Borderline Personality Disorder (BPD) & Deliberate Self Harm (DSH)

A series of blog posts by Stuart Sorensen
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About the author

Stuart Sorensen’s background is mental health nursing and as such he has a wealth of direct experience of working with people suffering from all forms of mental health problems. From early voluntary work with elderly people as a teenager to unregistered care assistant posts and then clinical practice as a qualified nurse Stuart has a real understanding of the issues faced by workers at all levels on a daily basis.

Stuart qualified as a nurse in the West Midlands in 1995 and gained his post graduate diploma in Psychosocial Interventions (PSI) from Sunderland University in 2003. His wealth of practical experience allows Stuart to engage with a variety of service-users as well as learners/participants in training courses that have the feel of reality about them rather than the ‘ivory tower’ type of presentation that comes from reading a book.

Stuart is passionate about recovery from mental disorders and much of his clinical and training work has been based around helping people to recover from serious mental disorders such as schizophrenia. He is particularly interested in ways of ensuring that vulnerable service-users are protected whilst still retaining the right to make decisions.

As a trainer Stuart is keen to help staff ‘at the coalface’ to find a balance between the conflicting (and seemingly impossible) rights of workers, carers and service-users. Stuart understands the difficulties and dilemmas facing workers on the front line because he has faced them too.

Stuart has extensive experience of delivering many aspects of training around care provision and human/civil rights including training around Balancing Rights and Responsibilities, the Mental Capacity Act and the Deprivation of Liberty Safeguards, Person-centred Planning and Maintaining Therapeutic Relationships, particularly in relation to Challenging Behaviour. He is also very experienced in delivering training on topics such as Introduction to Mental disorder, Safeguarding of Vulnerable Adults (SOVA), specialist training on mental health related issues and, of course, Deliberate Self Harm.

Stuart has long been interested in the effects of different communication styles and the effect of non-verbal communication strategies on service-users, colleagues and, of course, training participants. He also trains other trainers in these techniques as a method of developing and maintaining engagement or coping with disruptive participants without creating conflict.

Stuart is very well versed in the principles of therapeutic risk and enabling activities that carry the risk of harm having written and delivered training nationwide on Risk Appreciation to mixed groups of inspectors from both the Health & Safety Executive (HSE) and the now defunct Commission for Social Care Inspection (CSCI).

Generally speaking Stuart likes to begin by emphasising similarities between workers and service-users to develop empathy before using everyday situations to illustrate the points made throughout the training. He has worked extensively for various county and borough councils and also provided training on safeguarding and on mental capacity and related legislation on behalf of both the UK and Scottish governments.

This series of posts began online here:

BPD and DSH 1: outline

This is the proposed (I suppose ‘approximate’ might be a better word) outline for the blog series on Borderline Personality Disorder and Deliberate Self Harm. I’m going to cover the two topics together because that ‘kills two birds with one stone’. I’ve had requests for both.

This is not meant to imply that the two issues always go together.

However they do coincide often enough to make it possible to cover both together. There are also some very compelling arguments (both psychological and cultural) about why they should be considered ‘side by side’. Anyway – the broad outline will be as follows:

- What is personality disorder?
- What do we mean by Borderline Personality disorder?
- What are the diagnostic criteria for Borderline Personality disorder?
- Trauma and coping
- Instability of mood
- Dissociation
- Emotional trauma and early coping skill development
- Validation and the Invalidating Environment
- High Expressed Emotion
- Unstable relationships
- Black & White thinking
- Concrete thinking
- Paranoia
- Deliberate Self Harm in the wider community (smoking, drinking, tattooing, Body modification, piercing etc)
- Deliberate Self Harm as a strategy to define group membership
- Deliberate Self Harm in a clinical setting (and some of the more common myths associated with it)
- Deliberate Self Harm as a response to trauma
- Responding to people who harm themselves
- Working with people diagnosed with Borderline Personality Disorder

I’m certain that this outline will only partly reflect the finished article. As with the Emotional Management series I expect the series to develop and evolve as I go along. However it should stick more or less to the plan outlined here.

Please feel free to pass this pdf file around to whoever might want to see it. All I ask is that you keep the copyright and formatting intact.

Many thanks,

Stuart
BPD & DSH 2: What is Personality Disorder?

Of all the diagnoses used in mental health services the ‘personality disorder’ group is arguably the most controversial. In order to understand why this might be it’s helpful to consider where the diagnosis might have come from.

"6.1.5 Moral insanity gradually fell into disuse, but moral imbecility was defined further and incorporated in the Mental Deficiency Act of 1913, subsequently changed to “moral defective” in the Act of 1917. Its contemporary meaning, which is closer to anti-social personality, has evolved from the influence of French, German and American psychiatrists during the hundred years and more following Prichard when defects of “the moral sense” continued to persist, virtually until the Mental Health Act of 1959; indeed its current usage still has moral and pejorative resonance."

Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital The Stationery Office 1999

http://www.archive.official-documents.co.uk/document/cm41/4194/ash-06.htm

Modern mental health services have inherited a legacy from the past and the diagnoses we use have been left a legacy too. It’s always worth remembering that the services we deliver in 2010 are not the end of the road. Just as we are left to build upon the legacy of the past so we will leave our own mark on the services of the future. It’s all part of a much longer timeline of service development and provision. In fact, far from being particularly advanced in our current culture and understanding we’re probably very primitive today compared to what will happen in the future.

As I often say to my students:

“**It’s only 2010**”

An even more primitive forerunner of modern ‘personality disorder’ diagnoses was the now defunct categorisation of ‘moral defective’. This was a relatively common ‘diagnosis’ at the turn of the twentieth century and tended to result in long-term or even lifelong incarceration in a lunatic asylum.

Criteria for the ‘diagnosis’ of moral defective included:

- Childbirth out of wedlock (only if the woman lacked financial means);
- Petty criminals;
- Homosexuality.

It’s a good thing that these criteria are no longer used to determine personality disorder or things in the modern world might be very interesting indeed. Even back in Edwardian England it was apparent that the diagnosis had little to do with actual ‘disorder’ and a great deal to do with social ideas about acceptability, deservingness and expediency.

If the criteria for moral deficiency was really about morality then there would have been no prostitution outside the walls of the asylums. However the emphasis was not so much on moral conformity as the public purse. An unmarried mother who could not support herself and her offspring became a burden on local society – unless she was insane. The emphasis upon expediency is the reason the diagnosis only applied to unmarried mothers if they lacked the means to support themselves. Wealthy woman could have as many illegitimate children as they wished. Tongues might wag but they were unlikely to be incarcerated in an asylum for it.
Now I am not suggesting that modern personality disorder diagnoses depends upon financial means. That’s not the legacy that was handed down to us. I am suggesting (and I intend to demonstrate) that in 2010 the diagnoses that make up the personality disorder group depend upon ideas of acceptable behaviour and social value judgements just as surely as did their Edwardian predecessors.

There are no blood tests for personality disorders. Neither are there any physical examinations. In point of fact there is no evidence that personality disorders are ‘medical’ conditions at all. Hence the controversy.

What we have instead are judgements about behaviours. Some behaviours are thought to be ‘normal’ and some ‘abnormal’. However they remain no more than behaviours and coping strategies.

Alongside these we have judgements about what sort of emotions are ‘normal’ and the degree of emotional control that people are expected to exercise. People who fail to live up to the expectations of the psychiatric manuals, either because of their thoughts, their feelings or their behaviours are labelled as having a personality disorder of one type or another.

Of course there is nothing wrong with trying to understand the people we work with. In fact throughout this series of posts I hope to show that such understanding is vital if we truly are to help them. People do have different personalities and those differences really do present particular issues relevant for mental health. The more we know about these issues the more help we can be.

So there is value in classifying different personality traits and types because it helps us to work with people. However when personality classification strays into value judgements and decisions about ‘deservingness’ it becomes a very dangerous ‘double-edged sword’.

My own view is that this understanding is crucial and positive so long as we keep it in perspective and refrain from making judgements about a person’s worth or write them off as ‘incurable’. After all – we are not meant to ‘cure’ personality.

Really the work of mental health services can be boiled down (very broadly) into treating and/or alleviating four types of problem only. They are – anxiety, depression, psychosis and dementia. We can, however, treat these problems far more effectively when we understand the personality of the individual at hand.

It is my earnest hope that the legacy we leave for future generations of mental health service providers will be a focus upon understanding the personality without the value judgements that were bequeathed to us by our Edwardian predecessors.
BPD & DSH 3: What is Borderline Personality disorder?

