

## Working with personality disorders

People with a personality disorder have often been excluded from both statutory and voluntary sector service provision. The reasons for this are various and include a lack of funding, perceived lack of 'treatability', fears that these service users 'drain' staff time through 'attention seeking behaviour', and fears around safety of staff, volunteers and other service users. The National Institute for Mental Health in England (NIMHE) recently published the guidance 'Personality disorder: no longer a diagnosis of exclusion' and subsequent capabilities framework 'Breaking the cycle of rejection'. Staff and volunteers in the homelessness sector are often the last and sometimes only support for those vulnerable adults who have a personality disorder. Through the work of the NIMHE it is hoped that funding, training and resources will be earmarked for this group.

This briefing is intended to be a starting point for those staff and volunteers who may work with people with a personality disorder or be presented by someone who may have a personality disorder. Details of other resources are on the back of this briefing for further research and assistance.

### Common issues for individuals with a personality disorder are:

- Drug and alcohol misuse
- Housing and homelessness issues
- Unemployment
- Negative experiences when seeking medical and other support

## What is a personality disorder?

One of the difficulties for people in working with a person who has a 'personality disorder' is finding a definition. The following definitions are useful but are still, arguably, limited:

- 'A severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption.'  
*The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation 1992).*
- '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, 1994, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) 4th Ed.*

Other practitioners and service users would argue that the terminology surrounding 'personality disorder' isn't helpful and that personality disorders primarily occur because of emotional stress or trauma which causes the mind to react with various protective mechanisms. These aren't helpful to the individual in the long term and cause some degree of disability to that individual which has physically damaging and/or socially impairing side effects. Interestingly, carers are quite often relieved to have a 'diagnosis' and have less issue, in general, with the potentially stigmatising language which surrounds these illnesses.

'The model is simple -- children growing up require a sound parental attachment. Where this attachment is robust, damage from childhood trauma is ephemeral -- where it is not, then the long term effects of trauma closely resemble those of Post Traumatic Stress Disorder (PTSD). In effect, the individual becomes 'frozen' at an infantile stage -- whence the continuation into adult life of survival strategies painfully and deeply learnt in infancy. Adult reasoning is needed to ensure contact with today's reality. Once adult survival strategies are in place, and being fully relied upon, then all symptoms of disorderly socialisation evaporate.' *James Naylor Foundation www.jnf.org.uk*

### There are various different types of personality disorders but all of them share the following features:

- Most often the first signs of a personality disorder appear in late childhood or adolescence and continue during adulthood.
- Personality disorders in children or adolescence are sometimes described as conduct disorders. However most conduct disorders in children do not necessarily lead to personality disorders in adults.
- Someone with a personality disorder holds attitudes and behaves in ways that can cause considerable problems for themselves and others. For example the way they perceive the world; the way they think; the way they relate to other people; the way they do or don't get upset.
- People diagnosed with personality disorder may be inflexible in that they may have a narrow range of attitudes, behaviours and coping mechanisms
- These ways of behaving are long standing

### Other key points

- Most people diagnosed with a personality disorder fit the criteria for at least two different types of personality disorder
- Most people diagnosed with a personality disorder are not dangerous
- Dangerousness is most often but not exclusively associated with anti-social or psychopathic disorder
- People diagnosed as borderline or paranoid personality disorder may be at higher risk of self harm and/or suicide than other people
- People with personality disorders have multiple needs and vulnerabilities'

The Mental Health Foundation factsheet 'Personality Disorders' [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

# Working with personality disorders

## Cluster A - 'the odd or eccentric' types

### Paranoid

At least three of the following 'symptoms' need to be present before a diagnosis is made.

- Extremely sensitive to experiencing failure or rejection
- Hold grudges against people and will refuse to forgive insults, injuries or slights
- Very suspicious and will often misconstrue the friendly or neutral behaviour of other people as being unfriendly or hostile. Also constantly suspicious about the fidelity of sexual partners
- A preoccupation with personal rights and a sense of these being infringed even when this is not so. Often self centred and self important
- Prone to believing in conspiracy theories about events affecting their own lives and in the world at large

### Medication –

Should not be used unless absolutely necessary as will increase suspicion and anxiety. If they are prescribed they should be used for a brief period. Anti-anxiety and anti-psychotic medication may be used where required for short periods.

