

PAPERS

PERSONALITY DISORDER

Temperament or trauma? users' views on the nature and treatment of personality disorder

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The controversial diagnosis of personality disorder has become almost exclusively associated with negative connotations of violence, aggression and anti-social behaviour. People with this diagnosis carry a heavy burden of social prejudice, rejection by statutory services, and even the threat of indefinite detention. HEATHER CASTILLO describes a unique research study in which people diagnosed with personality disorder interviewed others to collect evidence of what it is like to have such a diagnosis, the actual problems people experience, and what they find helpful. *Mental Health & Learning Disabilities Care 2000; 4, 2: 53-58*

Personality disorder was first defined almost 200 years ago, in 1801, by the French psychiatrist Pinel, who described a 'manie sans delire': a mania without delirium.¹ He defined what might now be called dissocial personality disorder, characterised by unexplained outbursts of rage and violence but with no impaired intellectual function or delusion. In 1835 a Bristol doctor formulated a new term, moral insanity, that he defined as: 'a moral perversion of the natural feelings, affections, inclination, temper, habits, moral dispositions and natural impulses.'¹

Further classifications followed throughout the 19th century, with increased loading towards criminality. For example, in 1885 Henry Maudsley¹ described one patient as having 'no capacity for true moral feeling'. He also commented that the term moral insanity was: 'A form of mental alienation which has so much the look of vice or crime that many people regard it as an unfounded medical intervention.' The Lunacy Act at the turn of the 19th century did not include such 'socially dangerous' people, confining its definition of insanity to a 'disorder of intelligence ... delusion ... intellectual disorder, or intellectual defect'. It was only in 1913 that the definition 'moral defective' was incorporated into the Mental Deficiency Act. Borderline personality disorder was a concept devised around the 1950s to describe patients who were considered to be on the borderline between neurosis and psychosis. However this borderline was disputed by many clinicians, and the concept evolved into a personality disorder, defined in DSM IV as:² 'impulsive people [who] make recurrent suicide threats or attempts. Affectively unstable, they often show intense inappropriate anger. They feel empty and bored and they frantically try to avoid abandonment. They feel uncertain about who they are and lack the ability to maintain interpersonal relationships.' ICD 10, the UK classification of mental and behavioural disorders defines emotionally unstable borderline type as:³ 'Disturbed self image, aims and preferences. Chronic emptiness, intense unstable relationships and self-destructive behaviour.'

Psychopathy was not established as a legal definition of mental illness until the 1959 Mental Health Act, and it is this definition that is largely retained within the 1983 Mental Health Act. Antisocial or dissocial person-

ality disorder is used interchangeably with psychopathic disorder, which the 1983 Act defines as: 'A persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.' More recently still has emerged the newest categorisation: that of dangerous severe personality disorder,⁴ that encompasses the notion of untreatability. Thus the modern concept of personality disorder is represented by two connected notions: that the personality abnormality causes problems to self or/and others, or that the behaviour is so anti-social as to be danger to society.

However these concerns of the medical profession with definition and classification are challenged. Gelder and colleagues propose:¹ 'Human beings resist precise measurement and, unlike the phenomena of disease, abnormal individuals cannot be classified neatly into the manner of clinical diagnosis.' Dr David Fainman of the Henderson Hospital, a specialist centre for treating those with a diagnosis of personality disorder, argues: 'Behind the label of personality disorder there is a personality, behind which is a person. We have struggled with what these labels mean for years. All of us have personalities and ten per cent of us in the general population are considered to have a personality disorder.'⁵

