26.5.13 Personality disorders 6520 Iain Jordan

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SECTION 26 Psychiatric and drug-related disorders 6520 Psychological treatment The most widely used psychological treatments for SSD are behav- ioural or cognitive behavioural therapy (CBT). These therapies aim to help the patient change the thinking (cognitions) and ways of coping (behaviour) that are perpetuating their symptoms and asso- ciated concerns. Systematic reviews of CBT have found it be to mod- erately effective in SSD, but the psychological treatment of severe cases of SSD requires considerable expertise. Referral Reasons to refer patients with possible SSD include diagnostic un- certainty and the need for specialist management. Liaison psychiat- rists can be helpful both in reaching a positive diagnosis of SSD and in addressing the psychiatric differential diagnosis. Specialist med- ical services may be available for the treatment of particular symp- toms, for example, for chronic pain or chronic fatigue syndrome. Specialist psychology services may be able to offer cognitive behav- ioural therapy for SSD. How to refer When explaining the referral to the patient, it is wise to be positive about the service you are referring to. If you are referring them to a psychiatry or psychology service it is important to emphasize that the referral does not mean you regard the patient's symptoms as 'not real' or 'all in the mind'. A patient is more likely to attend the service to which you have referred if you say: 'I see you have real and troublesome symptoms. I am pleased to tell you that I can't find any evidence of serious disease but I am sorry to say that I do not have a simple cure that I can prescribe. However, I can recommend and refer you to a specialist service for your problem', than if you tell them: 'There is clearly nothing wrong with you; it must all be in your mind. There is nothing to do now but to refer you to the shrinks.' Management of severe SSD Patients with complex and severe SSD pose particular management challenges. They may seek care from multiple doctors and be per- plexing and challenging to manage, especially if they also have a serious medical condition. The help of a liaison psychiatrist should be sought early and a management plan agreed with all concerned, including the patient's primary care physician if possible. This is often best achieved by holding a case conference. The agreed plan should limit referrals and investigations and include proactive regular re- view of the patient, if possible by a single physician. Although time-consuming in the short term, this approach can both reduce iatrogenic harm and save time and resources in the longer term. Prognosis The prognosis of SSD will depend both on the nature of the patient's

presentation and how it is managed. Untreated, the prognosis for pa- tients with SSD severe enough to be referred to secondary care is not good, particularly if the disorder is not well managed. The prognosis is best for those patients who were well before the onset of symptoms and who have clear depressive and anxiety symptoms. It is worst for those patients with very long-standing multiple symptoms. Areas of uncertainty and controversy Many aspects of the nature and management of SSD are controver- sial. The core issue is whether it is best regarded as a psychiatric/ psychological problem or as a medical condition, with the risk that the patient may end up abandoned in a medical 'no man's land'. This problem has been played out particularly prominently in the de- bate over the chronic fatigue syndrome/myalgic encephalomyelitis.
A consideration of the changing medical fashions for the explan- ation of such symptoms over the last few hundred years should en- courage humility and suggests that current controversies may tell us more about the inadequacies of our conceptualization of illness and our health services than they do about our patients. FURTHER READING American Psychiatric Association (2013). Somatic symptom and re- lated disorders. In: Diagnostic and stastical manual of mental dis- orders, 5th edition (DSM-5). American Psychiatric Association, Arlington, VA. Dimsdale JE, et al. (2013). Somatic symptom disorder: an important change in DSM. J Psychosom Res, 75, 223–8. Kroenke K (2014). A practical and evidence-based approach to common symptoms: a narrative review. Ann Int Med, 161, 579–86. Sharpe M (2013). Somatic symptoms: beyond 'medically unexplained'. BJ Psych, 203, 320–1. Stone J, Carson A, Sharpe M (2005). Functional symptoms and signs in neurology: assessment and diagnosis. J Neurol Neurosurg Psychiatry, 76, i2–12. Stone J, Carson A, Sharpe M (2005). Functional symptoms in neur- ology: management. J Neurol Neurosurg Psychiatry, 76, i13–21. 26.5.13 Personality disorders Iain Jordan ESSENTIALS People have characteristic ways of perceiving, thinking about, and responding to the world around them that are relatively stable over time and across situations; this is referred to as their personality.
A diagnosis of personality disorder is made when the personality is extreme and maladaptive and causes difficulty or distress to the person themselves or to others. People with personality disorders are often encountered in medical settings, which may be because they have self-harmed, suffered problems from drug or alcohol use, or been injured because of unwise behaviour. Personality disorders also complicate the medical management of medical conditions, for ex- ample, by nonadherence to recommended treatment. The effective short-term management of personality disorders in medical settings requires: (a) recognition of the diagnosis; (b) creation of a manage- ment plan; and (c) consistent response to the problematic behav- iours adhered to by all relevant staff.

