Understanding and caring for people with personality disorders

Positive attitudes from professionals are crucial for interventions with people with personality disorders to be successful

"Manipulative", "difficult" and "attention seeking" are words that have been used by many health professionals to describe individuals with a diagnosis of personality disorder. Despite examples of good practice and positive attitudes (Castillo, 2003), psychiatric descriptions of personality disorder (American Psychiatric Association, 2000, 2012a, World Health Organisation, 1992) sound like moral, rather than medical, descriptions of behaviour (Gould, 2011).

This is one reason why some authors have criticised personality disorder as a diagnostic category and have argued that some health professionals make negative judgments about people so diagnosed, assuming that they are merely "bad", rather than in need of help (Gould, 2011).

In the past, this sometimes resulted in individuals with personality disorders being excluded from health services, partly because of "therapeutic nihilism" (Casey, 2011): a belief that any professional intervention would be of no benefit (Horn *et al,* 2007).

However, research suggests that a variety of approaches reduce distressing symptoms and help some individuals with personality disorder to change behaviours that cause distress to themselves or others (NICE, 2009b).

The Department of Health emphasised that personality disorder was "no longer a diagnosis of exclusion" (NIMHE & DH, 2003). Since the publication of this document, there have been an increased number of services for individuals with this diagnosis (Garrett *et al*, 2011).

But research suggests that professionals' positive attitudes are crucial for the success of interventions (Bowers, 2002). An empathetic understanding of the positive attributes and the difficulties of people with personality disorder is fundamental to all professional work with them. However, empathy can be hard to achieve, given some individuals' difficulties in trusting professionals and in building and maintaining relationships (Aiyegbusi & Clarke-Moore, 2009). It is easy to see why professionals in general, for example, in accident and emergency departments, may find these distressed individuals difficult to cope with. Without appropriate support, education and clinical supervision, there is a danger of negative responses: "Oh no, it's her again."

Understanding the nature of personality disorder, and causative factors involved, is crucial to work with individuals with this diagnostic category.

What it means to have a personality disorder

People with personality disorders always have strengths that should be recognised (Castillo, 2003), including positive aspects of their personality. Interventions need to enable them to develop strengths and abilities (Bowers, 2002). For example, an individual with antisocial personality disorder could be encouraged to channel "impulsivity", "high novelty seeking" and high "risk-taking" (Cloninger, 2005, p135) through exciting sports (Tetlie *et al*, 2009), such as skiing or bungee jumping.

However, it also needs to be recognised that people with personality disorder have "higher numbers of problematic personality traits and experience them to more extreme degrees" (MoJ & DH, 2011, p2), compared with other individuals who share the same culture. In addition, the way people with personality disorders think, behave and respond is often inflexible (APA, 2012b), which makes it difficult for them to adapt to changing circumstances (De Fife, 2010). But the cultural context of "personality disorder" needs to be understood. What is seen as "deviant" behaviour – and a feature of personality disorder – in one society may be socially valued in another (Corbett & Westwood, 2005).

People with personality disorder sometimes respond to crises and problems in ways that result in harm to

Target audience

- Professionals working with people who have been diagnosed with a personality disorder.

Take-home messages

- Maintaining positive attitudes when working with people with personality disorders is crucial.

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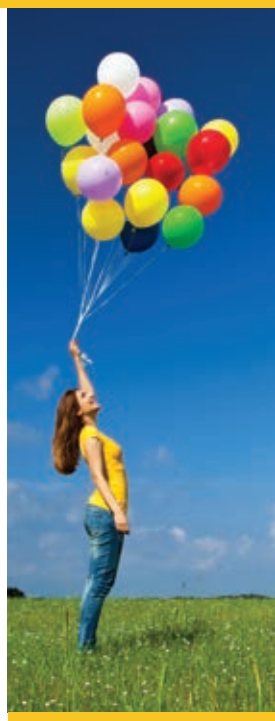

KEY WORDS

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Note: The hospital and NHS Trust where the authors previously worked is not named to ensure patient anonymity and confidentiality.

themselves and/or others, rather than finding creative solutions and resolutions. They find it difficult to achieve fulfilment in relationships, employment and other areas (MoJ & DH, 2011) and have "impairments in identity and sense of self and in the capacity for effective interpersonal functioning" (APA, 2012b). Considerable distress is generally experienced, usually related to trauma, especially in early childhood (Adshead & McGauley, 2010) and is worsened by rejection and stigmatising attitudes from others (Castillo, 2003).