According to ICD-10 (the World Health Organisation’s diagnostic manual) Personality Disorders comprise:

".....deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance."

"Personality disorders differ from personality change in their timing and the mode of their emergence: they are developmental conditions, which appear in childhood or adolescence and continue into adulthood."

WHO (1992)

This seems to be quite straightforward in many ways. It’s a description of lifelong problems that show up in all situations that individuals finds themselves in. To put it another way...

Wherever you go – you always take yourself with you.

Unfortunately there are very real problems with the way that psychiatry has developed and ultimately settled upon its notions of personality disorder. But that does not mean that we should ‘throw the baby out with the bathwater’. If nothing else the current medical diagnostic framework allows us a starting place to build upon so long as we do not allow ourselves to become complacent and simply settle for the current diagnostic paradigm:

"It is widely accepted that the psychiatric classification of personality disorders is unsatisfactory, but it provides a common terminology that is essential as a starting point for clinical communication and further research."

British Psychological Society (2006)

There are several types of personality disorder but we will focus upon only one throughout this series... Borderline Personality Disorder. This is not the only personality disorder that health and social care professionals will ever come across but it is probably the one most commonly encountered among service-users. It is also the diagnosis that seems to present many of the problems for both service-users and staff, not only because of the problems that lead to a person being given the diagnosis but also as a result of the very real stigma and prejudices that follow on as a result of it.

Borderline Personality Disorder is a distinct disorder in it’s own right. It is not, as many suppose, a ‘diagnosis of degree’. To put it another way someone with a diagnosis of Borderline Personality Disorder is not ‘half a psychopath’, nor is it valid to differentiate between the ‘borderline’ personality disorder and the ‘full-blown’.

The term borderline has associations with ‘halfway’ measures and so it is natural to assume that borderline personality disorder means ‘half a personality disorder’. Actually the term refers to the now outdated but once widely accepted notion that sufferers exist on the borderline between psychosis and neurosis.
The features (diagnostic criteria) of Borderline Personality Disorder as defined in ICD-10 are listed below:

’a lifelong tendency to quarrel and create conflict’ and at least four of the below (at least two of those printed in bold):

- A marked tendency to act unexpectedly without considering consequences.
- Outbursts of anger or violence, & inability to control resulting behaviour.
- Difficulty in working towards long term goals.
- Unstable mood.
- Uncertainty about self-image and identity (including sexual).
- Intense and unstable relationships, often leading to emotional crises.
- Excessive efforts to avoid abandonment/rejection.
- Repeated threats or acts of self-harm.
- Long-lasting feelings of emptiness.

Adapted from: World Health Organisation (1992)

It can be argued that many of these ‘symptoms’ or personality traits are not very different from the immature way that children and adolescents approach the world. It’s acceptable in young people but not so easy to swallow when coming from grown ups.

Traits such as ‘emotional instability’, ‘fear of abandonment’ and ‘unstable relationships’ present major difficulties for adults. It is unfortunate that these difficulties tend to be compounded by the response from other adults who interact with the ‘personality disordered’ individual.

Later in this series we will pick up on the theme of ‘immature’ behaviour – not to insult or infantilise people diagnosed with borderline personality disorder but to demonstrate that the disorder is actually a problem caused by the arrested development of coping techniques. As a result an adult who is completely mature in other areas of their lives may well find themselves at the mercy of the same, limited emotional ability that they had many years earlier.

We will consider the causes of this developmental delay and also look at the ways that it might be resolved. We’ll also take a step by step look at the different criteria, their relationship to each other and the circular reasoning that counts these inevitably linked personality traits as different ‘symptoms’ of disorder.

References:


World Health Organisation (1992), ICD-10, Geneva
BPD & DSH 4: Trauma and coping

The link between borderline personality disorder and trauma is well known and well documented. It is neither possible nor necessary to review all the available literature here although I will provide a brief reading list at the end of this section.

I would like to make a few points about the link between the two though, if only because I want to be sure that there are no misunderstandings.

Not too many years ago when this link was first discovered (or perhaps first acknowledged) an unfortunate assumption came along as well. The assumption was that borderline personality disorder wasn’t the result of just any old trauma – it was thought to be the result of childhood sexual abuse.

I’m happy to be able to report that this assumption went too far and was not really true. It is the case that childhood sexual abuse can lead to the problems associated with borderline personality disorder and therefore can lead to the diagnosis itself but so can many other forms of trauma.

Not everyone diagnosed with borderline personality disorder has suffered childhood sexual abuse.

Not everyone who has experienced childhood sexual abuse can be diagnosed with borderline personality disorder.

The reality is that any trauma that goes beyond our ability to cope with it will do. This is one reason why the emphasis, quite rightly is upon childhood trauma. Children take time to develop coping strategies and so trauma that is experienced before that emotional development is complete (in so far as it ever is completed) can be overwhelming.

We’ll see in a later post why this concept of early trauma is so significant. For now it’s enough to know that it takes many years to develop skills such as ‘self-soothing’ or ‘frustration tolerance’ and that overwhelming trauma has the power to stop the process in its tracks.

It is also extremely important to distinguish between trauma and abuse. Not all trauma is deliberate or even anyone else’s fault. Sometimes, as in the case of domestic violence or incest, there is very clear abuse involved but at other times the trauma might be unknown to anyone but the child who has created some overwhelming fear in their own imaginations. It’s not the case that parents can automatically be blamed for their child’s borderline personality disorder.

Trauma can be chronic (long-lasting) or acute (short-term/serious). The sudden stress of a very severe beating can be just as powerful as the long term but far less dramatic situation that Marsha Linehan describes as the Invalidating Environment. It’s interesting to note that Linehan’s Invalidating Environment of Borderline Personality Disorder is almost identical to the High Expressed Emotion environment that George Brown associated with the diagnosis of schizophrenia almost thirty years earlier. This similarity is extremely significant.

We know that coping skill development is important in the treatment of psychosis. We know that blockages in the development of coping skills can lead to a diagnosis of Borderline Personality Disorder. We know, thanks to the likes of George Brown and Marsha Linehan that traumatic events and environments are important to both disorders. It seems that life events are at least as significant as any theoretical biological cause and quite possible much more so.
However I would like to be very clear here. The fact that biological causes tend not to be proven beyond reasonable doubt does not mean that biology is not involved. There may be biological effects relating both to anatomy (structure of the developing brain for example) and physiology (the chemicals operating within the brain).

There has been some very promising work in the area of brain chemistry and the effects of neurotransmitters such as serotonin on the nervous systems of people with borderline personality disorder and this may well yield some extremely useful results as time progresses. Genetic research is also proving to be extremely informative. However, I’m assuming that most people reading my blog will not be prescribers or research scientists and so I’m going to stick to the more practical information that they can use in practice. After all there’s little point in understanding all about the role of neurotransmitters if you’re never going to be able to prescribe medications that will affect them.

Perhaps the most compelling evidence of the role of trauma in Borderline Personality disorder comes from the work of John Briere. Briere didn’t set out to study personality disorder at all. His interest was in Post Traumatic Stress Disorder (PTSD). As part of this work he devised a diagnostic tool to identify those people who suffered from PTSD. This was found to be remarkably accurate in identifying those people who had problems associated with sudden overwhelming trauma. Of course there’s nothing too surprising in that – it’s what the tool was designed for.

What was surprising was that Briere’s *Trauma Symptom Inventory* was just as accurate in identifying people diagnosed with Borderline Personality Disorder. It seems that what we traditionally have thought of as a personality disorder may actually be a complex form of Post Traumatic Stress Disorder.

In fact, as I write, the American diagnostic manual (DSM-IV) is undergoing review and one of the suggestions that has been made if for the diagnosis of Borderline Personality disorder to be changed to DESNOS (Disorder of Extreme Stress Not Otherwise Specified).

Such a change would also remove the negative assumptions about hopelessness, deservingness and untreatability that we discussed earlier in this series.

