PERSONALITY DISORDER & SERIOUS OFFENDING

HOSPITAL TREATMENT MODELS

EDITED BY CHRIS NEWRITH, CLIVE MEUX
& PAMELA J TAYLOR

Personality Disorder and Serious Offending

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Hospital treatment models

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FOREWORD

One of the strengths of forensic psychiatry in the UK is the emphatic focus on the nature of the therapeutic care and treatment of persons held in the custody of the justice system. For example, in a foundational textbook of British forensic psychiatry, *Forensic Psychiatry: clinical, legal and ethical issues* (Gunn and Taylor, 2000), great attention is paid to treatment of the mental disorders that one is likely to encounter in the clinical practice of psychiatry in forensic settings. The present book, by Newrith, Meux and Taylor, *Personality Disorder and Serious Offending: hospital treatment models*, is very much in keeping with the therapeutic focus of British forensic psychiatry.

In contrast, in the USA forensic psychiatry has largely addressed the non-therapeutic assessment and disposition of individuals in both criminal and civil law cases. For example, on 20 May 1985, the American Academy of Psychiatry and the Law (AAPL) adopted the following definition: 'Forensic psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters; forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry' (AAPL, 2004). AAPL's definition included 'correctional' legal matters, i.e. issues related to jail and prison confinement, but did not specifically include the provision of therapeutic treatment as one of those 'correctional' matters. Similarly, in *Principles and Practice of Forensic Psychiatry* (Rosner, 2003), produced for the AAPL's Tri-State Chapter, the focus is on the legal regulation of care and treatment, rather than on the nature of the care and treatment to provide to persons detained in the justice system. Even in *Correctional Psychiatry* (Rosner and Harmon, 1989), an earlier book prepared under the auspices of AAPL's Tri-State Chapter, there is only one chapter on therapy: 'Treatment of Antisocial and Other Personality Disorders in a Correctional Setting' (Weinstock, 1989).

In the USA throughout most of the twentieth century, treatment of persons held in detention in secure hospitals and correctional facilities was widely regarded as peripheral to the core of forensic psychiatry; that core was considered to be the examination and evaluation of persons for potential and actual report writing and testimony in court cases. In the late 1980s and early 1990s, as the price for formal recognition as a subspecialty of psychiatry, organized American forensic psychiatry was obliged to designate the special population forensic psychiatrists treat: persons in the custody of the justice system. In the 1990s, the American Psychiatric Association (APA) formally acknowledged forensic psychiatry as a subspecialty; the American Board of Psychiatry and Neurology (ABPN) replaced the American Board of Forensic Psychiatry as the organization to assess and certify the competence of practitioners of forensic psychiatry; and the Accreditation Council for Graduate Medical Education (ACGME) replaced the Accreditation Council on Fellowships in Forensic Psychiatry as the organization to assess and certify training programmes for forensic psychiatrists. The APA, ABPN, and ACGME made treatment of persons detained in the justice system move from the periphery into the core of American forensic psychiatry (Prosono, 2003). Treatment in secure hospitals and correctional facilities is now part of mainstream US forensic psychiatry, but it remains a relatively new and under-addressed field.

From the point of view of public health administration, one of the peculiarities of the USA is that the government does not have an affirmative obligation to identify persons at large in the community who are in need of mental health services, let alone to provide treatment for those persons. On the other hand, as soon as a person is involuntarily confined in a police lock-up, a jail or a prison, the government is required to quickly determine if the person has a diagnosable mental or physical disorder and is responsible for the provision of services to such a person. Thus, for Americans who lack the education, insight, motivation, or funding to seek mental health evaluation and treatment, being arrested and detained in the justice system may provide assessment and therapy for here-to-fore unknown and unattended mental disorders. Secure facilities in the USA now house and provide treatment for large numbers of mentally ill persons, who otherwise might be unidentified and untreated in the community.

In the USA, starting in the 1950s, with the introduction of effective neuroleptic medications, there began a process of de-institutionalization, i.e. the discharge from mental hospitals into the community of chronically mentally ill persons, in the hope that community-based outpatient mental health services would monitor and treat them. Alas, in accordance with the proverb, 'There is many a slip between the cup and the lip', many of the chronically mentally ill persons discharged into the community did not receive the ongoing community-based support and treatment that they needed. As a result, untreated mentally ill persons moved from the civil law mental health system to the criminal law mental health system. These chronically mentally ill patients, often with co-morbid personality disorders and superimposed substance abuse problems, moved into the domain of forensic psychiatry. Secure hospitals and correctional facilities now offer the only free, long-term, institutional care and treatment for the mentally ill in the USA.

The population in such facilities constitutes a public health challenge. The challenge is to find treatments that address all of the components of the chronic and multiple bio-psycho-social needs of these patients, are effective in real world settings, make the most therapeutic use of the period of institutional confinement, find ways to engage the competent informed cooperation of these patients, maximize compliance with treatment, bridge the post-discharge gap between institutional treatment and community-based treatment, and do so with the limited economic resources that society allocates to this population. Because our British colleagues in forensic psychiatry have long been addressing the therapeutic needs of persons held in the justice system, forensic psychiatrists in the USA have much to learn from them.

During the past five years, the AAPL's Tri-State Chapter, in co-operation with the Royal College of Psychiatrists' section on forensic psychiatry, has planned and implemented a series of international conferences on forensic psychiatry. These conferences, alternately meeting in London and New York, have provided an opportunity to explore commonalities and contrasts in the practice of forensic psychiatry in the UK and the USA. It has become clear that we can learn from one another's experience and strengths in different facets of our field. Because it is unrealistic for all of us personally to meet and share our knowledge and skills, it is important to use the exchange of written materials to foster our mutual education. One excellent example of what British forensic psychiatry has to teach American practitioners is the present volume, Newrith, Meux and Taylor's *Personality Disorder and Serious Offending: hospital treatment models*. Those in the UK will find this book of immediate relevance to the traditional focus of forensic psychiatry in their nation. Those in the USA will find it of importance to the therapeutic mission that has become an increasing concern of American forensic psychiatry. I commend this book to the attention of forensic psychiatrists on both sides of the Atlantic!

