Forensic Mental Health Nursing

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The author and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

Forensic Mental Health Nursing

Interventions with People with 'Personality Disorder'

Edited by the

National Forensic Nurses' Research and Development Group

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Chapter reviews by Mary Addo, Anne Aiyegbusi, Michael Coffey, Mick Collins, Mike Doyle, Gavin Garman and Carol Watson

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CHAPTER 1

Introduction

Richard Byrt and Phil Woods

Introduction

Welcome to this book on nursing interventions with individuals with personality disorder diagnoses. We hope that you will find it useful, enjoyable to read, and, above all, relevant to your own work and/or other experience with individuals with personality disorders. This book emerged from one of the National Forensic Nurses' Research and Development Group meetings, through what is often the central focus of these: how can we as a Group contribute to the development of forensic nursing and more widely mental health nursing? A seed was planted and this book was born!

As many of the authors in this book point out, people with personality disorders have had a rough deal from some mental health services, and have often been written off as 'untreatable' and perceived negatively by nurses and other professionals (National Institute for Mental Health in England, 2003). There has been a lack of adequate pre- and post-registration education for working with individuals with personality disorders. In addition, there has been a dearth of support and clinical supervision for staff (Bowers, 2002); and until recently, a limited amount of literature to relate to nursing practice. In particular, there has been a lack of research-based evidence to inform specific interventions (Woods and Richards, 2003).

This book aims to fill a gap in the literature. A pioneering text (Barnes, 1968) considered the nurse's role in working with individuals with personality disorders in therapeutic communities; and several generic and forensic mental health nursing texts include chapters on relevant nursing interventions (for example Houghton and Ousley, 2004; Parsons, 2003; Schafer, 2002; Woods, 2001). However, as far as we know, our book is the first to consider a wide range of nursing interventions with people with personality disorders, and to explore related issues.

This introductory chapter will provide a brief introduction to the concept of 'personality disorder' and to the main themes considered in the book.

The concept of personality

Personality has been defined as: 'The distinctive and characteristic patterns of thought, emotion and behaviour that define an individual's personal style of interacting with the physical and social environment' (Smith *et al*., 2003, p. 705). Since at least the 5th century BC, the literature of many cultures has indicated a fascination with personality and its effects on individuals' behaviours and relationships (Wells and Cowen Orlin, 2003). Livesley (2001, p. 7) comments on the proliferation of definitions of 'personality' used by psychologists. He concludes:

> ... However, a consensus exists about the essential elements of personality, and an *understanding of these elements clarifies our ideas about personality disorder*. First, the term refers to regularities and consistencies in behaviour and forms of experience .... It does not pertain to occasional behaviours, but, rather, to *behaviours that recur across situations and occasions. Personality also refers to consistencies in thinking, perceiving and feeling...* [Emphasis added]

What is 'personality disorder'?

This question is explored in much of this book. By way of introduction, the following points will be made:

- Personality disorder is used as a *diagnostic category*, for example in the International Classification of Diseases (ICD-10) (World Health Organization, 1992) and the Diagnostic Statistical Manual (DSM-IV) (American Psychiatric Association, 1994). As is indicated in several chapters of this book, and in much of the literature (Byrt *et al*., 2005), some professionals have used diagnoses of specific personality disorders to inform treatment and nursing and other interventions.
- However, sadly, 'personality disorder' has sometimes been used as a *negative label* and a *pejorative judgement*, applied to someone whose behaviours professionals find hard to understand or to like; and who does not appear to respond to attempts to help or to treat (Dolan and Coid, 1993).
- Several authors have reported that *negative professional attitudes* towards individuals with personality disorder cause them considerable problems. The latter add to the difficulties caused by the personality disorder itself, and often exacerbate the traumatic experiences that may have contributed to its development (Castillo, 2003).
- Several authors refer to *controversies about the nature and meaning* of personality disorder. Some critics have commented on the *lack of scientific validity or reliability* of this diagnostic category (Bowers, 2002; Magnavita, 2004; Pilgrim, 2001). ('Validity ... refers to the degree to which an instrument measures what it is supposed to be measuring, while reliability refers to the degree of consistency or accuracy with which the instrument (used under similar conditions) measures the attribute under investigation'; Carter and Porter, 2000, p. 29). In the case

of personality disorder, the 'instrument' is a list of characteristics or signs and symptoms specific to particular personality disorders, as outlined in the International Classification of Diseases (ICD-10) (World Health Organization, 1992) or the Diagnostic Statistical Manual (DSM-IV) (American Psychiatric Association, 1994).