### Psychotherapy –

This is the preferred option but this group will be difficult to build and maintain a relationship with. Caution support staff working with them against making rational arguments in challenging delusions as this is a 'waste of time' although they should also not reinforce delusions by 'humouring' clients.

### Schizoid

At least three of the following 'symptoms' need to be present before a diagnosis is made.

- Find pleasure in few, if any, aspects of their life
- Unemotional, seem to be cold and unfeeling and find it very difficult to express anger or warmth to other people
- Unaffected by the praise or criticism of others and noticeably insensitive to the norms and conventions held by society
- Prefer to be on their own and have little interest in relationships (including close friendships or sexual ones)
- Very introspective and preoccupied with fantasy

### Psychotherapy –

This will focus on Social Skills Training & behavioural approaches. Care should be taken in challenging delusions as with the Paranoid type and as with the Avoidant type this condition means that the client will lack social relationships and other outside support.

### Group therapy –

This may be useful but should be small and specialised.

### Medication –

Anti-psychotics may be used for transitory periods of psychosis during times of increased stress.

### Schizotypal

At least three of the following 'symptoms' need to be present before a diagnosis is made.

- Behaviour is cold and aloof and in other respects is regarded as strange and eccentric
- Experience difficulty in maintaining relationships and will tend to be socially withdrawn
- Hold unusual beliefs such as magical thinking which will influence the way they behave
- Hold ideas that are paranoid and overly suspicious
- Given to thinking obsessively about a subject without being able to let go, often this will be of a sexual or violent nature
- Unusual perceptions such as 'voices', 'visions', 'bodily experiences'. Sometimes experienced as intense 'psychotic' episodes

### Psychotherapy –

Care should be taken not to challenge delusional or inappropriate thoughts or feelings as this client type will distort reality more than the schizoid type. They will also have little social support as they cannot build relationships with others so the approach should be warm and client-centred.

### Medication –

Anti-psychotics may be used for transient psychotic episodes.

### Self-help –

Not likely to be appropriate for this group due their suspicious and paranoid symptoms.

## Cluster B - 'the dramatic, emotional or erratic types'

### Histrionic

At least three of the following 'symptoms' need to be present before a diagnosis is made.

- Given to theatricality, self dramatisation and exaggerating the expression of emotions
- Suggestible and easily influenced by others or circumstances
- A need to constantly find activities offering excitement and the opportunity to be the centre of attention and a longing to be appreciated by other people
- Over concern with physical attractiveness
- A tendency to act or appear in an inappropriately seductive way
- A tendency to be persistently manipulative to achieve what they want and to be easily hurt if obstructed.

### Psychotherapy –

It is easy to establish rapport with these clients but a contract about suicidal behaviour and self harm should be considered as this group are likely to have this behaviour. Suicidal intentions should not be ignored or dismissed. Boundaries are very important with these clients. The aim is to get the client to explore situations that are distressing to a logical conclusion and enable proportion to be gained.

### Medication –

Care should be taken with medications due to the prevalence of self-destructive behaviour and should only be given for other diagnoses.

### Self-help –

Unlikely to be of use to this client group as their social skills mean that they come across as shallow and over-dramatic.

### Narcissistic

- An obvious self-focus in interpersonal exchanges
- Problems in sustaining satisfying relationships
- A lack of psychological awareness
- Difficulty with empathy
- Problems distinguishing the self from others
- Hypersensitivity to any slights or imagined insults
- Vulnerability to shame rather than guilt
- Haughty body language
- Flatters people who admire and affirm him
- Detests those who do not admire him
- Uses other people without considering the cost of that for them
- Pretends to be more important than he is
- Brags and exaggerates his achievements
- Claims to be an 'expert' about most things
- Cannot view the world from the perspective of another person

[www.n-courage.net](http://www.n-courage.net)

