Chapter 1: Personality disorder and individuals with intellectual disabilities

This chapter explores what is meant by the terms 'personality' and 'personality disorder'. It examines the possible causes of personality disorder and the impact of having a personality disorder for the individual and society. It also looks at what an intellectual disability is and why individuals with intellectual disabilities may be vulnerable to developing personality disorders. It explores the impact of intellectual disabilities on the presentation and diagnosis of personality disorder. It looks at the challenges presented by individuals with intellectual disabilities and personality disorder and identifies approaches to intervention with these individuals.

Key topics

- Personality
- Personality disorders
- Problems associated with having a personality disorder
- Causes
- Intellectual disabilities
- Personality disorder in individuals with intellectual disabilities
- Diagnosis of personality disorder in individuals with intellectual disabilities
- Intervention

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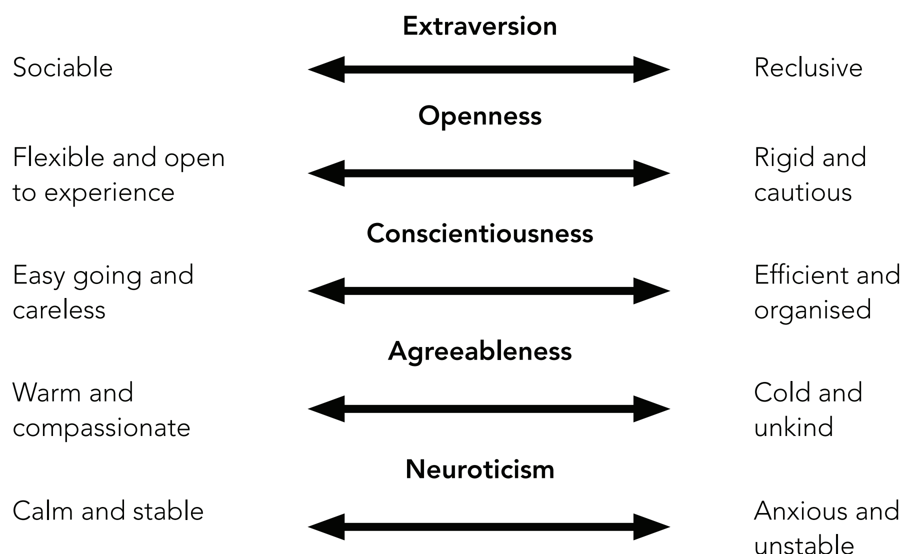
Personality

Personality may be understood as the lasting characteristics that influence a person's thoughts, feelings and behaviour. It shapes a person's view of themselves (their identity), other people and the world in general. It influences how they engage in relationships. Personality also underpins how people respond to situations (both emotionally and behaviourally) and how they cope with problems. Personality comprises an integrated system of traits and attributes that characterise the person.

Everyone's personality is unique. However, everyone's personality characteristics or 'traits' can be seen as falling somewhere on a range. For example, people differ in how sociable they are, from the most extravert and outgoing to the most introvert and reclusive. Box 1.1 shows the 'big five', the overarching personality traits consistently identified in research.

Box 1.1: The big five personality traits

The diagram below shows the 'big five' personality traits. The label on the arrow is the term often used to describe the personality trait. The labels at the ends of the arrow describe the extremes of that trait. If points are marked to show where individuals fall on each dimension they can be joined to create a profile. While there may be similarities, everyone will have a unique profile.



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While personality is a major influence, it is not the only cause of how people behave. For example, people may be influenced by factors such as changes in their mood or the characteristics of the situation they find themselves in.

Personality develops from childhood as a result of a person's biology, relationships and experiences. There appears to be a genetic component to personality as differences in temperament are evident from birth. Babies have been shown to differ in characteristics such as activity, sociability and emotional reactivity. Other personality traits become apparent during childhood but these are flexible and change as the person develops. A more consistent pattern of traits emerges in late teens or early adulthood. In adulthood, personality is much less flexible but it can and often does change as people mature and undergo different life experiences.

A healthy personality is central to successful functioning. It helps people to:

- have a stable sense of themselves (identity)
- have coherent internal experiences (perceptions, emotions and thoughts)
- have a stable sense of other people
- form successful relationships
- function independently
- function in groups
- function in wider society.

Consequently, an unhealthy personality will impact on all aspects of a person's functioning. The current term for difficulties arising from an unhealthy personality is 'personality disorder'.