Nevertheless, even though its clinical definitions incorporate the most timid to the most dangerous the classification of personality disorder continues to generate a moral panic in society, and where with other conditions understanding is offered, fear has emerged, with considerable implications for treatment. In his analysis of secure provision Gostin⁶ recognised the tendency for people diagnosed with personality disorder to be excluded from services or given inappropriate care in special hospitals or prison. Bell and McCann⁷ illustrate the attitudes that still prevail towards those with the diagnosis: 'Need to try harder because their behaviour is under control'; 'Not to be trusted and may attempt to kill themselves with medication'; '... have enduring patterns which may even worsen in therapy.' Lewis and Appleby's⁸ study of 'the patients psychiatrists dislike' found that patients with a previous history of personality disorder were seen by psychiatrists as difficult, annoying, manipulative, attention-seeking, in control of their suicidal urges and less deserving of care. They concluded: 'Personality disorder appears to be an enduring pejorative judgement, rather than a clinical diagnosis.' Dunn and Parry⁹ describe working with borderline patients who repeatedly cut themselves, try to hang themselves or overdose: 'The staff are often stressed and de-skilled, the psychiatrist is frustrated and irritated ... [Such clients] arouse negative feelings ... this is not mental illness, it is attention seeking, or acting out, or behavioural, or badness.' Hinselwood¹⁰ argues that, faced with a difficult patient, staff retreat emotionally into what he calls the 'scientific attitude': scientific justification blinds the professional to the subjective

PAPERS

PERSONALITY DISORDER

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experience of the patient and this blind spot 'feeds back directly into the patients' difficulties'.

This paper describes a study conducted by and of people with a diagnosis of personality disorder to discover what the diagnosis meant to them, and what interventions had or had not been useful to them. The project was based at the advocacy service run by Mind in Colchester and led by the advocacy service manager. It was initiated by service users themselves, a significant number of whom had contacted the advocacy service for help over recent years. Subsequently 16 service users with this diagnosis formed a group and worked with the local community health council, health authority, mental health trust and social services to produce good practice guidelines.¹²

The public and professional debate regarding personality disorder is largely uninformed by the user perspective.¹³ When service users are devalued it is difficult for them on their own to question the assumptions of the majority; the support of others is needed to help set in motion collective action that may challenge conventional wisdom.¹⁴ Lindow and Morris suggest that:¹⁵ 'the involvement of service users in setting the research agenda, developing the methodology, carrying out analysis and dissemination is crucial.' Rose and colleagues¹⁶ argue that involving service users in research 'can give rise to fruitful and valid findings which have implications for policy,' and found from their own user-led study of users' views that 'even very psychologically distressed people responded to questions about services and satisfaction with professionals coherently'.

Already the group had identified through its work on the good practice guidelines a number of concerns: one was common emerging patterns involving early life events that suggested a complex relationship between life events, response and disorder.¹⁷ The other was the proliferation of psychiatric diagnoses attached to personality disorder. It was Goffman¹⁸ who first suggested that psychiatric diagnosis swamps the person, coming to define them as an individual. Pilgrim¹⁹ has described personality disorder as a diagnosis with maximum stigma effect. The group wanted to know both what were people's experiences of life events and their experiences of the system.

The aims of the study were thus to attempt to distinguish between the cause, resulting self-state or condition and behavioural consequences of personality disorder, in order thence to discover what interventions have been and might be helpful. In this way we hoped to contribute to the development of a framework for treatment and support that might better meet the needs and vulnerabilities of people with this diagnosis.

Method

We decided to adopt three different approaches to data collection: qualitative and quantitative. These were:

- a narrative approach, involving the collection of journals, poems and letters and records of discussions among the study group members
- open-ended interviews with 50 people with the diagnosis of personality disorder
- quantitative questions to ascertain demographic, diagnostic and experiential data.

The study group comprised the 18 people with a diagnosis of personality disorder who were already members of the collective inquiry group involved in the good practice guidelines project. Five of the group expressed an interest in being trained as research interviewers. This was done with the assistance of supervisors from Anglia Polytechnic University. One person was not able to complete the training because of ill health, leaving four interviewers. The interview questionnaire was devised by the group again with the assistance of the supervisors from Anglia Polytechnic University. Prior to embarking on the interviews themselves the interviewers tested out their skills and the questionnaire on each other. The questionnaire was found to be workable, to facilitate answers, and to be a satisfactory method of collecting the required data. The interviews would, it was expected, take approximately one hour. The interviewers would be paid £30 for each interview conducted; the interviewees would receive £10. Travel expenses were paid for all the group members to attend meetings. We agreed that 50 interviewees would provide a representative sample. Permission was obtained by the local research ethics commission, but with some difficulty and reluctance on their part.

