Personality disorder and public mental health

Peter Tyrer

ABSTRACT – The diagnosis of personality disorder often appears to tell as much about the diagnoser as the diagnosed. For many it describes those who are deemed personally offensive, and as such it is not so much a diagnosis as a value judgment, the product of a negative interaction between two people that is given spurious respectability by a medical label. It is argued that these attitudes constitute a disastrous misperception of the truth, as personality disturbance (diathesis) in its many forms, including the unsatisfactory term 'disorder', is a highly significant contributor to human misery and handicap and a major cost to public mental health. It achieves this sorry record largely through stealth, because the current categorical system fails to embrace the breadth and heterogeneity of abnormal personality and the notion of offensive immutability makes the diagnosis a stigmatic one. This can be avoided by recoding personality in terms of severity. New treatments are now beginning to show evidence of efficacy and it is not unreasonable to hope that a condition that has been muttered about for years in parentheses will now be better recognised and defined, exposed without misunderstanding, and managed appropriately and well.

KEY WORDS: classification, costs, personality disorder, treatment

This article is based on the Milroy Lecture given at the Royal College of Physicians on 30 October 2007 by **Professor Peter Tyrer** FRCP FMedSci, Professor of Community Psychiatry, Imperial College London

Clin Med 2008;8:423–7

Introduction and history

The Milroy Lecture is traditionally an occasion to celebrate achievements in public health. This lecture, perhaps appropriately from the first psychiatrist, is doing the opposite; it is castigating the health professions for a failure to achieve, for hiding from view one of the major sources of suffering and health service costs in the developed world and failing to recognise its significance – personality disorder. In many ways this neglect is not unexpected. Personality disorder has until recently been in the fringes of psychiatry and sometimes attempts have been made to exclude it altogether, on the grounds that it did not belong to the mental health professions because it was untreatable. Bearing in mind that until a few years ago most psychiatric disorders were untreatable this appears to be a strange reason indeed. It began its life in the words of James Pritchard in 1835, as 'moral insanity', possibly the most left-handed of left-handed compliments as it cleared the subject of madness in general but questioned his ability to coexist with society. Later it became imbued with the notion of neurological degeneration, so after such poor beginnings it was difficult to resurrect as a diagnosis that the profession could respect. Yet, despite its negative connotations, psychiatrists, and indeed many other physicians, could not stop using the term as it was recognised that in the proper assessment of the psychiatric patients the traditional way in which they saw the world, whether described as style, character, temperament or personality, was an indissoluble component. The concept of personality disorder was finally nailed down by a committee, the task force for the *Diagnostic and statistical manual of mental disorders*, third edition (DSM-III) classification of personality disorders, in 1980, but failed basically because of a false premise, that it was possible to diagnose reliably and validly the individual categories of personality disorder first described by Schneider using defined operational criteria.[1,2] As a consequence, the individual disorders requiring classification today, such as paranoid, dependent and impulsive, are little more than labels used more in office gossip than office psychiatry and which are about as useful.[3] They also artificially separate pathological from normal when it is clear that some form of personality pathology is almost universal, and they hinder clinical practice as only practitioners in forensic psychiatry regularly use the term.

Resurrecting personality and public mental health

It is difficult doing research when the building blocks of your trade are defective, and in public health accuracy of diagnosis is of particular importance. Thus personality disorder is seldom diagnosed in official statistics, and there is considerable reluctance to use it in clinical practice too, except in snide asides directed conspiratorially to colleagues. It is curious to note that the prevalence of personality disorder steadily rises as patients ascend the pathways of care in psychiatry (Table 1) yet one seldom finds referral letters suggesting that a patient should be seen because of their personality pathology; they have problems such as 'extensive comorbidity', 'treatment

Table 1. Simplification of classification by clustering.

Cluster	Personality categories within cluster (DSM categories in brackets)	Title of cluster
A	Schizoid, paranoid, (Schizotypal)	Odd, eccentric group
B	Borderline, dissocial (anti-social), impulsive, histrionic, (narcissistic)	Flamboyant, erratic or dramatic group
C	Dependent, anxious (avoidant), obsessive-compulsive	Anxious or fearful group

