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Working effectively with people who receive a diagnosis of personality disorder

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Abstract

Personality disorder is a contentious diagnostic label that is associated with high levels of stigma, leading many practitioners and people with lived experience to call for a change in its use. This article explores this area further by addressing some of the knowledge deficits and highlighting opportunities for self-reflection and analysis. It also focuses on the importance of formulation for making sense of past experience, and as a tool to develop practitioner insight into suitable psychologically informed interpersonal approaches. Nurses frequently encounter people who have been given a diagnosis of personality disorder across various settings. This article provides a critique of this diagnosis and discusses the issues that are associated with this label.

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Keywords

Aims and intended learning outcomes

This article aims to enhance nurses' understanding of the sensitivities, misunderstandings, stigma and challenges that surround personality disorder. It discusses the important role nurses have in the care and support of people who have this diagnosis, differential diagnosis or associated issues. The article was co-produced, incorporating professional and lived experience perspectives. However, the authors acknowledge that the stance taken is not necessarily representative of all views held in this field of practice, particularly in relation to the use of language and diagnostic labels. After reading this article and completing the time out activities you should be able to:

1

» Appreciate the misunderstandings and stigma that people with complex emotional needs commonly experience.

» Recognise the crucial role of formulation and reflection in your nursing practice.

» Consider how you could adapt your approach to meet the needs of individual **service users**.

» Understand your contribution and responsibility in advocating for **service users'** individual needs.

Introduction

Personality disorder is defined as: '*an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment*' (American Psychiatric Association (APA) 2013).

Globally, personality disorder affects up to 7.8% of community populations (Winsper et al, 2020) and comorbidity with other mental health conditions is not uncommon (Hayward and Moran 2007). Personality disorders are biopsychosocial disorders that can adversely affect people's ability to function in everyday life. They are often described as developmental conditions in which adverse childhood experiences have psychological effects due to the social, environmental and biological factors that determine a person's ways of coping (Sampson et al 2006).

The DSM-5 TR (APA 2022) describes 10 types of personality disorder, with Borderline Personality Disorder (BPD), also known as emotionally unstable personality disorder (World Health Organization 1990), being the type most commonly diagnosed. These diagnostic labels refer to same condition but are often used interchangeably, despite a misconception they that are different. BPD is characterised by interpersonal difficulties, emotional dysregulation, impulse control and self-image deficits (Lieb et al 2004), and it is often assumed that the term 'borderline' means that someone may be on the 'cusp' of diagnosis. This misconception is concerning because people with this diagnosis are often those with the most unmet needs and highest levels of risk, particularly to themselves (Bohus et al, 2021). Despite the BPD diagnosis being highly contentious, it continues to be used in the Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA 2022), however, in the International Classification of Diseases 11th Revision (ICD-11) (World Health Organization, the way in which personality disorder is diagnosed has moved away from this categorical model whereby a person either has it or does not and must fit within one of the 10 types. Instead, there is a severity continuum with mild, moderate and severe personality difficulties. If severe difficulties are identified, then more descriptive terms relating to specific difficulties can be considered, for example 'with borderline pattern qualifier' (Mulder 2021). The differences in the DSM-5 and ICD-11, alongside the lack of agreement in the influential experts, leading their revisions, may add to the confusion and resentment many service users describe surrounding this diagnosis, while also causing confusion for practitioners.

Considering the systemic failures, high levels of stigma, the aetiology, and high levels of trauma encountered by people who receive this diagnosis, the sensitivities that arise are to be expected (Lamph et al 2021).

If one's personality is fundamentally considered to be a representation of one's being, it may be insensitive to describe it as 'disordered' or flawed in an often-traumatised client group, who may have had challenging childhood experiences. Doing so can activate emotions in the service user that are vulnerable to escalation, and may lead to further dissonance from service and practitioner responses. Therefore, it is important that education, knowledge and awareness are attended to, and that service users re directed to evidence-based interventions and support of benefit to them (Lamph et al 2021).

A study by Lamph et al (2021) explored the sensitivities surrounding the personality disorder label with practitioners and people with lived experience. It found that the importance of receiving sensitive and accurate information when receiving this label was paramount, but in practice this is not always people's experience. Practitioners are relied on to provide accurate information about this diagnosis and its implications; however, this can be challenging for them because of the changes to nurse education standards and the shift towards a generic nursing syllabus (Connell et al 2022). Therefore, enhancing nurses' understanding of personality disorder, the critical debate that surrounds the diagnosis and providing space for reflection and discussion are essential to enhancing working relationships with this misunderstood and highly stigmatised client group.