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Richard Rosner
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Sadly, George Fenton died before the book was complete. His research on behalf of offender patients, including Broadmoor Hospital patients, had been conducted over many years and he continued to advise on neurophysiological research almost until his death. His chapter illustrates the wealth of his knowledge. We are grateful to his widow for allowing us to publish it, even though he could not check our editing.

Our particular thanks go to the residents and staff of Woodstock, in Broadmoor Hospital, without whom the book would never have been written. All staff members are over-stretched, as they have to continue demanding work while under-resourcing bites, but many gave support and advice and some wrote substantial contributions for us. The patients often complain that we do not consistently live up to our philosophies and ideals and, unfortunately, they are right. This is generally due to the combination of short staffing and bureaucracy inherent in this kind of work, but sometimes simply to our own failings as human beings. Nevertheless, as others have shown, Woodstock has had considerable success, and the generosity of most of the patients belies the pejorative labels they have acquired over the years. They regularly contribute to research, whether ours or that of others. Finally, when we asked for help with the cover design, most of the patients made pictorial images for us that they considered represented something of the pain and stigma of having a personality disorder or the work involved in trying to do something about it. We have used one image on the cover, and others appear throughout the book. These are just tiny examples of the creativity that can emerge if we provide a stable framework and facilitate healing and growth through specific treatments.

Chris Newrith
Clive Meux
Pamela Taylor

CHAPTER 6

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CHAPTER 7

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CHAPTER 10

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CHAPTER 27

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LIST OF ABBREVIATIONS USED

AAI	adult attachment interview
ADHD	attention deficit hyperactivity disorder
BPD	borderline personality disorder
CAT	cognitive analytic therapy
CBT	cognitive behavioural therapy
CFI	Camberwell Family Interview
CI	confidence interval
CMRG	cerebral metabolic rates of glucose
CNV	contingent negative variation
CPA	Care Programme Approach, a structured approach to continuing clinical care required by the British government (see www.healthcarecommission.org.uk/informationforserviceproviders/guidanceforNHS)
CPN	community psychiatric nurse
CS	conditioned stimulus
CSF	cerebrospinal fluid
CT	computerized tomography
DBT	dialectical behavioural therapy
DIPD	diagnostic interview for personality disorders
DSM-IIIR	Diagnostic and Statistical Manual, Third Edition, Revised
DSM-IV	Diagnostic and Statistical Manual, Fourth Edition
DSPD	dangerous and severe personality disorder
ECHR	European Convention on Human Rights
EEG	electroencephalography
EFP	Expertise Centre for Forensic Psychiatry (Netherlands)
ERP	event related potentials
5-HIAA	5-hydroxyindoleacetic acid
5-HT	5-hydroxytryptophan (also called serotonin)
HVA	homovanillic acid
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
IPDE	International Personality Disorder Examination
IQ	intelligent quotient
MAO-A	monoamine oxidase A
MAPPP	Multi Agency Public Protection Panel
MCMI	Million Clinical Multiaxial Inventory
m-CPP	metachlorophenyl piperazine
MDMA	3, 4 methylenedioxymethamphetimine
MHA 1983	Mental Health Act 1983

MHAC	Mental Health Act Commission
MHPG	3-methoxy 4-hydroxy phenylglycol
MHRT	Mental Health Review Tribunal
MMPI	Minnesota Multiphasic Personality Inventory
MRI	magnetic resonance imaging
NHS	National Health Service
NVQ	National Vocational Qualification
OPD	operationalized psychodynamic diagnostics
OR	odds ratio
PAS	personality assessment schedule
PCL	psychopathy checklist
PCL-R	revised psychopathy checklist
PCL-SV	psychopathy checklist – screening version
PD	personality disorder
PET	positron emission tomography
PTSD	post-traumatic stress disorder
RCT	randomized control trial
RMO	responsible medical officer
RTS	rehabilitation therapy staff
SAP	standardized assessment of personality
SCR	skin conductance response
SPECT	single positron emission computerized tomography
SPET	single positron emission tomography
SSRI	selective serotonin reuptake inhibitor
TBS	Terbeschikkingstelling or Special Hospital Order (Netherlands)
TLE	temporal lobe epilepsy
UCS	unconditioned stimulus
VIM	violence inhibition model

INTRODUCTION

PERSONALITY DISORDER AND ITS TREATMENT: STARTING IS NOT DIFFICULT

Chris Newrith, Clive Meux and Pamela J. Taylor

Look … I've got an unfortunate character. I don't know how I came by it, whether it was the way I was brought up or whether it's just the way I'm made. All I know is that if I make other people unhappy, I'm no less unhappy myself. Not much comfort for them, perhaps, but there it is.

Let it suffice that the malady has been diagnosed – heaven alone knows how to cure it!

Lermontov, 1840

If we were to accept completely Willie Bosket's version of his life, in which racism alone turned him against society and the law, then we would have to believe, as some professed during the Sixties, that men like him are the vanguard of resistance to racism. But, experience and human nature argue against that completely heroic reading. When we consider Bosket's criminal career, it is his impulsiveness and readiness for maximum violence that strike us most …

As restless and impulsive as his father and grandfather and great grandfather, introduced to sodomy by his grandfather, he never has much of a chance …

[Willie's father had begun to function more normally in the same school to which his son later went, but he was discharged.] *That meant to a home that was not a home, and streets where the first law is survival. At home was his father, a violent alcoholic, and his mother, a prostitute.*

Fox Butterfield, 1995

The dilemmas associated with the treatment of someone who has a personality disorder and who offends are perhaps encapsulated in these two accounts. The first is fictional, but at least partly autobiographical; the second is factual. Of all mental disorders, personality disorder (of whatever type) is most readily recognized by its impact on both individual relationships and the collective relationship with society. How, then, can there be certainty about where exactly the disorder lies, or even if there is a disorder?