DSM = *Diagnostic and statistical manual of mental disorders.*

resistance', or are 'difficult to manage in our team'. This reluctance to attribute the diagnosis to patients is because it is seemingly considered to be stigmatic. Thus in one study the diagnosis of personality disorder by clinicians in a community mental health team was compared with a research worker's formal diagnosis using a personality disorder schedule. Although when clinicians did make a diagnosis of personality disorder they were almost always accurate (specificity of 98.3%) but they failed to detect many identified as having personality disorder by the research workers (sensitivity 27.8%).[4] The argument that the research workers' diagnosis was defective was not sustained as the symptomatology and function of those 'research diagnosed' was very similar to that of those patients diagnosed as having a personality disorder by the clinician. With this in mind it is not surprising that the formal figures of personality disorder diagnosis are low, with only 1% of those diagnosed in low-income countries having a diagnosis of personality disorder in both inpatient and outpatient settings and between 3% and 8% in more affluent countries.[5]

New diagnostic structure

Personality disorder shows the same pattern of distribution as normal personality and is best viewed as a dimensional condition. Although the individual personality disorders in *International statistical classification of diseases and related health problems* (ICD)-10 and DSM-IV do not show much relationship with normal personality variation they can be aggregated into clusters (Table 1) and these show a closer relationship to the four main factors identified in the general population (cluster C can be split with a category reserved for obsessive-compulsive disorder only).

Current guidelines dictate that all have to accept the current classification, and whether physicians and psychiatrists choose to seek out or ignore the diagnosis of personality disorder, it will nevertheless impinge on their practice. In Table 2 the prevalence of personality disorder in populations in different settings is illustrated. The prevalence varies from 4–12% in community studies but in other settings it rises steeply from around 30% in primary care attendees to 40–50% in secondary care, and between 70–90% in prisons and tertiary psychiatric services. It is also likely to be at a level of around 35% in most medical outpatient settings although good prevalence data here are lacking.

The problems with classification include multiple comorbidity between other psychiatric diagnoses and with other personality disorders and these overall figures are of limited use. A more reliable way of classifying personality disorder is to use five levels of severity which remove the artificial boundary between normal and abnormal pathology (Table 3).[6] This extends from

Table 2. Increasing prevalence of personality disorder (research diagnosed) in settings where some form of pre-selection is present.

Authors (size of sample)	Prevalence of main personality disorders (%)	Setting
Casey *et al*, 1984 (171)[7]	34	Urban general practice in area of social deprivation
Moran *et al*, 2000 (303)[8]	24	Suburban general practice
Tyrer *et al*, 1983 (316)[9]	40	Mainly non-psychotic psychiatric outpatients
Keown *et al*, 2002 (193)[10]	52	Community mental health team
Fazel and Danesh, 2002 (22,790)[11]	65	Prisons
Ranger *et al*, 2004 (73)[12]	92	Assertive outreach team

Table 3. Classification of personality pathology by severity. Reproduced with permission from American Psychiatric Association.[6]

Level of pathology	Diagnostic attributes (derived from present classifications)
0 (no personality disorder)	No evidence of abnormal personality features
1 (personality difficulty)	Sub-threshold score (one point below) for the criteria necessary for the diagnosis of a personality disorder
2 (simple disorder)	Identified personality disorder(s) in one cluster only
3 (complex (diffuse) disorder)	Two or more personality disorders in more than one cluster
4 (severe disorder)	One or more personality disorders leading to gross societal disturbance

mild personality abnormality through to severe personality disorder, and currently the only service that recognises this formally is the Dangerous and Severe Personality Disorder (DSPD) programme of the Home Office and Department of Health.[13] This grading of severity has been shown to be valuable in practice and also helps to accommodate the large number of patients who are given the diagnosis (personality disorder – not otherwise specified – itself an indictment of the standard classification), which is large enough to be almost regarded as a separate cluster.[14]

The value of this severity classification is illustrated in Tables 4 and 5, which are derived from one of the few national morbidity surveys to make a comprehensive assessment of personality disorder.[15] Personality pathology in the UK survey was assessed in a two stage process, with over 8,000 individuals being assessed in the first stage using a screening instrument and from these a selected weighted group of 626 were given the full interview. The results are striking in two ways:

- they demonstrate the pervasive impact of personality disorder on employment, with its clear economic and societal impact
- the data from the screening interview shows that more people (6,437), 72.4% of the total sample (8,886), had some personality disturbance than did not, and although this threshold might be considered far too low, its relationship to employment was just as strong at low levels of pathology as at higher ones, with a clear gradation through increasing severity and highly significant associations of employment and personality status (Tables 4 and 5).

