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Understanding Personality Disorder: A Report by the British Psychological Society

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Executive Summary

Personality disorder can be defined as variations or exaggerations of normal personality attributes. Personality disorders are often associated with antisocial behaviour, although the majority of people with a personality disorder do not display antisocial behaviour. Many people with mental health problems also have significant problems of personality, which can reduce the effectiveness of their treatments.

Research suggests that about ten per cent of people have problems that would meet the diagnostic criteria for personality disorder. Estimates are much higher among psychiatric patients, although they vary considerably: some studies have suggested prevalence rates among psychiatric outpatients that are in excess of 80 per cent. Between 50 per cent and 78 per cent of adult prisoners are believed to meet criteria for one or more personality disorder diagnoses, and even higher prevalence estimates have been reported among young offenders.

There is no single known cause of personality disorder: a combination of biological, social and psychological factors are implicated. Memory systems relating to the self and others are thought to be central to personality disorder, and the development of these systems depends on learning experiences in early relationships. Biological factors also influence personality development and may limit the extent to which traits of personality disorder can change. Many individuals are resilient to the biopsychosocial stress associated with the development of personality disorder; they would appear to possess resilient temperaments and/or have experienced adaptive socially environments and/or sought alternative positive attachments.

The first step in treating personality disorder is personality assessment, using carefully selected and structured instruments with established and well-documented psychometric properties. Self-report instruments and semi-structured interviews are recommended to establish goals, maintain focus in the therapeutic process, contribute to the choice and sensitivity of intervention strategies, and to monitor change over time.

Although there are few well controlled studies, research findings suggest that people with personality disorder can be treated successfully using psychological therapies. There is no clear evidence of the superiority of one type of treatment approach over another or for a particular method of service delivery (inpatient, outpatient, day programme). However, treatment benefits appear particularly evident when treatment is intensive, long-term, theoretically coherent, well structured and well integrated with other services, and where follow-up to residential care is provided. The efforts made in engaging patients and keeping them engaged in treatment, and the quality of the therapeutic alliance achieved, are crucial factors in determining treatment outcome. There is a need for further research with carefully defined populations, clearly defined treatment goals, and long follow-up periods incorporating cost benefit analyses.

Little is known about the relationship between different types of personality disorder and offending behaviour. Treatment in forensic populations should take account of the risk level of offenders, the factors associated with their offending, and the types of interventions to which they are likely to be responsive. Interventions with forensic populations have favoured social learning and cognitive-behavioural models. Democratic therapeutic communities have shown evidence of reducing symptoms of personality disorder in disturbed populations. Preparation, support and after-care for offenders are essential requirements in maximising the impact of rehabilitation programmes. Further research is needed on how different types of personality disordered offenders respond to current treatments and the conditions that are needed to sustain improvements following completion of treatment.

Recommendations

- The government's policy of ensuring that people with personality disorders are treated as part of core services in mental health and forensic settings, with access to specialist multidisciplinary personality disorder teams, is welcomed.
- Service developments that reflect this policy will require the skills of clinical and forensic psychologists as clinical leaders.
- Staff in a wide range of health and social care, education, criminal justice, and voluntary sector agencies require some level of training to understand personality disorder, ranging from basic awareness to specialist training.
- Structured assessments are essential to treatment based on a client's needs.

- People with personality disorder need a multidisciplinary and multi-agency service. Sharing of ideas and expertise between psychologists in forensic and general mental health services would enhance service development.
- Personality disorder is a problem that affects individuals across the lifecycle; to identify problems early, good communication between agencies is essential.
- Clinical supervision of staff working with individuals with personality disorder is essential to maintain the emotional health of staff.
- There is an urgent need for good quality research to inform service development.
- The views of service users should inform service development.

Preface

Personality disorder is a topic of increasing concern not only to mental health professionals but also to those working in primary care, social services and criminal justice agencies. This report presents an overview of personality disorders from a psychological viewpoint. Our purpose is to summarise current knowledge with a view to informing professional colleagues, service users and their carers, policy makers and interested lay people for whom the topic may still be relatively novel.

It is widely accepted that the psychiatric classification of personality disorders is unsatisfactory, but it provides a common terminology that is essential as a starting point for clinical communication and further research. In this report, we follow the current definition of personality disorder as a description of those enduring characteristics of a person that impair their well-being or social functioning. We recognise that some professionals and service users are uneasy with the idea that personality can be ‘disordered’ or ‘abnormal’, particularly since ‘personality disorder’ is sometimes used pejoratively. However, the term ‘disorder’ has no precise meaning in medicine or psychology, and criteria of ‘healthy’ functioning always depend on what society values rather than absolute standards. We nevertheless believe that these criteria are not entirely arbitrary. However, we emphasise that disabling personality characteristics are most appropriately viewed as part of a continuum of personality functioning, rather than as discrete abnormalities.

We also emphasise that personality disorders originate in complex interactions of biological, familial, and social influences. Better understanding of these dysfunctions and how they might be ameliorated must therefore come

from interdisciplinary collaboration and not simply the perspective of any single discipline. Nevertheless, we argue that psychological approaches have a major contribution to make because of the longstanding interest of psychology in personality and in psychological methods of intervention in human problems.

We acknowledge that there has never been a single psychological perspective on personality. For example, there have always been debates about whether the study of personality should focus on the unique characteristics of individuals or on those features that are shared in varying degrees by many people. Clinical practitioners always work with unique individuals, but generally recognise that it is impossible to understand uniqueness without the language of what is shared. Different theoretical approaches have also brought their own perspective on human personality, leading to disagreements about the most important aspects to study and understand. Some psychologists and other social scientists have even argued that personality is not an intrinsic characteristic of people, but rather exists only in the mind of the beholder.

These debates continue, but we can only touch on these wider issues here. In our view, personality refers to real human characteristics and includes some of the important factors that influence human behaviour in many contexts. In presenting a psychological viewpoint, we focus on those psychological approaches that seem promising in promoting our understanding of personality disorder. We do not attempt a synthesis of current approaches, but hope that we have highlighted where progress has been made and how this provides a foundation for further developments in helping people with these disabling problems.

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1. Understanding personality disorder

1.1 What is personality disorder?

Key points:

- Personality disorders are variations or exaggerations of normal personality attributes.
- Although Personality disorder is often associated with antisocial behaviour, the majority of people with a personality disorder do not display antisocial behaviour.
- Many people with mental health problems also have significant problems of personality.
- Disorders of personality reduce the effectiveness of treatments for major mental health problems.
- There is an urgent need for better understanding of personality disorders.

1.1.1 Introduction

People differ in the ways that they view themselves and others, engage in relationships, and cope with adversity. It is quite common for these characteristics to occasionally interfere with a person's ability to cope with life, and may also lead to difficulties in social interactions. When these difficulties are extreme and persistent, and when they lead to significant personal and/or social problems, they are described as personality disorders.

From the time of the ancient Greeks, people have tried to group individuals according to their characteristic approach to life, but the idea of personality as a stable feature of individuals emerged only a hundred years ago. Because they were the most important psychological theories of the time, initial attempts to understand both normal and abnormal personality were guided by psychoanalytic or Freudian ideas (Tyrer, 2000). During the 1930s and later, however, psychological and psychiatric approaches developed and changed. In particular, psychologists studying personality tended to concentrate on the population samples rather than individual case studies (Cattell, 1965; Eysenck, 1967). It has been argued that current approaches to personality disorder in mental health settings ignore several decades of research on personality in the general population (Livesley, 2001).

For a time, psychologists also disagreed on the usefulness of the idea of personality itself. In the 'person-situation' debate, some argued that the behaviours that are assumed to be expressions of personality have more to do with the situations in which people are observed than with stable characteristics (Mischel, 1968). This

debate has now largely subsided with the acceptance that behaviour depends on characteristics of both the person and the situation, and the psychology of personality has flourished (Cervone & Mischel, 2002; Kenrick & Funder, 1988).

Some psychologists remain sceptical about the utility of ideas of personality and personality disorder for clinical practice. However, research clearly shows that personality not only predicts significant life outcomes such as occupational functioning, health, and academic achievement, but can also be a risk factor for psychological problems such as depression (Krueger, Caspi, Moffitt, Silva & McGee, 1996). Many people referred to mental health services have significant problems of personality (Dolan-Sewell, Krueger & Shea, 2001), and abnormalities of personality may reduce the effectiveness of treatments for major mental health problems (Reich & Vasile, 1993). We believe that the influence of personality on mental health problems needs to be recognised in the interests of better mental health services.

It is now widely accepted that personality disorders are variations or exaggerations of normal personality characteristics, and the integration of traditional psychiatric and psychological approaches to personality has accelerated in recent years (Livesley, 2001; Widiger & Frances, 1994). Psychologists believe that developments in the scientific understanding of personality will help in the treatment and management of people with personality disorders (Cervone & Mischel, 2002).

1.1.2 Personality and personality traits

In everyday usage, personality is a global evaluation of a person's distinctive attributes (e.g. an 'interesting' personality). Psychological research also addresses individual distinctiveness, but there is no universally agreed definition of personality. From a psychological perspective, personality is best viewed as an area of scientific inquiry. The area is concerned with the coherent and enduring features of the individual person or the self, and the processes underlying them. However, recent work emphasises the differences between individuals in social behaviour, attitudes or beliefs, and emotional characteristics. This approach draws on research with large samples of the general population, derives assessment from psychological measurement (psychometric)

theory, and seeks general principles for understanding variations between people. The application of these principles to clinical problems recognises the uniqueness of individuals, but focuses on aspects that individuals share with others.

Personality traits describe regularities or consistencies of actions, thoughts, or feelings. Traits are part of common language (e.g. 'sociable', 'aggressive', 'energetic'), and are the basic elements in the study of personality. Traits are different from specific acts or temporary mood states because they indicate a tendency or disposition to behave in certain ways in certain circumstances. Further, traits describe average behaviour over many settings and occasions. To describe someone as 'aggressive' implies only a stronger likelihood of aggressive behaviour in relevant situations, not that the person invariably behaves that way. Behaviour also depends on situations, social roles, and norms, but dispositions influence the situations that people choose and create.

1.1.3 Classification of personality disorder

In Britain, personality disorder is often equated with socially deviant behaviour because of associations with the legal category of Psychopathic Disorder in the 1959 and 1983 Mental Health Acts for England and Wales ('a persistent disorder or disability of mind...which results in abnormally aggressive or seriously irresponsible conduct on the part of the person

concerned'). However, the classifications of personality disorder need to be based on personality theory and not antisocial behaviour or moral judgements (Blackburn, 1988).

The current classifications reflect the influence of the German psychiatrist Schneider (1950) who described personality disorders (psychopathic personalities) as abnormal personalities whose abnormality causes suffering to himself or herself or the community. Anticipating quantitative conceptions of personality, he construed abnormal personality statistically as deviation from average. Although etymologically the adjective 'psychopathic' simply means 'psychologically damaged', in Britain and America it was narrowed to mean 'socially damaging' (Blackburn, 1988), as reflected in recent notions of psychopathy (Hare, 1996) and the category of antisocial personality disorder. Paradoxically, the broader notion of personality disorder adopted in current classifications originates in Schneider's typology of psychopathic personalities.

The Diagnostic and Statistical Manual (DSM-IV; American Psychiatric Association, 1994) classification of personality disorder is based on the concept of personality traits described above. Traits, the basic units of personality disorder, are defined in DSM-IV as '...enduring patterns of perceiving, relating to, and thinking about the environment and oneself...' However, traits constitute personality disorder only when they are 'inflexible and

Cluster A <i>(odd/eccentric)</i>	Cluster B <i>(dramatic/erratic)</i>	Cluster C <i>(anxious/fearful)</i>
Paranoid distrusting and suspicious interpretation of the motives of others	Antisocial disregard for and violation of the rights of others	Avoidant socially inhibited feelings of inadequacy, hypersensitivity to negative evaluation
Schizoid social detachment and restricted emotional expression	Borderline unstable relationships, self-image, affects, and impulsivity	Dependent submissive behaviour, need to be taken care of
Schizotypal social discomfort, cognitive distortions, behavioural eccentricities	Histrionic excessive emotionality and attention seeking	Obsessive-compulsive preoccupation with orderliness, perfectionism, and control
	Narcissistic grandiosity, need for admiration, lack of empathy	

Figure 1.1: DSM-IV Personality Disorders Grouped into Three Clusters

maladaptive and cause significant functional impairment or subjective distress.’ Recent editions of the DSM classify the traditional mental disorders (clinical syndromes) on Axis I and personality disorder on Axis II.

DSM-IV gives a general definition of personality disorder as enduring patterns of cognition, affectivity, interpersonal behaviour, and impulse control that are culturally deviant, pervasive and inflexible, and lead to distress or social impairment. Ten patterns or categories of personality disorder are identified and grouped into three clusters as illustrated in Figure 1.1. Each category is operationally defined by between seven and nine specific criteria, a set number being required for diagnosis of the disorder. These are categories of disorder, not types of people, and individuals may meet criteria for more than one disorder.

1.1.4 Validity of diagnosis and classification

The different categories of personality disorder are human constructions (constructs); whether or not they are theoretically valid or useful has to be demonstrated through research. Systems such as DSM-IV are intended to be theoretically neutral classifications of mental disorders. In the case of personality disorder, however, this has resulted in categories that reflect a mixture of personality theories. Many researchers believe that this has led to a series of practical problems:

- The diagnosis of personality disorder has not proved reliable or consistent when clinicians base their assessments on unstructured interviews (Mellsop, Varghese, Joshua & Hicks, 1982).
- Reliability has been improved through semi-structured interviews (which give clinicians clear guidelines for their questioning and decision-making) and questionnaires, but there are still difficulties regarding the scientific and clinical validity of personality disorder categories.
- If different assessment methods are used, agreement on the diagnosis of specific categories of personality disorder is generally low, which is ‘not a scientifically acceptable state of affairs’ (Perry, 1992).
- Although the DSM-IV classification identifies discrete categories, many individuals accessing mental health services meet criteria for at least two, and often four or more personality disorders (Stuart *et al.*, 1998). This co-occurrence, or comorbidity, indicates that the categories are not independent.

- Statistical analyses of the categories show that there are three or four higher-order factors or groups (Austin & Deary, 2000; Blackburn & Coid, 1998), suggesting that there are too many categories.
- The specific DSM-IV diagnostic criteria do not clearly discriminate between categories, most criteria correlating with two or more categories (Blais & Norman, 1997).
- Most individuals with personality disorder also have other forms of mental disorder, and the distinction in DSM-IV between Axis I and Axis II lacks a clear rationale (Livesley, 2001). The distinction between the stable or enduring traits of personality and the less enduring symptoms of mental disorders (Foulds, 1971) is useful, but not absolute.

The DSM-IV classification is therefore seen by many clinicians as having only limited usefulness, particularly for treatment planning or measuring clinical outcomes because of the problems with reliability and validity outlined above.

Personality and Personality Disorder

1.1.5 Categories and dimensions of personality disorder

A major problem with the current classifications is that they rely on a categorical, all-or-none system for distinguishing types of disorder and for diagnosing individual problems. Categorical classification of personality disorder follows a medical model that implies qualitative distinctions between normality and abnormality (i.e. present or absent) and clear boundaries between categories. The alternative is a dimensional approach that assumes only quantitative distinctions (i.e. varying degrees of dysfunction).

Dimensional and categorical descriptions of personality disorder are not incompatible (Widiger & Frances, 1994). Categorical diagnoses can be thought of as based on a continuous dimension where a relatively arbitrary diagnostic cut-off has been applied. Evidence from research indicates that dimensional conceptions of personality disorder more accurately represent the organisational structure of personality dysfunction (Livesley, 2001). There are therefore good grounds for translating the categorical classification of personality disorder into dimensions of human variation identified through theory and research on the structure of normal personality.

1.1.6 The structure of personality

In personality research, traits are viewed as part of a hierarchy. Particular personality traits (such as dominance) are inferred from a person's tendency to behave in particular ways (such as taking the lead in group activities). Personality types or categories are identified when certain traits occur together in many individuals. Categories of personality disorder are constructs based on such personality types.

Psychologists have used statistical methods such as factor analysis to investigate how traits go together to form dimensions. Research has established that relationships between the vast number of normal range traits denoting behavioural, emotional and cognitive dispositions reflect a few robust dimensions.

While the number of dimensions identified has ranged from three to seven (Watson, Clark & Harkness, 1994), over time it has become apparent that most variation in personality is accounted for by the 'Big Five' factors. The 'Big Five' dimensions are Neuroticism vs stability, Extraversion vs introversion, Agreeableness vs antagonism, Conscientiousness vs lack of self-discipline, and Openness to experience vs rigidity. These five factors are believed to represent biologically derived basic tendencies, which are instrumental in shaping attitudes, goals, relationships and the self-concept, and influence our interactions with the social and physical environment (McCrae & Costa, 1996).

The five-factor model is widely regarded as the dimensional model most relevant to understanding personality disorder. It enables personality and personality disorder to be understood in terms of a small number of dimensions, and it allows personality disorder to be understood in the wider context of personality research. Further, studies of traits defining personality disorder also reveal that their structure follows that of the five-factor model (Clark, Livesley, Schroeder & Irish, 1996). We do not therefore need a separate trait language for describing disorders of personality. Although dimensions do not provide a diagnostic classification in the traditional sense, it is nevertheless possible to represent the current classes of personality disorder dimensionally as combinations of extremes on different dimensions (Widiger & Frances, 1994).

1.1.7 Statistical deviation and personality dysfunction

Although extreme manifestation of certain traits or dimensions seems necessary to define

abnormalities of personality, it may not be sufficient to identify disorder or dysfunction, as indicated by failures to perform social and occupational roles. Psychologists generally see normality and abnormality as falling on a quantitative continuum. A trait is abnormal when its manifestation is extreme relative to the population average, extremeness commonly being defined arbitrarily in psychological tests by the statistical criterion of two standard deviations from the mean, a position occupied by less than 2 per cent of the population. In these terms, disorders of personality are extreme variants of normal personality, and can hence be described by reference to dimensions of personality, such as the five-factor model.

However, personality dysfunction is not necessarily expressed in extreme traits because it depends on the context. Some people may have extreme traits but function adequately because their characteristics are not an impediment for a particular role or setting. This is recognised in the notions of discordant personality (Foulds, 1971) or personality accentuation (Tyrer, 2000), which fall short of disorder. The DSM-IV definition of personality disorders as traits that are inflexible and maladaptive and cause significant functional impairment or subjective distress follows Schneider's original distinction between abnormal personalities and those who 'suffer' from their abnormality (Livesley, 2001). This also implies that statistical deviation is necessary but not sufficient to define dysfunction.

