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Personality disorders

Treat or retreat?

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Assessments of personality style and personality disorder are important as they will shape the clinical assessment and management of the patient. 'Treatment', however, is difficult, the principal reasons being that a personality disorder is relatively ingrained and therefore difficult to modify, and that most affected individuals are not motivated to seek change.

Key points

- **Personality disorders are probably best viewed as being able to be categorised in terms of prototypic styles, but best modelled dimensionally in terms of severity of style and of disordered functioning.**
- **The author argues for a two-tier model that defines style at Tier I and disordered functioning at Tier II.**
- **Origins of personality disorders are likely to be a mix of genetic and developmental factors.**
- **'Treatment' is difficult, reflecting the constitutional weighting of personality and generally low motivation.**
- **Assessments of personality style and personality disorder are nevertheless important because they will shape the clinical assessment and management of the patient.**
- **Clinical and practice strategies for handling high-risk scenarios presented by explosive and borderline personality disorder patients are noted.**
- **Never tell a patient – or anyone else – that they have a personality disorder, as it is psychiatric shorthand for saying 'I do not like you'.**

A number of arguments can be advanced as to the importance of diagnosing the personality disorders but the extent to which they are 'treatable' or even 'modifiable' remains problematic.

The management of personality disorders is difficult, especially in those patients who put excessive demands on their doctor with either challenging behaviours and/or repeated consultations. This article presents a broad overview of personality disorders from the author's perspective, and does not aim to provide guidance on how to manage patients with particular disorders.

WHY SHOULD CLINICIANS KNOW SOMETHING ABOUT PERSONALITY DISORDERS?

Over the decades, many people have phoned me seeking advice about managing an employee or other individual who is creating a workplace problem. Sometimes the caller is concerned about an individual with a mood disorder and sometimes there is great concern about the possibility of a psychosis. However, most calls – and particularly those where the voice tone is more strident and the person is often perplexed – are about an employee who has a personality disorder and is creating havoc within the organisation.

All doctors who have worked in hospital environments would have been exposed to a wide range of personality disorders, evident either blatantly or subtly, in patients (and sometimes in co-workers), and would have observed their disruptive impact. In essence, having some understanding about personality disorders goes beyond dealing with patients and is relevant also to managing staff and work colleagues. And I will make no reference

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JOHN WILLIAM WATERHOUSE: ECHO AND NARCISSUS, 1903

to the third world of those who make the mistake of choosing a life partner with a personality disorder – where it more becomes a life sentence or, until there is a tumultuous break-up, a brief *rite de passage*.

As clinicians, it is important for us to assess any patient's personality style and the extent to which he or she has a personality disorder, as such judgements will commonly predict how the patient will respond to their illness (ranging from quiet acceptance to plaintive or even explosive responses), how they will relate to you as a practitioner, and the extent to which they may or may not be compliant with treatment and treatment recommendations. In addition, judgements about an individual's personality or personality disorder should inform us – as clinicians – as to how we should relate to them, such as being authoritative versus quiescent, active versus passive, and open versus guarded. Finally, if you judge that your practice is overrepresented with individuals who have a particular personality style, you may care to contemplate what it might say about your style as a medical practitioner and your own personality style. For example, is the doctor too much 'on call', encouraging dependency in their patients and, if so, for what reasons and for what benefit?

DEFINING PERSONALITY DISORDER

I have long appreciated and adopted a very simple definition of 'personality disorder' – in essence, that the individual has one or more distinctive personality traits that cause that individual and/or those around him or her to suffer as a consequence. Vague? Yes. Lacking clear-cut boundaries? Undeniably. But practically very useful.

The descriptor 'personality disorder' is made up of two components and we should therefore define 'personality' and 'disorder' separately, particularly if we are to distinguish disordered personality functioning from the normal realms that define personality style.

Personality, temperament, character

'Personality', 'temperament' and 'character' are sometimes viewed as synonymous. Here, we should ignore any reference to character, which is a term now rarely used other than by high school principals making reference to the character of a student about to leave school, whether redolent with 'high moral character' or, alternatively, a vague allusion to lack of character. 'Character' refers more to moral qualities or the 'moral constitution' of an individual. The term had some relevance when the personality disorders were primarily positioned as reflecting flawed moral values (and

termed 'character disorders'); antisocial or sociopathic personality disorder was (and is) clearly an exemplar of this focus. However, as a larger set of personality disorders were derived in formal classificatory systems, and where few had any direct or primary moral connotations, the phrase 'character disorder', and even reference to character, became irrelevant.