Personality disorders

Definition

There is much debate about the term 'personality disorder', how it should be defined and whether it should be used at all. In many ways it is a clumsy and unhelpful label. As research progresses it is to be hoped that a more helpful and less stigmatising name will be found for this constellation of difficulties. However, for the time-being this is the only widely understood term for these difficulties.

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Hence it is used here as shorthand for the problems that individuals experience, without necessarily accepting the 'medicalisation' of those difficulties implied by the term 'disorder'.

Personality disorder is the current term used when an adult has enduring personal characteristics (personality traits) that significantly impair their well-being and social functioning. Their approach to life will cause suffering to themselves, those close to them or to the wider community. In recognition of the greater flexibility of personality traits in childhood, personality disorder is not diagnosed in people younger than 18 years. One widely used definition of personality disorder is given in Box 1.2.

Box 1.2: Definition of personality disorder

Personality disorder is *'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'*.

American Psychiatric Association (2013) *DSM-IV*. Arlington. VA: APA.

A number of different types of personality disorders have been suggested, depending on the most noticeable characteristics. Some examples are given in Box 1.3. Where different diagnostic systems give different names for similar patterns of symptoms, both names have been included.

Box 1.3 shows one approach to grouping personality disorders according to the most prominent characteristics. Personality disorders may also be grouped on the basis of whether the main characteristics are related to behavioural 'acting out' or are more internalised and characterised by anxiety and over-thinking.

However, the diagnosis of specific types of personality disorder is unreliable; different assessors and different assessment tools can lead to the same individual being given different diagnoses. There is even disagreement between the two main diagnostic systems used by doctors; the *Diagnostic and Statistical Manual of Mental Disorders 5* (DSM-V) and the *International Classification of Diseases 10* (ICD-10). These systems give different names and slightly different diagnostic criteria for some of the most common personality disorders.

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Box 1.3: Types of personality disorder and their characteristics	
Type/cluster of personality disorder	**Main characteristics/pervasive patterns of behaviour**
A. Odd/eccentric	
Paranoid	Distrust and suspicion of others
Schizoid	Lack of social connection (few friends, does not seek social contact) and limited emotional expression (coldness, detached or flat emotions)
Schizotypal	Social discomfort, cognitive distortions and behavioural eccentricities
B. Dramatic/erratic	
Antisocial/dissocial	Ignore and break the rights of others
Borderline/emotionally unstable	Impulsive behaviour, unstable relationships and feelings
Histrionic	Excessive emotion and need for attention
Narcissistic	Pattern of grandiosity, need for admiration and lack of empathy
C. Anxious/fearful	
Avoidant/anxious	Social inhibition, feel inadequate, oversensitive to criticism
Obsessive-compulsive	Need for order, perfection and control
Dependent	Excessive need to be taken care of, submissive, unassertive and clinging behaviour, fear of separation/being alone, difficulties with decision making and taking responsibility, difficulties with initiating project
Other	
Personality disorder – mixed/trait specified	Where individual does not fit one category

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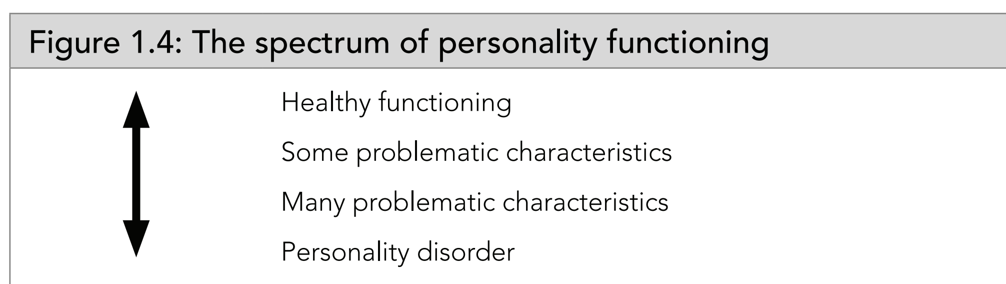
The term 'personality disorder' implies that there is a clear distinction between a healthy personality and an unhealthy personality and also between different types of personality disorder. In reality, the picture is much more complex and confusing. Some individuals may have only a few problematic characteristics and would not meet the diagnostic criteria for personality disorder despite these characteristics causing them extensive problems. Other individuals may have multiple problematic characteristics and could be diagnosed with several personality disorders. (The DSM-5 gives a proposed research model for personality disorder based on a dimensional model in recognition of the potential advantages of such an approach.)

