Understanding personality disorder

CHRISTIAN JARRETT *with an overview of a new Society report, looking at definitions, causes and treatments.*

TO many, the term personality disorder (PD) has become synonymous with stigma and confusion. It's said that if psychologists cannot agree on what exactly personality is or how to measure it, then surely it can't be meaningful or justified for clinicians to label someone's personality as disordered. Moreover, what could be more demeaning than for a person to be told that their very character is somehow dysfunctional?

And yet, despite these criticisms, it remains a stark fact that there are many people who, through a combination of their enduring traits and past traumatic experiences, suffer greatly and persistently, struggling with life and finding themselves in regular contact with mental health services. There is a perception that people with a personality disorder are often in trouble with the law, but a greater number will pose a risk to themselves, through self-harm, self-neglect and suicidal behaviour. Now, with a view to clearing the confusion, encouraging future research, and improving service provision for people diagnosed with PD, the British Psychological Society has published *Understanding Personality Disorder*.

What is personality disorder?

A person who has unusual, enduring traits that cause them to suffer, or that render them unable to cope with life, is considered to have a personality disorder (see 'Case vignettes' box). But who is to say what counts as a disordered personality? Most psychologists now agree that differences in personality can largely be accounted for by variation in the 'Big Five' personality dimensions of neuroticism vs. stability, extraversion vs. introversion, agreeableness vs. antagonism, conscientiousness vs. lack of self-discipline, and openness to experience vs. rigidity. The position of the authors of this BPS report on personality disorder is that enduring and persistently extreme scores on these dimensions are necessary, but not sufficient, for a diagnosis of PD; having an odd personality only becomes problematic, and a PD diagnosis appropriate, if the person in question, or those close to them, or both, consistently suffer because of it. Perhaps unsurprisingly, people diagnosed with PD also have other mental health problems.

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The classification of personality disorders is a grey area. The *Diagnostic and Statistical Manual* of the American Psychiatric Association takes a categorical approach to PD, outlining the descriptive criteria that need to be met for a diagnosis of 10 different personality disorders that are grouped into three clusters: paranoid, schizoid, schizotypal (the odd/eccentric cluster); antisocial, borderline, histrionic, narcissistic (the dramatic/erratic cluster); and avoidant, dependent and obsessive-compulsive (the anxious/fearful cluster). Many people fulfil the criteria for more than one of these PD categories, which some have said undermines their meaningfulness, but the Society's report notes that it is important to recognise that 'these are categories of disorder, not types of people'. Moreover, a cross-cultural study conducted in 1994 found that 'the categorical model of PD could be used to reliably diagnose PD across a range of cultures'.

Based on existing criteria, research suggests that around 10 per cent of the general public will have PD. Not surprisingly, among psychiatric outpatients and inpatients, prevalence rates are higher,

CASE VIGNETTES

Dave suffered from chronic anxiety, self-harmed, and overly controlled his eating. He was socially unstable – being friendly one minute and confrontational the next. Hospitalisation followed a suicide attempt, where efforts to manage his self-harming led to conflict with ward staff. Sensitive, in-depth psychological assessment revealed Dave had been neglected by his parents, had lost his sister to whom he was very close when he was just 13, and had been abused by an older woman he had formed a close relationship with from the age of 15. Dave avoided intimacy, feared rejection, yet craved love and protection.

Clare, who had always been shy and introverted, left a successful job at a bank saying she felt uncomfortable around her colleagues. She stopped going to the local pub on Fridays with her husband, which had been their routine for years. She denied being depressed and said she felt OK when alone. But eventually she told her GP her shyness was becoming debilitating and that she missed her friends and former activities. In-depth assessment revealed her excessively avoidant behaviour seemed to have begun when several events occurred close together, including losing her mother and her best friend's emigration to Canada.

