What Is Personality Disorder?

Hanna Pickard

The dsm-iv-tr (American Psychiatric Association 1994, 689) defines personality disorder (PD) as:

A. An enduring pattern of experience and behavior that deviates markedly from the expectations of an individual's culture. This pattern is manifested in two (or more) of the following areas:
   1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events);
   2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response);
   3. Interpersonal functioning; and
   4. Impulse control.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Unlike schizophrenia, bipolar disorder, and other Axis I conditions, PD is not conventionally understood as an illness or disease. Rather, as the name implies, it is a disorder of the personality: an 'enduring pattern of experience and behavior.' Metaphorically speaking, it is a condition that is internal to the kind of person someone is, a part of who they are. It is not an external condition that befalls them.

Very roughly, personality is the set of characteristics or traits that make us the kind of person we are: the ways we are inclined to think, feel, and act in response to particular circumstances, as well as more generally. All of us have one. PD occurs when the set of characteristics or traits that make a person the kind of person they are causes severe psychological distress and impairment in social, occupational, or other important contexts: the ways a person is inclined to think, feel, and act do them harm, directly or via the effects they have on relationships, work, and life more generally conceived. Diagnosis of a PD requires that these characteristics or traits be long-standing, pervasive, difficult to control or change, and markedly different from cultural expectations. Equally, the distress and impairment caused must be sufficiently extreme to warrant clinical attention: the person needs clinical care and help. Nonetheless, all of us possess characteristics or traits that sometimes incline us to think, feel, and act in ways that cause us distress and adversely affect our social, occupational, or other functioning. PD lies on a continuum with normal human personality.

The broad category of PD is currently divided into three subcategories or 'clusters.' Cluster A comprises paranoid, schizoid, and schizotypal PD. These are more colloquially known as the odd

© 2011 by The Johns Hopkins University Press

and eccentric or 'mad' PDs. Cluster B comprises narcissistic, borderline, histrionic, and antisocial PD. These are more colloquially known as the dramatic, emotional, and erratic or 'bad' PDs. Cluster C comprises obsessive-compulsive, avoidant, and dependent PD. These are more colloquially known as the anxious and fearful or 'sad' PDs. A person cannot be diagnosed with any particular PD unless there is clinically significant distress and impairment. But, given that this condition is met, which kind of PD they have depends on what kind of personality they have-on the nature of the problematic pattern of experience and behavior.

Stepping back and considering the wider context, the picture painted of PD is bleak. PD is associated with genetic factors (Jang and Vernon 2001) and also environmental conditions (Paris 2001). These include dysfunctional families, where there is breakdown, death, institutional care, and parental psychopathology; traumatic childhood experiences, with high levels of sexual, emotional, and physical abuse or neglect; and social stressors, such as war, poverty, and migration. There are high levels of comorbidity among PDs, and between PDs and psychotic disorders, eating disorders, anxiety, depression, and substance abuse (Moran 2002). Finally, there is also a strong association between PD and violence and crime, self-harm, and suicide (Moran 2002). As this picture suggests, people with PD often come from backgrounds of psychosocial adversity, and lead chaotic, fragmented, and despairing lives, suffering high levels of psychological pain and social isolation. They also place a heavy burden on psychiatric, medical, social, legal, and forensic services.

This volume begins with a first-person narrative describing what it is like to live with PD. Jessica Gray[1] is an ex-service user from the Oxfordshire Complex Needs Service, who was diagnosed with paranoid, borderline, antisocial, and avoidant PD, as well as strong but subdiagnostic traits of narcissistic and histrionic PD. Her contribution outlines her background and her understanding of how it contributed to the development of problematic characteristics and traits, and evocatively describes what it is like to be a person who suffers from PD and the effect this has had on her sense of self, her relationships, her education, and her occupational life.

Gray's account not only offers powerful insight into the nature of PD from the first-person perspective. It also throws three more theoretical points into sharp relief. The first is that, even though PD is not conventionally understood as an illness or disease, recovery is nonetheless possible: Gray's account is a testament to hope. With clinical help and care, and support from friends, family, and society at large, people with PD can work to change problematic characteristics and traits, and they can succeed. The second is that PD does indeed lie on a continuum with normal personality. Many readers will recognize elements of the experience and behavior that Gray describes in themselves. To be sure, these elements are taken to the extreme in PD, and as a result can seem extraordinary or hard to fathom when first encountered. But, aided by accounts such as Gray's, honest reflection on our own experience and behavior will often reveal similarities: the kernel of many elements of PD lies in ordinary experience and behavior. Finally, Gray describes with painful honesty not only the harm she has suffered from others, but the harm she has caused others through her anger, violence, distrust, and fear. The third point thrown into sharp relief by her account is what we might think of as the Janus-faced nature of PD: The fact that the characteristics and traits that cause distress and impairment to the individual often involve harm to others.

