



Review Article

Race, culture, ethnicity and personality disorder: Group Careif position paper

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Abstract. *This paper summaries the discussion points and conclusions from a UK Department of Health Funded exercise to develop a position statement on personality disorder and ethnicity. Unlike the significant literature on ethnicity and psychoses, detentions, admissions and pathways to care, there is little published on inequalities in access to and experience of effective mental health care for people with personality difficulties and personality disorders. Although notions of ethnicity, personality and personality disorders can each be contested as conceptually heterogenous categories, and that priority should be given to more in-depth validation work before considering practicalities, the development of personality disorder services, and the implications of overlooking the role of personality function in the planning and provision of services requires some position to be taken; a working paper was produced using a critical enquiry method.*

Keywords: Personality disorder, race, culture, ethnicity, policy, social exclusion

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INTRODUCTION This paper states the position of our group with regards to the interface between culture, ethnicity, race and personality as well as the research, training and practice priorities. It is envisaged the paper will be the starting point for a shared understanding of the issues pertaining to personality disorder assessment, diagnosis, aetiology and recovery for culturally and ethnically diverse populations.

Crime is perceived to be on the increase, and crimes committed by people with mental health problems have recently attracted a wide attention through the media. In particular, crimes committed by people who are found to have abnormal personalities have prompted the government to encourage psychiatrists to take a greater role in the management of people with criminal histories and in people with personality disorders. Personality Disorders (PD) are common in our society (Vizard *et al*, 2004), among people using mental health services (Casey, 2000) and in the prison population (Singleton *et al*, 1998). People suffering from specific Personality Disorders are perceived as heavy users of public

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services where they present with multiple and complex problems including substance misuse, self-harm, suicide risk, a higher risk of unnatural or accidental death (Martin *et al*, 1985), antisocial behaviours, chronic interpersonal difficulties, co-morbid mental health problems, housing needs, difficulties in sustaining employment and other social problems. They might also experience social exclusion and significant stigma.

Setting up specific services for Personality Disorders is high on the UK Government's agenda for public health and the Department of Health is currently in the process of issuing commissioning guidance for Personality Disorder services. The Government has set out several aims in relation to Personality Disorders through a number of specific policies with different aims: *Managing Dangerous People with Severe Personality Disorders* (Department of Health and Home Office, 1999); *Personality Disorders: no Longer a Diagnosis of Exclusion* (National Institute of Mental Health in England (NIMHE), 2003); *Breaking the Circle of Rejection: The Personality Disorders Capability Framework* (NIMHE, 2003). At the same time the government showed its great concern for public protection when it announced its own proposals that included the potentially indefinite detention of personality disordered individuals and the possible introduction of a third service for this group (Moran, 1999).

At a policy level, a special focus seems to have been placed so far on 1) those individuals defined as to be suffering from "Dangerous and Severe Personality Disorders" (although such diagnostic label is not included in any psychiatric classification of mental disorders) as they might pose the highest risk to the public; 2) on those suffering from Borderline Personality Disorders, who are often described as heavy users of mental health facilities, hinting at the possible high costs incurred by the community for their treatment or management.

At a practice level, the Mental Health Act 2007, recognizing a wide, single definition of mental disorder, as well as the Draft Code of Practice are likely to reverse the «pervasive culture in which PD patients have been seen as undeserving of mental health care» (Appleby, 2007).

At a research level, there is a clear imbalance among specific Personality Disorders with the highest focus on Antisocial and Borderline Personality Disorder. So far, little has been published about Race, Ethnicity, Culture and Personality Disorders. The wider topic of the interface between culture, race, ethnicity and Personality Disorders still remains relatively unexplored, as compared to other aspects of Personality Disorders. People from Black Minority Ethnic (BME) communities access PD services at a lower rate than the general population. This has been attributed to general patterns of misdiagnosis and lower access to talking therapies. There are indications that for BME communities patterns of diagnosis and treatment are not the same as for the white population, potentially leading to poorer outcomes. BME groups are diagnosed with Personality Disorders much less frequently than white people, although no specific reasons have so far been identified for a lower prevalence of these disorders among the BME groups. More research is needed in this field.