There are many definitions of temperament and personality that both define each and distinguish between them. I personally view 'temperament' as reflecting the individual's hard wiring, and thus strongly influenced by genetic factors. By contrast, I view 'personality' as the individual's temperament subsequently modified by environmental factors to derive a configuration that reflects both genetic and environmental influences. Such variable definitions and variable underpinnings contribute to our lack of precision in even attempting to answer the question as to whether personality disorders are primarily genetically or environmentally determined.[1]

More about temperament

Concepts of temperament have ranged widely over the centuries. We well know that in medieval times it was believed that an individual's well-being, including their temperament, reflected the balance between the four constituent humors of the human body, namely black bile, yellow bile, phlegm and blood.

Several decades ago, researchers focused on seeking to define key temperament constructs that they viewed as having continuity. As initially assessed in infants and young children, such constructs included activity levels, autonomic reactivity, fussiness or irritability, soothability, sleep–wake regularity, adaptability to change, 'slow to warm up' and social responsiveness. Of interest, when individuals were followed over short periods (say six months or a year), there tended to be strong continuity across those constructs. However, when they were followed over years, such continuity reduced distinctly and poor test–retest reliability became a general finding.

There were several reasons for this challenge to the view that temperament was a constant and relatively inviolate, reflecting its hard-wiring status. Firstly, 'heterotypy' may be operative – where surface manifestations may vary despite the hard-wiring being a constant (a good example of this is the caterpillar becoming a butterfly), so that age and development might be simply associated with the phenomenon of heterotypy, and thus contribute to seemingly poor continuity. Secondly, researchers became aware that temperament was intrinsically less 'fixed' than previously judged, perhaps reflecting the progression of temperament into personality style as a consequence of developmental factors. Thirdly, it became clear that the multiple constructs of temperament were far too narrow. If 'temperament' is modelled across principal molar constructs rather than at their lower-order facet levels then for more than 50 years research studies have shown consistency in identifying the two molar constructs of 'neuroticism' and 'extraversion'. In terms of 'neuroticism', people tend to constitutionally score relatively consistently on this domain (being sensitive, emotional and prone to upsetting feelings as against being secure, hardy and generally relaxed even under stressful conditions). Similarly, people score relatively consistently in relation to 'extraversion' (being either outgoing, active, high spirited and preferring to be around people most of the time as against being introverted, reserved, serious and preferring to be alone or having only a few close friends). When temperament is assessed at these higher order molar levels, then there is considerable continuity across childhood and adulthood.

More about personality

'Personality' can be considered the end result of our hard-wired temperament modified by developmental factors. For some individuals there will be no substantive developmental factors, and great continuity and congruence across temperament/personality will be evident over time. Conversely, as a consequence of exposure to violence, abuse or demeaning parenting in the early years, a reasonably happy child who scores high on extraversion and low on neuroticism might well become progressively insecure and anxious, and then score higher on neuroticism and introversion, reflecting the distinctive impact of such developmental factors.

How do we define 'personality'? A common definition in psychology texts and dictionaries is to suggest that it is the 'dynamic' organisation within an individual of 'psychophysical systems' that determine his or her 'unique adjustment to the environment'. This definition has a number of key components. Firstly, it allows us to attempt to define any individual in terms of their unique and individually distinct features. Secondly, it does not refer only to psychological components as the term 'psychophysical' extends beyond that realm. Thirdly, the 'dynamic' component is very important in that it suggests that it is normal for individuals to adjust their personality style to the environment – for example, the medical student sitting in a lecture may be attentive and even deferential to the lecturer but on returning home might be rude and even bullying towards a younger sibling.

In essence, individuals with a normal personality style will scan the environment, read the cues and adjust their psychological and interpersonal reactions in response to who they are interacting with at that particular time. By contrast, individuals with a personality disorder tend to lack this capacity and it is their inability to make this adjustment that can often be a clue to – and define – a personality disorder, as will be detailed later.

DISTINGUISHING PERSONALITY STYLE FROM PERSONALITY DISORDER DIMENSIONALLY

Some professionals, especially psychologists, tend to apply a simple dimensional model to detect a personality disorder. In essence, they seek to define the principal dimensions of personality style and argue that extreme positions along these dimensions are indicative of a personality disorder.