**It is becoming increasingly obvious that a diagnosis of Borderline Personality disorder that does not acknowledge both trauma and hope is superficial, pessimistic and inaccurate.**
Reading list

British Psychological Society & The Royal College of Psychiatrists (2004) **Self Harm**, BPS, Leicester

Briere J **Trauma Symptom Inventory (TSI)** [http://www.johnbriere.com/tsi.htm](http://www.johnbriere.com/tsi.htm)


Dept of Health/NIMHE (2003), **Personality disorder: No longer a diagnosis of exclusion**, HMSO

Herman (1992), *Trauma and Recovery*, Philadelphia


World Health Organisation (1992), **ICD-10**, Geneva

British Psychological Society & The Royal College of Psychiatrists (2004) **Self Harm**, BPS, Leicester
BPD & DSH 5: Appreciating the biological

Having devoted a post to the role of trauma in the development of borderline Personality disorder I think it necessary to balance the picture with a brief account of some of the genetic and neurological advances and discoveries of recent years. Although the emphasis throughout this blog will be upon the more social and psychological implications I’d hate to give people the impression that there was no biology behind disorders such as this. So...

Perhaps one of the most exciting developments in this area involves genetic research. Professor Timothy Trull of the University of Missouri together with a Dutch team of researchers studied the genes of 711 pairs of siblings and 561 parents and identified ‘chromosomal regions’ that could identify a genetic marker for the problems associated with Borderline Personality Disorder:


Trull and his colleagues found that around 42% of variation in BPD features may be attributable to genetic influences with approximately 58% likely to be the result of environmental or other influences. The strongest correlation was found on chromosome ‘9’.

Essentially it appears that problems with mood regulation may well be partly related to a biological vulnerability.

Regular readers of this blog will be aware of the concept of stress and vulnerability in mental disorder that we discussed in an earlier post:

http://stuartsorensen.wordpress.com/2010/03/02/emotional-management-24-introducing-%e2%80%98stress-and-vulnerability%e2%80%99/
http://stuartsorensen.wordpress.com/2010/03/15/emotional-management-30-biological-stressors/

In 2007 Pascual JC et al found a potential link with the 5-HTT gene relating to some of the traits associated with Borderline Personality Disorder:


There is also some evidence to suggest that the emotional instability seen in Borderline Personality Disorder might correlate to the functions of the amygdale, a region of the brain that is important in emotional regulation.

However this latter finding should be treated with caution. We know that the brain changes in relation to experience and so any alterations in brain function or structure may be the result of emotional difficulties rather than the cause.

However, as I stated in a previous article on Borderline Personality disorder:

Teicher et al (1994) identified dysfunction in the limbic system, particularly relating to the hippocampus and amygdala although the research was unclear as to whether this dysfunction was the result of neurological changes secondary to abuse.

"The Hippocampus"... is essential for the laying down of long term memory. The amygdala, in front of the Hippocampus, is the place where fear is registered and generated."(Carter R. 1998 p.42)

Given the essential functions of these two areas of the brain we can begin to understand the possible neuro-biological origins of certain Borderline traits such as emotional lability, splitting (the tendency to characterize things as 'all good' or 'all bad'), and the condition's dissociative traits.

It is interesting to note that many researchers have identified serotonergic dysfunction in the brains of BPs. This may have marked implications for the maintenance of mood and also go some way towards explaining the frustration and rage routinely exhibited by sufferers (Seiver L.J. 1997).

**Equifinality model**

The equifinality model postulates that both the 'nature' and 'nurture' paradigms are equally valid. In brief it suggests that a biological vulnerability, perhaps inherited in BPs with a family history of neurological disorder or created as a result of neurological changes secondary to PTSD in childhood is a necessary element of Borderline Personality disorder. The biological sequelae of childhood trauma is an area which we are only just beginning to understand. New studies suggest a wide range of neurobiological changes as a result of childhood sexual abuse (Seiver L. J. 1997).

In addition to the biological factor, however it may arise, trauma of one kind or another does appear to be vital. This may be sporadic as is often the case in physical or sexual abuse or more chronic as already noted via the mechanism of Linehan's 'invalidating environment'.

**Treatment**

It is no secret that this particular client group can present real problems when it comes to finding effective therapeutic interventions. The treatment of BP is fraught with difficulty, particularly in an inpatient setting where many ‘borderline behaviours’ result in discord among the staff or where the demands made upon an individual nurse can become extremely unrealistic.

Treatment of BP falls into two main categories - pharmacology, incorporating a range of medication options and psychotherapeutic techniques ranging from supportive counselling to psychoanalysis. Although many of the treatments available fall firmly outside the remit of the RMN it does no harm for nurses to understand the options available.
Pharmacological treatments include:

SSRIs to combat the deficiencies in serotonin absorption;
Neuroleptics to treat psychotic symptoms as well as dysphoria;
Carbamazepine has been used in the treatment of behavioural and affective problems
(Cowdry R.; Gardner D. 1988);

Thyroxin as many sufferers have symptoms of hypothyroidism.

It has been reported that alprazolam can decrease behavioural control and that
amitriptyline increases paranoia, assault and suicide threats (Cowdry R.; Gardner D. 1988).
BPD & DSH 6: Trauma and Coping

In previous posts I have talked about the link between past trauma and the diagnosis of Borderline Personality Disorder. Today I’d like to elaborate a little upon that link. This is a theme that will continue throughout the rest of this series of posts.

I would like to be clear that although we will concentrate today on the psychological, emotional and behavioural impact of trauma I am not suggesting that there is no biological element to this. Neurological research has demonstrated that there are very real changes in the brain associated with traumatic experience and there is good evidence to suggest that these changes are especially significant in the development of people subsequently diagnosed with BPD.

However – the fact that an individual’s brain may have undergone changes doesn’t prevent them from learning to cope per se – it just might make it more difficult. That’s why they’re service-users in the first place. We can acknowledge these realities without using them as a reason to give up on the task of helping the individual to overcome their problems.

So I’ll concentrate here upon the psychological and emotional simply because this is the area in which most people can have an impact – not because it’s all there is to the situation.

As we will see over the course of this series the emotional and behavioural difficulties associated with BPD can be thought of as difficulties in coping. In many cases the coping strategies employed by people who attract the BPD label seem to be those more commonly associated with children and adolescents.

In making this comparison with adolescent coping I am not attempting to criticise people or write them off as ‘childish’. Rather I wish to acknowledge from the outset the nature of the problem. This post aims to outline the reasons for this situation and why childhood trauma creates the problems we see. Let’s begin by thinking about ‘ideal’ or ‘normal’ emotional development in childhood.

Consider a newborn baby. What coping skills does this child possess?

She can cry and after a few hours she can smile and giggle to get others to meet her needs. However she does need others to do things for her. She is utterly dependent upon them for her survival and she is unable to ‘self-soothe’ to make herself feel better should others fail to respond. In other words she lacks ‘frustration tolerance’.

By the time that she is two years old our little baby, let’s call her ‘Judy’, has developed some limited coping skills.

Although it was difficult and quite unpleasant for her at first she has had to learn to accept the occasional, inevitable delay in having her needs met and as a result she’s learned how to deal with this delay so long as it’s not too long. Now Judy can self-soothe for a short time before she becomes distressed. There is a really important point here...

Judy only learned to deal with these short delays by facing them. It is experience that teaches us the lessons of life – including how to cope.

Let’s move forward another few years. It is Judy’s fifth birthday and already she has developed the ability to cope with delay and also to ‘give and take’ within her social
group. Judy has settled in at school where the demands of the other children alongside her own have meant more delays in getting attention from teachers. This experience has given her the opportunity to improve her frustration tolerance.

Over the next few years Judy will face more and more situations, each a little harder to deal with than the last and in doing so she will develop more and more coping skills. This is how most of us mature until eventually, sometime in our twenties, we find ourselves with a more or less full set of adult coping strategies.

We can get the sense of the gradual nature of this process if we think of the child’s development as a series of ‘snapshots’ in this way. The next snapshot we’ll consider in Judy’s life then is her tenth birthday.

By now she’s become much more emotionally secure. She can distract and soothe herself in a huge variety of ways from art to reading or imaginary play and she is much happier to spend significant periods of time alone. She is still dependent upon her parents but Judy can cope without their constant attention. She is a great deal more skilled than she was five years ago.

By the age of fifteen Judy has learned to handle an even greater range of stressors. She can cope with emotional distress, however unpleasant, and even the inevitable breakup with her first boyfriend. There will be tears and there may even be tantrums but she will survive it. In doing so Judy will rely heavily upon the coping skills she learned and practiced in the much less severe ‘fallings out’ she faced in the previous ten years of schoolyard politics and the ever shifting loyalties of children.

This is another major point...

**Stressors have themes.**

By learning how to deal with abandonment in a small way Judy developed the skills she’d need later to cope with a much more significant abandonment by her boyfriend years later.