The project began in March 1999 with the preparation of the interview schedule. The interview sample was obtained by self-selection and snowball sampling. Nine interviews were conducted at the Mind social centre, 19 at the respondents' homes, and 18 in hospital. Four responded by post. The first interviews were started in July, ethical permission was granted in August, and the final, 50th interview conducted on 20 December. During this time all the interviewers had periods when they were too unwell to work. For most of the study just two were active at any one time, although none dropped out and all the wider group continued to attend monthly meetings, some from hospital and even when sectioned.

The quantitative data were analysed simply, without the use of a statistical package. The open-ended questions were categorised by question and the answers divided into type of response, number responding and percentage of the sample, with illustrative quotes.

Findings

The sample comprised 20 males and 30 females, aged between 18 and 74. It proved impossible to contact anyone over 75. The bulk of the interviewees (43) were aged between 25 and 54. The majority were single, divorced or separated (86 per cent) and living alone (66 per cent). Most (88 per cent) were on long-term sickness or other benefits. Just one was employed full-time. Twenty nine had a diagnosis of borderline personality disorder and 14 dissociative personality disorder. In the

PAPERS

PERSONALITY DISORDER

T1 Experiences of mental health problems (n=50)

| | |
|---------------------------|----|
| Cutting | 32 |
| Destroying things | 28 |
| Disassociated/separate | 28 |
| Other types of self-harm | 24 |
| Being exploited | 23 |
| Imprisonment | 19 |
| Overdosing | 39 |
| Exploiting others | 3 |
| Relationship difficulties | 41 |
| Suicide attempts | 41 |
| Hospitalisation | 44 |
| Abandonment | 25 |
| Alcohol misuse | 23 |
| Sectioned | 30 |
| Loss of children | 19 |
| Drug abuse | 15 |
| Juvenile convictions | 6 |
| Early sexual abuse | 21 |
| Overwhelming anger | 37 |
| Adult convictions | 25 |
| Early violent abuse | 23 |
| Desire to hurt others | 24 |
| Rejection from services | 25 |
| Early emotional abuse | 39 |
| Violence to others | 21 |
| Isolation | 39 |
| Later abuse | 30 |

case of seven the type of personality disorder was not specified. More women than men were diagnosed with borderline personality disorder (23; 79% v 6; 21%); more men had a diagnosis of dissocial personality disorder (11; 79% v 3; 21%). Most common additional diagnoses were depression (39; 78%), anxiety (30; 60%), eating disorder (17; 34%), manic depression (11; 22%) and obsessive compulsive disorder (10; 20%). The respondents' experiences of their mental health problems are described in table one. The overwhelming majority (88 per cent) had experienced abuse of some kind, and 80 per cent had experienced childhood abuse. The support the respondents variously received and their perceptions of its helpfulness are described in table two.

Asked what the diagnosis 'personality disorder' meant to them, 26 per cent said they did not know, 22 per cent said it was 'a label you get when "they" don't know what else to do,' 18 per cent described mood swings or personality change ('Jekyll and Hyde'), ten per cent described it as something bad or evil ('Life sentence – untreatable – no hope'). Other responses included identity ('I don't know who I am'); developmental ('I didn't develop emotionally as a child'), self-destructive, relationship difficulties, and dissociation ('My mind and body are separate. I'm angry and disappointed and not able to cope').