RACE, ETHNICITY, CULTURE AND PERSONALITY DISORDERS

The diagnosis of a Personality Disorder, as well as the very definition of what constitutes a "normal personality" is entirely a cultural and social construct. Culture plays a role in the definition of the self, in the expectations on the orientation of the person (towards the individual or the social group) and in the definition of how a normal personality is constructed and expresses itself. The very difference between what is considered a normal or an abnormal personality depends on culture. Our concept of Personality Disorder is based on the Western notion of the individual as unique and independently functioning. Its applicability to people from cultures with different definitions of the individual's "normal" characteristics is thus open to potential criticism.

Psychiatric definitions of Personality Disorder usually offer a categorical approach to definition. For example, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) identifies the Anti-Social Personality Disorder (ASPD) as a pervasive pattern of disregard for and violation of rights of others, indicated by persistence of at least three of a number of antisocial behaviours: failure to conform to social norms with respect to lawful behaviour by

performing acts that are grounds for arrest, deceitfulness, impulsive behaviour or a failure of planning ahead, irritability and aggression, reckless regard for safety of self or others, irresponsibility as indicated by a failure to sustain consistent work behaviour or honour financial obligations, and a lack of remorse. This definition has been developed in the context of the currently dominant views in western society. However, there is considerable overlap in the diagnostic criteria of personality sub-types and population studies have failed to show points of rarity or a bimodal pattern in the distribution of personality traits (Moran, 1999). More recent work shows dimensions as a credible alternative way of describing personality (Nestadt *et al*, 2008). The clinical utility of dimensional approaches, not to mention the legal implications are yet to be tested.

A perspective from social and anthropological theory would suggest that it may be necessary to reflect on how far the conceptualisation and definition of anti-social behaviour is socially and culturally constructed. There is research suggesting that socially acceptable behaviour is to some extent variable between societies and over time. The significance placed on behaviour deemed to be deviant may, for example, be related to whether behaviour is seen to be threatening to the prevailing social order (e.g. Cohen, 1972). Young (1990) has referred to cultural imperialism, a social process by which the values of the dominant group and their experience and culture is viewed as a universal norm while groups which vary from this are viewed as inferior, deviant or inadequate. Raybeck (1988) reports that labelling as 'abnormal' of those who do not conform is less likely to occur in smaller societies. Personally well integrated values characterise small societies. Larger societies offer multiple competing value systems, that conflict with personal integration. The interdependence and equality in small scale societies works against the labelling of deviance, and where such labelling occurs, it is less likely to lead to the loss of power or status (Foulks, 1996). In large societies, the non-conformist is less likely to be an essential contributor.

In a multi-cultural and socially divided society there may be variation in the understanding of what comprises socially acceptable behaviour. The DSM-IV manual includes a caveat for cross cultural diagnosis of personality disorders. The emphasis is on a non-mechanical application of the diagnosis, the deviance must be a symptom of dysfunction in the individual, and the categorical approach to applying diagnosis must be set aside (Foulks, 1996).

The applicability of psychiatric diagnostic systems to all cultures has been criticised from the anthropological perspective. Lewis-Fernandez (1996) discusses the arguments in favour of 'cultural formulation' which documents «alternate nosologies affecting whole nations and ethnic groups», in order to problematize the universal applicability of Western nosologies. The use of case based ethnographies is encouraged in order to make culture more central to the process of clinical evaluation and treatment. Yet, do cultures identify individuals as being deviant in term of a personality disorder, a psychological perspective, or simply as deviant in terms of criminality, violence, or poor relationship skills?

Action 1: An ethnography of what clinicians call personality disorder is necessary

Rogler (1999) has reviewed methodological strategies in mental health research more generally, which may make it insensitive to cultural differences, including procedures for determining content validity of instruments and producing linguistic translations which may suppress, bias or deflect cultural understanding. Where race, ethnic and cultural status as well as other signifiers of difference, such as religion, are invoked to classify persons according to 'norms', historical experience shows black and ethnic minorities, religious minorities, and linguistically isolated groups 'generally' suffer more adverse conditions of living. These include homelessness, poverty, unemployment as well as over representation in the criminal justice system and general mental health and forensic services (Maden, 1993; Skellington, 1996; Fernando *et al*, 1998). Nevertheless, in a study of A+E presenters, 63% of *Caucasians* were regarded as having personality disorder compared to only 25% of non-*Caucasians* who were mainly African Caribbean (Tyrer *et al*, 1994). Anti-social personality disorders are more common among prisoners who rated themselves as white, whereas other personality disorders were commoner

amongst those calling themselves black (O'Brien *et al*, 1998). These differences might be interpreted as essential differences in prevalence, but are more likely to reflect fundamentally different constructions of personality and its degree of adaptiveness.