TIME OUT 1

Alternative conceptualisations of personality disorder

One of the issues associated with the personality disorder diagnosis is that it is deficit focused, locating problems within the individual, and ignoring such issues as past experiences, and current social context (Read and Harper 2022). Therefore, the authors suggest that there may be more helpful ways of conceptualising 'personality disorder'.

In 2018, The British Psychological Society issued the Power Threat Meaning Framework (Johnstone et al 2018), which presented an opportunity to approach the presentation of emotional distress in a different way. This framework suggests that an alternative approach to diagnosis and the focus on problematic behaviours is to consider what may have happened to someone, how power may have been misused in their life, and how the individual has made sense of these experiences (Johnstone et al 2018). Given that many people who receive a diagnosis of 'personality disorder' have experienced adversity in childhood (Porter et al 2020), this framework provides a more compassionate way of framing their difficulties. The emphasis moves from 'what's wrong with you?' to 'what has happened to you?', providing an opportunity for insight and kindness. This is a more helpful way of engaging with the origins and development of people's coping strategies and in understanding the effects of past experiences.

Groenewald (2018) described trauma as the 'suffering that remains'. Trauma can be physical, psychological, emotional or sexual, can be experienced at any life stage, and is the subjective experience of an individual. Exposure to traumatic events is not unusual, with studies estimating that around 80-90% of the general population in the UK may have experienced one such event (Sweeney et al 2018, Jowett et al 2020), and the experience of childhood adversity and trauma has significant and far-reaching consequences. In the late 1990s, Felitti et al (1998) investigated the association between childhood trauma and adult health in more than 13,400 people (predominantly white, middle-class Americans), and found that childhood trauma was common in that at least half reported one or more traumatic experiences. Their findings were supported in a later survey by Public Health Wales (2015) which reported that of 2,028 adults, 47% had experienced at least one adverse childhood experience, such as neglect, physical, emotional or sexual abuse.

Studies have consistently shown that people in contact with mental health services have experienced higher rates of interpersonal violence and trauma than the general population (Khalifeh et al 2015). Mauritz et al (2013) estimated that around half of those in the mental health system had experienced physical abuse and more than one third had experienced sexual abuse in childhood or adulthood, which is significantly higher than in the general population. Childhood trauma is associated with various physical health conditions in adults, including diabetes mellitus, cancer, heart disease and obesity (Afifi et al 2016).

Despite the evidence in relation to the experience and effects of trauma, few practitioners routinely ask about it, perhaps due to concerns about retraumatising people. However, by failing to do so, they risk compromising the understanding of someone's difficulties (Nicki 2016) and their subsequent access to appropriate interventions and support (Lietz et al 2014). A study by Purkey et al (2018), with 26 women who were frequent users of healthcare services, found that most of them had not been asked about trauma or adverse childhood experiences by healthcare professionals, and that most participants believed that their history of adverse childhood experiences was important to their health and that providers should ask about these. This was supported by Rye et al (2021), who identified that practitioners having an understanding of trauma had positive effects on their relationships with service users.

It has been suggested that BPD would be more appropriately described as complex post-traumatic stress disorder (C-PTSD) (Herman 1992, Ford and Courtois 2021). Framing their experiences in this way can be helpful for individuals because it normalises their responses to trauma, and provides a non-stigmatising explanation for both service users and practitioners in relation to the origins and development of their difficulties. According to Substance Abuse and Mental Health Administration (2014), it is helpful to consider the '3 Es' of trauma – events(s), experience of event(s) and effect. Wilson et al (2013) suggested that professionals should take into account the role that trauma and prolonged traumatic stress has in the lives of service users. By doing so they can influence entire organisations and systems that then may behave differently, and provide a strengths-based 'safe' base, using a collaborative, trustworthy, transparent and empowering approach (Boles 2017, Rye et al 2021).

Use of formulation

Given the issues related to diagnosis, and the need for practitioners to understand experiences of trauma, the authors suggest that a formulation-driven approach to working with people is the most effective way of ensuring a collaborative, empathic, empowering and strengths-based approach – as advocated by trauma-focused approaches (Shaw et al 2017).

While there is no universally agreed definition of formulation, The British Psychological Society (2011) suggested that its essential features are:

» It provides an overview of a person's presenting issues by making sense of information gathered during assessment.

