Understanding personality disorders

your guide to today's mental health issues

Personality disorder remains an area that is little understood by the general public and often inappropriately associated with violence. But it is more complex than that, as Tom Burns explains

Tom Burns is chief executive of the Ansel Group, an organisation dedicated to improving the level of understanding and support for people with a personality disorder. He is a clinician by background with over 30 years experience in health and social care. He is also chief executive of the Independent Living Group, a service for people with learning disabilities.

The understanding, identification, assessment and treatment of people with a personality disorder (PD) remains an area where there is little theoretical agreement and a relative paucity of comprehensive and useful research and data.

Patients will often present with co-morbidity and a complex clinical history that may have included access to forensic and/or specialist health care services. Additionally, individuals may well have been the subject of physical, emotional and/or sexual abuse. Patients will often have proved difficult to engage effectively with services, and their problems, in a few cases, may well have been expressed through impulsive, violent and self-harming behaviour. However, the need to acknowledge and meet the needs of people with a personality disorder is becoming a major issue in commissioning and providing appropriate services for this often marginalised and disadvantaged group. Existing bespoke provision remains rare and barriers to accessing appropriate services can be substantive.

In this briefing paper I will attempt to describe this patient group in a little more detail, highlight some of the challenges in trying to engage with these individuals and provide some messages about organising services to best meet their needs.

What are personality disorders?

Personality disorders have their origins in infancy; however, they become more obvious in early adolescence and young adulthood. This typically manifests itself in difficulties with managing emotions and attachment, often leading to a range of interpersonal problems. Later in life, people with personality disorders often need to be persuaded to present themselves to health or social care professionals, often by family or friends, or even by work colleagues or employers. By then the support systems around the individual are likely to be under sever strain or may have broken down. This can, in itself, make the person very frustrated and isolated and a sense of helplessness and abandonment can easily set in. If this is the case, then trying to engage or re-engage with the individual, particularly in attempting to give them help and support, can be very challenging for all concerned.

When attempting to work with this patient group it is helpful to know that personality disorder is not a single entity but rather a collection of disorders. A good starting point for understanding the disorders is either the American Psychiatric Association definition, DSM\IV\R, which describes 10 categories of personality disorder, or the World Health Organisation's International Classification of Disorder, better known as ICD\10, which describes nine categories.

However, the matter is further complicated by the fact that people with a personality disorder rarely belong to any single category of disorder. To address this the DSM provides a helpful solution by grouping the subcategories of personality disorder into three broad 'clusters', referred to as A, B, C. These are described in the following way.

- Cluster A (the 'odd or eccentric' types): paranoid, schizoid and schizotypal personality disorder.
- Cluster B (the 'dramatic, emotional or erratic' types): histrionic, narcissistic, antisocial, and borderline personality disorder.
- Cluster C (the 'anxious and fearful' types): obsessive-compulsive, avoidant and dependent.

For a more detailed example of each cluster, please refer to 'Personality Disorder: No longer a diagnosis of exclusion' published by the National Institute of Mental Health (NIMH) in 2003 (available at www.dh.gov.uk).

Current UK epidemiology indicates that one in 20 people in the UK has difficulties that would meet the criteria for a diagnosis of personality disorder and that between 50–85% of those within our prison service have been found to have an identifiable personality disorder. Clearly the problem is widespread and significant enough for service planners and providers to start giving this group of people ⇨

additional attention. The emergent policy framework supports this along with the recent issue of specific commissioning advice in relation to borderline and antisocial personality disorder from the National Institute for Health and Clinical Excellence.

As stated earlier, it is rare for people to present with one personality disorder. Just as significant is the fact that individuals often present with a range of Axis 1 disorders, commonly anxiety disorders, major depressive disorders and eating disorders.

In addition there is high co-morbidity between personality disorder and substance misuse. This is particularly concerning as there is evidence that the impulsivity and therefore vulnerability of these individuals increases when under the influence of such substances. Epidemiological studies have shown that 20–50% of clients with a personality disorder abuse substances and 5–30% of clients who attend substance misuse services have a diagnosis of personality disorder. To make matters worse, because of their complicated and at times chaotic lives, people with a personality disorder have a range of physical health needs, typically including liver and kidney disorders and blood borne viruses such as hepatitis B and C as well as HIV. People with a personality disorder are seen across the full spectrum of primary and secondary health services, some estimate that the cost to our health system can be twice that of a person without a personality disorder.

