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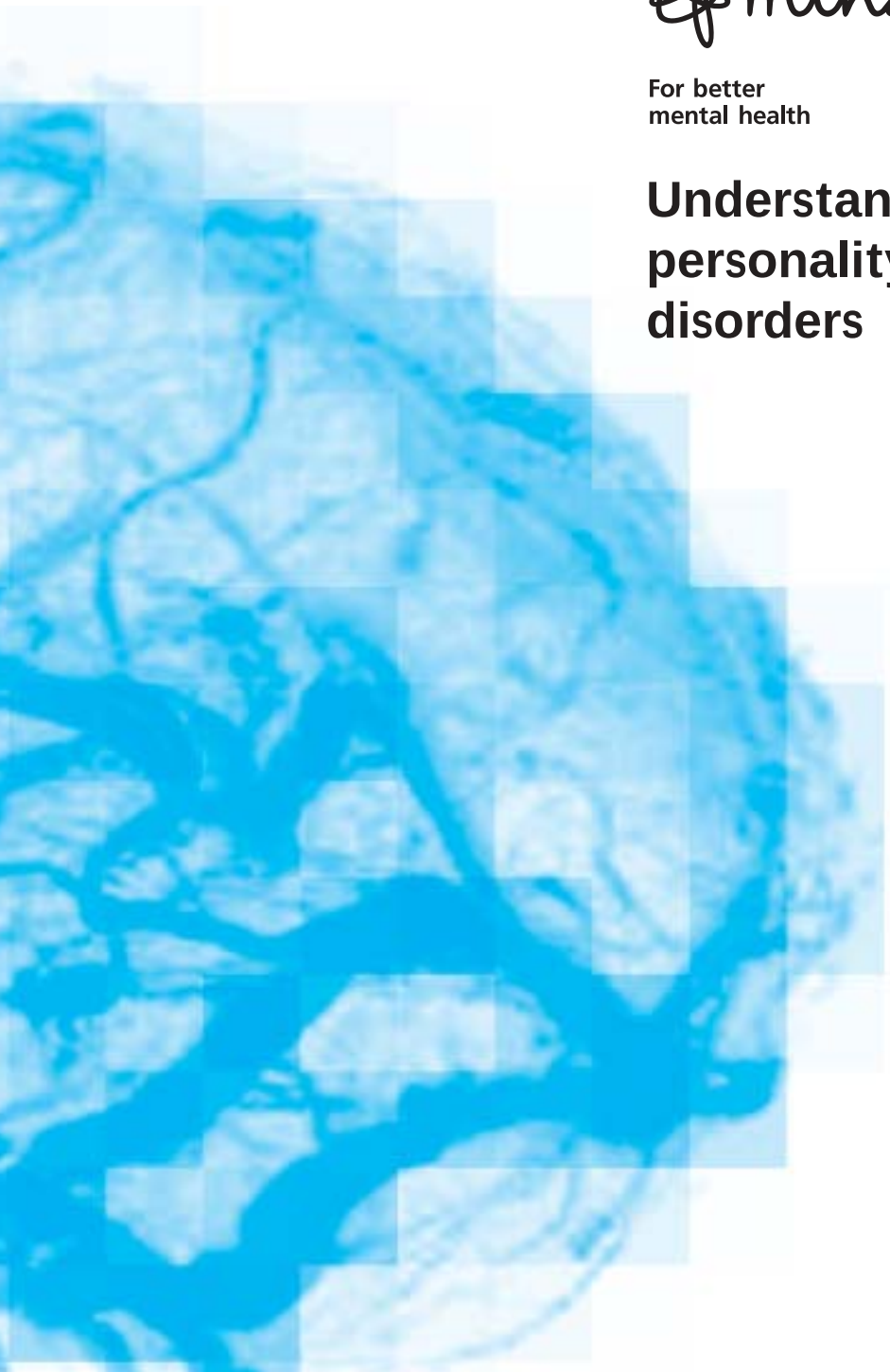
Understanding personality disorders



This booklet is for anyone who wants to know about personality disorder, including those diagnosed, their family, friends and professional health workers. It is one of the most controversial of all psychiatric diagnoses, but it does not include multiple personality disorder, which is a dissociative disorder, covered in a separate booklet.