George is serving a 14-year prison sentence for aggravated burglary and rape. He had a long record of criminal behaviour including arson, thefts, violence, drugs and fraud. As a child he was described as 'out of control', was known for local vandalism and truancy, and spent much of his time in local authority care. He described his latest crime as a 'misunderstanding', yet the police labelled it as a callous, sadistic attack. He dominated group therapy sessions in prison and staff described him as manipulative with a quick temper.

estimated at between 30 and 40 per cent, and between 40 and 50 per cent, respectively. It is in prison samples that prevalence rates are highest, especially in younger people. One study found 78 per cent of male remand prisoners met the diagnostic criteria for PD. Another study found rates as high as 88 per cent among young, male, sentenced offenders.

The traits traditionally used to diagnose and classify PD are descriptive and say nothing about the underlying beliefs, motives, schemas, defences and coping mechanisms – the 'source traits' – that underlie a person's dysfunctional behaviour and that ought to be the target of psychological treatment. This is partly due to a lack of communication between theoretical personality researchers and diagnosing clinicians. As the report concludes: 'There is an urgent need to integrate knowledge of abnormal personality developed by psychiatrists and psychologists in clinical studies with theory and research on the psychology of personality more generally.'

What causes personality disorder?

Personality disorders are caused by a combination of biological, psychological and social factors. Twin and adoption studies looking at healthy personalities have found between 40 and 50 per cent of variation between participants is explained by genetic inheritance. Other studies have found that personality problems tend to group in families; for example, antisocial behaviour and substance abuse will tend to co-occur in one family, while people with schizoid or schizotypal personality or with full-blown schizophrenia will tend to be found in another family.

Inevitably, experiences within the family may also sow the seed of personality disorder. There's evidence, for example, that childhood neglect and abuse are linked with PD. Indeed, the fact that girls are more often victims of sexual abuse than physical abuse, while the opposite is true for boys, is thought to predispose them to different kinds of psychological vulnerability. This could explain why some personality disorders, such as antisocial PD, are more common in men, whereas others, such as borderline PD, are more common in women. There is also evidence that people with PD often have post-traumatic stress disorder caused by terrifying childhood experiences. A father's antisocial behaviour, parental alcoholism and a chronic failure by parents to supervise or discipline their children have also all been linked with PD.

Of course, many people endure terrible experiences without going on to develop a personality disorder. Such people may be able to 'buffer themselves from more negative life experiences', either through having adaptive personality traits or active coping styles. The report adds that people who seem to have survived child abuse relatively unscarred 'would appear to recognise early on in their lives that their parent's behaviour is pathological and look elsewhere for attachment and behavioural models'. Understanding what protects some people from developing PD could hold the key to preventing vulnerable people developing PD in the future.

KEY RECOMMENDATIONS

- The government policy of treating people with PD in core mental health services is welcomed.
- Clinicians should conduct an in-depth formulation of clients' needs, not just a simple diagnosis.
- All core mental health staff should be trained in the needs of people with PD.
- Mental health teams must work with other agencies to address the complex needs of people with PD.
- More funding is needed to support research into personality development in order to understand why some individuals develop dysfunctional personalities and how their experience and genetic inheritance differs from individuals who develop functional personalities.
- Greater communication is needed between academic personality researchers and clinicians.
- Skills and knowledge regarding treatment strategies should be shared between forensic settings and core mental health teams.
- More randomised controlled trials of the efficacy of treatments for PD are needed.
- The views of people with PD should incorporated into service development.

How is personality disorder treated?

Despite widespread belief to the contrary, personality disorder can be successfully treated. 'Historically, there has been a tendency to assume that people with personality disorder are untreatable, as if treatability were a characteristic of those given this label rather than a reflection of our current state of knowledge,' the report says. However, there is no standard treatment for PD, and more research in the area is urgently needed. Currently, people diagnosed with PD are likely to be offered 'a bewildering array' of interventions including some, all or none of the following: drugs, psychoanalytic therapy, cognitive behavioural therapy (CBT), cognitive analytic therapy, dialectical behaviour therapy (DBT), supportive therapy and therapeutic community treatment.

There is a paucity of high-quality randomised controlled trials looking at the effectiveness of these different treatments.

