and posttraumatic stress disorder are found to be the least upsetting and distressing of the six mental health labels, with the negative terms summed mean for the "major depression" diagnostic label being slightly elevated above this but nevertheless being less than that for the three personality disorder labels. Anxiety disorder is shown to elicit the most interest and determination from participants.

Finally, the most "understandable" psychiatric label was major depression ($M = 5.30$), post hoc pairwise comparisons with the other five labels indicating statistically significant differences. Although not statistically significant, it is perhaps notable that the least understandable mental health label was "borderline personality disorder" ($M = 4.66$).

DISCUSSION

The focus of this study was to examine to what extent psychiatric diagnoses, with specific reference to PD variants, solicit distressing responses from those to whom they are applied. This is an important task, given the report by the World Health Organization (2001), which draws attention to the damaging effects of stigma associated with mental ill-health for individuals and their families.

The results of this study support the hypothesis that the most distressing psychiatric labels considered here are the three PD variants as compared with the three other non-PD mental health diagnostic labels included. In descending order of magnitude, respondents reported

TABLE 1. Means, Standard Deviations (in Parentheses) and Analyses of Variance for 16 Items Across Six Psychiatric Labels for $N = 173$ Respondents

Questions	1 Posttraumatic Stress Disorder	2 Borderline Personality Disorder	3 Major Depression	4 Paranoid Personality Disorder	5 Anxiety Disorder	6 Antisocial Personality Disorder	*F* Ratio (With Greenhouse-Geisser Correction)	*p*
(1) Upset	3.99^{a} (1.59)	5.41^{bc} (1.45)	5.03^{d} (1.67)	5.62^{be} (1.50)	4.13^{a} (1.69)	5.38^{cde} (1.8)	51.12	$p > .001$
(2) Embarrassed	3.31 (1.57)	5.11ab (1.96)	4.32 (2.05)	5.31^{ac} (1.87)	3.94 (1.74)	5.07^{bc} (1.98)	63.52	$p > .001$
(3) Misunderstood	3.35 (1.58)	4.83^{ag} (1.66)	4.24^{c} (1.69)	4.93^{ad} (1.58)	3.83^{c} (1.67)	4.97^{gd} (1.75)	47.60	$p > .001$
(4) Confused	3.55^{ab} (1.78)	4.84^{cd} (1.68)	3.81^{ae} (1.63)	4.91^{c} (1.64)	3.73^{fbe} (1.71)	4.77^{d} (1.75)	40.81	$p > .001$
(5) Determine	3.91^{abcf} (1.71)	4.28^{deg} (1.65)	4.18^{adhi} (1.67)	4.18^{be} (1.80)	3.90^{ch} (1.68)	4.29^{fgi} (1.80)	3.23	$p > .001$
(6) Uncomfortable	3.82^{a} (1.65)	4.95^{bc} (1.78)	4.35 (1.72)	5.01^{b} (1.78)	3.99^{ad} (1.71)	4.95^{ce} (1.69)	28.57	$p > .001$
(7) Burden	3.87^{a} (1.75)	4.79^{cbd} (1.70)	4.59^{be} (1.61)	4.91^{c} (1.68)	$3.94f^{a}$ (1.71)	4.73^{deg} (1.76)	23.49	$p > .001$
(8) Anxious	4.14^{a} (1.78)	4.82^{bcd} (1.63)	4.50^{cg} (1.62)	4.99^{ae} (1.70)	4.31^{df} (1.84)	4.78 (1.70)	12.70	$p > .001$
(9) Enlightened	3.46 (1.81)	3.63 (1.84)	3.55 (1.69)	3.63 (1.75)	3.46 (1.59)	3.60 (1.90)	0.70	*ns* ($p = .6$)
(10) Afraid	3.73^{a} (1.73)	4.98^{bc} (1.71)	4.20^{d} (1.73)	5.01^{b} (1.70)	3.73^{a} (1.67)	4.36^{d} (1.89)	25.91	$p > .001$
(11) Interested	4.07^{abc} (1.89)	4.57^{de} (1.77)	4.18^{afg} (1.70)	4.51^{d} (1.77)	3.89^{ijb} (1.69)	4.39^{ceh} (1.87)	7.24	$p > .001$
(12) Distressed	3.80^{ac} (1.70)	4.97^{bcd} (1.65)	4.69^{be} (1.64)	5.29^{c} (1.65)	4.03^{a} (1.73)	4.87^{de} (1.70)	34.67	$p > .001$
(13) Ashamed	3.25 (1.71)	4.82^{ab} (2.04)	4.33 (2.02)	5.06^{a} (2.05)	3.78^{c} (1.79)	4.94^{bd} (2.03)	53.06	$p > .001$
(14) Angry	3.11 (1.68)	4.37^{ab} (1.86)	3.80^{c} (1.75)	4.46^{ad} (1.90)	3.48^{c} (1.72)	4.49^{bd} (1.74)	38.35	$p > .001$
(15) Vulnerable	3.82^{a} (1.77)	4.67^{bcd} (1.68)	4.36^{be} (1.70)	4.93^{c} (1.67)	3.97^{a} (1.76)	4.47^{de} (1.76)	19.45	$p > .001$
(16) Understandable	4.77^{abcd} (1.65)	4.66^{aefg} (1.96)	5.30 (1.60)	4.83^{behi} (1.68)	4.83^{cfhj} (1.67)	4.83^{dgi} (1.78)	6.21	$p > .001$
Negative terms overall mean	3.65 (1.21)	4.85^{acv}(1.28)	4.35 (1.19)	5.03^{abd} (1.32)	3.91 (1.36)	4.81^{bcd} (1.41)	83.62	$p > .001$
Positive terms overall mean	3.81^{abcd} (1.45)	4.16^{efg} (1.36)	3.98^{aehij} (1.32)	4.11^{bfhk} (1.41)	3.75^{ci} (1.36)	4.09^{dgjk} (1.48)	5.60	$p >.001$