Indeed, it has been argued that the term personality disorder is itself stigmatising (Campling & Birtles, 2001) It is used in this article to reflect general usage.

About 4% of the population, roughly half of mental health inpatients (Adshead & McGauley, 2010, p180), and "between 60 and 70% of people in prison" (Behan & Spurr, 2011, p i) have been found to have a personality disorder. Individuals can have a mental illness and a personality disorder, but features of the latter do not include symptoms of mental illness. Thorough psychiatric assessment is crucial to establish diagnosis, including any comorbid conditions, such as bipolar disorder and problematic substance use (NICE, 2009a, 2009b).

However, some authors have argued that diagnostic categories of personality disorder in *Diagnostic Statistical Manual IV – TR* (DSM IV-TR) and *International Classification of Diseases 10* (ICD 10) (American Psychiatric Association, 2000, World Health Organization, 1992) do not have clear implications for treatment (Saradjian *et al*, 2010). Instead, it has been argued that assessment should include formulations of patients' specific problems to inform treatment and other interventions (Evans & Watson, 2010).

What causes personality disorder?

Understanding causative factors can help patients, their carers at home and professionals to appreciate the reasons for individuals' problems and influence therapeutic approaches (Bowers, 2002). Research suggests that personality disorder occurs in people with both a genetic predisposition, and, usually, dysfunctional or disordered attachment to parents in early childhood (Adshead & McGauley, 2010).

When working with these individuals it is necessary to keep in mind some of the psychological factors that have led them to develop a personality disorder. In general, although not exclusively, people with personality disorder have experienced remarkably disrupted and difficult childhoods, often including aspects of neglect and physical, sexual or emotional abuse. People with personality disorder may have been responsible for their own and their siblings' survival from a young age. They were dependent on their primary caregivers for security, which was either withheld, or came with emotional and physical pain (Adshead & McGauley, 2010).

Understanding causative factors can help patients, their carers at home and professionals to appreciate the reasons for individuals' problems and influence therapeutic approaches

Growing up in an environment such as this can lead to individuals' feelings of worthlessness or self-loathing: "If Mum didn't care about me, maybe I'm not worth caring about". It can also lead to anger at caregivers. This anger is dangerous to express, as it is directed towards a person whom they are also dependent upon. Strong feelings can then become directed towards a "safer" person, either the patient themselves in the form of self-harm, or perhaps professionals or other people who remind them of their original caregivers. Adverse experiences are likely to seriously affect the individual's self-concept, relationships and ability to trust others in childhood and adulthood (Adshead & McGauley, 2010).

Childhood trauma and disordered attachment have been found to affect part of "the prefrontal cortex, an area associated with social and moral behaviour" (Saradjian *et al*, 2010, p61, citing Anderson *et al*, 1999). Childhood abuse affects the secretion of cortisol in times of stress and the functioning of neurotransmitters affecting mood with "lower serotonin levels" influencing "impulsive aggression towards self and others" (Saradjian *et al*, 2010, p62). Psychologically adverse childhood experiences also affect the functioning of the amygdala in the temporal lobe, so that the individual may respond rapidly to (often erroneous) perceptions of risk (Plodowski *et al*, 2009).

"Persistent antisocial behaviour" in childhood is an important factor "in the development of antisocial personality disorder" in adult life (Moran & Hagell, 2001, p vi). Studies suggest this can be prevented if parents are helped to improve parenting and reduce poverty (NCCMH, 2010).

