Personality disorder: struggles with definition and determining its prevalence

Pamela J Taylor provides an overview of the situation facing those charged with determining severe personality disorder.

In rural Kent, a mother, her daughter and her dog were bludgeoned to death. Her other daughter miraculously survived the attack. The man who has been convicted of their murder had been seen by mental health professionals shortly before the killings, his so-called diagnosis of anti-social personality disorder was made and his dangerousness recognised, but *not* so any susceptibility to treatment. He was dismissed by psychiatric services as being beyond them.

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The stigma attaching to the man himself through his label and his deeds spread rapidly to psychiatrists. Melanie Phillips (1998), a journalist, wrote, some would say particularly perceptively:

'Personality disorder [is] the label psychiatrists hang around patients' necks when they know something is wrong with them but they don't know what it is. And the reason for this is they don't bother to find out. If it doesn't fit in with the categories of illness they can treat with drugs, they say it's merely a problem of containment and shunt the (non patient) in the direction of the prison system.'....'Drugs, in short, define their approach. Now drugs have their uses; but they reflect an assumption of a disease to be cured. Because psychopaths can't be cured, they are deemed untreatable.'

Almost on cue, a general psychiatrist (Wessely, 1998) said:

'he had an antisocial personality disorder, which is doctor-speak for being a nasty piece of work. There is debate among psychiatrists as to whether this is a mental illness, or a way of describing people no one likes and most are frightened of. There is less debate about whether psychiatrists can do anything about it - most psychiatrists say not.'

The Home Secretary (Straw, 1998) responded to the case with, on the face of it, a fairly simple statement, a response which twenty years ago might have been uncontentious.

'I continue to believe that psychiatrists are not making as much use as they could of the *1983 Mental Health Act* to care for those people with a psychopathic disorder who do fall within the remit of the Act. ....It is the opinion of many experienced observers of the system that psychiatrists are all too often using the treatability test in the Act as a way as absolving themselves from their duty of providing health care. The Government recognises that there is a need for special provision for people who are dangerous but should not be imprisoned and who, because they cannot be effectively treated, should not be in hospital either. ...We are determined to address this issue and both the Department of Health and the Home Office have been working closely together in order that we can better manage and control those who present a risk to the public and who prove resistant to treatment... I look to the psychiatric profession not to retreat into a defensive mode but rather to respond positively....'

Wessely (1998) was not impressed. 'if Jack Straw's vision came to pass, who would be around to put it into practice? Not me for sure.'

Jack Straw's expressed determination has, in part, resulted in publication of the document *Managing Dangerous People with Severe Personality Disorder*. (Home Office, Department of Health 1999).

What is severe personality disorder?

What, however, is 'severe' personality disorder (SPD)? This is not a condition clinicians or classifiers refer to, or would necessarily recognise. The document says:

- 'SPD' is not a category of mental illness;
- but can be regarded for legal purposes, as a cause of 'unsound mind'
- it includes mood, feeling, and behavioural disorder, incuding antisocial behaviour
- severe personality disordered offenders generally have an inability to relate to others, poor control of impulses, and difficulty in learning lessons from previous experience.
- severity may or may not, be related to the risk posed.

A medical concept of disorder or disease requires three things: that the category identified has some meaning in terms of aetiology or causation; of prognosis or untreated course; and thirdly, implications for intervention. Such meaning is established by substantial cross sectional studies, which serve to identify subgroups of people who differ from accepted norms but are similar to each other. Family and longitudinal study of individuals and groups with and without these characteristics and with and without interventions, are undertaken to clarify meaning as just described. Farrington (1993) lists and discusses some of the more prominent studies with such effects. Here, a good example of a published individual case and family history may best serve the purpose. It is American, but hardly uniquely American. The current representative at the focus of interest would surely fall within

any concept of severe and dangerous personality disorder.

Willie Bosket now lives in a prison cell especially constructed to contain him. Although, as Fox Butterfield (1995), his biographer, says, 'his boast at one of his trials to having committed over two thousand crimes by the age of fifteen may have been something of a 'psychopathic exaggeration', both his criminal and violence career are undoubtedly extensive. He is serving three consecutive twenty-five year to life sentences, and he continues to make murderous attacks in prison'. Butterfield traces the ancestry of Willie Bosket to 1820, when the earliest recorded member of the family was a slave, the first in a line to be sold, separated from family and brutalised by society's structures. One of the dilemmas for mental health workers immediately emerges in how to interpret Willie Bosket's paranoia:

'If we were to accept completely Willie Bosket's version of his life, in which racism alone turned him against the society and its law, then we would have to believe, as some professed during the '60s, that men like him are the vanguard of resistance to racism. But experience and human nature argue against that completely heroic reading. When we consider Bosket's criminal career, it is his impulsiveness and readiness for maximum violence that strike us most. At the same time.... there is a degree of truth in the claims Willie Bosket makes to be the product of racism and the representative of resistance to it. This is not good news for anyone He is an even worse avenger, the man with nothing to lose.'

