
Management of difficult personality disorder patients

Kingsley Norton

'...therapy often becomes part of the problem rather than vice versa'. George Lockwood, 1992

Ten per cent of the general adult population have a diagnosable personality disorder (Zimmerman & Coryell, 1990) and in 4% this is clinically severe (Tyrrer, 1988). The clinical management of such patients may be difficult. However, much clinical difficulty is generated by interpersonal aspects deriving from the particular interaction of the patient and psychiatrist involved and the respective roles they play.

It is important, therefore, to distinguish between the clinical problem proper and those aspects of the personal interaction of patient and psychiatrist which may unhelpfully (including via stigmatic labelling) contribute to the complexity of the case, further complicating the clinical management of it (Norton & Smith, 1994). This is because interpersonal issues often become so prominent, in clinical transactions with personality disordered patients, that they make it impossible to achieve or maintain an ordinary clinical focus which could identify relevant and achievable goals of treatment.

The psychiatrist can be side-tracked by such interpersonal aspects but recognising this may be problematic, since the distraction from a proper clinical focus may be subtle and is not necessarily negative in quality. There may be an inappropriately positive interpersonal influence, at least initially (Yeomans, 1993). Whether the distraction is positive or negative, what is missing is an appropriate level of mutual respect and trust, so vital for carrying out the professional level clinical tasks. Too often the psychiatrist mistakenly takes its existence for granted.

The aim of this paper is to identify some of the common pitfalls in the clinical management of personality disordered patients, indicating how

they can be avoided or otherwise dealt with, so making treatment less arduous.

Diagnosis and engagement

An unreliable or invalid diagnosis of personality disorder often reflects poor diagnostic technique, as much as it reflects inadequate definitions or inaccurate measures of personality disorder. Thus, sometimes there appears to be ignorance of the need to engage the personality disordered individual, as a patient, rather than to take for granted their ability to perform the role of patient successfully. Without adequate engagement, it is not possible to elicit an accurate history or mental state examination and so on, hence no diagnosis is reliable.

Diagnostic subcategories

The validity of subcategories of personality disorder is uncertain and some prefer to view personality disorder as a unitary syndrome (Coid, 1989), a view given support by the presence of more than one personality disorder subtype diagnosis in individual patients (Zimmerman *et al*, 1991). The number of personality disorder subtype diagnoses, per personality disordered patient, is associated with the particular psychiatric setting (see Dolan *et al*, 1995), the highest numbers being recorded in the most secure in-patient settings, wherein are experienced some of the greatest clinical management problems. In such settings it may be the exception, rather than the rule, to find single subcategory personality disorder diagnosis. The

Box 1. Clinical difficulty and PD patients

- (1) PD is not in itself inherently untreatable
- (2) PD patients can be difficult to manage because of :
 - (i) difficulties in diagnosing PD or a missed diagnosis of PD;
 - (ii) the coexistence of symptom disorder which complicates the treatment of PD and vice versa.
- (3) Some PD patients cannot or will not play their complementary role as patients.
- (4) Interpersonal problems between the psychiatrist and PD patient, arising out of (2) or (3), become the focus of the clinical encounter, thereby supplanting relevant clinical tasks and complicating treatment.

number of personality disorder subtype diagnoses in an individual patient therefore may be a marker of the severity of the overall personality disorder (Dolan *et al*, 1995).

In view of the presence of more than one personality disorder subtype in so many personality disordered psychiatric patients, especially in those who present extreme difficulty in their clinical management, personality disorder will be considered here as a unitary syndrome.

The patient's role

Initially, many with personality disorder who come into contact with psychiatrists are not meaningfully 'patients', in the sense of having a capacity to present a complaint or symptom with the expectation that appropriate professional treatment or help will be forthcoming. Their non-verbal, and sometimes their verbal, behaviour says: "Here I am! I've done my bit. Now it's your turn. What are you going to do about it (me)?"

