

## **EDITORIAL**

### **Personality Disorders – Issues from Research So Far**

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#### **INTRODUCTION**

Personality disorders are pervasive chronic psychological disorders. They exist on a continuum and can negatively affect one's work, family, and social life. There are no specific tests for personality disorders. Axis II of Diagnostic and Statistical Manual IVth Edition (DSM IV) describes three clusters of personality disorders. With the exception of anti-social personality disorder, all are characterised by the development of patterns of behaviour in early adulthood. The clusters are odd-eccentric, dramatic-erratic and anxious-fearful. However, there are problems in definition of personality disorder. Studies, even large scale ones, have failed to identify any predictive value in terms of response to a variety of treatments associated with categories of personality disorders, implying that current classifications may be erring toward over refined descriptive distinctions with few parallel benefits. The DSM IV, however, defines personality disorders as enduring subjective experiences and behaviour that deviate from cultural standards, are rigidly pervasive, have an onset in adolescence or early childhood, are stable through time, and lead to unhappiness and impairment. This is to be differentiated from personality which may be described as a person's characteristic totality of emotional and behavioural traits apparent in ordinary life, a totality that is usually stable and predictable. When this totality appears to differ in a way that exceeds the range of variation found in most people, and when personality traits are rigid, maladaptive, and produce functional impairment of subjective distress, a personality disorder may then be diagnosed.

An actual estimate of personality disorders is difficult to make because studies use different tools and the population used are variable. However, epidemiological surveys conducted using a range of standardised interview surveys found overall, around 10 – 13% of personality disorders diagnosed in community samples or in samples made up of relatives of patients with psychiatric problems. Women have a higher risk of developing borderline personality disorder as compared to men. However, men are much more likely than women to have anti-social personality disorder and obsessive-compulsive personality disorder. Some of the other risk factors for personality disorders include a family history of personality disorders, a history of childhood verbal, physical or sexual abuse, an unstable family life and a family history of schizophrenia. People with personality disorders are at significantly higher risk of social isolation, suicide, depression, anxiety and eating disorders, incarceration, substance abuse, self-destructive behaviour, violence and homicide.

## COMORBIDITY

### *Within Personality Disorders*

Paranoid, avoidant, and borderline personality disorders were almost always comorbid; 23% of subjects with personality disorders also met criteria for schizotypal personality disorder. Anti-social personality disorder was frequently diagnosed in people with borderline or schizotypal personality disorder. Half of those diagnosed with avoidant personality disorder also met the criteria for schizotypal personality disorder.

### *With Axis I Disorders*

There have been reports of very high rates of comorbid Axis I disorders in borderline patients; 56.4% had generalised anxiety disorders, 41.1% simple phobia, 40.7% major depression and 36.9% obsessive compulsive disorder.

### *Impact of Personality Disorders on Treatment Outcome of Axis I Disorders*

The obvious possibility is that treatment efficacy is usually reduced. The implication is that studies of outcome for personality disorders or Axis I disorders must take account of these high rates of comorbid disorders. It has been established that the presence of Cluster A and B personality disorders reduces the likelihood of good outcome from symptom oriented treatments of Axis I disorders, in particular, depression and anxiety

## STUDIES ON THE TREATMENT OF PERSONALITY DISORDERS

Structured treatment procedures for these patients are at a relatively early stage of evolution, with cognitive behavioural, interpersonal, and psycho-dynamic treatments having reached a stage of manualisation. Uncontrolled studies indicate that psycho-dynamic and interpersonal approaches may be helpful for these patients, particularly in the long term. However, these findings should be interpreted cautiously in the context of the general tendency of these patients to improve with time and the relatively small gains that even long-term treatments are able to achieve. The strongest evidence of effective psycho-therapeutic treatment in borderline patients comes from dialectical behaviour therapy, with demonstrated benefits in reduction of suicide attempts and the need for inpatient services.

Studies using appropriate control groups are very few in numbers and tend to be very small in size. Nevertheless, psycho-dynamic, interpersonal approaches and dialectical behaviour therapy appear to be the current treatments of choice for these disorders. Studies with relatively brief, non-continuous follow-up (less than two years) are relatively of little interest for this group of patients. This is because of the chronically cyclic nature of their disorder, characterised by a tendency toward periods of almost complete remission followed by episodes of great severity. Avoidant personality disorder may be addressed using social skills training or cognitive techniques, but the generalisation of improvements to other social contexts is not well demonstrated.

Medication (particularly neuroleptics and perhaps serotonin reuptake inhibitors) appear to be moderately effective in the short-term, reducing suicidal ideation and discontrol. The efficacy of long-term maintenance treatment remains to be demonstrated. While specific medications appear to be useful in treating particular symptoms of particular personality

disorders, there is no single treatment that can be recommended for treating any one category of disorder.

### IMPLICATIONS

It is not self-evident that a categorical (diagnosis)-based approach to studying the treatment of personality disorder is likely to yield unequivocal results. A problem-focused or dimensional approach may be more helpful in the long run in linking specific treatments to specific problems and specific personality traits. There is a need to identify ways of assessing the problems with which personality-disordered patients frequently present, such as aggression, anxious attachment, social avoidance, and lack of impulse control (disinhibition). Patients with severe personality disorders may not fit with the brief therapy models of most past outcome research. These patients may require long-term or even continuous psychotherapeutic treatment, or a schedule of shorter-term but readily available brief treatments to manage crises. The schedule of such treatment and the preferred intervention strategies have yet to be established.

In view of the major costs to the individual, society, and health services that personality-disordered individuals represent, the cost-effectiveness of intensive long-term treatment approaches for severely dysfunctional personality-disordered individuals should be a focus of scientific inquiry. The chronic nature of these disorders suggest that studies should take a lifespan developmental perspective. Treatments should be assessed in terms of their capacity to influence the trajectory that would be predicted from what is known about the natural history of the disorder. In the light of the relatively poor response of the individuals to currently available psychotherapeutic treatment, psycho-pathological investigations should focus on the preventable causes of these disorders. In particular, in ameliorating the effects of early deprivation, and examining the possibility of preventive measures in childhood for high-risk groups.