What is normal?

So, a not uncommon clinical dilemma emerges - when is an individual at war with society engaging in normal reactions to a seriously abnormal, damaging and dangerous situation, and when is he abnormal? In my practice I have not uncommonly heard people claiming that their thoughts and actions are normal and acceptable given the way they have been treated by families, society, government, mental health act structures and the Home Office. Possibly it is true in some cases, but even this does not necessarily mean that the individual is healthy or normal.

Nevertheless, in uncomplicated cases of personality disorder, it is acknowledged that clinician and non-clinician alike have difficulty in seeing why further assessment or treatment should be seen as a health service issue at all. Even in the absence of simultaneous presence of other psychiatric disorders, commonly called 'comorbidity', people with personality disorder do tend to have other health problems. There is evidence of increased risk of physical illness, particularly of lung and liver diseases (Felker et al, 1996). Suicide and other unnatural causes of death are among the leading concerns. In England and Wales, prison suicides are continuing to increase by about 6% per annum, and, given the Office of National Statistics (ONS) findings in a 1997 survey (Singleton et al, 1998), the likelihood is that many of these people have a personality disorder. A serious danger for such people is that indicators of impending suicide may, for whatever reason, be missed.

Kim Kirkman's case came to public inquiry in the UK and shows how much improved recognition, definition, and assessment is needed (Dick et al, 1991). He was a man who, after many years in secure hospitals, was on the point of discharge to the community when he became engaged to marry a fellow patient, had a child with her, and shortly afterwards, while still resident in a secure unit, killed his putative neighbour during an unescorted visit to his future home. He was questioned on June 14th 1990, made a full confession and remanded to jail. He could have been remanded back to his secure hospital unit - but he wasn't.

The Inquiry team wrote:

'We have tried from both professional and lay points of view, to understand what was thought to be wrong with Kirkman during his stay in hospital. Clearly he had abnormal characteristics, some of which were constant and some provoked by circumstances but he does not appear to have had symptoms in the usual sense of the word'.

Then on 17th August 1990 specialist assessment indicated:

'There had in fact been some return of fetishistic interest in women's footwear but he had told no-one about it. There was no reason to believe him to be suicidal or to transfer him to hospital for treatment of his mental illness'.

It was 17 days later that he hanged himself.

Kim Kirkman is unlikely to have been an isolated case. The ONS study confirmed that indicators of risk are strong, although here not separated by diagnosis.

Thirty-five per cent of male and 50% of women pre-trial prisoners had had suicidal thoughts in the year prior to interview for the study, while 15% and 27% respectively had actually attempted suicide. Figures for sentenced prisoners were somewhat lower, but still at important levels. The Howard League has long expressed wide ranging concerns about the imprisonment of vulnerable people. Their report (1999) focusing on this issue identified 554 completed suicides in prison since 1990, while their continued monitoring has confirmed 54 cases up to 23rd August during 1999 (Frances Crook, personal communication). While disorder links have not yet been formally tested, given the very high levels of personality disorder most recently suggested among prisoners (see below) a strong link is inevitable.

Suicide, however, is only one aspect of the distress, disability and damage the disorder may bring for the individual sufferer, as a semi-fictional, semiautobiographical account confirms.

Lermontov (1840/1966), was a Russian writer who was himself impulsive, admitted to violence as a solution to his problems, and failed to learn from the relevant experience of the death of his real life hero, the poet Pushkin, and then his own first duel and its punishments. He aroused passionate hostility from others to his book *A Hero of our Time*. Lermontov's subject indeed had heroic qualities - he was proud, energetic, strong-willed and ambitious, an intelligent individualist who was plausibly seen by some as being in revolt against the mediocrity of the society of his time. In the course of his career, however, he also destroyed the lives of many of the people with whom he came into contact. Lermontov has his 'hero' say:

'Look, I've got an unfortunate character. I don't know how I came by it, whether it was the way I was brought up or whether it's just the way I'm made. All I know is that if I make other people unhappy, I am no less unhappy myself. Not much comfort for them perhaps, but there it is'.