Mr Adams was smoking a cigarette as he entered the consulting room. The consultant psychiatrist had initially interviewed him the previous week, making a diagnosis of generalised anxiety disorder and personality disorder. He now indicated the discreet 'No Smoking' sign situated on the desk. Apparently not heeding this non-verbal request to extinguish the cigarette, Mr Adams continued to inhale. Indeed, he put the cigarette up to his lips and then removed it in an ostentatious manner. All the time he kept his eyes fixed on the consultant. The latter, attempting to meet Mr Adams' steady gaze, silently fumed! After a short while, and no longer able to contain his impatience

with what he perceived to be Mr Adams' contemptuous silence, he blurted out, "Really, Mr Adams, I must ask you to show more consideration for other people and to refrain from smoking". He then added, with a hint of remorse, "In any case, it's a very bad habit".

The consultant later confided to a colleague that he had regretted this outburst, albeit controlled, not least because Mr Adams had, in response, silently stood up and left the room, quietly closing the door behind him. He subsequently failed further appointments which were sent to him.

The first clinical task is thus to aim to ensure that the patient is engaged as a patient. Engagement entails the successful establishment of a collaborative clinical enterprise between psychiatrist and personality disordered individual, resulting in the negotiating of more or less clear and relevant goals relating to diagnosis and treatment. In the above example, the consultant had thought he had successfully engaged Mr Adams at their first interview and he believed there was sufficient trust and respect to permit him his non-verbal request to the patient. He was not aware that he would again have to prove his credit-worthiness, in terms of trust and respect, and could not take such aspects for granted at the second interview.

Obstacles to engagement

There are many obstacles to engagement, yet the development of a therapeutic alliance with the patient is essential as a vehicle of change (Horwitz, 1974; Frank, 1991). Some personality disordered individuals have totally unrealistic expectations of professionals (too high, too low or constantly oscillating between the two extremes) and so will make inappropriate or unrealistic demands. Disabusing them of their misapprehension or educating them about what is realistically available is crucial but it is often experienced as patronising or humiliating and the professional relationship may break down under the burden of the resulting disagreement, anger or disappointment. Failure to engage and maintain a therapeutic alliance (as with Mr Adams) only serves to reinforce the patient's basic mistrust of professionals and the psychiatrist's notion of the difficulty and untreatability of the patient.

Some personality disordered individuals, by virtue of their style of presentation, impel or seduce professionals into attempting to offer more than is realistically available. Such a temptation for the psychiatrist to be 'too good' or 'too powerful', often a reaction to the patient's unrealistically high expectations and the former's unwillingness to

state limits which might disappoint or frustrate the patient, needs to be avoided (Yeomans, 1993).

Insecure and disorganised attachments

The past

Personality disordered patients' basic and pervasive mistrust stems from neglectful and/or abusive childhoods during which parents (or their substitute adults) abused their authority, avoided their parental responsibilities or were highly inconsistent in attitude or behaviour towards their children, many parents being personality disordered themselves (Norton & Dolan, 1995b). The patients' formative years are thus scarred by insecure and disorganised attachments. As a result, their internal working models, influencing their later expectations of others and their styles of relating to them, reflect this (Bowlby, 1973).

Many personality disordered patients thus expect professionals to fail them (as did their parents) even though, usually secretly, they crave an individual who could meet their every need. In the face of this, psychiatrists often feel as if they cannot succeed. If psychiatrists only reinforce part of the patient's view – that no reliable help is available – then they fail the secret view (against all odds and previous experience) that there exists

someone who will help responsibly and not abuse their authority. However, any help which is provided is often perceived as insufficient. Falling so far short of the idealised 'perfect help', it can cause further pain and disappointment. As a consequence, the psychiatrist may feel 'damned if he does and damned if he does not' treat.

Patients' lack of familiarity with secure attachments and their ambivalence towards the psychiatrist and treatment therefore need to be assumed and addressed directly, as part of the (ongoing) task of engagement and the forging of a therapeutic alliance.

The present

In-patient staff, particularly, experience difficulties in providing care of consistently high quality in the face of the personality disordered patient's ambivalent wish for it and their consequent lack of engagement. Inconsistency in the delivery of planned treatments increases with the number of staff or number of different agencies which are involved with it. This results for two main reasons: covert inter-staff disagreements with the treatment approach, which are either unspoken and/or unresolved; and breakdowns in inter-staff communication or the communication of partial or inaccurate information between staff or between agencies (Stanton & Schwartz, 1954; Main, 1957).

