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EDITORIAL

Personality Disorder

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This Special Issue is intended to provide readers of the *Journal of Mental Health* with an overview of treatment options for personality disorder. The controversial diagnosis of personality disorder came into its own as a separate Axis (Axis-II) in the third edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (American Psychiatric Association, 1980). Distinguishing between three clusters of personality disorder, an attempt was made to identify personality prototypes based primarily on the clinical and academic experience of those working on the manual. We suspect now that it is a considerable oversimplification to assume that a pre-existing characterological basis to psychopathology can provide a breeding ground for psychiatric disorder. Nevertheless, this was the frame of reference within which a significant number of such disorders were described and operational criteria for the diagnosis agreed upon. Across studies, the median prevalence of any personality disorder is about 11% (Black, Goldstein, & Mason, 1992; Klein, Ouimette, Kelly, Ferro, & Riso, 1994; Lenzenweger, Loranger, Korfine, & Neff, 1997; Maier, Lichtermann, Minges, & Heun, 1992; Moldin, Rice, Erlenmeyer-Kimling, & Squires-Wheeler, 1994; Samuels et al., 2002; Torgersen, Kringlen, & Cramer, 2001; Zimmerman & Coryell, 1989). There is considerable variability in point prevalence with both common problems, such as obsessive-compulsive (mean 2.1, range 0.0–9.3), avoidant (mean 2.9, range 0.4–5.0) and passive-aggressive (mean 1.99, range 0.0–10.5) problems, and with less common problems, such as self-defeating (mean 0.7, range 0.0–0.8), narcissistic (mean 0.6, range 0.0–4.4) and schizoid (mean 1.0, range 0.0–1.6) problems.

The natural history of personality disorder had not been systematically studied until recently when several major cohort follow-along studies have yielded surprising data concerning symptomatic remissions (Cohen, Crawford, Johnson, & Kasen, 2005; Skodol et al., 2005; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005). Taking one example, 88% of those initially diagnosed with borderline personality disorder have remitted in the sense of no longer meeting the Diagnostic Inventory for Borderline–Revised (DIB-R) or the third Diagnostic and Statistical Manual of Mental Disorders (DSM-III) criteria for borderline personality disorder (BPD) for two years over a ten-year follow-along period (Zanarini et al., 2005). Only 18% of this sample met these criteria for two years after meeting the criteria for remission in a previous follow-up period. The symptoms that remit most readily appear to be acute ones such as self-injury, which are the best markers for the

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disorder. They are also often the main reason behind providing expensive forms of care. Temperamental symptoms, such as angry feelings and acts, distrust and suspicion and abandonment concerns resolve more slowly, are associated with ongoing psychosocial impairment, and are less specific to borderline personality disorder. In the Collaborative Longitudinal Study of personality disorder (Grilo et al., 2004), psychosocial functioning was seen as recovering far more slowly than acute symptoms. Thus, while 40% of those with major depression remitted over a four year period for 12 months, when remission was defined as a normal Global Assessment Function (GAF) score, only around 10% of those with schizotypal personality disorder or borderline personality disorder did so. Early remission in borderline patients is associated with younger age, good vocational record, low history of sexual abuse, no family history of substance abuse, the absence of an anxious cluster of personality disorder, low neuroticism and high agreeableness (Zanarini et al., 2005).

Personality disorders are important statistical predictors of quality of life and are more important than sociodemographic variables, somatic health, and Axis I disorder (Cramer, Torgersen, & Kringlen, 2006). Those with avoidant, schizotypal, paranoid, schizoid, and borderline PDs had the strongest and broadest reduction in quality of life, whereas those with histrionic, obsessive-compulsive, passive-aggressive, and sadistic PDs did not show any reduction. Individuals with personality disorder are known to be significant consumers of psychiatric treatment services. In the Collaborative Longitudinal Personality Study (CLPS), monitoring schizotypal, borderline, avoidant and obsessive-compulsive PDs, the mean lifetime months of outpatient treatment was over 50 months of individual therapy for BPDs, 43 months for schizotypal personality disorders (STPDs), 34 months for obsessive–compulsive personality disorders (OCPDs) and 31 months for antisocial personality disorders (APDs) (Bender et al., 2006). In addition, the mean lifetime weeks of partial hospitalization was 12 weeks for BPD and 8 weeks for STPD, and their treatment was 12 weeks for BPD and 8 weeks for STPD. Most of those with a BPD diagnosis, at least in the US, receive psychiatric medication: 60% antidepressants, 33% anti-anxiety medication, 10% antipsychotic medication. Fifty-five percent of those with avoidant personality disorder (AVPD) and 50% of those with STPD also receive antidepressants. The presence of co-morbid personality disorder on the whole increases the clinical severity of a range of diagnoses, such as panic disorder (Ozkan & Altindag, 2005), heroin dependence (Darke, Ross, Williamson, & Teesson, 2005), bipolar I disorder (Swartz, Pilkonis, Frank, Proietti, & Scott, 2005). A recent meta-analysis of studies of depression (Newton-Howes, Tyrer, & Johnson, 2006) showed that the odds ratio for poor outcome with personality disorder was 2.18 (95% CI: 1.7 – 2.8). This complication applied as much to psychopharmacological studies as to psychosocial interventions and was comparable in size for all treatments except electro–convulsive therapy (ECT).