What is a personality disorder?

The word 'personality' refers to the pattern of thoughts, feelings and behaviour that makes each of us individual. We tend to behave in fairly predictable ways, yet our personalities also develop and change as our circumstances change. Usually, people are flexible enough to be able to learn from past experiences and to change their behaviour to cope with life more effectively, but someone who has a personality disorder is likely to be quite inflexible. Their range of attitudes and behaviours is limited, and likely to be very different from what others might expect from their background and culture. Their attitudes and ways of behaving often cause distress to them and to others.

Personality disorders usually become noticeable in adolescence or early adulthood, but sometimes start in childhood. They make it difficult for someone to develop friendships, maintain a stable relationship and to work cooperatively with others, because their experience, responses and coping strategies are so limited. Not surprisingly, they can feel very alienated and alone and, unfortunately, the risk of suicide is about three times higher than average. (See Mind's booklet *How to help someone who is suicidal*. See p. 14 for details of this and other Mind booklets.)

Personality disorders will disrupt people's lives, and those around them, to different degrees, and the extent to which they are treatable also varies. Often, someone will have other problems going on at the same time, such as depression or phobia. For instance, someone with avoidant personality disorder may also suffer from agoraphobia. Even if the phobia is sorted out, stressful events can still trigger problems linked with the personality disorder, such as avoidance and dependency.

What are the different types?

There are ten personality disorders, according to the *DSM-IV (The American Psychiatric Association's diagnostic and statistical manual of mental disorders)*. Information about multiple personality disorder is not included here, since it is classified as a dissociative disorder. (See *Understanding dissociative disorders*, details under *Further reading,* on p. 14.)

Paranoid personality disorder

A continual and unwarranted distrust and suspicion of others is a sign that someone has this problem. They are always on their guard, in case someone harms them.

Schizoid personality disorder

A person with schizoid personality disorder isn't really interested in forming close relationships. He or she tends to be solitary, inward looking and cut off from other people.

Schizotypal personality disorder

Making close relationships is extremely difficult for anyone with this problem, which often involves social anxiety, eccentric behaviour and distorted thinking. A person might believe they can read minds and exercise magical control over other people, or that they have some huge part to play in world events. Some researchers suggest that this personality disorder is related to schizophrenia.

Borderline personality disorder (BPD)

This may involve:

- intense, unstable relationships
- highly impulsive behaviour
- major mood shifts
- inappropriate anger
- self-harm
- having a weak sense of identity
- long-term boredom and a sense of emptiness
- a fear of being abandoned.

People with BPD may cling on to very damaging relationships, because they don't have a strong sense of identity and are terrified of being alone. Many people with BPD also meet the criteria for histrionic, narcissistic or antisocial personality disorder (see below). (See, also, Mind's booklet, *Understanding borderline personality disorder*.)

Histrionic personality disorder

People who are histrionic tend to be highly emotional and attention-seeking in their behaviour. They are very dependent on the support and approval of others, and yet constantly in search of novelty and excitement.

Narcissistic personality disorder

Anyone with this diagnosis will have an over-inflated sense of their own importance, with fantasies of unlimited success or achievement, a constant need for attention and admiration, and a tendency to exploit others.

Antisocial personality disorder (APD)

Known as 'psychopathy', under the Mental Health Act 1983, this is the disorder most closely linked with adult criminal behaviour. Someone with APD is likely to ignore and ride roughshod over other people's rights. Although charming on the surface, they may be callous and self-serving underneath, and lack any empathy with other people. They may not be able to hold down a job for long or stay in a long-term relationship. They usually behave impulsively, without considering the consequences, and this is often linked to criminal offences, particularly involving violence. Central to the problem is a complete lack of guilt about their behaviour. There seems to be a higher rate of alcoholism and substance abuse among people with APD than in the rest of the population, and the effect of alcohol or drugs makes their behaviour even more extreme.

