Personality Disorders

Introduction

Personality

Personality was defined by Schneider in 1959 as "The unique quality of the individual, his feelings and personal goals.". 'Personality' has been further defined as the set of enduring qualities of an individual which are revealed in the ways she s/he behaves across a wide range of situations. Such characteristics are apparent from late adolescence onwards.

Personality Disorder

Personality traits are described as constituting 'Disorder' when two criteria are met:

Deviance - the individual's behaviour differs from the 'norm' on at least one aspect of behaviour; e.g. attachment behaviour: over attached ('Dependent') at one end of the spectrum to lacking attachment ('Schizoid') at the other

Distress - the behaviour causes suffering to the individual or to others.

Such a definition obviously creates problems; many psychiatrists and social commentators are uneasy with the medicalisation of social deviance; it is difficult to see how personality disorders could be described as illnesses in the way that say schizophrenia can be. Most psychiatrists take the pragmatic view that medical and psychiatric skills may ameliorate the suffering caused by personality disorder and therefore where possible they have a duty to offer help . Furthermore, individuals, their families and society make demands for intervention. (Understandably, but not always appropriately).

Classification

Attempts have been made to group personality disorders into categories. These have not been highly successful. Most psychiatrists (and in fact lay-people) would agree when a person's behaviour constitutes personality disorder, but there is much less agreement over which category of disorder a given person would have. In an attempt to tackle this problem ICD-10 has grouped together "a variety of clinically significant conditions and behaviour patterns which tend to be persistent and are the expression of an individual's characteristic lifestyle and mode of relating to self and others." These 8 groupings are:

Paranoid personality disorder.

These individuals have strong beliefs that others are intent upon causing harm to them and that they would not be able to cope with this. This results in excessive vigilance for signs of danger, questioning of other peoples motives and tendency to counter-attack in response to a perceived threat or insult.

Schizoid personality disorder.

This grouping includes those who have an indifference to relationships and others' feelings. This results in solitariness, few friendships and a restricted range of emotional expression.

Dissocial personality disorder

(previously called 'psychopathy' or 'antisocial').

These individuals' believe their desires justify their actions. They regard themselves as infallible and other peoples' needs and the risks of their conduct are not important. Such people appear impulsive, irresponsible, and callous, they exploit others, have unstable relationships and are drawn to criminality. This is an important category because of the forensic implications of the psychopathic personality disorders in the Mental Health Act.

Emotionally unstable personality disorder.

A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. Two subtypes are described:

Impulsive type: the predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.

Borderline type: there is marked instability of mood, relationships and self-image. They exhibit marked rapid mood shifts, intense unstable relationships and recurring impulsive self-damaging behaviour. They experience a persistent lack of identity, a sense of emptiness or boredom and they may engage in frantic efforts to avoid real or imagined abandonment.

Histrionic personality disorder.

These individuals believe that they are incapable of looking after themselves, that other people hold the key to fulfilment and that being loved by virtually everyone is essential. They therefore conducts a relentless search for reassurance, approval and praise, seek to be the centre of attention and exhibit exaggerated and inconsistent emotional responses.

Anankastic personality disorder.

This categorisation is characterised by feelings of excessive doubt and caution, preoccupation with details, rules, lists, order etc., perfectionism that interferes with task completion, pedantry, rigidity and stubbornness.

Anxious (avoidant) personality disorder.

These individuals have underlying beliefs that they are defective and unlikeable, they wish to be accepted but expect others to reject them. Such people exhibit excessive hurt following criticism, they avoid involvement with others and fear being embarrassed.

Dependent personality disorder.

These individuals believe that they are helpless and that they should be protected by someone else. They are excessively submissive, leaving important decisions to others, they are helpless when alone, they are easily hurt by criticism and fear rejection.

Great care should be made before diagnosing some categories such as histrionic. Some studies have shown the only consistent findings regarding these patients are that they are young women, treated by male doctors, with depressive symptoms but not being treated for depression. Personality disorders also confer non-specific vulnerability to developing mental illnesses, particularly of the depressive, anxious or adjustment disorder categories.