The dysfunctional component of personality disorder may to some extent be independent of extremes of personality. There is a clear parallel with learning disability. This is not identified by low intelligence alone but by dysfunctional adaptation under conditions requiring intellectual ability. One view is that dysfunction needs to be defined in terms of the basic functions of personality (Livesley, 2001). From an evolutionary perspective these are to attain the universal life tasks of:

- A stable self-system (identity, representations of self and others);
- Satisfying interpersonal functioning (attachment, intimacy, affiliation);
- Societal/group relationships (prosocial, co-operative behaviour);

Dysfunction or disorder is proposed to arise from impairment in the organisation, integration or regulation of underlying personality processes involved in these tasks. The personality and disorder components may therefore need to be

evaluated separately (Hill, Fudge, Harrington, Pickles & Rutter, 2000).

1.1.8 Classification of personality disorders and clinical practice

Trait description is a starting point for clinical understanding of personality disorders, but the limitations of traits in predicting and explaining individual behaviour need to be recognised. Whatever the advantages of dimensional representation, both categories and dimensions are essentially abstractions that provide no more than a global guide to dysfunction. While traits provide summary descriptions of behaviour, they do not explain behaviour because the causes of the trait-relevant behaviour remain to be identified.

Philosophers recognise a distinction between dispositional concepts that denote frequency of behaviour given certain conditions and those that are 'purposive-cognitive' (Alston, 1975). The former are close to the conventional meaning of trait and refer to surface regularities in behaviour. They predict probabilistically, but do not explain. The latter refer to 'deep' structures and processes posited by theory that are not directly observable but provide a more fundamental causal explanation of behaviour (e. g. motives, schemas, defences, coping mechanisms). Similar distinctions are made by psychologists between surface (phenotypic) and source (genotypic) traits. There is therefore more to personality than surface traits, and source or genotypic traits are

the more basic constituents of personality.

Theoretical models developed to guide treatment of personality disorder are concerned primarily with 'purposive-cognitive' dispositions rather than the surface traits defining personality disorder (Section 2.1). Attempts to improve the classification of personality disorder by reference to the structure of personality traits have therefore had only a limited impact on strategies for treating these disorders. An integration of trait description and theoretical constructs of personality is crucial if the classification of personality disorder is to assist clinicians.

1.1.9 Conclusions

The current psychiatric classifications of personality disorder have served to focus the attention of clinicians on this major area of problematic human behaviour. There is, however, general agreement that they are no more than a crude first step in describing the various ways in which abnormalities of personality lead to dysfunctional behaviour. As exaggerations or variations of normal personality traits, personality disorders need to be thought of in terms of continua rather than all-or-none categories, and a dimensional approach to describing these disorders has gained increasing acceptance. Different forms of personality disorder may therefore most usefully be described by reference to the dimensions of personality identified by several decades of research on the normal population. Description

Can children/adolescents have personality disorders?

The classificatory system (DSM-IV) states that personality disorders consist of patterns of thought, behaviour and emotions that can be traced back to late adolescence and early adulthood. DSM-IV cautions against diagnosing personality disorders in adolescence because of the significant developmental changes that occur during this time. To diagnose personality disorder in an individual under the age of eighteen, the features of that personality disorder must have been present for at least one year. The one exception to this is antisocial personality disorder, which cannot be diagnosed in individuals less than eighteen years of age. Many clinicians have concerns regarding the diagnosis of personality disorder in adolescents as it would be difficult to be certain that their presentation represents a repetitive or inflexible aspect of their psychological make up, which would be necessary for a diagnosis of personality disorder. Diagnosing adolescents could produce harmful results as the person may receive inappropriate treatment, an inaccurate label that may undermine their self esteem and lead other people to discriminate against them, including the denial of mental health services. However, it is also possible that failing to diagnose personality disorder accurately could result in an adolescent not receiving treatment that could help to alleviate their difficulties. Therefore, a cautious and conservative approach to the diagnosis of personality disorder in this group would be recommended. An alternative could be to focus upon formulating an adolescent's functional strengths and weaknesses; leading to a more needs based approach.

is not, however, sufficient for explanation and understanding, or for the development of effective clinical interventions. There is an urgent need to integrate knowledge of abnormal personality developed by psychiatrists and psychologists in clinical studies with theory and

research on the psychology of personality more generally. Without a clear conceptualisation of what needs to be changed, progress in delivering services for people with personality disorder will be limited.

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1.2 Prevalence of personality disorder

Key points:

- Research suggests that about ten per cent of community samples have problems that would meet the diagnostic criteria for personality disorder.
- In primary care, research has suggested that between 5 per cent and 8 per cent of patients have personality disorder as their main clinical diagnosis, although estimates rise to between 29 per cent and 33 per cent when all clinical diagnoses are considered and not just the primary diagnosis.
- Research suggests that 30 per cent to 40 per cent of psychiatric outpatients and between 40 per cent and 50 per cent of psychiatric inpatients are believed to meet the criteria for one or more personality disorders; estimates vary considerably, however, and some studies have suggested prevalence rates among psychiatric outpatients that are in excess of 80 per cent.
- Between 50 per cent and 78 per cent of adult prisoners are believed to meet criteria for one or more personality disorders, and even higher prevalence estimates have been reported among young offenders.
- Research has suggested that as many as two thirds of male mentally disordered offenders have one or more personality disorders. This estimate may be higher among women in forensic psychiatric settings.
- Some types of offending behaviour may be associated with personality disorder although an assessment of the full range of criminogenic or risk factors, which may or may not include personality disorder, is required to adequately formulate offending risk.

1.2.1 How common are personality disorders in the general population?

The prevalence of personality disorders in community samples has not been investigated with the same vigour as the prevalence of other psychiatric conditions (Casey, 2000; Mattia & Zimmerman, 2001). From the research that has been conducted over the last twenty or so years, findings suggest a lifetime prevalence of any single personality disorder in community samples of between 6.7 per cent and 33.1 per cent, with a median prevalence across studies of 12.9 per cent (Mattia & Zimmerman, 2001). Other research, based on more stringent diagnostic criteria, suggests more conservative lifetime prevalence estimates, of between 6.7 per cent (Lenzenweger *et al.*, 1997) and 9.4 per cent

(Maier *et al.*, 1995). The lifetime prevalence of individual personality disorders ranges from one per cent to three per cent, with paranoid, histrionic and obsessive-compulsive diagnoses occurring most frequently.

Personality disorders tend to co-occur with other Axis I disorders. Maier *et al.* (1995) reported that almost two thirds of individuals with a personality disorder diagnosis also had a diagnosis of an Axis I disorder. Swanson *et al.* (1994) reported that in a sample of individuals who had a diagnosis of antisocial personality disorder, in excess of 90 per cent had a co-occurring diagnosis of any Axis I disorder, mainly alcohol abuse or dependence. Personality disorders appear to be more prevalent in younger compared with older people (Zimmerman & Coryell, 1989), and the association with gender is equivocal although the prevalence of any personality disorder appears to be comparable between men and women (Maier *et al.*, 1992).

In primary care settings, abnormalities of personality are the primary clinical diagnosis for approximately five per cent to eight per cent of patients who have any conspicuous mental health needs (Casey, 2000). Personality difficulties in primary care settings appear more prevalent among men than women. However, when assessments are carried out on all patients irrespective of primary diagnosis and structured forms of personality disorder assessment are used, prevalence estimates tend to rise several-fold. For example, Casey *et al.* (1984) carried out a study of personality in every patient who had conspicuous mental health needs in an urban general practice. The authors reported that personality disorder was the primary diagnosis in between 6.4 per cent and 8.9 per cent of the sample, but when all diagnoses were considered, it was noted that just over a third of the entire sample had a diagnosis of a personality disorder. Similarly, Moran *et al.* (1999) examined the prevalence of personality disorder in 303 individuals attending primary care settings. These authors reported a prevalence of 29 per cent for any personality disorder in their sample, and found that Cluster B personality disorders were particularly likely to be associated with psychiatric morbidity.

In psychiatric in- or outpatient settings, the prevalence of personality disorders are thought to be higher still. Between 30 per cent and 40 per cent of outpatients and between 40 per cent and 50 per cent of psychiatric inpatients are thought to meet the criteria for a personality

disorder (Casey, 2000). One study of psychiatric out-patients in Norway reported that while 97 per cent had a diagnosis of an Axis I condition, 81 per cent had a co-occurring diagnosis of a personality disorder assessed using a semi-structured interview assessment (Alnaes & Torgersen, 1988). Other studies have confirmed that personality disorder diagnoses are common in psychiatric outpatients (e.g. Jackson *et al.*, 1991; Kass *et al.*, 1985).

Research suggests that dependent, passive-aggressive and histrionic personality disorders tend to be diagnosed more frequently in women, and that obsessive-compulsive, schizotypal and antisocial personality disorders tend to be diagnosed more frequently in men (e.g. Maier *et al.*, 1992). A number of studies have reported no statistically significant gender differences in studies of patients with borderline personality disorder after controlling for the effects of an Axis I diagnosis of mood disorder (e.g. Golomb *et al.* 1995; Mattia & Zimmerman, 2001). Indeed, the common belief that certain personality disorders, such as borderline, are more prevalent in women is challenged by research indicating that no personality disorder significantly predominated among women (Golomb *et al.*, 1995). However, in a case vignette study, clinicians were more likely to diagnose borderline personality disorder in women and antisocial personality disorder in men on the basis of identical descriptions, suggesting rater bias rather than the genuine effects of gender on prevalence (Adler *et al.*, 1990).

1.2.2 Prevalence of personality disorders in prison

In the UK, the Office for National Statistics *Study on Psychiatric Morbidity Among Prisoners* (Singleton *et al.*, 1998) found personality disorders in 50 per cent of female prisoners, compared with 78 per cent of male remand and 64 per cent of male sentenced prisoners. Antisocial personality disorder was the commonest specific diagnosis in both men and women, but it was more prevalent in men (63 per cent of remand and 49 per cent of sentenced males) compared with women (31 per cent of female prisoners). Paranoid personality disorder was the second most common personality disorder among men, whereas borderline personality disorder was the second most common personality disorder among women.

A survey of young offenders in prison (Lader, Singleton & Meltzer, 2003) showed even higher rates of personality disorder; prevalence rates for male young offenders were 84 per cent for those

on remand, 88 per cent for sentenced offenders. Personality disorders were most common among acquisitive offenders (those with charges/convictions for burglary, theft and robbery) and were less frequently diagnosed in sex and drug offenders.

An early paper by Cloninger and Guze (1970) noted that antisocial women were more likely to have dual diagnoses with 40 per cent of their study population fitting diagnostic criteria for hysteria as well as sociopathy (which is more or less synonymous with antisocial personality disorder). Mulder *et al.* (1994) also drew attention to the high prevalence of co-morbid psychiatric illnesses in women with antisocial personality disorder. This is a robust finding, and the treatment for female offenders including mentally disordered offenders is often dictated by the fact that they show symptoms of mental health problems in addition to personality disorder.

1.2.3 Prevalence of personality disorders in mentally disordered offenders

In a study of mentally disordered offenders in English and Scottish high secure hospital care, antisocial, narcissistic and borderline personality disorders were the most common personality disorder diagnoses; almost two thirds of a sample of 175 male patients in high secure forensic psychiatric care met criteria for a definite diagnosis of at least one personality disorder (Blackburn, Logan, Donnelly & Renwick, 2003). Evidence of significant psychopathic traits (as defined by elevated scores on the Psychopathy Checklist-Revised; Hare, 1991, 2003) was detected in almost one third of the same sample.

With respect to comorbidity in male mentally disordered offenders, research suggests that all personality disorders, with the exception of narcissistic, dependent and obsessive-compulsive disorders, are associated with an increased likelihood of at least one lifetime Axis I disorder diagnosis (Blackburn *et al.*, 2003). For example, a diagnosis of borderline personality disorder was associated with a significant likelihood of co-occurring diagnoses of depression, obsessive-compulsive disorder, post-traumatic stress disorder, and both alcohol and drug abuse. In contrast, avoidant personality disorder was associated with an increased likelihood of anxiety, bipolar disorders and post-traumatic stress disorders.

In a study of women in high secure prison and forensic psychiatric care using structured assessments of personality disorder (namely the Structured Clinical Interview for DSM-IV Axis II

Personality Disorder Diagnoses or SCID-II; First *et al.*, 1997), the most commonly occurring personality disorder diagnoses were antisocial and borderline personality disorders (Logan, 2002; Logan, 2003). In a sample of hospitalised women, the prevalence of borderline personality disorder just exceeded that of antisocial personality disorder. Over three quarters of the sample of hospitalised and imprisoned women received at least one definite personality disorder diagnosis, and comorbidity was common. For example, a diagnosis of any substance dependence disorder was almost six times more likely to be associated with a diagnosis of antisocial personality disorder and three times more likely to be associated with a diagnosis of borderline disorder. Also, a high level of comorbidity was detected between diagnoses of borderline personality disorder and psychotic disorders. Characteristics consistent with the clinical description of psychopathy were detected in 15 per cent of the women assessed in this study.

1.2.4 Criminal behaviour and personality disorder

Although most individuals who have a personality disorder are not involved in criminal behaviour, offenders who have a personality disorder may be at a higher risk of committing serious crimes (Blackburn, 2000). A recent Home Office study examined research on factors associated with increased risk for causing serious harm in different types of offenders (Powis, 2002). The results showed links between personality disorders and offences of general violence, domestic violence, sex offending, stalking and arson. However, the definitions of personality disorder used in the studies reviewed were not always consistent with DSM-IV.

The greatest volume of research on the links between criminal behaviour and personality disorder has been carried out into psychopathy, a type of serious personality dysfunction observable across the interpersonal, affective and behavioural domains. Psychopathy is traditionally measured using the Psychopathy Checklist-

Should people with personality disorder be held criminally responsible?

Legal determination of guilt is based on the law's view that people are autonomous agents who can be held morally, and hence criminally responsible. The law's concern with 'insanity' as an excuse from legal blame assumes that only in serious mental disorders is the ability to make 'free' choices impaired. Personality disorders are not considered sufficient to impair free choice, and few legal systems currently recognise these disorders as grounds for excusing a person from criminal responsibility.

In contrast to the law, psychology assumes that all behaviour is determined. In its extreme form, determinism negates the notion that people are blameworthy, but differing philosophical positions are identifiable (Blackburn, 1993). Hard determinism holds that human behaviour is completely determined by factors outside the conscious person: choice is irrelevant and is at best an illusion. Soft determinism accepts the reality of human choice, but argues that choices themselves are determined. Recent psychological views, however, see human agency as the basis for purposeful, intentional choices. Bandura (1986), for example, argues that although humans are never wholly autonomous, and behaviour is always constrained by an individual's experience and circumstances, self-regulating processes allow people to be partial authors of their situations.

Differences between the law and psychology may therefore lie less in acceptance of the human capacity for autonomy and free choice than in the extent to which constraints on choice and behaviour are recognised. Most psychological disorders impose constraints on people that seriously limit their options in making choices. Personality disorder is one such constraint. However, the insanity defence is no longer of practical significance in Britain, and a finding of guilt is not incompatible with diversion to the mental health system. Most psychologists would argue that personality disorders are psychological impairments that impair freedom of choice and this should be taken into account by the courts in determining the most appropriate disposal/sentencing.

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Revised (PCL-R; Hare, 1991, 2003). Male offenders who score highly on the PCL-R have been found to reoffend – generally and violently – on release from prison up to four times more frequently than those with lower scores (Hemphill *et al.*, 1998). In addition, research indicates that individuals with psychopathic traits tend to reoffend more quickly, they continue offending at a higher rate into middle age than those without such traits, and they are more violent when incarcerated (Doyle & Dolan, 2000; Hare & Hart, 1993). Psychopathy is a risk factor for sexual violence, although it is associated more with the nature and severity of sexual violence than with its likelihood (Hart *et al.*, 2003).

Some types of offending may be associated with personality disorders. For example, research has shown a link between arson and borderline personality disorder (e.g. Duggan & Shine, 2001). However, individuals who have been

diagnosed with personality disorder understandably feel unfairly stigmatised by the association with offending behaviour (Ferguson *et al.* 2003). Psychological perspectives on violence risk emphasise the importance of assessing the range of criminogenic or risk factors, of which personality disorder may be only one. Violent – and sexually violent – behaviour is linked to many factors such as substance misuse, contacts with criminal associates, criminal attitudes, a previous history of offending, lack of interpersonal and cognitive skills, and so on. Thus, it is vital to consider the range of relevant risk factors when assessing the nature and likelihood of future criminal behaviour and not personality disorders in isolation. Research into offending behaviour and the ways in which some types of offending may be associated with personality disorder will help to differentiate more clearly the links.

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2. Origins of personality disorder

2.1 Psychological approaches to personality disorder

Key points:

- Psychological perspectives on personality disorder originate in psychodynamic, behavioural, cognitive, and interpersonal theories of psychopathology.
- Although these approaches represent diverse assumptions about personality, a common theme is that memory systems relating to the self and others are central to personality disorder.
- The development of these systems depends on learning experiences in early relationships.
- Biological factors also influence personality development and may limit the extent to which traits of personality disorder can change.

2.1.1 Overview

Explanations of personality disorders have been developed by psychiatrists and psychologists working in clinical contexts. They attempt to identify the important aspects of behaviour, emotion or interpersonal relationships that need to change. The links between academic research into personality and the clinical work of therapists are often very tenuous. For example, treatment is rarely chosen in relation to personality traits. There is also a gap between the theories commonly used by therapists and the diagnostic descriptions of personality disorders based on traits (see Section 1.1). Some clinicians, however, argue that an understanding of personality traits is important in therapy because (a) traits are relatively fixed and there are limits to the possibilities for change, and (b) helping a person to express their personality traits in more effective ways is an important goal of therapy (Beck *et al.*, 1990; Livesley, 2001; Paris, 1998).

Psychological perspectives on personality disorder reflect approaches developed earlier in the treatment and understanding of other psychological disorders by psychodynamic, behavioural, and cognitive therapists. These approaches make different assumptions about the organisation of personality and theoretical integration is currently unlikely. However, an integrated approach in which components of different treatments might be used flexibly for different personality problems is described by Livesley (2003). What follows is a brief overview of the main psychological approaches guiding

current attempts to treat personality disorder. Treatment applications are discussed in Section 3.2.

