Personality (behavioural) disorders

Personality (behavioural) disorders - F60 (Clinical term: Disorders of adult personality and behaviour Eu60).

Some people find the term 'Personality disorder' inflammatory, and it is therefore perhaps preferable to talk to the patient about their ‘personality difficulties’.

Presenting complaints

Patients may present in a variety of ways:

- Constantly worrying or displaying excessive dependence on the primary care team
- Repeated consultations, including for unexplained physical symptoms
- Threatening self-harm or aggressive behaviour
- Intense and superficial relationships
- With complaints of another mental disorder: depression, anxiety, eating disorders and addictions are all more prevalent
- Impulsive or threatening behaviours, eg repeated self-harm.

These patients are usually difficult with multiple social problems; and they may have a previous history of problematic dealings with the health service. They are more likely to attend in a crisis but may then fail to re-attend for follow-up appointments.

Alternatively, the patient may come to the attention of the primary care team because of the impact their behaviour is having on others:

- Family and carers may express concern about the patient’s behaviour (eg threatening behaviour, self-harm).
- Through their antisocial behaviour, in which case they may be referred by the Criminal Justice System.

Diagnostic features

- Maladaptive patterns of behaviour, thinking and control of emotions.
- Disturbance is enduring and not limited to episodes of mental illness.
- Disorder leads to considerable personal distress and/or significant problems in occupational and social functioning.
- Early manifestations (eg conduct disorder) may appear in childhood, but Personality disorder should not be diagnosed in someone under the age of 18.

ICD-10 recognizes nine subcategories of Personality disorder, each with its own set of diagnostic criteria. They fall into three groups:

- **Group A:** Paranoid and schizoid; characterized by oddness, difficulty mixing with others and paranoid thinking
- **Group B:** Dissocial, emotionally unstable (impulsive type and borderline type) and histrionic; characterized by problems with impulse control, affect regulation and relationship instability

- **Group C:** Anankastic, anxious and dependent; characterized by anxiety, excessive dependency on others and obsessional behaviour.

Differential diagnosis

Although other mental disorders can occur in the context of a personality disorder, a primary diagnosis of personality disorder should only be made in the absence of mental illness. If possible, obtain an informant's account of the patient's personality.

Consider the following, particularly when behaviour is 'out of character':

- Depression - F32#
- Acute to chronic (persistent) psychotic disorder - F23, F20#
- Anxiety disorders
- Drug use disorders - F10 - F19#; these commonly occur in people with dissocial and emotionally unstable personality disorders
- A medical condition causing personality change (eg head injury, acute confusional state, Dementia – F03#.

Essential information for patient and family

- Mental illness and addictions occurring in people with personality disorders are treatable.
- Modification of problematic behaviour is possible, but the patient must be motivated to change his/her behaviour.
- Specialist treatment consists of a combination of psychological treatments (including group and individual psychotherapies) reinforced by drug therapy at critical times.
- Treatment of any sort (including for associated conditions) requires the patient's active involvement. The relationship with the professional concerned is crucial.

General management and advice to patient and family

(ref 195)

- Consistency and continuity in approach, basic problem-solving techniques, and assistance in containing psychological stress form the foundation for the clinical approach to these patients.
- Difficulties with others can be minimized, if the person is taught to avoid situations that lead them into conflict with others (eg avoiding group living if mixing with others makes them anxious).
- Ensure that both the patient and others involved in their care understand the treatment plan and aims.
- The practitioner needs to be very clear about his/her role and its boundaries.
- The practitioner needs to communicate effectively with others in their team. If several health professionals are involved in the patient's care, ensure that a consistent approach is adopted.
- Professional disputes about patient care (which commonly occur with this patient group) can be minimized by holding regular meetings with those involved with the patient.
- Establish a clear protocol for how all members of the team will respond to the patient during a crisis. Crisis contacts should be brief, focused and goal-oriented. If possible, give the patient some responsibility for resolving the crisis.
- Treat co-morbid conditions.

- Focus on immediate, everyday problems. The aim is not to cure the personality disorder but to help the patient deal with everyday life. Behavioural disturbances associated with Personality disorder tend to improve with advancing age.
- Specialist treatment of personality disorders consists of a combination of psychological treatments reinforced by drug therapy.
- Personality-disordered patients can be supported by a primary care team in conjunction with input from specialist psychiatric services where appropriate. The support generally needs to be long-term and the style of consultation needs to be adapted to the type of personality disorder that the patient has.

References

195 UK Department of Health guidelines on personality disorder. Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. URL http://www.doh.gov.uk/mentalhealth/personalitydisorder.htm.

Medication

(ref 195)

Medication, while of some benefit, is not the mainstay of treatment.

- Antidepressant medication: SSRIs have a growing evidence base in the management of impulsive behaviour (ref 1).
- Low-dose atypical antipsychotic medication: may help to reduce paranoid ideation and the level of arousal experienced by some personality-disordered patients. However, the long-term effectiveness is not yet established.
- Mood stabilizers: may help to ease the affective instability experienced by those with an emotionally unstable personality disorder.

Be mindful of the possibility of overdose in this group of patients.

References

1 World Health Organization. Schizophrenia: An International Follow-up Study. Chichester: John Wiley & Sons, 1979. (AIV) Large outcome study with two-year follow-up, showed that only 10-15% of patients did not recover from their illness in that two-year period. Another shorter-term follow-up study (Lieberman J, Jody D, Geisler S et al. Time course and biologic correlates of treatment response in first episode schizophrenia. Arch Gen Psychiatry 1993, 50: 369-376) showed that 83% of first-episode psychotic patients treated with antipsychotic medication remitted by one year post-inpatient admission.

195 UK Department of Health guidelines on personality disorder. Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. URL http://www.doh.gov.uk/mentalhealth/personalitydisorder.htm.

Referral

Referral to a community mental health team for an assessment can be helpful under the following circumstances:

- For diagnostic clarification
- If there is a risk of harm to self or others
- For treatment of co-morbid mental illness
- For specialist treatment of the underlying personality disorder

The referral might, however, be unsuccessful either because the patient does not want to be referred, does not attend for assessment or fails to co-operate with the treatment offered. Increasingly, it is the case that community mental health teams (whose main remit is to deal with severe mental illness) do not have the resources or expertise to manage personality-disordered patients. The need for specialist psychiatric services for this group of patients has recently been acknowledged by the Department of Health (ref 160).

References

195 UK Department of Health guidelines on personality disorder. Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. URL http://www.doh.gov.uk/mentalhealth/personalitydisorder.htm.

Resources for patients and families

Borderline http://www.BPDcentral.com
This site is mainly for families of people with Borderline personality disorder.

Borderline UK http://www.borderlineuk.co.uk
A national user-led network of people within the UK who have been diagnosed with Borderline personality disorder. The site provides detailed information on Borderline personality disorder.

Borderline Personality Disorder Research Foundation http://www.borderlineresearch.org
Provides details of research and other information

Understanding Personality Disorders. Available from MIND Publications, 15-19 Broadway, London E15 4BQ, tel: 020 8519 2122.
Leaflet with straightforward explanations. Useful for family members, staff and others.