Aspects of spirituality, such as feeling hopeless and having no purpose (Swinton, 2002) may result from, and contribute to, the effects of personality disorder. Sociological explanations relate to social and political factors that result in certain individuals being labelled "personality disordered", with resultant stigmatisation (Rogers & Pilgrim, 2010). Stereotypes concerning gender and ethnicity (Garrett *et al*, 2011) may affect psychiatric diagnosis. For example, women are more likely to be diagnosed with borderline personality disorder, possibly because they may be seen as less able to regulate their emotions (McClelland, 2006).

Although a minority of individuals with personality disorder physically harm others, most media images appear to be negative, and equate personality disorder with violence (Wedding & Boyd, 1999). "The whole diagnostic group... is... judged by the difficulties and anxieties caused by... the so-called "severely personality disordered"" (Mann & Moran, 2002, p16, quoted in Prins, 2010, p167). The "dangerous and severe personality disorder" initiative in England and Wales (HO & DH, 1999) has been criticised for initially over-responding to media portrayals of violence and personality disorder (Laurance, 2003).

Vignette: "Aca"

One of the authors (White) worked with Aca over several months in a locked mental health inpatient service. She was transferred to the service because of her escalating

aggression towards others. Her name and some details have been changed to protect confidentiality.

Aca came from a disrupted family home. Her father was physically abusive towards her and left when she was young; she was also sexually abused in childhood. Her mother experienced mental health problems, including depression and low self-esteem, leaving her unable to protect Aca or attend to her emotional needs. Aca's behaviour gradually deteriorated in adolescence, leading to exclusion from school because of fighting. She had a very short temper, especially if she felt she was being criticised. She found it hard to regulate her emotions, feeling euphoric one minute and suicidal the next. At these times, she resorted to serious self-harm, such as ligating or cutting deeply. She had a deep-seated lack of self-worth, extreme problems with relationships because of fear of being hurt, anger at perceived slights and a belief that no one could ever love her.

Following her admission, Aca appeared to initially benefit from the ward, which provided a secure, structured environment to ensure her and others' safety, opportunities to safely explore her problems and develop talents and self-esteem through participation in a variety of activities. These included painting, gardening and the opportunity to join a club outside the hospital.

Adverse experiences are likely to seriously affect the individual's self-concept, relationships and ability to trust others in childhood and adulthood

Unfortunately, Aca experienced a bereavement during her stay, when a friend – one of the few people she felt close to – died. Like many with personality disorders (Adshead & McGauley, 2010), Aca had considerable difficulty in regulating her feelings of anger and abandonment in response to her friend's sudden death. This precipitated physically violent behaviours towards others, reflecting Aca's previous use of violence, from childhood onwards, as a way of attempting to cope with stressful situations (Saradjian *et al*, 2010). At first, Aca's violent behaviours on the ward made it increasingly difficult to provide her with the emotional support she required.

Ensuring Aca's and others' safety, in relation to relieving her distress, was the basis of all the staff's work, including assessment of her risks to herself and others, implementing plans to prevent and reduce risks and identifying interventions and responsibilities of nursing and other staff (Woods & Kettles, 2009). At first, seclusion was sometimes used, in accordance with the Department of Health (2008) Code of Practice, when, sadly, this was the only way to prevent other patients and staff being physically assaulted.

Further research is needed on ways to reduce restrictive measures and develop care and treatment for the small minority of individuals with personality disorder who have long-term violent behaviours (NICE, 2009a). During Aca's long periods of time in seclusion, staff agonised over how to care for her at the same time as keeping other patients and themselves safe. Given research indicating the considerable harm that can result from seclusion (Abderhalden *et al*, 2006) this posed considerable ethical dilemmas for staff, who were aware that it could be traumatising and increase Aca's sense of abandonment at a time of bereavement. Additionally, there was concern that using seclusion prevented Aca from learning creative ways to reduce distress (Norton & Dolan, 1995).