The following points are based particularly on the writings of psychiatrists and psychologists, and are reflected in work by some mental health nurses (Bennett, 2003; Bowers, 2002; Paris, 2004; Perlin, 2001; Tyrer, 2000).

- Compared with most people in their cultural and social groups, individuals with personality disorders are described as having particularly *fixed, rigid and habitual* (i.e. frequent and repetitious) *patterns of behaviour, thinking and ways of responding to situations*.
- Personality disorder usually results in *(often considerable) distress* to individuals with this diagnosis, and sometimes, to other people. The personality disorder *adversely affects aspects of the individual's life*, such as his/her close relationships, ability to trust or relate to people, feelings of satisfaction with life, and desired educational, work and other achievements.
- Individuals with personality disorders *generally lack coping strategies to respond to stress in creative ways* that do not cause harm to themselves and/or others. However, the extent that different personality traits and ways of coping are 'adaptive or nonadaptive' *depends on the individual's culture* (Paris, 2004, p. 139).
- In general, people with personality disorders do not have signs and symptoms of mental illness as part of the personality disorder. However, some individuals can have *both* a personality disorder *and* a mental illness and/or problems related to alcohol and/or other drugs. This is referred to as a *dual (or even a triple) diagnosis*. (The care of individuals with personality disorder and alcohol/other drug problems is considered in Chapter 13).

What causes personality disorder?

This is probably the $1,000,000 question, and if health professionals had the answer, perhaps we would not need to publish this book. The actual causes of personality disorder are unclear from the literature, but research is continually progressing in this area and some clear indicators have emerged. A useful summary is given in Gelder *et al*. (2001), and by Bennett (2003). These authors refer to the following factors:

- **Genetic**: Studies of twins reared apart suggest that antisocial personality disorder (but not other types of personality disorder) has a genetic component (Gelder *et al.*, 2001).
- **Cerebral functioning**: Electroencephalogram (EEG) abnormalities have been found in some individuals with antisocial personality disorder, but Gelder *et al*. (2003, p. 176) conclude that the evidence for such abnormalities 'causing' antisocial personality disorder is 'weak'.
- **Low levels of brain 5-hydroxytryptamine (5-HT) neurotransmission** 'have been reported in patients with impulsive and aggressive behaviour. It has been suggested that the same abnormalities may be relevant to antisocial personality disorder' (Gelder *et al*. 2001, p. 176).

However, Gelder *et al*. also suggest that the evidence for this is limited. 5-hydroxytryptamine (5-HT) is a neurotransmitter: a chemical message passing from one neuron (nerve cell) to another (Gray and Bressington, 2004). This neurotransmitter appears to be involved in impulsivity and aggression and their expression (Gelder *et al*., 2001).

- **Serious neglect and/or physical, sexual and emotional abuse in childhood** has been found in many individuals with personality disorders, especially those with borderline personality disorder and antisocial personality disorder (Bennett, 2003).
- **Considerable conflict in relationships with parents and other significant people** has been suggested as important in some people with personality disorders (Bateman and Fonagy, 2004).
- **'Failure to learn normal social behaviour'** (Gelder *et al*., 2001, p. 176) or to learn the benefits of antisocial behaviours has been postulated as a causative factor in antisocial personality disorder.
- **'Attachment theory'** postulates that the features of personality disorder, and the associated distress, are caused, at least in part, by a lack of 'attachments' with parents or other adults in parental roles (Jeffcote and Travers, 2004, p. 24f):

  > ...When a child's caregivers do not respond to her [or his] anxiety, or respond with rejection, anger or fear, or abuse her [or him] physically or sexually, she [/he] must find ways of surviving and achieving some sort of safety as best she [/he] can. This may mean shutting overwhelming or unacceptable experiences and feelings out of consciousness, heightening her[/his] own attachment behaviour to obtain some attention, even if it is punitive or aggressive attention... [Because of the individual's early experiences], the idea of any continuity [consistency] in others' behaviour may be lacking altogether, or 'caring' relationships may only be understood as exploitative and abusive...

