Communicating with people with Personality Disorders

A resource prepared by the Intermediary Pilot Program

Background and Overview

Personality disorders

People with a personality disorder have a chronic and pervasive pattern of maladaptive thoughts, emotions and behaviours that impact their ability to relate to others and their environment, causing significant distress and interfering with most areas of their life.

Once established the features of personality disorder are stable across time, place and circumstance.

A personality disorder (or PD) is a psychiatric condition, which is thought to be caused by a complex interaction between genetic factors, environment and negative early life experiences. The features of personality disorder typically emerge during adolescence or early adulthood.

A personality disorder is not simply a flaw in the personality, nor is possessing one or some of the traits associated with a personality disorder sufficient for a diagnosis.

Types of personality disorders

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V)[i] identifies 10 types of personality disorder. Each is characterised by an inflexible and pervasive pattern of behaviour that includes:

Borderline PD	Instability in interpersonal relationships, self-image, mood, and impulse control. Significant difficulties with emotional regulation and being able to self-soothe in times of stress, with higher rates of deliberate self-harm and suicidality than in the general population. There is a high incidence of childhood trauma, neglect and abuse among those with Borderline PD (research suggests in up to 91%[ii] of cases), leading to calls to reconceptualise it as a trauma spectrum disorder (e.g. complex PTSD)[iii].
Narcissistic PD	Grandiosity (feelings of superiority), a need for admiration and a lack of empathy.
Antisocial PD	Disregard for and violation of the rights of others.
Histrionic PD	Excessive emotionality, as well as approval seeking and attention seeking behaviours.
Avoidant PD	Significant social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
Dependent PD	Excessive need to be taken care of, leading to submissive and clinging behaviour and fears of separation.
Obsessive Compulsive PD	Preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness, and efficiency.
Paranoid PD	Mistrust and suspiciousness of others, such that their motives are interpreted as malevolent.
Schizoid PD	Detachment from social relationships and a restricted range of emotional expression in interpersonal settings.
Schizotypal PD	Social and interpersonal deficits marked by acute discomfort and reduced capacity for close relationships. Also present are distortions of thinking and perception, and eccentric behaviour

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Common issues

There is a broad range of presentations among those with personality disorders, however the following common difficulties may be observed:

- may have limited insight about their condition and its impacts and believe that associated difficulties emanate from people and circumstances outside of themselves
- relationships (and other interpersonal interactions) may be unusually intense and unstable. May idealise a person and then rapidly devalue, dislike or become suspicious of them for reasons that may not be clear to others
- emotional state may fluctuate intensely and rapidly, without a clear reason to others as to why
- may react with disproportionately intense anger, irritability or distress and have difficulty managing these feelings. When distressed, may report feeling detached from their own emotions, bodies or surroundings (this is called dissociation)
- may have difficulty understanding and maintaining appropriate boundaries (e.g. being overfamiliar with professionals or new acquaintances or discussing topics that are inappropriate to the conversation or context).
- may behave impulsively or take risks that can be self-damaging (e.g. drug use and/or self-harm)
- research and practice evidence[iv] also demonstrate that people with borderline PD are more likely to experience impairments in their expressive language (communicating their message verbally). These communication difficulties are likely to be exacerbated when discussing emotionally charged content.

Case Example: Jenny

Jenny is a 30-year-old woman with a diagnosis of borderline personality disorder, PTSD and anxiety. Jenny is linked in with a Community Mental Health Service, and over the preceding six-months has had three admissions to an inpatient psychiatric unit due to significant difficulties with coping and suicidal ideation. In recent years, Jenny reports that she has struggled to maintain consistent employment, reporting difficulties in relationships with employers and managing work stress.*

During the intermediary assessment, Jenny was observed to be tangential in conversation, focussing on her experience of particular events at the expense of factual detail, making her narrative difficult to follow.

Jenny engaged inconsistently during the assessment, at times presenting as highly engaged and forthcoming, and at other times presenting as angry and dissatisfied with the interaction.

Jenny was observed to quickly become very distressed when speaking about her family of origin, becoming highly distressed and removing herself suddenly from the room.

Jenny was observed to require a long break before she was able to be calm enough to continue with the assessment.

Jenny also reported that when speaking about difficult experiences, she can "zone out for a while" and feel like she is outside of her body.

Strategies that assisted Jenny when giving her evidence included:

- *making sure that she is familiar with the people who will be asking questions of her*
- *clearly marking topics and structuring questions such that there is a series of questions related to each topic*
- *limiting open-ended questions*
- *monitoring her level of stress and providing longer breaks when she is exhibiting signs of distress or zoning out.*

*Name and details changed

Strategies

The information below outlines general strategies that can be adopted by representatives of the court to enhance communication with people diagnosed with a personality disorder:

- maintain clear boundaries in your interactions. Be supportive but clear about the purpose and limits of your role
- be open and neutral in your body language. Maintain comfortable eye contact, adopt a relaxed posture and a calm manner
- don't treat the person as irrational. Acknowledge that they may perceive and experience the world differently to you
- separate the person from their behaviour. Don't take negative or challenging body language or comments personally
- understand that affect regulation may be difficult for people with PD. If they become angry or distressed, don't ask them to 'calm down'. Taking a break may be helpful. Consider scheduling meetings when a trusted support person can also attend so they can assist
- keep sentences clear, brief and direct. Don't leave room for misinterpretation
- if the person is introducing topics that appear irrelevant to the context or purpose of the conversation, validate the importance of those issues for them before bringing them back to the question (e.g. *It seems like that is an issue that is important for you. At the moment we need to focus on the questions I am asking you. We can come back to that issue once we are finished)*
- understand that people with personality disorder may have difficulty with clear verbal expression particularly when discussing content that is emotionally laden. Clear scaffolds and structure will support them to provide the best evidence
- visual and verbal supports (such as a topic list, timeline and/or verbal signposts) may assist the person to remain on topic or reorient them back to topic if they become distracted
- when trying to separate facts from feelings, validate the feelings first *(I can see that speaking about this makes you distressed*) before further exploring the facts
- avoid questions that require the person with personality disorder to infer the feelings or intentions of others
- accommodate the person's idiosyncrasies (e.g. hyperemotionality, social oddness, lack of observed emotion) without challenging the behaviour. If a behaviour or statement requires further exploration, do so neutrally and non-judgmentally
- avoid asking directly whether the person has a diagnosis of personality disorder. They may have limited insight regarding their mental health and/or find that question challenging
- be consistent and reliable. If you say you are going to do something, ensure that you follow through
- ensure that a support person will check in with the person soon after your contact to manage any issues regarding risk of harm to self or others.

References

[i] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, Fifth edition (DSM-V).* Arlington, VA: American Psychiatric Association.

[ii] Lewis, K. L. & Grenyer, B. F. S. (2009). Borderline personality or complex posttraumatic stress disorder? An update on the controversy. *Harvard Review of Psychiatry, 17*(5), 322-328.

[iii] Kulkarni, J. (2017). Complex PTSD – A better description for borderline personality disorder? *Australasian Psychiatry*, *25*(4), 333-335.

[iv] Carter, P.E. & Grenyer, B.F.S. (2012). Expressive language disturbance in borderline personality disorder in response to emotional autobiographical stimuli. *Journal of Personality Disorders, 26*(3), 305-321.

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