"NPD is treated in talk therapy (psychodynamic or cognitive-behavioural). The prognosis for an adult narcissist is poor, though his adaptation to life and to others can improve with treatment. Medication is applied to side-effects and behaviours (such as mood or affect disorders and obsession-compulsion) - usually with some success. Narcissistic Personality Disorder (NPD) At a Glance By: Dr. Sam Vaknin Author of "Malignant Self Love - Narcissism Revisited"

"Most psychiatrists will, as a practical matter, treat most of their severely narcissistic patients for symptoms related to crises and relatively external [diagnoses], rather than in an effort to address the personality disorder itself. The therapist must be aware of the importance of narcissism to the contiguity of the patient's psyche, refrain from confronting the need for self-aggrandizement, and help the patient use his or her narcissistic tendencies to reconstitute an intact self image. Positive transference and therapeutic alliance should not be relied upon as the patient may not be able to acknowledge the real humanness of the therapist but may have to see him/her as either superhuman or devalued."

From Mental Health Net – [www.mentalhelp.net](http://www.mentalhelp.net)

### DO

- ✓ Not be offended by a clients need to antagonise by putting staff down by questioning their intelligence or importance
- ✓ Not be surprised by their insistence that only the 'top person' should be treating them or dealing with them
- ✓ 'Convey a feeling of respect and acknowledge the patient's sense of self-importance so that the patient can re-establish a coherent sense of self'
- ✓ Not reinforce pathological grandiosity or reinforce the sense of weakness they may feel on presenting with another issue

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## Cluster B

### Antisocial

At present there is no consensus as to its causes or treatment.

At least three of the following 'symptoms' need to be present before a diagnosis is made:

- Appear to be callous and unconcerned about how their behaviour makes other people feel, they do not feel guilt or profit from experience (for instance punishment).
- On the other hand will tend to blame other people for their problems or to find a way of rationalising what they have done
- Because of their disregard for social norms, rules and obligations they act in ways that are regarded as unacceptably and grossly irresponsible
- Cannot cope with a long term relationship, although forming one is not problematic
- Cannot tolerate frustration and are prone to outbursts of aggression and violence

**Psychotherapy** – As this is often imposed on this client group through the criminal justice system and rarely sought out by those who have 'non-offending' behaviour the perception is that this condition is inherently 'dangerous'. Also this leads to challenges in therapy as it is not willingly participated in. The therapist will however take a behaviour approach and seek to encourage the client to do the following:

- Draw links between feelings and behaviour
- Encourage feelings other than anger and frustration
- Acknowledge that this client may not have experienced an emotionally rewarding relationship and accept that building one may cause feelings of anxiety or depression and require a very supportive relationship with the therapist
- Accept that the morality and ethics of the client may be questionable and that challenging this issues is likely to cause mistrust from the client.

Medication may be used to treat mood swings or co-occurring issues.

**Other useful tools** –

- Outpatient care which focuses on building family relationships
- Group therapy and self help groups

**Useful resource** – A website which has been created by someone experiencing anti-social personality disorder who is campaigning against the 'dangerous' label is found at [www.asperdis.org](http://www.asperdis.org)

### Borderline

*(Information taken from the Borderline Personality Disorder Resource Center – [www.bpdresourcecenter.org](http://www.bpdresourcecenter.org) on 08/12/2003)*

'The symptoms of BPD can occur in a variety of combinations, and individuals with the disorder may have many, if not all of the following traits:

- Fears of abandonment
- Extreme mood swings
- Difficulty in relationships
- Unstable self image
- Difficulty managing emotions
- Impulsive behaviour
- Self injuring acts
- Suicidal ideation
- Transient psychotic episodes

### Co-Occuring disorders

BPD patients almost always have co-existing mental health problems that lead to an exacerbation of the patient's psychological and physical health. These most often include:

- Depression
- Substance abuse
- Eating disorders
- Anxiety disorders
- Bipolar disorder
- Antisocial personality disorder
- Narcissistic personality disorder
- Compulsive spending or gambling
- Compulsive and risky sexual behaviour
- Suicidal ideation
- Deceptiveness

### Dialectical Behaviour Therapy (DBT)

This form of treatment was devised by Marsha Linehan (1993) and is a systematic cognitive-behavioural approach to working with individuals who meet criteria for borderline personality disorder with the aim of reducing suicidal or other severe dysfunctional behaviours. The emphasis is on "dialectics" - the reconciliation of opposites in a continual process of making the individual whole. It addresses self harming behaviour, encourages acceptance and validation strategies with training in the acquisition of new skills. DBT tries to get the person to reflect on their own thoughts and feelings without the need to act upon them, and is delivered by trained therapists either one-to-one or in a group. People receiving DBT may also receive telephone support from the therapist. This is usually given for 1 to 4 hours per week and lasts for at least one year. The participants are expected to maintain a diary between sessions.

