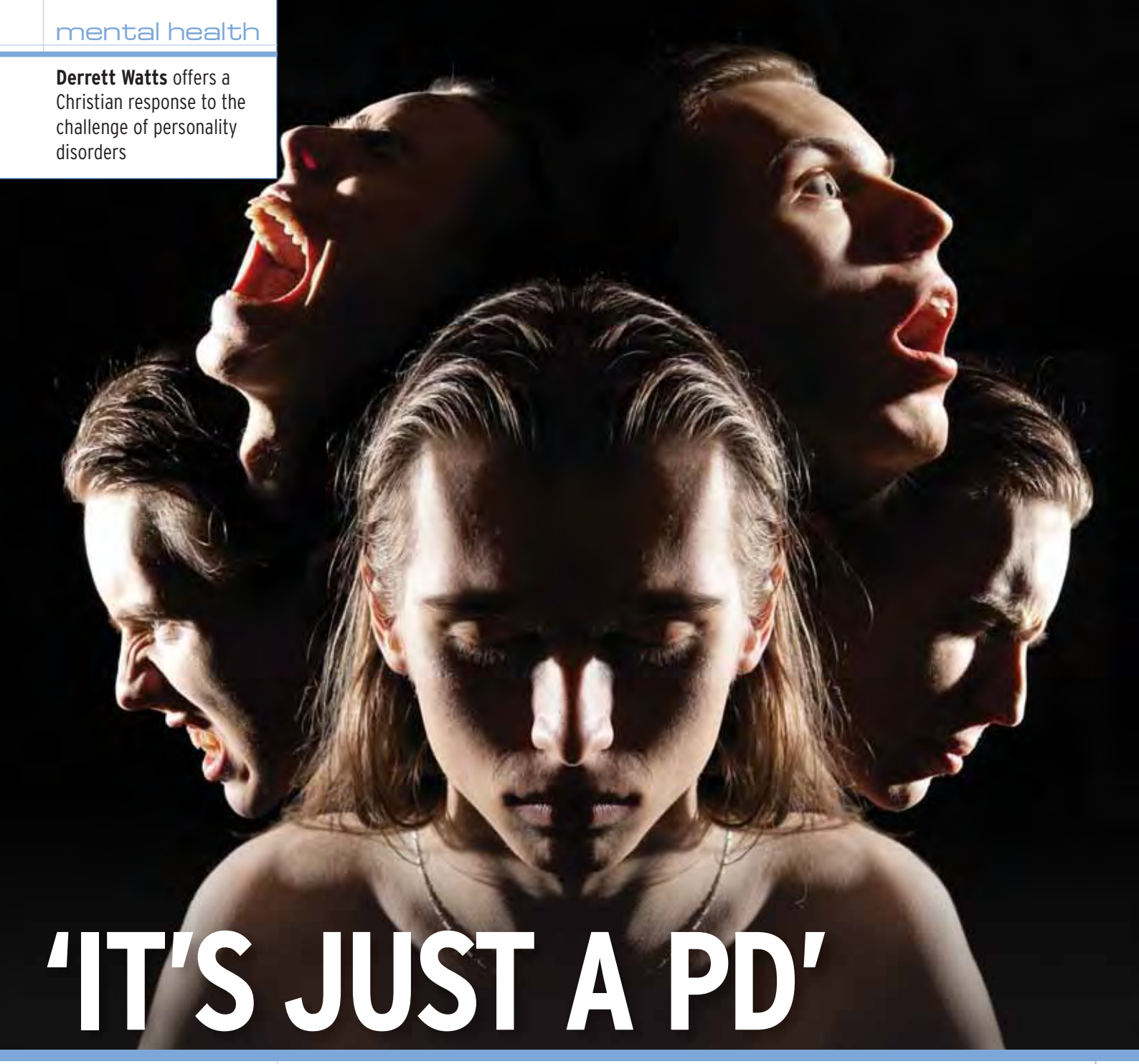
Derrett Watts offers a Christian response to the challenge of personality disorders



'IT'S JUST A PD'

key points

- The concept of PD was known by the ancient Greeks and most recently referred to as 'antisocial personality' (DSM III, IV).
- Depersonalising language is unhelpful and can reveal underlying prejudices.
- The view that PDs were untreatable has altered over recent decades and a range of treatments have shown efficacy.
- Christians believe no one is irredeemable, not least since the work of the Holy Spirit can make people new.