26.5.13 Personality disorders 6521 Introduction Everyone develops their own way of perceiving, thinking about, and relating to the world that is stable over time and across situations, which we call personality. Personality is a summary description of the pattern of these traits in an individual. Personality is usually ap- parent by mid-adolescence and remains relatively stable thereafter. At times of stress specific personality traits such as impulsiveness or suspiciousness may become more noticeable. Personality may be regarded as disordered when the traits are ex- treme and problematic, leading to distress and difficulty for the af- fected person and/or those who interact with them. Diagnostic classifications for personality disorder list many dif- ferent types. These are conventionally grouped into three clusters (see Table 26.5.13.1): • Cluster A (eccentric) includes paranoid, schizoid and schizotypal personality disorders; • Cluster B (dramatic) includes antisocial (also called psychopathic or dissocial), borderline (also called emotionally unstable), histri- onic and narcissistic personality disorders; • Cluster C (anxious) is composed of avoidant (also called

anxious), dependent, and obsessive-compulsive personality disorders. Describing personality disorders in a categorical way provides a useful shorthand but is artificial as personality traits and personality disorders are dimensional, meaning that the traits merge both into one another and into normality. Aetiology The aetiology of personality disorders is a result of an inter- action of genetic and environmental factors. There is evidence that genetic factors contribute both to personality traits such as impulsivity, neuroticism, and extraversion, and to personality disorders, especially obsessive-compulsive and dissocial types. Environmental factors such as early childhood experiences and adverse experiences such as neglect and abuse are also important contributors. Epidemiology By definition, the onset of personality disorder is in adolescence or early adulthood, although individuals may not come to the attention of medical services until later in their life when circumstances lead to an exacerbation of the resulting difficulties. Studies of the general population report prevalence estimates 4–22%, depending on the definition of disorder. They also suggest that the overall prevalence is similar in males and females. Clinical features The main features of the different types of personality disorders are described in Table 26.5.13.1. Clinicians working in general hospitals may encounter patients with personality disorders in several ways (see Box 26.5.13.1). In the emergency department, personality disorder is commonly associated with self-harm, injury because of combative, chaotic, or abusive relationships and disturbed behaviour, or because of sub- stance misuse. In inpatient and outpatient settings, personality disorder may manifest as noncompliance with treatment, unusual behaviour, and extreme emotional responses to events or as abnormal relationships Table 26.5.13.1 Features of specific personality disorders Cluster Specific personality disorder Features A Paranoid Distrust and suspicion of others Bears grudges Perceives threats and attacks on character or reputation Reluctant to confide in others Schizoid Detached, emotionally cold Little interest in social relationships Restricted range of activities Indifferent to praise or criticism Schizotypal Odd beliefs, behaviour, or speech Unusual perceptual experiences Suspiciousness Acute discomfort with close relationships B Antisocial Disregard for rights of others Deceitfulness, irresponsibility Impulsivity, aggression Lack of remorse Borderline Unstable personal relationships Impulsivity, recurrent self-harm, and suicidal behaviour Chronic feelings of emptiness, marked reactivity of mood Frantic efforts to avoid abandonment Histrionic Excessive emotionality and attention-seeking Inappropriate provocative behaviour Suggestible Theatrical, uses physical appearance to draw attention Narcissistic Grandiosity, need for admiration Preoccupied with fantasies of unlimited success or brilliance Sense of entitlement, believes self to be special Lack of empathy, exploits others to achieve own ends C Avoidant Socially inhibited, avoids activities with others Feelings of inadequacy, fear of being shamed or ridiculed Views self as socially inept Preoccupied with being rejected Dependent Excessive and pervasive need for advice and reassurance Goes to excessive lengths to obtain nurturance and support Feels helpless when alone Submissive, fears separation Obsessive- compulsive Preoccupation with orderliness Perfectionism that interferes with task completion Overly scrupulous and inflexible Unable to discard objects

