Irish Journal of Psychological Medicine (2020), **37**, 136–140. doi:10.1017/ipm.2018.32 PERSPECTIVE PIECE

Trainee experience in diagnosis and management of personality disorders

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The diagnosis and management of personality disorders continues to evolve and develop alongside psychiatry internationally, however, not always in a linear fashion. Trainees working in a variety of clinical areas have regular exposure to personality disorder presentations. Psychiatry training bodies continue to adapt their training structure and curriculum, however, there seems to be a lack of sufficient emphasis with regards this area. We are now embarking on a new diagnostic system for personality disorders; this may impact on our clinical practice and perspective of these patients. The role of psychiatrists in diagnosing and managing personality disorders can be unclear at times and may benefit from on-going reflection and standardization.

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As a psychiatry trainee early in my psychiatric training, I find the topic of personality disorders challenging in terms of their presentation, care planning and our role as trainees. It seems a necessary part of clinical practice to reflect on and understand the current role of the psychiatrist in diagnosing and managing personality disorders. An estimated 50% of patients attending UK outpatient psychiatric services have a personality disorder so therefore one would assume our training and resources would reflect that (Beckwith *et al*. 2014). Documentation of antisocial and borderline personality disorder diagnoses are routinely seen, but are all 10 current categories considered and incorporated into regular clinical practice? The only diagnoses often recorded are Diagnostic Statistical Manual (DSM-IV), International Classification of Disease (ICD-10), 'Axis 1' disorders, which do not always reflect the full complexity of our patient's presentation, their therapeutic needs and potential barriers to their recovery. Reference may be made to a patient being 'a PD' (personality disorder) during unofficial discussions outside of formal multidisciplinary team (MDT) meetings. If this is not documented or a patient is not aware of this, the role or use of the diagnostic label must be considered. For example Endocrinologists in a Diabetic Clinic are implored to avoid calling a patient 'a diabetic', as this disease does not define the patient as a person. As physicians, we thrive on reproducible and structured diagnoses, however, this is not the case for all allied health professionals. Psychologists often distance themselves from our medical language and definitions weakening the integration of a common understanding and unified thinking in terms of proposed therapies.

So, where and when do we see personality disorders as young inexperienced trainees? These patients often present to emergency departments with self-harm thoughts or behaviours, or perhaps in addiction and forensic settings. In outpatient departments where we assess new and longstanding patients with a variety of difficulties there are sometimes unidentified or unnamed personality traits evident, for example, dependant, avoidant or obsessive compulsive. These patients can often be challenging, have had poor therapeutic response and ongoing significant risk issues. Complicating the matter further, there are often serious co-morbidities in this cohort. These co-morbidities may encompass other mental illnesses, physical illnesses, substance misuse or a variety of maladaptive coping strategies (Newtown-Howes *et al*. 2009). Naming the multiple diagnoses should give an idea of the clinical complexity and aid in more accurate expectations in terms of treatment length and outcome.

If we look at an example of psychiatry training in Ireland, The College of Psychiatrists of Ireland was founded in 2009 following its separation from the Royal College of Psychiatrists (United Kingdom). The college while still in its infancy has made great progress with regards to the structure of training. The training has been split into a Foundation Year (FY), Basic Training (BST) Scheme over 3 years and Higher Specialist Training Scheme over 3 subsequent years. In relation to our training as BST's the goal is to satisfactorily meet the outcomes specified in our curriculum (College of

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Table 1. *Learning outcome attainment grid (psychiatry trainees Ireland)*

Grid		Learning outcomes
Foundation year grid	1; 1(d)	Obtain detailed and accurate histories from patients with personality disorders (College of Psychiatrists of Ireland, 2017c)
Foundation year grid	2; 2(d)	Elicit psychopathology from patients with personality disorders
Basic specialist trainee grid	5; 2(a)	Develop formulations on adult patients with personality disorders (College of Psychiatrists of Ireland, 2017a)