The model most commonly used by psychologists for describing an individual's personality style is the Five Factor Model, or FFM.[2] This model weights five dimensions, so allowing all individuals to be positioned along each of these dimensions, whether scoring high, low or in the middle. Two such dimensions (neuroticism and extraversion) have already been defined. A third dimension is 'agreeableness', with people ranging from being compassionate, good-natured and eager to cooperate to being, conversely, hard-headed, sceptical, competitive and often angry. The fourth dimension is 'conscientiousness', with people ranging from being more-organised, having high standards and always striving to achieve their goals as against being easygoing, preferring not to make plans and sometimes being quite careless. The fifth dimension is less clear-cut and is generally described as 'openness'. Here, individuals vary from being open to new experiences, having broad interests and being very imaginative to being more set in their ways, down-to-earth and traditional. Such a definition seems relatively straightforward but when tested empirically, those who score high on openness do not always conform to the general definition, and it frequently brings in the eccentrics and odd people in the world. As a consequence, openness has, in my view, little use in defining the normal dimensions of personality.

Many professionals, therefore, view an individual as likely to have a putative personality disorder simply on the basis of generating very high or very low scores on one or more of these dimensions. Another important component about these so-called 'personality' dimensions is that they probably are better defined as key dimensions of temperament (as defined earlier), as empirical studies identify that they are relatively independent and that they are strongly underpinned by genetic factors.

DISTINGUISHING PERSONALITY STYLE FROM PERSONALITY DISORDER CATEGORICALLY

As noted, a simple definition merely invokes assigning those who score high or low on principal temperament or personality dimensions. By contrast with that dimensional model, many professionals, and especially psychiatrists, operate to a more 'categorical' rather than dimensional model, and currently assume that approximately 10 constructs define the personality disorder world. These constructs are included in the current

editions of both the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision – *DSM-IV-TR*) and the *International Statistical Classification of Diseases and Related Health Problems* (10th edition – *ICD-10*). The DSM delineates three higher-order clusters, with Cluster A capturing 'odd or eccentric' personality disorders such as schizoid, schizotypal and paranoid; Cluster B capturing the dramatic, emotional or erratic styles such as antisocial, borderline, histrionic and narcissistic; and Cluster C capturing the anxious or fearful group, including avoidant, dependent and obsessive–compulsive.

Readers will be aware of each of these broad personality disorder categories and how they commonly manifest. It may be more important to offer a critique of the current DSM and ICD models. In positioning the personality disorders as Axis II categories (as against Axis I symptoms states) in the DSM model, the utility and practicality of such a model are limited. Firstly, numerous studies have shown that if an individual meets the criteria for any one personality disorder as defined by the DSM, he or she will also meet the criteria for three to five other personality disorders. The personality disorder categories are not pure categories but show high interdependency. For example, it would be a rare individual who met the criteria for histrionic personality disorder and did not also meet the criteria for narcissistic personality disorder. Secondly, individual descriptors of each of the DSM personality disorder conditions are an amalgam of descriptors of personality style and disordered personality functioning. This makes for difficulty in rating an item because the person doing so might affirm the disordered component ('ineffective' being a common descriptor) whether the 'style' component to the descriptor is salient or not. Such a model – amalgamating style and disordered functioning – again risks leading to 'overdiagnosis' and assigning individuals to more personality disorder categories than might be truly valid.[3,4]

In our research we have therefore argued against such an approach and more favour personality style and disordered functioning being assessed separately.[4-7] Given that caveat, how useful is the current set of DSM personality disorder categories? The answer is that Clusters A and B are probably useful and practical in capturing 'meaningful' personality styles (albeit with some overlap) that may or may not lead to disordered functioning. Cluster C is more problematic in that individuals who score high on the obsessive–compulsive construct may well be very productive individuals with high standards and highly dutiful, and therefore be constructive members of society and not necessarily deserving of a diagnosis of personality disorder. Secondly, although the 'avoidant personality disorder' style can present as a personality disorder operating at the DSM Axis II level, it is more commonly clinically manifested as the DSM Axis I symptom state of high trait and state anxiety.

DEFINING 'DISORDERED PERSONALITY FUNCTION'

'Disordered personality function' is perhaps the more productive construct for defining a personality disorder. Useful components include the individual having an inflexible or defective response style, a personality style giving personal discomfort or decreased opportunities for the individual, an inability to function effectively and efficiently, an inability to adjust to the environment, and self-defeating circles or cycles through life.

In our research, we sought to reduce the key constructs of disordered functioning to fundamental molar ones, and the solution was fairly parsimonious but has considerable practical utility, especially at the level of clinical assessment.[6,7] In essence, when we analysed all the descriptors of disordered personality functioning in the DSM system and reduced those constructs down to the molar dimensions, we were left with two: people with a personality disorder were essentially 'non-cooperative' and/or 'ineffective'.