When individuals who have acquired a diagnosis of personality disorder state that others are hostile, critical and denying them various positive experiences, or perhaps that

'the system' is against them, it is often true. Does the fact that others may indeed be hostile, or that health, social or criminal justice systems may be truly suspicious or rejecting, invalidate the concept of a primary disorder? The determination of critical timings can be helpful in trying to establish how mental illness relates to behaviour; that is less so in the case of personality disorder. Whether apparent disorder or apparent rejection came first is rarely a useful guide to how the presenting dynamic has emerged. There will probably have been lack of care in earlier life in most cases and, as children, many will have suffered prolonged physical or sexual abuse, or both. In circumstances of neglect and/or abuse, it is doubtful whether parents or others in the individual's early social circle will be able to give an accurate account of birth and early development. Some sufferers may have sustained physical damage, including brain damage, during mother's pregnancy or at birth; others may have acquired developmental delays for other physical reasons, such as early central nervous system infections. Under what circumstances is deprivation or abuse sufficient to instigate lifelong patterns of adverse relationships? What circumstances are necessary to give rise to innate vulnerabilities? By the time of presentation, it is often difficult or impossible to unravel the developmental pathways, yet people present in a position of being unable to make or maintain relationships, or as a party to habitually unhealthy and damaging relationships. They are generally, like Lermontov's hero, deeply unhappy. Suicide rates are at least as high as for other major mental disorders, but, not uncommonly, the misery and aggression are also projected onto others, and it is this that tends to lead to exclusion from sustained supportive or therapeutic services. Brief service contacts, with a general practitioner, in accident and emergency departments or in a brush with the criminal justice system, are common. Treatment for the personality disorder is not.

Sources of potential help for individuals suffering the effects of personality disorder are few, and those that exist are uneven in quality. Diagnostic confusion surrounding this disorder does not help the situation, and some service providers use it to deny services. There are important limits, however, to systems which simply operationalize description of what can be observed by interviewing clinicians. The 'disease classification' model supplied by the *International Classification of Diseases* (World Health Organization, 1992) or the US-based *Diagnostic and Statistical Manual* (American Psychiatric Association, 1994) provides a label for 'the malady' that may serve only to reinforce clinical nihilism. This labelling is a long way from the true medical concept of 'diagnosis', which implies understanding of the cause of the condition, its probable course if untreated, and the likely effect on that course of well-defined interventions. The term 'personality disorder', therefore, has much the same value as the term 'anaemia'. It denotes little more than recognition of some consistencies in unhealthy presentations that limit the individual concerned in some predictable ways. It should perhaps also put the clinician in mind of a list of treatments that may be helpful, but, on the basis of such labelling alone, treatment choice would largely be a process of trial and error. For it to be otherwise, a causal mechanism or developmental pathway would have to be known. In other words, while some basic clinical interventions might maintain the status quo, change is likely to depend on matching the treatment to the primary problem. Is the latter an external deficiency – or an internal inability to process the material being fed in? We also need to know whether, if a deficiency is prolonged, for example a deficiency in attachment, simple replacement therapy will, in itself, be insufficient.

So, Lermontov's tantalizing challenge 'Heaven alone knows how to cure it!' still holds some bite 150 years later in the twenty-first century. Even clinical optimists in the

field tend to think of treatment in terms of the phrases still enshrined in English mental health legislation: 'prevention of deterioration' or 'alleviation' rather than 'cure'. Even if it is accepted that an operational definition of what can be observed is possible, and 'the malady' can be diagnosed, is there any theoretical basis for it? There is no personality disorder virus, nor is there any consistently recognizable and specific deficit or reconfiguration of the brain that investigative techniques currently available can identify as uniquely indicative of a personality disorder. Indeed, some would argue that the greatest objection to the very concept of personality disorder is that the label is not indicative of specific and unequivocal primary pathology.

This book aims to acknowledge these dilemmas, but also to find a way of working that makes it possible to avoid therapeutic paralysis. At the centre of the book is a description of an evolving service in a high-security hospital setting. It is founded on the richness and complexity of the current evidence base concerning pathways into personality disorder and is, therefore, a complex, multi-modular approach. Before we describe this service, we explore in turn each of the aspects that may contribute to the development of personality disorder. The rationale for the therapeutic approach in this unit, which draws on many schools of thought, but has a clear and replicable framework, in which this knowledge is applied. The service aims to provide an environment that minimizes the repetition of early adverse experiences and disorder-maintaining practices. Within that context, assessments of the men described in subsequent chapters can be completed, and repeated as treatment progresses. An eclectic mix of established treatments is offered in a way that engages these residents in the standard framework, but allows for individual variation. Needless to say, the service does not always succeed in its lofty ideals. After the central chapter setting out this approach, we explore ways of extending or modifying it to accommodate variations in the disorder and its co-morbidities, and variations in the situational needs of subgroups of those who suffer with it.

If this sort of clinical eclecticism can be more or less justified in theory by pulling together a collection of partly understood pathways, such a solution does, in turn, raise further questions. For example, is there any evidence of an overall advantage in having individuals with such disorders living and working together, being in specified therapies together, and receiving additional individual treatments? Is coercion, such as compulsory detention in hospital, a barrier to or a brake on treatments, or an essential enabler of therapy? Is coercion of most value for specified subgroups of people with, say, a greater number of certain problems? Does sequencing in treatment matter? Does the individualized approach, which allows for different needs in varying the treatment menu, including timing of some of the elements, really provide an advantage for some over a systematic, tightly timed programme that is easier to run to measurable clinical standards? If so, who does better in which system? It will come as no surprise that we have to leave many of the questions unanswered, but we hope that the process of formulating them by bringing clinical and research experience together may in itself be helpful.