For many patients, the combined thrill and terror of the in-patient chase and capture, followed by enforced sedation and/or seclusion or specialling, represents familiar (albeit insecure) emotional territory. Paradoxically, they are reassured by many, though not all, aspects of it. This frantic mutual activity, however, disallows a novel experience which might impel the patients to question their habitual maladaptive attitudes and behaviour – its cognitive and emotional origins, antecedents, and its consequences. The patients' ingrained behaviour patterns and inflexible responses thus endure (Norton & Dolan, 1995c).

Where physical containment (for example, locked wards; enforced medication) predominates, personality disordered patients survive and function. This is because their existing 'inflexible responses' (part of the definition of personality disorder; WHO, 1992) have been shaped by issues of domination and control in the abusive and/or neglecting experiences received during their childhood and adolescence. In such an in-patient environment, just as in the past, apparent care and respect readily transform, either to punishment or else to a remote professional neutrality perceived

Box 2. Engaging the PD individual as a patient

- (1) The PD patient's capacity to engage in treatment should not be assumed.
- (2) Engagement is the result of an active and collaborative endeavour between psychiatrist and patient.
- (3) Without adequate engagement the quality and reliability of assessment information is impaired leading to diagnostic and treatment difficulties.
- (4) Commonly encountered obstacles to engagement include the patient's:
 - (i) unrealistic expectations of treatment;
 - (ii) basic mistrust in professionals;
 - (iii) ambivalence about seeking and receiving help.

Box 3. Correctable reasons for treatment failure

- (1) Inadequate engagement in treatment.
- (2) Unrealistic treatment expectations and time-frame.
- (3) Inconsistent delivery of treatment due to the involvement of more than one agent or agency, leading to:
 - (i) covert staff disagreements which are unresolved and/or
 - (ii) breakdown or other inadequacy in inter-staff communication.
- (4) Undue delay in response to deterioration or improvement in the patient's clinical status.

by the patient as neglect. Professional care is then viewed as counterfeit and simply as a manipulative or seductive camouflage.

Although simple physical containment can afford personality disordered patients temporary and familiar relief, in the longer term they are left feeling misunderstood, righteously indignant and victimised. Indeed, they can appear to be enveloped by such feelings as if in a welcomed embrace. In the absence of anxiety evoked by an environmental response which is felt by them to be empathic, hence novel, patients do not experience conflict sufficiently within themselves – there is a relative absence of a conflictual internal dialogue. They tend to remain more in conflict with others, mainly staff. Thereby, potentially creative internal conflict is avoided and potentially creative energy is discharged and wasted interpersonally.

The future

If patients are to change their mistrustful attitudes to staff, and to begin to work with them collaboratively, they need to give up their oppositional stance. However, this is only achievable if the staff's response is other than to reinforce such a stance. To facilitate this requires of the staff a capacity to consistently apply a treatment approach (withstanding the destructive aspects of staff disagreements and communication problems), and provide a response to the patients' testing behaviour (often violent and manipulative but sometimes involving seductive or erotic behaviour) which does not simply condemn or condone. Thus, staff are required to strive to remain balanced, not taking sides simply for or against, and to examine the particular situation and its relevance to the patient.

This approach may include reiterating that certain aspects of the patient's behaviour are not acceptable and will not be tolerated but it requires, in addition, a questioning and a quest to understand the antecedents and consequences of the behaviour.

In this way, the patient's behaviour may be both condemned and understood. This is a more complex construction than simply condemning or condoning and it can be communicated to the patient. Through this process, patients can learn to understand that they are perceived by others as more than just their 'behaviour' and that the condemnation of their behaviour is not a total personal attack or annihilation. The aim is to help the patients, in spite of their ambivalence about receiving help and their chronic low self-esteem, to become 'thinkers and feelers' rather than simply 'actors' of maladaptive behaviour (Masterson, 1972).

Using a treatment contract

Even with personality disordered patients who have not been particularly dangerous or disturbed, clinical transactions with them may be complicated rather than straightforward. Thus the ordinary collaborative goal-directed activity of the clinical encounter (out-patient or in-patient) may require buttressing by the establishment of a treatment contract.

A treatment contract involves formalising the usually implicit agreement which exists between patient and doctor in a straightforward clinical transaction. If it is established early, before basic mistrust and prior insecure or disorganised attachment patterns are reinforced by the current relationship and interaction, it can serve to anchor an agreement to achieve relevant goals by minimising the influence of destructive or distracting personality 'clashes' between patient and doctor. As a beneficial by-product, the patient may derive enhanced self-esteem, through being enabled to play the role of patient more successfully, and the psychiatrist may gain professional satisfaction.

