

Correspondence

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Personality disorder

Kendell (2002) refers to treatment factors influencing attitudes; I believe that level of understanding and the concept of mental illness are additional influences. Mental disorders can be defined as abnormalities of higher mental function (i.e. perception, thought, emotion, memory) and can be explained in relation to different degrees of reductionism, which is consistent with the application of a medical model. Some have evidence of biological dysfunction (e.g. epilepsy), others of psychological dysfunction (e.g. schizophrenia) and others of 'behavioural dysfunction' (e.g. personality disorders). The confidence in what constitutes a mental disorder is partly dependent on the level of explanatory power. Behaviour lacks explanatory power because of the difficulty in determining whether behaviours arise from normal or abnormal brain function. In this context operational definitions reliant on behaviour are based on poorer-quality evidence and more heavily influenced by sociocultural factors.

In addition, eliciting symptoms of mental illness relies on subjective reports of the experiential aspects of internal mental processes. A mental illness is recognised when qualities of internal mental experiences that are recognised as being different from normal mental experiences are reported, and the larger the difference the more likely it will be explained as mental illness. This phenomenon is usually lacking in people with personality disorders.

Thus, personality disorders lack good-quality evidence of altered higher mental function, including internal mental experiences, and using the definition above they would not be considered mental disorders. People with personality disorder experience disadvantage in their sociopolitical environment, often due to their behaviour, and in other circumstances 'disadvantage' has been sufficient to explain increased

morbidity. Until altered higher mental function can be reliably demonstrated it may not be appropriate to view personality disorders as mental disorders. The term 'challenging behaviour' is used in the psychiatry of learning disability and has the advantage of being descriptive, making no assumptions about aetiology, and is more explicit about a social dimension; it may be possible to develop a similar term for personality disorders. This does not obviate the need for management of personality disorders but clarifies the concept of what a mental disorder is.

Kendell, R. E. (2002) The distinction between personality disorder and mental illness. *British Journal of Psychiatry*, **180**, 110–115.

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Dr Kendell (2002) offers a number of explanations for the reluctance of British psychiatrists to treat patients with personality disorders. He also makes it clear that, whether personality disorder is regarded as an illness or not, it is usually associated with a range of other diagnoses and with a poor response to treatment. This indicates that psychiatrists need to understand them, but whether lack of knowledge of the 'underlying cerebral mechanisms' of these patients (or of the psychiatrists whom they irritate) is the problem is, in my view, dubious; the need is rather for an understanding of persons.

While it may have been true in the past that few links were made between the concept of personality disorder and the psychological literature on personality structure and development, the situation has changed considerably in recent years (see Livesley, 2001). One such link is offered by the model of borderline personality disorder developed within cognitive-analytic therapy – the 'multiple self states

model' (Ryle, 1997). This model is based on an understanding of development which emphasises the key role of the intense interactions between infants and their caretakers in shaping personality and patterns of interaction (Trevarthen, 2001). These patterns (called 'reciprocal role procedures' in cognitive-analytic therapy) determine subsequent ways of relating to others and of managing the self. In the case of people with borderline personality disorder, reciprocal role patterns of abusing–abused and neglecting–deprived are commonly acquired in childhood and these patients continue to expect and accept abuse from others and to inflict it on others and on themselves. Faced with perceived repetitions of abuse or neglect they commonly switch to partially dissociated, more manageable states, responding, for example, with pseudo-compliance, by seeking ideal care from idealised others or by maintaining emotional distance (with or without the use of drugs). Switching between states is often abrupt and evidently unprovoked and is confusing to the self and to others; it also disrupts what capacity patients have for self-reflection and learning from experience.

Clinical staff, whether offering nursing care or occupational, cognitive-behavioural or pharmacological treatments, are always liable to be perceived in terms of the patient's patterns and will often be induced or provoked to reciprocate with, for example, counter-hostility, withdrawal of care and attention, or unrealistic offers of help. They are also liable to be confused and de-skilled by the switches. It is here that management based on the multiple self states model can be valuable.

The model was developed in the context of individual psychotherapy. In practice it involves working with the patient to create diagrammatic descriptions of the different states and of the shifts between them. Such descriptions serve to increase the patient's capacity for self-reflection and control and the clinician's ability to avoid or correct responses likely to reinforce the damaging patterns. More recently, and of particular relevance to psychiatry, diagrammatic reformulation has proved valuable as a basis for care planning and staff supervision; applications in community mental health services and in forensic settings are reviewed in Ryle & Kerr (2002). Working with patients with damaging personality disorders using this approach allows clinicians to respond