BAD AND DANGEROUS, MAD AND DANGEROUS – JUST DESERTS OR SAFETY?

Treatment for any condition has to take place within its wider social context of resource availability and perceived worthiness of the group to be treated. Even in richer societies, resources are finite. It is not difficult to understand how meeting the needs of a premature baby could be seen as more important than meeting the needs of, say, a heroin addict. Provision for those who

do not have the respect of society becomes more complex when, in a democratic society, the ruling body endorses populist but treatment-hostile views. A former British Prime Minister (John Major), for example, suggested, in a debate on law and order, that we should be ready to 'condemn a little more and understand a little less'. For the offender with personality disorder, this requires that we confront a perhaps unforeseen risk. Failure to understand the problems that such people are experiencing or their derivation, increases the risk that society's response will be to use punitive measures that would probably result in the maintenance or even exacerbation of their pathology. This in turn is likely to confirm the sufferer's early experiences that power and authority are only ever improperly used, and that survival lies in fighting them. Approaches that do not involve an understanding of this group are, therefore, likely to increase the risk of harm to others.

Middle ways between embracing understanding and offering an entirely therapeutic response on the one hand and crude enclosure or punishment on the other can create further tensions between practice, terminology and reality. Introducing a 'treatment' that 'works' into the penal and probation system might lead to people being rejected from treatment in an evidence-based health service because 'treatment' is better provided elsewhere. Is it proper to call some of the programmes offered by correctional services 'treatment programmes', or would it be clearer to refer to them as 'training programmes'? Perhaps it does not matter, though, so long as an individual receives practical, helpful interventions, what these interventions are called. Does society prefer a punitive tone in the language and better accept interventions that include it? How can we engage in a more open dialogue about which treatment provides the best chance of improving the individual's condition and decreasing the risk to public safety?

RIGHTS AND TREATMENT MORALITIES

We may all regress at times of severe stress, but, for the person who suffers with personality disorder, regression is an almost permanent state of affairs. The tension between recognizing an adult's chronological maturity, while simultaneously allowing for their arrested or regressed emotional development can make for difficult ethical dilemmas. Do such people have capacity? They may have a better understanding than most of their legal rights and how to exercise them, but this does not necessarily mean that they have reached a developmental stage of being able to judge the realities of their mental state and its implications. To what extent are they able to take responsibility for their actions in this context? To what extent can they understand, in any useful sense, the proposed treatment and its implications? To what extent do they have the capacity – here meaning the volitional and motivational state – to maintain treatment once started? Being free to abandon treatment on the kind of impulse that necessitated it does not necessarily equate with being in a position to make a free and informed choice.

On the other side of the debate are questions such as what level of confidence in the effectiveness of treatment is necessary before coercion of an individual specifically in order to undergo it is justified? A related question is about the level of confidence in the effects of treatment that is needed in order to insist that certain levels of service are made widely available? In Britain, the government has set up a number of bodies – for example the National Institute for Clinical Excellence (NICE) – to review the evidence-based treatments provided in the health service. It has also set up a body called the Clinical Health Improvement and Audit (CHIA) Inspectorate to review the services responsible for the implementation of treatments. The evidence accumulated to date

for the effectiveness of treatments is reviewed in later chapters. More is known than is sometimes claimed, but still the evidence base is weaker by current standards than for many other disorders, even other major mental disorders. With respect to personality disorder, however, it may be important to question the extent to which reviews or bodies should set the randomized, controlled trial as the gold standard. Is the randomized, controlled trial really the best way of evaluating the treatment of a disorder that has complex causative pathways and, almost by definition, substantial individual variation, even within recognized sub-categories. Truly honest researchers might find it impossible to claim that they can identify a sufficiently homogenous sample for these kinds of group comparisons. If so, what are the alternatives?

Then there is the matter of cost effectiveness. Psychological and social treatments are labour intensive and appear expensive, if only as mental health treatments go. Who, though, has costed failures to treat offenders with personality disorder – whether in terms of institutional havoc or community tragedy? We know of only one US-based effort in this direction (Cohen et al., 1994). Then, too, although there has long been concern about inter-generational cycles in the development of personality disorder, the costs of interventions to minimize the cycles and of failing to intervene have barely been considered. The Bosket story is presented as one of social abuse, from which no generation of the family has yet escaped. The depth of the problem for this family is undoubted; the breadth of the problem is currently being investigated in birth cohort studies (e.g. Moffit et al., 2001).

Varying degrees of coercion into assessment and/or the treatment of personality disorder are permissible in most countries. In the UK, such coercion is explicit and subject to regular appeal, at least annually if the patient so wishes. When mental health legislation is used to detain the sufferer in hospital, such review applies most robustly to the fact of detention, and to any physical (drug) treatments; the effectiveness of psychological treatment in the individual is, in effect, only indirectly tested by an independent body called a Tribunal, when it reviews the evidence that the individual is proving 'treatable'. It is widely accepted that there must be some indication of consent and cooperation for psychological assessments and treatments to occur at all; this may be why, in legal terms, in the UK they are designated as 'treatments which do not require consent'. This refers to formal legal consents not real consent. In the criminal justice system, coercion is often more covert, perhaps allowing people to serve a sentence in the community if they cooperate in a treatment scheme, or to leave prison early for the same reason.