How best then to model the personality disorders? We favour a two-tier model whereby Tier I defines and quantifies the particular and distinctive personality styles evidenced by the individual with a personality disorder and Tier II considers the degree to which the individual is non-cooperative and/or ineffective, and so weights function/dysfunction. Both tiers are dimensionally based (as we do not view the personality disorders as categorical), overcoming confounding of style and function. The model is also relatively consistent with the concept of the personality disorders being maladaptive and extreme expressions of common personality traits rather than being qualitatively distinct from normal personality functioning – but it recognises and overcomes a key problem articulated below.

If descriptors of 'sociopathy' or 'antisocial personality disorder' are examined in any textbook, they are usually derived from studies undertaken of individuals living in, or graduates of, boys' homes or jails, and where the descriptors are weighted to that of the 'failed sociopath.' By contrast, there are a number of individuals who are undeniably sociopathic but highly successful in their day-to-day functioning, despite their career being marked by the standard exploitative and self-focused constructs integral to the truly sociopathic individual. As a consequence of such traits, these individuals are often the 'movers and shakers' in society, are more likely to be successful politicians in some countries and thrive in entrepreneurial societies, especially when the stock market is rising – but also being flushed out when it is falling.

Our model therefore allows individuals with a personality disorder to be quantified in terms of their personality style ingredients and the level of disordered functioning.

How might a practitioner diagnose a personality disorder? He or she should operate to the model that, if present, the personality manifestations will cause distress to the individual and/or those around them and be quite limiting to the individual's life trajectory. If such disordered functioning is evident or elicited, then secondary pursuit of the personality style is in order and can be pursued by using descriptor items from the DSM or ICD manuals or – more practically – by refined clinically-derived questions.

CAN WE TREAT PERSONALITY DISORDERS?

The parsimonious answer to whether personality disorders can be treated is rather negative. The principal reason is that a personality disorder, like personality and temperament themselves, is relatively ingrained and therefore difficult to modify. A second key factor is that most individuals with a personality disorder are not motivated to seek change. They usually only present to a clinician for 'help' when forced by a family member (usually out of desperation) or when they seek to avoid some penalty or even a jail term. If not driving the presenting reason, the personality disorder is the background terrain influencing the patient's interactive style with, and response to, the practitioner's management recommendations.

By and large, clinicians are more likely to see the worried relatives of a person with a personality disorder and be enjoined by them to 'do something' to 'treat' the disturbed but amotivated individual than they are to see the affected person him or herself.

Is there any good news? Some. Perhaps against expectation, empirical studies show that many personality disorders 'burn out' or significantly attenuate with time. Individuals with antisocial, explosive and other externalising personality disorders tend to become less volatile as they age, commonly reflecting the reduction in adolescent impulsivity and, at times, reflecting diminution in excessive drug taking and alcohol use. However, attenuation of other personality disorders in the Cluster B category has also been convincingly demonstrated, so that the incredibly demanding 'borderline' patient in his or her 20s or 30s may have a more pacific personality style in their 50s. This does not always hold true, and those individuals with a narcissistic personality style do not age well as their self-image is confronted over the years by mirror images. Telling patients or their relatives that their perturbations will diminish with time is unlikely to be appreciated but it should be factored into management.

Various therapies may assist some individuals with personality disorders. Dialectic behaviour therapy was designed to assist those with a borderline personality disorder. Anger management strategies may be of benefit to those with a short fuse and violent acting out behaviours, and assertiveness training and cognitive behaviour therapy may assist those with anxiety-based disorders. Referral to a psychiatrist may be useful to clarify the diagnosis and, at times, to provide an

intervention, and referral to a psychologist may lead to tailored program-based interventions.

However, rather than seeking to 'change' the individual with a personality disorder, it can often be as helpful to try to provide or encourage them to find a more suitable 'ecological niche' for their personality style. This is often best assisted by considering occupational choices. The schizoid individual who seeks to be alone and finds human interactions confronting would clearly function more comfortably as a librarian or lighthouse keeper, rather than attempting to sell mobile phones at an airport. The testosterone-charged and potentially sociopathic young male might get through their late adolescent years with less confrontation by taking an energy-sapping jackeroo role or taming wild horses on a distant rural property than working in an accountancy office. However, this approach does have its limitations. Encouraging a volatile sociopathic male with an explosive short-fused temperament to take a job as a bouncer might allow the individual to 'socialise' their behaviours to some degree but may have a number of negative downstream consequences by seemingly 'approving' and 'encouraging' their aggressive and high-risk propensities.