And finally:

'Let it suffice that the malady has been diagnosed - heaven alone knows how to cure it!'

Lermontov himself died in his second duel, at the age of just twenty-six.

Distress

This sense of distress is not uncommon. An indication of its presence among men with personality disorder who had also been recently convicted of an offence of serious personal assault, arose as part of a study of men with personality disorder in prison, who had been convicted of serious offences (Davison and Taylor, available from authors). Generally they had not been referred to mental health services even for further assessment of their personality disorder. All such men at the beginning of their sentences, in one prison, were asked to complete the Personality Diagnostic Questionnaire (PDQ-4 + revised) (Hyler et al, 1988), and the ninety item symptom checklist (SCL-90-R) (Derogatis et al, 1973). Eighty-nine (58%) did so. They did not differ significantly from non-responders in terms of age (mean 32), time since conviction, length of sentence or proportionate distribution of violent and sex offences. The PDQ purports to define individual personality disorders, but using this approach only 13 men (14%) failed to fulfil criteria for any DSM-IV personality disorder category. Using overall scores, by contrast, we were able to separate men scoring in the normal range, from those within a range suggestive of personality pathology found in an out-patient population, from a group, constituting one fifth of the men, with severe personality pathology. Levels of distress as indicated by the mean general symptomatic index of the SCL-90 significantly varied in a hierarchy with this range, with those designated as having 'severe' personality disorder showing most distress.

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assessment clinicians are presented with 200 statements, each on a separate card, to be sorted into categories for degree of match (0-7) to the person under assessment. Each statement may only be given one score, and there are limits to the number that can be placed within each scoring band. Examples of the statements include: tends to react to criticism with rage/hostility feelings; tends to get into power struggles; tends to act impulsively; has little empathy; tends to abuse alcohol.

Their preliminary work on the scale offers promise, but again many items appear subjective and some pejorative.

In Broadmoor Hospital, where I work, pre-admission assessments are necessarily quite limited. Commonly a psychiatrist alone goes to see the referred person; decisions are based on interview, any historical material available and reference to a multi-disciplinary admission panel. Once admitted, however, patients are subject to a broad approach which includes both semi-structured and unstructured psychiatrist interviews, is heavily dependent on nursing observations over weeks, even months as minimum, and strongly informed by a range of psychological assessments from a neuropsychological test battery, through standardised measures of personality, (e.g. Millon 1981) which assess personal characteristics, and Blackburn and Renwick's (1996) Interpersonal CIRCLE, which examines capacity for relationships. Target problems such as anger, sexual knowledge (or rather lack of it), or assertiveness, are also measured, while some patients receive speech and language assessments, testing pertaining to theory of mind, and/or psychodynamic assessment and research measures which may include the Adult Attachment Interview. Independent, contemporaneous accounts of development and behaviour are sought from schools, previous placements, and social work records, and in addition a full current social work assessment includes interview with as many significant others as possible within the family network.

In such a setting, a potential confounder of assessment is the extent of comorbidity and thus the need to assess and manage other disorders too. In a case record survey of all patients resident in a high security hospital from England and Wales during the first six months of 1 993, 71 3, just over 40% of the total had a personality disorder according to ICD-10 criteria (Taylor et al, 1998). Of those, only 40% were without at least one additional psychiatric disorder. Just over one quarter had additional schizophrenia or some other psychotic illness. The official classification systems mentioned tend to exclude this possibility, but these patients did not merely have the post-hoc personality deterioration, that commonly follows process schizophrenia, but established conduct and/or emotional disorders in childhood, generally continuous with a period of adult personality disorder, before a 'distinct break into conditions indistinguishable from schizophrenia.

It could be argued that such highly specialised hospitals would be likely to attract such co-morbidity, which goes beyond the more widely recognised association with paraphilias or substance misuse, and that maybe it does not even occur outside them, but the ONS study (Singleton et al, 1998), of psychiatric morbidity among the 62,000 prisoners in England and Wales in 1997, did enquire, and suggests otherwise. Personality disorder and psychosis comorbidity were perhaps the least common of the comorbidities, but present in far larger numbers in prison than in the special hospital.

Personality disorder and crime

My brief is to include a word on prevalence, and association of personality disorder with crime. In short there is rather little known except among those who have been institutionalised. I will focus on the two principal pieces of work covering England and Wales. The first thing to be said is that they underscore the extent to which different assessment approaches influence the figures. To a large extent this is a product of the tensions highlighted by Westen between research assessment instruments and clinician evaluation.