Coping skills are arranged in themes and we develop them gradually in little steps by facing a succession of stressors, each slightly, but only slightly, more difficult than the one before. The ideal is for each new situation to stretch the child’s coping ability but never to overwhelm them. It is the concept of overwhelming stress, of trauma, that we turn to next.

When children are faced with overwhelming trauma (stress that is beyond their limited coping skills to deal with) they can respond in several ways. Some children simply shut out the trauma and refuse to face it. This is what many people mean when they say that the child (or adult) is in ‘denial’. If they don’t acknowledge the trauma they don’t have to face the emotional pain that accompanies it.

Unfortunately it’s not only coping skills that we arrange in themes. We arrange traumatic experiences thematically too. If we shut out one traumatic experience we tend to shut out the entire theme too. This means that we can’t let ourselves acknowledge and face any similar traumas, however small, without the overwhelming one cropping up as well.

To illustrate this let’s imagine that our imaginary little girl, Judy, has developed normally until the age of twelve. Unfortunately though, disaster strikes on her twelfth birthday. She is the sole survivor of a road traffic accident that wiped out the rest of her entire family. Understandably this trauma goes way beyond anything she’s learned to deal with
until now and is overwhelming for her. It would take some dealing with for an adult come
to that but at twelve Judy is almost certain to lack the necessary coping skills.

There are many possible themes for Judy in this situation but we will consider only one –
abandonment.

At twelve years old Judy is still dependent upon her parents. Their sudden death leaves
her alone and yet still unable to fend for herself. Of course society will step in to look
after her and she will be fed and housed. She might be lucky enough to get the sort of
sensitive adult care she needs to deal with the trauma but she might not. However
unintentional it may be the fact is that in Judy’s little mind she has been abandoned –
and it hurts.

The emotional distress she feels is so overwhelming that she shuts it out and refuses to
look at it again. At the same time she refuses to acknowledge any other ‘abandonment’
trauma.

**We develop coping skills by facing stressors. When Judy stops facing
abandonment stressors she also stops learning how to deal with it.**

This has major implications for future coping and also for two of the terms we’ll define in
future posts. These terms are ‘instability of mood’ and ‘dissociation’.

For now it’s enough simply to know that even as an adult it is likely that Judy’s response
to abandonment, from divorce to arguments or even brief periods of separation from
loved ones will mirror that of a traumatised twelve year old because she’s never allowed
herself to learn anything better.

We can see then why this sort of overwhelming acute trauma can affect the development
of coping skills. The same principles are relevant to more chronic (long term) trauma
although the mechanism may be a little different.

Imagine that Judy hadn’t experienced anything so sudden or dramatic as a car accident.
Instead she had spent her developing years dealing with criticism and hostility so that
whatever she did she couldn’t succeed. Imagine what it would be like for Judy to be
scapegoated by her family and blamed for every little mishap.

What if Judy was beaten or neglected? What if every attempt she made to assert herself
or her independence was met with aggression or hostility? It’s not hard to see why she’d
shut out her emotions in these circumstances just as surely as if she’d been suddenly
bereaved. It may well have been her only viable defence as a helpless child but it would
also prevent her from learning how to cope.

In the following posts we’ll build upon this general explanation to look at some more
specific ‘symptoms’ or traits of Borderline Personality disorder, how they relate to coping
and how best to help the individual concerned.
BPD & DSH 7: Instability of mood and Dissociation

In the preceding post of this series we considered the way that trauma affects coping. The significant mechanism here is a response to overwhelming emotional distress. Let’s examine what that distress might be like.

One of the core tasks in developing emotional control is to learn how to tell the difference between the various emotions we feel – to categorise them if you will. You can get a sense of this emerging classification of emotions by talking with children of different ages and also with adults about their feelings.

Young children have only limited understanding of their emotions. They may not be able to define much more than the very basic distinctions between ‘happy’ and ‘sad’. As they get older they develop a clearer understanding until the emotionally healthy adult (if there is such a thing) can differentiate between literally dozens of moods and feelings.

Remember our imaginary twelve year old, Judy from the last section:

http://stuartsorensen.wordpress.com/2010/03/31/bpd-dsh-5-trauma-and-coping/

When she stopped developing coping skills she also stopped learning how to categorise her feelings. She is as confused about what she feels (and about what she thinks she ‘ought to’ feel) as any other twelve year old. The problem is that unless something changes she may never learn to be any more precise about her emotions, even as an adult.

This ability to define our emotions seems to be important in our selection of emotions. As we saw in an earlier post on the cognitive model thoughts and feeling are inextricably linked:


It seems that the ability to name our emotions is important too.

The upshot is that people diagnosed with Borderline Personality disorder often go through periods of ‘instability of mood’ during which they seem to experience a jumbled mixture of ill-defined emotions. As one former service-user said to me:

"It's like feeling all emotions at the same time and no single emotion in particular."

This is both distressing and bewildering.

Another common response to stress is known as ‘dissociation’. This is what happens when, in order to escape distressing emotions, the individual shuts them out at a deep psychological level. As a way to make sense of dissociation I’d like to begin by relating it to a much more ordinary, everyday phenomenon.

Have you ever had the following experience?

You have a long distance to drive along familiar or uninteresting roads. There’s nothing particularly fascinating about the journey – it’s just long.

You arrive at your destination and someone asks you if you had a good trip but you don’t really know what to say. This is because although you can remember getting into the car
and you can remember getting out of the car you can’t remember what happened in between.

Most drivers can relate to this experience. They don’t remember the journey because it was boring. They let their thoughts ‘wander’ as they drove and so they can’t recall the journey because they weren’t paying attention to it at the time.

Of course most drivers aren’t completely inattentive and if the car in front brakes suddenly they immediately shift their attention back again and apply the brakes themselves. Nevertheless, for most of the time drivers are dissociating, however ‘mildly’ from the journey at hand. However the sort of dissociation we’ll consider in these blog posts is much deeper than that.

**Drivers dissociate because they’re bored.**

**Traumatised people dissociate because they’re overwhelmed.**

Remember the concept of emotional ‘themes’. This is why it is not uncommon for people who have experienced extreme trauma to dissociate away from conversations or seemingly innocuous events that remind them of their distress. This can make therapeutic work with such individuals extremely difficult and there is a high risk that they will disengage from therapy unless it is handled sensitively and with real understanding. This also goes some way toward explaining why relationships with people diagnosed with Borderline Personality Disorder can be so unstable although it’s not the only reason.

Whether they disengage from therapy or not this type of dissociation is often so deep that the person cannot easily be brought back into ‘normal’ consciousness. It is also the state of mind in which many people go on to harm themselves.

There’s a clue here to one of the reasons for self harm and we’ll pick up on that later.
BPD & DSH 8: The Invalidating Environment

“The environmental disorder is any set of circumstances that pervasively punish, traumatize, or neglect this emotional vulnerability specifically, or the individual's emotional self generally, termed the invalidating environment. The model hypothesizes that BPD results from a transaction over time that can follow several different pathways, with the initial degree of disorder more on the biological side in some cases and more on the environmental side in others. The main point is that the final result, BPD, is due to a transaction where both the individual and the environment co-create each other over time with the individual becoming progressively more emotionally unregulated and the environment becoming progressively more invalidating.”

Linehan M (1997)

Marsha Linehan, quoted above, is famous for her work on the subject of Borderline Personality disorder and the creation of Dialectical Behaviour Therapy, a blend of various principles from cognitive therapy and Zen Buddhism among others. Linehan studied the various factors that contribute to the creation of Borderline Personality Disorder and looked both at the causes and the ways to overcome them. The result, DBT is one of the most evidence-based and verifiable approaches to the treatment of people diagnosed with BPD.

We'll look at DBT in more detail in a later post. For now I’d like to spend a little time covering the very basic principles of what Linehan called the Invalidating Environment’.

“An emotionally invalidating environment is any environment in which a person’s emotional experiences are not responded to appropriately or are responded to inconsistently. For example, in an emotionally invalidating home environment, a child who becomes frustrated and cries may be told

"stop being such a baby."

In extreme examples, a child may be physically assaulted for expressing feelings. ”

Kristalyn Salters-Pedneault, PhD (2008)

When we discussed the role of trauma in an earlier post we made the point that trauma does not necessarily need to be acute (sudden/intense). It can be chronic (long-lasting) and might be relatively undramatic. This is the case with the Invalidating environment that Marsha Linehan identified.

In essence the very basis of emotional development is destabilised by the environment itself – or rather by the people who share that environment with the developing child. And it doesn’t really matter what the response is so long as it demonstrates that the child is ‘in the wrong’ or that their feelings are somehow inappropriate.

