Correspondence

EDITED BY KHALIDA ISMAIL

Personality disorder

Kendell (2002) refers to treatment factors influencing attitudes; I believe that level of understanding and the concept of mental illness are additional influences. Mental disorders can be defined as abnormalities of higher mental function (i.e. perception, thought, emotion, memory) and can be explained in relation to different degrees of reductionism, which is consistent with the application of a medical model. Some have evidence of biological dysfunction (e.g. epilepsy), others of psychological dysfunction (e.g. schizophrenia) and others of 'behavioural dysfunction' (e.g. personality disorders). The confidence in what constitutes a mental disorder is partly dependent on the level of explanatory power. Behaviour lacks explanatory power because of the difficulty in determining whether behaviours arise from normal or abnormal brain function. In this context operational definitions reliant on behaviour are based on poorer-quality evidence and more heavily influenced by sociocultural factors.

In addition, eliciting symptoms of mental illness relies on subjective reports of the experiential aspects of internal mental processes. A mental illness is recognised when qualities of internal mental experiences that are recognised as being different from normal mental experiences are reported, and the larger the difference the more likely it will be explained as mental illness. This phenomenon is usually lacking in people with personality disorders.

Thus, personality disorders lack good-quality evidence of altered higher mental function, including internal mental experiences, and using the definition above they would not be considered mental disorders. People with personality disorder experience disadvantage in their sociopolitical environment, often due to their behaviour, and in other circumstances 'disadvantage' has been sufficient to explain increased morbidity. Until altered higher mental function can be reliably demonstrated it may not be appropriate to view personality disorders as mental disorders. The term 'challenging behaviour' is used in the psychiatry of learning disability and has the advantage of being descriptive, making no assumptions about aetiology, and is more explicit about a social dimension; it may be possible to develop a similar term for personality disorders. This does not obviate the need for management of personality disorders but clarifies the concept of what a mental disorder is.

Kendell, R. E. (2002) The distinction between personality disorder and mental illness. *British Journal of Psychiatry*, **180**, 110–115.

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Dr Kendell (2002) offers a number of explanations for the reluctance of British psychiatrists to treat patients with personality disorders. He also makes it clear that, whether personality disorder is regarded as an illness or not, it is usually associated with a range of other diagnoses and with a poor response to treatment. This indicates that psychiatrists need to understand them, but whether lack of knowledge of the 'underlying cerebral mechanisms' of these patients (or of the psychiatrists whom they irritate) is the problem is, in my view, dubious; the need is rather for an understanding of persons.

While it may have been true in the past that few links were made between the concept of personality disorder and the psychological literature on personality structure and development, the situation has changed considerably in recent years (see Livesley, 2001). One such link is offered by the model of borderline personality disorder developed within cognitive–analytic therapy – the 'multiple self states model' (Ryle, 1997). This model is based on an understanding of development which emphasises the key role of the intense interactions between infants and their caretakers in shaping personality and patterns of interaction (Trevarthen, 2001). These patterns (called 'reciprocal role procedures' in cognitive–analytic therapy) determine subsequent ways of relating to others and of managing the self. In the case of people with borderline personality disorder, reciprocal role patterns of abusing–abused and neglecting–deprived are commonly acquired in childhood and these patients continue to expect and accept abuse from others and to inflict it on others and on themselves. Faced with perceived repetitions of abuse or neglect they commonly switch to partially dissociated, more manageable states, responding, for example, with pseudo-compliance, by seeking ideal care from idealised others or by maintaining emotional distance (with or without the use of drugs). Switching between states is often abrupt and evidently unprovoked and is confusing to the self and to others; it also disrupts what capacity patients have for self-reflection and learning from experience.

Clinical staff, whether offering nursing care or occupational, cognitive–behavioural or pharmacological treatments, are always liable to be perceived in terms of the patient's patterns and will often be induced or provoked to reciprocate with, for example, counter-hostility, withdrawal of care and attention, or unrealistic offers of help. They are also liable to be confused and de-skilled by the switches. It is here that management based on the multiple self states model can be valuable.

The model was developed in the context of individual psychotherapy. In practice it involves working with the patient to create diagrammatic descriptions of the different states and of the shifts between them. Such descriptions serve to increase the patient's capacity for self-reflection and control and the clinician's ability to avoid or correct responses likely to reinforce the damaging patterns. More recently, and of particular relevance to psychiatry, diagrammatic reformulation has proved valuable as a basis for care planning and staff supervision; applications in community mental health services and in forensic settings are reviewed in Ryle & Kerr (2002). Working with patients with damaging personality disorders using this approach allows clinicians to respond

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appropriately, consistently and non-collusively, rather than to react. It can, I believe, be both more effective and professionally more rewarding and could overcome the reluctance of psychiatrists to take responsibility for these neglected patients.