The treatment contract may usefully involve people from the patient's wider social network, especially where they are likely to be directly affected by the meeting of contractual conditions. It can help to have the patient, staff and, in some cases family and/or friends, as literal co-signatories to the contract (Miller, 1989). The more staff or agencies who are involved the more urgent is the need to have regular meetings of all concerned, lest inconsistencies in the treatment approach emerge and remain undetected and unremedied.

Establishing a treatment contract is easier said than done. It often entails exploring and changing the patient's basic mistrust; ambivalence about seeking help; low self-esteem; ways of dealing with impulses to injure (self or others); and idiosyncratic obstacles to giving up an immature chemical dependence (on drugs or alcohol) in favour of a more mature dependence on people.

Pitfalls

The most common pitfall is for the treatment contract to be introduced at a time when either or both the psychiatrist and the patient are feeling hostile to one another. Under such circumstances it is not likely to succeed in its stated aims. Hostility, especially where this may have formed part of the psychiatrist's motivation to implement the contract in the first place, must have begun to subside before a treatment contract can be successfully negotiated.

Negotiating the contract may require considerable time, tact and diplomacy just when such attributes are in short supply. The patient may experience the psychiatrist as authoritarian or patronising, especially if there is, or has been in the past, compulsory treatment or if contractual conditions are set which the patient cannot meet. If this is the case, the contract is likely to break down even if there has been an apparent initial agreement to it.

Ms Banks, an in-patient for more than six months, had been compulsorily admitted. The diagnosis was of anorexia nervosa with features of a coexisting affective disorder (including serious suicidal ideation and parasuicidal activity) and an underlying dyssocial personality disorder. She made little progress initially and, with staff's mounting anxiety about the unlikelihood of her survival, a treatment contract was established out of desperation and frustration, with little staff confidence that it might help.

The contract stated that Ms Banks would accept a high calorie diet with the aim of achieving a weight increase to a mutually agreed level. Staff agreed to stop their cajoling and coaxing of Ms Banks to eat in return for her agreement to attend and speak in her individual sessions. (She had often found reasons not to attend and had avoided talking in depth.)

To the surprise of the team, Ms Banks began to accept her diet and achieved her contracted target weight. However, she did this without divulging any personal difficulties or other information about herself. The staff treating her were grateful that compliance with re-feeding had resulted and that the immediate threat of suicide and death had receded. The treatment contract was regarded to have 'worked' in spite of the fact that she had not complied fully with the contractual agreement. Consequently, discharge from hospital was arranged. At this point

Ms Banks broke a mirror in the Unit and used the shards to repeatedly cut her forearms. Feeling frustrated and defeated, the staff felt compelled to shelve the discharge plans.

Treatment contracts require monitoring and if specified goals are not achieved these need discarding, re-negotiating or else discussion to establish why. If the contractual conditions pertaining to the personality disordered patient require them to give up the only defences they have against intolerable feelings, and if no viable alternative outlet or coping strategy is provided or available to them, the contract will not succeed. Therefore it is important that any conditions attached to the contract are realistically achievable. With Ms Banks, it was eventually decided to reinstate and update the treatment contract and to reiterate the need for her to speak in her individual sessions in order to address the maladaptive self-harming behaviour. With regard to the latter, nursing staff's time was made available to her whenever she recognised the impulse to self-mutilate, regardless of the time of day or night.

Prescribing medication

While psychological treatments of the personality disorder itself form the mainstay, there is a limited role for drug treatment (see Stein, 1992 for review). Symptom disorder and personality disorder comorbidity is common (Du Fort *et al*, 1993), therefore a substantial proportion of personality disordered patients have a coexisting symptom disorder which may require treatment in its own right, including relevant pharmacotherapy.

In out-patients where impulse control problems are predominant or in patients who are acutely disturbed or dangerous, there will be a place for the combination of psychotherapy (at least supportive psychotherapy) and pharmacotherapy. However, with many personality disordered patients there is a risk of addiction or of fatal overdose. Under such circumstances there is clearly a need for judicious prescribing. Small doses of an oral neuroleptic, prescribed and dispensed in non-lethal amounts, may represent the safest of medication.

