International guidelines for the management of personality disorders

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Purpose of review

Individuals with personality disorders have difficulties in finding specific institutions or services that are designated to bind this kind of problem. These are people who are required to go through many diagnoses and consult many professionals before someone produces the correct diagnosis for their condition. This article reviews the new evidence in the management of personality disorders and incorporates reliable data to determine global clinical recommendations for treatment.

Recent findings

This review suggests that, although pharmacotherapy forms the cornerstone of the management, utilization of adjunctive psychosocial treatments and incorporation of a model that involves a healthcare team are required to provide optimal management for patients with personality disorders.

Summary

The authors related the experience obtained in the Personality Disorder Ambulatory of the Department of Psychiatry of Sao Paulo University Medical School in the handling of the people with personality disorders and proposed the use of gabapentin as a coactuator in the treatment of persons with these conditions.

Keywords

drug therapy, management, personality disorder, treatment

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Abbreviations

DSM-IV Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
PCL-R Psychopathy Checklist-Revised

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Introduction

Individuals with personality disorder are seen by the layman as problematic persons and those with difficulties in interpersonal relationships. They are considered non-productive when their life history is reviewed. They end up by not being able to establish themselves. Frequently, they get involved into legal lawsuits, civil or criminal, and blame others for their lack of success.

The particular behavior of persons with personality disorders is translated by important conflicts in interpersonal relationships, apparently related to the excitability and impulse control [1]. They have an evident impairment in their personality organization and integration of their affective/emotional lives.

When the degree of insensibility against the others is shown elevated, conducting to higher affective unconcern, the clinical picture of the personality disorders assumes the form of psychopathy [1,2**]. People with such condition frequently get involved in crimes and/or deep damage to someone; consequently, psychopathy becomes a forensic denomination [2**].

Personality disorders cannot be considered an illness in its narrow sense. In fact, this class of disturbance is considered as an anomaly of the psychological development [1,2**], which includes disharmony in affectivity, excitability, and impulse integration deficiency in their attitudes and conducts, all expressing themselves in interpersonal relationships and thus blocking the appropriate social integration in a continuing and persistent way.

Psychopaths exclude themselves from society because of the lack of achievement of a socialized internal unity.

Epidemiology

Persons with personality disorders represent a relevant subset of the clinical psychiatric population and in an even larger extent, a population with a comorbid condition leading to an Axis I diagnosis [3**]. This is why they all should be evaluated as psychiatric patients.

The prevalence of personality disorders in the general population is estimated to be 10–13%, but it rises to 20–30% when based on the primary care outpatient settings [4].

Neurobiology

The development of the technique of cerebral images revealed some peculiarities supposedly associated to some types of personality disorders. Recently, Berlin *et al.* [5•] suggested an association between a dysfunction in the orbitofrontal cortex and the characteristic impulsiveness of borderline personality disorder.

Comorbidity

Retrospective studies [6] on people with personality disorders revealed characteristic infant–juvenile and adult comorbidity. In the infant–juvenile period, most prevalent comorbid conditions were substance abuse disorders, attention deficit disorder and deficient academic production. In adults, the authors [7] found strong association between alcohol-related disorders and affective dysfunction (lack of remorse or guilt, shallow affect, lack of empathy, and failure to accept responsibility for one's own actions) that is supposed to be responsible for the increase in aggressiveness.

Borderline personality disorders versus bipolar disorder

Growing evidence suggests that two drugs used in the treatment of bipolar disorder, lithium and carbamazepine, may have independent effects in controlling aggression and impulsiveness and could be of value in borderline and antisocial personality disorders [8].

The recent theory that associates borderline personality disorder to the bipolar spectrum is based on the hypothesis of both conditions sharing common factors, which is conductive to the concept that the treatment of borderline disorder can follow the same pharmacology of bipolar disorders guidelines [9]. By contrast, Bajaj and Tyrer [10••] consider that personality disorders generally have a negative influence on the outcome of mood disorders.

Garno *et al.* [11] identified in one study a significant comorbidity prevalence of cluster B with bipolar disorder, with this also contributing to the increase in suicide risk. Paris [12], however, while revising the literature related to this theme, did not find convincing evidence that borderline personality disorder may be a variant of Axis I disorder. Independent of this controversy, mood stabilizers have been found effective in controlling core symptoms of borderline condition, particularly in the control of impulsive behavior and mood instability [13].

Distinguishing borderline personality disorder from bipolar disorder is not easy. Both conditions have an overlapping of traits and tendencies, impulsivity being the main aspect to establish the differential diagnosis. Lithium has been shown to be more effective in bipolar I with mood stabilizers being more effective in bipolar II and borderline disorders. This indicates that only bipolar II and others can be compared to borderline condition and it may be possible that the comorbidities of these two conditions are a matter of misdiagnosis.