Over half (56 per cent) had received their diagnosis from a psychiatrist, but 16 per cent (8) found out from their records or reports:

'After I was discharged I opened a letter from my psychiatrist to the GP. It said it there. I was a bit stumped – shocked. I'd heard about people that had

T2 Sources of support and perceptions of helpfulness (n=50)

| % | Response | Very helpful | Helpful | OK | Not helpful | Harmful | Helpful/harmful split |
|-------------------------------------|----------|--------------|---------|----|-------------|---------|-----------------------|
| Family | 100 | 10 | 16 | 8 | 24 | 22 | 20 |
| Friends | 100 | 22 | 32 | 28 | 16 | 2 | 0 |
| Church and spiritual beliefs | 64 | 34 | 22 | 13 | 22 | 9 | 0 |
| Hospital | 92 | 2 | 30 | 33 | 26 | 7 | 2 |
| Day hospital | 70 | 0 | 23 | 37 | 31 | 6 | 3 |
| Therapeutic community | 22 | 27 | 10 | 18 | 18 | 27 | 0 |
| Safe house/crisis house | 4 | 50 | 0 | 50 | 0 | 0 | 0 |
| Voluntary centre | 64 | 56 | 22 | 16 | 6 | 0 | 0 |
| Community mental health team | 86 | 12 | 23 | 18 | 33 | 12 | 2 |
| Criminal justice mental health team | 42 | 14 | 24 | 24 | 29 | 9 | 0 |
| The police | 70 | 9 | 11 | 26 | 17 | 34 | 3 |
| Solicitor | 78 | 38 | 29 | 18 | 10 | 5 | 0 |
| Armed forces | 12 | 17 | 17 | 0 | 0 | 66 | 0 |
| Supported housing | 32 | 25 | 31 | 0 | 31 | 13 | 0 |
| Medication | 100 | 18 | 28 | 26 | 18 | 8 | 2 |
| Psychiatrist | 96 | 13 | 15 | 19 | 20 | 23 | 10 |
| Psychotherapist/counsellor | 86 | 25 | 30 | 15 | 25 | 5 | 0 |
| Nurse | 80 | 12 | 33 | 35 | 10 | 8 | 2 |
| Occupational therapist | 54 | 22 | 19 | 33 | 22 | 4 | 0 |
| Mental health social worker | 50 | 28 | 16 | 24 | 24 | 8 | 0 |
| Child protection social worker | 30 | 0 | 13 | 0 | 20 | 67 | 0 |
| Advocate | 90 | 71 | 27 | 2 | 0 | 0 | 0 |
| Accident & Emergency | 86 | 20 | 16 | 32 | 30 | 2 | 0 |
| General hospital | 86 | 26 | 26 | 26 | 18 | 4 | 0 |
| GP | 100 | 36 | 24 | 18 | 16 | 6 | 0 |

been diagnosed with personality disorder being the black sheep of the community. It made me feel I didn't belong anywhere.'

'I found out from the psychiatrist's report for a child care case. It was the first time I knew. It made me feel very low about myself – helpless.'

Ten per cent had never been given a diagnosis, and had guessed or inferred it. Other sources mentioned were advocates, social workers, GPs, or a nurse.

Asked what they considered to be their problem, 36 per cent mentioned depression, either on its own or with other problems; 28 per cent explained it as abuse or blaming self ('Suffering the effects of being sexually abused as a child – depression, panic, bulimia, don't belong, anxiety, stress, insomnia, self-harm'; 'Feel I'm to blame – need to cut to release blame – can't make a marriage work'); 22 per cent mentioned stress or not coping ('Feel unable to cope with the stresses of life – let people wind me up – anxiety – bottled up feelings – fear of rejection'), and 14 per cent described substance abuse.

Asked what they considered to be their strengths, 38 per cent described themselves as caring ('I try to listen to other people and give them a chance'; 'Being able to talk about problems and get on with people') and 28 per cent mentioned endurance or strength ('Determined to get better, artistic and willing to change'; 'Willpower – to fight the drugs and get my kids back'; 'Capability to cope with whatever happens'). Other qualities included cre-

PAPERS

PERSONALITY DISORDER

In an ideal world they wanted: 'To be listened to, treated with respect, understood – people who are straight-up and honest and will help you'

ative, religious, humour, expressiveness and intelligence. Six people (12%) described themselves as having no strengths ('... just a mass of weaknesses').