According to Linehan DBT consists of a combination of: "Concomitant weekly individual behavioural psychotherapy sessions and psycho-educational skills training groups in its treatment plan. Individual therapy focuses primarily on motivational issues, including the motivation to stay alive, and the specific session agenda is determined by the patient's behaviour since the last session. Behaviours highest on the dialectical behaviour therapy target list that are still problematic receive the most attention. Group therapy teaches self-regulation and changes skills (interpersonal, emotional-regulation skills) and self and other acceptance skills (distress tolerance, mindfulness skills). As whole, dialectical behaviour therapy blends validation and acceptance treatment strategies (similar to client-centred, Eastern and Zen psychologies, and psychodynamic approaches) with comprehensive cognitive behaviour therapy (including problem solving, contingency management, cognitive modification, exposure-based procedures and skills training)" (Linehan, M.M et al, 1994)

From [www.borderlineuk.co.uk](http://www.borderlineuk.co.uk)

Other approaches used in conjunction with DBT are telephone contact and group skills training. Often other therapies are used to treat co-occurring issues which may include medication and in-patient care.

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## Cluster C - the 'anxious and fearful' types

### Obsessive-compulsive (Ankastic)

Obsessive-Compulsive Disorder

(Information taken from the Mental Health Foundation website's factsheet on Obsessive Compulsive Disorder www.mentalhealth.org.uk on 08/12/2003)

The most common features of OCD are obsessional thoughts and compulsive behaviour. Obsessional thoughts are distressing, repetitive thoughts which you know are your own (unlike hallucinations) but cannot ignore; some people describe these as being like a 'stuck record'. Compulsions are ritual actions or mental processes which you feel you have to repeat in order to relieve anxiety and temporarily stop obsessional thoughts. For example, you may have an obsessional thought that your hands are dirty and repeatedly wash them over and over again. Obsessional thoughts and compulsive rituals can take up many hours of each day. In its most severe form OCD can prevent you from completing even simple tasks such as washing the dishes.

**Most common obsessions:** •Fear of contamination •Fear of causing harm to someone else •Fear of making a mistake •Fear of behaving unacceptably •Need for symmetry or exactness •Excessive doubt

**Most common compulsions:**

- Cleaning and washing
- Checking
- Arranging and organising
- Collecting and hoarding
- Counting and repeating

**Medication**–

Research clearly shows that the serotonin reuptake inhibitors (SRIs) are uniquely effective treatments for OCD. These medications increase the concentration of serotonin, a chemical messenger in the brain.

**Psychotherapy** –

Once a rapport has been established this client will stick regimentally to the treatment. Treatment is most often focussed on short term relief and teaching new coping strategies. The focus should be moving the client away from objective description of situations and events and enabling them to describe their feelings in those situations. Homework may be given which is to keep a feelings diary in order to help progress in therapy. In-patient care is very rare and only needed in a crisis where the client's obsessions are aggravated by a situation to the point where they are unable to get out of bed or eat etc. It is usually not helpful in other situations.

**Self-help** –

This can be a useful tool for those affected by this disorder.

### Avoidant

At least three of the following 'symptoms' need to be present before a diagnosis is made.

- Persistent and pervasive feelings of shyness, insecurity, apprehension and tension leading to restrictions in lifestyle
- Believing oneself to be unlikeable, undeserving, socially inept, and less important than other people leading to a reluctance to get involved in relationships unless certain of being liked
- Over-concerned by the fear of being criticised or rejected in social or work situations leading to an avoidance of any activity that involves having to inter-relate with other people

**Medication** – Only if required through a concurrent condition otherwise where 'avoidance is situational' it will interfere with psychotherapy.