2.1.2 Psychodynamic perspectives

The psychodynamic approach refers both to long-term classical psychoanalysis and a variety of shorter psychoanalytic psychotherapies. Recent theorising has shifted from an early focus on unconscious conflicts arising from instinctual libidinal (pleasure-seeking) and aggressive drives to a greater concern with more conscious, reality-oriented (ego) functions and object relations. Object relations refer to enduring patterns of relating to others and the processes of thought and emotion that guide these relationships (Westen, 1991). Thus, intimate relationships are believed to be externalisations of internal mental representations of interpersonal functioning formed early in development through relationships with caretakers. Consequently, distressing and dysfunctional relationships characteristic of personality disorder reflect distortions in these internal representations.

Although more eclectic, attachment theory is also linked to object relations theory (Ainsworth & Bowlby, 1991). The motivation of offspring to form a secure relationship with the parent is universal among mammals. Attachment theory focuses on the quality of infant-caregiver attachment during the first year of life as a determinant of later cognitive and social development. Early attachment is held to affect later behaviour through an ‘internal working model’ of intimate relationships. As a result of insecure attachment, for example, children may come to expect that others are not available for support and cannot be trusted. Such children are subsequently likely to select and shape disordered interactions that recreate aspects of relationships experienced earlier.

Childhood attachment patterns may be risk factors for later problems, but their effects on adult behaviour depend on other developmental experiences. Nevertheless, some aspects of personality disorder may represent disturbances of attachment. Fonagy (1998), for example, proposes that borderline personality disorder is a disorder of attachment, separation tolerance, and ability to understand others’ mental states (‘theory of mind’).

Kernberg (1996) has developed an influential object relations approach to personality disorder.

Dave

Dave initially sought help from his GP for anxiety problems following the loss of his job. He was offered a short-term treatment focusing on anxiety management. The therapist became increasingly concerned at Dave's social isolation and chronic obsessional washing and began to question the regular appearance of bruising to Dave's arms and face. Dave was asked about any experiences of violent conflict but disclosed this was a pattern of self-harm he used to relieve tension. Following this disclosure, the focus of treatment changed to reducing self-harming behaviour. Unfortunately, shortly after this change in focus Dave attempted to hang himself resulting in hospital admission. On review it appeared the self-harming behaviour had helped to control overwhelming feelings of self-hatred, which had precipitated the suicide attempt.

Whilst in hospital Dave was observed to sleep very little, to over control his eating and then binge eat, to be at times appeasing and other times confrontational and to become easily aroused in situations of conflict. When medically examined, it also became apparent that Dave was regularly cutting his arms and stomach. The ward staff had difficulty managing Dave's behaviour as, despite attempts to address his behaviour, Dave continued to engage in his eating and cutting behaviour. This resulted in Dave using increasingly secretive means to continue with these behaviours. The ward staff became exasperated with his behaviour, with some staff supportive of Dave and others hostile to him. This resulted in situations of conflict between the staff and Dave, during which staff were threatened and intimidated by Dave's highly aroused and confrontational manner.

At this point a psychological assessment of Dave was sought. Dave was initially hostile and suspicious of this process and refused to engage in any discussion of his aggressive behaviour or problems with eating and self-harm. Over time the assessment allowed Dave the opportunity to explore his life experiences and the impact of these on how he currently felt. Personality testing augmented this. Dave began to trust the assessor, whom he considered was attempting to understand him, was honest with him and gave him clear, unambiguous messages. Through this process, an initial formulation of Dave's difficulties revealed an individual who had been emotionally neglected by two parents who were focussed on their own career development. Dave was left with a number of carers and there appeared to be no consistent or predictably warm figure he could trust. He became a withdrawn child who was ostracised and bullied at school. Dave formed a close and loving attachment to his older sister who died in a road traffic accident when Dave was 13 years old. Dave left home at 15 and formed a relationship with an older woman, whom he considered to be loving and protective. Over time it became apparent this woman was a controlling and emotionally abusive person and Dave became physically abusive of this woman before deciding to leave the relationship. The personality testing indicated Dave would attempt to avoid intimacy because it was associated with rejection and conflict. However, he continued to desire closeness and protection from others. Therefore, he was drawn to form relationships with people who could support and protect him. He would please and placate these people to ensure himself of enduring support and protection, which left him open to abuse. Dave was also hypervigilant to rejection within relationships and if he perceived himself to be let down or betrayed could become emotionally or physically aggressive.

Dave considered the assessment process helped him to understand himself. The assessment was useful in negotiating a care plan with Dave, professionals in the community and a local specialist personality disorder service. Dave recognised the need to address a number of complex issues including interpersonal relationships, self-harm and violence to others. Dave trusts those he is working with as they provide a consistent and reliable response to him within clear negotiated boundaries. He finds the process difficult and at times becomes withdrawn and rejecting of services, but the consistent support helps him to return to services and continue to work towards a more stable lifestyle.

Healthy or normal personality functioning is characterised by the following:

- ego identity (integration of self concept and concept of significant others);
- ego strength (control of affects and impulses);

- an integrated and mature superego (internalised social values); and
- effective management of libidinal and aggressive impulses.

Personality disorders reflect developmental

failures in one or more of these areas.

Kernberg's concept of Borderline Personality Organisation (which includes all of the DSM-IV cluster A and B disorders: see Section 1.1) is characterised by identity diffusion (i.e. confused ego identity), primitive internal defensive operations such as idealised object representations (i.e. seeing specific people as faultless), denial or splitting (i.e. seeing people or relationships as all good or all bad), and varying degrees of superego disorganisation. Failures of mature development are seen in distortions in interpersonal relations and the control of emotional impulses, pathological rage being central to borderline disorders.

Psychoanalytic psychotherapy for personality disorders takes a variety of individual and group forms (Bateman & Fonagy, 2001; Clarkin, Yeomans & Kernberg, 1999). A common goal is to change those characteristics of the individual's internalised object relations that lead to repetitive maladaptive behaviours and long-term emotional and cognitive disturbances. This is achieved through identifying the dominant object-relations emerging in the transference, that is, the reactivation in therapy of internalised relationships based on early experience (Clarkin *et al.*, 1999).

2.1.3 Behavioural and cognitive-behavioural approaches

Where psychodynamic theories are based in observations of distressed individuals undergoing therapy, behavioural approaches originate in observations of animal and human learning in psychological research. Applied behaviour analysts believe that behaviour is controlled by its antecedents and consequences in the environment, behaviours with positive effects being reinforced or strengthened, those with aversive effects being weakened. These principles are basic to behavioural intervention strategies for developing adaptive social and coping skills. A functional analysis is necessary to determine the personal and environmental factors that are controlling behaviour and therefore need to be the targets of intervention.

Behaviourists are critical of concepts of personality disorder and traits, seeing them as uninformative labels that simply describe the form but not the function of behaviour (Follette, 1997). Problematic behaviours serve different purposes for different individuals and on different occasions. Rather than diagnosing personality disorder, the need is to determine the groupings of response that share the same

function for the particular individual. For example, suicide attempts, lashing out at others, substance abuse, dissociation, and withdrawal may all function to avoid emotional intimacy that has in the past led to hurt and rejection. Interventions should be guided by experimental research on behaviour.

Cognitive-behavioural approaches share these basic principles but accord greater significance to cognitive activities in controlling behaviour, drawing on computer analogies of how information is processed. Attitudes, beliefs, and expectations are acquired through social learning processes of observation and reinforcement, but then come to influence how we interpret and react to environmental events.

Cognitive-behavioural therapy (CBT) is concerned with ameliorating dysfunctional emotional and social reactions through educational and behavioural skills training procedures such as cognitive restructuring, relaxation training, social skills training, self-control methods, and problem-solving techniques. The aim is to provide the person with strategies for coping with problematic situations. Because the focus is on problem behaviours as they occur in specific contexts, CBT makes little use of concepts of personality traits or disorders.

Some therapists, however, see personality disorders as descriptions of unskilled or ineffective interpersonal behaviours that produce either social isolation (lack of positive social reinforcement) or aversive behaviours from others (social punishment; Marshall & Barbaree, 1984). The criteria identifying personality disorders are hence seen as dysfunctional exaggerations of normal behaviours that can be related to behavioural categories dealt with by CBT. Avoidant personality disorder, for example, can be construed as a combination of inappropriate assertive responses, dysfunctional social cognitions, and social anxiety. Social and cognitive skills training may therefore be appropriate interventions for people with a personality disorder.

Dialectical Behaviour Therapy (DBT) for borderline personality disorder is the most explicit application of CBT to personality disorder (Linehan, 1994). DBT integrates CBT with Zen and dialectical philosophical principles of the synthesis of opposites. Treatment targets the parasuicidal behaviours of borderline patients. Linehan's biosocial theory sees borderline disorder as a dysfunction of the

emotional regulation system stemming from biological irregularities interacting with an adverse, invalidating (rejecting) environment. The consequences are difficulties in labelling and regulating emotions and trusting one's own experience as valid, and self-mutilation functions to reduce intolerable painful emotion.

Emotional dysregulation takes the form of rapid, intense reactions, and these produce the characteristic problems in relationships, sense of self, impulse control, and cognitive distortion.

Skills training and problem-solving techniques are applied in group treatment to improve interpersonal conflict resolution, distress tolerance, and emotion regulation, but these are balanced by individual supportive techniques (reflection, empathy, acceptance) from Eastern philosophies (Zen) and the use of meditation. Dialectical strategies also pervade therapy. These include teaching the patient more balanced patterns of thinking and behaviour and balancing therapist strategies of change with acceptance of the patient's experience.

DBT has been used effectively to reduce parasuicidal behaviours, and is currently being extended to other self-defeating behaviours such as substance abuse and aggression. It is not, however, a generalised approach to personality disorder.

2.1.4 Cognitive approaches

CBT approaches emphasise a molecular level of behaviour analysis and avoid broader concepts of personality traits. Beck and colleagues note that the presence of a personality disorder reduces the effectiveness of treatment focusing on skills training alone (Beck *et al.*, 1990). They argue for a broader approach to problem behaviours that incorporates a theory of normal and abnormal personality. Taking an evolutionary perspective, they suggest that personality patterns or traits are genetically determined 'strategies' favoured by natural selection. Behaviours such as attacking, freezing, avoiding, seeking help, being suspicious, or seeking attention may all have had survival value in some situations but not others. Personality strategies are overt expressions of tacit or deep cognitive schemas (core beliefs) resulting from genetic-environmental interaction.

Personality disorders reflect dysfunctional beliefs and maladaptive strategies that are over-generalised, inflexible, imperative, and resistant to change. Each disorder is characterised by a distinct cognitive profile, a composite of beliefs, attitudes, and emotions organised around a general theme of the nature of self and others

that dictates a generalised behaviour strategy. For example, the cognitive profile of antisocial personalities embodies a concept of others as vulnerable and exploitative and of self as autonomous, strong, and entitled to break rules. This dictates a behavioural strategy of exploiting and attacking others.

Cognitive therapy originates in Beck's earlier theory that emotional disorders reflect biased information processing resulting from dysfunctional cognitive schemas. In the case of personality disorders, cognitive therapists place a greater emphasis on developmental issues, the therapist-client relationship, and the need for a longer duration of treatment. Therapy modifies the cognitive profile through guided discussion, structured cognitive exercises, and behavioural experiences. The goal is not to replace schemata, but to modify beliefs or make more adaptive use of strategies. For example, an individual with antisocial personality traits would be guided by the therapist from a strategy of unqualified self-interest to one of qualified self-interest that takes account of the needs of others.

Schema-focused therapy is a related cognitive approach developed by Young (1994). It is not based on a comprehensive theory of personality, but rather focuses on early maladaptive schemas (EMS) held to be common in emotional and personality disorders. EMS are broad and pervasive themes about oneself and relationships with others that originate during childhood and provide templates for processing later experiences. They are the cumulative result of dysfunctional early experiences rather than specific traumas.

EMS are activated by schema-relevant events and generate disruptive emotions that interfere with core needs for self-expression, autonomy, interpersonal relatedness, social validation, and social integration that are central to the sense of self. Young identifies a number of EMS, such as expectations of abandonment, failure, or subjugation to others. These EMS fall into broad domains of disconnection and rejection, impaired autonomy and performance, impaired limits, other-directedness, over-vigilance and inhibition, each of these being associated with a particular parenting style. He also identifies several processes through which schemas are maintained and affect behaviour, such as cognitive distortions, avoidance of schema-related thoughts and behaviour, and the development of overcompensatory styles opposite to EMS.

In therapy, EMS are identified through a self-

report questionnaire and activated through imagery and dialogue. Exploration of EMS focuses on their developmental origins and attachment issues, while CBT techniques are used to challenge and invalidate EMS. However, more use is made of the therapeutic relationship and there is a greater emphasis on emotional experience. Young suggests that this approach is 'constructivist' in that rather than correcting cognitive distortions to comply with an assumed reality, therapy focuses creatively on personal meanings and narrative and what is adaptive for the individual.

Cognitive Analytic Therapy (CAT) is an integrative, short-term therapy drawing on concepts from psychoanalysis, cognitive research, and developmental psychology (Ryle, 1997). It has affinities with object relations theory, while emphasising actual childhood experiences rather than unconscious fantasies, and makes use of CBT techniques while rejecting information processing models of knowledge and feeling. The developmental perspective emphasises that meanings, emotional experiences, and self-definition evolve in childhood as the internalisation of external dialogue through active engagement with others who transmit their own meanings and those of the culture. The focus is therefore on how people attempt to elicit reciprocal and confirming responses from others in their interactions.

In CAT, the basic descriptive unit is the procedure, which summarises motivated, intentional acts or enactments of roles in relationships as a learned psychological sequence progressing from perception to enactment and revision of aims based on evaluation of the consequences. The procedures of concern in psychotherapy of personality disorders are those controlling interpersonal action and self-management, a central concept being the reciprocal role procedure (RRP). RRP are characteristic ways of interacting with others based on an individual's early experiences with their mother and other significant caregivers. For instance, a needy child may experience a satisfying or depriving caregiver, and will internalise these reciprocal roles (e.g. needy – depriving). These roles become part of their self-concept and behavioural repertoire in their interactions with others. RRP, therefore, reflect how we anticipate the role behaviour of others and the consequences of our role behaviour to them. Thus, the sequences within RRP are governed by internalised dialogue about self-other and self-self relationships. A characteristic

of people with personality disorders is that they have a restricted and often self-defeating repertoire of RRP. RRP may, for example, induce others to take a reciprocal nurturing role through self-injury. They may also dictate the enactment of two poles in a relationship unit, for example those of caregiver and care-receiver, or those of abuser and victim.

A component of RRP is the experience or construal of roles, described as self-states. In borderline personality disorder, self-states may become partially dissociated RRP into which the person may switch abruptly to avoid unmanageable feelings. These dissociated self-states usually entail a dominant RRP in which attempts to elicit confirmation from the other are intense. Failure to elicit confirmation is a source of disappointment and often rage.

CAT is collaborative and descriptive rather than interpretive. Presenting problems are linked to cyclical patterns of procedures originating from and returning to the patient's RRP through procedural loops that maintain and reinforce dysfunctional patterns. Identification of these patterns is facilitated by the construction of sequential diagrams of the main recurrent patterns. These are agreed with the client and become the basis for targeting the problem procedures that need to be revised. Revision aims at disconfirming expectations of relationships in RRP and the integration of dissociated self-states through self-reflection, self-monitoring, and CBT procedures.

2.1.5 Interpersonal approaches

An interpersonal approach to personality disorder was first described by Leary (1957) and has subsequently been developed by several psychotherapists (Kiesler, 1996). As in object relations theory, personality disorder is seen as primarily a problem of interpersonal relationships. Some theorists also draw on cognitive social learning theory and focus on dysfunctional beliefs (Carson, 1979), while Benjamin (1996) presents a complex development of the theory incorporating concepts from psychodynamic and attachment theories. A common emphasis is on using the interpersonal context of therapy as a means of change.

The basis for theoretical developments is the interpersonal circle, a descriptive system in which interpersonal behaviours are portrayed as varying combinations of two independent dimensions of power or control (dominance-submission) and affiliation (hostility-friendliness). These appear to be the main

themes elicited when people interact. The interpersonal circle is an empirically well supported scheme, which permits analysis of interactions at the level of specific interactions, but also at the broader level of personality traits and disorders.

The traits of personality disorder are construed as rigid and inflexible interpersonal styles or predominant modes of relating to others that overemphasise a particular segment of the interpersonal circle. For example, schizoid and avoidant disorders are characterised by withdrawn (hostile-submissive) styles, while narcissistic disorders are expressed in arrogant and aggressive (hostile-dominant) styles. Psychopathy can similarly be construed in interpersonal terms (Blackburn, 1998).

A central concept is complementarity. Leary (1957) proposed that behaviour pulls a reaction from the other person, within a limited range. Along the dominant-submissive axis, complementary behaviour is reciprocal (dominant behaviour pulls submission), while along the hostile-friendly axis, complementary behaviour is corresponding or congruent (hostility pulls hostility and friendliness elicits friendly reactions). This produces expected combinations around the circle. For example, an accusation (hostile-dominance) is likely to elicit an excuse or self-justification (hostile-submission). Anti-complementary reactions (e.g. friendly-dominance is met with hostile-dominance) produce discomfort and disengagement. People with rigid styles are more likely to produce anti-complementary reactions that are aversive to others.

Carson (1979) proposed a cognitive theory to explain how people elicit and interpret signals coming from the other person. In any interaction, the two parties have certain goals and behaviour aims to induce a reaction from the other relative to those goals. People elicit behaviour from the other in accordance with their concept of self and the relationship. For example, a friendly overture entails verbal and nonverbal messages inviting a friendly reaction that then provides feedback. People therefore behave in ways that extract information from others that confirms expectations.

Extending complementarity principles to personality disorder, Carson (1979) proposes that dysfunctional interpersonal styles are maintained by the self-fulfilling prophecy. Early adverse relationships restrict learning experiences and create distorted expectations of how others will react, and this creates destructive

styles of interaction. For example, a hostile person expects hostile reactions and behaves in ways that attract them. People with extreme styles therefore create interactions that minimise the chance of disconfirming experiences.

The implications for change through therapeutic intervention are that the cycle of the self-fulfilling prophecy needs to be broken by providing clients with new experiences that disconfirm distorted expectations of others. Carson proposes that complementarity principles can be used by the therapist to provide these new experiences. Kiesler (1996) presents a similar model of changing maladaptive interpersonal styles.

One alternative to the interpersonal circle is the interpersonal octagon (Birchnell, 2002). In this model, interpersonal relationships are thought to be best described again on two dimensions. The first concerns becoming more closely involved with other people versus becoming separated from other people. The second dimension is explained in terms of whether the person tends to relate 'from below' as opposed to 'from above'. The octagon is based on evolutionary principles. Therefore, the dimensions relate to the basic objectives of relationships that carry advantages for the individual and give pleasure. This results in eight types of relationship – the four possible combinations of the two dimensions plus the difference between successful and maladaptive relationships. Within this model, the problems that lead to a diagnosis of personality disorder can be understood as types of incompetence in relationships. There has been research suggesting that the interpersonal octagon can be related to the ten DSM-IV diagnoses of personality disorder (Birchnell & Shine, 2000), and Birchnell (2002) has developed a model of psychotherapy based on these ideas.