» It suggests how the person's issues may link to and maintain one another by drawing on psychological principles and theories.

» It suggests a plan of intervention based on those psychological principles and theories.

» It is open to revision and reformulation.

» It is a collaborative process (Cox 2020) that can provide individuals with a means of understanding the origins of their difficulties and what maintains these (van Bilsen and Thomson 2011).

There are various models of formulation, including: generic models such as the Five-Aspects model (Greenberger and Padesky 1995); problem-specific formulations such as Clark and Wells' (1995) cognitive model of social phobia; and idiosyncratic formulations, which can be helpful if individuals present with multiple issues or with issues for which there is no validated model.

One widely used approach is the '5Ps formulation' (Box 1) (Macneil et al 2012), which provides a framework comprising five areas, each of which can be explored collaboratively with an individual.

Box 1. 5Ps formulation

Presenting problem
» What is the problem or issues that has arisen?

Predisposing factors
» What has happened to you?
» Explore earlier experiences that might be affecting the person's current presentation
» Are there any vulnerability factors you can illicit?

Precipitating factors
» What has led to the problem or difficulty the person is experiencing on this occasion? Can you identify the trigger?

Perpetuating factors
» What is keeping the problems going? Is there anything fuelling these problems or making them more challenging to overcome?

Protective factors
» Are there any strengths or protective factors you can identify?
» Is there anything that may have helped this time or in the past?
» Have they felt this way before, and if so, can they recall what helped?
» Develop a plan to overcome or assist with the presenting problem
(Macneil et al, 2012)

The main concept of the Power Threat Meaning Framework is that those who present with complex needs have been subjected to the misuse of power (Boyle 2022). Therefore, the authors suggest that engaging in an individualised, strengths-based approach based on a collaborative formulation **is** wholly appropriate. According to Katsakou et al (2012), this approach is likely to support service users with their recovery, provided it includes treatment goals that are important to them, long-term plans as to how these goals will be met, and which services may be involved.

Evidence-based interventions

There is a growing body of evidence on effective treatments for personality disorder, particularly BPD. This treatment is usually provided in specialist mental health secondary services. National Institute for Health and Care Excellence (NICE) 2009) guidelines do not promote the use of pharmacological intervention for BPD due to a lack of evidence of its effectiveness, unless it is directed at treating comorbid mental health issues such as anxiety and depression. Despite this guidance, medicines such as anti-psychotics are often prescribed to people with personality disorder. NICE (2009) guidelines recommend psychological therapy approaches such as dialectic behavioural therapy (DBT), which is underpinned by a combination of cognitive behavioural interventions and mindfulness exercises (Linehan 1993). Stoffers et al (2012) conducted a systematic review of psychological treatments for BPD and found DBT to have the strongest evidence.

Mentalisation-based therapy is a structured therapy which has a growing evidence base. It includes both group and individual sessions underpinned by psychoanalytic approaches (Bateman and Fonagy 2012), designed to improve service users capacity to understand the intentional mental states of themselves and others– to think about thinking, which can improve emotional stability (Gardner et al, 2019). While it is becoming more frequently offered as a treatment approach across the UK, it does not yet have the depth of replication studies that are present in the DBT literature (Stoffers et al 2012).

Schema-focused therapy and Transference-focused therapy are effective interventions for BPD, however require further research and replication (Stoffers et al 2012). Schema-focused therapy is underpinned by cognitive therapy but focuses on early childhood and developmental experiences (Young et al 2003), whereas in Transference-focused therapy, which is a type of psychoanalytic psychotherapy, there is an emphasis on the relationship between therapist and service user and therapy aims to explore unhelpful interpersonal and thinking patterns. Cognitive behavioural therapy for personality disorders is also indicated as an effective treatment for borderline personality disorder and avoidant personality disorder (Davidson 2008).

DBT and mentalisation-based therapy are long term psychological interventions provided using multimodal approaches with a combination of individual and group-based interventions (Richards et al 2012). Cognitive behavioural therapy, schema-focused therapy and transference-focused therapy are usually delivered as an individual one-to-one therapy. Other newer approaches to working effectively with personality disorder include structured clinical management, in which there is an emphasis on the provision of consistency, continuity and coherence of interventions, and on problem-solving, effective crisis planning, medication review and assertive follow-up if service users disengage (Bateman and Krawitz 2013; Bateman and Fonagy, 2009). Despite this approach becoming increasingly popular within mental health services, further research of its effectiveness is required. A new approach known as structured psychological support is currently being trialled and focuses on the provision of brief low-intensity interventions in secondary mental health services (Crawford et al 2020).