Asked what they felt to be the implications of their diagnosis, 44 per cent said it had resulted in their being treated badly ('Staff didn't want to know'; 'Told I was attention seeking'; 'Treated less sympathetically ... not mental illness – something you've brought on yourself'; 'People don't believe there's anything wrong with you if you've got personality disorder'). Some (20%) described mixed treatment ('There's two groups of people: those who try to understand and those who think you're just attention-seeking and you don't deserve treatment'; 'In one area they may give you help. In another area you don't get help. It's very patchy'). Other responses included no difference (10%); treated badly by social services (8%), and picked up by the police (4%). Just two people (4%) described good support.

Asked what they would like in an ideal world in terms of treatment and response, 34 per cent said better services. Comments included:

'To be listened to, treated with respect, understood – people who are straight-up and honest and will help you.'

'Less medication, more talking to find deep-rooted problems. Not to give the diagnosis willy nilly when there's so much stigma attached.'

'They should take time out to explain in more detail about the illness, instead of giving you loads of drugs.'

'For staff to listen and take things seriously. Chance for an in-depth consultation. Feel secure – safety net.'

Others mentioned out-of-hours or helpline services and a safe house (12%); the label to be changed (12%); activities or occupation (10%); home and family (8%), and parenting help (8%). Three said they didn't know. One simply wanted: 'To be given another chance in life, that's all I ask.'

Asked what had helped them most, 36 per cent said family, and 34 per cent said therapists; frequently CAT therapy, or occupational therapy. A quarter (26%) had found medication helpful; 24% mentioned psychiatrists, hospital or their hospital keyworker, and 22 per cent had found their community mental health team helpful: 'Social workers – brings me back to reality, puts things in perspective, and support worker helped me get back into the community – got me a place at college and some voluntary work.'

Some (14%) had been helped by their GP. A third

(34%) had found advocacy helpful and 24 per cent mentioned the voluntary sector (drop-in centres, self-help groups and Mind groups). Other replies included friends, other clients, church/spiritual beliefs, accommodation, child care, education and creativity. Two people said 'self-harm'.

Discussion

Trauma, especially prolonged trauma from caregivers, has a profound effect on personality development.²⁰ If abuse is traumatising, then the individuals in this sample are almost all victims of trauma, mostly in childhood. Of 50 people 88 per cent suffered abuse, and 80 per cent of this was childhood abuse. Further, 78 per cent had at some time been given a diagnosis of depression and 60 per cent had been diagnosed with anxiety. In the descriptions of their problems from their perspective 36 per cent of respondents mentioned depression, 28 per cent abuse, and 22 per cent stress, or combinations of all three. That 86 per cent of service users in this study described their difficulties in terms of depression, anxiety and often both surely raises questions as to why they should have attracted a diagnosis of personality disorder.

Morrison suggests that borderline personality disorder is easily confused with other mental disorders and argues it is probably attached to a larger number of patients than is justified.²¹ He attributes its popularity as a diagnosis to the fact that: 'So many patients can be shoehorned into its capacious definition.' His argument that many have more easily treatable disorders, including major depressive disorder, has importance for those in this sample with depressive symptoms. Allotted a category that is recognised as psychiatrically untreatable, they are effectively abandoned in a hinterland devoid of real legitimacy and thus disadvantaged from the start in terms of response and treatment.

The symptomatology of the sample (table one) shows, among other things, high rates of suicidality and self-harm (82 and 88 per cent respectively). Herman²⁰ outlines extensive empirical support for the concept of a post-traumatic syndrome in survivors of prolonged and repeated victimisation. Behaviours such as self-mutilisation, re-victimisation, victimising others, dissociative disorders, substance abuse and eating disorders – all used as strategies aimed at restoring internal equilibrium – have been identified in victims of early trauma.^{20,22} There is an unmistakable consistency here with the reported experiences of the majority of our sample.