2.1.6 Therapeutic communities

Residential Democratic Therapeutic Communities (TCs) were first developed during World War II to manage 'shell-shocked' war veterans. They reflected a shift in psychiatric thinking from an authoritarian style of doctor-patient interaction to a more democratic style in which the community is the therapeutic agent. Rapoport (1960) identified four key principles underlying therapeutic community treatment: community living, democratisation, permissiveness, and reality confrontation. Clients are centrally involved in the day to day running of the community,

including making decisions about most aspects of its functioning. By working collaboratively with staff, unhelpful ‘them and us’ attitudes are reduced. Clients are also crucially involved in supporting each other’s treatment and in confronting each other’s self-destructive, anti-social and inappropriate behaviour. Community discussion and debate aimed at understanding the causes of destructive behaviour, including destructive staff/staff and staff/patient interactions commonly experienced in treatment with this client group, is a constant feature. Group processes affecting the interpersonal and social functioning of the community, are of key importance.

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2.2 Causes of personality disorder

Key points:

- There is no single known cause of personality disorder.
- A combination of biological, social and psychological factors are implicated in the development of personality disorders.
- Personality disorders consist of manifestations of extreme forms of normal behaviours/emotions/beliefs.
- Many individuals are resilient to the biopsychosocial stress associated with the development of personality disorders; they would appear to possess resilient temperaments and/or have experienced adaptive socially environments and/or sought alternative positive attachments.
- Stress vulnerability would appear to be a mediating factor in the development and maintenance of personality disorders.

2.2.1 Biological factors in personality disorder

2.2.1a Genetic factors

Studies looking at genetic factors have examined either the heritability of normal personality traits and concentrated upon dimensional and psychobiological models of personality, or they have studied the heritability of pathological personality and concentrated upon categorical models of personality. The studies concentrating upon the heritability of normal personality have drawn information from a variety of dimensional models (Livesley, 2001). Using data from twin and adoption studies, there is evidence to suggest that personality dimensions are highly heritable, with an inherited component of 40 to 50 per cent (Paris, 1996). Other studies have shown that attributes such as callousness, identity problems, narcissism and oppositionality are highly heritable, whereas social closeness, self-harm and submissiveness are only moderately heritable (Paris, 1996). The psychobiological models focus on evolutionary determined behavioural adaptations that are perceived to result in heritable temperamental traits, that is, novelty seeking, harm avoidance, reward dependence and persistence, which shape personality development (Cloninger *et al.*, 1993). Studies concentrating upon the heritability of personality disorder have suggested three causal mechanisms in the development of personality disorder. First, it has been found that antisocial personality, borderline personality and substance abuse frequently occur together in family

studies, resulting in the hypothesis that they form a group of impulsive spectrum disorders associated with a common temperament (Zanarini, 1993). Second, individuals with schizoid, paranoid and schizotypal personality disorders tend to have relatives with schizophrenia or schizophrenia spectrum disorders (Paris, 1996). Third, individuals with avoidant, dependent and compulsive personality disorders tend to have relatives with anxiety disorders (Paris, 1996).

2.2.1b Temperament factors

Children vary in their response to their environment and the variability of behaviour in newborns is considered to have an underlying biological base. Newborns show individual differences in reactivity and self-regulation that are assumed to have a constitutional basis (Rothbart, 1991). From this original base, it has been observed that children affect the quality of the environment they receive by shaping the responses of carers to conform to their temperament (Scarr & McCartney, 1983). Some connections between underlying temperament and personality development have been observed (Rothbart & Ahadi, 1994) indicating that high fearfulness and high irritability are connected to the development of neurosis. High activity and positive affect are indicated in the development of an extraverted personality style. Attentional persistence is indicated in the development of conscientiousness and a proneness to distress is linked to attachment problems. These insights would explain a level of temperament variability within human beings but would not explain the development of pathological personality patterns. In order to understand the connection between variability of temperament and personality pathology, two potential pathways have been identified. First, an individual temperament can create problems for an individual's peers and parents that can lead to an amplification of their difficulties (Rutter & Quinton, 1984). Second, certain characteristics of temperament may make children more susceptible to environmental stressors (Paris, 1996). Cloninger *et al.* (1993) have made a further distinction by suggesting personality is composed of heritable temperament traits and character traits (self-directedness, cooperativeness and self-transcendence). The contention is that temperament is linked to the development of personality traits, whereas character determines whether temperament traits will be expressed as

personality disorder. There is a hypothesis that temperament and character are expressed through different memory pathways, suggesting temperament is unconscious and character conscious. However, as temperament and character are linked, it suggests strong links and connections between these memory pathways.

2.2.1c Neuroanatomical and biochemical factors

Research in neuroanatomy has shown particular connections between the development or stimulation of areas of the brain and particular emotional difficulties. The hypothalamus has been associated with the development of problems with anxiety (Gray, 1982). Studies using Magnetic Resonance Imaging (MRI scanning) have indicated that violent and impulsive behaviour is associated with dysfunction in the interior frontal cortex and the amygdala (Hoptman, 2003). Psychopathy has been linked to deficits in emotional processing, which has been associated with the amygdala (Blair & Frith, 2000). Research in brain biochemistry has shown we inherit 'chemical templates' that produce and regulate proteins involved in the structure of the nervous system and the neurotransmitters, enzymes and hormones that regulate them (Zuckerman, 1995). Therefore, we are not born impulsive sensation seekers or antisocial personalities but have differing levels of reactivity to stimulation of brain structures and an individual 'chemical template'.

2.2.2 Psychological factors in personality disorders

Studies looking at genetic factors in the development of personality traits suggest that genetic variables account for up to 50 per cent of the components of personality. The factors of the environment that contribute to the remaining 50 per cent, would appear to come from the 'unshared environment' (Dunn & Plomin, 1990), which would indicate that the environmental factors involved in the development of personality disorders do not primarily relate to being raised within a particular family. Therefore, whilst some personality traits are strongly heritable and the development of personality disorders would appear to be genetically influenced, researchers generally accept environment plays a major role in the development of personality disorders (Paris, 1996).

2.2.2a Childhood neglect

Those infants raised in environments lacking in individual attention, cognitive stimulation,

emotional affection or other enrichment have consistently shown lower intelligence and a greater tendency to display autistic spectrum disorders (Perry, 2002). It is apparent that childhood neglect leads to physiological changes in children, with a lack of sensory input in infancy being associated with decreased brain size and decreased metabolic activity in the orbital frontal gyrus, the infra-limbic prefrontal cortex, the amygdala and head of the hippocampus, the lateral cortex and in the brainstem (Perry, 2002). These findings suggest a global set of abnormalities matched by functional abnormalities in cognitive, emotional, behavioural and social functioning. Neglect during childhood has also been associated with diagnoses of antisocial, avoidant, borderline, dependent, narcissistic, paranoid and schizoid personality disorders (Johnson *et al.*, 1999).

2.2.2b Childhood abuse

A history of childhood abuse or neglect would appear to be associated with personality disorder. There is some indication that a history of physical abuse is associated with antisocial, borderline, passive aggressive and psychopathic personality disorders, whereas sexual abuse is associated with borderline, histrionic and depressive personality disorders (Johnson *et al.*, 1999). However, trauma alone is neither a necessary nor sufficient cause of personality disorders and other factors including temperamental vulnerability and multiple distressing life experiences are also necessary in their aetiology (Paris, 1996).

2.2.2c Post-traumatic stress disorder

Post-traumatic stress disorder occurs when an individual has been overwhelmed by terror and helplessness. It is manifest as reliving traumatic events, avoidance of remembering the trauma, and heightened arousal linked to perceived threat. Many people abused in childhood have been placed in terrifying situations where they have felt helpless. Therefore, it is not surprising that in clinical settings many individuals with personality disorder, particularly borderline personality disorder, are observed to suffer from post-traumatic stress disorder (Herman, 1992). It has been observed that neurophysiological changes take place in individuals with post-traumatic stress disorder. The speech area of the left hemisphere of the brain decreases in activity as the activity of visual cortex and right limbic and para-limbic systems increase (Rauch, van der Kolk, Fisler *et al.*, 1996). This could explain the

tendency towards flashbacks and the difficulty with speech noted when individuals with personality disorder attempt to recall traumatic material (de Zulueta, 1999).

2.2.2d Family history

There is evidence of a high degree of psychological and social dysfunction in the families of individuals who develop personality disorders and in particular the presence of depression, alcoholism as well as personality disorder amongst their parents (Paris, 1996). There would also appear to be a high instance of poverty, unemployment, family breakdown, periods of time in local authority care, and witnessing of domestic violence amongst individuals with personality disorders (Paris, 1996). With respect to antisocial personality disorder, one study (Robins, 1966) showed that, in families with children who later developed antisocial behaviour, the highest risk factor for the development of psychopathy and antisocial behaviours was antisocial behaviour in the father, although there was also a high frequency of antisocial behaviour in the mother and more parental alcoholism. It was hypothesised that individuals with antisocial personalities develop within a family structure where there is a chronic failure to discipline or supervise children (Robins, 1966).

2.2.2e Parent/child relationship

One aspect of normal parenting involves the quality of parent/child relationships. It has been hypothesised that adults with a personality disorder have been emotionally neglected during their childhood (Adler, 1985). Research suggests that personality disordered individuals frequently report having had problems in bonding with their parents and report difficulties concerned with lack of affection (neglect), lack of discipline/boundaries (under-control), and lack of autonomy (over-control) (Paris, 1996). However, difficulties with parental bonding are not specific to personality disorders and have been reported for individuals with various psychiatric diagnoses (Parker, 1983).

2.2.3 Social factors in personality disorder

2.2.3a Culture

Cross-cultural studies using dimensional models of personality have shown that the same personality traits occur in the majority of human societies (Costa & Widiger, 1994; Eysenck, 1991). There have been criticisms of these studies for

attempting to apply western concepts of personality to non-western societies (Fernandez & Climan, 1994). However, an assessment of personality disorder diagnosis across cultures found that categorical model of personality disorder could be used reliably to diagnose personality disorders across a range of cultures (Loranger, Sartorius, Andreoli *et al.*, 1994). This study found relatively small cross-cultural differences between societies and could not determine whether these differences indicated biological differences between cultures or the cultural shaping of personality traits by social expectation. There have been several studies (e.g. Weisz, Sigman, Weiss *et al.*, 1993) that have shown consistent differences in behavioural problems across societies. It would appear that children raised in cultures that value traditional social mores develop psychopathological symptoms associated with over-control whereas children raised in societies that value progressive change in social mores are likely to suffer more from symptoms of under-control.

2.2.3b Peer groups

Little research has been carried out in this area. However, Harris proposes that there is an impact of peer groups upon the development of social mores and norms (Harris, 1995). This theory suggests that individuals move during childhood from forming major relationships with their families to their peer groups. As a consequence, the function of these peer groups has a significant influence upon the development of their behaviour and attitudes, which can influence their personality functioning. American research has indicated that those belonging to delinquent peer groups are more likely to misuse substances, behave antisocially and become members of urban gangs (Elliot, Huizmya & Ageton, 1985; Patterson, 1986). A study assessing Harris's theory found some support for peer influence in shaping personality (Loehlin, 1997).

2.2.3c Socio-economic disadvantage and personality disorder

Little systematic research has been carried out in this area but there is an indication that poverty, unemployment and poor scholastic achievement are correlated with raised levels of antisocial activity and personality disorder in particular individuals. The majority of studies of the community prevalence of antisocial personality disorder indicate a clear link with low socio-economic status (Kohn, Dohrenwend &

Mirotznic, 1998). The only other personality disorders considered in this context suggest obsessive-compulsive personality disorder is significantly more prevalent in higher socio-economic groups (Samuels *et al.*, 1994).

2.2.3d Gender and personality disorder

There have been concerns that different prevalence rates in particular personality disorders could reflect a gender bias. This could be due to a combination of three factors: diagnosis-based bias, biased research samples, and/or biased assessment tools. Diagnostic bias is perceived to stem from a gender bias in the personality disorder constructs, such that to behave in a stereotypically feminine manner is associated with a personality disorder diagnosis (e.g. dependent, histrionic) whereas stereotypically male behaviour is not (Kaplan, 1983). However, six of the personality disorders are diagnosed more commonly in males as opposed to three for females (American Psychiatric Association, 1994). The purpose of the classification system is to diagnose psychopathology accurately, thus there is no reason to presume men and women would be equally personality disordered.

Differences in gender prevalence among the personality disorders may be more easily accepted if personality disorders were conceptualized as extreme, maladaptive forms of normal personality traits (Corbitt & Widiger, 1995). Should it be true there are personality disorders with different gender prevalence that are consistent with the normative differences between men and women, the diagnosis of these disorders could still be biased if different thresholds are used for male stereotyped as opposed to female stereotyped personality disorders. However, bias in the application of diagnostic criteria has the most empirical support (Widiger, 1998). Clinicians appear to favour diagnosing female patients with histrionic personality disorder and males with antisocial personality disorder, and it was failure to adhere to diagnostic criteria that was connected to a misdiagnosis (Widiger, 1998). Clinicians using unstructured clinical interviews appear to over-diagnose dependent and histrionic personality disorders; an unbiased, systematic assessment appears to reduce the gender bias, but there continues to be a gender bias with more women than men meeting criteria for these disorders (Widiger, 1998).

It has been suggested that the perception of gender bias in research into dependent and

histrionic personality disorders reflects the higher number of women in clinical settings. However, this gender prevalence may reflect the fact that, as there were more women at the clinic, more women suffer from the disorder. This would be consistent with the prevalence information available, which suggests that more women than men have dependent personality disorder (Reich, 1987). However, an accurate measure of gender prevalence would require epidemiological studies that have obtained representative samples of respective populations, which have yet to be carried out.

It has been suggested there are gender biases within the assessment tools used to measure personality disorders. Gender bias could occur if an assessment item scored positively for an attribute/trait that did not indicate dysfunction and it applied to one gender more than the other. This could lead to gender biased false positive diagnoses of personality disorder. A study of assessment tools found that there was a level of gender bias in the assessments and that this bias was more evident in personality disorders diagnosed with greater regularity in men (Lindsay & Widiger, 1995). Therefore, gender bias may best be addressed through emphasis upon adherence to the personality disorder criteria and diagnostic rules and to construct and apply a set of diagnostic criteria that minimise false positive and false negative errors for both men and women.

2.2.3e Gender and childhood maltreatment

Girls are at a higher risk of intra-familial sexual abuse whereas boys are more likely to be sexually molested by strangers or to be physically abused (Rogers & Terry, 1984). Community survey estimates of unwanted sexual contact with adults for boys and girls before the age of 18 vary from 38 per cent (Russell, 1983) to 59 per cent (Wyatt, 1985). Another indication of childhood sexual victimisation comes from lifetime prevalence studies of rape using the retrospective accounts of female adult victims. One study found that 21.6 per cent of first rapes occurred when the victim was less than 12 years of age and 32.4 per cent when the victim was 12 to 17 years (Tjaden & Thoennes, 1998). The gender ratio of victims of sexual assault in childhood has been estimated to be between 1.5 and 3 females to every one male (Katz & Watkins, 1998). Therefore, there are gender differences in the probability of different types of childhood maltreatment. This is likely to predispose men and women to different sorts of

personal dysfunction in the context of male and female identities developing differentially in society as a whole

2.2.4 Resilience to psychopathology

There is evidence to suggest that 25 per cent of individuals traumatised during childhood later developed significant psychopathology as adults (Werner & Smith, 1992). As the majority did not, this would indicate that some individuals are more resilient to the development of psychological distress. It may be that adaptive personality traits protect certain individuals against psychopathology. This resilience to distress may also be based upon an ability to buffer themselves from more negative life experiences and that some individuals need to experience more negative life events before their coping abilities are overwhelmed (Rutter, 1987) or the development of active coping styles in seeking social support (Runtz & Schallow, 1997). Social mechanisms may explain the relative lack of vulnerability of some children. These children would appear to recognise early on in their lives that their parent's behaviour is pathological and look elsewhere for attachment and behavioural models (Werner & Smith, 1992). It has been noted that positive experiences outside the

family, and particularly positive school experiences, may protect children by providing children with experiences of competence or a positive bond with a particular teacher (Rutter & Rutter, 1993). Schools and other social structures, such as athletics and social clubs may, therefore, reduce the risk of delinquency (Rutter & Rutter, 1993).

2.2.5 Conclusions

It is difficult to determine whether biological, psychological or social causes are predominant in any individual case or to discriminate between these factors. However, it is apparent that no single factor within an individual's environment, even in combination with a biological vulnerability, would be likely to produce a significant level of personality disorder. Therefore, multiple adverse life experiences are likely to be necessary.

Social rules determine which behaviours society considers disordered. These rules are important during the identifying of certain behaviours, thoughts and emotional responses as unacceptable and serve to shape the responses of individuals to meet the needs of their society. This would indicate that there is a link between cultural norms and the threshold for diagnosing

Can personality change?

Personality traits appear to be stable from around the age of 30 years. This has led some people to conclude that resistance to change is a fundamental attribute of personality and that the possibilities for changing adult personality are limited (Costa & McCrae, 1994). However, less is known about the stability of personality processes underlying traits, and goals or motives may be more subject to change across the life span. For example, our priorities or 'personal projects' change at different stages of life.

There have been few studies exploring whether the symptoms of personality disorder change over time, but it is generally assumed that because the definition of personality disorder refers to 'enduring patterns', this therefore implies temporal continuity. Research studies have, however, found that some of the problems associated with borderline and antisocial personality disorders reduce steadily over time, even without treatment (Moran, 1999; Stone, 1993; Zanarini *et al.*, 2003). This improvement in functioning may be due to people tending to become less impulsive as they get older (Harpur & Hare, 1994). Whether personality can be changed by clinical intervention, and what aspects of personality might be amenable to change, therefore remain significant questions to be answered by research.

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personality disorder. Therefore, the diagnosis of personality disorder is influenced by a combination of social and economic factors, gender-linked role expectations and childhood social injury, psychological manifestations of which are often present in childhood and early adolescence (Rutter *et al.*, 1999). This triple combination is also at work in increasing the chances of people having other problems, such as substance misuse and chronic depression or anxiety, which overlap with, and sometimes contribute to, the diagnosis of personality disorder.

