Personality Disorders and Psychopathy

Introduction

This article refers to the International Classification of Diseases 10th edition (ICD-10) which is the official classification system for mental health professionals working in NHS clinical practice. The literature occasionally refers to the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system which - whilst used in clinical practice in the USA - is primarily used for research purposes elsewhere.

The ICD-10 (World Health Organization 1992) defines a personality disorder as: a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable personal and social disruption.

In the American Psychiatric Association's DSM 4th edition (DSM-IV), a personality disorder was defined as: an enduring pattern of inner experience and behaviour that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances.

The DSM 5th edition (DSM-5) takes an entirely different approach to personality disorder and has stimulated debate about how the condition should be diagnosed and categorised. It acknowledges that such an approach may well be difficult to use in a clinical situation, which has led to proposals for hybrid and compromise systems. As mentioned above, this article relies mainly on the ICD-10 definition.

The aetiology of personality disorders remains obscure. Traditional belief is that these behaviours result from a dysfunctional early environment that prevents the evolution of adaptive patterns of perception, response and defence.

Factors in childhood which are postulated to be linked to personality disorder include:[1]

- Sexual abuse
- Physical abuse
- Emotional abuse
- Neglect
- Being bullied

Emotional or behavioural factors that might play a part include:

- Truanting.
- Bullying others.
- Being expelled/suspended.
- Running away from home.
- Deliberate self-harm.
- Prolonged periods of misery.

The evidence base supporting a link between personality disorder and genetic factors is growing.[2]

People with personality disorders are at increased risk for many psychiatric disorders. Mood disorders are a particular risk across all personality diagnoses. Patients with depression and personality disorder have a more persistent condition than those who have depression alone. [3] Some types of mental illnesses are more specific to particular personality disorders.

It is unsurprising from the above that many people with personality disorders offend against the law.[1]

Classification[4]

The ICD-10 gives nine categories of personality disorder. In DSM-IV there are ten personality disorders that are divided into three clusters, designated A, B, C. The ICD-10 classification, listed under the code F60, is as follows:

F60 Specific personality disorders

- F60.0 Paranoid personality disorder.
- F60.1 Schizoid personality disorder.
- F60.2 Dissocial personality disorder.
- F60.3 Emotionally unstable personality disorder:
  - .30 Impulsive type
- Borderline type
- F60.4 Histrionic personality disorder.
- F60.5 Anankastic personality disorder.
- F60.6 Anxious (avoidant) personality disorder.
- F60.7 Dependent personality disorder.
- F60.8 Other specific personality disorders including:
  - Eccentric
  - "Haltlose" type
  - Immature
  - Narcissistic
  - Passive-aggressive
  - Psychoneurotic

- F60.9 Personality disorder, unspecified - this encompasses character neurosis and pathological personality disorder.

These are the main types, although ICD-10 subdivides some categories into further subtypes. ICD-10 also identifies an additional category, 'Unspecified personality disorder'.

**Epidemiology**[^5]

Studies estimate that personality disorder affects 4-11% of the UK population and between 60-70% of the prison population.[^6] This is so common as to be almost a variation of normal rather than pathological. Many of the features we can possibly recognise in ourselves or others but, often, several features are required to make a diagnosis. In the prison population there are probably comparatively few who do not have at least one of personality disorder, mental illness, learning difficulties and substance abuse. International figures must be viewed with caution, as the diagnosis is highly dependent upon culture.

A UK study (albeit using the DSM-IV categories) reported that rates were highest among men, and separated and unemployed participants in urban locations. It identified a subgroup of people who tended not to use local health services but drifted from childcare services to the criminal justice system at an early age.[^5]

A study of psychiatric patients managed by mental health teams showed that in total, 40% of all patients in secondary care had at least one personality disorder suggesting a significant degree of comorbidity with other psychopathology.[^7]