The ONS survey as a 1997 study is the more recent. A sampling fraction of one in 34 male sentenced, one in 8 male pre-trial and 1 in 3 women prisoners was adopted. Nearly 90% of those approached cooperated, yielding 1250 pre-trial men; 1121 sentenced men; 218 pre-trial women and 676 sentenced women. The assessment of personality disorder was by way of lay interview and the selfcompletion of the (Structured Clinical Interview for DSM-IV)

SCID-II screening instrument for all subjects, and clinician interview, inclusive of the SCID-II interview for a one in five subsample. Seventy-eight per cent of pre-trial men, 64% of sentenced ones and 50% of women had a personality disorder as assessed by the clinician rated SCID-II. Excluding antisocial personality disorder alone, as a possibly circular definition, the SCID rates were still high - 50%, 47% and 39% respectively. As might have been predicted with such an instrument, multiple diagnoses of personality disorder were common with a minimum of 35% of pretrial men, 20% sentenced men and 20% of women showing this alleged type of co-morbidity.

John Gunn, Tony Maden and colleagues did two studies - the first of sentenced prisoners, sampling in 1988/89 (Gunn et al, 1991) when the prison population was still under 40,000, and the second of pre-trial prisoners in late 1993 and 1994 (Maden et al, 1996). The sentenced survey was of 5% of men and about 20% of the much smaller population of women; the figures were 10% and over 80% respectively for the pre-trial group. A complex sampling frame was applied to the male sentenced prisoner population to ensure that it was representative. Numbers interviewed, in all cases by clinicians, were only slightly different from the study sample in the ONS survey.

The clinical interviewing was designed to replicate clinical psychiatric assessment in a prison or hospital, and thus required extraction of data from records and a short semi-structured clinical interview. A random sample of vignettes derived from these assessments were put to a multidisciplinary panel for consensus decision on diagnosis and treatment needs; vignettes of all doubtful cases were also presented.

The most striking thing about the findings is the lower estimates for personality disorder. Among sentenced prisoners 7.3% of the adult men, 11.4% of the male youth and 8.4% of the women were given a primary diagnosis of personality disorder. Among pre-trial prisoners the figures were 11%, 11.7% and 15.5% respectively. Perhaps among prisoners, under the stress often of recent imprisonment, standardised questionnaires are over-inclusive compared with clinical judgement? Even at these levels, however, extrapolation from research numbers would suggest that England and Wales generate a substantial number of cases in the prison system.

Even identification of clinical 'caseness' in this way however, did not necessarily imply treatment needs. For a majority the needs seemed clear. Twenty-five per cent of the subgroup of adult men interviewed (n = 99) were regarded as having no treatment needs, and 19% 'treatable' in prison; 31% were considered as likely to benefit from a therapeutic community and 4% from more conventional NHS treatment. The remainder were considered cases for further assessment. Figures varied only slightly for the male youths, but only one of the 23 women was considered to have no treatment needs. Slightly different approaches to need calculations in the pre-trial group showed a male range with overall about half likely to benefit from treatment for personality disorder and one third needing NHS care for co-morbid mental disorders. A case, then, was being built for quite substantial prison based services, some specialist therapeutic community development and a small, dedicated health service provision.

This may be the most practical approach for defining service need and planning for provision. Both the ONS and Institute of Psychiatry surveys make it clear that being a prisoner is not synonymous with having a personality disorder, although the ONS survey is less discriminating in this respect. The Institute studies further refined calculations by submitting cases to a multidisciplinary clinical team for decision on 'ideal' placement thus applying a method very close to real clinical practice in those centres which accept people with personality disorder for treatment.

We need large scale, community based personality disorder studies to make definitive observations on the association between personality disorder and crime. The American based Epidemiologic Catchment Area Studies, so good for guiding calculations with respect to other mental disorders, do not help here because they used chosen definers of personality disorder as indicators of crime. It is clear even from these prison studies that most serious crime is committed by people without designated personality disorder. It is still not clear how many people with personality disorder do *not* commit crimes, but I guess the proportion is high taking all types of personality disorder together.

Is treatment possible?