To date, proposals for mental health legislative reform in the UK have united all interested parties – patients and their organizations, carers and theirs, clinicians and civil rights lawyers. The exceptionally broad definition of mental disorder (of which personality disorder could be one unspecified component), explicit limits to clinical confidentiality, and concepts of preventive detention without treatment are just three of the many concerns about the proposed reforms. Legislation in such a difficult area is coercive of clinicians and patients alike. It may threaten the trust between them, and could place insurmountable barriers in the way of treatment, although perhaps less so for those with personality disorder who have been convicted of a criminal offence. It could deter treatment seeking by those who have not yet offended and might have been prevented through treatment.

THE WORK AND THE BOOK

Belief systems are powerful in the field covered by this book. We have them too, and doubtless they will break through in the

writing from time to time. There is now more substance than mere belief to support the treatment of offenders with personality disorder, but there is still a long way to go. The dilemmas and difficulties raised by working in this field make it rewarding as well as frustrating. We think that the contributors to this text have conveyed in their writing both evidence-based knowledge and their enthusiasm for their respective areas of expertise. We certainly wanted them to bring that combination. We would like the book to stimulate questions and debate. Clinical work and evidence will continue to develop as the book goes through the publishing process.

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Part 1

DEFINING AND DIAGNOSING

Chapter 1

PRESENTING CHARACTERISTICS OF PERSONALITY DISORDER

Sophie Davison

INTRODUCTION

The management of offenders with personality disorder remains a controversial area. A number of factors contribute to the underdiagnosis and misdiagnosis of personality disorder in clinical practice (Paris, 1996). Many clinicians are sceptical that personality can be assessed reliably and often consider patients with personality disorder to be 'untreatable'. Some have argued that personality disorder is an ill-defined concept used to stigmatize those individuals whose behaviour deviates from social norms and to exclude them from services. Some have even suggested that the diagnosis should be abandoned on these grounds (Lewis and Appleby, 1988).

However, denying the existence of personality disorders will not make them or their associated problems go away. Personality disorders place a huge burden on individuals and the societies in which they live. Uncertainty about the response to the available treatments and lack of appropriate services are invalid reasons for failing to diagnose and assess personality disorders properly.

Professionals throughout the mental health, general medical and criminal justice systems and the associated public and voluntary agencies deal regularly with individuals whose longstanding difficulties in the way they think, feel, behave and relate to others (i.e. who suffer from a personality disorder) make their management a particular challenge. There is evidence that individuals with personality disorder are amongst the heaviest users of mental health services (Reich et al., 1989; Menzies et al., 1993; Saarento et al., 1997; Williams et al., 1998). Many present repeatedly, take up disproportionate time, effort and resources and often do not complete treatment. Understanding their difficulties is crucial in planning appropriate services and managing individual cases.

Despite all the debate, practitioners dealing with individuals with personality disorder are generally very good at identifying them, even if they do not all use the same theoretical frameworks or nomenclature in their approach to management.

This chapter concentrates on the practical identification and assessment of personality disorder in a clinical setting. It describes some of the many ways in which personality disorder may present in practice and the features that may alert a practitioner to its presence. First and foremost, it demonstrates that the principles involved in identifying and assessing individuals with personality disorder are no different from those used in good clinical practice to assess any individual presenting with mental health problems and associated psycho-social difficulties.

DEFINITIONS

This section concentrates on the key features that are useful for recognizing individuals with personality disorder when they present. In Chapter 3, Professor Blackburn discusses the problem of defining when personality traits (that run along a continuum from normal to abnormal) constitute a disorder. This debate is not unique to disorders of personality; it applies to many other mental and physical disorders.

Although the debate about where the cut-off point should be is interesting for research purposes, practitioners rarely have problems in their everyday work identifying what constitutes a disorder and what does not. In clinical practice, where the aim is to decide whether or not an intervention is necessary, the cut-off point used is a functional and pragmatic one. A set of problems and symptoms is usually considered to constitute a disorder when the individual suffers as a result of it or when the problems interfere with social functioning. This is reflected in the *International Classification of Diseases – 10* (ICD-10) classification system (World Health Organization, 1992), in which a mental disorder is defined as '… a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone without personal dysfunction should not be included in mental disorder as defined here.' Personality disorders are no exception. Thus deviant behaviour in the absence of personal distress or impairment of personal functioning is not considered a disorder, nor are personality traits that differ from the norm but do not lead to distress or impairment of functioning.

Most classification systems differentiate between those disorders that have a defined onset after a period of normality – often referred to as 'mental illness' within British psychiatry, or Axis I disorders in the case of *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition (DSM-IV) (American Psychiatric Association, 1994) – and those that are persistent and can be identified as having arisen out of a developmental process – personality disorders and learning disability. The official classification systems, DSM-IV and ICD-10, differ slightly in their wording of the definition of personality disorder, but they and almost all other definitions include several key concepts, one of which is that the onset is usually in childhood or adolescence and the disorder is persistent over a long time into adulthood. This is the key feature in differentiating personality disorders from Axis I mental disorders.

The following are other features common to all definitions.

- There are enduring maladaptive and inflexible patterns of thinking (i.e. ways of perceiving and interpreting self, other people and events), feeling (i.e. the range, intensity, lability and appropriateness of emotional responses), behaving (e.g. impulse control) and relating to others. These differ from the way the average person in the same culture thinks, feels and acts.
- Several of these different areas of psychological functioning are abnormal.
- The disorder is pervasive. This means it is manifest across a broad range of personal and social situations.
- The disorder is associated with a substantial degree of personal distress and/or problems in occupational and social performance (De Girolamo and Reich, 1993).

IDENTIFYING PERSONALITY DISORDER IN CLINICAL PRACTICE

It is the associated distress and impairment in personal functioning that bring individuals

with personality disorder to the attention of services. The task for a practitioner is then to recognize whether or not the distress and functional impairment are caused by a personality disorder.