Note. Pairs of means without a common superscript are significantly different at $p < .05$ and also when employing Bonferroni adjustment for multiple comparisons. Negative terms overall mean = (Q1 + Q2 + Q3 + Q4 + Q6 + Q7 + Q8 + Q10 + Q12 + Q13 + Q14 + Q15) / 12, and positive terms overall mean = (Q5 + Q9 + Q11) / 3.

greater negative emotions in relation to PPD, BPD, and ASPD diagnostic labels. Responses across all 12 negative emotion terms were highest for the PPD label, which was also experienced as an understandable diagnostic term. This pronounced pattern of responding is likely to be attributable to the unique component of the label, namely the term *paranoid*. Commonly held understandings of the term *paranoid* can be accessed through a definition of the term in the Concise Oxford English Dictionary (Thompson, 1995), which describes "paranoia" as "an abnormal tendency to suspect and mistrust others," whereas the American Psychiatric Association (2013) in *DSM-5* defines paranoia as "a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent" (p. 649). From the data, it is apparent then that respondents react especially strongly and aversely to such a suggestion. The designation of paranoia in combination with "personality disorder" may have been construed by respondents as implying an inadequacy, insufficiency, or weakness of the self. Thereby, respondents may well have experienced the designation of PPD as a negative form of medicalized name-tagging to which they reacted strongly.

BPD was also rated by respondents as being distressing. In addition, this label was rated also as the least understandable of the six diagnostic terms in the study, with a mean of 4.66. "Major depression" was rated as the most understandable label. This finding supports the suggestions of Heller (as cited in Bogod, 2009) that a name change for BPD is needed, given the current appellation is neither self-explanatory nor avoids the risk of being construed as implying the existence of an ongoing fault with the individual's personality. Furthermore, the continued use of the BPD label is disputable given an examination of the stability of the disorder over time: In a 6-year follow-up study of 290 patients diagnosed with BPD, Zanarini, Frankenburg, Hennen, and Silk (2003) found that after 2 years, 34.5% no longer met the criteria for BPD, with this increasing to 73.5% over the entire follow-up period. In addition, inappropriate labeling and inaccurate recognition of such mental health difficulties is associated with poor help seeking and development of poor treatment preferences. Wright, Jorm, Harris, and McGorry (2007), for example, have found that accurate recognition and labeling of mental disorders by young people is associated with better help seeking and treatment preferences, arguing that mental health labels function as a cue to activate schemas for appropriate action to be taken. Arguably, "BPD" is not immediately comprehensible to members of a nonprofessional audience, so cannot help cue treatment preferences. Furthermore, both Gallop et al. (1989) and Aviram, Brodsky, and Stanley (2006) report how clinicians react negatively and distance themselves from patients with BPD, given the therapeutic and relational challenges associated with these clients. This is particularly contraindicated given BPD patient's pronounced sensitivity to perceived rejection and abandonment, to which they may react negatively by, for example, harming themselves or withdrawing from treatment. Notably, Link (1987) reports that social rejection is greater for patients with BPD than for either depression or schizophrenia. As consistent with what is suggested here, Markham and Trower (2003) report that the actual name, BPD, is the source of stigma and of unhelpful causal attributions about associated challenging behaviors.