Employment is selected only for illustration purposes; the same applies to a host of other variables. It is partly for this reason that the term 'personality diathesis' is preferable to 'personality disorder'.[16] A very large number of people are affected by the diathesis, a much less stigmatising term than disorder, and, characteristically, it makes them vulnerable in all sorts of ways to the vicissitudes of life to a greater extent than those who lack the diathesis. It is also highly unfortunate that the official classification does not allow personality disorder to be diagnosed before the age of 18. Much of the genesis of personality disorder takes place in early years and if we were able to target pathology early or introduce preventive measures to those at risk the public health benefits would be enormous.[17]

The last reason for taking personality disorder more seriously is that, after years being in the no hope category, some effective treatments for the condition now exist. This is being taken on board by decision makers, and in this context it is relevant that the National Institute for Health and Clinical Excellence currently has two guideline development groups examining the evidence for interventions in two personality disorders, the borderline and antisocial (dissocial) ones.[18,19] The gains of successful treatment are not yet, in public health terms, likely to have significant impact, but they hold promise and may offer clues about successful prevention.

Available treatments

It is first important to emphasise that most patients with personality disorder do not desire treatment. Less than one in three patients with a personality disorder are type S (treatment seeking), most are type R (treatment resisting),[20] and the proportion in the ordinary population is only around one in five (Kirby *et al*, to be published). This sometimes appears odd to those who see lives devastated by those who have these conditions, but sufferers often show a surprising lack of awareness of the consequences of their behaviour and frequently remain indifferent or blame others for the chaos and distress that follows their actions and interactions. There is one exception. The personality disorder that stands out from all the others in being often associated with intense and determined treatment seeking is borderline personality disorder. I personally feel that this, and other characteristics such as identity and mood disturbance, makes it so unlike other personality disorders that it ought to be considered a separate and important syndrome among the emotional disorders,[21] but at present it continues to remain within the ambit of personality disorders. In one sense this is a gain, because the attention paid to borderline personality disorder has stimulated interest in other disorders that would otherwise have been completely neglected. However, when taking the evidence from studies of treatment of borderline personality disorder the dangers of extrapolation to conditions which are very different, as are the attitudes of those exposed to the same treatment, should be remembered.

Table 4. Employment and personality status by severity of personality disorder in weighted sample of 626 subjects in UK National Survey (χ^2 = 35.17, df=9, p<0.0001). Tyrer, Coid and Yang, 2008, to be published.

Occupation	None (%)	Difficulty (%)	Disorder (%)	Complex (%)
Full time	214 (76.7)	49 (17.6)	15 (5.4)	1 (0.4)
Part time	98 (86.0)	10 (8.8)	3 (2.6)	3 (2.6)
Unemployed	14 (66.7)	1 (4.8)	5 (23.8)	1 (4.8)
Inactive	139 (67.1)	36 (17.4)	24 (11.6)	8 (3.9)

Table 5. Employment and personality status by severity of personality disorder[6] in original sample in UK National Survey scoring at some level of personality abnormality (only 2449 had no personality disturbance) (χ^2 = 66.9, df=9, p<0.0001).[1] Tyrer, Coid and Yang, 2008, to be published.

Occupation	None (%)	Difficulty (%)	Disorder (%)	Complex (%)
Full time	984 (23.9)	2,018 (49.0)	862 (20.9)	253 (6.1)
Part time	382 (25.0)	768 (50.3)	269 (17.6)	107 (7.0)
Unemployed	49 (19.5)	101 (40.2)	65 (25.9)	36 (14.3)
Inactive	513 (20.8)	1,158 (46.9)	589 (23.8)	211 (8.5)

Drug treatments

The main drivers behind many therapeutic advances in psychiatry have been drug treatments such as imipramine for depression and chlorpromazine for schizophrenia, but the same cannot be said for personality disorders on current evidence. Although drug treatment is widely used in the treatment of personality disorder – indeed, polypharmacy is sadly almost the norm in borderline personality disorder[22] – there is little evidence of substantial benefit either in the short or longer term with any of the drugs – antipsychotics, mood stabilisers and selective serotonin reuptake inhibitors (SSEIs) commonly used to treat any of the individual personality disorders. This does not mean drugs are not of help at times; it is just that the evidence base is very limited at present and may have been oversold.[23]