The papers in this Special Section are concerned with treatments specially developed for personality disorder. This collection, as per other compendia of studies, focuses primarily on BPD. Whilst there have been a number of meta-analyses of psychosocial therapies for PD (Leichsenring & Leibing, 2003; Perry, Banon, & Ianni, 1999), the relative paucity of good-quality trials restricts the conclusions that can be drawn from meta-analyses. In only a limited number of effectiveness or efficacy studies was Axis II disorder the primary focus of treatment (Roth & Fonagy, 2004). There are special difficulties in evaluating treatment trials of personality disorder, such as the high level of comorbidity between personality disorder diagnoses in addition to the comorbidity with Axis I diagnoses. An ideal strategy would be to assign patients to treatment groups on the basis of matched Axis I and comorbid Axis II diagnoses, but this has not so far been attempted. The current compendium of papers overviews the range of treatments currently available for personality disorder as well as some

promising interventions under development. It is by no means a comprehensive collection. There are important omissions; for example, schema-focused therapy (Giesen-Bloo et al., 2006) and transference-focused psychotherapy (Levy et al., 2006) are not presented. Triebwasser and Siever, however, provide a masterly review of the current state of pharmacotherapy for personality disorder. Feigenbaum overviews the application of Dialectic Behavior Therapy (DBT) for BPD as well as evidence for it's effectiveness in addressing other problems such as substance abuse. Hoffman, also adopting a broadly DBT therapeutic framework, explores evidence for improving family adaptation through a combination of educational, skills and supportive methodologies. Fonagy and Bateman review the mentalization-based treatment approach, which has a more limited evidence base than DBT but nevertheless has been tested in a randomized controlled trial. Markowitz describes an innovative adaptation of an evidence-based treatment, interpersonal psychotherapy (IPT) to borderline personality disorder (BPT), whilst Tyrer describes an entirely new treatment, nidotherapy, which is a protocol for the management of chronic and persistent mental disorders. Livesley offers an organizing clinical framework for a range of treatments that are evidently important for the successful delivery of psychiatric services to individuals in this group. Finally, Horn provides an essential user perspective on the treatment of personality disorder.

The treatment of personality disorder is at a crossroads. At the same time that meta-analyses have found important Axis I disorders, such as major depression, respond far less well to treatment in the long term than previously thought (National Institute for Clinical Excellence, 2004), disorders traditionally regarded as treatment-resistant such as BPD (Stone, 1993) turn out to be relatively rapidly remitting. This of course brings into question the conceptual framework within which we normally consider personality disorders as enduring structures upon which psychiatric syndromes are imposed. The field is clearly ripe for dramatic reconceptualization where temperamental and acute symptomatic variables are separated in making PD diagnoses. At the moment the treatment of personality disorder is largely defined in terms of successful addressing of symptoms. A developmental framework would be preferable. This would simultaneously take into consideration the emergence of personality traits and indications of adjustment problems that are the likely developmental consequences of a variety of biological and psychosocial risk factors. As longitudinal studies make us increasingly aware, psychiatric disorders do not emerge de novo but in the majority of instances are antedated by problems that emerge in the course of development (e.g., Kim-Cohen, Caspi, Moffitt, Harrington, & Milne, 2003). We are likely to see behavioural organizations that we currently term personality disorders as age-specific adaptations to biopsychosocial pressures, which are best treated by developmentally specific interventions that could be primarily preventative, curative or rehabilitative in nature. However, this kind of comprehensive dynamic developmental approach to personality disorder is still some way in the future. For the moment we should celebrate the emergence of effective biological and psychosocial treatments for this group of individuals who have been so poorly served by psychiatric services in the past (Department of Health, 2003).

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