In truth all people have a perfect right to feel whatever they feel in any given situation. That is our private emotional life and it’s entirely up to us how we run our emotions. It may be reasonable to help people to control their emotions better but the fact remains that they can choose what emotion to feel for themselves. They can feel whatever they like. The only real question then might be:

“But why would you want to?”
By helping people to understand their choices we can help them to develop self control. By invalidating the choices they have already made and blaming them for feeling bad for example all we do is introduce doubt and confusion into their emotional world. After a while the child comes to believe that they can neither control nor even trust their emotions. This is one possible explanation for the tendency to experience instability of mood in adults with the diagnosis of BPD. They don't trust their emotions enough to know what to feel and so they end up experiencing a jumbled emotional mass that they cannot fully understand.

It is not necessary for the child to be beaten or abused sexually for this to happen. All it takes is for the child to be exposed to consistent criticism or for their beliefs to be undermined without rational explanation. If the way the child is treated by caregivers is inconsistent or if they are placed in the stereotypical ‘double-bind’ situation in which whatever they do they will be wrong then we have an Invalidating Environment.

The antidote to this is to acknowledge the child’s feelings – be clear that they are perfectly entitled to feel what they do and then, whenever possible, ‘catch them doing it right’. Many households have fallen into the habit of catching the child doing things wrong and then either punishing or mistreating them as a result. This is one of the hallmarks of an Invalidating environment.

The validating environment is at least as likely (if not more so) to catch the child doing it right – especially in matters of emotional control. So the child who feels angry but then manages to control their aggression is praised for their control – not criticised for the anger. The angry emotion is acknowledged as valid even if it’s not the best or most effective emotion that the child could have chosen. It’s OK to explain that anger is not always an appropriate response in difficult situations (that helps the child to develop understanding) but not to say that the feeling itself isn’t valid.

There’s a time and a place for every emotion – even anger.

**A validating environment catches the child ‘doing it right’**.

I need to be absolutely clear here – the invalidating environment is not the ‘norm’. Almost all families have moments of invalidation during which people’s emotions and opinions are not considered. As a father and stepfather I am well aware of the limitations of ‘good enough’ parents and none of us are perfect. This is not a problem.

Invalidating environments are those in which criticism and invalidation are constant. It takes more than the occasional row with your mother to constitute an Invalidating environment. It takes more than the odd inattentive moment from your father. These are the normal experiences of the average childhood.

In the Invalidating environment the child is seen as a problem ‘in themselves’. They are criticised for having problems and the ease with which those problems might be solved is also exaggerated. The child is then criticised for failing to solve the problem on their own and then, to add insult to injury, further blamed and criticised for feeling bad about their inability to overcome their difficulties.

The net result of this is that the child grows up believing themselves to be useless and possible even ‘evil’ or ‘unworthy’. They experience guilt about every little mishap – even if it’s not their fault because they failed to prevent it (as usual) and they also come to believe that they cannot rely upon themselves to keep safe. So, no matter how toxic the environment they are in might be they are frightened of being rejected by those they are close to – of abandonment because they do not trust themselves to survive alone.
They can’t even decide what to feel unless someone else tells them. This, of course, means that adults with a history of Invalidating Environments as children often lurch from one abusive relationship after another because the control they experience lets them off the emotional hook. They can rely upon others to tell them what to feel. It also explains why it can be so hard for them to remain in more normal relationships where they are expected to run their own emotional life. After all – a caring partner will want to understand what the other person feels. This is a source of real confusion and often fear for the individual who has never learned to make sense of their emotions in the first place.

References

Linehan M. (1997) Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder The Journal Vol. 8/Iss. 1

Kristalyn Salters-Pedneault, PhD 2008 http://bpd.about.com/od/glossary/g/invalid.htm
BPD/DSH 9: Unstable relationships

Think back, if you will, to the diagnostic criteria for Borderline Personality Disorder as defined in an earlier post:

http://stuartsorensen.wordpress.com/2010/03/25/bpd-dsh-3-what-is-borderline-personality-disorder/

’a lifelong tendency to quarrel and create conflict’ and at least four of the below (at least two of those printed in bold).

- A marked tendency to act unexpectedly without considering consequences.
- Outbursts of anger or violence, & inability to control resulting behaviour.
- Difficulty in working towards long term goals.
- Unstable mood.
- Uncertainty about self-image and identity (including sexual).
- Intense and unstable relationships, often leading to emotional crises.
- Excessive efforts to avoid abandonment/rejection.
- Repeated threats or acts of self-harm.
- Long-lasting feelings of emptiness.

Adapted from:
World Health Organisation (1992)

By now it should be becoming clear how early trauma, with or without a co-existing biological vulnerability, can create problems in emotion regulation. In the following few posts I hope to show how the very issue of trauma contributes to the criteria above and how, far from being a list of symptoms in their own right, they are all simply different reactions to the original trauma. In essence the criteria for Borderline Personality disorder are little more than a description of a traumatised individual.

For now we’ll focus primarily upon the unstable relationship criterion although this, in itself, is really just the inevitable outcome of the rest of the ‘symptoms’ or traits of the Borderline Personality disorder’ diagnosis.

It’s no surprise that Borderline Personality disorder is found in the category of ‘emotionally unstable’ personality disorders. Let’s look at the interpersonal impact of that emotional instability. Imagine yourself in a relationship with someone diagnosed with Borderline Personality Disorder.

Your partner, as we have seen, cannot rely upon his or her own emotional control. This bewildering state of affairs makes them prone to act irrationally and impulsively. It also makes aggression more likely than it might be for other people as the lack of emotional control is inherently frustrating. These outbursts are most likely to be directed toward you, if only because you happen to be present at the time.

The other reason for you to be the target is because, since people with a diagnosis of borderline Personality disorder rely upon others to direct their emotional life, you will be blamed for their distress whether or not you had anything to do with it. As one author famously put it – you are the emotional mirror (see Lost in the Mirror by Richard A. Moskovitz).

Unless you’re exceptionally placid and understanding you will find this extremely difficult to cope with. You too will become emotionally disrupted resulting in quarrels and
arguments. It is an almost inevitable outcome of the equally inevitable need your partner has to push until they get a response. That’s how they know how to feel – it’s your response that guides them. This is the mechanism behind the ‘quarrelsome’ criterion.

A common reaction from partners is simply to give up and leave the relationship. They are effectively driven away by the chaos they experience in trying to stay with the Borderline Personality disordered person. However the split triggers another of the BPD criteria – the fear of abandonment. Without the other person to act as an emotional mirror they are lost, bewildered and even more needy. Hence the frantic attempts to avoid abandonment by making up with their partner – you.

Over time this pattern of hostility and reconciliation comes to characterise an extremely unstable relationship. Just like the rest of the borderline Personality disorder criteria it is an inevitable and logical outcome of the early trauma we described earlier.

In the next few posts we will build upon this basic explanation by considering the effect of other borderline Personality disorder ‘traits’ such as:

Black & White Thinking

Concrete thinking

Paranoia

Transient psychotic episodes
BPD/DSH 10: ‘Borderline’ thinking

In this section I’d like to consider some of the characteristic thinking ‘styles’ prevalent among people who attract the diagnosis of Borderline Personality disorder. To understand why these thinking styles are so prevalent it’s important to remember what we said about ‘arrested emotional development’.

In ‘normal’ development as people move from childhood through adolescence and on into adulthood they refine their awareness of the world and their thinking develops along with it. Unfortunately, just as early trauma can interfere with emotional development the same is often true of the development of thinking styles.

So the thinking habits we will discuss here are essentially adolescent or even child-like in nature. I realise that in making this point I’m inviting a degree of criticism from people who may be offended by my comments. However I do not believe that I can do justice to the topic of Borderline Personality Disorder if I miss out such a fundamental aspect of the condition.

As a matter of fact Marsha Linehan’s famous model of ‘Dialectic Behaviour Therapy’ is as it is precisely because of the first of these thinking styles.....

Black and White Thinking

This is the world view that deals in opposites. Mature thinkers accept the presence of ‘grey areas’ in the world. For example they understand that nobody is perfect and that all people, however nice or well-meaning have ‘feet of clay’. We are all fallible.

This can be a difficult concept for Black & White thinkers. In their world view, based as it is upon polar opposites the world and the people in it (including themselves) are either completely good or completely bad. The concept of ‘good’ people having faults or imperfections is very hard for them to deal with.