SECTION 26 Psychiatric and drug-related disorders 6522 with staff. It is the nature of personality disorder that clinical staff may find themselves behaving differently toward the affected pa- tient. For example, they may have unusually strong emotional re- actions to such patients, both negative and positive. They may also treat them differently, for example, by booking additional consult- ations or avoiding conversations with them. Case examples Case 1. A 22-year-old woman presents to the emergency depart- ment after taking an overdose. She felt rejected by her boyfriend who had not called her for three days. She has taken multiple over- doses in the past and reports being

sexually abused by her uncle. The clinical team are split into those who feel very sorry for her and those who consider her actions irresponsible and wasteful of healthcare resources. The diagnosis is borderline personality disorder. Case 2. A 45-year-old man has been admitted to hospital for a knee arthroscopy. He calls the nursing staff every 20 minutes for pain relief or to ask their advice about whether he should have the operation. He telephones his partner repeatedly to seek re- assurance and becomes inconsolable when he cannot reach them, fearing he will be left to take care of himself. The diagnosis is de- pendent personality disorder. Differential diagnosis The main differential diagnosis of personality disorders is a normal personality under stress (adjustment disorder). Other differentials include exacerbation of normal personality traits due to depression, psychotic disorders such as schizophrenia or delusional disorder (especially for the cluster A personality disorders), bipolar disorder (especially for borderline personality disorder), altered personality due to a medical disorder (for examples, see Box 26.5.13.2), and substance misuse disorders. Assessment Care should be taken in diagnosing someone with a personality dis- order. The diagnosis may have long lasting negative consequences for the patient and may be misused to apportion blame solely to them for any difficult clinical interactions. While personality dis- order often contributes to difficult interaction with doctors, such difficulties may also reflect a variety of factors unrelated to the patient's personality. It is consequently important to distinguish long-term, stable, mal- adaptive personality traits that have been present since adolescence or early adulthood from transiently severe disturbances of behav- iour. The diagnosis requires an assessment of personality traits and functioning over the long term and in many different situations, thus it is often necessary to obtain collateral information from other people such as their friends, family, and primary care physician. While the diagnosis of personality disorder requires that the patient's behaviour is not better explained by another mental dis- order, it is important to note that many patients with personality disorders also have comorbid mental conditions, for example, depression, anxiety disorders, and substance misuse disorders. Assessment for the presence of these comorbid disorders is im- portant as treatment of them may improve the patient's behaviour. It is also important to assess any risk that the patient with personality disorder may pose to themselves and to others. If a diagnosis of personality disorder is made, the following should be specified: • The behaviour upon which this is based. • The specific personality disorder type (or a cluster level diagnosis given with the relevant elements of each specific personality dis- order described, for example, if the patient has a cluster A type personality disorder with elements of borderline and antisocial personality disorders). • It can be helpful to also note positive as well as negative person- ality attributes. • Situations or stressors that are recurrently problematic for the person should be described along with their typical response (e.g. feelings of abandonment after discharge from medical care leading to self-harm). Treatment An adult's personality cannot, by definition, be substantially altered. The overall aim of treatment for personality disorders is therefore to help the patient to be aware of their most problematic personality traits, to identify the stressors that lead to difficulties, and to develop better strategies to manage them. Box 26.5.13.1 Modes of presentation of personality disorder to the general or specialist physiciana • Emotional distress • Self-harm, including nonfatal self-harm and suicide attempts • Interpersonal conflict manifest in medical consultations or on the wards • Substance misuse • Multiple medically unexplained symptoms • Consequences of chaotic lifestyle/impulsivity/interpersonal problems • Victim or perpetrator of violence or abuse (e.g. through the criminal justice system) • The medical consequences of impulsivity and intoxication a Note that these presentations are not specific to individuals with personality disorder. Box 26.5.13.2 Examples of medical disorders which may cause personality change • Central nervous system neoplasms (primary or metastatic) •