A brief mention of 'treatability' is unavoidable, as this may be fundamental to any concept of severity, and highlight the real need for completely new services and safeguards. A psychiatrist researcher, Darryl Gregory, has completed a case note survey of all those with personality disorder turned away from Broadmoor high security hospital as 'untreatable' over the four years between April 1994 and December 1997. There were thirty, all referred on this occasion via the criminal justice system. The most striking thing about the group was that only five had never been placed to receive treatment previously - a twenty-seven year old woman and four men of ages 31, 43, 50 and 64, together well over the average age (32) for admission to Broadmoor for men with personality disorder. Some would argue that little personality change can be achieved after forty. It thus might appear something of a triumph of hope over experience that these older men, and the twenty-five others apparently with extensive previous treatment attempts had been referred at all. This persistence however, is not unusual; among the 116 people admitted during the same period, nearly 30% had had at least one previous special hospital admission, and half of the rest at least one previous admission to another psychiatric hospital. Qualities in the previous treatments offered are rarely transparent, and it perhaps should be a priority to understand better the needs of this subgroup of people so consistently believed to be 'needy' of health services.

There are certainly grounds for shifting from some of the therapeutic pessimism, even nihilism that pervades this field. An English group, led by a sociologist from Nottingham University (Manning), has conducted a systematic review of the international literature on outcome research on the effectiveness of therapeutic communities (TCs) for people with personality disorder and mentally disordered offenders in secure and non-secure settings, from the time of inception of therapeutic communities (Lees et al, 1999). The number and distribution of articles identified is impressive, with 8160 identified, covering 285 individual TCs - secure and non-secure - in 30 countries. The most respected method of research in such circumstances, where subjective judgement may affect ratings, is the randomisation of people to groups receiving treatment or no treatment (or more conventional treatment, if such exists). Eleven studies using this approach (randomised controlled trials) (RCTs) were identified.

Of the ten completed RCTs, seven showed better results for the therapeutic community, including all five completed in the last ten years. The comparative studies were less positive (only four good or better outcomes), but the controlled studies again encouraging with 23 showing a good or better outcome.

Moving away from the therapeutic community, and also from the more serious end of the personality disorder and risk spectrum, Steadman and colleagues (1998) have provided data to counter therapeutic despair in relation to people with personality disorder presenting to general psychiatric services. They studied a sample of 18-40 year olds leaving in-patient care after a brief stay in one of three types of hospital, each in a different city in the USA between 1992-1995; I cannot think of a comparable English study. Their major mental disorder group consisted mainly of people with psychosis and their 'other mental disorder' group' mainly of people with personality disorder or adjustment disorder. Nine hundred and fifty-one completed at least one follow up. Although only about 50% of about 1500 entrants to the study completed all re-evaluations, there no evidence that those who were subsequently violent were disproportionately likely to drop out. For the purposes of considering progress for people with personality disorder, I have excluded *all* patients without co-

morbidity for substance misuse, since the authors say that the personality disorder subgroup without this complication was too small for analysis. This left 468 people in the psychosis group and 185 in the personality disorder group. The proportions of people in these samples who had been violent in the ten weeks prior to hospital admission were remarkably similar in round figures 23% and 25% respectively, with an additional 30% committing other aggressive acts. The psychotic substance misusers as a sub-group were perhaps more rapidly responsive to treatment in the sense of fall in actual violence (although not other aggressive acts) but overall there was no significant difference between the groups in decline in violent acts over the year.

We may have to acknowledge that there is a small group of people with personality disorder who also offend, and prove a substantial risk to others, who may not be treatable in the sense that they show little if any positive response to treatment. We may also need to recognise however, that it is this very group that poses the greatest challenge to all services and society and there is some urgency for understanding them better. This seems a reasonable health service task; there may also be a case for health service input of palliative care, if change cannot be brought about, and certainly for treatment of other disorders which may co-exist.

For the rest, I have tried to convey a message of some continuing difficulties of definition and assessment, but that the picture is not as gloomy as our projections on to it. People who have some disorder of health which may conveniently and perhaps correctly be referred to as a personality disorder and who come into contact with the criminal justice system may be potentially dangerous, but are generally very disabled and/or distressed. The latter in particular may be easy to miss as their means of communicating distress may be deviant. Severity may perhaps commonly be construed in terms of the number of abnormal personality traits, the extent to which they are abnormal, very early childhood onset of disorder, degrees of distress or disablement, but rarely in terms of resistance to treatment. Even the British Government has acknowledged that severity is not coterminous with risk to others. The challenge of providing better, and better informed services for people distressed, damaged and sometimes damaging in the context of a condition we can recognise but still only moderately well define poses an important and I think attainable goal for 2000 and beyond.

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