Dangerous and Severe Personality Disorder

Response and role of the psychiatric team

Len Bowers

London and New York

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People with personality disorders are to be found in all branches of psychiatric services, as outpatients, as acute inpatients, and in the community. Their behaviour can be manipulative and threatening and they are hard to manage in institutional settings. *Dangerous and Severe Personality Disorder* is based on a unique research study conducted in the three English High Security Hospitals-Ashworth, Rampton and Broadmoor. Through in-depth analysis of an extensive questionnaire survey followed by personal interviews, Len Bowers shows how positive or negative attitudes to PD patients arise and are maintained over time, discusses what impact these attitudes have upon nurses and the care they provide to patients, and draws some practical conclusions.

The difficulties facing staff who care for and treat PD patients are enormous and constitute a significant personal challenge for the psychiatric professional of any discipline. For the first time this book provides details of the most effective ways of creating a positive context for working with Personality Disorder and offers a blueprint for training and organizational structures across the professional spectrum.

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To Jessica, Sam and George

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work in the High Security Psychiatric Hospitals. In caring for people who have committed serious crimes, they embody and express some of the highest values of our civilisation and culture. The work they do is atrociously difficult, demanding and psychologically pressurised. I have the deepest respect for all of them, even those that fail in their task. They do not receive one-tenth of the public respect and sympathy they deserve. In many ways what I have to present in this book is a summary of their wisdom, experience and knowledge. Without their support and cooperation, there would have been no book at all. The work is therefore largely theirs, and I hope that they feel that I have gone some way towards explaining what it is really like to do the work they do.

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‘Welcome to the world of PD’

‘Welcome to the world of PD.’ This greeting, offered by one of the nurses I interviewed in an English High Security Psychiatric Hospital, speaks volumes about the chasm that lies between our own everyday lives and that of people suffering from a personality disorder (PD). In that world, actions do not necessarily have the same meaning and consequences, even when they appear to do so. PD patients look the same, talk the same, and in many if not most situations act the same. Yet regularly and periodically they act in ways that demonstrate that they inhabit an entirely different psychological and social world, one where our normal rules for understanding and morally judging behaviour simply do not count. Unlike those who suffer from psychoses, they largely do not have strange beliefs, nor do they hallucinate, hear voices or become disorganised and agitated in their thoughts and actions. However, their view of society and of us is just as perverse, and just as different, if not as obviously evident or visible.

Although the High Security Psychiatric Hospitals are surrounded by high walls and intensive security, those who work there are constantly under the microscope of governmental and public scmtiny. The smallest action can result in critical newspaper headlines. Many of the patients incarcerated there have committed such horrendous crimes that their names are notorious, and familiar to everyone who watches television or reads newspapers. Over the past 30 years a series of high-profile public inquiries has been conducted into these settings and, in addition, industrial action has been taken by the Prison Officers Association—a Trade Union to which many of the nurses belong. Psychiatric nurses working in the hospitals have been accused of meting out harsh treatment to patients and of being overly security conscious. In recent years they have also been accused of the opposite—of not being conscious enough of security and being too soft towards the patients. To be a service manager in this setting is to be vulnerable to the accusation, on the occurrence of any untoward event, of having failed. One way or another, many nurses have lost their careers by working there. A host of concealed dangers and traps thus surround those who deliver nursing care in this setting.

This book describes a research study conducted in the three English High Security Hospitals during 1998–1999. At every level of psychiatric services, from the outpatient clinic to the forensic services, PD patients are an acknowledged problem. Their behaviour is difficult, obnoxious, threatening, and they are hard to manage in institutional settings. It is not easy (indeed sometimes impossible) to engage them in psychiatric treatment over a sustained period of time. Even if one is successful, the outcome of treatment is uncertain. When at large in the community they cause problems for others through their antisocial and irresponsible conduct. Their incessant and contradictory demands upon health service resources (e.g. through repetitive suicidal gestures like overdoses) evoke negative reactions from all professions. Some psychiatric staff reject them completely,

seeing them as ‘psychological vampires’ fully responsible for their behaviour, and appropriate cases for punishment rather than treatment. Yet if held in prison, their behaviour remains disordered. Even in that setting they are difficult to manage, and though recognizably mentally disturbed their transfer to psychiatric care is, in most cases, impossible. Generally speaking, they are people no one wants.

