Journal & Proceedings of the Royal Society of New South Wales, vol. 157, part 1, 2024, pp. 59–63. ISSN 0035-9173/24/01059-05

Not waving but drowning: personality development and Personality Disorder

Andrew Chanen

Orygen & The University of Melbourne[1]

andrew.chanen@orygen.org.au

I'm going to try to describe the interaction between ourselves and our environment in terms of personality development and what can go wrong. I'm very mindful of speaking before a philosopher and talking about the self, and I think we might have a very interesting debate about that. But what I want to describe to you is how the notion of personality and Personality Disorder has developed over time, and to describe some of the controversies around this issue of how we develop as people.

What is personality? When we think about personality, there's a very simple way of thinking about it: it's what makes us who we are. It essentially describes our character, characteristic ways of behaving, experiencing life, perceiving and interpreting ourselves and other people, and the environment within which we exist. It's relatively stable over time and situations. And I think people would hopefully see that as a reasonably acceptable common definition.

We are more than a collection of traits. It gets a little more complex than that though. Dan McAdams describes it very nicely that it's a layered concept. There are essentially three layers: (1) we are born with dispositional temperaments which he describes as the self as a social actor, (2) then we adapt to our environment (and I'll talk a bit more about this) as a motivated agent, and then we (3) form a narrative identity over the top which binds those two layers together into what we recognise as ourselves (the self as an autobiographical author). And I won't go into all the detail.

Layer 1: Dispositional temperament traits

Dispositional traits are the basic biological individual differences that we are born with; they're linked to underlying neural networks and they show strong similarities to the structure of temperament in other animal species as well. This "genotypic self," this self that we're endowed with when we are born, is predisposed to and capable of intersubjectivity. And there are lovely experiments looking at infant development straight after birth, showing the intersubjectivity of human infants. But at this stage we don't have the reflective capacity in our relational environment.

Layer 2: Characteristic adaptations

Layer 2 is where the temperamental traits that become transformed through reciprocal interaction with the environment into what we would think of in common language as personality traits. They're essentially the same in content and structure, but they're broader. We have a wider repertoire of traits.

There is a large body of research that is largely settled on what are called the big five basic higher-order dispositions: essen-

1 This is an edited transcript of the address [Ed.]

tially they're: (1) openness to experience, or our intellect, (2) our conscientiousness, (3) extroversion, which essentially is our capacity for positive emotionality, (4) agreeableness, which is as it says, and (5) neuroticism, which is very important for mental health, which describes propensity for negative emotionality.

But traits are largely descriptive: they don't describe us as human beings. Where the debate is at in the field at the moment, a lot of trait psychologists would say traits are enough to describe a person. There is a great deal of dissent around that — they don't capture the complexity of what it is to be a human being. And so characteristic adaptations, as McAdams describes it, encompass the motivational, social, cognitive, and developmental adaptations that are specific to our time and place, where we exist. They start to develop around the age of 5 to 7 and with increasing cognitive capacity. Children begin to have goals and to link these with motives and behaviours.

Layer 3: Narrative identity

Traits continue to influence our personality functioning. But the really decisive ingredient is the changes that happen around puberty that allow us to develop reflective capacity and develop a narrative identity. This is where we actively integrate life experiences into an internalised evolving narrative of ourselves with a sense of unity and purpose in life. It requires coherence of time, biography, cause, and thematic coherence, as well as the necessary cognitive mechanisms that we require to develop. This doesn't really develop until puberty, so what could possibly go wrong in the development of human beings?

What could possibly go wrong?

Gary David was a notorious prisoner in the 1980s who sadly died in the early '90s. There was a huge debate around his offending, about Personality Disorder, was it a mental illness? The glib kind of aphorism — was he mad or bad? — really captured the debate at the time. He suffered terribly in life but was portrayed as an aggressor. If you look in Wikipedia now, it'll say he died by suicide by ingesting razor blades — actually death was really an artifact of his self-harm. This was the most extreme form of Personality Disorder.

One thing that's really changed — and I think of society as a kind of barometer of the way we perceive Personality Disorder — is that there have been a number of judgments recently that have taken Personality Disorder to be a mitigating factor in sentencing. Codey Herrmann is one of the well-known cases. I had involvement with two of the other relatively recent cases and it actually says that his Personality Disorder reduced his moral culpability for the murder.

Again another young woman, Dal Brown. It's on the record — so I'm not breaching confidence — that she was under our care, and again her fire-setting, which nearly killed a large number of people, was the only way that she could have control in her life. I think this really sums the shift, where a number of people who testified in another case — Andy Carrol, who's a forensic psychiatrist, described to the court that this is among the most disturbing of all disorders. And Jim Ogloff, a very eminent forensic psychologist, said, "I'd rather have schizophrenia than have borderline personality disorder." I think that represents a substantial shift in the way that we see Personality Disorder.

What is Personality Disorder?

Personality Disorder is when our personality structure prevents us from achieving adaptive solutions to life's universal tasks: having a stable and integrated sense of ourself and other people and being able to have the capacity for intimacy, attachment, affiliation, pro-social behaviour, and cooperative relationships. It is a developmental disorder, although it's not been thought of as a developmental disorder hitherto. And it only becomes observable when people develop the capacity for what's called metacognition — thinking about thinking — being able to reflect upon oneself — and it's this disturbance of that narrative identity that is fundamental to what is Personality Disorder.

How would I recognise someone living with PD?