Psychological treatments

Ever since Sigmund Freud first noted the importance of the 'neurotic character' in treatment there has been strong interest in the psychological treatment of personality disorder. On the positive side a number of treatments for borderline personality disorder exist that have been, or are in the process of being, manualised and which have shown some relatively convincing evidence of benefit over periods ranging from six months to three years. These include dialectical behaviour therapy, mentalisation-based therapy, cognitive behaviour therapy, schema-focused therapy, transference-focused and cognitive analytical therapy.[24] There is now an evidence base for at least some level of effectiveness for most of these but a negative aspect from the point of view of public mental health is that they are time consuming (all involving many hours of individual therapy and often group work also), require staff to be trained to deliver the intervention, require checks on the fidelity of the intervention, and need considerable motivation from the patient. It is also unknown if there are specific elements in the psychological therapy that are intrinsic to success, as without these it is possible to conclude that any coherent psychological treatment addressing the central features of personality disorder are as successful as any named therapy.

Treatments for type R personality disorders

Those with type R personality disorders create more distress to themselves and others yet paradoxically do not want treatment. This particularly applies to those with antisocial (dissocial) personality disorder, 9 out of 10 of whom do not want any form of treatment spontaneously.[20] This number rises to nearly 50% when there is an element of coercion involved, as for example in the DSPD programme where prisoners feel that early parole may be given if they cooperate with a treatment programme, but is unlikely to represent a true expression of their wishes.[25]

A new intervention, nidotherapy (from *nidus,* L. 'nest'), has recently been introduced which does not attempt to change patients' symptoms or behaviour directly but instead concentrates on changing the environment in a systematic and collaborative way.[26–27] The great advantages of this approach, which involves a nidotherapist helping to formulate a patient's needs and wishes and testing out their feasibility, are that it is well received by those who are excited by the possibility of the world fitting into their wishes rather than them having to force themselves, in a Procrustean fashion, into fitting in with the world. While the notion of using a change in the environment to help people is hardly new in medicine, most such changes have been regarded as temporary for the purposes of effecting recovery rather than as permanent solutions to underlying handicap. Part of the reluctance to embrace environmental interventions is that in this day and age we are aggressively therapeutic in medicine; we are no longer satisfied with the concept of disability as a permanent feature, but regard people with continuing handicap as suffering from 'treatment resistance' or a chronic but still eminently treatable condition that is just waiting for the discovery of the right remedy.

Nidotherapy may have important implications for public mental health, but it is far too early to make predictions. It developed from experiences in assertive outreach teams, one of the tertiary services in psychiatry where patients are referred when all other treatments, evidence based and evidence free, have failed. These patients tend to have multiple psychopathology, with more than 90% showing significant personality disorder as well as severe mental illness.[12] Nidotherapy-enhanced care, in a pilot randomised trial of 52 patients, was shown to improve some aspects of psychopathology, reduced inpatient bed use greatly, and as a consequence made considerable cost savings (Ranger *et al*, to be published). Nidotherapy may also be of value in the treatment of antisocial personality disorder, where antipathy to other psychological treatments is often pronounced. It is also being developed for the treatment of autistic spectrum disorders and intellectual disability.

There is now a reasonable prospect that the poorer outcome of comorbid disorders such as personality disorder and depression can be corrected by not just treating the mental state disorder but also the personality one using a combined strategy in which both pathologies are addressed.[26]

Where do we go now?

Personality abnormality, however imperfectly it is described, represents one of the major unsolved problems of public health.[27] It is beginning to be appreciated by the current Labour government, perhaps more so than any other, as a threat to quality of life, an important drain on public finances and a stigmatised grossly under-appreciated subject in clinical practice. When all the excitement about early interventions in psychosis, breakthrough in the genetic pathways to common psychiatric disorders, and a dramatic increase in the introduction of psychological therapies, has died down, the diathesis of personality vulnerability will stand up boldly and say, 'good, now you've solved these problems, what about me?'. It is our collective task to ensure we are ready to deal with this challenge when the appropriate resources come our way.

Acknowledgements

I thank Min Yang and Jeremy Coid for providing statistics from the UK National Morbidity Survey, Phil Harrison-Read for stimulating the development of nidotherapy, the National Forensic Programme for Mental Health for grant support, and Kate Davidson, Conor Duggan, Giles Newton-Howes, Helen Seivewright, Tim Weaver, Anthony Bateman, Barbara Barrett and Roger Mulder for assisting me in preventing the subject of personality disorder from becoming lost to general view.