Avoidant personality disorder

Feelings of inadequacy, and fear of disapproval, criticism or rejection will make someone with this problem avoid social situations. Although it's similar to social phobia, it's more about fear of social relationships and intimacy than of social situations, as such. (This is also known as anxious personality disorder.)

Dependent personality disorder

Driven by an overwhelming fear of separation and a need to be taken care of, people with dependent personality disorder tend to become very clinging and submissive towards others.

Obsessive-compulsive personality disorder (OCPD)

OCPD sufferers are preoccupied with orderliness, perfectionism and keeping everything under control. They set unrealistically high standards for themselves and others. OCPD is not necessarily linked with obsessive-compulsive disorder (OCD) and the other obsessional disorders, but some people may be diagnosed with both. (OCD is likely to interfere much more with someone's day-to-day life.) Someone with OCPD may also suffer from depression or social phobia. (See *Understanding obsessive compulsive disorder*, details under *Further reading,* on p. 14.)

What are the problems diagnosing it?

Experts describe personality disorders as syndromes that are 'fuzzy at the edges'. There are strong similarities, for instance, between avoidant and dependent personality disorder, and between histrionic and narcissistic personality disorder. One person may qualify for several different disorders, while a wide range of people may fit different criteria for the same disorder, despite having very different personalities.

Each individual is unique, and personality is so complex that slotting people into neat psychiatric categories is an almost impossible task. It's not safe to assume that giving people labels means knowing more about them, and too easy to use these terms in a judgemental way.

Personality disorders can be seen as extreme examples of tendencies that everybody shares. Negative personality traits and extremes of behaviour are often regarded as quite excusable and unremarkable in gifted, famous or socially dominant individuals. Some people may have one or two particularly offensive traits, such as being perpetually irritable, or smug, which cause them more rejection than someone with a personality disorder whose overall personality is more pleasant.

Misdiagnosis

Diagnosing personality disorders is open to mistakes, especially since it's often used to describe symptoms that don't fit any other category. But putting labels on people, such as 'masochistic', 'dependent' and 'inadequate' can be seen as insulting and persecuting. Often, the labels are applied to people who are regarded as 'difficult' in some way.

Many survivors of domestic violence or child abuse have been mistakenly diagnosed with a personality disorder. This is because the post-traumatic symptoms they developed as a result are so persistent and wide-ranging. These symptoms are often misread as being part of their basic personality, and this can lead to them being misdiagnosed with either dependent or avoidant personality disorder.

What causes a personality disorder?

Although a great deal of research has concentrated on the causes of antisocial personality disorder (see opposite) there's been little in-depth investigation into the causes of other personality disorders.

There seems to be a strong genetic basis to obsessive-compulsive personality disorder, and there may also be a genetic link between personality disorders and certain mental health problems. There have been reports that relatives of people suffering from schizophrenia and manic depression are more prone than other people to having a personality disorder.

Negative experiences, such as poor parenting, rejection, lack of love, or abuse when young may all play a part. Many people diagnosed with BPD report having been neglected, or physically or sexually abused as children. (See *Further reading*, on p. 14, for more information.)

What about antisocial personality disorder (APD)?

Antisocial behaviour in childhood seems to be linked to antisocial behaviour in adults. High levels of stress and family problems are important causes of behaviour problems in childhood, and the significant factors here seem to be:

- no warm, intimate and constant relationship with parents
- inconsistent discipline and supervision
- parents who have APD, or who abuse drugs or alcohol.

Children of divorced parents may be at greater risk of getting into trouble, but this seems to be to do with the quality of life at home. Neglectful, quarrelling parents, who stay together, are more likely to produce troubled and troublesome children than more stable single-parent homes. Upbringing is an important cause of APD in adults, according to some experts, but others point out that most people who have had painful childhoods don't go on to develop APD as adults.