Rather than thinking only of diagnostic categories, it can be helpful to think of individuals as falling on a spectrum of personality functioning. This is shown in Figure 1.4.

Figure 1.4: The spectrum of personality functioning



In a similar way, the problematic characteristics can be seen as falling towards the extreme end of the range on certain personality traits. For example, an individual with antisocial personality disorder, who disregards the needs of others, would be expected to fall at the far end of the 'agreeableness' trait (cold and unkind).

Occurrence

Research suggests that about 10% of the general adult population has a personality disorder, with borderline personality disorder being by far the most frequent (about six per cent) (Alwin *et al*, 2006). Personality disorders occur in similar numbers in men and women. However, specific types of personality disorder may have different gender ratios, for example, borderline personality disorder is more commonly diagnosed in women, while antisocial personality disorder is more commonly diagnosed in men. There are some differences in rates of diagnosis between different ethnic groups. However it is not clear if these are real differences or just reflect differences in diagnostic practices (for example, the influence of gender or other stereotypes).

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Individuals with cluster B or 'acting out' personality disorders, such as borderline and antisocial personality disorder, are most frequently seen by health services.

Outcome

It used to be thought that the outcome for individuals with personality disorder was inevitably poor; individuals do not respond to short-term treatment and there is a high suicide rate (almost 10%). However, more recently research has shown more positive outcomes for individuals with a cluster B personality disorder; many individuals 'mature out' of the diagnosis by their mid-thirties. Many individuals respond well to longer term, specialist treatment approaches. After regular treatment for at least 15 months about half of individuals improve sufficiently to no longer meet the diagnostic criteria for personality disorder.

Research has identified a number of factors that are associated with more positive outcomes for individuals with cluster B personality disorders (Kreisman & Straus, 2004). These are given in Table 1.5.

Table 1.5: Factors associated with outcome in cluster B personality disorder

Favourable outcome	Unfavourable outcome
Short-term	
Early and rapid progress in treatment Supportive relationships Friendliness and likeability	Chronic symptoms Severe symptoms Co-morbidity Greater impulsivity Impaired relationship with parents Disability Poor physical health eg. diabetes, arthritis, obesity
Long-term	
Higher intelligence Physical attractiveness Artistic talent Self-discipline Involvement in 12-step treatment programme if have addiction (eg. Alcoholics Anonymous)	Chronic hostility and irritability History of antisocial behaviour History of severe parental abuse Severe jealousy Poverty Addiction but not in 12-step

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Problems associated with having a personality disorder

Individuals with personality disorder are more likely to experience a range of problems including: problems with self-image and self-esteem, high levels of emotional distress or anxiety, difficulties with impulsive behaviours and substance misuse, and distorted thinking patterns. Individuals often appear to be entangled in a complex web of unhelpful and abusive relationships. They are also more likely to experience adverse life events, including difficulties with accommodation and employment.

Individuals with personality disorder may engage in a range of high risk or antisocial behaviours. A diagnosis of a cluster B personality disorder is linked to future aggression and re-offending in those who have committed crimes.

Individuals with borderline personality disorder often experience crises which rapidly escalate and may include self-harm or suicidal behaviour. They frequently use services such as A&E departments and often have contact with many different services. However, individuals often have negative experiences with services. They may receive poor care as the result of misunderstanding or prejudice and may be excluded from accessing some services. Many individuals with personality disorder find it very difficult to engage with services; they may repeatedly ask for help only to fail to attend appointments or fail to follow the advice given.

Individuals can provoke strong emotional reactions in those trying to help and support them. Staff members may feel deskilled, manipulated, powerless or angry. Members within a team may have very different images of the person and there may be conflict or 'splitting' within and between teams.

Causes

The causes of personality disorder are not fully understood and there are many different theories. One helpful way of understanding personality disorder is the biosocial developmental model developed to help understand borderline personality disorder. This approach suggests that for biologically vulnerable individuals certain psychological, social and environmental experiences can combine to shape their emotions, thoughts and behaviours, leading to the patterns of responding that are called personality disorder. Some of these factors and the way they influence development are explored next.