A majority (66 per cent) of this sample lived alone; 78 per cent reported experiencing isolation; 82 per cent said they had relationship difficulties, and 86 per cent were either single or divorced. Traumatized people have characteristic difficulties with close relationships and are also vulnerable to being re-victimised and may engage in destructive interactions with others. It is of note that 72 per cent of the sample considered they had been either badly treated by mental health services or had received mixed treatment that included inappropriate, bad or no treatment. Here we can arguably see a tendency to re-victimisation. But we can also see something of Hinshelwood's¹⁰ hypothesis that difficult clients create reactions in those who try to care for and treat them. He suggests that those with a personality disorder

PAPERS

PERSONALITY DISORDER

diagnosis offer a relationship too intensely suffused with human feelings. Professionals, because they are being made to feel, are in danger of being overwhelmed, resulting in emotional retreat and a compounding of moral judgement. This perception is supported by the experiential evidence in the personal journals and writings submitted to this study:

'We make you feel. We also make you suffer. Why? Because in that space after frustration and anger is your desire to wash your hands of us.'

'As a group we already feel sub-human, misunderstood and vulnerable, and now we are tarred with the brush of being bad as well as mad. I do believe that, subconsciously, we posit such a threat that professionals have lost their way.'

A new construct

Whether or not one acknowledges trauma as a potential cause of anti-social or otherwise unacceptable behaviours associated with the personality disorder diagnosis, it can be argued that it has to be better for society as a whole to try to understand and treat such behaviour, especially where it involves risk of harm to others.

In a welfare state response to illness is entitlement to help, access to professionals who understand the condition, and availability of support and treatment. Why is it that this particular group of people is seen as not deserving of treatment? Are psychiatric services aiming to offer treatment, even? From the responses to our study, very often it would seem not.

If treatment does occur, whether in the community, hospital, prison or therapeutic community, correct assessment of dimension of need in relation to the severity of the disorder is surely required. Encompassed in this criteria is assessment of significant suffering, risk of harm to self, and risk of harm to others in the form of poor parenting, crime and bodily harm. However even if these assessment criteria are met, it may be that until moral opinions regarding entitlement are examined and more fully understood, a true engagement with such individuals will not occur.

The degree to which engagement has occurred in our sample and an analysis of whether their needs have been met is revealed in the views of respondents on the different types of interventions they have experienced (table two). In terms of what helped most, support outside the professional arena, from the family, was rated highest at 36 per cent. Particular disciplines from primary and secondary care received either positive or fair responses. Voluntary centres received a very good rating from those who had attended them. Of the 32 per cent of respondents who had experience of supported housing, more found it helpful than harmful. Medication received a fair to mixed response overall, although it was chosen as the fourth most helpful intervention at 26 per cent.

Second most helpful after family support was therapy, cited by 34 per cent. The two main therapies were cognitive analytic therapy (CAT) and occupational therapy (OT). OTs in the area covered by this study often use a cognitive and solution-focused approach, and sometimes Parks' inner child therapy.²³ What appears to have been unhelpful was group psychotherapy. This may be

because people who have experienced abuse, and early abuse in particular, find it difficult to explore such experiences in depth in a group environment. Roth and Fonagy²⁴ in their analysis of 'What Works for Whom' conclude that psychodynamic psychotherapy has limited effectiveness, and that dialectical behaviour therapy is the most effective treatment for personality disorder. Individual psychotherapy did not emerge in this study as a helpful intervention. It may be those with this diagnosis appreciate and more functional and interactive approach where the emphasis is not all on the client to bring something to the discussion. Ego strength may be poor among this client group, and self-esteem low.

Emphasis in a cognitive approach is on partnership, and might be perceived as more 'holding'. Twelve per cent had found CAT most helpful: 'He's [the CAT therapist] done more than the whole services put together.' Considering the kind of dissociative states experienced by some in this client group, an appreciation of the kind of distorted sense of self which is experienced might be achieved through CAT. Where early life has been sexually or violently abusive, or simply included an unloving and devastating non-response from caregivers, the blunt limitations of their experience arguably leave some stripped of control and disempowered. Ryle's concept of CAT therapy incorporates an integrative approach that fully acknowledges role limitation and the deeply powerful transference issues likely to arise.²⁵ However CAT is time-limited. Ryle might argue that endings are in themselves part of the therapeutic process. However given the degree of deprivation suffered by some clients, one might question whether 24 weeks is sufficient time to assimilate such trauma and dissociated parts of the personality. CAT psychologists in the Colchester area appear to be adopting a more flexible, open-ended approach.