**Psychotherapy** –

- ✓ Do look for non-verbal clues during evaluation sessions
- ✓ Expect an early termination from individual's experiencing this form of disorder and take special care to prevent this by establishing rapport
- ✓ Be cautious about exploring new material as this may cause drop out from sessions
- ✓ Aim to make this a short and targeted intervention

**Group therapy** – Unlikely to be helpful as this type will not respond well to social situations

**Other useful tools** –

- ✓ Relaxation tapes and techniques in order that the individual can manage their own anxiety and stress
- ✓ Aromatherapy

### Dependent

At least three of the following 'symptoms' need to be present before a diagnosis is made.

- Encouraging or allowing others to make important life decisions and a limited ability to make every day decisions unless given excessive reassurance and advice
- Unwilling to make demands on people, especially those people who play an important part in their life and by doing so becoming compliant and subordinate to other people's wishes
- Feelings of helplessness and discomfort when alone and anxiety about being abandoned by loved ones due to fears of being unable to care for themselves.

**Medication** – only to treat other co-occurring issues. Medication should be prescribed with caution to this group as they will become dependent on the 'use of medication'.

**Psychotherapy** – This is the recommended treatment but should be short term and focussed as this group will quickly become over dependant on the therapist. The therapist must carefully manage the exit of these clients as they can feel extremely anxious or depressed if they haven't jointly discussed and agreed the exit date.

Clear boundaries from the outset are essential for working with this group.

Other useful tools: ✓ Assertiveness training ✓ Behavioural approaches  
✓ Relaxation techniques in order that the individual can manage their own anxiety and stress ✓ Support groups (after psychotherapy)

(Unless otherwise cited information used in the table on symptoms taken from the Mental Health Foundation website www.mentalhealth.org.uk on 08/12/2003 and treatment from the Mental Health Help website www.mentalhelp.net on 08/12/2003, the information has been summarised)

**RESOURCES:**

**The Mental Health Foundation**

This is an excellent website featuring factsheets and signposting to further resources. It can be found at [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

**Mental Health Help**

This is an American website which is continually updated and is an excellent resource for the professional working in the field of mental health care. It has many useful features which benefit the Health Care worker to the psychiatrist and would be of interest to service users. [www.mentalhelp.net](http://www.mentalhelp.net)

**Borderline UK**

This is currently in development and already contains a variety of useful information. This resource has been set up by service users and carers in the UK and is set to become the premier resource for those working with or experiencing Borderline Personality Disorder. The web address is [www.borderlineuk.co.uk](http://www.borderlineuk.co.uk)

**n-Courage**

This website is of limited help to those experiencing Narcissistic personality disorder as it like many websites around Anti-Social personality disorder is focussed around the 'victims' of those who may have a personality disorder. However there is some interesting material on the site. [www.n-courage.net](http://www.n-courage.net)

**OCD Action**

This site provides resources specifically targeted at those experiencing OCD and provides advice, information and support. [www.ocdaction.org.uk](http://www.ocdaction.org.uk)

**NIMHE**

'Personality disorder: no longer a diagnosis of exclusion' and the Capabilities framework for working with Personality Disorders 'Breaking the cycle of rejection' can be found at [www.nimhe.org.uk](http://www.nimhe.org.uk) or NIMHE, Blenheim House, West One, Duncombe Street, Leeds, LS1 4PL. Tel: 0113 254 3811

**VHG Training Courses related to this subject:**

*Working with People that self-injure.*  
19th May 2004 Venue – Norwich.

*Developing Professional Boundaries.*  
30th June 2004 Venue – Norwich.

*Working with Psychosis.*  
8th September 2004 Venue – Norwich.

*Cognitive behavioural therapy.*  
24th November 2004 Venue – Norwich.

All courses cost £75 (VHG Members) or £125 (Non members). All courses are one day and the price includes lunch.