Action 2: Thus research to explore whether antisocial personality disorder is recognised to be the same entity in a diversity of cultural groups is necessary, whilst indigenous constructions of personality or character and its diversity is also crucial (Foulks, 1996)

Mezzich *et al* (1996) assert that psychopathic disorder (an alternative name for very severe antisocial personality disorder) is less frequently diagnosed among African Caribbeans in the USA. Reed (1992) confirmed that in the UK, although ethnic minorities were over-represented in medium secure units they were under-represented in the category of psychopathic disorder. Medical perceptions of a cultural baseline may be uncertain and psychiatrists may be reluctant to make a diagnosis of psychopathic disorder (Preddie & Awai-Boyce, 1999).

In a study of psychiatric intensive care units, 186 patients on 17 National Health Service (NHS) Psychiatric Intensive Care Units (PICUs) in London, 80% of patients were male, 50% were Black and all but 2 were involuntarily detained. 66% had a diagnosis of schizophrenia and 55% of admissions were due to physical aggression. 73% of the sample had at least one 'complex need' which was most commonly substance misuse. Black patients were younger, more likely to be male and to have a forensic history (54% vs 31%) than white patients. A slightly lower percentage (70% vs 79%) of Black patients were described as having complex needs. White patients were more likely to have a personality disorder or a second diagnosis (Pereira *et al*, 2005). Thus black patients' problems may have been seen as a complex need rather than as a psychological problem including personality disorder. It is likely that personality influences on the presentation and treatment will not then be fully targeted for intervention.

Culture and social factors might also influence the gender distribution of the diagnosis of Personality Disorder. For example, ASPD is more prevalent in boys and men than girls and women (Coid, 2003; Robins, 1986; Maughan & McCarthy, 1997). This may relate to the socially determined behavioural norms for the different genders, as well as to the level of exposure to risks for development of anti-social behaviour and personality disorders (see below). Some authors (e.g. Levant *et al*, 1998) suggest that cultures may define masculine and feminine roles in different ways, which might generate culturally variable gender related effects on risks of antisocial behaviour. Early experience of socio-economic disadvantage increases the risk for boys more than girls (e.g. Robins, 1985; 1986). This might be because boys are more susceptible to risk factors, or that they are more likely to be exposed to risk factors. This might warrant further research, building on existing knowledge. Social expectations of masculine behaviour may be more likely to encourage risk taking and challenging behaviour, while the social construction of feminine behaviour may emphasise risk avoidance and submissive behaviour. Also, the socially determined patterns of behaviour for boys and girls, in terms of the geographical and social extent of their permitted field of autonomous action could be relevant to the risks at the community level (Mathews, 1992).

Some studies have suggested that tolerance or interpretation of certain behaviours may vary within countries at the regional or community level. For example, work in Canada (Lester & Leenaars, 1998) and discussion of behaviour in areas of America with large black and 'Latino' populations has sometimes invoked the idea of 'sub-cultures of violence'. However, Fergusson (1998) has pointed to the risks that these interpretations may stigmatise or essentialise certain groups in ways which are not helpful to real understanding.

Furthermore, each society appears to idealise particular personality attributes, giving rise to its own standards of normality. It is important to note the distinction between the ideal, typical and atypical personality that any one society promotes. Some personalities may be seen as atypical, but may still not

be considered abnormal, and may serve a particular function in that society. Thus mystics, artists, priests and ministers who transcend typical ideal social roles make a contribution to their society (Foulks, 1996). Collective acts of protest that evolve into destructive riots can be construed as anti-social, thus oppositional tactics of a community might be considered to be antisocial. As many as a half of inner city youth in the United States could have the diagnosis misapplied, in a culture in which value systems and behavioural rules make learning into a violent and protective activity (Alarcon *et al*, 1998). In culturally diverse societies like that in Britain, it is important to bear in mind that social construction of these aspects of mental health and behaviour is likely to be variable *within*, as well as *between* social groups.