Personality disorders should not normally be diagnosed in children and adolescents because the development of personality is incomplete and symptomatic traits may not persist into adulthood. However, trajectory studies suggest that some adults with personality disorder have traits which can be detected in childhood.[^8] It has been traditionally considered that the diagnosis of personality disorder in the elderly should be made with caution, due to the attenuation of symptoms, failure to comply with the old DSM criteria and the difficulties of separating the symptomatology of dementia. However, more recent meta-analyses suggest that personality disorder may be a valid diagnosis, particularly in some elderly patients with depression. Further research is needed.[^9]
Personality disorders present with a wide range of problems in social relationships and regulation of mood. Such individuals have usually been like it throughout their adult lives. The patterns of perception, thought and response are fixed and inflexible, although their behaviour is often unpredictable. These patterns do not adhere to their own culture's expectations. The ICD-10 criteria for clinical diagnosis refer to conditions not directly attributable to gross brain damage or disease, or to another psychiatric disorder, which meet the following criteria:

- Markedly disharmonious attitudes and behaviour, involving usually several areas of functioning - eg, affectivity, arousal, impulse control and relationships with others.
- The abnormal behaviour pattern is persistent, lasts for a long time and is not limited to episodes of mental illness.
- The abnormal behaviour pattern is widespread and obviously maladaptive to a broad range of personal and social situations.
- The above manifestations always appear during childhood or adolescence and continue into adulthood.
- The disorder leads to considerable personal distress but this may only become apparent at a later stage.
- The disorder is usually, but not always, associated with significant difficulties with work and social relationships. Clinically significant distress or impairment must occur in all settings and not be limited to one area only.
- Common presenting features are as follows:

  - **Paranoid** - they display pervasive distrust and suspicion. Common beliefs include:
    - Others are exploiting or deceiving them.
    - Friends and associates are untrustworthy.
    - Information confided to others will be used maliciously.
    - There is hidden meaning in remarks or events others perceive as benign.
    - The spouse or partner is unfaithful. Pathological jealousy is sometimes called the Othello syndrome.

  - **Schizoid** - this is characterised by withdrawal from affectional, social and other contacts. This type of person is isolated and has a limited capacity to experience pleasure and express feelings.

  - **Dissocial** - there is a tendency to act outside social norms, a disregard for the feelings of others and an inability to modify behaviour in response to adverse events (eg, punishment). A low threshold for violence and a tendency to blame others may be features.

  - **Emotionally unstable** - people with this personality disorder tend to be impulsive and unpredictable. They may act without appreciating the consequences. Outbursts of emotion and quarrelsome behaviour may be exhibited. Relationships tend to be unstable and there may be suicidal gestures and attempts.

  - **Histrionic** - this is characterised by shallow and labile affectivity and theatricality. There is lack of consideration for others and a tendency for egocentricity. People with this type of personality often crave excitement and attention.

  - **Anankastic** - this is characterised by feelings of doubt, perfectionism and excessive conscientiousness. There is a compulsion to check and a preoccupation with details. This personality type tends to be stubborn, cautious and rigid. Insistent and unwelcome thoughts may intrude or impulses that do not attain the severity of an obsessive-compulsive disorder.

  - **Anxious (avoidant)** - this is characterised by feelings of tension and apprehension, insecurity and inferiority. People with this type yearn to be liked and accepted, are sensitive to rejection. There is a tendency to exaggerate potential dangers and risks, leading to an avoidance of everyday activities.

  - **Dependent** - this is characterised by a reliance on others to take decisions and a fear of abandonment. There is an excessive reliance on authority figures and difficulty in acting independently. This can affect the capacity to deal with the intellectual and emotional demands of daily life.
Associated features\[^4\]

Physical findings
There are no physical abnormalities to help diagnose personality disorders but there may be findings related to the consequences of various personality disorders.

- Those especially with emotionally unstable personality disorders may show signs of intentional self-harm or stigmata of substance abuse. There may be scars from self-inflicted wounds.
- Substance abuse is common and may present the physical stigmata of alcoholism or drug abuse.

Mental status
- Patients with histrionic personality disorder may display ‘la belle indifférence’, a seemingly indifferent detachment, while describing dramatic physical symptoms.
- A hostile attitude is typical of patients with dissocial personality disorder.
- Patients with paranoid personality disorder voice persecutory ideation without the formal thought disorder observed in schizophrenia.
- Patients with schizoid personality disorder speak with odd or idiosyncratic use of language.