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3. Psychological interventions for individuals with personality disorder

3.1 Assessment and formulation

Key points:

- Psychological perspectives on personality disorder originate in psychodynamic, behavioural, cognitive, and interpersonal theories of psychopathology.
- Personality assessment is relevant to individual formulation, specifically the tasks of establishing goals, tailoring and maintaining focus in the therapeutic process, contributing to the choice and sensitivity of intervention strategies, and monitoring change over time.
- Personality disorder may require treatment in its own right.
- Personality disorder can also be a complicating factor in respect of the assessment, treatment, and successful management of Axis I clinical syndromes.
- Unstructured assessments of personality disorders are not recommended because they are unreliable, of questionable validity, and provide almost no basis for the evaluation of change over time.
- Instruments designed for the structured assessment of personality traits and disorders are recommended and should be carefully selected for their relevance to the treatment and management needs of individual clients.
- A combination of self-report instruments and semi-structured interview is recommended as good practice in personality disorder assessment.
- Only instruments that have a good history of application in clinical settings and that have established and well-documented psychometric properties should be considered for use.

3.1.1 General issues

Unstructured assessments of personality disorders are not recommended because they are unreliable, of questionable validity, and provide almost no basis for the evaluation of change over time (Zimmerman, 1994).

Structured assessments of personality, as with other psychological constructs, are preferable to unstructured assessments for a number of reasons (Pfeiffer *et al.*, 1976):

- They can help to clarify treatment goals and facilitate the development of contracting for new behaviours.

- They provide for comparisons between individual clients and normative groups.
- They can sensitise clients and therapists to the multifaceted nature of therapeutic change.
- Feedback from assessments can be helpful to clients.
- They encourage client participation in the treatment process, improve communication between client and therapist and help the therapist to focus and manage therapy more effectively.
- They provide a good baseline from which to measure changes to a client's functioning as a result of treatment.
- They facilitate the longitudinal assessment of therapeutic change (i.e. before, midpoint, termination, and on follow-up).

Instruments designed for the structured assessment of personality traits and disorders should be carefully selected for their relevance to the treatment and management needs of individual clients. Only instruments that have a good history of application in clinical settings and with established and well-documented psychometric properties should be considered for use (MacKenzie, 2001). It is common to use several instruments in order to cover several areas directly applicable to the general features of personality disorder; for example, symptoms of psychological distress, personality disorder diagnostic criteria, personality traits or patterns, relationship stability and attachments, and social functioning. It is also common to use more than one method of assessing personality and personality dysfunction; for example, self-report instruments, a semi-structured interview schedule, collateral information, and observation

3.1.2 Choosing a structured assessment

Interview-based assessments are considered the 'gold standard' for diagnosing personality disorders (Clark & Harrison, 2001). However, problems may be encountered in the reconciliation of conflicting information reported in interview and derived from collateral sources. Self-report instruments are thought to have validity in the broader assessment of personality traits but are of less use in personality disorder diagnosis; self-report instruments tend

to yield higher prevalence estimates for Axis II disorders when compared with interview methods (Dolan-Sewell *et al.*, 2001), and consist of a series of uncorroborated statements or self-presentations made by the client (Hart, 2001). Recent research suggests that, in forensic populations at least, interview and self-report methods in fact perform equally well in the assessment of personality disorder characteristics, although assessment methods may be differentially sensitive to the personality disorder problems being examined (Blackburn, Donnelly, Logan & Renwick, 2004). That is, traits reflecting beliefs about the self or others may be reliably assessed by self-report questionnaires due to respondents' access to autobiographical memory. In contrast, stylistic traits involving undesirable effects on others may be evaluated more adequately by means of semi-structured interview methods (also Clark & Harrison, 2001).

Semi-structured interviews for the assessment of personality disorders may be organised by topic or domain (e.g. the International Personality Disorder Examination or IPDE; Loranger, 1999) or by disorder (e.g. the Structured Clinical Interview for DSM-IV Axis II Disorders or SCID-II; First *et al.*, 1997). The arrangement of criteria by diagnosis facilitates rater judgement as to whether a particular characteristic exemplifies a core characteristic of the target disorder. However, the weakness of this approach is the potential for biased judgement or the 'halo' effect. For example, if a client has a positive rating on the first two or three criteria for a particular personality disorder diagnosis, the clinician may not rate subsequent criteria with appropriate objectivity and instead under-probe items in a possibly unconscious attempt to confirm the initial diagnostic impression (Clark & Harrison, 2001). The arrangement of interview items by topic is thought to give a more natural interview because it facilitates client reflection on various life domains (e.g. employment, self, interpersonal relationships), much as they would in ordinary discourse. Strong empirical data supporting the validity of one format over the other is so far absent and the choice would appear to be largely a matter of the preference or theoretical predilection of the clinician.

3.1.3 Multiple sources of information and dealing with conflict

Data obtained at interview should not necessarily be taken at face value. The responses of clients to interview questions may be limited by poor

insight into personality functioning and clients in forensic settings may be additionally hampered by a desire to mislead the interviewer about the presence of characteristics perceived to be negative (e.g. lack of empathy). Attempts should be made to confirm or deny important claims made by the client using clinical notes compiled by others, criminal, educational and employment records, and interviews with relatives and friends. Where conflicts exist between client and informant information, and collateral information is thought to be credible, this should alert the interviewer to the possibility that the client is engaging in impression management. New information should be sought and careful consideration should be given to sources that suggest greater difficulty or pathology on the assumption that some people may under-report or minimise pathological symptomatology.

3.1.4 Comorbidity

Comorbidity refers to the co-occurrence of different clinical or personality disorders. Comorbidity may arise because disorders are distinct and incidentally co-occurring. Alternatively, co-occurrence may be an artefact of, for example, shared or similar diagnostic criteria, a common aetiology, sub-clinical versus clinical representations of pathology (e.g. schizotypal or paranoid personality disorder as sub-clinical forms of psychotic disorder), or vulnerability (e.g. the presence of avoidant personality disorder creates a vulnerability to the development of anxiety disorders). Comorbidity research to date demonstrates the marked tendency for Axis I and Axis II disorders to co-occur. For example, research suggests that between 66 per cent (Dahl, 1986) and 97 per cent (Alnaes & Torgersen, 1988) of clients with an Axis II disorder also have a diagnosable Axis I disorder. Examined from the reverse perspective, studies indicate that the number of clients with Axis I disorders who also have an Axis II disorder ranges from 13 per cent (Fabrega *et al.*, 1990) to 81 per cent (Alnaes & Torgersen, 1988).

In general, the strongest relationships appear to be between the substance use disorders and the Cluster B personality disorders (the relationship between antisocial personality disorder and alcohol abuse and dependence is particularly strong; Tyrer *et al.*, 1997), and between the somatoform and anxiety disorders and the Cluster C personality disorders. Beyond these conclusions, however, there is little evidence for specific relationships between

Assessing personality disorder in clients with learning disability

Only a small number of studies have been carried out into the assessment and diagnosis of personality disorder in individuals who have learning disabilities. Studies of prevalence suggest that using structured forms of assessment, estimates approximately match those reported for individuals without learning disabilities (e.g. Goldberg, Gitta, & Puddephatt, 1995; Khan, Cowan & Roy, 1997; Niak, Gangadharan, & Alexander, 2002). However, a number of researchers have questioned the usefulness of diagnostic systems with clients with learning disabilities, especially those whose impairment is severe. Gostasson (1987) and Reid and Ballinger (1987), for example, commented that the diagnostic criteria for personality disorder did not really apply to people with severe learning disability and suggested instead that a typology based on developmental concepts might be more useful. Similarly, Alexander and Cooray (2003) complained about the lack of diagnostic instruments validated for use with clients with learning disabilities, problems with agreement about the definition of personality disorder in this population, and the difficulty of distinguishing personality disorders from other problems integral to intellectual impairment (e.g. problems with communication or sensory perception). Consequently, Alexander and Coorey (2003) recommended the development of more coherent and sensitive diagnostic criteria, and encouraged the use of behavioural observations and informant information to supplement that obtained in interview.

The Royal College of Psychiatrists takes a more cautious view (Royal College of Psychiatrists, 2001). In a review of diagnostic criteria, the Royal College recommends that a diagnosis of personality disorder should not be made in a person with severe and profound learning disability and made only with caution in clients with less severe disabilities. Instead, discussion should focus around personality presentation and the impact of personality traits on functioning. In general, the use of multiple sources of information (e.g. information from structured interview, responses to self-report questionnaires, interviews with carers and care providers, and behavioural observations over time) are likely to offer the best opportunities to determine consistencies in personality traits and dysfunction in clients with learning disabilities, with the level of reliance on other sources apart from the client increasing proportionate to the level of disability.

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disorders (Dolan-Sewell *et al.*, 2001). That is, anxiety disorders are noted to occur at significant rates not only with Cluster C personality disorders but also with the Cluster B disorders. In general, personality disorder is a sensitive indicator of proneness to Axis I disorders (including psychosis), although Cluster A personality disorders reflect a more specific proneness to psychosis (Dolan-Sewell *et al.*, 2001). In order to maximise awareness about possibly co-occurring conditions, professionals are recommended to conduct comprehensive

assessments of clinical syndromes before making diagnoses of personality disorder; the extent to which Axis I symptomatology may influence opinions related to personality disorder requires clarification in many cases (Hart, 2001).

3.1.5 Practitioners should focus on needs formulation not simply diagnosis

The provision of effective treatment for individuals with personality disorder requires the ability to place their experiences in a contextual and explanatory framework that can help to

raise that person's own awareness of their behaviours, thoughts and emotions. This is the core of formulation: a sophisticated, detailed and dynamic understanding of a person as an individual, and its process directly informs interventions to generate positive change. Formulation is necessary in addition to diagnosis; while diagnosis is a useful starting point, providing baseline information about type

and level of disorder, it is inflexible and impersonal and therefore limited in its utility in individuals with personality disorder difficulties. Formulation goes beyond diagnosis through the generation of a working model based on an assessment of the range of personality traits presented and a linked set of hypotheses that are addressed in the course of a systemic response to the needs presented.

Clare

Clare is a 34-year old woman who is married to James. She works as a care assistant in a nursing home for older people though she only does the night shift. She used to work in a bank and was doing very well there until she decided to leave because she felt so unhappy about being around her colleagues. When her line manager asked her why she was so unhappy that she wanted to leave, she told her that it was because she felt so afraid that she was doing things wrong and that her colleagues were criticising her and didn't care to associate with her. Her line manager pointed out that she did not associate with them, that she seemed to make a point of keeping herself to herself. Clare had nothing to say in response and looked very unhappy indeed.

James was becoming increasingly more concerned about Clare's social withdrawal. She had always been a very shy and introverted woman. He liked that because he was a quiet, shy man himself. They never had a fancy lifestyle, but now Clare was refusing to go to the small local pub with him on a Friday evening, their habit all their married life until recently. When he asked why, she told him that she was worried people were looking at her and that she didn't feel as good as or as interesting as the other women who were there. When James asked Clare if she thought she might be depressed, as she had been for several months after the death of her mother when she was 28-years old, she said that she wasn't. She was fine when she was on her own and when she was at work in the nursing home, with only one or two people to talk to at a time whom she never felt judged her. But James was unhappy because he felt their lives were becoming very restricted and dull. He felt himself becoming irritable with Clare and feeling envious of his friends who went to parties and on holiday.

Over the space of several months, James convinced Clare that her shyness and desire for solitude were worse than they had ever been and that they might be responsible for some of the irritability that he had been experiencing towards her. James convinced Clare to come with him to their GP, just so that they could talk it over with an independent person who might be able to help. James explained to the GP how Clare had changed in the last few years and how their plans at the time of their marriage – to work and travel and eventually have children – were falling by the wayside because Clare was having increasing difficulty being around people. He told the GP that he worried that she might not want to be around him for very much longer. Clare began to cry and was able to tell the doctor that she too was worried by her increasing and debilitating shyness and that she too missed their friends and their former activities and worried for their future.

Clare's doctor arranged for her to visit a clinical psychologist for an assessment prior to the recommendation of treatment. The psychologist asked Clare to tell her what it felt like to be her and how who she was now was different from the person she was 10 years ago and from the person she was as an adolescent. The psychologist asked her to tell her about how she met James and what she liked and disliked about him. She asked about Clare's health and her employment, her upbringing and her family, and she also asked her about her thoughts about the future. She asked whether Clare was anxious and whether she had ever had a panic attack, and she asked if she was worried about leaving the house alone or being in crowded places.

As a result of Clare's responses to the questions posed, the psychologist was able to rule out panic disorder and agoraphobia. The psychologist thought that instead Clare could be depressed, or she could have characteristics of avoidant personality disorder, or both. Clare was obviously a bright young woman and she had no physical worries, and while she had lost her mother, the remainder of her family were close and there was no conflict there that was adding to Clare's

presentation. Clare had always been very shy, but it seemed to the psychologist that a variety of events had happened around the same time (i.e. the death of her mother, changes in the bank, a new and bossy boss, the emigration to Canada of her closest friend), which were enough for her shyness to become much more salient. Her withdrawal from her employment in the bank and from her friends seemed to make her feel better even though she was generally unhappy with the consequences for her life with James.

The psychologist tested her hypotheses by carrying out a personality assessment using the International Personality Disorder Examination, which is a semi-structured interview during which clients are asked about all sorts of personality traits. It was very clear from this examination that Clare met the criteria for a diagnosis of avoidant personality disorder. This was a good assessment to do because, in the course of the interview, it was possible for Clare to start to see patterns in her behaviour that she had not really noticed before, and she felt good about talking about this with someone who seemed to understand that was happening. This assessment lasted two sessions. The psychologist also asked Clare to complete the Beck Depression Inventory (BDI).

The results on the BDI indicated that Clare was not depressed although she reported increasing anxiety about the way she was and how it was affecting her much treasured relationship with James. The psychologist concluded that Clare's primary presenting problem was avoidant personality disorder and marked its onset to the period following Clare's 25th birthday although she had personality traits consistent with a premorbid avoidant presentation.

3.1.6 Personality disorder assessment in legal settings

Hart has described a number of important points about personality disorder assessment and crime (Hart, 2001).

First, the problems that contribute to personality disorders are unlikely to result in major impairments of thought and speech or in obviously irrational perceptions of and beliefs about the external world. Therefore, in most jurisdictions in Europe and North America, a diagnosis of personality disorder is not thought to be sufficient to make a person incompetent to stand trial or not criminally responsible with respect to any particular criminal act. (See also Melton *et al.*, 1997).

Second, in legal settings symptoms of personality disorder should be assessed using methods that integrate information obtained from a number of different sources (e.g. family, employment, and education sources) in addition to information obtained directly from the client during a clinical interview. Assessments based only on interviews or written self-reports should not be relied upon.

Third, practitioners should provide information about the context in which personality disorders are interpreted including information about their prevalence in relevant settings, such as prisons or forensic psychiatric hospitals. In particular, practitioners should not over-emphasise the significance of antisocial behaviour in the assessment of personality disorders in forensic settings (Hart, 2001); the problems that lead to a diagnosis of antisocial personality disorder are common in those who reoffend.

Fourth, when writing reports or giving evidence, psychologists should explain the ways in which he or she believes the individual's diagnosis of personality disorder is linked to their risk to others and to any other legally relevant impairment from which the person suffers.

Fifth, in legal proceedings involving individuals with many different types of mental health needs, practitioners commonly make the mistake of offering opinions about diagnosis or assessment when they are already involved in treating the person or offering therapy. It is difficult to switch from the role of treatment provider, where the practitioner works for a person and advocates his or her well-being or best interests, to that of neutral assessor in which the assessor is required – and sometimes paid – to offer an objective opinion. Ethical codes of practice warn psychologists about the problems that can arise from conflicts of interest and lawyers are increasingly sensitive to the bias that may result from such conflicts. Structured assessments of personality disorders as well as risk mitigate against such bias.

Finally, a most basic mistake made by practitioners is to be unfamiliar with the law relevant to the issue being decided. Ignorance of the law can lead to a variety of sometimes very costly errors. For example, if the practitioner forms an opinion based on evidence that is legally inadmissible (such as hearsay), their opinion can be disregarded because it could be unreliable or prejudicial. Practitioners are obliged to learn the basics of the law as it relates to their professional practice.

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3.2 Psychological interventions in health service settings

Key points:

- Individuals with personality disorder are heavy users of health services.
- Establishing the efficacy of psychological therapy for personality disorders should be a priority for clinicians and researchers.
- Decisions about clinical care should be based on the best available evidence.
- Although there are few well controlled studies, research findings suggest that people with personality disorder can be successfully treated using psychological therapies.
- There is no clear evidence of the superiority of one type of treatment approach over another or for a particular method of service delivery (inpatient, outpatient, day programme).
- Treatment benefits appear particularly evident when treatment is intensive, long-term, theoretically coherent, well structured and well integrated with other services and, where treatment has been provided in a residential setting, follow-up care is provided.
- The efforts made in engaging patients and keeping them engaged in treatment, and the quality of the therapeutic alliance achieved, are crucial factors in determining treatment outcome.
- There is a need for further research with carefully defined populations, clearly defined treatment goals, and long follow-up periods incorporating cost benefit analyses.

3.2.1 Psychological therapies

Individuals with personality disorder are heavy users of mental health services (Dolan, Warren, Menzies *et al*, 1996; Perry, Lavori & Hoke, 1987; Skodol, Buckley & Charles, 1983), and often come to services seeking help with other mental health disorders or, in the case of borderline personality disorder, because they have deliberately harmed themselves. The range of health services used by those with personality disorders is extensive and the pattern of use of services highly variable. For example, some individuals may require lengthy inpatient services, some may frequently use accident and emergency services, and some may attend their general practitioners regularly. This section will only discuss treatments that have an evidence base.

There is no standard treatment for individuals with personality disorders in the UK, nor has any treatment been shown to be superior to any other (Bateman & Fonagy, 1999). Presently, those with personality disorders tend

to receive a rather bewildering array of interventions: pharmacotherapy to help with problems such as unstable mood and impulsivity, inpatient treatment when there is a risk of serious self-harm or a coexisting mental illness, psychoanalytic therapy, cognitive therapy, cognitive analytic therapy, dialectical behaviour therapy, supportive therapy, and specialised therapeutic community settings. This list is not exhaustive and to date few treatments have been systematically evaluated for their efficacy in treating personality disorders; there are few randomised controlled trials (RCT), many of the studies reported to date are small (under 50 patients), and few have undergone replication by independent researchers.