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Biological vulnerability

Some individuals appear to be biologically vulnerable to developing personality disorder. Genetics may play a role in this. A study of twins suggested that an inheritability factor for borderline personality disorder is 0.69 (Torgersen *et al*, 2000). There may be inherited traits, such as impulsivity, that contribute to developing a personality disorder. Individuals who develop personality disorder may also have some differences in the way parts of their brains are structured or function, or the levels of key chemicals (neurotransmitters) in areas of their brains. These differences may make it more difficult to control emotions and behaviour.

Parenting

Note: The terms 'parent' and 'parenting' will be used throughout to include all those who care for children, including biological, step, foster and adopted parents and paid carers.

Individuals with personality disorders are likely to have grown up in families where both parents found bringing up a child very difficult. The parents may have had problems with addiction or mental health problems that led them to be emotionally unavailable and neglectful of their children. In these circumstances family life may be unstable and uncaring. Parents may have been so absorbed in their own difficulties that they could not see things from the child's perspective or recognise the child's needs.

Some children may also have experienced the care system. Sadly, paid carers may also not provide good enough parenting. 'Looked after' children may experience multiple relocations and placement failures. These experiences will impair an individual's ability to form attachments and manage their emotions.

Abuse

A high proportion of individuals with personality disorder have experienced physical, sexual and/or emotional abuse. Children who are neglected or abused often learn to think only of themselves. They need to be selfish and ruthless to protect themselves and get as much as they can in situations where there is not enough to go round. Children who are exposed to harsh or neglectful parenting will absorb negative views of themselves and the world. They will also learn a narrow range of unhelpful ways of interacting with others. For example, individuals may adopt the role of either victim or bully depending on who they are

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interacting with and be unaware that there are other ways of behaving in these situations. However, many individuals survive abuse with healthy personalities. It is thought that how other people respond to the abuse is important. Personality disorder may develop when no one is able to recognise the child's pain and support them in coming to terms with the abuse.

Attachments

Experiences of neglect, rejection, inconsistency and confusion make it difficult for a child to form healthy bonds or attachments to their parents. These early bonds with parents form the pattern for all future relationships. Individuals with personality disorder often form attachments that are described as 'insecure' or 'disorganised'. These styles are explored more fully in Chapter 4. Their early experiences meant that they did not gain confidence from their parents but rather were anxious and unsure about them. Where abuse or neglect was more extreme, the child would be very confused; they would both fear and need their parents. After such experiences it is very hard for an individual to trust others not to hurt or abandon them. Consequently, relationships become a source of anxiety and it is hard to draw comfort from others.

Attachment problems can also arise where there is a mismatch between the personality of the child and the parent. This mismatch can make it difficult for the parent to relate to the child and understand their needs. These misunderstandings then distress and upset the child, making it harder for the parent to relate to them. Such mismatches can also occur when a baby has additional needs. Where there are serious health problems, sensory problems, difficulties feeding or the baby cries a lot and cannot be comforted, parents may struggle to meet the child's needs. Some parents may struggle to accept and love such a child. These difficulties may also result in insecure attachments.

Understanding mental states (mentalising)

Consistent and caring parents help children to understand their own and others' actions. Parents explain the child's emotions to them and signal that it is OK to feel that way. They also explain why others might have behaved in certain ways. For example, *'John hit you because he was tired of waiting for a go on the swing, you are upset because it was your turn'*. This develops into the ability to understand actions by working out what is going on in their own and other people's minds. This process is called 'mentalising', 'social cognition' or more informally, 'mind-reading'. It is thought that the early experiences of individuals with personality disorder interfere with learning how to understand their own

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and others' thoughts, feelings and behaviour. Without the ability to mentalise, a person's own behaviour and emotions and those of others will often be experienced as confusing, unpredictable and frightening. Lacking this ability may make it very hard for an individual to consider others' needs; they may even be totally oblivious of the pain they cause others.

Managing emotions

Parents also teach children how to manage their emotions and to calm themselves when distressed. Initially the parent does this for the baby but, as the child grows, parents gradually teach the child to manage alone. When parents are unable to do this, the child can find emotions overwhelming and unmanageable and may develop extreme responses such as self-harm to block them out.

Reinforcement of unhelpful behaviour patterns

In families where parents are overwhelmed by their own needs and the pressures of daily life, children's needs are often overlooked. Children who behave appropriately are often ignored. However, it is difficult to ignore extreme behaviours such as screaming or running away. Hence children learn that only extreme behaviours are effective in getting their needs met and these will increasingly be their first response.

In summary, personality disorders may develop in biologically vulnerable individuals when their early family environment is unable to meet their needs. This leads to the pervasive social, cognitive, emotional and behavioural problems that contribute to the diagnosis of personality disorder.