- **Response to trauma** has been postulated as contributing to the behaviours and reactions of some individuals with personality disorders, particularly borderline personality disorder. Some authorities have likened borderline personality disorder, in particular, to post-traumatic stress disorder. Trauma is often associated, in individuals with personality disorder, with childhood neglect, abuse and lack of attachment (Castillo, 2003) (see Chapter 6 of this book).
- **Spiritual factors**, such as a loss of hope, purpose or meaning may both result from, and contribute to the effects of personality disorder. Spiritual factors in relation to individuals with personality disorder do not appear to have been widely considered in the literature (see Chapter 5 of this book).
- **Sociological explanations: stigmatisation, labelling, negative discrimination and social exclusion**. Finally, some sociologists consider that the problems faced by individuals with personality disorder are related, at least in part, to the attitudes of other people (e.g. those in wider society, or held by some professionals). These attitudes may result in *stigmatisation* and *labelling*, where the individual is seen as different, inferior and perceived to have negative attributes (e.g. everything he or she does may be judged to be 'manipulative'). Some people with personality disorders also face *negative discrimination* and *social exclusion* (lack of access to opportunities that most of us have; Sayce, 2000). These issues are discussed in Chapter 4. Stigmatisation, labelling, negative discrimination and social exclusion may occur particularly in individuals with personality disorder from minority ethnic groups or who are lesbian, gay, bisexual or transsexual (see Chapters 5 and 8).

Topics covered in this book

In **Chapter 2**, Phil Woods considers the *types of personality disorders* outlined in the International Classification of Diseases (ICD-10) (World Health Organization, 1992) and the Diagnostic Statistical Manual (DSM-IV) (American Psychiatric Association, 1994). Phil also considers aspects of *assessment* and the differences and similarities between 'personality disorder' and 'psychopathic disorder'. He concludes with a consideration of the components of 'effective treatment' (p. 16) for individuals with personality disorders.

Chapter 3 includes Richard Byrt's consideration of the *social consequences* of a 'personality disorder' diagnosis and the effects of specific personality disorders on individuals. A brief account of the history of 'personality disorder' is followed by a consideration, with a contribution by Jim Dooher, of *social and political attitudes* towards people with personality disorders, with reference to media presentations (mostly related to images of violence) and the 'dangerous and severe personality disorder' programme.

Chapter 4 considers *service users' views* and *professional attitudes*, both positive and negative. These topics are explored through the perspectives of three people with service user experience (Rachel Studley, 'R' and Roberta Graley-Wetherell); and contributors with professional (Karen D'Silva) or student nurse (Linnette James and Tom Pocock) experience. This chapter includes two poems by Linnette and Tom; and a review, by Richard Byrt, of relevant research and of websites and organisations for individuals with personality disorder and their informal carers. This chapter, and other parts of the book, indicate the importance of positive professional attitudes.

In **Chapter 5**, Mary Addo gives a detailed account of the *spiritual and cultural needs* of people with personality disorders. She points out that individuals with a personality disorder often experience a lack of hope and meaning. Mary considers the nature of spirituality; and the role of the nurse in meeting the individual's spiritual and cultural needs. She refers to the importance of 'cultural competence' and 'cultural awareness, knowledge and sensitivity' (p. 69), and considers related *ethical issues*.

In **Chapter 6**, Anne Aiyegbusi discusses the '*emotional impact* of working with people with personality disorders' (p. 81) in relation to the problems that many of these individuals have experienced in past relationships. Anne explains that early abusive experiences can become replicated in relationships with staff, whom the individual has difficulty in trusting. Despite the individual's need for understanding, professionals may respond with negative attitudes and exclusion from services.

Carol Watson and Alyson McGregor Kettles, in **Chapter 7**, comment on the lack of relevant *staff education, training and support*, a point made by other contributors. Carol and Alyson refer to the need for primary healthcare professionals and 'service planners and managers' (p. 93), as well as mental health nurses, to receive appropriate education and supervision to reduce 'staff burnout and low morale' (p. 93). Education, rather than focusing on narrow competencies, should enable staff to examine attitudes and appreciate service users' perspectives in relation to 'complex legal, ethical and interpersonal... issues' (p. 94).

