# Disruptive and distressed doctors: Relevance of personality disorder

Gwen Adshead, Broadmoor Hospital
Clare Gerada, PHP
Martin Black, PHP
Contact: Gwen.adshead@wlmht.nhs.uk

# Disruption

- Breaking something apart: in this case team or group working
- Angry feelings ‘erupt’ and create fear/shame/rage in others
- Behaviours: usually shouting but may involve throwing or breaking things
- Doctors may be clinically excellent; have ‘banks’ of goodwill which are exhausted

# Common factors

- Often clinically excellent
- Do not necessarily have history
- More likely to be perfectionist and compulsive than antisocial
- May have had change in own attachment relationships in last year
- May follow change in management
- Issues of shame and status

# Personality

- From ‘persona’: the mask
- The interface between our individual experience and the social world
- Two main functions: (1) internal regulation of negative arousal and affect
- (2) Caregiving and care-eliciting relationships with peers and in kinships

# Normal stress and its management

- Perceived threat (Reptilian Brain) causes arousal ( 5HT) then sympathetic NAdr, followed by cortisol response
- Emotions generated in limbic brain: fear, anger, loss, shame, disgust, pain
- Neo-cortical management: left brain executive: self-soothing cognitions and appropriate care eliciting behaviour
- Self-reflective, learning and memory processes: right brain

# Dysfunctional stress responses

- Persistent arousal: can’t self-soothe
- Externalising: others alienated or seen as threat
- Internalising: no care eliciting
- Displacement of distress: taking it out elsewhere; somatisation
- Denial and abolition of affect: substance misuse

# So what's personality disorder?

- Affect dysregulation
- Disruption of care-giving and care eliciting relationships
- Problems in maintaining a sense of self
- Interpersonal dysfunction
- (rarely) Self destructive or antisocial behaviours
- Starts in childhood

# PD: A disorder of homeostasis

- Like Diabetes Mellitus
- Childhood onset: associated with genetic vulnerability and environmental risk; potentially more severe outcomes and multiple co-morbid conditions
- Adult onset: milder, dietary control, triggered by environmental factors

# Prevalence of personality disorder

- UK Community: 4% ( but <1% severe: Yang et al 2010)
- Primary care: 10% ( mainly affect dysregulation and somatisation)
- Secondary mental health care: 33%-60%
- Specialist services: 60+%
  Prisons/Forensic services: 70%

# Problem

- Personality disorders have to be of sufficient severity to be diagnosable
- Rare in the general population (4%). Socially severe is even rarer (<2%)
- Medicine selects *against* negative personality dimensions/traits
- And selects *for* positive resilience and traits

# Personality traits in doctors

- Doubt, guilt, compulsively responsible
- Studies in different specialities find slightly different profiles
- Medical school studies: Normal ‘ Big 5’ profiles compared to other students
- Conscientiousness predicts success
- Those high in neuroticism struggle later

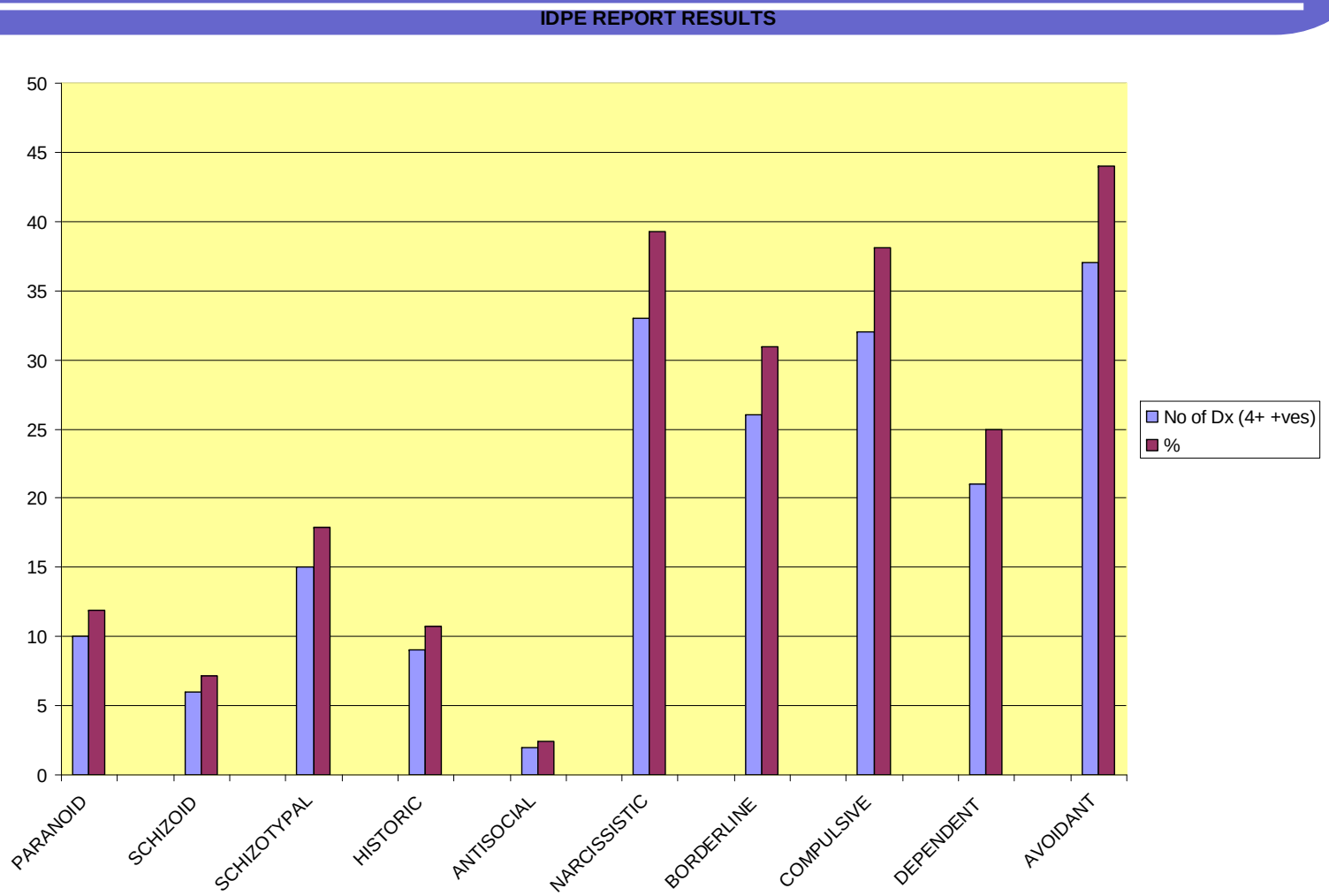
# Personality traits in doctors (2)