References

1 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders.* Washington DC: American Psychiatric Association, 1980.
2 Schneider K. *Die psychopathischen Persönlichkeiten.* Vienna: Deutike, 1950.
3 Livesley WJ, Jackson DN. The internal consistency and factorial structures of behaviors judged to be associated with DSM-III personality disorders. *Am J Psychiatry* 1993;143:1473–4.
4 Newton-Howes G, Weaver T, Tyrer P. Stigmatic perceptions of staff towards patients with personality disorder in community mental health teams. *Aust NZ J Psychiat* (in press).
5 Saxena S, Lora A, van Ommeren M *et al.* Assessment Instrument for Mental Health Systems: collecting essential information for policy and service delivery. *Psychiatr Serv* 2007;58:816–21.
6 Tyrer P, Johnson T. Establishing the severity of personality disorder. *Am J Psychiatry* 1996;153:1593–7.
7 Casey PR, Dillon S, Tyrer PJ. The diagnostic status of psychiatric patients with conspicuous psychiatric morbidity in primary care. *Psychol Med* 1984;14:673–81.
8 Moran P, Jenkins R, Tylee A *et al.* The prevalence of personality disorder among UK primary care attenders. *Acta Psychiat Scand* 2000; 102:52–7.
9 Tyrer P, Casey P, Gall J. The relationship between neurosis and personality disorder. *Br J Psychiatry* 1983;142:404–8.
10 Keown P, Holloway F, Kuipers E. The prevalence of personality disorders, psychotic disorders and affective disorders amongst the patients seen by a community mental health team in London. *Soc Psychiatry & Psychiat Epidemiol* 2002;37:225–9.
11 Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. *Lancet* 2002;359:545–50.
12 Ranger M, Methuen C, Rutter D *et al.* Prevalence of personality disorder in the caseload of an inner city assertive outreach team. *Psychiat Bull* 2004;28:441–3.
13 Home Office and Department of Health. *DSPD Programme: Dangerous People with Severe Personality Disorder Initiative: Progress Report.* London: Home Office, 2001.
14 Verheul R, Bartak A, Widiger T. Prevalence and construct validity of Personality Disorder Not Otherwise Specified (PDNOS). *J Personal Disord* 2007;21:359–70.
15 Coid J, Yang M, Tyrer P, Roberts A, Singleton N. Prevalence and correlates of personality disorder among adults aged 16 to 74 in Great Britain. *Br J Psychiatry* 2006;188:423–31.
16 Tyrer P. Personality diatheses: a superior explanation than disorder. *Psychological Med* 2007;37:1521–5.
17 Coid JW. Epidemiology, public health and the problem of personality disorder. *Br J Psychiatry* 2003;182(Suppl 44):s3–s10.
18 National Institute for Health and Clinical Excellence. *Personality disorders – borderline: consultation on the draft guideline.* London: NICE, in preparation. www.nice.org.uk/guidance/index.jsp?action=folder&o=40839
19 National Institute for Health and Clinical Excellence. *Antisocial (dissocial) personality disorders: treatment, management and prevention.* London: NICE, in preparation. www.nice.org.uk/guidance/index.jsp?action=byid&o=11650
20 Tyrer P, Mitchard S, Methuen C, Ranger M. Treatment-rejecting and treatment-seeking personality disorders: Type R and Type S. *J Personal Disord* 2003;17:265–70.
21 Tyrer P. Borderline personality disorder: a motley diagnosis in need of reform. *Lancet* 1999;354:2095–6.
22 Zanarini MC, Frankenburg FR, Hennen J, Silk KR. Mental Health Service utilization by borderline personality disorder patients and Axis II comparison subjects followed prospectively for 6 years. *J Clin Psychiatry* 2004;65:28–36.
23 Newton-Howes G, Tyrer P. Pharmacotherapy for personality disorders. *Expert Op Pharmacother* 2003;4:1643–9.
24 Verheul R, Herbrink M. The efficacy of various modalities of psychotherapy for personality disorders: a systematic review of the evidence and clinical recommendations. *Int Rev Psychiatry* 2007;19:25–38.
25 Tyrer P, Barrett B, Byford S *et al. Evaluation of the assessment procedure at two pilot sites in the DSPD programme (IMPALOX Study).* London: Home Office, 2007.
26 Newton-Howes G, Tyrer P, Johnson T. Personality disorder and the outcome of depression: a meta-analysis of published studies. *Br J Psychiatry* 2006;188:13–20.
27 Tyrer P, Coombs N, Ibrahami F *et al.* Critical developments in the assessment of personality disorder, *Br J Psychiatry* 2007;190(Suppl 49): s51–s59.