Personality Disorder

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From Evidence to Understanding

Peter Tyrer
Consultant in Transformation Psychiatry, Lincolnshire Partnership NHS Foundation Trust and Emeritus Professor of Community Psychiatry, Imperial College, London

Roger Mulder
University of Otago, Christchurch

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Dedicated to all those with personality disorder who have yet to be acknowledged

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Foreword

When asked about those we love, we are likely to describe admirable aspects of their personality (or temperament and character). When describing those we hate, we are likely to describe defects in their personality. In routine domestic or work settings, discussion of persons tends to involve a combination of physical characteristics, present mental state and ... their characteristic personality traits. When I asked young people in two Youth Offending Teams what characteristics they sought, 'fit', 'cool' and 'good sense of humour' emerged, for boys and girls.

The impetus for this book was the International Classification of Diseases (ICD), whose recent revision 'ICD-11' needed to shed light on disorders of personality in a way that actually helped professionals working in many settings and languages and to recognise and address these conditions. Peter Tyrer and Roger Mulder, the authors of the present volume, were part of the international team making these revisions for the World Health Organization.

The nineteenth century saw the beginnings of formal diagnostic systems for mental health care in hospital populations, and also new health systems for non-clinical settings such as schools, the military or prisons. The ancient Greeks had developed systems for classifying the world around them, including its people – our modern concept 'typology' derives from two Greek words (tupos + logos), first combined in English around 1845. As an undergraduate, Charles Darwin (1809–82) displayed skill in classification of rocks that led his geology professor to choose him for the *Beagle* expedition in 1831. During that voyage his classification skills developed in biology and anthropology. In subsequent decades, several academic disciplines attempted to explore specific aspects of personality, including psychology, anthropology, criminology, philosophy and education. Medical practice generated the broad territory of 'psychopathology', within whose diagnoses some patients were described in terms of *disorder* (i.e. an abnormality) of personality. The Victorian era was also a time of charting and measuring, for example at a time when some patients in asylums were encouraged to undertake physical activity, tracking gentlemen's cricket scores might be used to measure the progress of their treatment. In the nineteenth century, there were many unhelpful avenues explored, such as the physical anthropology of 'criminality' or the genetics of moral 'degeneracy', but the early twentieth century saw measurement applied more productively in areas like occupational psychology and education. At the beginning of that century, the Vienna Psychoanalytic Society was the fulcrum of debate on mental health. Impaired social functioning is a characteristic of personality disorders. The Viennese doctor Alfred Adler (1870–1937) was particularly interested in 'character' and its shaping in childhood, first through relationships across all family members and then in community relationships. Like the authors of this book, Adler was optimistic that much suffering could be prevented, with *early* interventions during an individual's lifecourse, but we have yet to learn if this can indeed be achieved.

The horrific slaughter of the 1914–18 war saw an unprecedented, monstrous 'natural experiment' in term of medical classification. Among the wounded, the observational skills of Henry Head (1861–1940) and William Rivers (1864–1922) began a pioneering synthesis of trauma (both physical and psychological), neuroscience, social anthropology, language

and psychotherapeutics. For their patients, changes in personality were notable (e.g. pre-war, in the crisis of war and post-war). However, for a hundred years, the usefulness of *evidence* based on even huge clinical case series has proved limited. Today, we have two much more potent methods to use: experimental medicine (clinical trials) and population science (epidemiology).

Today, the ICD-11 classification also gives opportunity for new research and the design and evaluation of innovative services that are grounded in research evidence. Central to the ICD approach is that it is informed by statistical science and includes 'related health problems': this is helpful when caring for patients with complex histories who are distressed (and sometimes distressing). Not only do health statistics link people in different services, they provide a common language for international collaboration. For example, in my own experience such linkages were vital in planning a mother-and-baby service for socially isolated women dependent on heroin with a long history of overdosing, contact with both social services and the criminal justice system, and limited understanding of parenting. In that hospital, the mother I remember best also had the related health problem of AIDS.

Years ago, I felt very proud when the Institute of Psychiatry made me an honorary lecturer, but most of my teaching has been in primary health care. Participants included general practitioners (GPs), school nurses, prison medical officers, occupational therapists and public health specialists. GPs see most of the patients with mental disorders, but unlike the 'common' illnesses that present in primary care (depression, anxiety or mixed anxiety and depression), there is no evidence-based pill for personality that they can offer as a first-line treatment. Using the ideas developed by Michael Balint (1896–1970), the first-line 'treatment' is usually the personality and understanding of the practitioner.