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However, DBT has been found to be effective at helping women diagnosed with borderline PD who deliberately harm themselves. DBT group work teaches clients self-management skills, distress-tolerance skills and social skills, while individual therapy encourages clients to accept negative mood states without resorting to self-harm. There is some evidence for the efficacy of CBT for treating PD, and a shortened form of CBT using a self-help manual was found to be a cost-effective treatment for clients who self-harm, 90 per cent of whom had PD. Furthermore, two randomised controlled trials of interpersonal group therapy and individual psychodynamic therapy found improvement in social functioning and depression, relative to controls. Therapeutic communities, in which clients are involved in the day-to-day running of the community and support each others' needs, have also shown promise, although research into their efficacy is hampered by methodological difficulties, such as the lack of suitable control groups.

Taken all together, the BPS report says that these results show 'structured and systematic psychological treatments can be effective at reducing self-harm and improving social and interpersonal functioning in clients with borderline PD', but cautions that 'most studies have been on small samples…and larger more generalisable studies, involving more than one centre, are needed'. The report notes again that future research would benefit from efforts to bridge the 'tenuous links' between academic research into personality and the clinical work of therapists. Regardless of the specific treatment approach, the report stresses that interventions are most successful when they are 'intensive, long term, theoretically coherent, well structured, well integrated with other services and where follow up to residential care is provided'.

Also key to any treatment is the way in which clients are assessed initially. Interview-based assessments are invaluable, especially in combination with self-report or questionnaire methods; the use of self-report methods alone, especially in forensic settings, is discouraged. It is also important to review information from sources other than the client, when this is available, in order to gain a different perspective from those of the client and the practitioner. At the heart of the approach recommended by the new BPS report is that clinicians should conduct a needs-based 'formulation', not a simple diagnosis. This 'requires the ability to place [a client's] experiences in a contextual and explanatory framework that can help to raise a person's own awareness of their behaviours, thoughts and emotions.' Whereas diagnosis is a useful starting point, formulation 'is a sophisticated, detailed and dynamic understanding of the person as an individual, and its process directly informs interventions to generate positive change'. Other clinical syndromes should always be assessed before making a diagnosis of PD.

Mental health and forensic services could benefit from sharing their knowledge

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In prison settings, there are treatment programmes accredited by the Home Office based on a body of evidence known collectively as 'What Works'. Because of the high prevalence of PD among prison inmates, it's likely many prisoners with PD participate in these programmes. Although aimed at reducing offending behaviour rather than treating mental ill health, there is evidence that these programmes, which focus on cognitive skills and problem solving, may help address some of the needs of offenders with PD. The Society's report recommends that offenders be assessed for PD before beginning treatment and that general mental health services and forensic services could benefit from sharing their knowledge and techniques. 'The therapeutic skills used in both environments could be of benefit to both,' it says.

What next?

In 2003 the National Institute for Mental Health in England (NIMHE) published guidelines for the treatment of PD. This recommended that specialist PD teams be created to act as a bridge between core mental health services and people with PD. 'Psychologists have particular skills in assessment and formulation that would be invaluable to any specialist multidisciplinary PD team,' the report says, and so demand on psychologists will inevitably increase with the formation of these teams. Because people with PD have complex needs, encompassing difficulties with the law, housing, finances, relationships, emotions and social behaviour, mental health services will also need to develop further their relationships with probation services, prison staff, child protection officers and housing services. It can be extremely difficult to help people with PD, so it's vital that staff working with this client group also receive regular support themselves.

Specialist PD teams will hopefully encourage more people with PD to engage with core mental health services. In turn, staff working in core services need training to raise their awareness of the problems faced by people with PD – '…it is essential that all staff groups, and in particular those training to be clinical and forensic psychologists, be equipped to deal with clients with these problems,' the report says. Before now, because of the widespread misconception that PD cannot be treated, many people have been denied access to services. This has led many people with PD to be wary and distrusting of mental health professionals. 'In order to engage these people in services', the report says, 'it will be necessary to foster an attitude of respect for their suffering and an approach that recognises their dignity as fellow human beings.'

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