

HOW WE ARE

Personality disorder: temperament or trauma?

"THE classification of personality disorder continues to generate a kind of moral panic in society, although its clinical definitions range from the most timid to the most dangerous among us. The diagnosis is characterised by confusion and lack of agreement. Where understanding is required, fear has emerged."

So says Heather Castillo, from Colchester Mind Advocacy Service, in her report on personality disorders.¹ She and others aired the issue recently at the annual conference of the James Nayler Foundation this spring, when once more the conventional belief that personality disorder resists treatment was challenged. The Foundation is concerned with preventing the circumstances that can lead to severe personality disorder and violence.

There are 10 sub-classifications of personality disorder, of which borderline personality disorder (BPD) and dissocial personality disorder (DPD) are the most commonly used. BPD is described in the British Classification of Mental and Behavioural Disorders, ICD 10, as "disturbed self image, aims and preferences, chronic emptiness, intense unstable relationships, self destructive behaviour". DPD, also often termed psychopathy, is described as



disregard for social obligations, callous unconcern for others, low frustration tolerance, tendency to blame others, deviant social behaviour.

Because a likelihood of response to treatment is required before an individual can be detained under the Mental Health Act, and because psychiatrists commonly believe that sufferers from personality disorder

can't be treated, those who break the law tend to end up in prison. More recently, because of government concerns about public safety, there have been proposals to enable those termed as suffering from 'dangerous severe personality disorder' to be detained without time limit, even if they are not convicted of any current criminal offence.²

Belief in untreatability is so strong that it has even been suggested, by a consultant psychiatrist writing in the *Guardian*, that resources might be more usefully deployed if all sufferers from personality disorder were denied admission to hospitals.³ This prompted a young woman diagnosed with personality disorder to respond, "I am a victim of childhood sexual and ritual abuse ... I am not yet a 'survivor'. ... I don't see why I should be deprived of the care and expert counselling that I most definitely need. It was, after all, not me who carried out abuse on a minor. I am just trying to cope with the aftermath."

A user perspective

As Castillo has pointed out in her report, psychiatrists appear to view those diagnosed with personality disorders as heartsink patients. In one study, 240 psychiatrists were randomly assigned one of six case histories. Patients who had a previous history of personality disorder were seen as difficult, annoying, manipulative, attention seeking, in control of their suicidal urges and less deserving of care.⁴

"Thoughts of the past prominent in my head. Bad person, naughty baby, no wonder my birth mother didn't want me. I'm not deserving of anything good in my life. I need to be punished just because I'm alive. Mind swirling, too many thoughts at once, can't cope. Worthless, burden, angry. The anger is initially directed at the right people. However it doesn't stay there for long. I soon turn it around and, consequently, the anger returns to me, as it should do, because that's my lot in life. ... Once more a failure. Get my 'equipment' out, place it in the usual position – razor blades, steristrips, gauze, tape. ... Fighting a losing battle – need to cut for a release, a short time without the bad

thoughts. Physical pain important, as is the bleeding – some of my badness coming out – good. ... Feelings change again. Self-loathing, intense guilt – why did I do it? ... Tired all of a sudden. Put all the equipment away until the next time, because there is going to be a next time."

"I could either shoot or stab to death (with a carving knife) everybody in this so called 'human race', so that I would be the only one left, apart from all the animals, birds, insects and nature itself. Then I would be happy because no one could hurt me, laugh at me, disbelieve me, sh** or urinate on me and talk 'down' to me. I've just had enough of all that. So basically I would never be taken advantage

*of ever again. I would be free ... happy ... peaceful ... content ... (lovely) so f*** off all of you."*

"I am a direct product of abusive influences and it is not possible to just wipe away the last 28 years. I genuinely feel that nothing good will ever happen to me, because I seem to go from one disaster and major trauma to the next, but that doesn't mean that I don't want things to change."

"We already feel sub-human, threatened, misunderstood and vulnerable, and now we are tarred with the brush of being bad as well as mad."

In 1999, 18 clients of the advocacy service at Colchester Mind decided to group together to challenge public and professional perceptions of personality disorder. All had been given the label of BPD or DPD and all were frightened by the possible ramifications of government's proposals for indefinite detention of those deemed to represent a serious risk to the public. With Heather Castillo acting as the project coordinator, group members undertook their own research into the history of the diagnosis of personality disorder, and four trained as interviewers so that they could carry out interviews with individuals labelled with BPD or DPD. A questionnaire was devised with the aid of supervisors at Anglia Polytechnic University and ethical permission was granted for the study. Over a nine month period, despite their own frequent episodes of illness or hospital admissions, the user group completed 50 interviews with patients identified by local consultant psychiatrists.