Psychiatrists of Ireland, 2017b). Work place-based assessments are used to demonstrate competency in the learning outcomes on a training grid. In the FY Grid there are 2 of 75 specific personality disorder outcomes to be attained. With regard to the BST grid there is just 1 of 228 (Table 1). Attitudes towards patients with personality disorders are often reflective of abilities in approach and appropriate management of this cohort. Is it fair that they are stigmatised because of our lack of experience, as the most experienced clinicians have been found to be the most empathetic to this group of patients (Bodner *et al*. 2011). A greater emphasis on skills would improve our confidence when meeting these patients daily but also hopefully begin to decrease fundamental attribution error towards this vulnerable group. These patients are susceptible to multiple cognitive heuristics which can have a significant impact on diagnosis, clinical decision making and outcomes (Crumlish & Kelly, 2009). Sometimes it is easy to forget that we are treating people in great distress, often longstanding and because of this have a far higher morbidity and mortality compared to the general population (Fok *et al*. 2012).

Early in my training one multidisciplinary team noted that some patients repeatedly presented with similar complaints about psychological distress, but these individuals had sometimes been managed mainly medically with only partial improvements. This varied from patients with recurrent depressive disorder, to Obsessive–Compulsive Disorder to eating disorders. We began to use the SCID-PD (Structured Clinical Interview DSM-5 Personality Diagnosis) as a diagnostic tool to ascertain whether we could confidently name personality disorders, beyond Borderline or Antisocial and discuss their clinical significance. The team found patients were receptive to the tool both with regards openness and acceptance of diagnosis with associated vulnerabilities. I feel the use of the tool enhanced my clinical experience and skills as a trainee, improving my confidence and knowledge of personality disorders. Although the tool was easy to use and increased personal insight into the patient from time spent administering the tool, fitting it into a busy job was challenging at times. Consideration could have been given to the use of a self rated screening tool, such as the Standardised Assessment of Personality-Abbreviated Scale which may fit more readily into clinical practise and may yield similar diagnostic impressions (Moran *et al.* 2003).

Table 2. *Personality disorder classification*

Schneider	DSM-V (American Psychiatric Publishing, 2014)	ICD-10 (Department of Health and Human Services, Public Health Service, Health Care Financing Administration, 1991)
Emotionally unstable	Borderline	Emotionally unstable Borderline type Impulsive type
Explosive	Antisocial	Dissocial
Self-seeking	Narcissistic	
	Histrionic	Histrionic
Depressive		
Asthenic	Avoidant	Anxious (avoidant)
Weak-willed	Dependant	Dependant
Affectless	Schizoid	Schizoid
	Schizotypal	
Insecure sensitive	Paranoid	Paranoid
Insecure anankastic	Obsessive–compulsive	Anankastic
Fanatical		
Hyperthymic		

DSM, Diagnostic Statistical Manual; ICD, International Classification of Diseases.

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Table 3. *Summary of International Classification of Disease 11 reclassification of personality disorder (Tyrer **et al**. 2015)*

Personality Disorder
A pervasive disturbance in how an individual experiences and thinks about the self, others and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression and behaviour
The maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships
The disturbance is manifest across a range of personal and social situations
The disturbance is relatively stable over time and is of long duration. Most commonly, personality disorder has its first manifestations in childhood and is clearly evident in adolescence
Late Onset Qualifier
If the disturbance has its origin in adulthood, the qualifier for 'late onset' may be added. This should be used for cases in which, by history, there is no evidence of personality disorder or its early manifestations prior to age 25 years
Mild
There are notable problems in many interpersonal relationships and the performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out. Typically not associated with substantial harm to self or others
Moderate
There are marked problems in most interpersonal relationships and in the performance of expected occupational and social roles across a wide range of situations that are sufficiently extensive that most are compromised to some degree. Often associated with a past history and future expectation of harm to self or others
Severe
There are severe problems in interpersonal functioning affecting all areas of life. The individual's general social dysfunction is profound and the ability and/or willingness to perform expected occupational and social roles is absent or severely compromised. Usually associated with a past history and future expectation of severe harm to self or others., that has caused long-term damage or endangered life
Domain Traits
1 Negative affective features
2 Dissocial features
3 Features of disinhibition
4 Anankastic features
5 Features of detachment