Action 3: It is important that all such complex aspects of the relationship between culture and personality are included in the curricula and training of the mental health work force across diverse professions, if we are to minimize the risk of misdiagnoses and stigmatization of Personality Disorders, and to develop targeted and culturally safe and effective services

THE SOCIAL AND SPATIAL CONTEXT FOR INDIVIDUAL ANTI-SOCIAL BEHAVIOUR

Perspectives from social epidemiology, sociology and geography also encourage a focus on the significance of social and spatial context for risks of ASPD. Several reviews have outlined the theoretical and empirical evidence for the role of ‘place’ and local context for various aspects of health inequality (eg. MacIntyre *et al*, 1993; MacIntyre, 1999; Popay *et al*, 1998; Curtis & Jones, 1998). This literature draws our attention to what might be seen as the impact of social and physical ‘landscapes’ on health (Curtis & Jones, 1998).

Here we can consider, for example, the role of various dimensions of the social capital resources of communities to reinforce shared values and a sense of coherence and to provide childcare networks extending beyond the immediate family. Wilkinson *et al* (1998) discuss the ecological association between indicators of the social environment such as ‘social trust’ and indicators of violent crime. Some protective and mediating effects of community seem to interact with individual risk factors for ASPD, discussed below, and these might also be considered to be operating at the community level. Work on ‘therapeutic landscapes’ (eg. Gesler, 1992) and the extent of influence of urban design on antisocial behaviour (eg. Coleman, 1985; Trench, 1992) can also be considered. Aspects of material living conditions and ‘landscapes of consumption’ at neighbourhood level are also likely to be significant (MacIntyre *et al*, 1993; Curtis & Jones, 1998). For example, the availability of good quality welfare support services, leisure facilities and opportunities for education and training, could also be relevant to risk of manifestation of anti-social behaviour. The growing social control of some parts of public space increasingly excludes people exhibiting (or thought likely to exhibit) anti-social behaviour from quasi-public places like shopping centres, leisure complexes and similar spaces (eg. Crawford, 1992; Goss, 1993; Sandercock, 1998; Loukaitou-Sideris, 1993) and may cause anti-social behaviours to seem more concentrated in other, less controlled areas.

Wallace and Wallace (Wallace, 1990; Wallace & Wallace, 1997) and Dear and Wolch (1987) provide coherent theoretical models to explain how social, economic and political processes result in the impoverishment and concentration of poverty and disadvantage in certain geographical areas (especially the inner city). This is associated with concentration of populations with generally poor levels of public health, and with high incidence of anti-social behavioural traits and mental disorders. These authors identify several key trends which may account for the concentration of problems of mental illness and antisocial behaviour in certain parts of North American cities. Wallace and Wallace describe this concentration of pathology as being associated with a ‘hollowing out’ (degradation) of inner cities, while Dear and Wolch describe the development in inner cities of what they call the ‘service dependent ghetto’.

These models highlight the shift in health and welfare policies away from asylum or institutional care models, which isolate people with mental illness (and to some extent anti-social behaviour) in psychiatric institutions, special schools, or other institutions. Current approaches have shifted towards a model of care and containment in the community and in mainstream institutions. Thus people whose behaviour challenges social norms occupy space shared with the general population and become more 'visible' to wider society. Dear and Wolch also suggest that the functioning of networks of professionals in health and social care tends to encourage spatial grouping to form a 'critical mass' of personnel specialised in working with groups who have challenging behaviours. By attracting clients who need to use such services into areas where they are already provided, this contributes to the 'service dependent ghetto' effect, described by Dear and Wolch. Dear and Wolch also point to the NIMBY (i.e., "Not-In-My-Back-Yard") syndrome in negotiation over the location of facilities for socially excluded groups who may tend to exhibit behaviours which are not socially acceptable to the majority (such as people who are homeless, mentally ill, or drug users). Disadvantaged communities may be in a weaker position to reject these facilities from their neighbourhood and, furthermore, lower property prices, and greater levels of population, need argue for location in poorer areas.

Wallace and Wallace on the other hand, emphasise the political and social drivers to withdrawal, or degrading, of some key services for enforcement of law and order, public safety, welfare and health in deprived areas where populations are disempowered in political debate and decision making.

These models highlight the significance of some general social, economic and political trends in the political economy of major cities, which influence employment markets, housing markets and the bid rent values of space in the city for welfare facilities. These trends are associated with increased socio-economic inequality and with growing spatial separation of rich, powerful populations from poor, disempowered groups.