Some of the presentations discussed below may raise the index of suspicion that an individual has a personality disorder, but the only way to be sure is to take a longitudinal approach. A one-off assessment is just a snapshot in time of a person's functioning. Without taking a thorough life history, it is impossible to determine whether the problems presenting at that time are tendencies to feel, think or behave in particular ways that have been present since adolescence and are manifest in many areas of the individual's life, or whether they have arisen as a result of a mental illness with a specified onset following a period of normal functioning.

Research has shown that most experienced clinicians make the diagnosis of personality disorder by taking a systematic history and listening to patients' narratives of their lives (Westen, 1997). Patients tell the story of their relationships with family, loved ones, friends, authorities and colleagues at home, at work, at leisure and at school. Clinicians look for recurring patterns of behaviour and interpersonal interactions from which they draw inferences about characteristic patterns of relating to others, behaviour patterns, coping mechanisms, belief patterns, hopes, fears and emotional responses (Perry, 1992; Westen, 1997).

It is also important to obtain information from as many different sources as possible, as an individual's current mental state may confound an assessment. For example, individuals who are severely depressed may re-interpret their whole history and feel they have always been this way, whereas close relatives will say that they used to be cheerful and function well. This additional information will also shed light on which areas of a patient's life are affected.

DESCRIBING PERSONALITY DISORDER IN CLINICAL PRACTICE

The psychiatric classification systems (ICD-10 and DSM-IV) divide personality disorders into various discrete categories (see Chapter 4). Trying to pigeonhole individuals into categories is useful for research purposes to ensure like is being compared with like. It may also provide a convenient shorthand for communicating in very broad terms the sorts of problems an individual is likely to have. However, the categories have been criticized for their lack of specificity, the fact that they overlap and because reliability between clinicians is very poor in identifying the individual categories (Perry, 1992; Livesley et al., 1994). In addition, providing personality disorder category labels does not provide the accurate information about the individual's actual difficulties and circumstances that is required to plan and prioritize interventions.

Everyone has to develop their own way of organizing the information they collect about personality disorders. Allnutt and Links (1996) have suggested that clinicians be aware of the factors that raise suspicion that there might be a personality disorder and then ask a few brief screening questions to establish whether the individual has any features suggestive of each type of personality disorder.

However, research has confirmed that clinicians do not find a checklist of direct questions about particular traits very useful in the clinical setting (Westen, 1997). For practical purposes, it has been suggested that it is more useful to undertake a functional assessment of personality. This is essentially a case formulation addressing the relevant areas of abnormal functioning (Gunn, 1993; Westen and Arkowitz-Westen, 1998). Gunn (1993) suggests listing the abnormal traits and the functional impairment or distress they cause under the headings 'thinking', 'feelings and emotions', 'behaviour', 'social functions' and 'insight'. The 'thinking' heading would include

any beliefs people have about themselves (e.g. low self-esteem) and their beliefs about others (e.g. everyone is hostile and untrustworthy). The 'feelings and emotions' heading would include any abnormalities in the quality or intensity of emotions. Gunn (1993) argues that setting out a functional analysis in this way gives a clearer picture of the therapeutic task by separating out different problems, each of which can be tackled in its own right.

PERSONALITY DISORDER PRESENTING AS PSYCHOLOGICAL DISTRESS AND PSYCHIATRIC SYMPTOMS

Individuals with personality disorder may present with psychiatric symptoms similar to those of people with other mental disorders. These symptoms can be distressing and relate to their abnormal ways of thinking and feeling or to social difficulties. Examples of the symptoms sometimes complained of include low mood, anxiety, insomnia, irritability, labile mood, feelings of emptiness and episodes of sudden intense rage.

The level of personal distress experienced by a patient cannot be used to distinguish whether that patient is suffering from a personality disorder or an Axis I disorder, despite suggestions that personality disorders may be less likely to present as a result of personal distress (Paris, 1996). Many individuals with personality disorder experience considerable distress as a result of their disorder, and not all patients with Axis I disorders experience distress (for example, the early stages of hypomania may be experienced as very pleasant by a patient).

PERSONALITY DISORDER PRESENTING WITH CO-MORBID AXIS I PSYCHIATRIC DISORDERS

Sometimes, presenting psychiatric symptoms may be due to a co-occurring Axis I psychiatric disorder. A large proportion of individuals with personality disorder present with Axis I disorders as their primary problem (Casey and Tyrer, 1990). Individuals with personality disorder are at greater risk of developing affective disorders, anxiety disorders, eating disorders, and substance misuse disorders (de Girolamo and Reich, 1993; Gunderson and Sabo, 1993; Links, 1996). It has also been suggested that patients with borderline personality disorder are particularly vulnerable to developing post-traumatic stress disorders in response to what for others would be sub-threshold stressors (Gunderson and Sabo, 1993). Less has been written about the co-occurrence of psychosis and personality disorder, but this is of particular relevance in forensic psychiatry in which a proportion of patients have a history of antisocial personality traits pre-dating the onset of their schizophrenic illness. (This is dealt with in more detail in Chapter 14.)

It is important to explore whether the distress or functional impairment experienced by an individual with personality disorder is being exacerbated by a superimposed Axis I disorder. Successful treatment of the Axis I disorder might improve the patient's functioning and quality of life.

Conversely, recognizing an underlying personality disorder has important implications for the management of Axis I disorders: having a personality disorder increases the severity of the symptoms; worsens the prognosis of treatment, especially of depression, anxiety disorder and obsessive–compulsive disorders; increases the likelihood of episodes of incomplete treatment; and is associated with longer and costlier treatments (Reich and Green, 1991; Tyrer et al., 1990).

Finally, it has been suggested that occasionally individuals with antisocial personality disorder may present with feigned mental symptoms in order to avoid the consequences of their law breaking by obtaining patient status rather than law-breaker status (Turkat, 1990). One must, however, be extremely

cautious about labelling someone as feigning, as it is possible to be genuinely distressed as well as to have difficulties accepting responsibility for one's own behaviour. In addition, if individuals repeatedly feign psychological symptoms, this itself may be a manifestation of an abnormal personality (Mullen, 1993).