Establishing good communication among staff is a basis for therapeutic communication with patients with personality disorder

Over several weeks, every time Aca was assessed to be safe to leave seclusion, her behaviours presented increasing challenges for staff. Whenever they showed a gap in their communications, for example, being unsure of items or activities that were safe, she became increasingly aggressive and frightening. During this time, staff met regularly to air grievances or opinions about Aca's care. These meetings were vital to ensure safety and to increase understanding of Aca's behaviour in relation to her past experiences, personality disorder and current grief (Aiyegbusi & Clarke-Moore, 2009).

Good communication essential

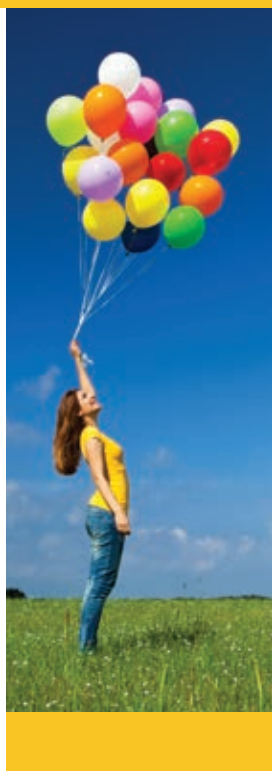
It is easy to see from this vignette how good relationships with patients with personality disorders can break down very quickly. This is partly due to many patients' past experiences of poor caregiving, leading them to be suspicious of others who attempt to care for them. This suspicion is then seemingly confirmed by staff when they are compelled to contain aggressive and violent behaviours.

Good communication among staff is the only way to come through situations such as this. Regular meetings with a diverse range of staff can help with understanding and remembering the context in which violent behaviour occurs. This then limits any feelings of resentment that may develop among staff who spend many hours with the patient, often in intense, emotionally charged situations.

Any member of staff who feels affected by a difficult situation must be encouraged to recognise this and discuss it with a trusted colleague. This will not only help them and their understanding of the individuals they work with, but also lead to better patient care. Self-awareness and effective communication avoids staff splitting: disagreement and opposed views about a patient. Splitting may mirror patients' childhood experiences of divisions and disagreements within their families (Aiyegbusi & Clarke-Moore, 2009).

Communication with Aca

Establishing good communication among staff is a basis for therapeutic communication with patients with personality disorder (Aiyegbusi & Clarke-Moore, 2009; Castillo 2003). In work with Aca, empathy involved being prepared to understand her feelings and ways of seeing the world; communicating this understanding to



her and practical interventions in response to her needs and experiences (Kunyck & Olsen, 2001).

However, at times, it was hard to maintain empathy, given Aca's difficulties in trusting staff sufficiently to interact with them without being hostile and rejecting. Like some others with personality disorders, Aca sometimes appeared to unconsciously make interactions with staff feel unpleasant as a psychological defence: for example, to reject others before they rejected her (Aiyegbusi & Clarke-Moore, 2009).

Validation included indicating to Aca that we took her thoughts and feelings seriously and wished to understand the reasons for her violent and self-harming behaviours (Robins *et al*, 2001). This approach was combined with efforts to help Aca express her anger and other, often painful, feelings assertively and in ways that did not harm herself or others (Aiyegbusi & Clarke-Moore, 2009). She was involved in care plans to prevent and reduce risky behaviours and became increasingly skilled at recognising early signs of distress and anger and developing strategies to cope with these feelings. For example, during Aca's recovery, she was gradually able to replace being violent with acceptance of staff offers to talk about and safely express her feelings and to channel her anger creatively through painting, an activity she enjoyed and was good at.

