Personality Disorders
A guide for GPs

Introduction

Classically a personality disorder is diagnosed in an individual who exhibits characteristics and behaviours which cause them to have difficulties within their relationships and functioning in their cultural milieu. The disorders are persistent and cause distress to both the individual and society. However there are flaws in classifying personality disorders in this way as people tend to demonstrate a number of different traits spanning a number of different 'personality disorder diagnoses'. There are also fluctuations in severity and characteristics over a lifetime. More recently personality disorders are catagorised in clusters. This allows for some overlap of traits and also suggests some fluctuations on terms of severity of characteristics. This clustering is also less stigmatising and perceived as less pejorative than 'one label'.

The clusters are:
- Cluster A - Odd and Eccentric e.g. schizoid;
- Cluster B – Flamboyant and Dramatic e.g. antisocial and emotionally unstable;
- Cluster C – Anxious and Fearful e.g. anxious avoidant.
- There is also a Cluster D – Obsessional and Rigid, although this is often subsumed into Cluster C

Personality disorders are common affecting 7-10% of the population.

Emotionally Unstable Personality Disorder (Borderline PD)/Cluster B Personality Traits

This is the most common of the personality disorders, the traits falling into Cluster B. In some American studies it has been suggested this cluster of personality traits are more prevalent in patients with addiction problems and eating disorders.

Characteristics are:
1. Severe mood swings
2. Outbursts of anger, often inappropriate
3. Identity confusion or lack of clear sense of identity, e.g. gender, sexuality
4. Frantic efforts to avoid real or perceived abandonment
5. Self-harming behaviour, e.g. suicidal threats, self-mutilating behaviour
6. Development of intense interpersonal relationships which are unstable
7. Chronic feelings of emptiness or boredom
8. Impulsivity especially with regards to potentially self-damaging behaviours, e.g. substance abuse, sex, shop lifting, binge eating.

These patients are at a higher risk than the general population of completed suicide.

Obviously these personality difficulties can coexist with other psychiatric disorders e.g. depression, anxiety, panic disorder and even psychosis.

Differential Diagnosis
1. Manic depressive disorder
2. Addiction
3. Depression and Anxiety
4. Psychosis

Treatment
It is probably fair to say that there are no satisfactory treatments for personality disorders currently however there are various treatment methods which can be helpful in some patients.

Pharmacological Treatments
Many drug trials have been carried out with most psychotropic medications being investigated to some extent. There are varying results in terms of efficacy, one of the reasons for this being that patients with personality disorders are notoriously unreliable in terms of taking medication consistently.

Depressive symptoms do respond to antidepressant medication and there is some evidence to suggest that Lithium Carbonate is effective in treating mood instability and curtailing impulsivity and anger.

Pregabalin can helpful in managing anxiety. Benzodiazepines should be avoided in the longer termas patients often exhibit tendencies towards addiction.

Psychological Treatments
1. Dynamic and Analytical Psychotherapies
These therapies are the mainstay of managing this personality disorder; nonetheless this has been insufficiently researched.

Bateman and Fonagy describe a combination of psychoanalytical psychotherapy and partial hospitalisation, Day Care, as being effective. This treatment regime centres around Mentalization Based Treatment – Mentalization being: 'making sense of the actions of oneself and others on the basis of intentional mental states such as desires, feelings and beliefs. It involves the recognition that what is in the mind is in the mind and reflects knowledge of one's own and others' mental states as mental states'.

2. Cognitive Behaviour Therapy (CBT)
There is evidence to suggest that CBT is effective in reducing suicidality in patients exhibiting Cluster B personality traits, especially borderline traits. It is, of course also effective in managing anxiety and depression.

There are variants of CBT, such as Schema – Focussed Therapy which is a more intensive form of CBT and which has been shown to be effective in some borderline patients.

3. Cognitive Analytical Therapy (CAT) – Anthony Ryle
This form of treatment which is a combination of CBT and a more psychoanalytical approach is the mainstay of treatment for emotionally unstable personality disordered patients. It has been shown to be effective in RCTs.

Key Facts for GPs
1. Personality difficulties such as emotionally unstable personality traits are common
2. The disorders vary in terms of severity
3. Treatments ARE available although these are not always entirely effective
4. Medication can be helpful, although specialist help is advisable
5. The 'diagnosis' should not be viewed as pejorative
6. Patients with Cluster B personality traits/disorders are more at risk than the general population of completed suicide.

<div align="right">

Dr Frances Connell
Consultant Psychiatrist

</div>