Investigations\[^11\]
Psychological testing may support or direct the clinical diagnosis.

- The Minnesota Multiphasic Personality Inventory (MMPI) is the best-known psychological test.
- The Eysenck Personality Inventory and the Personality Diagnostic Questionnaire are also used.
- A structured psychometric assessment - this is particularly relevant to dissocial and emotionally unstable personality disorders.\[^12\]

Management\[^12, 13\]

General approach
The National Institute for Health and Care Excellence (NICE) has published guidance on the treatment, management and prevention of antisocial personality disorder and borderline personality disorder. This maps to the ICD-10 categories of dissocial and emotional unstable personality disorder respectively and so remains relevant. NICE has also published quality standards advice aimed at commissioners of mental health services.\[^14\] This provides guidance on a number of diagnostic and management issues.

Psychotherapy
It used to be taught that psychopaths and personality disorders were untreatable. Psychotherapy is the basis of care for personality disorders. Personality disorders produce symptoms as a result of poor or limited coping skills. Therefore, psychotherapy aims to improve perceptions of and responses to social and environmental triggers.\[^12, 15\]

- Psychodynamic psychotherapy examines the ways that events are perceived. It states that perceptions are shaped by experiences in early life and therapy aims to identify perceptual distortions and their origin and to facilitate the development of more adaptive modes of perception and response. Treatment is usually prolonged over a course of several years at intervals from several times a week to once a month. It uses transference.
- Cognitive and behavioural therapy (CBT) suggests that cognitive errors based on long-standing beliefs influence the meaning attached to interpersonal events. It explores how people think about their world and their perception of it. It is a very active form of therapy that identifies the distortions and engages the patient in efforts to reformulate perceptions and behaviours. This therapy is usually limited to episodes of 6 to 20 weeks at intervals of once a week. For personality disorders, therapy is repeated often over the course of years.
- Interpersonal therapy (IPT) assumes that difficulties result from a limited range of interpersonal problems, including such issues as role definition and grief. Current problems are interpreted narrowly through the screen of these formulations and solutions are framed in interpersonal terms. Therapy is usually weekly for a period of 6 to 20 sessions. It is used mostly for anxiety and depression and is not widely practised.
- Group psychotherapy allows interpersonal problems to be displayed among a peer group, whose feedback is used by the therapist to identify and correct maladaptive ideas, communication and behaviour. Sessions are usually once weekly over a course that may range from several months to years. The technique enables several people to be treated simultaneously, reducing cost per patient.
- Dialectical behavioural therapy (DBT) is a skills-based therapy that can be used in both individual and group formats. It has been applied to borderline personality disorder. The emphasis is on the development of coping skills to improve affective stability and impulse control and on reducing self-harmful behaviour. This treatment is also being used with other cluster B personality disorders, to reduce impulsive behaviour.

Pharmacotherapy
Drugs do not cure personality disorders but they may be useful as an adjunct so that the patient may productively engage in psychotherapy. The focus is on treatment of symptom clusters such as cognitive-perceptual symptoms, affective dysregulation and impulsive-behavioural dyscontrol. Such symptoms may complicate almost all personality disorders to some degree but all of them have been noted in borderline personality disorder. NICE recommends that antipsychotic or sedative medication such as benzodiazepines should only be used for short-term crisis management or treatment of comorbid conditions in dissocial or emotionally unstable personality disorder.\[^14\]
A Cochrane systematic review found that mood stabilisers and second-generation antipsychotics may be helpful for specific symptoms in borderline personality disorder but that pharmacotherapy did not affect the overall severity of the condition. \[16\]

Anticonvulsants help to stabilise the affective extremes in patients with bipolar disorder but are less effective for that purpose in patients with personality disorders. They have some benefit in suppressing impulsive and particularly aggressive behaviour in patients with personality disorder.

