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ABC of mental health: Disorders of personality

[Clinical Review]

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Personality disorders are widespread and present a major challenge in most areas of health care. They can be difficult to treat, complicate the management and adversely affect the outcome of other conditions, and exert a disproportionate effect on the workload of staff dealing with them. Finding appropriate placement for sufferers can cause difficulties for doctors and the courts. (Figure 1)

Figure 1. No caption available.

Definition and classification

Definition

The study of the personality disorders has been beset by problems, and, as a result, the use of such diagnoses is often questioned. The World Health Organisation defines these conditions as comprising "deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations."

They are associated with ways of thinking, perceiving, and responding emotionally that differ substantially from those generally accepted within a patient's culture. As a result, patients tend to exhibit a severely limited repertoire of stereotyped responses in diverse social and personal contexts. These patterns are usually evident during late childhood or adolescence, but the requirement to establish their stability and persistence restricts the use of the term "disorder" to adults.

Classification

There are two main approaches to classification-dimensional and categorical.

Dimensional classification-This defines the degree to which a person displays each of a number of personality traits and behavioural problems. This approach is proving useful in investigating the biochemical underpinnings of many of these disorders.

Categorical classification-This, the basis of the major clinical systems for classifying mental disorders, assumes the existence of distinct types of personality disorder with distinctive features. The World Health Organisation's classification of personality disorders has undergone much revision in the past 20 years and has been complicated by the recent addition of behavioural syndromes such as pathological gambling and kleptomania.

Problems in defining personality disorders

- Lack of a standard of normal personality or behaviour

- Confusing terminology derived from different theoretical perspectives

- Two approaches to classification

- Dimensional approach useful in research

- Categorical approach used clinically

- Blurred boundaries with mental illness

- Tendency of clinicians to prefer unitary to multiple diagnoses

- Use of term "personality disorder" as a pejorative label

World Health Organisation's classification of personality disorders *

F60 Specific personality disorders

Paranoid-Includes formerly used categories of sensitive and querulant personality

Schizoid-Distinct from schizotypal disorder, which is related to schizophrenia

Dissocial-Formerly called antisocial, asocial, psychopathic, or sociopathic personality

Emotionally unstable-Includes impulsive (explosive) and borderline types

Histrionic-Formerly hysterical personality

Anankastic-Formerly obsessional personality

Anxious-Also called avoidant personality

Dependent-Formerly asthenic, inadequate, or passive personality

F61 Mixed personality disorders

F62 Enduring personality changes

Includes permanent changes after catastrophic experiences (such as hostage taking, torture, or other disaster) or severe mental illness, but excludes changes due to brain damage

F63 Habit and impulse disorders

Includes pathological gambling, fire setting (pyromania), stealing (kleptomania), hair pulling (trichotillomania), and others

F68 Other disorders of personality

A mixed category including elaboration of physical symptoms for psychological reasons and intentional production of symptoms (factitious disorder)

F21 Schizotypal disorder

This category is included for completeness, but it is best avoided as its status as a variant of schizophrenia or of personality disorder is not clear

Epidemiology and aetiology

In Britain the prevalence of personality disorder ranges from 2% to 13% in the general population, and the prevalence is higher in institutional settings (such as in hospitals, residential settings, and prisons). Some diagnoses are made more commonly in men (such as dissocial personality disorder), while others are more common in women (such as histrionic and borderline personality disorders). Some common forms of presentation should prompt consideration of an

underlying personality disorder: the association between dissocial personality disorder and alcohol and substance misuse is particularly important.

There are both biological and psychosocial theories of the aetiology of personality and behavioural disorders. Biological and psychosocial theories are not mutually exclusive, and many have contributed to treatment strategies.

Possible causes of personality disorders

- There is mounting evidence to support a genetic component for some behaviours (such as alcoholism of early onset in men)

- Neurochemical research has found serotonin metabolism in the brain to be related to abnormal impulsiveness and aggression

- Some personality disorders can be thought of as attenuated forms of mental illness, the strongest link being between those found in cluster A and schizophrenia

- Psychological theories have focused on failure to progress through early developmental stages as a result of adverse conditions, leading to problems in maintaining relationships in later life

Diagnosis of personality disorder

It is generally agreed that the diagnosis of personality disorder of any type should not be made unless certain conditions are met. For practical purposes, these disorders are often grouped into three clusters that share clinical features:

Cluster A-Patients often seem odd or eccentric (such as paranoid or schizoid). Schizotypal disorder is often included in this cluster

Cluster B-Patients may seem dramatic, emotional, or erratic (such as dissocial, histrionic, or borderline type of emotionally unstable personality)

Cluster C-Patients present as anxious or fearful (such as dependent, anxious, anankastic).