Many people working in primary care have been unwilling to apply diagnostic 'labels' to their patients with mental health needs. In this book, Tyrer and Mulder explore many reasons why psychiatrists may have been reluctant to use the term personality disorder with their patients at all. I gained some related insight while teaching GPs about the ICD-10PHC diagnoses. ICD-10PHC had printed guidelines on two sides of plastic cards: one for diagnosis and one for management of each condition. I was working then for a world-renowned professor who liked to start each seminar before handing over to me to finish up the routine bits. When the GPs asked him for authoritative advice about patients with personality disorders, he told them not to bother, 'because there was nothing they could do for them'. It seems that therapeutic pessimism can stifle engagement with these patients and Tyrer and Mulder want to change our attitudes here. In a very different setting, I was gathering data from all the 'customers' of a Job Centre Plus, including the use of the Standardised Assessment of Personality – Abbreviated Scale (SAPAS) screening questionnaire (see Chapter 10 of this book). We also questioned the employment advisors about those who had completed the SAPAS. The most common response of the advisors when finding that the 'customer' had problems related to their personality was: 'hopeless'.

Before the discovery of antibiotics, therapeutic pessimism was common in patients with sexually transmitted infections. To be able to witness some improvement in the lives of service users makes a big difference for any therapeutic alliance. In my lifetime, the two most common labels for personality disorders have been antisocial and borderline, and I remember when the National Health Service would fund a few residential patients in therapeutic communities (TCs). For patients with very long-term, pervasive problems, I witnessed clear improvements in two TCs (one with mainly 'antisocial' residents and one with mainly 'borderline' residents). Individuals typically had multiple problems

affecting their social functioning, such as 'complex' post-traumatic stress disorder after prolonged childhood sexual abuse or chronic dependence on alcohol. Nonetheless, over months, social functioning gradually improved and objective measures of behaviour such as attendance at accident and emergency services or police contacts changed substantially. Sadly, changes in NHS funding streams saw both those TCs close. I am on a steering group for a project about self-harm in prisons, and until the current Coronavirus pandemic my impression from psychologists in that setting was they were beginning to see some reduction in both self-harm and offending . . . I am holding my breath to see if that is maintained when the pandemic abates. The population for whom I am most optimistic was the one I saw in the first Youth Offending Teams, courtesy of funding from the charity Barnardo's. In adolescence, we could sometimes observe a real change in their trajectory over a few months, using various creative arts with groups of young people. However, that young population rarely had thorough assessments: this is where a clear, practical system like the ICD-11 could open doors to early treatment and lasting change.

In what way is ICD-11 more practical than older systems? Clinically or epidemiologically, it is clear the categorical labels of the past are no longer of value. Peter Tyrer himself led a challenge to the totally impractical terminology of 'dangerous and severe personality disorders'. A label like that practically guarantees social stigma and increased health inequalities when such people are predictably excluded from services. Across all types of people in the ICD-11 system, the severity of personality disorder is measured by the complexity of a person's problems. Patients whose functioning is significantly impaired (personality disorder) are distinguished from the much larger number with Personality difficulties – this awareness of a personality spectrum is vital to develop appropriate public health responses. Classification matters – no one likes to be called 'fat' – but a spectrum of adiposity from underweight to overweight is helpful in describing populations and morbid obesity should ring clinical alarm bells.

Thus a key message in this book is to 'embrace the personality spectrum'. To promote understanding, the World Health Organization has chosen 25th May as International Personality Spectra Day. Please note and celebrate it.

Here in the UK, the Government is in the process of reforming the Mental Health Act. This reform is long overdue, to ensure the rights of service users, appropriate training for mental health professionals and resources to provide care for people whose needs are not being met at present. A key driver of change is the NHS Long Term Plan, which commits to expanding services 'delivered through new models of integrated primary, community and social care'. Crucially the wording of this should be remembered by all:

> The new models will incorporate care for people with eating disorders, mental health rehabilitation needs and those with a diagnosis of a 'personality disorder', among other groups.

Woody Caan
Professorial Fellow, Royal Society for Public Health

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