Many individuals with a personality disorder will be known to GPs and hospital accident and emergency services as frequent attendees following self-harming behaviours. In addition, people with a personality disorder are at significant risk of suicide and accidental death. It has been estimated that reducing suicide in this high risk group by 25% would reduce overall suicide rates by more than five percent.

Working with and supporting individuals with a personality disorder therefore brings a whole range of health issues and challenges that will test the resolve of many individuals and teams.

Is personality disorder treatable?

As a result of experiences in early life, often as a result of poor parenting, neglect or abuse, patterns of behaviour are established, which are often well ingrained. People with a personality disorder are often quite difficult to engage in services, they are wary of rejection, find it difficult to build trust in others and are worried about how others might see or judge them. They often have poor problem solving and interpersonal skills. For some, because of their history of rejection, they may also feel shame, guilt or even anger and as stated earlier they may well have a range of other health care needs that have not been addressed.

Because of the complexity of their needs and presentation and for some, the severity of their behaviour, a consistent and supportive approach is required.

Mary Haley, a psychotherapist and ex-prison governor, works with staff at HMP Whitemoor in Cambridgeshire and helps train staff working with a personality disorder. She gave the following advice for staff in a recent Sainsbury Centre for Mental Health publication.

- Treat clients with respect – don't expect to like people with personality disorders or be liked by them
- Offer consistency – both in how staff work with people with personality disorders and in which staff are working with them
- Show fairness and honesty – staff should do what they say they will do
- Staff should stay calm and not take things personally
- Ensure clear boundary management – restrict personal knowledge so it becomes something 'special'
- Aim for setting small goals – try to give a sense of achievement, not failure
- Develop a team approach – agree ways of working and mutual support
- Make sure staff should look after themselves – ensure good support mechanisms.

Key to the success of any support or range of interventions is high quality integrated care planning, a strong implementation plan, robust communications and ideally accepting the patient as part of the 'team'. It is only by working in this way that the patient will build trust and increase engagement. There is also a need to have agreement with the patient as to the response.

There is a growing evidence and practice base that people with a personality disorder are treatable. A range of psychological therapies has been shown to be effective in treating people with a personality disorder. The use of dialectical behaviour therapy (DBT), cognitive behaviour therapy (CBT), mentalisation-based therapy, therapeutic communities and psychodynamic psychotherapies have in various effectiveness studies demonstrated a reduction in self-harm, reduced suicide rates and a reduced use of health services including re-admission rates to mental health inpatient facilities. Such treatment models need to be integrated with other activities in a coherent and structured way and may include recovery focused activity, such as everyday living skills, education and employment.

What is also evident in all treatments for personality disorder is the need for long- term intensive treatment programmes that involve multiple clinical models of intervention underpinned by an organisational framework that ensures consistency, good training and team working, evidence of reflective practice and supervision and a supportive physical environment, particularly where such services are delivered on an inpatient basis. It is also suggested that service models that focus specifically on personality disorders are more effective than general psychiatric care.

Personality disorder and offenders

The NHS has responsibility for the health care of prisoners and this includes the needs of offenders in the community as well as those in custody in our prison service.

In June 2009 the Ministry of Justice published Lord Bradley's review on people with mental health problems or learning disabilities in the criminal justice system (see www.justice.gov.uk).

Included in the report are some interesting key facts and based on these you could be forgiven for believing that our prisons are rapidly becoming the new psychiatric asylums.

Key facts

- Since 1995 the prison population in England and Wales has increased by 60% and stood at 85,201 on 21 May 2010
- The prison suicide rate in England and Wales was 114 per 100,000 prisoners in 2007. The suicide rate for the general population is 8.3 per 100,000
- 66% of the prison population suffer from a personality disorder as opposed to 5.3% of the general population
- An Office of National Statistics report showed 78% of male remand prisoners with a personality disorder, 64% of male sentenced prisoners and 50% of female prisoners.

Clearly this is a major challenge for health service in-reach teams and operational staff within the prison service. The report goes on to highlight that although prisoners' mental health needs are no different from those of people in the general population, prisons are struggling to be able to adequately meet those needs and, in particular, certain elements of the prison population with mental health problems are not receiving any treatment at all.