Further complications arise because dissocial personality disorder (in the guise of psychopathic disorder or psychopathy) is included in the Mental Health Act 1983 and, if thought to be treatable, can be the basis for compulsory admission to hospital. It is variously defined but can be regarded as a severe example of a cluster B personality disorder.

Prerequisites for diagnosis of personality disorder

Patient displays a pattern of...

- Behaviour

- Emotional response

- Perception of self, others and the environment

which is...

- Evident in early life

- Persists into adulthood

- Pervasive

- Inflexible

- A deviation from patient's cultural norm

and leads to...

- Distress to self, others, or society

- Dysfunction in interpersonal, social, or working relationships

but is not attributable to

- Other psychiatric disorder (such as schizophrenia, depression, drug misuse)

- Other physical disorder (such as acute intoxication, organic brain disease)

Assessment

Patients with personality disorder may present in various ways. Some behaviours suggestive of personality disorder may be overt (such as extreme aggression), but others may be subtle (such as pronounced difficulty in assertiveness or avoidance behaviour). Temporary reactions to particular circumstances do not justify a diagnosis of personality disorder.

Problems presenting for the first time in adulthood may point to a functional or an organic mental illness. A collateral history from a relative or close friend is useful in distinguishing personality traits from mental illness. Patients' social circumstances need to be considered in order to identify solutions to immediate crises. Time spent on the presenting problem may help patients to identify solutions for themselves.

It is important to differentiate personality disorders in cluster A from psychotic mental illness, and personality disorders in cluster C from anxiety and depression whenever possible. However, personality disorder commonly coexists with mental disorder, and a patient may have symptoms of both. Thus, the inclination to withdraw all treatment and support once a personality disorder is suspected should be resisted. Diagnostic uncertainty is an indication for referral to specialist

mental health services.

Common presentations of personality disorder

- Aggression

- Alcohol and substance misuse

- Anxiety and depression

- Deliberate self harm

- Bingeing, vomiting, purging, and other eating problems

General practitioners, who may have known a patient since childhood, are in a good position to distinguish between transient and enduring patterns of behaviour

Assessment

In addition to routine psychiatric assessment, in cases of suspected personality disorder particular attention should be paid to the following:

- Presenting problems

- Childhood history and experiences, especially of severe illness, abuse or behavioural disturbance

- Reactions to life events

- Violent outbursts or episodes, and their precipitating factors

- Risk taking behaviour

- Relationships, of what kind and how stable

- History of relevant physical disorder, such as head injury, epilepsy, or substance misuse

- Comorbid physical or mental disorders

People suffering from personality disorders in cluster B commonly present with aggressive behaviour. Any history of abuse or behavioural disturbance in childhood should be elicited, and details taken of episodes of violence in public and at home, offending or criminal behaviour, and any experiences of imprisonment. Ideas or threats of harm to self or others should be openly discussed and carefully recorded.

Intervention

The basic principles of intervention include a clear consistent approach, with offers of help being made and delivered within realistic limits. The stance is one of helping patients with their problems without being cast into extreme positions (often as either the "ideal" professional or the "useless" one) or reinforcing avoidance and dependence by denying patients the opportunity to assume responsibility for their actions.

Inevitably, attempting to help a person who has difficulty in forming relationships may be hampered by that difficulty. When several professionals are involved, who is doing what and to what end must be communicated clearly between the professionals and, most importantly, to the patient. Ultimately, developing a working relationship and enhancing the motivation for change are the main foundations of any specific intervention to change behaviour. When these conditions are not met, simple problem solving and recognising and reinforcing individual patients' capacity to change their immediate situation at times of crisis may be useful.