Cerebrovascular disease • Epilepsy • Huntington’s disease • Hypothyroidism • Infections affecting the central nervous system • Paraneoplastic syndromes • Traumatic brain injury

26.5.13 Personality disorders 6523 The specific aims of treatment depend on the type of personality disorder and the associated problematic perceptions, thoughts, and ways of coping. They may include reducing emotional dis- tress, improving compliance with medical treatment, stopping self-harming behaviour, and in the case of antisocial personality disorder, reducing the risk of aggressive behaviour. The treatment of coexisting psychiatric disorders, including substance misuse, is important as such comorbidity can greatly exacerbate problematic behaviour in people with a personality disorder. Several psychological treatments are used to treat people with per- sonality disorder. These include behavioural therapy, dialectic be- haviour therapy, cognitive analytic therapy, psychodynamic therapy, and therapeutic community-based approaches. Dialectic behavioural therapy (see Box 26.5.13.3) is used for the treatment of so-called borderline or emotionally unstable person- ality disorder. It includes individual therapy (focused on the reduc- tion of self-harming behaviour and improvement in quality of life), group-based skills training (focused on increasing tolerance of dis- tress, improving interpersonal relationships, regulating emotions, and mindfulness) and telephone contact at times of crisis. There is a limited role for drug treatment of personality disorder. There is some evidence for the use of antipsychotics and mood-stabilizing medication to treat impulsivity and aggression in people with borderline personality disorder. There is less evidence for the use of antidepressant medication, but comorbid mental disorders such as anxiety and depression may respond well to pharmacotherapy. Admission to a psychiatric hospital ward is rarely helpful as it may exacerbate rather than reduce problem behaviours and may lead to problematic interactions with other patients. This is therefore usu- ally reserved for those cases where risk to self or others cannot be satisfactorily managed in the community. The successful management of personality disorder in the medical setting requires the recognition of the problem and a clear and con- sistent plan for how to respond to the patient’s behaviour. A written care plan can be helpful. It is important that all clinicians involved in the patient’s care understand that the person has a diagnosis of personality disorder and what specific problems that poses both for the patient and those caring for them. It is important for staff to rec- ognize what difficulties arise in interactions with the patient, to be aware of these, and to avoid being drawn into behaving in a dismis- sive, punitive, or overly caring way. Outcome By definition, personality disorders tend to persist. Patients with personality disorders with traits such as sensitivity to rejection and impulsive behaviour are at increased risk of suicide and other causes of premature mortality. However, many of the problematic behaviours associated with some types of personality disorder, such as self-harm, excessive use of healthcare services, aggression, and offending behaviours, tend to improve over time. FURTHER READING Goves, JE (1978). Taking care of the hateful patient. N Engl J Med, 298, 883–7. Stoffers JM, et al. (2012). Psychological therapies for people with bor- derline personality disorder (Review). Cochrane Database Syst Rev, 8. CD005652. Tyrer P, Reed GM, Crawford MJ (2015). Classification, assessment, prevalence, and effect of personality disorder. Lancet, 385, 717–26. Box 26.5.13.3 Dialectical behaviour therapy for the treatment of borderline personality disorder Dialectics is a philosophical term which describes the process of re- solving seemingly contradictory positions. Core dialectic of dialetical behavioural therapy: The individual learns to accept the way they are, while at the same time, striving to make positive changes in their life. Structure of dialetical behavioural therapy

1. Individual therapy addresses the core treatment goals: • Reduction of self-harming behaviour • Reduction of behaviours that interfere with therapy • Improvement of quality

of life

2. Group-based skills training: • Distress tolerance aims to improve the person’s ability to tolerate and manage extreme distress. • Interpersonal effectiveness aims to teach skills which allow im- proved interpersonal relationships. • Emotion regulation aims to improve the ability to control disturb- ances in mood and other distressing emotions. • Mindfulness is a set of skills whose aim is to cultivate greater awareness of the current state of the mind and body, instead of becoming preoccupied with worries and falling into a spiral of distressing emotion.
3. Individuals may also telephone their therapist during crises to learn how to use skills in real-life situations.
4. Therapists meet weekly for group supervision with other practitioners of dialetical behavioural therapy where issues relating to therapy can be discussed.

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