- Depends on sample and purpose of study
- Doctors referred for problems show more abnormal traits
- Strengths may become weaknesses
- Co-morbid depression exacerbates negative traits
- Group dynamics?

# Personality disorders in doctors

- A slight excess of pd in medical students
- 2% in physicians, 9% in anaesthetists!
- Doctors referred for SBV: show antisocial personality traits
- Addiction services: 59% of doctors
- In one study, 24% psychiatrists score highly on a psychopathy scale!

# IPDE RESULTS – (COHORT 84)



# What's happening?

- Doctors who really always had a pd but hid it well until now ? *( doesn't fit with personality theory)*
- Doctors becoming personality disordered? (*ditto: but means they could recover?)*
- Personality strengths become weaknesses? (*relevance of stressful environments and group dynamics?)*

# Does the medical culture support and select for these beliefs?

- Narcissism: I am the greatest
- Perfectionism: I must do this right and mistakes are intolerable in me/others
- Compulsiveness: I have to do this, and I can’t give up till I finish
- Denigration of vulnerability: People who need help are failures
- Shame: if I am in need, I am a failure

# What might disorder a personality in adulthood?

- Head injury
- Trauma: witnessing distressing sounds and sights
- Loss and death events: bereavement reactions last longer than we think
- New caregiving responsibilities: becoming a parent, looking after elderly parents

# Relevance to doctors

- Witnesses to trauma
- Regular dealing with loss events
- Dealing with other people's distress
- May acquire new care-giving responsibilities ***outside*** work just as they become most responsible ***at*** work
- Selected for traits that increase vulnerability if stress is longterm: perfectionism, compulsiveness

# Psychological vulnerabilities in doctors

- Doctors are highly selected group
- External selection: intelligence, social function, altruism, conformity, consistency
- Self selection: conscious altruism, social care and authority, high achievers
- Unconscious: compulsive care giving, perfectionism, compulsiveness, self-criticism, unresolved experience of loss or illness

# Relevance for PHPs

- Persistent childhood onset PD may be rare in doctors: but adult onset?
- Mild degrees of pd: common or temporary but never reach caseness unless/until there is stress at home or new stress at work…..
- Effect of resilience factors: intelligence, warmth, talents, mature defences, attachments?
- Co-morbid depression

# Current evidence

- Personality *vulnerabilities* likely to be present in as many as 30% of clinicians
- But severe personality disorders (especially antisocial) likely to be very rare ( 2-4%)
- Mild-to-moderate levels will be common in PHPs
- Job stress may increase morbidity i.e burn out more of the more vulnerable

# Questions

- Is the job unusually socially demanding? E.g Persistent care giving? Working in teams?
- Is there an unusual prevalence of vulnerable people joining up?
- Or is the job so inherently stressful that it exhausts even the resilient?

# So what shall we do?

- Assess severity: may need new tools for this group
- Be positive: this should be a treatable group of people
- Help this group develop reflective ways of dealing with anger and shame
- Group interventions promote perspective taking and team work

# Conclusion

- Better assessment: defences & attachments
- We will need psychological interventions for doctors that address negative personality pathology
- NICE guidelines for pd and depression plus reflective groups
- Who will pay and provide?

# References


- Borges, N & Osman, W (2001) Personality and medical specialty choice. Journal of vocational behaviour, 58: 22-35
- Gardiner,C et al (2010) Association of treatment resisting and treatment seeking personalities in medical students. Personality & Mental health, 4: 59-63
- Garfinkel, Pet al (1997) Boundary violations and personality traits among psychiatrists. Can J psych, 42: 758-763
- Kluger, M et al (1999) Personality traits of anaesthetists and physicians. Anaesthesia, 54: 926-935
- Knights,J & Kennedy, B (2006) Medical school selection: screening for dysfunctional traits. Medical education, 40: 1058-1064
- NCAA (2004) Understanding performance difficulties in doctors. London: National Clinical assessment Authority
- Roback, H et al (2007) Problematic physicians: a comparison of personality profiles by offence type. Can. Journal Psychiatry, 52: 5 : 315-322
- Tyrer, P et al (2010) Personality disorder: a new global perspective. World Psychiatry, ( : 56-60
- Vaidya, NA et al (2004) Relationship between specialty choice, medical school temperament and character. Teaching and learning in medicine, 16 92) 150-156.
- Widiger, T (2003) Personality disorder diagnosis. World Psychiatry, 2: 3: 131-134
- Zeldow,P & Daugherty S (1991) Personality profiles and speciality choices of student s from two medical school classes. Academic Medicine, 6: 5: 283-287