Kendell, R. E. (2002) The distinction between personality disorder and mental illness. *British Journal of Psychiatry*, **180**, 110–115.

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I would like to offer three comments on Kendell's useful conceptual exploration of personality disorder (Kendell, 2002). First, reduced life expectancy, which Kendell passes on to us, sceptically from Scadding, as a core, defining feature of disorder is implausible. As this criterion refers to aggregate data about a social group, not a claimed causal link about a particular individual, it prompts an odd conclusion. For example, both male gender and poverty predict (reduced) longevity. Does this mean that being male or poor are medical disorders? Such a medicalisation of material or existential disadvantage would surely stretch a metaphor very thinly.

Second, a categorical diagnostic approach (disordered/non-disordered) makes us a hostage to fortune when researching interventions. If we are obliged to ask the categorical question 'is personality disorder treatable?', it will produce a predictably ambiguous answer (Dolan & Coid, 1993). From this flows an understandable ambivalence about the willingness to 'treat' among general psychiatrists (Cawthra & Gibb, 1998) and even among some forensic psychiatrists (Cope, 1993). If we asked a different sort of question, such as, 'can we reduce the re-offending rates of sex offenders using this specific intervention', we might get a useful probabilistic answer about trying to change some people who habitually offend our moral order in a particular way. For example, it is cost-effective to offer psychological interventions (note: not 'treatment') to detained sex offenders as a group, even though risk prediction at the individual level remains problematic on release.

Third, the ambiguities Kendell correctly exposes about the relationship between personality disorder and mental illness also apply to the permeable boundary with normality. Common aspects of parliamentary life (e.g. sexual and financial 'sleaze' and the routine impression-management of politicians), some sport (e.g. boxing and hunting) and some private sexual activity (e.g. consensual sadomasochism) overlap strongly with DSM criteria for variants of 'dramatic' personality disorder. In my view, this points to the logical superiority of a dimensional over a categorical approach (Pilgrim, 2001).

Readers may correctly spot that this dimensional preference is predictable from a psychologist, which highlights that the 'nature' of 'personality disorder' is bound up with the constructs favoured by particular professional groups. However, Kendell, a psychiatrist, also argues that a dimensional view makes more sense (he calls them 'graded traits') – suggesting that a categorical approach has now failed us all, both scientifically and pragmatically. The category of personality disorder is not inherent to those who gain the label, but is a by-product of our professional discourse. A further indication of this point is that whether a detected child molester becomes a prisoner or a patient is a function of multi-party professional judgements. Thus, 'personality disorder' is socially negotiated – it does not exist 'out there' waiting to be discovered. If we go looking, we find 'it', in vast amounts, via circular psychiatric epidemiology (Kuller, 1999), particularly in prison populations. In my view we should abandon the concept of personality disorder altogether and appraise whether and how society (not just mental health professionals) can respond correctively to the wide range of role/rule violations it subsumes.

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Author's reply: Dr Bennett's, Dr Ryle's and Professor Pilgrim's letters raise several very different issues, which makes it impossible for me to respond to, or even comment upon, more than a few of them.

Dr Bennett's argument that the concept of mental illness assumes an 'abnormality of higher mental function' and that personality disorders 'lack good-quality evidence of altered higher mental function' is essentially the same as Aubrey Lewis's contention that mental illness involves an 'evident disturbance of part-function as well as of general efficiency', and that 'until the category (of psychopathic personality) is . . . shown to be characterised by specified abnormality of psychological functions, it will not be possible to consider those who fall within it to be unhealthy' (Lewis, 1953). Lewis's views had a considerable influence on my generation of psychiatrists but now, 50 years on, the limitations of this criterion for distinguishing between personality disorder and mental illness are increasingly apparent, mainly because of the evidence that some personality disorders and some mental disorders share the same genetic diathesis, and are sometimes amenable to the same treatments. As a result, confusion reigns. The affective personality disorder of ICD–9 has been replaced by two new mental disorders, cyclothymia and dysthymia, in ICD–10; schizotypal disorder is classed as a personality disorder in DSM–IV but with schizophrenia and delusional disorders in ICD–10; and the authors of DSM–IV wonder whether avoidant personality disorder may simply be an 'alternative conceptualisation' of generalised social phobia.

Dr Ryle argues that the behaviour of people identified as having 'borderline personality disorders' is understandable in the light of their childhood experience

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