Personality pathology needs adaptation, not treatment

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The diagnosis and treatment of personality disorder are both highly contentious subjects. It is argued in this article that we have misunderstood personality pathology as yet another form of mental illness that should require treatment for its alleviation or removal. But it is not a typical mental illness; personality is a stable persistent component of the self and needs a different treatment approach based on adaptation.

Keywords Adaptive designs; personality disorders; psychological treatments; diagnosis and classification; comorbidity.

It is common to regard personality disorder as a form of mental illness with a range of pathology that creates difficulties for the person or society and so requires appropriate treatment or management.

In their book *Textbook of Personality Disorders*, a distinguished trio of editors, John Oldham, Andrew Skodol and Donna Bender,[1] with 71 other authors (including me), describe personality disorder carefully and in detail, beginning with its origin and concepts, followed by its causes, treatment and outcome. Nearly half of the 650 pages are devoted to describing its treatment, ranging from psychoanalysis, other focused psychotherapies, dialectical behaviour therapy, mentalisation based therapy, interpersonal therapy, supportive and group therapies, family therapy, therapeutic communities, psychoeducation, pharmacotherapy and collaborative joint treatments. 'What is so unusual about that?' you may ask. This is a standard way of describing mental illness and its treatment.

But personality and its associated disorders are not mental illnesses. They develop in childhood from a mix of genetic and environmental factors, are modified slightly by circumstances and persist through to old age. The central domain traits of personality change little over time[2] and until we become programmed in a dystopian world[3] we will retain them throughout life as individually as a fingerprint. Personality problems also differ from mental illness in that they involve other people and external settings; they arise through interaction, without which they do not exist.

The awareness of personality persistence is one of the reasons why many health professionals regard the diagnosis as one to be avoided, in the belief that as nothing can be done to help it is best ignored. This can be reinforced by the evidence that most people with personality disorders do not want treatment and reject efforts to provide it.[4] But this does not mean that they are beyond good interventions. People

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with personality problems change greatly over time,[5] especially young people,[6] and the reasons for improvement can usually be found in better adaptation to the environment in all its forms.[7]

Instead of trying to change people with personality disorders we need to promote their better adjustment. This can be done in several ways: careful matching of occupation to personality,[8] promoting environmental changes that reduce personal susceptibility[9] and allowing domain traits such as neuroticism to be accepted as a gain to performance[10] rather than something to be erased.

But does this mean that all the pages in Oldham et al[1] describing treatment are valueless? No, because almost all of these are concerned with borderline personality disorder, a portmanteau diagnosis combining the features of at least five mental illnesses that is shortly going to be abandoned altogether[11] as it has no scientific validity. It has recently been reworded in this journal as emotional intensity disorder,[12] and this would represent an advance as it could be examined and treated completely separately from personality dysfunction. It is a mental disorder of high affective reactivity and poor emotional regulation but although it overlaps with personality dysfunction it should not be defined or included within this group. Almost all current treatments for this condition are focused on emotional dysregulation but this is not, and never has been, a personality trait.

Once borderline personality can be relegated to the history books clinicians and researchers will need to separate appropriate treatments for emotional intensity from the very different management of those requiring general adaptation and adjustment, including therapeutic communities, nidotherapy, educational interventions, art therapies and parental interventions for young people.[13] Only one current treatment, acceptance and commitment therapy, has a foot in both these camps.

These changes should have a major impact on stigma. If emotional intensity can be regarded as a condition within the broad range of affective disorders it will greatly reduce stigma, especially as advances in its treatment should lead to greater societal acceptance, and a focus on adjustment for those with personality disorder will improve enrolment in treatment programmes and widen its management beyond the province of health professionals. This is the way forward for clinical practice; we have failed those who have personality pathology unnecessarily and for far too long.

About the author

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Declaration of interest

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