There are, nevertheless, psychiatric nurses who manage to maintain a positive attitude to working with PD patients, viewing them as ‘misunderstood misfits’, even at the level of PD pathology to be found in those detained within the High Security Hospitals. My study set out to discover what was different about those nurses. How did they manage to sustain a positive approach in the face of the challenges presented by these hostile, obstreperous, demanding and challenging patients? In the course of that study a great deal was learned about the ways in which it is possible to view, understand, conceptualize and respond to personality disordered people who have committed serious crimes. This book is about those findings.

However, it is first necessary to provide some background about personality disorder itself, what it is, what might be its causes, what types of treatment are used, etc. This chapter will provide that information, while the second will describe in a little more detail the research that was conducted. Thereafter the book will be a presentation of, and reflection on, the results.

The provision of a ‘state of the art’ explanation of PD is by no means easy, as this is an area of psychiatry in which there are many hotly contested debates and arguments. Even the term ‘personality disorder’ itself is not uniformly used, with the same group of patients (or different subgroups of them) sometimes being called psychopaths or sociopaths. Notwithstanding these disputes, the remainder of this chapter seeks to provide a relatively simple and accessible overview of the psychiatry of PD.

The nature of PD

Perhaps the only thing about personality disorder on which every written authority agrees is that nobody comprehensively knows what it is, which makes my task of describing it quite difficult. There are many competing systems available to describe and categorise PD. Some are based on particular theories about its nature and cause—for example, psychologists who follow trait models of personality use statistically determined models, whereas those from a psychoanalytic background use the theoretical apparatus initially defined by Freud. Other classification attempts have been made by seeking cross-disciplinary consensus on schemes for categorizing those who already receive psychiatric help in one form or another. The two largest of these exercises are the *Diagnostic and Statistical Manual of Mental Disorders* (currently in its fourth edition—DSM-IV) produced by the American Psychiatric Association (1995) and the *International Classification of Diseases* (currently in its tenth edition—ICD-10) produced by the World Health Organization (1989). Although these dominate both debate and clinical practice, the schemes for the definition and classification of personality disorder that they contain are not the same. In fact both attract support and attack in equal measure, with occasional traces of fraying psychiatric temper visible in the literature and at conference debates.

Such is the degree of dissension aroused by the diagnosis of PD that it is hard to come to any conclusion other than the whole thing is a terrible mess. New trait psychology terms are introduced and overlap with older, psychoanalytically based psychodynamic models. Descriptive words are used which, although the same (e.g. 'borderline'), can refer to quite different collections of attributes when used by different authors from different traditions. To add more complexity, people with other mental disorders, for example schizophrenia, sometimes also suffer from a personality disorder, while the lifestyle of the PD patient generates stress and dysphoria to the extent of precipitating a mood disorder like depression. Many people with a PD use or abuse drugs, or become addicted through reckless experimentation, leading to additional psychiatric and practical problems. Not only that, but the boundary between PD and other mental disorders is fuzzy, in that many of those suffering from PD also suffer, far more commonly than would be expected through chance, from other mental disorders, e.g. phobias, anxiety, mood disorders and schizophrenia. In the latter case the boundary is even more obscure because some PD sufferers seem to slip transiently in and out of a psychotic state, or acquire false beliefs of a delusional intensity. All efforts at categorizing PD tend to have poor reliability when put to the test. Different schemes describe overlapping, but different, populations. Nevertheless, people with PD exist, suffer, definitely cause problems for others, and occasionally commit serious crimes.