The similarities between some features of personality disorder and mental illness can bring about diagnostic confusion. It is vital that the diagnosis of personality disorder only be made after a careful longitudinal history, ideally from a reliable other. Personality influences responses to physical as well as mental illnesses and should therefore be taken into account in the assessment of patients in a wide variety of settings.

Aetiology

Little is known for certain about the exact origins of personality. Genetic and environmental factors clearly play a part, and both of these are involved in psychological development. In addition, cerebral pathology may play a part in some disorders.

Genetic

Some general aspects of behaviour are inherited and can be seen even in very young infants. This is referred to as temperament. There is evidence that some temperamental characteristics persist over time. Adult monozygotic twins brought up apart share similar personality profiles. Twin studies of probands with dissocial personality disorder show a higher concordance rate for mono-zygotic twins than dizygotic. Note that genetic factors can greatly influence a persons interaction with their environment, with consequent "environmental factors" modifying personality. For example genetically determined behaviour may provoke specific types of responses that further reinforce the behaviour. In addition, the environment that an individual "seeks out" will depend in part on genetically determined factors.

Psychological Development

Different schools of thought speculate that certain different aspects of development are important to the origins of personality disorder. Thus attachment theory emphasises the role of disruption in a person's key relationships (i.e. mother/infant bond). Learning theory proposes that a person's experiences lead to some behaviours being reinforced by the patterns of rewards and punishments in their environment while other behaviours may be acquired by imitating (modelling) other people. Psychodynamic theory proposes that failure to negotiate certain critical developmental stages may lead to a person failing to relinquish patterns of behaviour characteristic of that stage of development. Thus a model for the development of dissocial personality disorder may be that:

The individual did not enjoy a stable secure relationship with a mother figure (attachment theory).

They failed to learn the normal rules of human behaviour either because his/her family of origin was antisocial or because they could not apply normal rules consistently (learning theory).

Their development was arrested at the oral stage of libidinal development resulting in self-centred patterns of behaviour (psychodynamic theory).

Cerebral Pathology

A higher incidence of EEG abnormalities is seen among individuals with dissocial personality disorder

Prognosis

Personality disorders which do not bring about the social isolation of the individual, such as the dissocial, emotionally unstable (impulsive, borderline), histrionic and dependent do seem to become less florid over time. As they grow older they have fewer crises and make less demands upon services.

In contrast, personality disorders which isolate the individual from opportunities to learn from experience, such as the paranoid, schizoid and anankastic change little and may actually become more fixed as the person ages.

Management

There is great variation in the presentation of personality disorders, but there are a few common principles for all when it comes to management. Inevitably progress will be slow since ingrained behaviour is being dealt with. It should never be forgotten that people who have personality disorders also get conventional psychiatric illnesses, particularly depression, and those should be treated. Often the main aim of therapy is to help the individual change their situation to one that is less discordant with their personality. Finally, it should be borne in mind that these patients do badly being passed from one doctor to another every few months.

Personality Restructuring.

Individuals with milder forms of personality disorder may benefit from a long term psychotherapy (psychodynamic or cognitive). Such a therapy would enable him/her to understand the effects his/her behaviour has on others, to understand their feelings and to make changes. Often there is benefit from conducting this in a group setting.

Support and Problem Solving

Most patients with personality disorders will not be suitable for restructuring psychotherapy. They will need support, particularly through times of crisis. A long-term consistent relationship with a concerned clinician (GP, psychiatrist etc.) is often of fundamental importance. Such a relationship will emphasise the importance of the patient taking responsibility for themselves and will seek to limit the damage caused by the patient's unhelpful behaviours. Some will benefit from problem focused therapies to ameliorate specific difficulties, e.g. assertiveness training for anxious (avoidant) personality disorder.

Medication

Drug treatments are of limited benefit in most personality disorders. Particularly care should be taken with the prescription of any drug with potential for dependence formation, e.g. benzodiazepines and attention should be paid to the risk of deliberate over-dosage. Occasionally patients who are prone to suspiciousness and patients who have poor impulse control benefit from low doses of major tranquillisers. In addition patients with impulsive, borderline and dissocial may gain benefit from SSRIs, which can ameliorate impulsive behaviours.