PERSONALITY DISORDER PRESENTING AS PROBLEM BEHAVIOUR

Maladaptive and abnormal behaviours frequently bring individuals with personality disorders, especially Cluster B disorders, to the attention of professionals. These behaviours may or may not cause distress to the individual, but always lead to impairment of social and interpersonal functioning and may make others suffer.

Individuals with personality disorder tend to find maladaptive ways of reducing their psychological distress and bolstering their fragile self-esteem, for example with illicit or prescribed drugs, alcohol, self-harm or impulsive behaviours, including sexual promiscuity, binge eating, impulsive spending and reckless driving. Individuals may present as a result of any of the adverse consequences of these behaviours.

Self-harm is of particular concern, as it is often repeated and is associated with a higher risk of completed suicide. Patients with antisocial personality disorder have a much higher accidental and violent death and suicide rate than patients with other disorders (Martin et al., 1985). Patients with borderline personality disorder have been found to have a 3–9 per cent suicide rate on 15–20-year follow-up, which increased to 19 per cent if they were also alcohol dependent, and to 38 per cent if they were alcohol dependent and suffering from major affective disorder (Stone, 1993; de Girolamo and Reich, 1993).

The most common behaviours associated with personality disorder that present to services involved in the criminal justice system are criminal and antisocial behaviours. These may take the form of sexual or physical violence and aggression or repeated offences of other natures. Some definitions of antisocial personality disorder have been criticized for placing too great an emphasis on antisocial behaviour without including other abnormal traits. However, antisocial personality disorder is not synonymous with criminality: not all criminals have a personality disorder. It is not only antisocial personality disorder that is associated with antisocial behaviour. Many people with antisocial personality disorder also have features of other personality disorders, and individuals with other personality disorders but not antisocial personality disorder may engage in criminal behaviour. This is borne out by studies of populations of offenders in prison and special hospitals (Coid, 1992; Singleton et al., 1998).

Although maladaptive and problem behaviours may be one of the more common presentations of personality disorder, they are not diagnostic, and other mental disorders may present with problem behaviour. Taking a snapshot view and assuming that a patient presenting with a behaviour problem automatically has a personality disorder can lead to misdiagnosis. For some patients with Axis I disorders such as schizophrenia, schizoaffective disorder and bipolar disorder, symptoms such as behavioural disturbance, aggression and uncooperativeness may be associated with relapse of their illness. It is only by taking a longitudinal approach, and discovering that patients have episodes of normal behaviour when well, that misdiagnosis can be avoided.

PERSONALITY DISORDER PRESENTING WITH PHYSICAL SYMPTOMS AND DISORDERS

Individuals with personality disorder have high rates of physical morbidity as well as of

psychiatric morbidity, which have significant public health implications (Norton, 1992). This is because many dysfunctional behaviours may have adverse physical as well as psychological and social consequences. Substance misuse places individuals at risk of the physical consequences of acute intoxication, withdrawal, chronic use and the complications of injecting. Addictive behaviour may also place them at risk from tobacco-related illnesses. Sexual disinhibition may increase the risk of sexually transmitted disease. Self-harm and suicidal behaviour may have physical consequences. Individuals with personality disorder may present with head or other injuries due to accidents and violence. In addition, somatization disorder, characterized by multiple and recurrent physical complaints for which medical attention is sought and that are not due to any apparent physical cause, has been linked with personality disorder in women (Emerson et al., 1994; see Dowson, 1995a, for overview).

PERSONALITY DISORDER PRESENTING WITH SUFFERING OF OTHERS AND DYSFUNCTION IN INTERPERSONAL RELATIONSHIPS

Some of the most prominent features of personality disorder are profound interpersonal difficulties manifest in intimate, family, social and occupational relationships that cause the individual and those around him or her to suffer. Individuals with personality disorder may present in a number of ways as a result of these difficulties, for example, in crisis following the break-up of a relationship, contemplating suicide and self-harm or drinking heavily; causing concern by showing morbid jealousy or harassing a former partner; having relationship difficulties resulting from violent behaviour; suspected of child abuse or neglect; or in crisis having lost their accommodation or their job.

Individuals with antisocial personality disorder are more likely to be divorced, unemployed and engage in spouse or child abuse than the general population, and antisocial personality disorder is especially prevalent among the unemployed, homeless, wife batterers and child abusers. Antisocial personality disorder in parents is associated with psychiatric disorders in their children, which may be mediated, at least in part, by poor parenting (see Dowson, 1995a, and Moran, 1999, for overviews).

Individuals with personality disorder may present seeking help for themselves or under pressure from someone else. It is often useful to reflect on why an individual is presenting at a particular time and who suggested they seek help or brought them to the attention of services. This may provide a clue as to the areas of the individual's life that may be affected and to who else might be suffering.

WHERE PERSONALITY DISORDERS PRESENT

Personality disorders may result in a great deal of distress and behaviour that inevitably causes others to intervene (Dolan and Coid, 1993). This means that the sufferers present to a wide range of agencies in a wide range of settings.

PERSONALITY DISORDER PRESENTING TO HEALTH SERVICES

About one in ten of the general population are thought to have a personality disorder (de Girolamo and Reich, 1993). In primary care settings, Casey and Tyrer (1990) found that about a third of people attending general practitioners (GPs) had a personality disorder, even though for the vast majority it was not assessed by the GPs as the primary reason for presenting. Many of these patients had other co-morbid primary diagnoses such as anxiety, depression and alcohol misuse. Cluster C personality disorders are the commonest personality disorders encountered in

primary care attenders (Moran et al., 2000). Patients with personality disorder are more likely to be frequent GP attenders (Moran et al., 2001), and may present to accident and emergency departments or to general medical and surgical specialties with the physical and psychiatric symptoms described above.