A further element of confusion has been added in the UK by the Mental Health legislation in operation (at the time of writing). The legislation allows courts to detain an offender in a psychiatric hospital under the category of 'psychopath'. As such disposal decisions are made by courts only partly on the basis of properly conducted psychiatric assessments, not all of those legally detained as 'psychopaths' actually suffer from that condition but may, instead, have other psychiatric conditions. In this book we are concerned with those who fit the clinical rather than the legal category of psychopath/personality disorder.

Despite this controversy, the DSM-IV and ICD-10 exercises in psychiatric classification offer a good way to enter the topic and at least begin to describe what people with PD are like as people. To aid me in doing so, I shall use the DSM-IV system, solely on the grounds that it is the one that I personally find easier to describe.

People with a personality disorder are different. They differ in the way that they think, feel, relate to others, and contain (or fail to contain) their impulses. These differences are quite specific in form, dissimilar to other mental disorders such as schizophrenia or depression, and are described in more detail below under the different categories of PD. However, on meeting a person with a PD these differences are not immediately apparent. It might be necessary to spend some time with such patients, know them for a while, ask the right questions or have available reports from others, in order to determine that someone has a PD. Nevertheless, depending on the severity of the condition, it will become apparent quite quickly, for PD leads to distress for the sufferers, or more frequently for those around them who find their behaviour difficult to tolerate. People with a PD thus have poor relationships with others, difficulties at work, etc., and can be severely psychologically and socially disabled. Although those around the PD person may readily recognize that he or she has a problem, the individual does not always accept this. The ways in which PD people act are pervasive and stable over time. In other words,

they behave in accord with their disorder in all settings (home, work, socially) and at all times (generally speaking, throughout their adult lives), not just when under stress, or when depressed, or when intoxicated. The ten types of PD listed in the DSM-IV are detailed below.

Antisocial

These PD sufferers care little for the rights or needs of others: thus they are exploitative, manipulative and deceitful to their own benefit. They do not respect the law which they may, through violence or fraud, break at will. They may be impulsive, taking sudden major decisions such as changing employment, relationships, or residence, without thinking through the consequences. Their behaviour is irresponsible and uncontrolled, and they engage in high-risk behaviours without concern for themselves or others (e.g. drunk driving, unprotected sex). Because of their reckless behaviour they find it hard to keep a job, and repeatedly default on social responsibilities—for example, childcare, child support, financial debts. After the event they are not remorseful for their acts, but rationalize them or blame others, including the victims of their crimes.

Avoidant

Those with this type of PD are hypersensitive to criticism, subject to feelings of inadequacy, and find social interaction difficult. They avoid activities where they might experience disapproval or rejection by others, and thus have a restricted range of friends and acquaintances. Even with them they may find it difficult to be intimate, as they fear being shamed or laughed at to an excessive degree. Their emotional response even to very minor criticism, or what they perceive as subtle signs of ridicule, is disproportionately large. They believe themselves to be inferior to others, and in order to feel safe and secure may live a restricted, isolated lifestyle.

Borderline

These people endure unstable emotions, a changeable image of themselves, and impulsiveness. In consequence, their relationships are also fragile and changeable, as the borderline individual swings suddenly between an idealized and a devalued picture of the other. They fear rejection, and respond with extreme emotions to the slightest hint that such a rejection is about to occur. They do not appear to know who they are, and may make sudden changes to their sexual orientation, value system, goals in life, ambitions, etc. Prone to reckless and irresponsible behaviour, they may mutilate themselves or make repeated impulsive suicidal gestures. Such behaviour can occur in the presence of extreme unpleasant emotions (e.g. anger, fear, despair), and, when angry, they may have difficulty in self-control, engaging in outbursts of bitterness, sarcasm or verbal abuse.

Dependent

These sufferers from PD have an excessively strong need for the support and

encouragement of others, without which they feel unable to function. Even for trivial decisions they feel they need advice and reassurance from others. Thus they depend upon others to take decisions for them, even major life decisions, and remain passive, allowing themselves to be led. Because their need for others is so strong, they have difficulty is disagreeing or arguing with them (even when circumstances justify anger), as they feel that any conflict risks a withdrawal of the support upon which they are so dependent. They will submit to unpleasant tasks, or even violent or sexual abuse, in order to sustain a relationship upon which they are dependent. The loss of a major supportive relationship will precipitate a desperate and haphazard search for a replacement.