Psychological treatments

If personality disordered patients receive any treatment, it is most likely to be individual

supportive psychotherapy (Winston *et al*, 1994; Monsen *et al*, 1995). This is not necessarily easy to provide, on an out-patient or in-patient basis, and may require senior and skilled personnel to provide it effectively (see Hartland, 1991). Often, more specialised psychotherapeutic techniques, for example, dynamic psychotherapy, cognitive therapy or dialectical behaviour therapy (Shearer & Linehan, 1994) are required to avoid deterioration in clinical status or to promote beneficial change.

Dynamic psychotherapy aims to facilitate the development of the immature and unintegrated personality through the establishment of a transference-countertransference relationship and its resolution via interpretation as part of a modified, more active, psychoanalytic technique (Kernberg, 1984). Cognitive psychotherapy focuses on the identification of the patient's important cognitive distortions or schemas and examines the way in which these are reiterated and maintained in everyday life. Discussion of such self-defeating and maladaptive manoeuvres is aimed at atrophying their use and replacing them with more self-affirming and adaptive cognitive strategies linked with appropriate affect (for example Young, 1990).

A review of treatment outcome and related issues is beyond the scope of this paper and is available elsewhere (Higgitt & Fonagy, 1992; Stein, 1992; Dolan & Coid, 1993; Norton & Dolan, 1995c; Ruegg & Frances, 1995).

Non-individual therapies

For a disorder which is known to have such prominent environmental aetiological factors, it is surprising that family therapy is under-represented in the personality disorder literature and perhaps

under-utilised as a therapy in clinical practice. This may reflect the absence of an intact family and/or the presence of acrimonious or ambivalent relationships with those family members with whom the patient is still in contact. Sometimes, however, it is not entertained as a treatment because the psychiatrist feels unskilled and/or it is not otherwise available. Family therapy, where family members and treatment resources permit, may have a therapeutic contribution to make, especially in patients' families which are separation-sensitive or enmeshed.

Reports of the use of group therapy are also under-represented in the literature (Dolan & Coid, 1993), given many personality disordered patients find their way into psychotherapy and clinical psychology departments where they are treated by group dynamic psychotherapeutic methods. The beneficial effect of peer group influences in challenging and shaping personality disordered patients' aberrant or maladaptive attitudes and behaviour, however, is well-established (Bion, 1961; Foulkes, 1964; Tschuschke & Dies, 1994).

Specialist in-patient units

Referral to a specialist in-patient unit may be indicated where there is: a history of failed out-patient and general psychiatric in-patient treatment; an accumulating number of failed relationships; a poor occupational record; and evidence that hopelessness and destructive living styles have become incorporated into the patient's personality (Greben, 1983). Basic educational achievement, a period of stable employment, maintenance of interpersonal stability in an intimate relationship for longer than six months and a recall of a positive enduring relationship during childhood may be good prognostic indicators of a successful outcome with specialist treatment (Whiteley, 1970; Healy & Kennedy, 1993). Any referral and/or transfer, however, needs to be carefully discussed with the personality disordered patient if it is not to be experienced by them as a rejection or as a confirmation of their inherent badness, paradoxically, as confirmation of their untreatability.

One of the advantages of the specialist in-patient unit lies in its power to select its patients and to deploy a coherent and coordinated treatment strategy via staff who have become expert in the particular method. The usual therapeutic emphasis is psychodynamic and in some units no psychotropic medication is prescribed (Norton, 1992). Units vary in the extent to which they utilise the therapeutic influence of the personality disordered patient's peer group (Hinshelwood, 1988; Norton & Dolan, 1995a; Reiss *et al*, 1996). Most require

Box 4. Managing the destructive effect of inter-staff 'splits'

- (1) Education of staff regarding the phenomenon of 'splitting' and its inevitable presence in treatment involving more than one staff member and/or agency.
- (2) The use of treatment contracts which specify what staff are able and prepared to provide and/or tolerate.
- (3) Regular meetings of all relevant staff to identify and resolve differing attitudes to treatment which affect the consistency and speed of its delivery.
- (4) Staff support systems for those involved in significant face-to-face contact with PD patients in residential settings.

motivated and voluntary participation in treatment and some capacity to experience subjective distress. Treatment lasts between 6 and 18 months and there is accumulating evidence of the success of such units in terms of change in behaviour (Copas *et al*, 1986; Cullen, 1994) psychological improvement (Dolan *et al*, 1992; Stone, 1993) and cost-offset following treatment (Dolan *et al*, 1996).