Most adults with APD showed this behaviour as children although most children with behaviour problems don't grow up to have APD. Children with an early and long history of antisocial behaviour are the most likely to develop into antisocial adults. They may play truant, run away from home, start fights with weapons, sexually abuse other children or be cruel to animals or people. They may be responsible for acts of vandalism, starting fires, lying or stealing. These children often have problems concentrating and paying attention, which makes it difficult for them to learn. There seems to be a link between hyperactivity, behaviour problems and juvenile crime, while aggressive behaviour seems to be linked to having poor language skills and home environment.

There is evidence that inheritance plays a part. Studies involving identical twins found that if one of the pair had committed a criminal offence, it was more likely that the other twin had done so, too. Antisocial behaviour is more common in children whose own biological parents were antisocial, even when they are brought up by adoptive parents.

Brain chemistry and self-control

Serotonin, a brain chemical, affects our ability to control our impulses. If levels are too low, it means people may have less self-control, and are likely to be more irritable, and perhaps prone to impulsive acts of violence. Research shows that people with antisocial or borderline personality disorder, and a reputation for violence of this kind, are likely to have low serotonin levels. There is also a link between physical and environmental causes, because serotonin levels can be affected by outside factors. For example, feeling socially isolated or deprived makes people stressed, and this will cause levels to drop.

Physical differences

Tests involving habitually aggressive men, convicted of violent offences, have shown that they have problems connected with brain function or brain damage. This would make it more difficult for them to think about what they are doing, to judge the consequences, to learn from experience and to feel fear or remorse. People with antisocial personality disorder don't seem to react with the same anxiety as other people to potential stress. Because of this relative lack of anxiety, they may not learn to avoid threatening situations and, instead, may actively seek out danger in order to feel stimulated and alive.

Are personality disorders treatable?

All personality disorders are difficult to treat, because they involve deeply rooted patterns of thoughts, feelings and ways of relating. But many people are able to change their thinking and behaviour and eventually lead more fulfilling lives. The milder forms, such as obsessive-compulsive, avoidant and dependent personality disorders, usually have the best chances. But some people with severe personality disorders may be able to modify and change their outlook, over a period of years.

Talking treatments

There's good evidence that psychological treatments can be helpful, especially for less severe personality disorders. People who lay all the blame on others and on outside circumstances are unlikely to benefit. It's more likely to be successful if people are:

- motivated
- introspective (able to examine their own thoughts)
- honest
- willing to acknowledge imperfections
- able to accept responsibility for their problems.

Some practical changes can be brought about quite quickly but, for many, progress through therapy may be slow and difficult.

Group therapy is a chance to practise doing things differently. It can be particularly helpful for people who avoid social situations, or who usually depend too much on one person. Someone with borderline personality disorder tends to form intense 'special' one-to-one relationships, so a group gives them the chance to widen their range.

Counselling may be useful when it takes a problem-solving approach, focusing on practical issues and analysing current relationship difficulties. Social skills training and assertiveness training also have very practical aims, and offer opportunities for trying out new behaviour.

Cognitive therapy can help someone examine their usual pattern of thoughts and attitudes, and so challenge and change their mistaken ideas. When someone is too dependent, for instance, therapy might focus on challenging their fixed belief that they are so helpless and incompetent that they need someone else to rely on. Therapy for obsessive-compulsive personality disorder could challenge the person's conviction that they musn't make any mistakes, at all costs. It can help expand their narrow focus on duties and work.

Individual therapy is not always a good idea, because it can make some undesirable behaviour worse, at least to begin with. The intense one-to-one relationship encourages people to become even more dependent, or, in the case of antisocial or narcissistic disorders, more manipulative and exploitative. However, it can work if people are well motivated, and can be honest with themselves and come to trust another person. (For information on various talking treatments, see *Further reading*, on p. 14.)

Therapeutic communities

Living in a therapeutic community, for a number of months, has proved very helpful for more severe personality disorders. The NHS runs some inpatient therapeutic communities, which specialise in treating clients with these problems. The emphasis is on working together, democratically, so that the staff and residents share responsibility for tasks and decisions. People are encouraged to express their feelings about one another's behaviour in a group discussion. This inevitably involves residents having to face up to the effects their attitudes and behaviour have on others. People have to be very well motivated, able to talk about their problems and open to change.