Some personality disorders, especially borderline personality disorder, produce transient psychotic periods, while others such as schizoid personality disorder show chronic idiosyncratic ideation bordering on psychosis. Response to antipsychotics is less dramatic than in true psychotic disorders but symptoms such as anxiety, hostility and sensitivity to rejection may be reduced. Antipsychotics are normally used for a short period while the symptoms are active. The atypical antipsychotics have almost completely replaced the older neuroleptics because of their margin of safety but neurological side-effects including tardive dyskinesia and neuroleptic malignant syndrome do sometimes occur. Risperidone, olanzapine and aripiprazole are often used. There is no evidence of superior efficacy of any product and each one may have advantages and disadvantages of adverse effects. \[16\]

**Crisis management**

Consult the patient’s crisis plan (a plan devised to identify trigger factors, advise on self-help strategies and identify when the individual should seek professional help).

**Assess problem and risk**
- Maintain a calm and non-threatening attitude.
- Try to understand the crisis from the person's point of view.
- Explore the person's reasons for distress.
- Use empathetic open questioning, including validating statements, to identify the onset and the course of the current problems.
- Seek to stimulate reflection about solutions.
- Avoid minimising the person's stated reasons for the crisis.
- Wait for full clarification of the problems before offering solutions.
- Explore other options before considering admission to a crisis unit or inpatient admission.
- Offer appropriate follow-up within a timeframe agreed with the person.
- Assess risk to self or to others.
- Ask about previous episodes and effective management strategies used in the past.
Help to manage their anxiety by enhancing coping skills and helping them to focus on the current problems. 
Encourage them to identify manageable changes that will enable them to deal with the current problems. 
Offer a follow-up appointment at an agreed time.

Refer in crisis to the community mental health services
Especially when:
- Levels of distress and/or the risk of harm to self or to others is increasing.
- Levels of distress and/or the risk of harm to self or to others has not subsided despite attempts to reduce anxiety and improve coping skills.
- Patients request further help from specialist services.

Complications
The following may occur more often than expected:
- Suicide.
- Substance abuse (including alcoholism).
- Accidents and injuries.
- Depression.
- Homicide.

Frequent enquiries about suicidal ideation are warranted, regardless of whether the patient spontaneously raises the subject.[17] There is no risk of implanting the idea of suicide in a patient who is not already considering it. Enquiry about drugs and other available means of suicide may help prevention.

Patients with personality disorder who have children should be asked frequently and in detail about their parenting practices. Their low frustration tolerance, externalisation of blame for psychological distress and impaired impulse control put the children of these patients at risk of neglect or abuse.

Prevention
The NICE guidance puts some emphasis on identification of individuals at risk of developing personality disorders.[13] A variety of interventions is suggested to try to prevent some of the consequences of the personality disorders covered by this guidance. For example, NICE suggests that services should establish robust methods to identify children at risk of developing conduct problems and that vulnerable parents could be identified antenatally - for example, in antisocial personality, by identifying:
- Parents with other mental health problems, or with significant drug or alcohol problems.
- Mothers younger than 18 years, particularly those with a history of maltreatment in childhood.
- Parents with a history of residential care.
- Parents with significant previous or current contact with the criminal justice system.

A wide variety of different interventions is then suggested, ranging from anger management to parenting classes.

Prognosis
It is not uncommon for people with personality disorders to offend against the law and come into contact with the criminal justice system.[1] They are often held to be untreatable. Treatment is prolonged, difficult and far from universally successful. When society is preoccupied with a punitive approach to offenders rather than the rehabilitation of offenders, the result is overcrowded prisons and recidivism amongst offenders. Jack Straw, when he was Home Secretary, wrote that one of the most important steps for the prevention of re-offending was that the person should secure a job. However, most employers enquire about criminal records and hold it against potential employees. The management of those with personality disorders, including those who have run foul of the law, is not easy and success is limited but the stakes are such that it is essential that society make the effort. The guidance from NICE poses challenges to the different agencies involved in the management and care of individuals with personality disorders.[13, 12] The NICE quality standards recommend that people with borderline or antisocial personality disorder should have their long term goals for education and employment identified in their care plan.[14]

Further reading & references
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