In spite of such intensive and expert treatment, after-care is often required in many cases of severe personality disorder and treatment may need to be long-term, lasting for a number of years. Information regarding this can be shared with the patient to facilitate engagement in treatment, not least because of its introduction of a realistic time-frame in which treatment goals can be negotiated and tackled. Failure to introduce this aspect early on can contribute to unrealistic expectations and treatment failure, however, such information needs to be imparted sensitively so as not to extinguish all hope or optimism that the patient has in the treatment.

Conclusions

Many of the clinical needs of personality disordered patients do not differ fundamentally from those of other non-psychotic patients. However, the experience of most psychiatrists is that some of these patients are numbered among the most problematic clinical management problems which they encounter. Characteristically, difficulties arise because the patient is relatively or absolutely unable to perform the role of patient and because clinical issues are supplanted by interpersonal problems. Knowing this can save the psychiatrist some disappointment and frustration since it can lead to education of the patient about the expected role of patients thus keeping expectations of help and treatment within reasonable bounds. This therapeutic endeavour can be helped by the careful and judicious introduction of a treatment contract. The latter serves to bolster the legitimate professional activity by describing the actual limits of the professional input, including the proscription of some of the interpersonal aspects whose distracting presence only undermines the professional level activity. However, there are many pitfalls in the use of treatment contracts which need to be avoided.

In the management of any case where there is more than one professional or more than one agency involved, there is a potential for unhelpful 'splitting'. The most regular destructive effect of this is the production of an inconsistent delivery of treatment, regardless of type or model. To avoid

this, all relevant staff must meet regularly and, if necessary, frequently, to iron out disagreements or other inconsistencies. Only in this way can the patient experience treatment which is simultaneously emotionally containing and appropriately confronting and challenging.

The marshalling of professional resources, and in some cases those of other patients (as in group, milieu or therapeutic community treatment) or members of the personality disordered patient's wider social network (as in marital and family work), need to be carefully coordinated. Only if this is so can the predictable (external) organisational structure be assimilated by the patient for later internalisation. Well organised and coordinated treatment plans can convey a predictable and responsive experience of the world to patients for whom this was previously lacking. Maintaining such a concerted stance, however, may require specialised in-patient psychotherapeutic management as part of a long-term treatment plan.

Acknowledgement

I thank Dr Bridget Dolan for her helpful editorial comments and suggested improvements to an earlier draft of this paper.

References

- Bion, W. R. (1961) *Experience in Groups*. London: Tavistock.
- Bowlby, J. (1973) *Attachment and Loss, Vol. 2. Separation: Anxiety and Anger*. New York: Basic Books.
- Coid, J. W. (1989) Psychopathic disorders. *Current Opinion in Psychiatry*, 2, 750–756.
- Copas, J. B., O'Brien, M., Roberts, J.C., *et al* (1986) Treatment outcome in personality disorder: the effect of social, psychological and behavioural variables. *Personality and Individual Differences*, 5, 565–573.
- Cullen, E. (1994) Grendon: The therapeutic prison that works. *Therapeutic Communities*, 15, 301–311.
- Dolan, B., Evans, C. & Wilson, J. (1992) Therapeutic community treatment for personality disordered adults: changes in neurotic symptomatology on follow-up. *International Journal of Social Psychiatry*, 38, 242–250.
- & Coid, J. (1993) *Psychopathic and Antisocial Personality Disorders: Treatment and Research Issues*. London: Gaskell.
- , Evans, C. & Norton, K. (1995) Multiple Axis II diagnosis of personality disorder. *British Journal of Psychiatry*, 166, 107–112.
- , Warren, F., Menzies, D., *et al* (1996) Cost-offset following specialist treatment of severe personality disorders. *Psychiatric Bulletin*, 20, 413–417.
- Du Fort, G. G., Newman, S. C. & Bland, R. C. (1993) Psychiatric comorbidity and treatment seeking: sources of selection bias in the study of clinical populations. *Journal of Nervous and Mental Diseases*, 18, 467–474.
- Foulkes, S. (1964) *Therapeutic Group Analysis*. London: George Allen & Unwin.
- Frank, A. F. (1991) The therapeutic alliances of borderline patients. In *Borderline Personality Disorder: Clinical and Empirical Perspectives* (eds. J. Clarkin, E. Marziali & H. Munroe-Blum). New York: Guilford.