Although communities vary, there's often no individual therapy and no medication involved. Therapy may take place, informally, through the day-to-day process of community living and through group psychotherapy, community meetings and other types of group activities. There are similar therapeutic communities within the prison system (see *Useful organisations*, on p. 12, and *Further reading*, on p. 14).

Medication

Doctors sometimes prescribe medication to treat a particular symptom of a personality disorder. For example, antidepressants may help with irritability or depression. It can take some time to find a drug that works. If medication does seem to be of benefit, it may be most effective when combined with a talking treatment.

What else can friends, family and health workers do?

It's important to emphasise the positive aspects of someone's personality, and to encourage each individual to make the most of their strengths and abilities. Someone may have a diagnosis of BPD and be likeable, intelligent, highly motivated or creative.

Good information is crucial. Being told that they are 'narcissistic' or 'dependent' without an explanation of what this means is unhelpful. It's also important to discuss what treatment approaches might be useful, and how people can best help themselves. For instance, misusing alcohol or drugs, or entering into an abusive relationship, will only add to someone's problems. People need encouragement from friends, family and professionals to change. Being judgemental and using blanket terms, such as 'immature' or 'inadequate', is unlikely to help. We may all behave immaturely or inadequately in particular situations.

It's important to identify situations that bring out the best or worst in people. For example, someone who is fearful of intimacy and ill at ease with people may lose their inhibitions when discussing a subject that really interests them, so joining a particular society, club or further education class may be a way of learning to enjoy the company of others.

Advocacy

There is a concern that people regarded as difficult to treat may be given a diagnosis of personality disorder and then denied access to services. Advocacy can be very useful for people who feel they can't get the help they need. (For more information, see The *Mind guide to advocacy*, under *Further reading*, on p. 14.)

Personality disorders and violent behaviour

Despite the stories that often appear in the press, most people diagnosed with a personality disorder are not violent. Violence, if it does occur, usually involves people diagnosed as having antisocial personality disorder. People with personality disorder, especially a borderline or paranoid personality disorder, are at a higher risk of self-harming or committing suicide than other people. They need help, not stigmatisation.

A new draft of the Mental Health Act 1983 aimed to ensure that 'high risk' patients, including those with a Dangerous and Severe Personality Disorder (not an acknowledged diagnosis), could be kept in detention for as long as they posed a high risk to others. This was widely criticised. It offered the prospect of locking someone up because they have a mental health problem (which is poorly defined), simply on the grounds that they might harm someone. In other words not because of something they have done, but because of something they might do. As of December 2003, the Government has now agreed to revise the draft. For the latest information on the Reform of the Mental Health Act visit www.mentalhealthalliance.org.uk

Useful organisations

Mind
Mind is the leading mental health organisation in England and Wales, providing a unique range of services through its local associations, to enable people with experience of mental distress to have a better quality of life. For more information about any mental health issues, including details of your nearest local Mind association, contact the Mind website: www.mind.org.uk or Mind*info*line on 0845 766 0163

Association of Therapeutic Communities
Barns Centre, Church Lane, Toddington, near Cheltenham, Gloucestershire GL54 5DQ
tel./fax: 01242 620 077, web: www.therapeuticcommunities.org
Directory of therapeutic communities available online

Borderline UK
PO Box 42, Cockermouth, Cumbria CA13 0WB
email: info@borderlineuk.co.uk web: www.borderlineuk.co.uk
National user-led network of people with a BPD diagnosis

British Association for Behavioural and Cognitive Psychotherapies (BABCP)
The Globe Centre, PO Box 9, Accrington BB5 0XB
tel. 01254 875 277, web: www.babcp.com
Full directory of psychotherapists available online