Organising and commissioning services

One of the biggest challenges facing people with a personality disorder and the staff who support them is the public perception that people who have a personality disorder are dangerous. This has not been helped by the small number of people who, because of the clear and present danger they present to themselves or others, are held in prison or in one of the three high secure hospitals in England and Wales. The associated publicity that surrounds these and similar cases does not help those who have a personality disorder.

Quite conversely, the overwhelming majority of people with a personality disorder live in the community and, where they receive it, are supported by community based professional health and social care staff.

Conclusion

The needs of people with a personality disorder are both diverse and complex. Equally, the demands made on health and social care professionals are wide ranging and challenging. However, working with this patient group brings its own rewards and opportunities and as the evidence base improves and our knowledge and understanding of what works improves, the reality for many people with a personality disorder is that they will be supported by a wide range of professionals who will have the ability and skills to help them make more sense of and gain more control of their lives. ■

Further information about the Ansel group, which provides services for people with personality disorders, can be found at: www.anselgroup.co.uk

mentalhealth Today

Who does what: Mental Health Today's guide to personality disorder treatments

Check the Mental Health Today table for an at a glance guide to the main providers of services for people with personality disorders	Ansel Group	Brookdale Care	Care Aspirations	Choice Care Group	Care UK	Cygnet Hospital Group	Horizon Care	MHC	Network Adults	One step at a time	Partnerships in Care	Penrose	Priory Group	Rialto
Challenging Behaviour	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Services for Young People				■	◆				■	■			■	
Secure Services for Deaf Men														
Secure Services for Deaf Women														
Secure Services for Deaf Men with LD			■											
Secure Services for Women					■	■			■		■		■	
Secure Servies for Men	■	■			■	■		■	■		■		■	
Asperger's Syndrome		■		■			■		■	■	■		■	■
Autistic Spectrum Disorders		■	■	■			■	■	■	■	■		■	■
Dual Diagnosis	■	■	■	■	■	■	■	■	■	■	■		■	■
24-Hour Emergency Placements	■	■	■	■	■	■			■	■	■		■	■
Mother & Baby										■			■	■
Korsakoff's Syndrome				■	■		■		■				■	■
Personality Disorders	■		■	■	■	■	■	■	■	■	■	■	■	■
Complex Needs	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Huntington's Syndrome		■					■		■				■	■
Brain Injuries				■	▲		■		■	■	■		■	■
Management of Violence and Aggression	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Low Secure Provision	■	■	■		■	■		■	■		■		■	
Rehabilitation	■	■	■	■	■	■	■	■	■		■	■	■	■
Day Services		■	■		■	■	■		■				■	
Residential Care		■	■	■	■	■	■	■	■			■	■	
Continuing Care		■	■	■	■		■	■	■		■		■	■
Self-Injurious Behaviour	■	■	■	■	■	■		■	■	■	■	■	■	■
Forensic Needs	■	■	■	■	■	■		■	■		■	■	■	■
Eating Disorders		■			■	■	■		■		■		■	■
Drugs and Alcohol		■		■	■		■	■	■	■	■		■	■
Learning Disabilities		■	■	■			■	■	■	■	■		■	■
Supported Living		■	■		■		■	■	■	■	■	■		■
Dementia							■		■	■			■	■
Preparing Individuals for Independent Living	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Schizophrenia		■	■	■	■	■	■	■	■	■	■	■	■	■
Psychosis and Bipolar Disorder		■	■	■	■	■	■	■	■	■	■	■	■	■
Holistic, Multi-disciplinary Assessments	■	■	■	■	■	■		■	■		■		■	
Training Services		■					■	■			■			■
National Curriculum Education													■	
Psychotherapy Services		■			■			■	■		■	■	■	
Assessment Placements		■	■		■	■		■	■	■	■		■	■
Respite Care					■		■		■		■		■	■
Transitional Care	■	■		■	■	■	■	■	■	■	■		■	■
Crisis Intervention		■	■	■	■	■			■				■	
Panic Disorder		■		■	■	■	■		■				■	
Social Phobia		■		■	■	■	■		■	■	■		■	■
Anxiety Disorder		■	■	■	■	■	■	■	■	■	■		■	■
Depression		■	■	■	■	■	■	■	■	■	■	■	■	■
Post Traumatic Stress Disorder		■	■	■	■	■	■	■	■	■	■		■	■

◆ Aged 16+

▲ In development