SOME CLINICAL OBSERVATIONS

Assessing an individual's personality style and the extent to which he or she may or may not have a personality disorder should be part of the diagnostic process adopted by all doctors, whether they operate in psychiatry or another medical discipline. It will inform the doctor about how they should interact with the patient, it will provide early information on the extent to which the individual will be adherent with treatment plans and compliant with medication (and even in turning up for appointments), it will inform as to whether the patient is at risk of becoming highly dependent on the doctor (with attendant disadvantages) and it will, at times, be alerting to serious risks.

The most distinctive risks for doctors come from volatile and violent patients and from those with a borderline personality disorder. If a doctor is aware that they have a particularly volatile, intemperate, demanding and explosive patient booking an appointment, different appointment strategies may be appropriate, as agreed with key practice staff. Such a patient might be seen rapidly (without waiting), at a time of the day when there are many staff available, with the consulting room cleared of any potential weapons and with the doctor closer than the patient to the door (in case there is a need to run). For these patients, staff should be aware of pre-emptive and operative emergency procedures if the patient does become violent, and these days there is great wisdom in surgeries being designed to ensure the safety of all staff, including receptionist staff.

Patients with a borderline personality disorder may seek to seduce their doctor, metaphorically and/or physically. One of the most common reasons for male doctors appearing before medical boards is their nonprofessional encounters and boundary violations with patients with a borderline personality disorder. Again, such patients should be seen when the practice is busy and when a practice staff member is in the reception area. Such patients may wish to make physical contact with the doctor and, while a handshake may be acceptable, anything beyond that may encourage the patient to take the doctor down the slippery slope of boundary violations. A doctor seeing a patient advancing at the end of a consultation to give a hug or a kiss may care to engage in a variant of a rolling rugby maul whereby physical contact is avoided while the doctor maintains (or strives to maintain) his or her authoritative status.

WHAT HAVE I LEARNED ABOUT PERSONALITY DISORDERS?

In addition to some nihilistic pessimism, recourse to trying to reposition or relocate rather than change the individual and also spending more time in educating family members than the putative 'patient', one lesson stands out: never tell anyone (patient, family member or partner) that they have a personality disorder. It is never constructive and, as psychiatry shorthand for saying 'I don't like you', it is almost invariably interpreted as an ad hominem statement. In addition, never write 'personality disorder' in any assessment letter to a medical colleague, both for similar reasons as for not telling anyone and also because patients with a personality disorder are highly likely to obtain file copies and often have retributive capacities.

Informing the individual that some aspects of their personality may be contributing to their distress or life trajectory problems allows the patient to discern the practitioner's concern, but avoids the negativity associated with the phrase 'personality disorder'.

WHAT HAVE I FAILED TO LEARN ABOUT PERSONALITY DISORDERS?

Over four decades of being a psychiatrist I have learned quite a lot about personality disorders in terms of detection, management strategies and risks. However, I still fail to pick a percentage of high-level sociopaths and have wondered about this lack of perspicacity.

In my first year of psychiatry a man gave me a fairly persuasive story but it did not entirely check out when I sought to verify some facts. When I gently challenged him that we had failed to find any evidence that he had served in the Vietnam War (when he had presented to our unit with post-Vietnam post-traumatic stress disorder), he asked what name I had used to run the check. When assured that I had given his name, he indicated that was the explanation as he had used a different name in earlier years. His confident reply and maintenance of eye contact caused me to apologise during the encounter. A week later when I indicated that we had failed to find that name in the check, he asked which army dataset had been examined. When I indicated that we had made contact with the Australian Army, he quickly indicated (again while maintaining eye contact and a confident interactive style) that was clearly the source of the error, as in those days he had been serving in the New Zealand Army. Such interchanges went on for a while before, even at that neophyte stage of my training, I recognised one of the key ingredients of the successful sociopath.

Now, decades later and with multiple diagnostic antennae refined by clinical experience, I can still view an individual as warm, generous, generative and of high moral character only to find out later – and usually quite later – substantive moral flaws and well-disguised sociopathy providing the beat to the individual's daily drum. Only recently, I expressed my perplexity at this lack of diagnostic perspicacity and a dinner party psychiatrist companion made an interesting observation. He suggested that to function in medicine we need to operate to a model of trust and to operate at the opposite level would be the antithesis of being a doctor. I suspect there is some truth to that observation but would still like to identify the subliminal signals to the successful sociopath at an earlier stage.

As most individuals with a personality disorder cannot disguise the key components and cannot stop or correct being 'themselves', we can usually identify or be highly suspicious of an underlying personality disorder, whether based on facts that emerge from history taking or from their interactive style, or even – in the case of those with a borderline personality disorder – by pheromone-like signals.

There must be some subtle signals that other medical practitioners have identified as having utility. Can I put that question out for contemplation? MT

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