- Greben, S. (1983) The multi-dimensional inpatient treatment of severe character disorders. *Canadian Journal of Psychiatry*, **28**, 97–101.
- Hartland, S. (1991) Supportive psychotherapy. In *Textbook of Psychotherapy in Psychiatric Practice* (ed. J. Holmes), pp. 213–235. London: Churchill Livingstone.
- Healey, K. & Kennedy, R. (1993) Which families benefit from in-patient psychotherapeutic work at the Cassel Hospital? *British Journal of Psychotherapy*, **9**, 394–404.
- Higgitt, A. & Fonagy, P. (1992) Psychotherapy in borderline and narcissistic personality disorder. *British Journal of Psychiatry*, **161**, 23–43.
- Hinshelwood, R. (1988) Psychotherapy in an in-patient setting. *Current Opinion in Psychiatry*, **1**, 304–308.
- Horwitz, L. (1974) *Clinical Prediction in Psychotherapy*. New York: Jason Aronson.
- Kernberg, O. F. (1984) *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven and London: Yale University Press.
- Lockwood, G. (1992) Psychoanalysis and the cognitive therapy of personality disorders. *Journal of Cognitive Psychotherapy*, **6**, 25–42.
- Main, T. (1957) The ailment. *British Journal of Medical Psychology*, **30**, 129–145. Reprinted in T. Main (1989) *The Ailment and other Psycho-Analytic Essays*. London: Free Association Books.
- Masterson, J. F. (1972) *Treatment of the Borderline Adolescent: A Development Approach*. New York: Wiley.
- Miller, L. J. (1989) Inpatient management of borderline personality disorder: a review and update. *Journal of Personality Disorders*, **3**, 122–134.
- Monsen, J. T., Odland, T., Faugli, A., et al (1995) Personality disorders: changes and stability after intensive psychotherapy focusing on affect consciousness. *Psychotherapy Research*, **5**, 33–48.
- Norton, K. R. W. (1992) Personality disordered individuals: the Henderson Hospital model of treatment. *Criminal Behaviour and Mental Health*, **2**, 80–191.
- & Smith, S. (1994) *Problems with Patients: Managing Complicated Clinical Transactions*. Cambridge: Cambridge University Press.
- & Dolan, B. (1995a) Acting out and the institutional response. *Journal of Forensic Psychiatry*, **6**, 317–332.
- & — (1995b) Personality disorders and parenting. In *Parental Psychiatric Disorders* (eds M. Gopfert, J. Webster & M. Seeman), pp. 219–232. Cambridge: Cambridge University Press.
- & — (1995c) Personality disorder: assessing change. *Current Opinions in Psychiatry*, **8**, 371–375.
- Reiss, D., Grubin, D. & Meux, C. (1996) Young ‘psychopaths’ in special hospitals: treatment and outcome. *British Journal of Psychiatry*, **168**, 99–104.
- Reugg, R. & Frances, A. (1995) New research in personality disorders. *Journal of Personality Disorders*, **9**, 1–48.
- Shearer, E. N. & Linehan, M. (1994) Dialectical behaviour therapy for borderline personality disorder: theoretical and empirical foundations. *Acta Psychiatrica Scandinavica*, **89** (suppl. 379), 61–68.
- Stanton, A. H. & Schwartz, M. S. (1954) *The Mental Hospital*. New York: Basic Books.
- Stein, G. (1992) Drug treatment of the personality disorders. *British Journal of Psychiatry*, **161**, 167–184.
- Stone, M. H. (1993) Long-term outcome in personality disorder. *British Journal of Psychiatry*, **162**, 299–313.
- Tschuschke, V. & Dies, R. R. (1994) Intensive analysis of therapeutic factors and outcome in long-term in-patient groups. *International Journal of Group Psychotherapy*, **44**, 185–208.
- Tyrer, P. (1988) *Personality Disorder, Diagnosis, Management and Care*. London: Wright.
- Whiteley, S. (1970) The response of psychopaths to a therapeutic community. *British Journal of Psychiatry*, **166**, 517–529.
- Winston, A., Laikin, M., Pollace, J., et al (1994) Short-term psychotherapy of personality disorders. *American Journal of Psychiatry*, **151**, 190–194.
- World Health Organization (1992) *The Tenth Revision of the International Classification of Mental and Behavioural Disorders (ICD-10)*. Geneva: WHO.
- Yeomans, F. (1993) When a therapist over-indulges a demanding borderline patient. *Hospital and Community Psychiatry*, **44**, 334–336.
- Young, J. (1990) *Cognitive Therapy for Personality Disorders: A Schema Focused Approach*. Sarasota, FL: Professional Resources Exchange.
- Zimmerman, M. & Coryell, W. H. (1990) Diagnosing personality disorder in the community. *Archives of General Psychiatry*, **47**, 527–531.
- , Pfohl, B. & Coryell, W. H. (1991) Major depression and personality disorder. *Journal of Affective Disorders*, **22**, 199–210.