Bloom *et al.* [14] suggested that the impulsive tendency and/or aggressive behavior can be associated with epilepsy spectrum. This hypothesis is important for explaining the success of the anticonvulsive drugs used as mood stabilizers in the treatment of borderline personality disorder.

We can summarize this argument in the fact that bipolarity is not a disorder itself, but it is proper of instinctive life. The course of bipolar disorders is characterized by a periodic form, occurs by bipolar or monopolar phases and is essentially a reversible pathology. Not only the mood is involved with bipolar disorders, but other disorders that follow the same pathogenic dynamics are also involved. By contrast, in borderline condition, there is a very rapid alternation on its clinical expression and we cannot identify a real clinical phase.

Infancy, childhood, and adolescence

Special attention must be given to the children with conduct disorder. These children represent an elevated risk of becoming an adult with personality disorder [7]. It is important to highlight that the precocious recognition and adequate treatment with family and institutional accompaniment is of utmost importance. The precocious intervention can produce significant changes to attenuate or to control the antisocial behavior in the future.

In Brazil, 5% of the children of school age suffer from attention deficit disorder. Among them, 14% also suffer from conduct disorder and 40% from oppositional defiant disorder in childhood, totalizing 54% of children who will probably develop a personality disorder in adult life [15].

Treatment

Historical and symptom profiles help with treatment selection. With the growing recognition of personality disorders, it is anticipated that a larger body of evidence will become available to guide the treatment of this common and disabling condition.

First-line treatments include combinations of mood stabilizers and antidepressant agents.

Anticonvulsive drugs have been indicated for the instability of the emotional disorders, and serotonin selective reuptake inhibitors (SSRIs) have been indicated for the impulsive spectrum disorders and obsessive tendencies.

Low doses of antipsychotic agents have been used with some results in borderline and antisocial personality disorders and in the schizotypal and schizoid group.

It deserves special attention that topiramate, which nowadays is recognized as a broad antiimpulsive spectrum drug, is widely indicated for alcohol dependence [14], cocaine dependence [16], pathological gambling [17], and all the eating disorders spectrum, including nervous bulimia [18]. It is also indicated for the treatment of personality disorders dominated by impulsivity disorder.

These treatments do not modify the patient's personality; they just allow the individual to find a better adaptation level. This thought is corroborated by Wedekind *et al.* [3**], 'The treatment is consequently symptom-related and not specific of any personality disorder. It must be stressed that certain features but not the entire personality can be modified by the drug treatment'.

Psychosocial rehabilitation

Matters related to the psychosocial rehabilitation of personality disorders still offer much controversy.

Cognitive and behavioral psychotherapies have been praised as being beneficial for personality disorder management. This kind of therapy implies in life rules and behaviors guides to be followed under orientation. For this purpose, it is necessary that patients have a minimum capacity of organizing their thoughts. One of the main difficulties that people with personality disorders have to face, irrespective of the type, is the lack of ability to organize and plan their activities. One of the main characteristics of such problems is just being intolerant of the rules. Persons with obsessive–compulsive disorders, despite popular impressions to the contrary, also present disharmony in their activities.

Formal psychotherapy is counterproductive in managing patients with personality disorders. According to Randy and Ward [19], 'These patients do not respond appropriately to affective cues from the physician, and are unable to form connections on a basic emotional level'.

Psychopathy

The effects of an intramural cognitive-behavioral treatment for forensic inpatients with personality disorders in a high-security hospital were examined by Timmerman and Emmelkamp [20**]. It was found that only a minority of patients showed reliable change over time at the individual level.

Quinsey and Lalumière [21] report that therapies with orientation for insight induce the psychopaths to a larger relapse when compared with nonpsychopaths. According to these authors, the rate of relapse into crime for the inmate psychopaths was more than twice of that for the inmate nonpsychopaths, whereas the rate of violence was more than three times in the same settings. The psychotherapy sessions finished developing abilities of psychopaths, psychological manipulation of others, and at the same time, the psychopaths did not recognize the need to change their 'admirable personalities' [22].

Perhaps the Criminality General Excitation Theory [23] is the one that better explains the psychopathic nature in the biological bases. According to Eysenck and Gudjonsson, there would be a common underlying biological condition of the psychopath's behavioral predispositions. Psychopathic personalities could be extroversive, impulsive, and emotional hunters, having a nervous system relatively insensitive to low levels of stimulation. They do not please themselves in little and, to increase their excitation, get involved in high-risk activities such as criminal activities. This behavior perhaps is associated to low levels of dopamine.