British Association for Counselling and Psychotherapy
BACP House, 35–37 Albert Street, Rugby CV21 2SG
tel. 0870 443 5252, web: www.bacp.co.uk
See website or send A5 SAE for details of local practitioners

The Cassel Hospital
1 Ham Common, Richmond, Surrey TW10 7JF
tel. 020 8940 8181, web: www.thecasselhospital.org
For people with less severe personality disorder

First Steps to Freedom
1 Taylor Close, Kenilworth CV8 2LW
helpline: 01926 851 608, web: www.first-steps.org
Supports friends and relatives of those with BPD

The Henderson Hospital
2 Homeland Drive, Sutton, Surrey SM2 5LT
tel. 020 8661 1611
Three therapeutic communities for people with severe personality disorder

NAPAC
42 Curtain Road, London EC2A 3NH
helpline: 0800 085 3330, web: www.napac.org.uk
National information service for people abused in childhood

The National Drugs Helpline
tel. 0800 776600, web: www.ndh.org.uk
Gives 24-hour free information and confidential advice about drugs

The Prison Reform Trust
15 Northburgh Street, London EC1V 0RJ
tel. 020 7251 5070, web: www.prisonreformtrust.org.uk
Advice and information for prisoners and their families

YoungMinds
102–108 Clerkenwell Road, London EC1M 5SA
parents information service: 0800 018 2138
web: www.youngminds.org.uk
For any adult with concerns about the mental health of a child or young person

Further reading

- ☐ *The anger control workbook* M. McKay, P. Rodgers (New Harbinger Press 2000) £13.99
- ☐ *The assertiveness workbook: how to express your ideas and stand up for yourself at work and in relationships* R. J. Paterson (New Harbinger Press 2000) £12.99
- ☐ *Hostage of the mind: living with obsessive-compulsive disorder from the point of view of a sufferer* A. Lowe (A. Lowe 1998) £11.99
- ☐ *How to assert yourself* (Mind 2003) £1
- ☐ *How to deal with anger* (Mind 2003) £1
- ☐ *How to help someone who is suicidal* (Mind 2002) £1
- ☐ *How to look after yourself* (Mind 2002) £1
- ☐ *How to restrain your violent impulses* (Mind 2002) £1
- ☐ *Living with mental illness: a book for relatives and friends* E. Kuipers, P. Bebbington (Souvenir Press 1997) £9.99
- ☐ *Making sense of cognitive behaviour therapy* (Mind 2001) £3.50
- ☐ *Managing anger* G. Lindenfield (Thorsons 2000) £7.99
- ☐ *Overcoming anger and irritability* W. Davies (Robinson, 2000) £7.99
- ☐ *Overcoming social anxiety and shyness: a self-help guide using cognitive-behavioural techniques* G Butler (Robinson 1999) £7.99
- ☐ *The Mind guide to advocacy* (Mind 2000) £1
- ☐ *Understanding anxiety* (Mind 2003) £1
- ☐ *Understanding borderline personality disorder* (Mind 2001) £1
- ☐ *Understanding depression* (Mind 2004) £1
- ☐ *Understanding dissociative disorders* (Mind 2003) £1
- ☐ *Understanding mental illness* (Mind 2004) £1
- ☐ *Understanding obsessive-compulsive disorder* (Mind 2002) £1
- ☐ *Understanding paranoia* (Mind 2002) £1
- ☐ *Understanding post-traumatic stress disorder* (Mind 2003) £1
- ☐ *Understanding phobias* (Mind 2002) £1
- ☐ *Understanding the psychological effects of street drugs* (Mind 2004) £1
- ☐ *Understanding schizophrenia* (Mind 2003) £1
- ☐ *Understanding self-harm* (Mind 2003) £1
- ☐ *Understanding talking treatments* (Mind 2002) £1
- ☐ *Working with personality disorders* S.Hannell, C. Kinsella (ROCC 2001) £10

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autonomy, equality, knowledge, participation and respect.

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Scottish Association for Mental Health tel. 0141 568 7000

Northern Ireland Association for Mental Health tel. 028 9032 8474

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