Studies have confirmed that individuals with personality disorder are frequent users of in-patient, out-patient and emergency psychiatric services (Reich et al., 1989; Menzies et al., 1993; Saarento et al., 1997; Williams et al., 1998) and those with co-morbid Axis I disorders are amongst the heaviest users (Kent et al., 1995). It has been reported that, in England and Wales in 1985, only 7.6 per cent of psychiatric admissions had a personality disorder diagnosis (Department of Health and Social Security, 1985). However, these figures only included those patients for whom personality disorder was the only and main diagnosis. Studies using research diagnostic instruments have found that 20–40 per cent of psychiatric out-patients and about half of psychiatric in-patients fulfil the diagnostic criteria for a personality disorder, often in addition to other Axis I disorders (see de Girolamo and Dotto, 2000, Dowson, 1995b, and Moran, 1999, for overviews).

PERSONALITY DISORDERS PRESENTING TO CRIMINAL JUSTICE AGENCIES

Individuals with personality disorder do not present exclusively to medical services; those engaging in antisocial behaviour frequently present to the criminal justice system. Spence and McPhillips (1995) found that individuals with personality disorder accounted for the largest numbers of assessment of patients detained by police under Section 136 of the Mental Health Act 1983 in an area of London.

A survey of psychiatric morbidity in prisons estimated that 78 per cent of male remand prisoners, 64 per cent of male sentenced prisoners and 50 per cent of female prisoners had a personality disorder (Singleton et al., 1998). Coid (1992) found that 98 per cent of prisoners on special units for the management of dangerous and disruptive prisoners had a personality disorder. It is likely that individuals with personality disorder are over-represented amongst those prisoners presenting management problems, who often spend long periods in segregation or are moved frequently around the system because of the disruption they cause (Gunn et al., 1991).

In practice, it is apparent that a number of individuals with personality disorder are being managed by the probation service, which may be providing interventions for certain aspects of their disordered behaviour. For example, Dolan et al. (1995) found that 67 per cent of offenders attending an intensive probation programme that aimed to divert offenders from custody, reduce offending and facilitate change in psychological functioning and problems associated with offending behaviour fulfilled the diagnostic criteria for a personality disorder.

PERSONALITY DISORDER PRESENTING TO OTHER STATUTORY AND VOLUNTARY AGENCIES

In addition, individuals with personality disorder may present to a range of other agencies as a result of their social dysfunction. This includes agencies involved in child care, housing, employment, family law and debt collection. Those with paranoid personality disorder may present in the courts, litigating against their neighbours and others.

HOW PERSONALITY DISORDERS PRESENT AT INTERVIEW

Observation of patients' interactions and behaviours at interview can reveal much about the patients, their experiences and habitual

ways of interacting and how these lead them into difficulties. Individuals may relate to professionals in the same problematic way that they relate to others, which Westen (1997) found to be useful diagnostically to experienced clinicians. Patients with personality disorder often invite rejection and punitive reactions from others. Clinicians may feel they are being coerced or manipulated by patients who present as helpless and wanting the clinician to take control. The patients then frustrate the clinicians' attempt to do so, leaving the latter feeling angry, frustrated and helpless. Patients may appear ambivalent about treatment or present in crisis in a chaotic, unplanned way. Those with personality disorder may also provoke different reactions in different professionals, causing disagreements amongst them (referred to as splitting). Monitoring one's own reaction can thus alert one to the possibility that an individual who is presenting has a personality disorder.

Dowson (1995c) described in more detail the different ways that individuals with particular types of personality disorder may interact with clinicians. He suggested that patients with paranoid personality disorder may be guarded and suspicious and have concerns about confidentiality. Patients with borderline personality disorder often demand urgent help in a crisis and may present inconsistently and react catastrophically to changes in arrangements. Histrionic traits may be suspected if patients show dramatic mood variations during the interview and draw attention to themselves in the way they dress or behave. Individuals with narcissistic traits may appear to be trying to impress the clinician, and may be difficult to interview because of their condescending manner, demands for special treatment and questioning of the ability of the professional. Patients with obsessive–compulsive personality traits may be difficult to interview because their rigidity and attention to detail may make it difficult for them to get to the point, thus frustrating and irritating the clinician. Those with dependent traits may illicit impatience and irritation as an emotional response to their passive helplessness or, conversely, may induce some to provide extra help and become overly involved.

Whilst monitoring and reflecting on these reactions to patients is extremely useful in alerting one to the possibility of personality disorder, it is important to remember that not all patients who elicit negative reactions in clinicians have a personality disorder, and that not all patients with a personality disorder elicit negative reactions. As discussed earlier, a diagnosis of personality disorder can only be made when a longitudinal approach to the individual's life reveals that the way he or she is interacting in the clinical situation is part of a longstanding pattern that has been manifest for many years in a wide range of situations and relationships. Observing the patient longitudinally over time and in a number of settings is also particularly helpful. Jumping to conclusions on the basis of a one-off snapshot leads to misdiagnosis. Patients with mania or schizophrenia who are uncooperative and manifest behavioural disturbance as part of their illness are sometimes mislabelled as having a personality disorder and are rejected from services.

CONCLUSIONS

Individuals with personality disorder present in a range of ways to a range of agencies. They usually present as a result of personal distress, physical disorders, problematic behaviour, dysfunction in social, family, intimate and occupational relationships and/or as a result of the suffering of others. Personality disorders often present in association with co-morbid Axis I psychiatric disorders. Diagnosis is made on the basis of a longitudinal assessment of the presenting problems and the individual's life history. The correct identification and assessment of personality disorder have important implications for

service planning and individual case management. Lack of adequate knowledge about effective interventions and lack of adequate services are not valid reasons for failing to diagnose personality disorder.

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