Personality function must be assessed independently of current mental state

General principles of intervention

- Be realistic about what can be delivered, by whom and in what period

- Avoid being cast as angel or tyrant

- Communicate clearly with the patient and other professionals involved

- Aim for a stable, long term therapeutic relationship: this may need to be at a fairly low level of contact

- Aim to improve the patient's

Self worth

Problem solving abilities in the short run

Motivation for change in the long run

Specific measures

When another disorder coexists the intervention should initially be directed at this but working within the general framework given above. Referral to a specialist service may be indicated for specific problems (such as substance misuse and eating disorder).

Drug treatment-Depot antipsychotic drugs have been reported to benefit patients who harm themselves impulsively, and those who display symptoms suggestive (but falling short) of frank psychotic illness. Serotonin reuptake inhibitors have been used in patients with borderline personality disorder to reported good effect. However, these interventions are not supported by much research evidence, and the benefits of any drug must be weighed against the risk of side

effects and toxicity in overdose. Full discussion with individual patients is needed before embarking on such interventions.

Psychosocial intervention-Group and family psychotherapy have their proponents in treating disorders in cluster B on an outpatient basis, but individual cognitive or psychodynamic psychotherapy is usually preferred. Assertiveness training, anxiety management, and behavioural approaches may be useful with disorders in cluster C, as may short term, focused psychotherapy.

Specific measures for intervention

Treat comorbid mental or physical illness

Consider specific drug treatment

- Depot antipsychotic drugs for impulsive self harm

- Selective serotonin reuptake inhibitors for borderline type emotional instability

- Carbamazepine for aggressive behaviour

Consider specific psychological treatments

- Cognitive-behavioural therapy has been found effective in several personality disorders

- Assertiveness training and anxiety management for dependent and anxious patients

- Techniques for managing anger for patients with aggressive behaviour

Self help organisations

- Befriending services or voluntary agencies may support patients with disorders in cluster C and reduce their need for protracted involvement with health services

- Patients with habit disorders can obtain much needed advice and support from self help groups such as Gamblers Anonymous, Narcotics Anonymous, and Alcoholics Anonymous

- Telephone numbers of local and national agencies organising self help groups can be found in the telephone directory or Yellow Pages

Deliberate self harm

There is no clear consensus as to the best management of deliberate self harm in patients with personality disorder. While admission to a general psychiatric hospital may provide apparent safety, security, and containment, self harming may actually worsen-particularly if the admission is unfocused, not part of an overall plan, and the staff have little experience in dealing with problem.

Managing deliberate self harm

- Admit patients to hospital only as part of a carefully prepared treatment plan

- Relative indications for admission are for assessment of coexisting illness or risk of suicide

- Inpatient contracts, drawn up and signed by patient and staff, have been advocated and may provide a patient with the necessary structure within which help can be offered and received

- The content of a contract must be carefully considered if it is to be a constructive tool rather than a prescription of punishment

- When available, specialist inpatient units allow a much better opportunity for changing recurrent self harm than do general psychiatric units

Aggressive behaviour

In various patient groups aggressive behaviour has been shown to respond to carefully monitored carbamazepine treatment. This is especially true of patients in whom there are associated features such as a history of head injury, genuine amnesia for assaults, the deja vu phenomenon, olfactory hallucinations, and abnormalities shown by electroencephalography or brain imaging.

Psychological techniques for managing anger are useful for patients who are able to tolerate a therapeutic environment and to discuss their own behaviour. The key issue is to identify triggering situations and the automatic patterns of thought that precede an outburst of aggression.

Dealing with aggressive patients

- Be supportive to patients-explain their options and choices positively

- Take a forgiving attitude to rudeness

- Don't keep agitated patients waiting

- Don't see patients in isolated areas

- Don't be patronising or tell patients off

Clinicians who deal with aggressive patients should take basic safety precautions such as not seeing patients in isolated areas and ensuring the availability of alarm systems. More importantly, they should never criticise or admonish such patients and should always try to appear relaxed whatever feelings a patient may engender. Training in break away techniques-physical menoeuvres to escape from an assault-is helpful in maintaining confidence. The boundaries of acceptable and unacceptable behaviour should be clearly explained to patients in the context of helping them to avoid getting into difficulty.

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Further reading

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* ICD-10 (international classification of diseases, 10th edition). This no longer recognises some previously used descriptions of personality disorder as distinct categories. These include eccentric, immature, narcissistic, and passive-aggressive types

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