Psychiatry itself is a new and developing science and continues to evolve. It has moved from description to criterion based approaches to diagnosis. One factor in this change which began in the 1970s was the improvement in medications and the consequent need for consistency and reliability in diagnoses for research and prescribing purposes (Shorter, 2008). Although the momentum for change was heavily influenced by pharmaceutical industries it was also widely recognised between psychiatrists that a higher standard was needed, as was shown in the Rosenhan experiment which had a great influence on DSM-3 (Rosenhan, 1974). It is one of psychiatry's strengths that it is continually re-evaluating diagnostic approaches (Table 2). With regards to personality disorders the classifications have been similar and transferable from Schneider's first descriptions of emotionally unstable and explosive, through to the various ICD and DSM publications (Table 2) (Schneider, 1929).

Over time they have become more refined, precise and rigid. To fit certain extremes of behaviour that interfere with daily functioning and interpersonal relationships into nine or 10 carefully defined and structured personality diagnoses is not always easy or reflective of complexity. DSM-IV further categorised psychiatric illness compared to poor mental health with the multiaxial system, which lead to an exclusion of patients with a diagnosis of a personality disorder from many psychiatric services (American Psychiatric Publishing, 1996). As was pointed out quite eloquently by Tom Burns psychiatry diagnosis now 'dismisses experience and treats as important what can be measured rather than measuring what is important'(2013).

This shortcoming in the current criterion based diagnostic structure had been noticed by the writers of DSM-5 and they had proposed an alternative dimensional approach. During early training I found the SCID-PD helpful with the classification and familiarisation of personality disorder psychopathology, however, as my experience continued this newly evolving approach to diagnosis was intriguing. It suggested incorporating both subjective and objective reports in its diagnostic structure and placing emphasis on accumulative traits as opposed to single categories (Krueger *et al*. 2011). The advantage to this structure is the enhanced significance of severity which we know is the best predictor of outcome (Hopwood *et al*. 2011). At the time of writing the

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DSM-5 the American Board did not feel it held enough weight and evidence to put into clinical practice.

We are now expecting the awaited ICD-11 to shadow this new dimensional system, which leaves behind 'traits' as a subclinical category (Table 3). It breaks down into mild, moderate and severe, giving examples of the level of functioning disturbed and risk of harm that are generally required (Table 3). The third and final element is a description of domains, less rigid than current categories these domains are descriptions and rely on the clinicians knowledge of the patient and own judgement (Tyrer *et al*. 2011). The advantages seem to be that the system takes into account the current presentation and recent past which are both extremely relevant and help contextualise the fluctuant nature and complexity of interplay of personality disorders (Crawford *et al*. 2011). From a trainee perspective it is potentially more accessible, less stigmatising and clearer of the impact on functioning and treatment resistance. There are still a lot of questions and clarity needed, and experience with regards clinical judgement will be more important compared to the previously more structured categorical system.

There are many reasons why correct recognition of personality disorders is so important; they make life more stressful for the patient and their family while increasing the risk of mental illness and other co-morbidities, their presence affects treatment outcomes and there is significantly increased risk associated with this population. Again reflecting on our roles as psychiatrists, should we have more of an emphasis on diagnosis and skills to manage personality disorders as trainees? Psychiatry training bodies should consider incorporating a more skills based curriculum, with Dialectical Behavioural Therapy, formulation and risk management being at the forefront of this. Additional learning outcomes in our training grid could also be the use of diagnostic tools following benefits experienced from using the SCID-PD. All of this should improve overall psychological understanding of our patients, leaving us more than just prescribers. As we have moved so drastically from the Freudian based approached to the almost completely biological, a happy medium now needs to be found which is better for both doctor and patient. In time, this should lead to us feeling comfortable and confident in our skills to sufficiently evaluate and appropriately care plan for these patients. These encompass some of the daily challenges psychiatric trainees are faced with, but which are surmountable with enhanced training in this complex area.

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Conflicts of Interest

None.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this perspective piece was not required by their local Ethics Committee.

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