WORKING WITH PEOPLE WITH PERSONALITY DISORDER:

PD Clinical Network, Leeds

AIMS:
To increase knowledge and awareness of personality disorders and the factors involved in working more successfully with this group.

OBJECTIVES:
Through group discussion, informational inputs and discussion of an anonymised case, to increase understanding of:

- The diagnostic category "personality disorder"
- Its aetiology/origins/risk factors
- The clinical picture and the underlying psychological issues
- The likely issues for workers and teams, and factors involved in increased effectiveness in work with this group.

Diagnostic criteria (DSM-IV)

- An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two or more of the following areas:

  Cognition, affect, interpersonal functioning and impulse control.

Diagnostic criteria (DSM-IV)

- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Stable pattern, long duration (at least early adolescence)

Diagnostic criteria (DSM-IV)

- Enduring pattern not due to direct physiological effects of a substance or general medical condition.

Personality Disorders

- Paranoid, schizoid, schizotypal
- **Cluster A – 'odd, eccentric'**
- **Cluster B – 'emotional, dramatic'**
- Antisocial, borderline, histrionic, narcissistic
- **Cluster C – 'anxious, fearful'**
- Avoidant, dependent, obsessive

Criticisms of categorisation

- Unreliable
- Overlap between categories
- Difficulty discriminating between mental disorder and personality disorder
- Artificiality of 'abnormal'/'normal' distinction
- PD no more than 'medicalised moral judgement'
- No consensus re 'personality' (what is disordered?)
- Diagnosis can be used to dismiss difficult patients.

Psychological understanding of personality disorder

- 'Failure to achieve adaptive solutions to life tasks' (Livesley et al, 1994)
  - Failure to establish stable and integrated representations of self and others
  - Interpersonal dysfunction
  - Failure to function adaptively in the social group.

Clinical signs of Axis II disorder

- Stability and longevity of the problem or pattern.
- Patient regularly fails to turn up for appointments
- No matter how much time you allocate, it is 'never enough'
- Problems are often externalised so there is poor motivation to change
- Patient is unaware of the impact of their own behaviour
- One week you are the best thing since sliced bread, the next week you could not be the worst possible person

•You might be great, but the patient can't stand the rest of the clinical team

•You are tempted to 'tread on eggshells' to avoid upsetting the patient

•Interpersonal relationships are of poor quality and are usually characterised by conflict

•Within in-patient settings, the patient is constantly comparing what they get with what other patients get

•Conflicting professional opinions of what is wrong with the patient

•Patient tries to make you feel responsible for them.

How staff tend to experience clients with personality disorder

- Stir up extreme feelings in staff
- Staff feel abused and/or deceived
- Clients treat staff members as either god-like or as demons
- Issues of suicidality are intensely challenging – staff can feel responsible.

Derived from Fagin (2004)

When working with this client group:

- We should expect to be dealing with intense longing, hatred and anger

O Kernberg (2004)

Borderline Personality Disorder: The Clinical Picture

- Diagnosis of BPD controversial
- However, following clinical picture is recognisable:
  - Disturbed attachments with dread of abandonment
  - Unstable self-image
  - Affective lability (instability of mood)
  - Transient psychotic-like thinking
  - Overwhelming angry demands/feeling entitled
  - Impulsive/manipulative self-destructive behaviour.

From Leonard Fagin (2004)

Borderline Personality Disorder: The Clinical Picture

"Borderline Personality Disorder is a complex and serious mental disorder that is characterised by a pervasive pattern of difficulties with emotive regulation, impulse control and instability in both relationships and in self-image"

Bateman + Fonagy (2004)

Understanding the clinical picture of Borderline Personality Disorder

Instability in relationships

- Patterns of insecure attachment get repeated
- Intense attachment, then rupture or complete breakdown in the relationship
- Closeness/care sought, but person interprets rejection or abandonment.

- At times of crisis or change (eg discharge): wish for proof of care/recognition is intensified:
  - Feelings of abandonment
  - Reports of symptoms and self-harming behaviours increase.

- Pattern of alternating idealising – devaluing:

  Often a feeling that attention must be paid to the enormity of emotional pain/woundedness client feels worse than everybody else (entitlement)

  Leads to demand for ideal care and attention, but ideal picture is punctured, worker now experienced as useless, bad, abusive.

  Angry denigration follows:
  May include furious demands and destructive behaviours.

Understanding of the clinical picture of Borderline Personality Disorder:

Instability of self-image and mood

Eg. self descriptions tend to be contradictory, unintegrated; radical changes of image, 'identity', changing name: pattern of switching allegiances; feelings of emptiness

- Unstable self-image is derived from disturbed/chaotic early relationships
- Lack of integrated image of good enough parent leads to unintegrated self.

Implications of unstable self/identity:

- Terrible feelings of emptiness, disintegration, conflicting/confusing thoughts and feelings leads to feeling of urgent need. Powerful impulses to get out of this feeling state via action eg. self harm, drugs, fighting, sexual activity, etc = acting out.

- Poor 'inner model' for tolerating/processing difficult thoughts and feelings.

  Leads to pattern of maladaptive coping strategies., eg. self-harm, impulsive actions, angry attempts to control.