How many doctors say, 'It's just a PD'? This often-used phrase may be heard before or following an assessment when someone presents with psychological distress. Acronyms throughout medicine are legendary, used by all practitioners at some point as shorthand in communication. Rarely would these terms flatter. Worse, they may reveal underlying prejudices which could affect treatment delivery.

Let's stop for a moment and think about the language being used here. 'It's.' This is depersonalising language. 'Just.' This is minimising language. 'A PD.' Here we have a single term being used to amalgamate a range of diverse conditions. Part of the particular challenge personality disorders pose is that this is 'the crux of the mad/bad debate',[1] raising the question of responsibility for actions (madness or badness).

This article explores the recognition and management of people presenting with personality disorders and asks why it may be viewed differently from other conditions. Finally it seeks to examine how Christians might respond.

Definitions

We begin by asking 'What are personality disorders?' The English word 'Personality' comes from the Latin word persona, meaning a mask. Assessing personality involves understanding the mask people portray and the internal processes which influence it. Allport's classic definition puts it thus: 'Personality is the dynamic organisation within the individual of those psychophysical systems that determine his characteristic behaviour and thought.'[2] Various theories describe different aspects of personality development. Freud developed his Psychosexual and Structural Model;

Table 1 (Adapted from Hermann et al, 2013)[3]

Cluster	Type	Description
Cluster A (Odd, Eccentric)	Paranoid Personality Disorder	Pervasive distrust and suspiciousness of other people
	Schizoid Personality Disorder	Pervasive pattern of social detachment and restricted range of emotional expression
	Schizotypal Personality Disorder	Pervasive pattern of social and interpersonal limitations
Cluster B (Dramatic, Emotional, Erratic)	Antisocial Personality Disorder	Pervasive pattern of disregard for the rights of other people that often manifests as hostility and/or aggression. Deceit and manipulation are also central features
	Borderline Personality Disorder	Experience intense and unstable emotions and moods that can shift fairly quickly
	Histrionic Personality Disorder	Pattern of excessive emotionality and attention seeking
	Narcissistic Personality Disorder	Significant problems with sense of self-worth stemming from a powerful sense of entitlement
Cluster C (Anxious, Fearful)	Avoidant Personality Disorder	Pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation
	Dependent Personality Disorder	Strong need to be taken care of by other people
	Obsessive-Compulsive Personality Disorder	Preoccupied with rules, regulations, and orderliness

Piaget: Cognition; Erikson: Psychosocial; and Kohlberg: Moral.

The concept of personality disorder was known to the Greeks. Theophrastus, Aristotle's pupil, identified 30 'characters' (eg dissimulator, distrustful man, unpleasant man). These ideas persisted until around the end of the eighteenth century, when Pinel described '*manie sans delire*' (insanity without delusion). Prichard (1837) spoke of 'moral insanity' – no apparent illness but gross disturbance of behaviour. This led to personality disorder being differentiated from other mental illnesses.

The term 'moral insanity' fell out of use with the work of Koch (1888) and it was replaced by the term 'psychopathic inferiority'. Koch's thought was influenced by Darwinian thinking, suggesting this was due to degeneration of the nervous system. Then in 1935 William White in the USA described 'psychopathy', whilst the UK 1959 Mental Health Act included psychopathic disorders amongst those patients who could be detained. The 1952 version of the *Diagnostic and Statistical Manual* (DSM) included the term 'sociopathic personality disturbance' whilst the 1968 revision used 'antisocial personality,' and this was retained in *DSM-III* and *-IV*.

Core Features

From *ICD-10* and *DSM-IV*, five characteristics can be identified to assist identification of personality disorder: An enduring pattern of *inner experience deviating markedly* from expectations of one's culture. This pattern is *inflexible* and *pervasive*. It leads to clinically significant *distress* and/or functional *impairment*. The pattern is stable, *long-standing*, beginning in adolescence or early childhood. This pattern is *not attributed to another mental disorder or substance misuse*.

Types of disorder

Some ten distinct types are found which may be placed into three clusters as shown above.

Some people may have traits rather than a disorder; they demonstrate some of the behaviours but without interference in daily functioning as for those with a disorder.