Gender and sexuality issues are considered in **Chapter 8** by Anne Aiyegbusi and Richard Byrt. This chapter highlights the need for nurses to be sensitive to the specific needs of women with personality disorders, in relation to their frequent experiences of early trauma. Individuals' psychosexual needs and deprivations are considered. The chapter concludes with a review

of nursing interventions with people with personality disorder who are gay, lesbian, bisexual or transsexual; and a need for awareness of the discrimination that many of these individuals have experienced.

In **Chapter 9**, Michael Coffey reminds us that many individuals with personality disorders receive care from generic mental health teams. Michael considers how research findings on *community interventions* with individuals with mental illness can be applied to the care of service users with personality disorders. Relevant principles include establishing a therapeutic alliance, trust, respect and engagement. The chapter concludes with a consideration of the need to engender hope through effective social support, enabling 'problem-solving behaviours' (p. 127) and risk assessment and risk management.

Mike Doyle and David Duffy point out that '*risk assessment and risk management* are key components of clinical practice' (**Chapter 10**, p. 135). Mike gives a detailed review of instruments to measure psychopathy and the risk of harm to others. He includes a critical consideration of the reliability and 'predictive validity' (p. 139) of various measures. David considers self harm as an 'expression of personal distress' (p. 143) in relation to assessments which seek to appreciate individuals' perspectives, previous experiences and meanings. The chapter concludes with an account of Mike Doyle's (1998) risk management cycle.

In **Chapter 11**, Mick Collins, Steffan Davies and Chris Ashwell consider *assessment of security need*. They stress the importance of maintaining safe environments to ensure that other nursing interventions and treatment are effective, and the need for levels of security proportionate to the individual's assessed risk. However, there are wide variations in aspects of security across supposedly similar services. Physical, procedural and relational security are outlined. The chapter concludes with a description of Mick Collins' and Steffan Davies' (2001) Security Needs Assessment Profile, which can 'build a comprehensive picture of the security requirements of individual patients' (p. 156).

Alyson McGregor Kettles and Jean Woodally (**Chapter 12**) consider *observation with engagement*. Research has found that observation levels were related to nurses' subjective judgements, rather than more objective assessments (Kettles *et al*., 2004). Alyson and Jean outline problems from the observation of individuals with personality disorders, including a tendency to 'perpetuate... behaviours' (p. 164). The nature of engagement, in relation to the 'person to person relationship' is explored. The authors conclude that further research is needed to establish the benefits of 'observation and/or engagement' (p. 170).

Chapter 13, by Alyson McGregor Kettles, reports research on the high prevalence of *substance misuse* amongst individuals with personality disorders. This is outlined in relation to particular types of personality disorder. Alyson refers to the lack of agreement on the appropriateness of particular aetiological (causative) models; and the paucity of literature on nursing interventions with people with the *dual diagnosis* of personality disorder and substance misuse. Nursing interventions are described. These include screening for readiness for treatment; assessment; the maintenance of positive attitudes and a therapeutic nurse–patient relationship; and aspects of limit-setting.

In **Chapter 14**, Richard Byrt outlines aspects of the social environment and types of therapeutic groups in *therapeutic communities*. There is a review of the nurse's role, in relation to the nurse–resident relationship and communication; and enabling residents to develop inner controls, strengths, talents and involvement in responsibility. The nurse's role in crises, activities and therapeutic groups is considered. Self-awareness, transference and countertransference are outlined, as

is the need for effective staff communication and support. The chapter concludes with a review of relevant research findings and views of former residents.

Mike Doyle, Anne Aiyegbusi and Paul Burbery outline, in **Chapter 15**, *specialist psychological approaches*. They suggest that some of these 'have shown promise' (p. 210), with individuals with personality disorders, despite the lack of conclusive evidence for the effectiveness of nursing interventions (Woods and Richards 2003). 'A *psychodynamic nursing approach*' can explain individuals' behaviours in relation to early 'adverse developmental experiences' (p. 211), reflected in later relationships with professionals. The latter need to recognise this to avoid perpetuating the individual's experience of rejection and abuse. The same chapter outlines *cognitive behavioural therapy* concerned with 'problem orientation' in the 'here and now' (p. 215), particularly related to the beliefs underlying individuals' behaviours and coping strategies. *Schema-focused therapy* can change ineffective strategies in relationships and problem solving; and enable nurses to communicate more effectively with, and understand, service users.

Finally, in **Chapter 16**, Alyson McGregor Kettles, Phil Woods and Richard Byrt *draw together important themes* from the whole book.

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