This is a necessary stage in the development of a child. Young people need to rely upon their parents or other care-givers to keep them safe and this is much easier and less frightening if they believe that their protector is infallible. This is one reason why even in abusive relationships children remain loyal to their adult ‘protectors’. It’s just too frightening to admit that their survival depends upon someone who might make mistakes.

Only as we develop and become more confident that we can keep ourselves safe can we begin to acknowledge the deficiencies of care-givers. Until that time we are emotionally and psychologically obliged to think of that other person as perfect and infallible.

Bear in mind that it is this very self-reliance that is so hard for the traumatised child to develop. People diagnosed with borderline Personality disorder may never have moved beyond the stage of needing to rely upon someone else. They lost the ability to rely upon their own resources, emotions and responses before that ability really developed in the first place.

The other side of this is that people who do not live up to our imagined standard of perfection must be completely ‘bad’. Remember that there is no grey area. The inevitable result is that people are placed into extreme and polarised categories of ‘good’ and ‘bad’ with no intermediate.
The problems this causes in adult thinking are extreme both for social relationships and therapeutic or professional ones.

"Don't put me on a pedestal because I won't be able to keep it clean."

The fact is that nobody can ever really live up to the standards set for them by a person with Borderline Personality disorder. If you are a carer, nurse or support worker it is vital that you absolutely refuse to allow the service-user to put you on a pedestal. If you do it will only be a matter of time before you fail to meet expectations. You will come crashing down to earth with a bang. At this time, since you clearly are not completely ‘good’ you must be completely ‘bad’ in the mind of the service-user. This is part of the reason for the paranoia that we will consider later.

Since you have fallen off your imaginary pedestal you are no longer in a position to keep the service-user safe. You are fallible. This means that the service-user needs to find another protector. If you work as part of a care team you will already be familiar with this pattern of ‘shifting loyalties’ as different team members find themselves variously ‘on’ and ‘off’ the pedestal.

This is not, as some suppose, a ‘manipulative strategy’ designed to ‘play one off against the other’. In reality this behaviour is not about ‘us’ as workers at all. We’re not that special. This pattern of shifting allegiances is the interpersonal result of a desperate search for a reliable protector.

To treat the service-user as ‘manipulative’ because of this is at best superficial and at worst psychologically abusive. The most reasonable response is to share both credit and blame throughout the whole team and refuse either to get on the pedestal or to criticise colleagues in front of the service-user.

Never forget however that complaints by service-users must be investigated properly. Abuse does happen and the moment we start to disregard a service-user’s allegations because of their diagnosis we create the conditions that attract abusers to that person purely because they will never be taken seriously. So follow procedures when the allegations come - just don't get into ‘pedestal hopping’ as well.
BPD/DSH 11: More thinking styles

In the last post we looked at black and white thinking. In this section we will consider another 'adolescent style' of thinking known as 'concrete thinking'. Like the concrete used in building this style of thinking rapidly 'sets' to become fixed and unyielding.

Continuing the theme of emotional and psychological security, young people tend to fix their opinions and do not easily consider alternatives. This thinking style is very evident among teenagers who may come to define communism as unquestionably fair or teachers to be unerringly cruel. As you can see these are also examples of black and white thinking. It is the inability (or at least extreme reluctance) to consider alternatives that make these attitudes and opinions fixed or 'concrete'.

Remember: There is security in certainty

It is this same combination of black and white thinking and concrete thinking that gives racism its power. It is no surprise that in these times of financial uncertainty so many people feel uneasy and resort to concrete thinking in order to provide a scapegoat. I blogged about this process earlier in relation to the UK's own neo-Nazi party – The British National Party – not that I'm suggesting any particular connection between Borderline Personality Disorder and the BNP.


It is interesting although not surprising to note that the BNP has since provided further evidence of paranoia (a common outcome for black and white thinkers) and it seems that even within its own ranks there is division and discrimination.


This is an excellent example of the problem with continuing adolescent thinking styles into adulthood and even into political organisations.

Of course I am not attempting to suggest that all people diagnosed with Borderline Personality Disorder are supporters of the British National Party. That would be a ludicrous assertion to make. Nor am I suggesting that all members of the BNP should be diagnosed with Borderline Personality Disorder. That would be equally ludicrous.

I am simply using this example to illustrate the way that such thinking styles can come together to create very real problems in relationships and in approaching life in general. The need for psychological security can lead people to all sorts of irrational conclusions. The paranoia and dichotomous (black and white) thinking of neo Nazi organisations like the BNP is one such example but it is most certainly not the only one.

There is psychological security in scapegoating others, no matter how irrational that scapegoating might be.

Another characteristic of people diagnosed with Borderline Personality Disorder is the tendency to experience episodes of psychosis. This can mean hallucinations (hearing voices for example) which are often associated with trauma. However it can also mean delusions which are defined as:
Fixed, false beliefs not amenable to reason.

It’s not difficult to see how a combination of ‘black and white’ and ‘concrete’ thinking coupled with a need for emotional and psychological security can lead to this sort of belief.

This is why members of the BNP are paranoid and racist;

This is why religious fundamentalist terrorists ignore the realities of multi-cultural societies and the common human qualities that we all share;

This is why people diagnosed with Borderline Personality Disorder adopt all sorts of irrational beliefs and can be extremely difficult to reason with.

All three of the groups mentioned above are different and the nature of their beliefs vary but all can become delusional and therefore psychotic. Additionally these beliefs all seem to spring from anxiety and a need for emotional and psychological security.
BPD/DSH 12: DSH in the community

Look at the list of activities below. Give yourself one point for each behaviour you indulge in. Give yourself an additional point for each behaviour you indulge in when you’re stressed or under pressure:

- Smoking
- Drinking alcohol
- Using prescribed medication or illicit/recreational drugs
- Over-eating
- Over-exercising
- Punching inanimate objects/throwing things/breaking things
- Hitting others/starting fights
- Biting nails/fingers until they bleed
- Pulling out your own hair

How did you score?

There’s no scoring matrix to match your score against and there are no deep psychological insights into your temperament and personality to follow. I simply want to make the point that these are all coping skills and they all have a couple of things in common:

- They all are designed to make us feel better;
- They all create their own problems and are in some way harmful to us.

Many of us respond to stress by doing things that damage us in the long term (or even the short term) but that briefly allow us to feel better or to forget our troubles for a while. Psychologists call these activities ‘safety behaviours’. They give the illusion of safety or security but tend to make things worse in the long term. They are a remarkably common aspect of human coping.

When we look at the more extreme forms of these self-damaging behaviours such as violence or over indulgence in intoxicating substances such as alcohol it is easy to see the folly. Yet these behaviours are just the extreme end of a continuum, a ‘sliding scale’ if you will of self injury with a cream cake at one end and a razor blade at the other.

Deliberate self harm then is widespread throughout Western society as a coping strategy – a response to stress. Why then are some forms of self-injury, heavy drinking for example more acceptable than others such as self-mutilation?

Actually they’re not necessarily. For example in the ‘EMO’ culture among young people (I still want to call them ‘Goths’) deliberate self harm through cutting for example is much more acceptable than others such as self-mutilation.

"About 1 in 10 young people will self-harm at some point, but it can occur at any age. It is more common in young women than men. Gay and bisexual people seem to be more likely to self-harm."

Sometimes groups of young people self-harm together – having a friend who self-harms may increase your chances of doing it as well. Self-harm is more common in some subcultures – ‘goths’ seem to be particularly vulnerable."

Royal College of Psychiatrists leaflet: ‘Self Harm’

www.rcpsych.ac.uk
However in the West Cumbrian, working culture of the 1970s in which I grew up the reverse was true. As a young man I would never have dreamed of taking a razor blade to my arm but I’d think nothing of settling my problems with my fists. I’m happy to say that I’ve since changed my attitude to violence but the point still stands. Every culture and sub-culture has its own acceptable forms of self harm in response to stress although some of them are more ‘diagnosable’ than others.

Some groups actually use deliberate self harm and the scars associated with it as a kind of ‘badge of honour’. It’s as though deliberate self harm has become the ‘price of admission’ and social acceptance just as the ability to hold your own in a fight or to drink more than the next man defines group identity in other circles. In the EMO culture I mentioned above self-inflicted wounds and scars can be thought of as evidence of emotional sensitivity and in that sense they are just as valid as the intricate scarification and body modification found in some isolated Amazonian tribes – not to mention the West coast of the United States.