As two pre-eminently distressing labels, BPD and ASPD have been shown to constitute highly comorbid diagnoses. In a study of 615 current heroin users by Darke, Williamson, Ross, Teeson, and Lynskey (2003), it was found that 46% met the criteria for BPD, 71% for ASPD, and 38% for both. Therefore, it is probable that these two distressing labels often may both be applied clinically to the same individual, with attendant risks of additive or multiplicative iatrogenic effects. Batemen and Fonagy (2008) argue that where these

diagnoses occur together, such individuals tend to misinterpret others' motives. As this may be so, the question is begged as to how such individuals might interpret the motives of clinicians ascribing labels to them that even for non-PD respondents (as sampled in this study) tend to evoke strong negative emotional responses. The implication of this is clear: New, more sympathetic terms are needed to denote those who currently are diagnosed as BPD and/or ASPD.

Developing further the "PD" critique here, it is notable that the notion of personality rests on the assumption that cross-situational consistencies in behavior are observable. Yet, according to reversal theory (Apter, 2001), what is conspicuous about the human condition is the inconsistency of an individual's behavior across situations, thereby calling into question the very concept of personality. Also, for the concept of personality to be tenable, agreement should be observable between different measures of the same personality construct. However, Ajzen (2005) concludes that " . . . empirical research has shown very little support for consistency between different behaviours presumed to reflect the same underlying disposition" (p. 33). It follows, that if personality cannot be reliably designated or assessed, it is questionable whether "personality" itself can be "disordered." Rather, research suggests that what is disordered and is a source of reoccurring distress in such instances is a profound difficulty in forming and maintaining relationships with others, whether it be informal, transitory associations, or close, enduring emotional bonds. For example, Haslam, Reichert, and Fiske (2002) found, among 57 participants experiencing significant interpersonal difficulties, that "aberrant social relations," particularly in "authority-based and equality-based relationships," are related to many PD symptoms. The focus on difficulty forming and maintaining relationships is echoed further in Linehan's (1993) proposition that BPD develops when people with a dispositional vulnerability in terms of difficulty controlling their emotions are raised in a family that is invalidating, where emotions are discounted and disrespected. The relational theme is also to be found in Fonagy et al. (1996) where they observe that those classified as having a "preoccupied/enmeshed" attachment style are more likely to have a BPD diagnosis than those with standard attachment and likewise in the work of Nickel et al. (2004) who found that those sexually abused during childhood (a precursor of nonstandard attachment) are significantly more likely to develop BPD as adults than those who were not. Similarly, the interpersonal narrative appears in Hill, Fudge, Harrington, Pickles, and Rutter (2000), who compared personality assessment methods and conclude that PD may be assessed in terms of interpersonal and social role performance because " . . . abnormal traits are generally seen within an interpersonal context" (p. 991). Even those epistemologically opposed to such positivist research would appear to agree that relationships and the nonobservance of the rules of social engagement lie at the core of PD formulations, with Pilgrim and Hewitt (2001) asserting that "variants of the PD diagnosis are medical codifications of the violation of social norms" (p. 527). What is common to PD formulations then is not disorder of personality per se but rather disordered and dysfunctional relationship formation and maintenance. This in itself may account for the high rates of comorbidity observed among PDs, with Dolan, Evans, and Norton (1995), for example, reporting that the average number of PDs diagnosed for a patient is between 1.3 and 5.6. However, this overlap arguably does not indicate comorbidity but rather signals consanguinity: that is to say, fundamentally the same "disorder" in different guises.

It is to be concluded from this data and analysis that the designation of "personality disorder" is markedly distressing for those to whom it is applied, and the continued use of

these terms is not justifiable given the evidence of their effects. What is needed is accessible, self-explanatory terminology that makes clear the role of the severe and chronic difficulties experienced forming and maintaining relationships, which lie at the center of these disorders. We conclude that given the adverse effects of PD labels and conceptual problems associated with the notion of "personality disorder," such labels should be replaced by more compassionate terms, which reflect the interpersonal difficulties that underpin this group of presenting complaints. Further research is needed, perhaps using qualitative or mixed methods to explore in greater depth respondents' reactions to these diagnostic labels to confirm or disconfirm explanations proffered here for their observed effects.

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