Empathy involved staff trying to appreciate the trauma Aca had experienced as a child and teenager; and being honest about limits to their understanding. Staff tried to appreciate that, like many people with personality disorders, Aca's relationship difficulties, from childhood onwards, made it difficult for her to trust them, with resultant violence or aggression, or rejection of attempts to help (Aiyegbusi & Clarke-Moore, 2009). We also tried to demonstrate unconditional positive regard, including acceptance, respect and validation of Aca and her experiences, problems and strengths, without necessarily agreeing with behaviours. In line with Bowers' (2002) research, we endeavoured to recognise Aca's positive attributes – for example, her skills in painting and gardening – rather than just concentrating on negative behaviours.

Maintaining professional boundaries and positive attitudes

Establishing professional boundaries, and ensuring that these were clear to Aca, was especially important, as is the case with people with personality disorders in general. This required workers to be self-aware, through clinical supervision, education and other means to enable reflection. We tried to avoid withdrawal from interaction in relation to Aca's hostile behaviours; and over-involvement in response to her overwhelming needs (Aiyegbusi & Clarke-Moore, 2009). This was in line with research findings that unresolved negative attitudes affect professionals' abilities to work therapeutically with individuals with personality disorder, but positive attitudes enable high standards of care (Bowers, 2002).

In our experience, it is important to recognise that maintaining positive attitudes is sometimes hard to achieve and requires considerable staff support, especially when nurses work closely with patients whose stressful behaviours continue over many weeks (Aiyegbusi & Clarke-Moore, 2009). In such circumstances, it is easy to become angry and frustrated at perceived lack of progress and to blame the patient for this. Sometimes this creates a divide between nurses and doctors, as the latter are less closely involved in 24-hour care and management.

In treating and caring for Aca, staff tried to place risk management in the context of her other needs, rather than only focusing on restrictions. They also endeavoured to be aware of possible transference issues, for example, Aca's direction of strong negative feelings about her mother towards a nurse; and their own countertransference – strong feelings evoked by Aca and our past experiences of people significant to us (Aiyegbusi & Clarke-Moore, 2009).

Inter-professional working is important, with close collaboration among colleagues, enabling patients to benefit from a variety of professional skills and the exchange of ideas.

Meanwhile, staff from different disciplines benefit from sharing communication, support and difficult decision-making (Murphy, 2010). Inter-professional working also ensures that assessment, care and treatment is holistic: meeting a range of needs, including those related to reducing risk and preserving safety (Woods & Kettles, 2009); psychological, physical and spiritual health, culture, sexuality, advocacy, and aspects of equality and diversity (Ventegodt *et al*, 2010).

Gradually, Aca and the staff who cared for her came through an extremely difficult time. Aca slowly healed and a few months later, she was relatively peaceful and enjoyed a humorous discussion about her rude language towards me (White) some time before! She was able to reflect, to some degree, about her life during this period. She had felt increasingly that staff didn't understand her and were being unnecessarily punitive. Aca had become "paranoid" about us; assuming that we disliked her and did not have her best interests at heart. This is not surprising, given her tendency to see care-givers as harmful and the adverse effects of seclusion (Abderhalden *et al*, 2006).

A way forward was found through continuing to forge and maintain a therapeutic alliance, despite difficulties, and by enabling Aca to recognise when she was at risk of harming herself or others and develop positive strategies to cope, safely and creatively, with difficult feelings (Aiyegbusi & Clarke-Moore, 2009). ■

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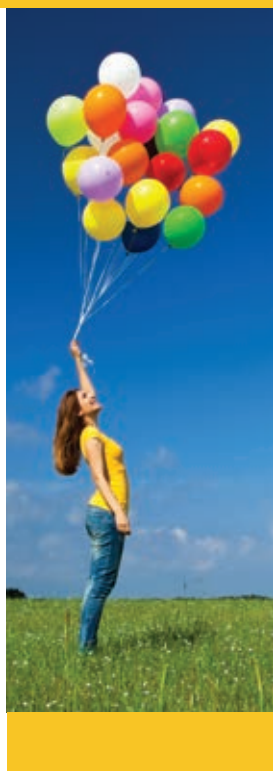

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