Management of severe personality disorders

Each of the personality disorder types has a prominent and dominant characteristic of expression that must be the main focus of instituted treatment. It is necessary to adapt the therapeutics to the core characteristics of each personality disorder. For such purpose, the semiological study of each case is necessary, which allows physicians to recognize, diagnose, and manage these patients. This is denominated in literature as symptom-targeted strategies [24]. According to Bender [25**], the complexity of character pathology demands that physicians consider 'which aspects of a patient's personality pathology are dominant at the moment when considering prominent elements of the therapeutic alliance'.

According to this principle, if the patient presents paranoid personality tendency or self-referent tendency and hostile characteristic behavior that are associated to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) cluster A, antipsychotic use is indicated. In our experience, olanzapine in doses of 10 mg produces good results. If the patient presents dysthymic tendency, hyperthymic instability or lability of affect, antidepressant drugs are indicated. These cases include all the DSM-IV cluster C types (avoidant, dependent, and obsessive–compulsive), as well as the histrionic and narcissistic types from DSM-IV cluster B.

The drugs used to manage personality disorders must be administered chronically and in subtherapeutic doses. Heinze *et al.* [26] confirms these data by stating, 'There are a symptom-driven, polypragmatic and often off-label use of psychotropic drugs in personality disorders'.

The therapeutic result shows more efficiency according to the more attenuated clinical conditions associated with personality disorder. In severe personality disorders, low doses of drugs and at the same time combination of one or

more mood stabilizers are recommended. (The most recommended ones are valproic acid, lamotrigine, and topiramate.)

The experience of the ambulatory of the Department of Psychiatry of Sao Paulo University Medical School

This service was created by the first author (H.C.P.M.) in 1999, up to this moment being one of the very few specialized ambulatories in the assistance of personality disorders in Brazil. The theoretical frame of our experience in this service is briefly exposed.

Patients with personality disorder demand excessive attention by the multiprofessional team, causing serious problems of countertransference. The improvement of the infraction behavior and turbulence in the interpersonal relationship is very slow, giving little recompense to the team; consequently, most specialists avoid this kind of patient. Adherence to treatment is often unsatisfactory.

Our assistance consists in several interviews with patients and their families, looking for the standard conduct disorder that is dominant along their life history. The psychology team that follows the procedures applies intelligence tests, personality tests (Rorschach Test) [27,28], Psychopathy Checklist-Revised (PCL-R) [29], and Global Assessment of Functioning Scale score [30]. Once the personality disorder condition has been diagnosed, the patients and their families are informed and specific drugs and psychotherapeutic intervention are introduced.

The specific psychotherapeutic intervention consists in clarifying, patients and their families, about the real personality condition in its permanent and refractory characteristics. We also proceed with the orientation regarding the consequences of the patients' acts and the resulting consequences for their future life.

Almost all the patients who attended the ambulatory service had admitted knowing that they are considered as 'bad character people,' in the lay sense and do not express themselves surprised when confronted with these information.

Since the beginning of the personality disorders ambulatory, we seek to protocol the outcoming of several drugs suggested by the medical literature for the treatment of personality disorders. After more than 4 years of studies [31], we found that about 79.3% of the patients treated with gabapentin improved the antisocial behavior traits, as reported by the patient informers. We observed the decrease of aggressiveness and impulsiveness and decline of offender behavior as well as a reduction in drug abuse. A general improvement was also observed in tolerance, concentration, and prospective capacity, with larger interest for productive activities. Although these are only preliminary data, considering the difficulty in measuring the result of therapeutic intervention, it becomes evident that gabapentin provided improvements in excitability and turbulent behavior.

Conclusion

The management of personality disorders is not a standardized procedure. The evaluation of the set of personality factors and the global individual performance should be considered before the treatment. The identification of related psychopathologic aspects associated with impulsiveness, mood standard, emotional lability, and frustration intolerance should be accessible to drug treatment and the psychosocial rehabilitation. In turn, adjusted development of the social feelings, as expression of the capacity of consideration to others and to have ethical conscience may better guide treatment decision.

In synthesis, the target condition to be controlled in patients with personality disorders is the underlying biological condition that conducts them to the need of seeking for exciting situations. It is not possible to modify the patient's standard of character, but we can mitigate the inadequate behavior through the use of mood stabilizers for long time periods. In our experience, gabapentin is the most efficient mood stabilizer for the treatment of personality disorders.

References and recommended reading

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Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 550–551).

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