BORDERLINE PERSONALITY DISORDER
DSM-IV 30 01 83

A pervasive pattern of instability of interpersonal relationships, self-image and affects and marked impulsivity, beginning by early adulthood and present in a variety of contexts by 5 (or more) of the following:

1 Frantic efforts to avoid real or imagined abandonment. NB: do not include suicidal or self- mutilating behaviour covered in criterion 5.

2 A pattern of unstable and intense interpersonal relationships, characterised by alternating between extremes of idealisation and devaluation.

3 Identify disturbance, markedly and persistently unstable self image or sense of self.

BORDERLINE PERSONALITY DISORDER
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4 Impulsivity in at least two areas that are potentially self damaging (eg spending, sex, substance abuse, reckless driving, binge eating). NOTE: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.

5 Recurrent suicidal behaviour, gestures or threats, or self mutilating behaviour.

6 Affective instability due to a marked reactivity of mood (eg intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).

7 Chronic feelings of emptiness.

BORDERLINE PERSONALITY DISORDER
DSM-IV 30 01 83

8 Inappropriate intense anger or difficulty controlling anger, recurrent physical fights.

9 Transient, stress-related paranoid ideation or severe disassociative symptoms.

AETIOLOGY – Magnavita (2004)

- There is no simple answer – the aetiology is multi-factorial and complex.
- Attempts to reduce the cause to one level of abstraction such as biology trauma , social or interpersonal are likely to be fruitless.
- There are major models that, when blended, have good theoretical coherence and explanatory value.

AETIOLOGY: 'risk' factors for Borderline Personality Disorder

- Childhood trauma, maltreatment and neglect
- Higher incidence of physical and sexual abuse in BPD than in other groups
- BPD has particularly high incidence of sexual abuse by a main care-giver.

HOWEVER,

- Many sexually abused children do not develop BPD
- Sexual abuse is not present in many cases of BPD
- Sexual/physical abuse is not causal, but childhood maltreatment and/or neglect produces an elevated risk of BPD.

Studies show risk factors also include:

- Emotional/physical neglect
- Unempathic parenting
- Confictional relationships with both parents
- Prolonged separations, or losses in early childhood
- Insecure attachment pattern in childhood

- Insecure attachment patterns persists into adulthood in BPD:
  - Core issue – intolerance of feeling alone
  - Disrupted/unempathic parenting leads to lack of internal image of a good enough care giver
  - Insecure attachment pattern in BPD: clinginess, terror of abandonment, constant monitoring of care-giver, feeling needy – hating to be needy dilemma

Biological/Neurological considerations:

Genetic factors:

- Research is showing that people may be pre-disposed to impulsiveness, aggressiveness, lack of tolerance of frustration, etc.
- Emotional dysregulation is in part genetic predisposition
- About 50% of the personality seems to be genetic pre-disposition

Neurological factors:

Research going on into:

- Abnormalities in the serotonergic system
- Abnormalities in certain areas of the brain

  These seem to have an effect on the affective and cognitive processes.

- 'Multiple pathway' models emphasise constitutional vulnerability and environmental stress → increased risk of developing BDP.

Aetiology: risk factors for Borderline Personality Disorder

"It seems likely that aetiology is a complex matter of biological, psychological, social/environmental, constitutional factors and their inter-play".

Bateman and Fonagy (2004)

Effective working – some thoughts

- Expect yearning for unrealistic 'perfect' care/support
- Expect expressions of hurt and rage
- Expect clients to have quickly changing feeling-states and attitudes
- Expect patterns to get repeated with you.
- Remember that the clients have responsibility for their own behaviour and for themselves.

- Watch for impulse in yourself to be the 'rescuer', to make up for the client's past bad treatment.
- Watch for impulse to be the ideal worker, or to prove your care and commitment to a client – be realistic
- Watch for punitive responses in yourself

derived from
Gabbard and Wilkinson (2000)

Working with clients with personality disorder

- A difficult balance needs to be arrived at between support/safety on the one hand, and on the other, avoidance of collusion with helplessness and abdication of responsibility by the patient.

» Derived from Gabbard and Wilkinson (2000)

Helpful features in workers

- Open to working with clients with Personality Disorder
- Non-perjorative but appropriately boundaried
- Able to confront clients' behaviours (eg describe their reactions, behaviours with them).
- Open and able to seek advise and support
- Reflective and able to expect and withstand emotional impact of this work.

» Derived from Bateman & Fonagy (2004)

Effective features of team working

High level of structure in the service provided

- Setting necessary limits
- Clarity of purpose
- Consistency, constancy and coherence

Effective Communication

- Team supervision
- Avoid and understand splitting
- Shared understanding

Therapeutic Relationship

- Establish and maintain a therapeutic alliance
- Promote reflection for the client
- Tolerate intense anger, aggression and hate
- Monitor your own feelings towards the client.

Flexibility

- Balance between flexibility and maintaining professional boundaries.
- Initial flexibility aids in engagement and developing a therapeutic alliance.

Individual approaches are:

- Attentiveness, listening, challenge and responsiveness
- Should not lead to 'specialness' or interference with the overall treatment plan.
- Both can be beneficial

Avoid splitting between psychotherapy and pharmacotherapy

- Use of medication should be discussed as a team
- Use and effects of medication to be discussed with patients prior to prescribing, the target symptoms clearly identified.

Bateman and Fonagy (2004), Fagin (2004)