In terms of entitlement, our sample has over the years evidently accessed statutory support: 88 per cent said they had been admitted to hospital, and 60 per cent had at some time been sectioned. For some, the treatment spanned decades, but were the kinds of support they received likely to alleviate or exacerbate difficulties? Many of the sample lived alone, were isolated, and 88 per cent were on sickness and welfare benefits. Many were still depressed and anxious. Yet the most often reported and most distressing response from professionals was being told they were 'attention seeking'. Might not 'attention-seeking' be seen rather as 'attachment seeking', and better understood in relation to Bowlby's attachment theory and separation anxiety?²⁶ Here the individual tries to maintain proximity to someone perceived as being better able to cope with the world, who is expected to provide care, comfort and security. Bowlby recognised that although attachment theory is emphasised in childhood it continues throughout life. For those who have experienced early trauma, attachment seeking is a likely yet much misunderstood behaviour resulting sometimes in a continual neediness that may make considerable emotional demands on professionals. This in turn may lead to rejection that itself can exacerbate attachment seeking behaviour.

Szaz argues that a reductionist or medical model of psychiatry can pathologise and prolong human suffering.²⁷ A 'revolving-door' syndrome apparent among

PAPERS

PERSONALITY DISORDER

This construct points to the need for a reframing and renaming of the concept of personality disorder into a category that offers a better understanding of this human condition

some of our sample may say something about the need for a wiser use of limited resources. This also highlights the desirability of cost-effective and productive psychological treatments. It may also say something about staff responses in general, and how lack of understanding and inappropriate responses can re-enforce dysfunctional behaviour that may inadvertently compound symptoms. Linehan²⁸ has a particular aversion to the use of the word 'manipulative', pointing out that the implication is that the individual is skilled in managing people when the opposite is the case: 'Also the fact that the therapist may feel manipulated does not necessarily imply that this was the intention of the patient.'²⁹

Advocacy services received a particularly positive response in this study. This does suggest a 'halo effect' because respondents were aware that their completed interview would be returned to the advocacy service and may have wished to be more positive because of this. However it is also relevant that many of the sample turned to advocacy services for help in moments of desperation and perceived rejection. Although the service has offered support, it has not always been productive and still appreciation was expressed. As with the efforts of OTs, advocacy services have perhaps applied the along-side engagement and interactivity that embodies Linehan's call for acceptance, partnership and encouragement.²⁸

Conclusion

Respondents in this study highlight inadequate statutory service provision and response and point in their answers to what might alleviate and potentially heal. In so doing they are presenting a new construct for consideration: a construct that is informed by an exploration of the inner world of those who have attracted a diagnosis of personality disorder. This reformulation suggests that, for a significant percentage, life events involving early trauma may offer a theory about the aetiology of the disorder. Their responses also suggest that the term 'personality disorder', with its history of negative judgemental language, is so very stigmatising that it can of itself compound the effects of trauma, both by reinforcing a damaged sense of self and precipitating a negative service response.

The association between categories of early life events and later symptomatology suggest that the inclusive regime adopted by the Henderson Hospital could be welded in some way with other interventions such as CAT and DBT. Early intervention and community treatment for those judged to have sufficient dimensions of need might begin with a more human and accepting approach. This suggests not only the requirement for

training to increase understanding and skills, but also the need for support for those staff engaged in the treatment of service users who may offer presentations suffused with great suffering and deep or difficult emotions.

This proposed construct points overwhelmingly to the need for a reframing and renaming of the concept of personality disorder into a category that more clearly suggests aetiology and offers a better understanding of this human condition. Issues concerning knowledge, understanding, entitlement and resource constraints may all have contributed to colouring the professional response to this client group. But can their evident need for effective treatment be ignored, either in human terms, or in terms of cost-effectiveness? In the words of the respondent: 'I do so want to just curl up and die, to end this relentless misery once and for all. This existence is really terrible.'

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