Prevalence

The overall prevalence rate for personality disorders is estimated to be 4.4%,[4] rising to 10–12% in primary care, 33% in general psychiatric outpatients and 70% in prisoners.[5] Rates are highest amongst men, separated, unemployed and those living in urban areas. Cluster B, including antisocial and borderline types which cause the most concern, has a prevalence of 1.2%.[6]

Associations

Across the clusters there are increased rates of social and health related difficulties. Cluster A disorder patients are three times more likely to have been in local authority care before the age of 16 years, Cluster B patients are more likely to have had a criminal conviction, been in prison and/or been in local authority or institutional care, and Cluster C patients are more likely to have received psychotropic medication and counselling.[7]

Both borderline and antisocial personality disorders can cause serious impairment and are commonly

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Table 2 – Principles of treatment approach (Derived from Kendell et al, 2009)[13]

	Antisocial Personality Disorder (NICE CG 77)	Borderline Personality Disorder (NICE CG 78)
Attitude to Treatment	■ Treatment resisting	■ Treatment seeking
Treatment Agencies	■ Specialist personality teams or forensic service ■ Need effective interagency working with clear pathways	■ Community mental health services responsible for routine assessment, treatment, and management ■ Should not exclude from any health or social care service because of the diagnosis
The role of psychological treatment	■ People in community or institutional care, consider group-based cognitive and behavioural interventions focused on reducing offending and other antisocial behaviour	■ Structured care along with supervision for the therapist ■ Generally avoid brief psychological interventions (less than three months) specifically for borderline personality disorder
The role of drug treatment	■ Offer treatment for any comorbid disorders in line with other NICE clinical guidelines ■ Do not exclude people from treatment	■ Do not use drug treatment specifically for borderline personality disorder or for associated individual symptoms or behaviour ■ Use for short term in crisis periods ■ Avoid polpharmacy
Treatment Approach (to both)	■ Open, engaging, and non-judgmental manner ■ Be consistent and reliable	

associated with depression and anxiety.[8] Conditions such as opiate and alcohol dependence, and PTSD are strongly associated with Cluster B disorders, whilst Obessisve Compulsive Disorder and Social Phobia is likewise linked to Cluster C disorders.

Some 8% of all people committing suicides in England were found to have a primary diagnosis of personality disorder, rising to 18% for under 25 year olds. Some 73% were found to have a co-morbid psychiatric disorder, most commonly alcohol dependence/misuse (43%) or drug dependence/misuse (32%).[9] Aetiologically, the association with events in childhood is strong. Borderline personality disorder is 'all too often the late result of significant harm to personality development from neglect, abuse or trauma in childhood'.[10]

What treatments work

The view that personality disorders were untreatable has altered over the last 20 years, with increasing evidence for interventions.[11] A range of psychological treatments treatments have shown efficacy including: Psychodynamic Therapy; Cognitive Behavioural Therapy; Dialectical Behaviour Therapy; Therapeutic Community; Cognitive Analytic Therapy; Behaviour therapy and Nidotherapy.[12]

Respecting the particular concern for Cluster B, NICE guidelines have been issued for antisocial and borderline personality disorders, and are summarised in Table 2 above.

A subsequent Cochrane review has suggested a more expanded role for medication, particularly, mood stabilisers for symptoms such as affective dysregulation and impulsive-behavioural dyscontrol.[14]

The Christian Response

Rick Warren, pastor of Saddleback Church, California, whose son suffered from Borderline Personality Disorder and depression and committed suicide in 2013, stated in his first sermon following this event that 'God is calling us as a church to remove the stigma of mental illness.'[15]

Borderline Personality Disorder has 'a stigma associated with it that goes beyond those associated with other mental illnesses', and this may cause practitioners to minimise symptoms[16] ('It's Just a PD') and distance themselves, reducing the likelihood of therapeutic success. The previous views of therapeutic nihilism as discussed above have added to this.

Dr Bob Johnson, speaking from experience of working in prisons, stated that 'untreatability has gained a sickening hold on academic psychiatry ...but the Christian view is that no-one is irredeemable...'. He felt that the attributes required for successful therapists are patience, firmness, discernment and empathy.[17]

Clearly these attributes are not restricted to Christians, but the difference is that for Christians, they will be present because of God working within us – the fruit of the Holy Spirit[18] – rather than our own ability. We can say with Paul, 'I can do all things through Christ who strengthens me.[19] The hope is that 'a Christ-like approach invoking the compassion of the Servant King and the power of the Holy Spirit may help to engage the damage person who is barricaded behind his mental defences.'

The gospel speaks relevantly to the situation of persons struggling with their sense of self: be it lost altogether, disordered or overtly strong (manifesting in antisocial traits). Christians witness to the liberation that comes through discovering personal identity in Christ, and thus being made new. Herein is an opportunity for the church in mission.

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