These general trends may combine to contribute to the 'drift effect', whereby people with mental health problems or anti-social behaviour tend to move towards poorer areas (a process reinforced by differential social housing allocation of these groups into poorer housing stock in deprived areas). These groups of people may also be drawn by the location of facilities intended to meet their needs which are concentrated in the 'service dependent ghetto'. This is the drift hypothesis, but there is also a 'breeder' hypothesis that postulates that deprived conditions in inner cities increase the risk for the development of future personality disorders, mental health and behavioural problems.

In Britain the empirical evidence for this 'hollowing out', or 'ghettoisation' is more equivocal. Social and spatial polarisation may not yet be as extreme as in the US and some British research questions whether the phenomenon of the 'service dependent ghetto' is restricted to the inner city in quite the ways that Dear and Wolch describe (eg. Milligan, 1996). Nevertheless, a good deal of current policy rhetoric emphasises the issue of 'problem estates' and it is clear that there is growing socio-geographical polarisation and concentration of deprived populations with high prevalence of anti-social behaviour and various aspects of pathology in these areas (Social Exclusion Unit, 1999; Shaw *et al.*, 1999).

Action 4: Understanding risk factors for the future development of personality problems in young adults is therefore essential if preventive actions are to be applied early in the life course. Some of these perspectives on the association of prevalence of ASPD with environmental factors beyond the immediate family might therefore be prioritized for research in Britain

Citing strategies for prevention proposed by Rose (1992), Coid (2003) has argued that this understanding is important for policy because community based interventions may be more effective as strategies to address ASPD, rather than individually targeted interventions. A number of aspects of context might be explored through this research, in terms of their impact on risk of ASPD. The theoretical models proposed by authors such as Wallace and Wallace (1997) and Dear and Wolch

(1987) indicate that contextual dimensions requiring attention would include: the policy context, the role of professionals and service organization in the health and welfare sector, the political economy of cities, issues of social participation and social capital, as well as the mobility of groups with high risk of ASPD and the interaction of individual risk factors with aspects of the wider contextual situation.

Social exclusion and anti-social behaviour show strong links, with the two probably being mutually reinforcing; social exclusion of disadvantaged groups from normal levels of social and economic participation may increase risks of ASPD, and ASPD may contribute to social exclusion. For example, exclusion from school of pupils with disruptive behaviour or unwillingness of employers to tolerate ASPD in their employees may result in further marginalisation of those whose behaviour is antisocial and may aggravate the risks of such behaviour becoming persistent.

There seems to be a question mark over the relevance of individual ethnic and cultural differences in relation to anti-social behaviour. Some authors suggest higher prevalence of conduct disorders in young black people, while it has also been suggested that these are less likely to be associated with ASPD in adulthood than is the case for white majority populations in Britain (e.g., Rutter *et al*, 1974). Some studies suggest that in certain ethnic minority groups there may be additional protective factors operating to reduce the prevalence of ASPD (eg. Hall *et al*, 1998).

However, it seems quite difficult to interpret the results of studies showing associations between ethnicity and variations in the prevalence of ASPD. Socio-economic factors may well be confounded with cultural and ethnic factors, since ethnic minority groups show high levels of disadvantage. White majority definitions of conduct disorders are being applied to ethnically and culturally different populations, which may be problematic for reasons already outlined above. Racism at the personal and institutional levels is likely to be an important factor in the detection, reporting and treatment of delinquent or criminal behaviour.

Action 5: Further analysis and research aiming to explore how far ethnicity may operate causally as a risk factor for antisocial behaviour or personality disorder would need to be sensitive to these issues (Ferguson, 1998).

The priority for further research now seems to be the exploration of the extent to which the associations between social and cultural characteristics are indicative of causal pathways, operating over the life course of individuals, linking social disadvantage at the family level with ASPD. Such research would also need to clarify how mediating factors may influence susceptibility of individuals and groups to risk factors ASPD and should aim to explain the lack of specificity in the long term linkages. As indicated in the previous section, the interplay of individual and family factors with wider environmental factors would also be a useful focus for further work.

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RACE, CULTURE, ETHNICITY AND PERSONALITY DISORDER GROUP CAREIF POSITION PAPER

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