Multiple choice questions

- 1 Engagement:
 - a refers to the development of a therapeutic alliance
 - b is clinically relevant only with severe PD patients
 - c is a necessary prerequisite of psychological but not drug treatments of PD
 - d requires particular knowledge and clinical skills of the psychiatrist
 - e is stable, once achieved
- 2 In-patient staff, in their management of PD patients:
 - a are split by patients they all dislike
 - b must be empathic at all costs
 - c can use a treatment contract to improve treatment outcome
 - d should strive to avoid simple oppositional responses
 - e need to be clear in either condemning or condoning maladaptive behaviour
- 3 A treatment contract:
 - a is easier to establish when the PD patient is compulsorily detained
 - b should be made when the PD patient and psychiatrist heatedly disagree about treatment
 - c requires negotiated goals to be successful
 - d should specify alternatives to the PD patient's maladaptive ways of coping with psychic distress
 - e requires the support of all relevant personnel
- 4 For a PD patient in an out-patient setting:
 - a supportive psychotherapy is seldom indicated
 - b combined pharmacotherapy and psychotherapy is contraindicated
 - c long-term treatment plans may incorporate specialist in-patient psychotherapy
 - d psychotropic medication has an established place in treating basic PD phenomena
 - e family therapy is frequently indicated

- 5 Transfers and discharges of PD patients should:
- a be planned well in advance
 - b be negotiated with the patient
 - c reflect genuine clinical change
 - d include meetings of relevant staff
 - e involve members of the patient's wider social network, in selected cases

MCQ answers

1	2	3	4	5
a T	a F	a F	a F	a T
b F	b F	b F	b F	b T
c F	c T	c T	c T	c T
d T	d T	d T	d F	d T
e F	e F	e T	e F	e T

Forthcoming Royal College of Psychiatrists CPD Events

19–21 September 1996, Hotel de France, Jersey
Child and Adolescent Psychiatry Specialist Section Residential Conference. Contact: Annabel Thomas or Mairead Burke on extension 142 at the College

26–28 September 1996, Newcastle-upon-Tyne
Section of the Psychiatry of Learning Disability Residential Conference. Contact: Annabel Thomas or Mairead Burke on extension 142 at the College

31 October 1996, Crown Hotel, Harrogate
ECT Training Course. Contact: David Hills on extension 108 at the College

14–16 November 1996, Dublin
Social, Community and Rehabilitation Psychiatry Specialist Section Residential Conference. Contact: Annabel Thomas or Mairead Burke on extension 142 at the College

22 November 1996, Royal Society of Medicine, London
Depression and Prediction of Suicide. Joint meeting with Royal Society of Medicine. Contact: Annabel Thomas or Mairead Burke on extension 142 at the College

25 November 1996, Royal College of Psychiatrists
Factitious Illness by Proxy – Munchausen Syndrome by Proxy. Contact: David Hills on extension 108 at the College

29 November 1996, Regent's College, London
Behavioural–Cognitive Psychotherapy of Enduring Mental Disorder. Contact: Annabel Thomas or Mairead Burke on extension 142 at the College

1–2 December 1996, London
Joint Meeting Liaison Group/ Society of Psychosomatic Research. Contact: David Hills on extension 108 at the College