For information or to book on these training courses please contact Anne Stolworthy on 01603 617299 or by email [anne@vhg-east.org](mailto:anne@vhg-east.org)

**VHG**

**1st Floor 36 St. Giles Street  
Norwich NR2 1LL  
tel: 01603 617299  
fax: 01603 621521  
Email [vhg-east@tiscali.co.uk](mailto:vhg-east@tiscali.co.uk)  
Web <http://www.vhg-east.org>**

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**Understanding issues faced by people who have a personality disorder**

**Self harming behaviour**

This is most commonly seen as 'nuisance' or 'attention-seeking behaviour' which is extremely unhelpful to those who feel compelled to do this. In fact it can accompany many personality disorders. Self harming behaviour can be upsetting to witness in a professional role and difficult to tackle. If faced with this behaviour the professional should remain calm, non-judgemental and 'matter of fact'. The approach taken should be one of 'harm minimisation'. Ensure that the individual has access to sterile wipes and bandages if required. If cuts are deep, medical attention should be sought and this again should be approached in a calm, supportive manner. Cutting does hurt and is dangerous – if your client is compelled to cut (which may be a means of shutting out voices etc) then they need to try not to make deep cuts and to ensure that the materials they use are clean and sterile.

**DO**

- ✓ Ensure that you remain calm and non-judgemental so that your client does not feel that they must hide this behaviour from you although it would not be appropriate for them to do this in communal areas as it may cause distress to others
- ✓ Ensure that the individual has access to sterile wipes etc to prevent infection
- ✓ If cuts are deep then ensure that the individual has access to appropriate medical treatment
- ✓ Encourage the individual to be in control of this behaviour themselves rather than directly prevent self harm by, for example, hiding any implements which can be used. (nb. This is distinct from suicidal behaviour)
- ✓ Do not assume that this is 'a cry for help' or 'attention seeking' – this behaviour can be a compulsion and/or be used as a coping mechanism

**Depersonalisation**

Depersonalisation is the state in which an individual feels 'unreal' or detached from himself. This can include:

- Feelings of watching oneself from a distance (akin to an 'out of body experience')
- Feelings as if one were in a dream
- Feeling that one's voice or movements are not under one's control
- Inability to experience feelings
- Inability to experience emotions 'normally' – which may lead to difficulties in daily living

Depersonalisation can be experienced by normies. For example, following sleep deprivation, during meditation or transiently under stress. Depersonalisation can also be induced by alcohol, Cannabis and other mind-altering substances. In the world of mental health, depersonalisation is seen both as a symptom of psychiatric disorder and as an illness in its own right. Depersonalisation has been seen to occur in most well-known psychiatric conditions (e.g. depression, panic attacks etc) but has also been seen to occur on its own. In the latter scenario, it is referred to as 'Primary Depersonalisation Disorder.'

From *Borderline UK* – [www.borderlineuk.co.uk](http://www.borderlineuk.co.uk)

**Using Aromatherapy to help Mental Health Related Difficulties**

CONDITION	ESSENTIAL OIL(S)	APPLICATION METHOD
Anxiety / Nervous Tension	Chamomile, Clary Sage, Juniper, Lavender, Neroli, Rosemary, Ylang Ylang	Bath, Burner, Massage
Stress	Geranium, Jasmine, Lavender, Marjoram, Ylang Ylang	Bath, Burner, Massage
Lack of Emotional Strength	Basil, Rosemary, Peppermint, Lemon	Massage
Insomnia	Chamomile, Lavender, Rose, Sandalwood	Bath, Burner, Massage
Depression (Irritable / Restless)	Clary Sage, Sandalwood, Ylang Ylang	All esp. Massage
Depression (Withdrawn / Lethargic)	Lime, Bergamot, Mandarin	All esp. Massage
Addiction (s)	Black Pepper	Massage
No Appetite	Aniseed, Garlic, Ginger, Orange	Massage
Excessive Appetite	Fennel, Patchouli, Rosemary	Massage
Mental Fatigue	Citronella, Grapefruit, Peppermint, Rosemary	Bath, Burner, Massage
Bad Memory / Poor Concentration	Lemon, Rosemary	Burner
Anger	Ylang Ylang	Burner, Massage
Grief	Melissa	Burner
Boredom	Lemongrass	Burner