Intellectual disabilities

The term 'intellectual disabilities' is used here synonymously with the British term 'learning disabilities' to represent the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.

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Estimates of the prevalence of intellectual disabilities vary. It is suggested that between two and three per cent of the population may have intellectual disabilities (Emerson & Hatton, 2008). The great majority of these individuals (more than 75%) will have mild intellectual disabilities (Emerson & Hatton 2008). Intellectual disabilities may be caused by a number of factors, including genetic and chromosomal disorders, but for many the cause is not known. Intellectual disabilities are not a mental health problem and most individuals with intellectual disabilities have good mental health. However, a significant minority (10–40%) also experience mental health problems (Emerson & Hatton, 2008; Deb *et al*, 2001). It is also possible for an individual with intellectual disabilities to have a personality disorder.

Personality and intellectual disabilities

It might be assumed that individuals with intellectual disabilities would have personalities that show the same 'big five' traits that have been identified in the general population. However, there is some research that suggests the experience of growing up with intellectual disabilities has a profound effect on the development of personality. It has been suggested that repeated experiences of failure may shape the approach of individuals with intellectual disabilities to new challenges; making them avoid new tasks, expect failure and look to others for cues as to how to solve problems. These experiences might make individuals with intellectual disabilities less open to new experiences and more anxious. The impact of these experiences is such that some researchers have suggested that the personality of individuals with intellectual disabilities may be characterised by seven personality traits (see Box 1.6).

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Box 1.6: Seven personality dimensions identified in children with intellectual disabilities

1. Positive reaction tendency – a heightened motivation to interact with and be dependent upon a supportive adult
2. Negative reaction tendency – initial wariness shown with interacting with strange adults
3. Expectancy of success – degree to which the individual expects to succeed or fail when presented with a new task
4. Outer directedness – tendency to look to others for solutions to difficult or ambiguous tasks
5. Efficacy motivation – the pleasure derived from tackling and solving difficult problems
6. Obedience
7. Curiosity/creativity

Zigler *et al* (2002)

At first glance the seven traits bear little resemblance to the 'big five'. They also do not include factors related to mood or emotion. These differences may reflect genuine differences in the personality structure of individuals with intellectual disabilities.

However, they may also be influenced by characteristics of the research approach that developed them. These traits were identified in children, using observation of behaviour on different tasks or ratings by teachers. There was no attempt to talk to the participants to explore their inner worlds. The researchers were looking for traits that distinguished individuals with intellectual disabilities from their more able peers and hence did not explore areas of similarity.

The language used to describe the traits may also reflect the unconscious bias of the researchers about the position of children with intellectual disabilities in society. This may make the traits appear more different from the 'big five' than is perhaps the case. For example, 'obedience' might reflect the dimension of conscientiousness, 'positive reaction tendency' might relate to extraversion and 'curiosity/creativity' to openness. It is to be hoped that these issues will be clarified by future research.

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Personality disorder in individuals with intellectual disabilities

Some individuals with intellectual disabilities show the enduring patterns of inner experience and behaviour that constitute personality disorder. However many people with intellectual disabilities who show problem behaviours will not have personality disorders. Therefore it is important that the possibility that an individual has personality disorder is considered when assessing problematic behaviours. An individual with intellectual disabilities may also have a personality disorder if they show a range of severe, persistent problems with managing their own behaviour and relating to other people.

Some of the types of problems likely to be encountered in individuals with personality disorder and intellectual disabilities are given in Box 1.7.

Box 1.7: Problems experienced by individuals with intellectual disabilities and personality disorder

- Unhealthy self-image and low self-esteem
- Emotional distress eg. intense, changeable emotions
- Interpersonal difficulties eg. difficulty making and keeping friendships, conflict with other individuals
- Difficulties with self-control and impulsivity including substance misuse and offending behaviour
- Distorted thinking eg. black and white thinking
- Problems with physical health eg. poor treatment compliance
- Co-morbid mental health problems eg. depression, anxiety
- Challenging behaviours eg. verbal and physical aggression
- Suicidal behaviour and self-harm including self-injury and self-poisoning
- Frequent crises eg. placement breakdown and multiple admissions to hospital
- Difficulties engaging with services eg. missed appointments
- Creating tensions and disagreements within and between teams
- Complex family and relationship networks, including people who may exploit or abuse the individual and may come into conflict with the services supporting them

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