At present, evidence-based psychological interventions for people with personality disorder are only available to those with the most severe presentations in specialist secondary mental health services. There is a need to develop whole systems approaches to working effectively with people with personality disorder, but research to support this and the development of such interventions are in their infancy (Lamph et al 2019, 2020) There is often a reported disparity or 'postcode lottery' of service provision for this client group, which will hopefully be addressed via changes in the healthcare system (Royal College of Psychiatrists 2020).

Interpersonal effectiveness

It has been suggested that 'personality disorder' is essentially an interpersonal disorder (Wilson et al 2017, Gardner et al 2020), which reinforces the importance of developing effective therapeutic relationships. This suggests that to work with individuals

effectively, practitioners need to have high levels of self-awareness and an awareness of their own schemas and triggers, as well as those of their colleagues and team. Schemas are memories, thoughts and feelings that develop through childhood and adolescence that significantly affect an individual's reactions to internal or external triggers that relate to their early experiences (Puri et al 2021). According to several studies, people who present with BPD tend to have developed maladaptive or unhelpful schemas as a result of their early experiences (Bach and Farrell 2018, Puri et al 2021). Therefore, an awareness of one's own schemas and responses is important to prevent these from becoming a barrier to sensitive relational work. This awareness is important since there is evidence to suggest that those who present with personality difficulties may have an issue related to theory of mind, which is the ability to attribute mental states (beliefs, emotions, intent and desires) to oneself and others (Premack and Woodruff 1978).

One way of conceptualising how nurses and other healthcare professionals work with individuals is the 'boundary seesaw' (Hamilton 2010), where the ideal position would be in the centre of the seesaw, but there are times when we move up and down the seesaw, for example 'pacifying' service users, or becoming more 'controlling' rather than 'negotiating' depending on factors such as our relationships with service users, colleagues, the prevailing culture within the team, resources, and our role within the team and with the service user. The authors suggest that insight into this is essential, because without it practitioners could potentially reinforce some of the harmful messages that exist in healthcare in relation to this client group.

Such harmful messages serve to maintain unhelpful narratives, therapeutic nihilism (which is the belief that people cannot be treated effectively) and stigma in relation to people who present with personality difficulties for example that they are 'untreatable', manipulative (Nicki 2016, Rye et al 2021) and undeserving of treatment when compared with people with mental illness (Lanfredi et al 2019), meaning that people might be offered inappropriate or inadequate interventions (Paris and Black 2015), and may be excluded from services (Ferguson 2016) due to organisational anxieties about how best to manage their difficulties and support them.

This demonstrates the need for practitioners to work in a relational way with individuals, and to have an optimistic and hopeful approach that supports the notion that 'recovery' – an idea that has different meanings for different people – is possible. It has also been suggested that using the term 'recovery' in this context is problematic, because some people believe it implies there was something fundamentally 'wrong' with them. However, others view it as an open-ended journey, meaning that they learn to cope with their difficulties and live a meaningful life despite these (Katsakou et al 2012). Practices such as supervision and reflection have been shown to support practitioners who work with people who present with personality difficulties and complex needs, and can enable them to develop therapeutic, collaborative, trauma-informed and empowering relationships (Rigby and Longford 2004, Farrell et al 2010).

TIME OUT 5

Think about your team and how you initiate, maintain and develop therapeutic relationships. Where are you and your colleagues usually positioned on the boundary seesaw?
Think about when and why that changes, and how you and your team could mitigate against the effect of factors that move you towards either end of the seesaw?

Conclusion

The diagnosis of personality disorder is a highly sensitive and contentious label. Those who receive this diagnosis have often endured significant trauma and adversity in early life, then are further stigmatised when given this diagnosis, with many experiencing of rejection, lack of treatment options and exclusion from services. Despite some significant improvements and training initiatives to enhance staff knowledge and challenge stigma, many people continue to report feeling misunderstood.

Mental health nurses have an important role in the care and support of people who have this diagnosis, differential diagnosis or associated issues. The authors encourage mental health nurses to engage in ongoing reflective practice and undertake any local personality disorder training initiatives to develop their knowledge, since this area of practice is rapidly evolving.

TIME OUT 6

Identify how working effectively with people who receive a diagnosis of BPD applies to your practice and the requirements of your regulatory body

TIME OUT 7

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