However there are two significant problems with this rather liberal understanding of deliberate self harm:

- Like most mental health classifications deliberate self harm can legitimately be considered from a wider cultural context and the majority of people in Western culture consider it to be inappropriate, at least in the more clinically defined versions of self harm;
- Deliberate Self Harm creates genuine injury and as such it is reasonable for clinicians and others to consider it a problem.

However the fact that you or I might consider deliberate self harm to be a problem does not automatically mean that our service-users will agree. Any intervention that does not acknowledge the sub-cultural acceptability and even benefits of deliberate self harm is likely to fail.
BPD/DSH 13: Clinically significant Self Harm

As we have seen some forms of deliberate self harm are more socially acceptable than others. The specific delineation between ‘acceptable’ and ‘unacceptable’ changes as society evolves. A topical example of the way that society’s tolerances change relates to smoking. Twenty years ago this form of deliberate self harm was completely acceptable. Today society has a rather uneasy relationship with the habit. It may be that in just a few more decades it will be just as socially unacceptable as opium use is today – a state of affairs that would have been very hard for our Victorian forebears to understand.

For today though Deliberate Self Harm is generally considered to mean physical injury or ingestion of substances, prescribed or otherwise, that harm the person.

According to the National Institute for Clinical Excellence (NICE)(2004) self-harm means:

“self-poisoning or self-injury, irrespective of the apparent purpose of the act”.


The words ‘irrespective of the apparent purpose of the act’ seem reasonable in that the body doesn’t know how many tablets are supposed to be harmful and so whatever the reason for taking 20 sleeping tablets, even if you just want a good night’s sleep, the harm is real and should be taken seriously by clinicians.

Unfortunately the NICE guidelines go on to confuse the issue and the document appears to contradict itself a few sentences later:

“The guideline focuses on those acts of self-harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person’s control or even awareness, during ‘trance-like’, or dissociative, states. It therefore uses the term ‘self-harm’ rather than ‘deliberate self harm’.”


This seems to be an attempt to get past the problems with definition, acceptability and unacceptability we outlined earlier. The statement is contradictory because society’s attitude is contradictory and the closer we look at self harm (deliberate or otherwise) the more we see the double standard. Still, at least the guidelines do acknowledge that self harm is often a response to distress

The most common reasons given were ‘to get relief from a terrible state of mind’ followed by ‘to die’, although there were differences between those cutting themselves and those taking overdoses. About half the young people decided to harm themselves in the hour before doing so, and many did not attend hospital or tell anyone else. Just over half those who had harmed themselves during the previous year reported more than one episode over their lifetime.”

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Deliberate Self Harm can also be the result of dissociation – a psychological state we mentioned earlier and that we will pick up on again shortly.

I don’t want to get too deeply into a discussion of addiction as a reason for deliberate self harm here because that will only cloud an already confused issue of definition. All I will say is that there is an assumption that addiction to a chemical is treated differently from deliberate self harm even though in many cases the actual chemical effect of causing physical trauma is directly comparable to the effects of illicit substance use.

It has been said that the main problem associated with Deliberate self Harm is not the physical damage itself so much as the stigma that surrounds it. Personally I don’t think that this is true – at least not in every case but there is certainly a major issue with stigma and the attitudes of some workers toward people who harm themselves.

Much of the stigma comes from the many myths and misconceptions that abound among professionals and the public alike about the reasons behind Deliberate Self Harm. I remember as a student nurse in the early 1990s being fed these same myths by nursing and medical staff. The failure to see past our own perceived importance as professional ‘experts’ was rife and it led to some extremely damaging and cruel approaches to people who harm themselves. Let’s look at some of the more common misconceptions.

Perhaps one of the most common myths is to do with the notion of the ‘cry for help’. The idea is that by cutting or otherwise injuring themselves clients are trying to get some sort of assistance from services. If this is true then as professionals working in the field we need to ask ourselves some very difficult questions such as......

- Do these people really not know how to ask for help?
- If not – why not?
- What sort of help can I offer them that is worth self-mutilation in order to achieve it?
- Am I really that special?
- How good am I at noticing people’s distress if they need to resort to self-harm to get my attention?
- What’s wrong with our access policies?
- How good are my listening skills?
- How ‘accessible’ am I if people can’t just talk to me and ask for what they want?
- What does this say about me as a professional and as a person?

Another myth is that self harm is an attempt to manipulate or emotionally blackmail professionals.

- Do we really believe ourselves to be so important that people will mutilate themselves just to influence our thoughts, feelings and behaviours?
- Is deliberate self-harm really all about us as professionals or is it more to do with the personal needs of the client?

Then there is the good old ‘attention seeking’ myth. It doesn’t take a genius to work out how inaccurate such an assumption is likely to be when we understand that the vast majority of deliberate self harm is done secretly and in private.

“Since many acts of self-harm do not come to the attention of healthcare services, hospital attendance rates do not reflect the true scale of the problem.”

Self Harm
The British Psychological Society
& The Royal College of Psychiatrists, 2004
What we do know is that the incidence of clinically significant Deliberate Self Harm is rising in UK.

“Although the prevalence statistics are not as reliable as one would like, there is no disputing the fact that self-harm has increased markedly in the UK in recent years. Indeed the rate of self-harm in the UK is amongst the highest in Europe”

The Psychologist
Vol.18 – Part 7 – July 2005

Although this series of essays deliberately aims to discuss the ‘crossover’ population of people with a diagnosis of Borderline Personality Disorder who also engage in Deliberate Self Harm, we also know that it is unhelpful to assume the diagnosis and even more unhelpful to focus upon it rather than the problems the human being before us is experiencing irrespective of diagnosis.

“Certain psychological characteristics are more common among the group of people who self-harm, including impulsivity, poor problem-solving and hopelessness. Also, people who self-harm more often have interpersonal difficulties. It is possible to apply diagnostic criteria to these characteristics. This explains why nearly one-half of those who present to an emergency department meet criteria for having a personality disorder. However, there are problems with doing this because:

1. There is an unhelpful circularity in that self-harm is considered to be one of the defining features of both borderline and histrionic personality disorder.
2. The diagnostic label tends to divert attention from helping the person to overcome their problems and can even lead to the person being denied help (National Institute for Mental Health in England, 2003).
3. Some people who self-harm consider the term personality disorder to be offensive and to create a stereotype that can lead to damaging stigmatisation by care workers.”

Self Harm
The British Psychological Society
& The Royal College of Psychiatrists, 2004

Ironically it seems that this trend of increasing deliberate self harm might actually be the result of society’s angst over the issue. One interesting theory about the rise of deliberate self harm, particularly among the young is that by raising awareness and normalising the behaviour well-meaning campaigns are creating an environment that encourages it:

“In my view, as long as self-injury is discussed as a common and legitimate expression of distress amongst students and young people, and as long as the behaviour is normalised and publicised through awareness initiatives, people will increasingly turn to this very behaviour as a way of communicating and relieving their discomfort. We must therefore seek to question the necessity for, and challenge the usefulness of, such campaigns, and ultimately ask: ‘Is awareness making us ill?’ ”

Crowley R.
The Psychologist
Volume 20 – Part 5
May 2007
BPD/DSH 14: Self harm as a response to trauma

Before we go any further let’s acknowledge the thing we’ve been neglecting throughout this series. Some people harm themselves to get a response from others. However they are not the majority. In fact, most people who harm themselves for the benefit of others or to get a reaction of some kind tend not to repeat the experience very often – or their self harm is very superficial. If you want attention there are many less harmful behaviours that will achieve the same result without the pain. Shouting and stamping your feet or undressing in public for example. There are many ways to get a response without resorting to overdosing or extinguishing cigarettes on your skin.

Contrary to popular belief, deliberate self-harm is not usually an attempt to manipulate others. Nor is it usually a ‘cry for help’. Most people are quite able to ask for help without self-harming and the secrecy that often accompanies self-harm demonstrates that something else is going on. That ‘something’ is known as ‘Instability of mood’.

Many people, particularly those diagnosed with Post-Traumatic Stress Disorder or Borderline Personality Disorder experience emotions in a particular way (Kroll J. 1988). When under pressure they may find it impossible to make sense of what they feel and become ‘Emotionally unstable’.

This means that they experience all emotions at the same time but no single emotion in particular. This, understandably enough, is difficult to bear.

One way to ‘reset’ the emotional balance is through physical pain. Self-harm prompts the brain to produce endorphins, a kind of natural opiate, which overcomes Instability of mood and allows the person to feel better. So when a resident deliberately self-harms it’s likely that they’re feeling stressed and overwhelmed. It doesn’t matter how stressful others believe their situation to be. Different people have different coping abilities and what may be no problem at all for one person might well overwhelm another (Zubin & Spring 1977).