A different picture

The 20 male and 30 female interviewees were aged between 25 and 54. Most were single, separated or divorced, and living alone on benefits. Just one person had a full-time job. More than three quarters of the women had received a diagnosis of BPD and more than three quarters of the men were diagnosed with DPD. (Yet 35 per cent of the borderline women had been violent.)

Very many of the respondents felt that they had been given the personality disorder label because no one knew what to do with them. The very term personality disorder seemed to imply something permanent and unchangeable. "I thought it meant like a bad person. I thought it meant there was something apparently bad and evil about me that meant I couldn't be good. Because I don't think you can change someone's personality. You are born with your personality."

The interviews revealed that 88 per cent had been physically and/or sexually abused, 80 per cent of them as children, and 78 per cent had also been diagnosed at some time with depression. Eighty two per cent had at some time attempted suicide and 88 per cent had self harmed. Three quarters

experienced overwhelming anger and nearly half felt a desire to hurt others. Most appeared to be victims of prolonged trauma from caregivers, with resultant profound adverse effects on their personality development.⁵

The report catalogues individuals' fear, anger, confusion and despair, and their experiences of hospital, prison and child protection services (see samples of responses in panel on page opposite). Castillo believes it has much to tell professionals: "Service users who have attracted the diagnosis of personality disorder may help others to look not so much at how they are but how they came to be that way. In so doing they also offer abundant knowledge about symptomatology. They may not always know what is helpful but they frequently know what is unhelpful, what is upsetting and what provides a trigger for the worsening of their difficulties. They seem to be saying that acceptance and understanding will get professionals halfway there."

The report also details therapy methods which individuals have found helpful and unhelpful, the latter significantly more common than the former. It is clear that there is a long way to go before the necessary effective forms of help are on offer – and, clearly, the essential first step is to deem sufferers deserving of treatment. ■

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1. Castillo, H (2000). Personality Disorder – Temperament or Trauma: a cooperative inquiry, by service users, into the nature and treatment of personality disorder. Colchester Mind Advocacy Service, Colchester. (Telephone 01206 228730 or email mail@colchestermind.org – for copies.)
2. Department of Health (1999). Managing Dangerous People with Severe Personality Disorder: Home Office proposals for policy development. HMSO, London.
3. Ooi, R (1997). Everyone's life has a price. The Guardian, 22/7/97.
4. Lewis, G and Appleby, L (1988). Personality disorder: the patients psychiatrists dislike. British Journal of Psychiatry, 153, 44–49.
5. Herman, J and Van der Kolk, B (1987). Traumatic origins of borderline personality disorder in psychological trauma. American Psychiatric Press, Washington, DC.

IN BRIEF

CHILDREN who get more colds early in life are less likely to develop asthma and other allergies later, German researchers have found. Of 1300 children born in 1990, children who had only one or no infections at all before their first birthday were twice as likely to have developed asthma by the age of seven as those who had had at least two mild virus infections before they were one. The findings support the 'hygiene hypothesis' which blames squeaky clean modern lifestyles for the increase in autoimmune diseases and allergies. (*New Scientist*, 2001, February 24, page 16.)

SUICIDE rates increased substantially for 15–19 year old males between the 1970s and the 1990s. The increase was associated with a rise in self poisoning with vehicle exhaust gas in the 1980s, which decreased in the mid-1990s (due in part to the introduction of catalytic converters), and a rise in hangings which has persisted. Suicide by overdosing peaked in the 1970s and has subsequently decreased. Although suicide figures for young females fell, 'undetermined' deaths increased. (*British Journal of Psychiatry*, 2001, 178, 469–474.)

WOMEN doctors working within the NHS are twice as likely to commit suicide as women in the general population, according to a study based on deaths of doctors between 1979 and 1995. The rate among male doctors is two thirds that of the general male population. However, the suicide rates for both male and female anaesthetists, community health doctors, GPs and psychiatrists are higher than for doctors in general hospital medicine. Female doctors are particularly likely to follow women's tendency to choose drug overdose as the means of suicide. (*Journal of Epidemiology and Community Health*, 2001, 55, 296.)