To see the force of this last point, consider some of the defining and diagnostic traits for the Cluster B PDs. Narcissistic PD involves lack of empathy, grandiosity, need for admiration, and a willingness to exploit others. Histrionic PD involves an excessive demand for attention and 'inappropriate' sexual behavior. Borderline PD involves extreme and inappropriate anger toward self and others, instability in self-image and interpersonal relationships, marked recklessness, impulsivity, and paranoia. Finally, antisocial PD involves disregard for others and violation of their rights, criminal behavior, and lack of remorse. Common sense counts such characteristics as failures of morality or virtue (Charland 2004, 2006; Pickard 2009; Pearce and Pickard 2009). And, although Cluster A and C PDs may not be diagnosed via traits that are so clearly connected to failures of morality or virtue, they are nonetheless diagnosed via traits

that greatly affect the capacity to develop relationships with others that express mutual regard, care, trust, and respect. Consider just one example from each cluster. Paranoid PD involves unjustified suspicion and distrust, and a tendency to hold grudges against others. Obsessive-compulsive PD involves forsaking friendship for productivity, obedience to rules and authority at the expense of the good of self and others, miserliness, stubbornness, and a desire for interpersonal control. Hence, although harm to others, broadly conceived, is not part of the DSM-IV-TR definition of PD, it is part of how particular kinds of PD are diagnosed: via characteristics or traits that count as failures of morality or virtue and thus impair social, occupational, or other areas of interpersonal functioning.

This Janus-faced nature of PD is the central theme that unites the academic contributions to this volume. These contributions address questions about PD from a number of perspectives, most notably, psychiatric science and practice, philosophy, and the law. The issues they raise are many and varied, arising from within each of these disciplines. Nonetheless, they cohere around the point that PD is a psychiatric condition that essentially involves a moral component. In their own way and from their own disciplinary perspective, each contribution grapples with this fact.

Peter Zachar addresses the significance of this point with respect to psychiatric science. Does acknowledging the moral component of PD threaten its status as a clinically valid psychiatric kind? Responding to Louis Charland's recent challenge to this effect (Charland 2004, 2006), Zachar canvasses extant models of PD and assesses their potential to meet it.

In turn, Steve Pearce raises objections to how Zachar employs these models to meet Charland's challenge. He suggests that we should instead question Charland's argument directly: reflection on psychiatric practice presents a complicated picture, with no clear distinction between the clinical and moral features of disorder.

Hanna Pickard addresses the significance of this point with respect to psychiatric practice and philosophy. Effective treatment requires clinicians to hold service users responsible for the moral component of PD without blaming them. How is this possible? Pickard offers a two-part solution to this question: She develops a conceptual framework that clearly distinguishes between ideas of responsibility, blameworthiness, and blame; and suggests that, in practice, blame but not responsibility is avoided by attention to psychosocial adversity in individual history.

In commenting, Nancy Nyquist Potter urges Pickard to situate this discussion within a cultural and political context that may discriminate unfairly against PD service users. She also questions Pickard's account of blame and expands her notion of entitlement.

Jill Peay addresses the significance of this point with respect to the law. She examines whether offenders with PD have sufficient capacity for understanding moral wrong and self-control to be held responsible before the law, and outlines a series of legal principles and decisions relevant to PD which cannot easily be reconciled into a coherent legislative system.

In response, Walter Sinott-Armstrong questions the possibility of making generalizations across a category as broad as PD, and focuses on how Peay's arguments call for more radical reform to the law surrounding psychopathy than she seems prepared to acknowledge.

PD presents a very real challenge. It is a terrible burden for individuals and society. But, to understand what it is and what should be done, requires a multidisciplinary effort. This volume draws together psychiatric, philosophical, and legal perspectives on PD. It no doubt omits many other perspectives that are also important. But it aims to show that such collaborative effort is not only necessary, but fruitful. There is hope for better understanding of both the scientific and moral nature of PD, effective treatment for service users, and a just and safe society for all.[2]

Notes

1. This is a pseudonym.

2. This volume developed out of a Workshop on Philosophical Perspectives on Personality Disorder held at the University of Oxford in the spring of 2009 and sponsored by All Souls College, The Laces Foundation, and the Faculty of Philosophy. I am very grateful to the sponsors, the speakers, and the audience for their contribution to that event, and to Bill Fulford for co-organizing it with me. I am also grateful to Bill and John Sadler for their support for this volume, and to all the

authors for their contributions and willingness to work within tight deadlines. Special thanks as always are due to Ian Phillips for his support for this project as well as innumerable helpful philosophical discussions. This research is funded through a Wellcome Trust Biomedical Ethics Clinical Research Fellowship.

References

American Psychiatric Association. 1994. *Diagnostic and statistical manual of mental disorders IV-TR*. Washington, DC: Author.

Charland, L. 2004. Moral treatment and the personality disorders. In *The philosophy of psychiatry: A companion*, ed. J. Radden, 64–77. Oxford: Oxford University Press.

Charland, L. 2006. Moral nature of the DSM-IV-TR Cluster B personality disorders. *Journal of personality disorders* 20:116–25.

Jang, K., and P. Vernon. 2001. Genetics. In *Handbook of personality disorders*, ed. W. J. Livesley, 231–41. New York: Guildford Press.

Moran, P. 2002. The epidemiology of personality disorders. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4130845.pdf

Paris, J. 2001. Psychosocial adversity. In *Handbook of personality disorders*, ed. W. J. Livesley, 231–41. New York: Guildford Press.

Pearce, S, and H. Pickard. 2009. The moral content of psychiatric treatment. *British Journal of Psychiatry* 195:281–2.

Pickard, H. 2009. Mental illness is indeed a myth. In *Psychiatry as cognitive neuroscience*, eds. M. R. Broome and L. Bortolotti, 83–101. Oxford: Oxford University Press.