These are some lay descriptions that we developed as part of a study. I won't go through all the detail except to show you that it ranges from mild — and you will know many people in your life who have mild Personality Disorder, where someone might have an unrealistically high or low sense of worth, experience difficulties in conflict in relationships, in setting goals, whatever it might be — right through to severe: the Gary David-type experience of someone who experiences extreme self-hatred or extreme inflation of self-esteem (I won't talk about any former Presidents, but you might want to extrapolate) and someone who has no sense of purpose in life, cannot engage effectively. People with severe Personality Disorder live very lonely and isolated and often very unhappy lives, and I'll show you why in just a minute.

A developmental model for PD

So essentially we've turned McAdam's model, with my colleague Sharp and also Bo from Denmark, into a model of personality pathology development. Essentially it takes the same model but overlays abnormal development, where you might begin with dispositional traits that are not in and of themselves pathological — everybody knows irritable children or children who are overly adventurous and that non-reflexive genotypic self through reciprocal interaction with environment, especially the caregiving environment. Then [the child?] develops goals and values and motives and by about 5 to 7 years of age certain behaviours are not tolerated within group settings: you have to take your turn, you're not allowed to steal other kids' toys, etc. These problematic behaviours are not Personality Disorder, they are problematic behaviours, but they begin in the mental health realm. I think you've probably heard a bit about that this morning. When early development goes awry but this sense of self at this stage is piecemeal and rudimentary.

Puberty brings this transition that then facilitates this Layer 3 — the self as author — and it's really only now that Personality Disorder becomes apparent. This "phenotypic self" (Level 3) integrates and binds abnormal traits. And the organising structure of the self becomes disrupted at this stage. That's what leads to the development of Personality Disorder. It might wax and wane — someone might have functional periods — but it breaks down usually under social stress laws.

Personality Disorder is essentially construed as a self and relational disorder.

Relational problems are the source of the disorder, as opposed to disorders of mental state in which the relational problems are usually a consequence of the disorder — like depression or a psychosis or some other disorder.

What have we learned about the development of PD?

We've learned a lot. The headline is it's complex and multifactorial. There's a very important role for this reciprocal interaction, and a very strong influence of social, cultural, economic, and historical mechanisms. There's a six-fold higher treated incidence of Personality Disorder in low socioeconomic communities. We know that symptoms and their expression are shaped by culture. We know that the global prevalence varies — it's lower in low and middle-income countries. We know that trends might be related, the trends in incidents might be related to the breakdown of social cohesion and social capital in modern societies. In a sense, our young might be the "sentinel species" for what is happening in our society — they are the warning sign for the social changes that are leading to the current rise in mental ill health.

Reductionism is scientifically wrong and harmful

What we know also is that reductionism is scientifically wrong and unjustified. You'll hear some people tell you it's all about trauma, it's all about attachment, it's all about emotion dysregulation, or it's all about abnormal brains or genes. None of these is correct. In fact, it is a much more complex and nuanced aetiology.

Developmental trauma is neither necessary nor sufficient for development of PD

Two-thirds of Australians experience developmental trauma yet only a very small percentage develop Personality Disorder, so why should we be concerned? Well, because actually about 10% of the population have mild and above Personality Disorder. About 3% of young people have severe Personality Disorder, about 1% of adults [meaning?] and, by age 24, about one in five people will have met the criteria for Personality Disorder, and about a fifth of them will have had severe Personality Disorder.

Why should we be concerned about PD?

We know that it is the fourth leading cause of the burden of disease of all mental disorders, so it is an important form of mental ill health that has hitherto been ignored. We know that these problems commence in adolescence and young adulthood. It used to be that you couldn't diagnose it in young people. And you can see not only the broad range of outcomes of problems that people present with, but also of outcomes from this disorder. It acts as a gateway to other disorders. And the family and friends of those people also struggle and have terrible experiences of mental health. It's a gateway not just to the personal costs but the social and economic costs of Personality Disorder, particularly employment and education outcomes, which are very poor among this group. You have nine times greater likelihood of being unemployed or being on the disability support pension. It's a stronger predictor of disability support than anxiety or depression. And the high health care costs are a huge burden for society. Most

tragically the mortality is 10 times that of the general population for people in the first 5 years after they have been diagnosed with the Disorder, and the life expectancy of people with severe Personality Disorder is reduced by two decades. The suicide rate is about 8 to 10%. That doesn't account for the premature mortality. And sadly it is the most stigmatised of all mental disorders — not by you the general public, but actually by my colleagues. And it is still the whipping boy for people's frustrations and dissatisfaction. People say things about people with Personality Disorder they would never dare say about any other patient presenting for care. And people perceive less of a sense of purpose in working with people with Personality Disorder.

So we've learned a lot: we know actually that treatment is effective, we know that medication is ineffective for Personality Disorder, we know that early identification leads to earlier effective treatment, and we know that treatment for most people with Personality Disorder is actually not as complex as people have tried to tell us in the past. But we also know that the people who most need treatment are rarely the people who get it, and we also know that "treatment" can harm, and that many of the things we think about as being associated with Personality Disorder are actually harms perpetrated by the health system.

To conclude: Personality Disorder is a developmental disorder characterised by maladaptive self and interpersonal functioning. It begins from puberty and has its onset by young adulthood. Like all of the other major mental disorders, it's strongly influenced by social, cultural, economic, and historical mechanisms. It has very high potential to disrupt the successful transition to adulthood and it has lifelong personal, social, and economic consequences. We know that treatment is effective, access is very poor, and that the biggest barriers to reform are actually bigotry and sectarianism, not a lack of effective treatments.