Existing treatment approaches for people with acute mental health needs may not be optimal for individuals with personality disorders because their service use tends to be characterised by problems such as high rates of premature termination, poor patient outcomes and high treatment cost (Waldinger & Gunderson, 1984). Thus, there is a need to develop more appropriate services. Some clinicians have suggested that services for those with personality disorder require highly specialised skills and need to be developed as separate – or tertiary – services; there are problems in engaging those with personality disorder in treatment and specialised dedicated services may be better at this. Specialised services would also be able to provide the more focused and lengthier treatments required, more so than general mental health services where there is a necessity to treat a wider variety and greater number of patients. Others argue that focusing only on specialised services would be inappropriate given the potentially large numbers involved and the range of problems likely to be encountered. In order to make the best use of resources, it may be better to train staff in more general mental health settings to be able to offer appropriate interventions for patients with personality disturbance or disorder who often attend these services because of the high prevalence of other co-existing psychiatric disorders. Treatments that are both structured and focused increase compliance and the likelihood of patients and therapists forming a collaborative working alliance, and they are likely to be more effective as a consequence.

Drug treatments

There are no drugs that specifically treat personality disorder although medication can be helpful in alleviating some of the symptoms. There is little evidence as to which medication may be most effective with which problems, and research has been hampered by inadequate research methodology, small sample sizes, high dropout rates and strong placebo effects. Despite this, drugs are frequently used, and often several different types of drugs are used at the same time. This can be very counter-productive, especially if ever increasing doses are used when problems seem intractable: drug treatments may lead to unacceptable side effects and can be dangerous in overdose. Also, because everyone is unique, it is difficult to know which medication will be best for each person. This means that drug treatment can involve some trial and error before the most helpful medication is identified. Therefore, it is important that patients understand the limitations of medication so that their expectations are not raised unrealistically. Reviews by Markovitz (2001) and Tyrer and Bateman (2004) are helpful summaries of outcome studies.

Psychologists generally feel that in most cases treatment works better if patients are not taking medication. The fact that some therapeutic communities insist that patients are medication free before undergoing treatment also suggests that even in cases of severe personality disorders medication is often not necessary if psychological treatments are in place to support the patient.

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3.2.2 Effectiveness of therapies for personality disorder

Decisions about clinical care should be based on available research evidence. The evidence used to make decisions about clinical care is based on a hierarchy, with the best level of evidence coming from meta-analyses and systematic reviews (using grouped data from randomised controlled trials), followed by single randomised controlled trials, cohort studies and cross sectional surveys and case controls at lower levels of evidence. Randomised controlled trials (RCTs) are therefore considered the 'gold standard' of evidence in medicine as a whole. This type of study design is the most appropriate to answer highly specific questions, usually of the form 'Is treatment X better than treatment Y for patients with a specific disorder?' Without a randomised controlled design, conclusions cannot be definitive about the effectiveness of one treatment compared to another.

Seligman (1995) has argued that the properties that make an RCT so scientifically rigorous make it the wrong method for evaluating psychotherapies because RCTs do not reflect what is done in routine clinical practice. Criticisms of RCTs, particularly from practitioners of psychological therapies, have centred round a number of issues (Persons & Silberschatz, 1998; Slade & Priebe, 2001). The main issue is that RCTs involve grouping patients, typically by

diagnosis or by a specific problem, such as deliberate self-harm. This assumes that all people with the same diagnosis or problem are similar, and that by dividing them at random into groups, individual differences between people are taken into account. In RCTs, the patients entered into the study are often a highly selected group that fit specific entry criteria and many patients may be excluded, thus reducing the degree to which the patients are representative of the group as a whole that may be suitable for treatment. Randomisation of patients in itself introduces artificiality as it does not consider what the patient would have chosen if offered a choice of therapies. This issue is of importance if one considers that patients are not passive recipients of treatment and that their level of participation in a clinical trial can vary from full participation to dropping out altogether, introducing an important source of bias in the results. Psychological treatment research using randomised controlled designs often utilises treatment manuals that may accurately describe the treatment patients receive but it can be argued that therapists in naturalistic settings behave differently and more flexibly, adapting the therapy to the patient, rather than following a rigid treatment protocol. Although individuals may have the same disorder, one individual may have a different set of problems and psychological issues from another.

Other problems associated with clinical trials are to do with measurement and statistical power (Roth & Fonagy, 1996). In personality disorder treatment research, there are a variety of important outcomes that could be measured such as self-harm, depression, hopelessness, anger, and offending behaviour. Note that these are not measures of change in personality or personality disorder status. Therapy tends to focus on the patient's presenting problems and few individuals come to therapy asking for their personality disorder to be changed.

Psychological therapy for a specific disorder may be based on a recognisable set of therapeutic strategies and techniques but clinicians will tend to base their interventions on an individualised formulation of a patient's problems rather than diagnosis *per se*. It could therefore be argued that psychological therapy is based on an individual and that the effectiveness of an intervention should be assessed at a more individual-level research design, such as single case designs. However, this in itself raises other problems, particularly those of generalisability of results. On the whole, treatment outcome research in this area has concentrated on the domains of social functioning (such as relationships and work) and symptoms (affect, cognition and behaviour) and there is a need for greater consensus from patients, therapists, and other stakeholders about what changes are important and can be reliably and validly measured and achieved in therapy (Slade & Priebe, 2001).

Effectiveness studies, where treatments are examined in a more naturalistic setting and a less highly selected group of patients are studied have many advantages and can also comply with many of the high standards set by randomised controlled trials and the results may be more applicable to routine clinical settings. Well-defined study questions, adequate patient selection criteria, clear procedures for randomisation, and adequate concealment of treatment allocation help eliminate potential investigator bias in studies and improve the internal validity of studies. There is a strong case for effectiveness studies as the results are more likely to be generalisable.

RCTs have an important place in evidence-based health care and give a more definitive answer to questions of efficacy than any other type of study design. The fact that a therapy has not been demonstrated to be effective in a controlled study does not mean that it is ineffective but we have no compelling reason to believe that it would be effective, and

importantly, we do not know if it is harmful. Many psychological therapies, particularly cognitive behavioural therapies, have been demonstrated to be effective in randomised controlled trials. There are few specific reasons why controlled studies cannot be carried out in individuals with personality disorder and we need to continue to establish the evidence base for psychological therapy at the highest level of evidence possible.

3.2.2a Cognitive and cognitive behavioural therapies

Cognitive therapies for the personality disorders are structured individual treatments that are problem-focused and less intensive in terms of time than either psychodynamic psychotherapy or dialectical behaviour therapy. These treatments have developed from cognitive behavioural therapy for mental disorders such as depression, which is widely practised in the UK. Importance is placed on engaging the client in therapy through a formulation of their problems and forming a collaborative alliance with the client. The first stage of therapy therefore involves arriving at a formulation to understand the client's difficulties. This working hypothesis ties together the client's long-standing problematic behaviours, interpersonal problems and hypothesized underlying dysfunctional core beliefs that may have arisen as a result of childhood experiences. It also has a pragmatic application in determining which strategies are likely to be the most useful in promoting effective change in the client. Cognitive strategies are used to modify maladaptive core beliefs about self and others. Behavioural strategies are used to promote a reduction in self-harm and other maladaptive behaviours, as well as to help people to develop better ways of coping with their difficulties. An abbreviated manualised form of cognitive behavioural therapy (MACT) has been shown to be a cost-effective in patients who repeatedly self-harm, up to 90 per cent of whom had personality disturbance or disorder (Byford *et al.*, 2003; Davidson *et al.*, 2004; Tyrer *et al.*, 2003). In addition, therapist competence was shown to be a moderator of clinical outcome (Davidson *et al.*, 2004), indicating that high levels of competence are required to treat those with personality disorder effectively. There is now evidence of effectiveness of CBT in the treatment of borderline personality disorder from a randomised controlled trial of one hundred and six patients who received either cognitive behavioural therapy in addition to their usual

treatment or their usual treatment alone (Davidson *et al.*, in press). Across both treatment arms there was gradual and sustained improvement, with evidence of benefit for the addition of CBT on the positive symptom distress index at one year (the end of the active therapy period), and on state anxiety, dysfunctional beliefs and the quantity of suicidal acts at two year follow-up (Davidson *et al.*, 2005).

DBT involves both individual therapy and a group psycho-educational component. In the group component, patients are taught self-management skills, distress tolerance skills and how to deal with interpersonal situations more effectively. In the accompanying individual therapy sessions, the therapist first focuses on behavioural and supportive techniques to reduce self-harm, before moving on to apply other directive and supportive techniques to other problem areas including any behaviour which interferes with ongoing work in therapy. DBT encourage patients to accept negative mood states without resorting to self-harm or other maladaptive behaviours.

DBT for women with borderline personality disorder has been shown to be effective in reducing self-harm during treatment (Linehan *et al.*, 1991; Verheul, 2003). However, no differences were found between those who had DBT and those who had treatment as usual in respect of reported levels of depression, suicidal ideation, hopelessness and reasons for living at the time of treatment (Linehan *et al.*, 1991, 1994). For those who had received DBT, the positive effect of treatment on episodes of self-harm continued for six months after treatment ended, but during the subsequent six to twelve months follow-up period, no differences were found between the groups in the number of suicide attempts (Linehan *et al.*, 1993).

In a study of female military veterans (Koons *et al.*, 2001), only 40 per cent of whom had an episode of deliberate self harm in the previous six-months, those who received DBT improved on measures of depression and hopelessness compared to those receiving treatment as usual but no difference in rates of self-harm or inpatient days during treatment were found (Koons *et al.*, 2001). As there is only one study of DBT with women with borderline personality disorder that has followed-up patients after treatment, more follow-up studies are needed to assess the longevity of changes in self-harm. However, from the evidence available, it does appear that for women with borderline personality disorder, DBT can be an effective

treatment for self-harm and differences between the studies may be due to the different sample of women selected, and particularly the frequency of self-harm in the samples studied.

Several studies have examined the efficacy of an adapted form of DBT for women with borderline personality disorder and comorbid substance abuse (Linehan *et al.*, 1999; Linehan *et al.*, 2002). During treatment, the results showed few differences between DBT and treatment as usual, but at follow-up, those who received DBT showed important gains in terms of abstinence from drugs and less parasuicidal behaviour. However, when DBT was compared to a more structured psychological treatment, namely comprehensive validation therapy, no differences were found in outcomes on any measure (Linehan *et al.*, 2002). It may be that treatment may need to be longer for some patients, and as DBT has developed, more long-term contact has been offered to patients. Positive findings need to be replicated using larger numbers of patients and in more independent studies.

3.2.2b Psychodynamic psychotherapy

Psychodynamic psychotherapy has been evaluated using randomised controlled trial. Two forms of psychodynamic therapy have been compared, interpersonal group therapy and individual dynamic psychotherapy (Munro-Blum & Marziali, 1995). Of the men and women who remained in the study (28 per cent of the sample withdrew), both forms of therapy demonstrated improvement on measures such as levels of social functioning and depression at follow-up, regardless of treatment condition.

Psychodynamic psychotherapy associated with partial hospitalisation has been found to be more effective than standard psychiatric care in the treatment of men and women with a diagnosis of borderline personality disorder (Bateman & Fonagy, 1999). Partial hospitalisation was intensive, and like DBT, included both group and individual therapy, lasting for 18-months. The control group received regular psychiatric review approximately twice a month and, if appropriate, in-patient treatment with out-patient follow-up at discharge. At 18 months follow up, the results still showed an advantage for those who had psychodynamic psychotherapy and partial hospitalisation (Bateman & Fonagy, 2001). Although the results for partial hospitalisation are promising, there are some methodological problems with this study as 16 per cent of patients were not treated in their original group

and patients continued to receive treatment during the follow-up period, although this was not as intensive as the first 18 months. Also, it is not possible to identify the essential ingredients of treatment from this research.

When considered together, studies using randomised controlled group designs demonstrate that structured and systematic psychological treatments can be effective at reducing self-harm and improving social and interpersonal functioning in patients with BPD. Importantly these gains are maintained, on the whole for at least six months in a naturalistic setting and for longer when patients continue to receive therapy (Bateman & Fonagy, 2001). However, most studies have been on small samples of patients and larger more generalisable studies, involving more than one centre, are needed.

3.2.2c Democratic therapeutic communities

Although there have been several large scale literature reviews of the effectiveness of therapeutic community (TC) approaches (Lees, Manning & Rawlings, 1999; Warren, Preedy *et al.*, 2002), methodological difficulties inherent in the research have so far prevented the emergence of clear conclusions. Additionally, serious ethical concerns have been expressed about the appropriateness of randomised control trials for this population (Norton & Warren, 2004; Roth & Parry, 1997; Slade & Priebe, 2001). Also, the different types of clients, treatment settings, treatment interventions and research methods involved make it difficult to compare the results of different studies. Further problems arise from the lack of appropriate control groups and the difficulty of controlling for external influences, such as the passage of time and other interventions received during the follow up periods.

Despite these difficulties, research reviews have suggested that the use of TC approaches with personality disordered patients is promising. For instance, a five-year follow-up study of the Henderson Hospital found an absence of convictions and hospital admissions in 36 per cent of the treated group versus 19 per cent of non-admitted controls. The success rate increased to 65 per cent for those spending nine months or more in treatment (Copas *et al.*, 1984). A more recent replication of this study using as a comparison group those not admitted due to funding problems achieved similar results (Dolan, Warren *et al.*, 1995). Similarly, 42.9 per cent of a treatment group showed significant

clinical improvement on the Borderline Syndrome Index compared to 17.9 per cent of non-treated patients (Dolan, Warren & Norton, 1997). Chiesa and Fonagy (2000) have compared the results of an in-patient only programme (up to 16 months) with a shorter-term six-month residential programme combined with 12–18 month group therapy at follow-up and outreach intervention. The combined treatment was more successful, emphasising the importance of continuing support in the community. A control group receiving Community Mental Health Team treatment as usual showed little or no improvement over time (Chiesa, Fonagy, Holmes *et al.*, 2002). A more recent 12-month follow-up study using a similar comparison group found significant reductions in impulsive urges and behaviour in those who had received treatment in a democratic therapeutic community compared to a non-admitted sample. These changes were particularly striking in relation to self-harm (Warren, Evans, Dolan & Norton, 2004).

Research has examined the cost-benefits of therapeutic community treatment. Dolan *et al.*, (1996) identified an average saving of £12,658 per patient in costs of psychiatric and prison care in the year following treatment compared to the year before treatment. Other researchers have reported similar cost-benefits with residential therapeutic community treatment (Chiesa, Iccoponi & Morris, 1996; Davies, 1999).

3.2.3 Final thoughts

Historically, there has been a tendency to assume that people with personality disorder are untreatable, as if treatability were a characteristic of those given this label rather than reflective of our current state of knowledge. Treatment evaluation is hampered by methodological difficulties and inadequacies. In particular, people with personality disorder are often hard to engage in treatment and research, and drop out rates are high. Despite these difficulties, literature reviews suggest that there are some promising psychological treatments for the personality disorders, including therapeutic communities, and psychoanalytic, cognitive behavioural and dialectical behaviour therapy approaches.

The poorer overall response to treatment found with this client group may indicate that their problems are more deep rooted and require more intense and extensive treatment. This idea is supported by research, which found that individuals with personality disorder require more therapy to produce the same effect as

Jane

Jane was 13 years old when she first came to the attention of psychiatric services as a result of taking a serious overdose. When admitted, many scars were noted on her wrists and abdomen where she had cut herself. She was keen to leave hospital as soon as possible, and resisted attempts to obtain a history of her difficulties or involve her in therapy. This was the first of many brief admissions following self-harm and suicide attempts. When 18, she became pregnant and had an abortion. She became severely depressed and was again admitted to hospital following a nearly fatal overdose. She settled in hospital, but whenever her discharge from hospital was discussed, she began a pattern of self-destructive behaviour involving absconding from hospital and putting herself in dangerous situations, drinking excessively, taking drugs and attempting suicide, for instance by running in front of cars. Her behaviour on the ward also started deteriorating, with increasingly frequent episodes of self-harm leading to her being given increasing doses of medication. Many different types of medication were tried without success. By the age of 20 she needed constant supervision by two members of staff in an unsuccessful attempt to prevent her self-harm. Staff were at their wits end, and ward rounds were often the scene of angry disagreement about how she should be managed.

Psychological assessment using the Personality Diagnostic Questionnaire (PDQ-4; Hyler et al, 1992) revealed that she scored within the clinical range on a number of personality disorder diagnoses, in particular borderline, histrionic, paranoid and anti-social types. On the Beck Depression Inventory she scored as moderately depressed, and on the Spielberger State-Trait Anxiety Inventory she scored highly on both current and trait anxiety. Additionally, when referred for CBT, assessment using Young's Schema Questionnaire showed dysfunctional thinking on all schemas assessed. Although she attended the assessment, she was unwilling to give a full history and failed to attend further appointments. A behavioural management programme was constructed to try to reduce her self-harm, but merely led to an increase.

Jane eventually agreed to be referred to a residential therapeutic community to attempt to break the destructive cycle of her behaviour. The benefits were seen as shifting responsibility for her behaviour to herself rather than staff, and providing her with an environment in which she could be supported by peers with similar problems 24 hours a day. Additionally, the tight daily structure and clear rules existing provided her with supportive boundaries and offered alternative ways for her to manage her distressing emotions and impulses. In this environment she was able for the first time to talk about her experiences of sexual and physical abuse as a child, gaining an understanding of why she felt compelled to harm herself. She also found that she could be helpful to others in the community, increasing her self-esteem. Seeing others making changes to their behaviour also gave her hope and encouragement. Although she continued to act destructively at times, her self-harm ceased after a few weeks, and after a year's treatment she was able to leave therapy and pursue her education.

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neurotic subjects (Dolan, 1998; Lipsey, 1995). Similarly, personality disorder symptoms improve less with psychotherapy and at a slower rate than symptoms of acute or chronic distress (Kopta, Howard, Lowry & Beutler, 1994). The presence of personality disorder also predicts poorer outcome in treatments for other mental health difficulties (Reich & Vasile, 1993). There are few studies that have measured changes to core

pathology as a result of treatment. Those studies that have, however, indicate that treatment can have a clinically significant effect in changing personality (Dolan, Warren, & Norton, 1997).

Research suggests that no psychological model or treatment is superior to any other. Developing a range of psychological treatments encompassing a diverse range of models would therefore have advantages in attempting to

provide the therapeutic model that best fits each individual's needs.

In relation to important therapeutic ingredients, research suggests that treatments with people with personality disorder are most successful when they are intensive, long term, theoretically coherent, well structured, well integrated with other services and where follow up to residential care is provided. Also when care is taken to engage personality disordered clients in treatment, and keep them engaged (Bateman

& Fonagy, 2000; Rawlings, 2001).