Histrionic

These people are characterized by attention-seeking behaviour and the exhibition of strong emotions. They are charming and like to be the centre of attention in any group. In order to achieve this they behave dramatically, talk theatrically, dress outrageously or in an exaggerated fashion, or act in a sexually provocative or seductive manner. They are easily influenced by others, emotionally taking on board opinions that are strongly expressed, rather than being persuaded through rational argument. Relationships therefore tend to be shallow and changeable.

Narcissistic

Sufferers of this type of PD think very highly of themselves, need (and feel they deserve) a great deal of admiration, and lack empathy with others. They exaggerate their own accomplishments and denigrate the activities or contributions of others, while fantasizing about their own successful achievements or other superior qualities. They seek to associate themselves with people who they see as being of high status, and feel entitled to (and expect) special treatment. Although strongly asserted, their sense of self-importance is, at its core, very fragile. Therefore when others fail to accommodate them, or give due praise or privilege, they may become upset and angry. Also, because they pay no attention to the needs of others, they may behave in a hurtful, exploitative or manipulative fashion.

Obsessive-compulsive

Sufferers from this condition strive for perfectionism at the cost of efficiency. They achieve a sense of control over events through careful attention to rules, details and procedures, but get so engrossed in those things that they may be unable to complete the task they are undertaking. They also set high standards for themselves, sometimes so high that the end result is, again, failure to complete the task in hand through constant changes to the final product. They are devoted to work, and have difficulty taking time off and relaxing, and even when they do, any leisure task is turned into something to be worked at and perfected. They may be highly moral people, following a strict and rigid code of conduct, and may be hypercritical of their own mistakes. They may hoard useless objects in order to ensure that nothing is wasted, be miserly with their economic resources, and

find it difficult to delegate tasks or work with others.

Paranoid

These people are mistrustful and suspicious of others. Even in the absence of evidence, they suspect that others harbour harmful plans or intentions towards them. To this end they interpret the behaviour of others as hostile even when it is not. The slightest sign that others are not fully trustworthy is taken as an indication that they are never trustworthy. They are unforgiving of mistakes or slights, imaginary or real, and remain angry for long periods. They may fight back against their originators engaging in attacks which, to the victim, may be unexpected because in reality there has been no insult. Because they lack essential trust in others they do not confide, and find it hard to develop sustained intimate relationships. They are also prone to pathological jealousy over the fidelity of their partner, without any real justification.

Schizoid

Sufferers from this condition are loners who have little interest in social interaction. By their own preference they have few or no friends or confidants, and choose solitary activities of a mechanical nature, rather than those that require company or cooperation. They do not seem to get any, or as much, pleasure as normal people from sensory or interpersonal experiences, and have little interest in sex. They care little what others think of them and are generally socially unresponsive or possibly inept, perhaps appearing to be superficial or self-absorbed.

Schizotypal

These people are very uncomfortable in social situations and eccentric in their behaviour. They may see disconnected events in the world, large or small, local or international, as possessing some unusual meaning, specifically for them. They may be superstitious, or feel that they have paranormal powers or can read others' thoughts, and may engage in informal magical rituals in efforts to produce a desired outcome. Their perceptions may be distorted, and their speech content may be vague or difficult to understand. Because of this, others may consider them odd, social interaction is not smooth, and contact with others may breed anxiety. They have few or no friends, and may also be suspicious of others.

Consequences

It can readily be seen that having a personality disorder is not life enhancing. Sufferers may cause difficulties for others or, in extreme cases, commit serious crimes, but they are unable to live full, productive lives. In the main they find it difficult to sustain positive intimate relationships with others, whether those be friends or partners. They find it difficult to work, or are at best restricted to a range of occupational slots that fit their