Therapeutic alliance is a strong predictor of outcome in psychotherapy (Luborsky & Auerbach, 1985), and the quality of the working relationship that an individual with personality disorder forms with their therapist is likely to be of particular importance, as this group of individuals have significant relationship problems. Paying particular attention to ways of forming and maintaining a good working alliance is, therefore, likely to improve treatment outcome.

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3.3 Psychological interventions in forensic settings

Key points:

- Little is known about the relationship between different types of personality disorder and offending behaviour.
- Treatment in forensic populations should take account of the risk level of offenders, the factors associated with their offending and the types of interventions to which they are likely to be responsive.
- Interventions with forensic populations have increasingly favoured social learning and cognitive-behavioural models.
- There is evidence that cognitive-behavioural methods and concept based therapeutic communities can be effective in reducing re-offending if properly implemented.
- Democratic therapeutic communities have shown consistent evidence of reducing symptoms of personality disorder in disturbed populations.
- Preparation, support and after-care for offenders are essential requirements in maximising the impact of rehabilitation programmes.
- Further research is needed on how different types of personality disordered offenders respond to current treatments and the conditions that are needed to sustain improvements following completion of treatment.

3.3.1 Psychological interventions with personality disordered offenders in forensic settings

A range of treatment interventions are available for offenders serving custodial and community sentences and those detained under the Mental Health Act in medium or high security conditions. However, although the diagnostic category of personality disorder is routinely used in secure services for patients detained under the Mental Health Act, this is not the case for offenders serving custodial or community sentences. Because of this, it is difficult to ascertain how many of the offenders undertaking treatment programmes in prisons or on community sentences are personality disordered. As prevalence rates for personality disorders (particularly antisocial) are very high in forensic populations, it is likely that a considerable proportion of those treated in these settings meet the diagnostic criteria for at least one personality disorder, although the precise figures are a matter for future research. However, little is known about how personality disorders mediate

antisocial behaviour. Ideally, individuals who are accepted onto treatment programmes should be routinely assessed for personality disorders prior to admission. This would facilitate a better understanding of how particular categories of disorder respond to treatment in forensic settings and the relationship between personality disturbance and offending behaviour.

Most interventions provided by the prison and probation services are aimed at reducing the risk of re-offending, rather than treating the symptoms of personality disorder. In recent years, the development of interventions offered to offenders has been greatly influenced by a widely cited body of research evidence collectively known as 'What Works'. Based on aggregated data from hundreds of studies, this literature has proposed that certain types of approaches can be effective in reducing re-offending if properly implemented (i.e. using appropriate methods, targeted at appropriate groups of offenders, delivered with high quality and consistency and supported by good after-care). For example, McGuire (2002) summarised the results of 30 meta-analytic reviews published between 1985 and 2001. The results indicated that those approaches targeted on 'criminogenic needs' (risk factors that predispose individuals to offending) and delivered using behavioural, cognitive-behavioural and social learning methods were the most promising in reducing recidivism. Although most of the studies were carried out in Canada and North America, European meta-analyses were broadly in line with these conclusions (Redondo *et al.*, 1997).

The reductions in re-offending rates were typically around 5–10 per cent, although higher reductions in re-offending have been reported for programmes that followed the principles of effective implementation more closely (Vennard, Sugg & Hedderman, 1997). Approaches based on psychodynamic methods were generally ineffective and in some cases seemed to increase recidivism (see Cooke & Philip, 2001 for a summary). Although the evidence suggests that psychodynamic approaches are unsuitable when given as stand alone treatments, their efficacy for personality disordered offenders may be enhanced when integrated with cognitive behavioural approaches and delivered in structured therapeutic environments (see, for example, Reiss, Grubin & Meux, 1996).

In the light of the What Works research reviews, the Home Office has developed a set of criteria to accredit programmes and

George

George is 45 years old and serving a 14-year prison sentence for aggravated burglary and rape. He had a long history of previous offending involving a wide range of crimes including arson, thefts, violence, drugs and fraud. He also had convictions for various breaches of bail and supervision orders, plus attempted escapes from custody.

During his childhood he exhibited severe behavioural problems and was sometimes described as 'out of control'. In his local area he was known for tormenting neighbours and was involved in fire setting and vandalism. At school he was involved in persistent truanting and many disruptive incidents including stabbing a teacher with a compass and bullying and extortion activities. Because of his disruptive behaviour at home and school he spent much of his childhood in Local Authority homes. Staff views were divided: some noted that he could be sincere and charming; others were more sceptical, describing him as unable to separate fact from fantasy and always looking to exploit others for his own ends. His intelligence was assessed as above average but he obtained few qualifications.

After leaving school he was employed in a variety of short-term jobs but either left quickly or was fired for misdemeanours such as stealing from employers. He spent most of his adult life in prison or on community sentences. In between he drifted from one part of the country to another. He had been involved in numerous short-term relationships and had fathered several children but maintained little contact with them and quickly moved on to form new relationships.

His current offence explanation changed several times. Initially he stated that he could not remember what happened but later argued that the victim consented and falsely claimed she was raped in order to gain compensation. In the most recent account, he claimed that the offence was a 'misunderstanding' with tragic consequences for many people, including himself. The police reports indicated that the offence was a callous and sadistic attack and that the victim was lucky to escape with her life. George argued that he was innocent throughout his trial and made an unsuccessful appeal against his conviction.

George enrolled for several prison treatment programmes and there was evidence that these were beneficial, at least in the short term. Self-report questionnaires, completed before and after participation, showed improvements on impulsiveness, socialisation and self-esteem. This was confirmed by improvements in self-management, as assessed by an officer-completed behaviour checklist. However, reports on his progress included some worrying observations. For example, therapy staff commented that although he sometimes made valuable and insightful contributions to the sessions, he would often dominate the group proceedings and seemed to like being in control. His contributions were frequently verbose and rambling and it was occasionally difficult to assess whether he was telling the truth, as his narrative sometimes contained contradictions. They also commented that several times he made hostile and vindictive verbal attacks on other group members or therapy staff. When it was pointed out how frightening this could be, he seemed unconcerned and claimed that he was the only member of the group with the honesty to speak his mind: 'if you don't like the heat – get out of the kitchen.' Staff felt that he would often look for opportunities to split the therapy team and play one member against another. Although he appeared adept at learning the language of therapy, and appeared to make some genuine improvements, there was limited evidence that he could put this into practice on a sustained basis. As one prison officer commented: 'he talks the talk but can't walk the walk.'

Reports in his file gave differing views; staff who interviewed him on an individual basis sometimes described him as co-operative, remorseful and showing a genuine desire to change. On the other hand, prison staff who observed his behaviour over time were more sceptical, reporting that he was very manipulative and had a quick temper. His prison record contained reports of several assaults and a hostage incident. Security information reports indicated that he was suspected of being involved in scams and activities such as dealing in drugs or illegal pornography.

Although George appeared to accept some responsibility for his problems (and these improved following treatment) he would quickly enter into long justifications for his criminal record when questioned. He argued that he was a victim of 'the system' and that crime was his way of coping. He would occasionally enter into long diatribes, listing the injustices he had suffered, and his mood would range from bitter resentment and anger to tearfulness. He claimed to be depressed by the separation from his children but, when asked, could not remember simple details about them such as their birthdays. He did not appear to have coherent plans for his future but appeared to spend a lot of his time involved in complaints and litigation against the prison authorities.

interventions that are most likely to reduce offending. Examples of the criteria are having a clear model of change backed by research evidence, specifying how the programme targets criminogenic needs in offenders, using appropriate methods and having in place monitoring and evaluation systems. The prison and probation service now has a curriculum of programmes that have been accredited under this system. A number of the same programmes are run in secure services for patients detained under the Mental Health Act. Some examples are given below.

3.3.1a Sex offender treatment programme (SOTP)

The broad aims of this programme are to help sex offenders acknowledge the scope and seriousness of their offending, enhance their social and empathy skills, change sexual arousal, develop awareness of the harm caused to victims and help offenders to acquire and apply relapse prevention skills (Mann & Thornton, 1998). Most sex offenders serving custodial sentences of four years or over are considered for this programme. Supplementary programmes are available for high-risk sex offenders (extended programme), offenders with learning difficulties (adapted programme), and those who require additional work on relapse prevention (booster programme). A number of accredited community based sex offender programmes are run by the probation service using similar principles.

3.3.1b General offending programmes

There is considerable research evidence indicating that offenders display thinking or 'cognitive skills' deficits and that these play a role in offending behaviour. For example, offenders tend to show impaired perspective taking and problem solving skills and are more likely to act impulsively compared to non-offenders (see Al-Attar, 2001, for summary). A number of programmes have been developed to help offenders improve their cognitive skills as a way of reducing recidivism. An example of such an approach is the Enhanced Thinking Skills Programme (Clark, 2000). The aims of this programme include helping develop skills in problem solving, self-control, perspective taking, critical reasoning and moral reasoning. A number of similar programmes are run by the probation service and are aimed at helping offenders achieve similar treatment goals. A common feature of these approaches is the emphasis on active engagement of offenders through techniques such as modelling, role-play,

structured small group exercises, and games linked to the learning objectives of the programme.

3.3.1c Violent offenders

Several programmes have been designed to target the treatment needs of violent offenders. An example is Controlling Anger and Learning to Manage it (CALM) (Winogran *et al.*, 1997). The goals of the CALM programme are to assist offenders to understand the factors that trigger their anger and aggression. Offenders learn to challenge the cognitions that create, sustain and escalate emotional arousal; they learn skills to reduce their levels of emotional arousal and skills to resolve conflict effectively. They also learn to manage other negative emotions related to offending and plan how to deal with relapse into former patterns of aggression. The programme is multi-modal, drawing on several different intervention strategies, proven to be effective in both the treatment of anger and offending behaviour. It aims to facilitate change through the processes of cognitive preparation, self-monitoring and self-regulation, cognitive restructuring, social skills acquisition, and rehearsal/practice. Motivational enhancement exercises help offenders define for themselves the value of regulating their expression of anger and reducing their levels of aggression. Participants begin to define their own anger/aggression cycle that will contribute to the final relapse prevention planning phase at the end of the programme.

3.3.1d Therapeutic communities

Most of the approaches accredited by the Home Office are primarily aimed at reducing the risk of re-offending. Whilst this is clearly an important aim of any treatment approach with offenders, it is important to remember that many personality disordered offenders present with significant clinical and management problems within institutions. These include self-harm or suicide ideation, aggressive behaviour, personal distress, mood instability, excessive emotionality and low self-esteem. Problems such as these can lead to personality disordered offenders being high users of medical and psychological services in forensic settings. Treatment approaches need to take account of these problems in designing appropriate interventions.

The therapeutic community approach (described in section 2.1.6) has been adapted for use in forensic settings, and aims to address both the symptoms of personality disorder and reduce the risk of re-offending (Cullen, Jones &

Woodward, 1997; HM Prison Service, 2003). In the Prison Service, there are currently two establishments that are run as therapeutic communities: Grendon and Dovegate, plus a number of smaller units within prisons.

Although concept based therapeutic communities focus on the assessment and treatment of substance misuse, in practice many of the participants will also meet the criteria for personality disorder (Verheul, *et al.*, 1995). There are currently a number of concept based therapeutic communities run in the prisons as part of a wider strategy for combating drug misuse within the prison service.

3.3.2 Evidence for effectiveness

Some of the recent evaluations of accredited interventions in forensic settings are summarised in this section. Evaluations in the UK are ongoing and for some programmes results will not be available for a number of years. For example, the probation service currently has a suite of 15 accredited programmes, most of which have only recently been implemented on a large scale.

3.3.2a Sex Offender Treatment Programmes

An evaluation of the prison-based SOTP was recently published (Friendship *et al.*, 2003). The results showed that, with the exception of high-risk offenders, those who participated on the programme had lower reconviction rates for sexual and violent re-offending within two years of release. A recent review examining the effectiveness of psychological treatment of sex offenders (Hanson *et al.*, 2002) reported that current treatments were effective in reducing recidivism. There was some evidence that insight oriented therapies increased recidivism rates. Evaluations of community-based sex offender programmes run by the probation service have also shown evidence of effectiveness in reducing re-offending (Beech *et al.*, 2001). There is a general consensus that cognitive-behavioural treatment can be effective in reducing recidivism, at least for some types of sex offenders, although some researchers (Rice & Harris, 2003) have dissented from this view. It is generally agreed that better quality research is needed.

Dangerous and Severe Personality Disorder (DSPD)

In its plans to reform the Mental Health Act in 2000, the Government proposed to introduce a new category of 'dangerous as a result of severe personality disorder' (DSPD). This provoked widespread concern among mental health professionals, service users, lawyers, and others concerned with civil liberties because of the implications for the extension of state coercion, and the possibility that people with no history of offending could be arrested and detained indefinitely. Such a category also lacked any scientific basis. Not only is risk assessment a developing art, little is known about the relationship of risk to personality disorder other than psychopathy as assessed by the PCL-R. Also, using the term 'severe' to indicate risk rather than clinical severity causes confusion.

The Government responded positively to these criticisms. DSPD will no longer appear as a formal category in the reformed Mental Health Act, and DSPD is now specified to be a description of 'a programme' rather than a legal or clinical category. The aim of this programme is not only to provide public protection but also to deliver high quality services to offenders with serious mental health problems, and it is now thought improbable that people without a history of violent or sexual offending could be admitted to the programme. The programme is viewed as a pilot project, subject to change in the light of research findings on its utility.

Four units within high security prisons or special hospitals are currently being developed to provide services for 300 male offenders, all units being led by psychologists or psychiatrists. A comparable service for women is under review. The development of such units also implies a need for treatment facilities at lower levels of security to which offenders who have shown sufficient progress can be moved. Some regional secure services are involved in planning services for this group as well as becoming more responsive to the needs of personality disordered patients generally. The Government has acknowledged the urgent need for research into the effectiveness of risk assessment methods and the development of effective psychological treatments for personality disorder. To this end, the DSPD programme is commissioning a number of relevant research projects by leading behavioural scientists. The programme now involves considerable investment in meeting the clinical needs of a hitherto poorly serviced group, and has the potential to benefit both the public and offenders themselves.

3.3.2b Cognitive skills programmes

Research has shown that cognitive skills programmes can be effective in reducing recidivism, particularly for medium to high-risk offenders. For example, Robinson (1995) followed up over 2,000 offenders who participated in a well known programme (Reasoning and Rehabilitation) and found that cognitive skills training significantly reduced recidivism rates for violent, sexual and drug offenders (see Robinson & Poporino, 2004, for a review).

Recent studies in Britain have provided some support for the effectiveness of cognitive skills programmes in reducing re-offending. For example, Farrington *et al.*, (2002) reported that a sample of young offenders who participated in a high intensity regime, which included the Enhanced Thinking Skills programme together with education and mentoring, reduced re-offending rates by 10 per cent after one year compared to a control group. Friendship *et al.*, (2002) compared 667 adults who participated in the Reasoning and Rehabilitation or the Enhanced Thinking Skills programmes with a comparison group of 1801 men who were matched on similar criteria who did not participate on the programmes. The results showed that the men who participated on the cognitive skills programmes had lower reconviction rates than the control groups, the largest difference being 14 per cent for men in the low/medium risk category. However, these results were not replicated in a subsequent study (Falshaw *et al.*, 2003). A further evaluation showed that although there were no overall significant differences between men who participated in cognitive skills programmes and comparison groups, prisoners who completed the programmes had significantly lower reconviction rates after one year (Cann *et al.*, 2003).

Although cognitive skills programmes are primarily aimed at reducing offending they do appear to have wider effects. For example, Blud and Travers (2001), examined changes in psychometric tests given before and after programme participation in a sample of over 5,000 offenders. The results showed that as well as producing better pro-social decision making, participants showed gains in terms of reduced impulsiveness, increased self-esteem, higher levels of socialisation and better custodial adjustment. This was supported by the staff observation checklist, which tends to show positive gains in self-management. This indicates that cognitive skills programmes may address some of the needs of personality disordered offenders.

Although there is considerable evidence of the short-term effectiveness of cognitive skills programmes in the UK, the evidence in terms of reduced recidivism is mixed. This has prompted further consideration of the factors that seem to be important in influencing longer term effectiveness. One of the factors might be that the later evaluations took place at a time when the programmes underwent major expansions and there may have been a loss of treatment integrity as a result. For example, unsuitable offenders may have been referred onto programmes in order to meet completion targets. Some authors (e.g. Ellis & Winstone, 2002) have noted that large-scale expansion may also mitigate against a culture of responsibility within programme delivery, which is an important factor in the success of cognitive-behavioural models.

An additional factor is the need to integrate programme work with overall offender case management more effectively. This was highlighted in a recent report by Clark, *et al.*, (2004), who conducted a qualitative study examining the experiences of a sample of prisoners who took part in cognitive skills programmes. They reported that the large majority of the sample benefited from participating on the programme and felt it was helpful in providing them with skills to avoid re-offending. However, these gains were not always reinforced once offenders had completed the courses. Clark *et al.*, (2004) argued that this highlighted the importance of providing support and aftercare for offenders to help them maintain and apply the skills they have learnt on programmes. They also drew attention to the social and institutional factors that enabled offenders to make the best use of treatment programmes and argued that they should be delivered as a part of a holistic approach to addressing offenders' needs. The Home Office is taking steps to implement lessons from this research by giving greater emphasis to the integration of case management with the delivery of programmes.

3.3.2c Violent offenders

Cognitive-behavioural interventions for violent offenders have shown some evidence of effectiveness, but this research mainly derives from North American studies (Baldock, 1998; Kemshall, 2000; Motuik *et al.*, 1996). An early study examining reconviction rates for offenders participating in a community based cognitive behavioural programme run by the Wiltshire

Probation service, indicated that overall the results were positive, with evidence of improvements in offending behaviour after one year (Sugg, 2000). The programmes for violent offenders are still in relatively early stages of roll out and evaluation results are awaited.

3.3.2d Therapeutic communities

Research has also shown that concept based therapeutic communities are effective in terms of both reduced drug use and lower levels of re-offending following treatment (Lipton *et al.*, 2002). Evaluations such as these have led some authors to conclude that concept based therapeutic communities should be the 'treatment of choice' for drug misusers (Wexler, 1997).

Research on prison democratic therapeutic communities has also shown consistently that men who participate in this form of treatment improve on a range of measures such as relationships with staff, self-esteem, anxiety, hostility and general psychological health (Rawlings, 1998; Shine; 2000). These effects were most pronounced in men who participated in therapy for 12–18 months or more. However, evidence for the effectiveness of democratic therapeutic communities in reducing re-offending is equivocal (McMurran, 2002).

Although evidence for the effectiveness for the treatment approaches described above is generally encouraging, they may not be suitable for all types of offenders. Some studies have found that recidivism rates following treatment have increased for offenders who score highly on the PCL-R. One study (Rice, Harris, & Cormier, 1992) followed up a sample of men who attended a therapeutic community in a maximum-security establishment in Canada. Those who scored low on the PCL-R had lower reconviction rates than a matched control group who did not receive treatment, indicating a positive treatment effect for this group. However, those offenders who scored high on the PCL-R had higher reconviction rates than the control group for violent offences. This suggests that, for this group, the treatment had made the men more dangerous. An evaluation of a cognitive-behavioural treatment programme for sex offenders in Warkworth, Canada also found that sex offenders who scored highly on the PCL-R had reconviction rates that were greater than might be expected if they had not received treatment (Seto & Barbaree, 1998).

However, research on the effectiveness of treatment for psychopathic offenders is still at a relatively early stage. It is also important to note that most research to date has involved evaluating approaches that have not been designed to meet the treatment needs of psychopathic offenders. In recognition of this the Prison Service and the Department of Health have developed a programme for psychopathic offenders, which is currently being piloted at a number of sites.

A position paper by the Forensic Clinical Psychology Special Interest Group suggested that all research participants should be screened for psychopathy and that treatment outcome studies should routinely report results for psychopaths and non-psychopaths separately (Cousins & Bailes, 2000). This would help to establish criteria that could identify treatment resistant individuals as well as increase understanding of the relationship between psychopathy and personality disorder.

3.3.3 Summary

The last decade has seen a large expansion of interventions for offenders in criminal justice settings in the UK. This has been strongly influenced by the international What Works literature, which has successfully overtaken the previously widespread view that 'Nothing Works' in changing offending behaviour. This literature has been helpful in drawing attention to the general principles needed to implement effective interventions (structured, multi-modal approaches that target criminogenic needs) and in providing guidelines for policy and practice. It is likely that many offenders who participate on offending behaviour programmes in forensic settings meet the criteria for at least one type of personality disorder. There is suggestive evidence (cited above) from positive changes in psychometric test scores that the programmes may be beneficial in meeting some of their treatment needs. Further research is now required to understand how different types of personality disordered offenders respond to current treatments and to investigate whether these approaches need to be developed to take account of their needs. Further work is also needed on the conditions that are necessary to sustain improvements following completion of treatment for these offenders, given the chronic nature of their disorders.

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4. Recommendations

Key points:

- The government's policy of ensuring people with personality disorders are treated as part of core services in mental health and forensic settings, with access to specialist multidisciplinary personality disorder teams, is welcomed.
- Service developments that reflect this policy would need the skills of clinical and forensic psychologists as clinical leaders.
- Staff in a wide range of health and social care, education, criminal justice and voluntary sector agencies require some level of training to understand personality disorders, ranging from basic awareness to specialist training.
- Structured assessments are essential to services treating individuals with the problems of personality disorder.
- Services should focus on formulating a client's needs and goals for treatment.
- People with personality disorder need a multidisciplinary and multiagency service.
- Sharing of ideas and expertise between psychologists in forensic and general mental health services would enhance service development.
- Because personality disorders are a problem that affects individuals across the lifecycle, good communication between agencies is essential at an early stage.
- Clinical supervision of staff working with individuals with personality disorders is essential to maintain the emotional health of staff.
- Good quality research is urgently needed to inform service development.
- User views should inform service development.

4.1.1 Government Policy and Service Development

The National Institute for Mental Health in England (NIMHE) recently published guidelines for the treatment of personality disorders (NIMHE, 2003), which have been well received. There is a welcome focus in the guidelines upon the inclusion of those with personality disorders within core mental health services and recognition that personality disorders are treatable conditions. The guidelines recognise that people with personality disorders present to services as complex and emotionally difficult individuals. They often produce feelings of anxiety, anger, helplessness or confusion in staff

trying to assess their needs. This has resulted in a tendency to exclude these individuals from active treatment and to respond to their needs in crisis. Many individuals with personality disorder avoid services either because they do not receive an appropriate response or because they only present when in acute emotional distress and then disengage when that distress resolves. Therefore, for many reasons both to do with the services and the individual, those with personality disorders have been difficult to engage and treat. The guidelines recommend the formation of specialist personality disorder teams that could be an important bridge between services and individuals with personality disorder. Such teams could promote a longer-term approach to treatment, stressing the need to develop care packages aimed at preparing the individual for treatment, the delivery of a treatment package and support following treatment. However, not all individuals with personality disorders are able to engage in a treatment process. These individuals may present significant risks to themselves or others and need intervention from mental health services. Therefore, it will be necessary to develop the skills of staff within health, social care and criminal justice agencies to recognise, support and manage these individuals in a positive and constructive manner. Specialist personality disorder teams could have a positive impact upon the treatment of individuals with personality disorder providing the service model includes:

- Clear inclusion/exclusion criteria and care pathways;
- A clear, coherent, evidence based therapeutic model of personality disorder;
- A circumscribed therapeutic role for some referred clients;
- Residential and non-residential facilities;
- A strong assessment, training and consultancy role to enable general services to contain the majority of people in a locality with personality disorder.

The changes to working practices that would result from the development of specialist personality disorder services are likely to result in an increased demand for psychological services. Psychologists have particular skills in assessment and formulation that would be invaluable to any specialist multidisciplinary personality disorder team. However, the services outlined in this document can only develop and

flourish with the commitment of key stakeholders including Government, Service Users, Primary Health Care Trusts, Forensic Services, Criminal Justice Agencies and Social Services.

4.2 Staff from a wide range of services require training to work with personality disordered individuals

As has been outlined in this document, people with personality disorders are difficult to treat, can induce difficult and complex feelings in those treating them, and can be harmful to themselves and/or others. Historically, mental health services have not perceived treating people with such problems as part of their core services. As a consequence, many services either do not provide any services or only provide non-specialised services to this client group. Other agencies too often have little awareness of the difficulties faced by individuals with personality disorders. As a result, such clients may receive inappropriate responses to their difficulties and/or may be excluded from services.

The National Institute for Mental Health in England (NIMHE) have published a capabilities framework for the development of skills for working with individuals with personality disorders (NIMHE, 2003). This framework provides a useful starting point to consider the skill mix required within the workforce. There needs to be a comprehensive training initiative to raise awareness of the problems experienced by people with personality disorder. Training needs to range from basic awareness-raising, to facilitate appropriate identification of individuals with personality disorder, through intermediate training, to develop skills in the management and treatment of individuals with personality disorder, to specialist training in clinical management to develop skills in assessment, formulation, treatment, consultancy and supervision.

With the increased focus on personality disorder in health services, it is essential that all staff groups, and in particular those training to be clinical and forensic psychologists, be equipped to deal with clients with these problems. Theoretical and practical input on the assessment and treatment of personality disorder should become a standard component of all training programmes. Links between personality theory and personality disorder should also be covered. Opportunities for supervised practical experience should be encouraged as part of adult mental health placements and specialist multidisciplinary personality disorder teams will need to offer specialist placements for trainees of

all disciplines to meet future needs for staff with appropriate skills in this area. Forensic clinical psychologists generally have particular expertise in this area and provide an important resource in planning and providing services and training.

4.3 The need for specialist psychological skills within personality disorder services

The NIMHE guidelines and capabilities framework stress the need for psychosocial treatments and the primacy of psychological models and therapies in treatment. To implement such a service model would require a change of working practice within forensic and mental health services. Currently many services work on a medical diagnostic approach to personality disorder with treatment based upon observed symptoms (e.g. anxiety, depression, self harm). A psychological approach would place more emphasis upon a formulation of an individual's needs based upon functional difficulties (e.g. homelessness, impulsivity, frustration). The importance of skills in assessment and formulation are outlined in recommendation 4.4. In addition, analysis of the skills of clinical psychologists (Management Advisory Service, 1989) indicates they combine information from the academic and clinical knowledge base to develop individually tailored treatment packages. Such a change in service delivery would necessitate the development of services with clinical/forensic psychologists employed as clinical leaders within specialist personality disorder teams, with a remit to provide assessment, treatment, research, consultancy, training and supervision.

4.4 Structured assessments and detailed case formulations are an essential component of services for individuals with personality disorder

The assessment of personality as a component of mental health problems is a sophisticated undertaking. It requires a good understanding of psychological theory, especially developmental psychology, trauma-related phenomena, assessing organic dysfunction, and personality theory. The assessment process needs to combine a wide ranging clinical interview, focused upon a need to reach a shared understanding of an individual's interpersonal, social and psychological difficulties, and an objective assessment of personality functioning to assess an individual's coping style. Behavioural observation may be useful in some cases and assessment of risk to self and others needs to be incorporated.

In addition, it may be helpful where possible, and with the consent of the individual, to obtain information from family members and friends. This can enrich the assessment process and provide an alternative perspective that can corroborate or challenge the individual's presentation of their problems. Psychometric assessment, including assessment of personality, intellectual functioning, learning difficulties, social and assertiveness skills and mood, may also be helpful.

The assessment process needs to inform a clear conceptualisation, or formulation, of why an individual has developed the problems manifest in their presentation and how this relates to their life experience and biological inheritance. This formulation can then form the basis of collaborative interventions to address issues of concern and can be updated and amended as new information becomes apparent from the individual's self-disclosure and/or behaviour, further disclosure from family members/friends and observations of the individual by professionals involved in their care. This formulation should always be open to amendment and be considered the best working model of an individual's difficulties currently available.

This report has provided some basic guidelines for assessing personality disorders, both in terms of making the choice of assessment procedure and good practice in the conduct and interpretation of assessment processes.

4.5 People with personality disorder need multidisciplinary and multiagency services

People with personality disorder have multiple problems that can undermine their day-to-day functioning and emotional well-being. Not all people with these difficulties will be severely affected by their psychological problems, but for those who are, a comprehensive range of services will be needed to meet their complex needs. Their difficulties may include housing, financial and legal problems, relationship problems, depression, anxiety, self-harm and suicidal thoughts, impulsiveness, conduct disorder and anger control. There needs to be a concerted attempt to develop well-integrated multidisciplinary teams. These teams may need to incorporate skills from professionals not usually considered part of mental health multidisciplinary working. For instance, mental health services may need to develop close working relationships with probation officers, prison staff, police officers, child protection professionals, and housing services. Forensic

services may need to develop close working relationships with GPs and local mental health services. These services will need to provide a theoretically coherent approach with consistent and predictable boundaries and be able to provide long-term intensive treatments. This will require even more emphasis on effective team working in mental health and forensic services. These changes to working practices will also need active management and development within individual organisations.

4.6 Communication between forensic and general mental health services

Services developed within forensic and general mental health settings have largely developed in isolation from each other. Forensic services have developed a treatment focus upon the reduction of offending behaviour. Therefore, forensic services have concentrated upon targeting specific behaviours, such as sexual offending and anger control, using predominantly cognitive behavioural treatment models. General mental health services have concentrated upon alleviating the distress created by personality disorders. Therefore, general mental health services have concentrated upon helping the individual to gain insight into, reflect upon and opt to change aspects of their interpersonal functioning, for example becoming more assertive, increasing self esteem or challenging particular fears. The treatment models have been more diverse within general mental health settings, reflecting the more diverse and individual treatment outcomes, with psychodynamic, cognitive and behavioural treatments regularly used. The therapeutic skills used in both environments could be of benefit to both. Forensic services could benefit from a more individual approach and general mental health services could benefit from targeting specific behaviours, such as anger, sexual exploitation and self-harm. There is a need for regular and consistent communication between psychologists within these services to share ideas and expertise with the aim of developing more coherent and client-focused approaches to treating the internal, cognitive and emotional, and the external, behavioural, aspects of personality disorders.

4.7 Personality disorders across the life cycle

Individuals with personality disorder have experienced multiple difficulties encompassing aspects of their biological, psychological and social functioning. They are likely to have

experienced adverse childhood events including disruptions to their attachments, trauma, death of a parent, and so on, and to have difficulties integrating with their peers both as adults and children. Their problems are likely to be long term and cyclical leading to chronic and/or repeated presentations to agencies throughout their lives. These individuals are likely to come into contact with many health, social care, voluntary, or criminal justice agencies. In order to provide effective interventions for these individuals, it is necessary to consider an all-embracing approach to identifying the potential for personality disorders and acting to promote positive change at the earliest opportunity. This would require good communication between education, health and social services for children. Children identified as at risk of developing a personality disorder would need to access early intervention services, which could include family based interventions to help parents rectify any difficulties with their parenting that may be exacerbating the situation. This approach would be consistent with recent changes to the children at risk services (Department of Health, 2004). There is also a need to provide a seamless

transition between services that meet the needs of the client at each stage in their lives, moving through services for children to adolescent services to adult services to services for older adults. Many of these services exist within current service provision but do not routinely communicate. Communication has been a long-term problem in health and social care (Laming, 2003). There is no simple solution to this problem but specialist personality disorder teams providing input across the life cycle could act as a central point of contact for all agencies and promote multi-agency treatment as the norm for this client group.

4.8 Attitudes to individuals with personality disorder

Many individuals with personality disorder have faced hostility and disbelief from mental health service professionals. There has been a tendency to deny these individuals access to services as they were deemed untreatable. A very negative approach to individuals with personality disorder has developed from these attitudes. As a consequence, people with personality disorder tend to be wary and distrusting of health

Users Perspectives

The contribution of service users is vital to the development a modern health service and is consistent with current clinical governance frameworks. However, the views of individuals suffering from a mental disorder have not been sought with the same vigour. In particular, individuals who have a diagnosis of personality disorder have been almost excluded from discussions and developments relating to their care and treatment. Only very recent attempts to include service user perspectives in the debate about services for personality disorders have provided important contributions to positive change in this area.

For example, attempts have been made to include the perspectives of service users in the development of the Policy Implementation Guidance for Services for People with a Personality Disorder (e.g. National Institute for Mental Health in England, 2003). Focus groups of service users, and discussions with organisations representing service users and carers were set up to contribute to the policy guidance (Haigh, 2002). This process indicated that the diagnosis of personality disorder carries a greater stigma than any other mental disorder, and that individuals may feel judged by both professionals and society. It was generally felt by users and carers that many professionals did not understand the diagnosis, and service users were left feeling that their difficulties were untreatable.

Focus groups were asked to identify aspects of mental health services they found helpful. The following provision was described as helpful: early interventions, before crisis point; specialist services that were not part of mainstream mental health services; being able to make choices from a range of treatment options; the presence of therapeutic optimism and expectations of positive change; care that is tailored to individual needs; skill acquisition as a key care task; the encouragement of creativity; clear and negotiated treatment contracts; accepting, reliable, and consistent care; care that focuses on education and personal development; a good link between assessment and treatment; supportive peer networks; a care team that listens to feedback; a shared understanding of boundaries; appropriate follow up and continuing care; an atmosphere of truth and trust; and an attitude of acceptance and sympathy.

In contrast, the following service provisions were found to be unhelpful by service users: where the availability of care is determined by postcode; being cared for by staff who do not have the appropriate training; a lack of continuity in staffing; care in office hours only; care teams that are unable to fulfil the promises made; staff who are critical of expressed needs or who only respond to behaviour rather than anticipate and manage changes in behaviour; long-term admissions; staff who are not interested in the causes of behaviour or who have pessimistic attitudes; a rigid adherence to a therapeutic model without adaptation to individual needs; abuses of confidentiality; the use of physical restraint and obtrusive levels of observation; the inappropriate, automatic or forcible use of medication; the withdrawal of contact used as sanction; and treatment determined only by funding/availability/diagnosis.

Ramon, Castillo and Morant (2001) carried out a study in which they trained individuals with a diagnosis of personality disorder to interview people with a similar diagnosis. A number of important findings were made. First, the negative impact of the label of personality disorder was identified along with a gap between the perspectives of service users about their difficulties and those of the professionals who cared for them. Second, service users commonly reported that a diagnosis of personality disorder impacted negatively on professional views of them across a range of different agencies; a diagnosis of personality disorder resulted in an improvement in treatment for only a minority of the sample (20 per cent). Therefore, the authors concluded that 'as a rule, we seem to be at the stage of containment and control, where understanding and sufficiently effective, caring interventions are an exception' (p13). These authors suggested that the use of service users as researchers appeared to give value to their perspectives on personality disorder diagnosis and intervention.

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services. In order to engage these people in services it will be necessary to foster an attitude of respect for their suffering and an approach that recognises their dignity as fellow human beings. Others may find the thinking, behaviour and emotions of individuals with a diagnosis of personality disorder difficult to comprehend and they may feel angry, frightened or dismissive at their actions. However, individuals with personality disorder can respond to treatment and if treated with dignity and respect, can come to trust and work with professional staff. It is important for professionals to provide a personalised package of care designed to offer the person an informed choice of possible actions and encouragement to engage in a process of change. This will not always be successful and professionals may be challenged by people who attempt to hurt or reject them in order to maintain their emotional equilibrium. The danger in this situation is that professionals resort to stereotyping of the individual as incapable of change, which can result in the individual's exclusion from services.

4.9 Supporting staff working with personality disordered individuals

People with personality disorders can be physically and emotionally difficult to work with. It is distressing to see a person regularly attempt suicide, disfigure themselves through self harm, or subject themselves to sexual exploitation. Similarly, it is difficult to understand why someone you are trying to help would want to insult you, hit you or reject you. People with personality disorders often get rejected by services which do not understand why they do what they do and, instead, make negative judgements about them, to make the behaviour explainable. For instance, pejorative labels such as attention seeking, manipulative or childish may be used. The staff in such situations often feel helpless to effect positive change and can become disillusioned and depressed. In order to prevent such a negative chain of events regular support for staff working with this client group is essential. Staff need to be given a clear and coherent model of personality disorder to help them understand why these individuals respond

as they do. This initial training needs to be followed by regular clinical supervision to reinforce the training and provide an environment where potential problems can be discussed, which allows intervention to resolve potential difficulties to occur at an early stage and can prevent many serious problems developing.

4.10 Personality disorder research funding

Personality disorders are poorly understood and, as this document has outlined, there is no agreed definition of personality disorder or understanding of causal mechanisms. To develop our understanding of personality disorders much more research is needed. There has recently

been an increase in the research budget for research into personality disorder within forensic settings. This is to be welcomed but there are still problems obtaining funding for research into personality disorders within general mental health settings. There is a great need for research into personality development in order to understand why some individuals develop dysfunctional personalities and how their experience and inheritance differ from those who develop functional personalities. This could further our understanding of the role of stress vulnerability in the development of psychopathology and the factors that make an individual resilient to psychopathology.

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