The key to understanding this process is by looking a little (and only a little) at the body’s response to trauma. The endorphins mentioned above are very similar in effect to opiates such as heroin although the effect may be milder. The result is a state of euphoria (a pleasant, almost dreamy state) that over turns the instability of mood. That’s why in an earlier post I likened the effects of deliberate self harm to the effects of illicit drug use and why it may not be quite so valid to think of addiction and self harm as very different processes.

Incidentally the same endorphins are produced when the body is subject to other types of stressors such as over exertion and this explains why some people become psychologically addicted to exercise. It’s not the purpose of this series to explore eating disorders in any detail but it is significant that the exercise regimes that people diagnosed with anorexia nervosa often employ carry the same endorphin-related response. There is also a very real statistical correlation between the diagnoses of Borderline Personality Disorder and Anorexia with many people receiving both diagnoses at the same time. Of course there’s a ‘chicken and egg’ argument here as there is with all the personality disorder diagnoses but it’s interesting none the less.

Many people who self harm do so during a state of dissociation. This isn’t so surprising given what we know about dissociation already and the link to overwhelming emotional trauma. The adult who learned to dissociate from trauma as a child will do so when stressed. They dissociate away from the instability of mood but they still need to ‘reset the balance’ as we outlined earlier. So dissociation and deliberate self harm often go hand in hand.
This provides a stereotypical pattern (although not everyone follows it) that goes something like this:

1. Distress
2. Dissociation
3. Deliberate self Harm
4. Euphoria

I know of several people who cannot remember the act of self harm at all. This is because they have dissociated away from the trauma before they harm themselves. It’s not unlike the dissociation we encountered in an earlier post that drivers experience during long journeys. The difference here though is that the dissociation is more complete.

Only when the ensuing euphoria wears off do they notice the self inflicted wounds and realise what they have done. This is why the NICE guidelines make the distinction that not all self harm is deliberate. It is difficult to say that an act is purposeful when the individual is in a dissociative state at the time.

In Dialectic Behaviour Therapy (Linehan M. 1993, 1&2) one of the key skills is ‘mindfulness’. This is a technique specifically taught to people diagnosed with borderline Personality disorder to help them to ‘remain present’ and not dissociate away from their situation. It’s a simple technique in theory involving taking note of the minute details of their surroundings and consciously cataloguing them in their minds. I describe it as simple in theory because in practice it takes a fair amount of training to develop the skill – the pull to dissociate is so strong.

The point here is that more often than not deliberate self harm is a response to trauma and stress. It’s ironic then that the judgemental attitudes of some care workers actually recreate the emotional turmoil that the service-user has just dealt with by reacting in overly hostile or critical ways to the only coping strategy they know.

Extreme criticism to a black and white, concrete thinker (as most people diagnosed with Borderline Personality Disorder are) simply recreates the invalidating environment that caused the problem in the first place. There is a moiré appropriate and more helpful way to respond to people who self harm and that will be the focus of the next post.

References


BPD/DSH 15: Responding to a person who harms themselves

Working with people who hurt themselves can be a confusing and bewildering experience. It is often extremely frustrating and distressing for the staff who may well be at a loss to understand why their resident keeps on injuring themselves. Traditional views about ‘manipulation’ or a ‘cry for help’ may bring some limited sense of explanation but they do little or nothing to help prevent future self-harm. This article explores some alternative notions about deliberate self-harm and examines ways that workers can make a difference in a genuinely difficult situation.

First of all bear in mind that you are not alone. No single person can do everything. Whilst deliberate self-harm does not necessarily lead to suicide these things do happen and it’s always a good idea to liaise with other, specialist professionals. A decent GP, Psychiatrist or community psychiatric nurse will be worth their weight in gold. It is important that you and the resident, together with input from other professionals, perform a thorough risk assessment. Agree how to manage future problems and when to seek outside or emergency help.

All that aside though, there is much that workers can do on their own.

A resident’s ability to manage is greatly enhanced by good support from their surroundings and social group (British Psychological Society 2000). In supported housing this means that the staff can influence significantly the resident’s coping skills.

Back in the 1950s George Brown began studying the effects of families and social groups on coping and mental health (Brown G. et al 1965? & Brown GW 1985). This research led to the concept of ‘High Expressed Emotion’. A few decades later in the USA Marsha Linehan came up with the concept of the ‘Invalidating Environment’ (Linehan M. 1993, 1 & 2). Both these concepts outline the ways in which certain types of interaction increase stress, reduce coping and lead to the conditions which encourage psychological and behavioural problems including deliberate self-harm.

These include:

**High Expressed Emotion**

- Aggression and hostility
- Criticism
- Emotional over-involvement

**The Invalidating Environment**

- Erratic, inappropriate responses from significant others to the individual’s thoughts, beliefs and emotions.
- Oversimplifying the ease with which problems can be solved.
- Blaming the individual for not solving difficulties with ease.
- A chronic and classical ‘double bind’ scenario in which the individual cannot ‘win’ whatever he or she does.

It clearly would be inappropriate for all workers to undertake full-scale psychotherapy. However, attention to the concepts of expressed emotion and the invalidating environment is appropriate for us all to take on board and can make a huge difference. Remember that befriending is an extremely effective method of supporting people, with or without external therapy.
I hope that by now as we reach the end of this series it is clear that deliberate self harm is likely to represent a coping strategy. For many people it is the only effective strategy they know. Often in training sessions I use the analogy of a small child in a sweet shop. They can have anything they want but there's a problem. The lights are turned off and all they have is a small 'pen' torch – the kind with a very narrow beam that only illuminates a small are of the shop.

Whatever they can see in the torchlight they can have but it's a very limited choice because most of the sweets on display are in darkness. They're effectively invisible. Clearly the child will choose from very limited options – not because the other sweets aren't available but because he doesn't know about them.

In one sense this is what it's like for people with limited coping skills. The other coping strategies are available to them but they don't know about them or they don't believe that they will work. The coping strategies are the sweets in the shop in other words and your job is to turn the lights on.

Don't waste time attacking the only coping strategy the service-user knows. That is unlikely to succeed and, quite frankly you wouldn't want it to. If you remove the only coping skill a person has then they may see no alternative but suicide. It is no coincidence that service-users who harm themselves are around 50 times more likely than the general population to kill themselves.

"About 3 in 100 people who self-harm over 15 years will actually kill themselves. This is more than 50 times the rate for people who don't self-harm. The risk increases with age, and is much greater for men."

Royal College of Psychiatrists leaflet: ‘Self Harm’
www.rcpsych.ac.uk

Instead acknowledge the benefits of deliberate self harm as discussed earlier and then work on discovering and experimenting with other, less injurious methods of dealing with stress. It may well be that to begin with this will amount to nothing more than some slightly less injurious methods of self harming but this is a step in the right direction. Build upon what you can and remember that Rome wasn't built in a day. Overt criticism of the service-user is likely to create a barrier between you that may never come down again.

The chart below outlines some of the things support workers can do to support people who self-harm and suggests responses to likely situations.
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<th>Don’t</th>
<th>Do</th>
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<tr>
<td>Environmental</td>
<td>Criticise</td>
<td>Gently challenge the service-user to consider their actions objective.</td>
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<td></td>
<td>Be hostile or agressive</td>
<td>Be assertive (stand up but don’t fight).</td>
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<td></td>
<td>Be emotionally over involved</td>
<td>Respect their choices.</td>
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<td></td>
<td>Invalidate</td>
<td>Respect their rights, their opinions, their emotional life</td>
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<td>Treat service-users as adults</td>
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<td>Do the best you can for them</td>
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<td></td>
<td>Expect the best from them</td>
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<td></td>
<td>Ignore this</td>
<td>Discuss this with the service-user and risk-assess.</td>
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<td></td>
<td>Over-react to this</td>
<td>Call for assistance if necessary.</td>
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<td>Discuss coping with the service-user and monitor the situation as closely as is appropriate.</td>
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<td>Ignore this</td>
<td>Ensure the service-user has access to appropriate first aid if applicable.</td>
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<td>Over-react to this</td>
<td>Discuss this with the service-user and risk assess</td>
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<td>Call for assistance if necessary</td>
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<td>If not necessary discuss coping options and practical needs.</td>
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<td>Discuss this with the multi-disciplinary team as soon as possible</td>
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<td></td>
<td>Ignore this</td>
<td>Get emergency help immediately.</td>
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<td></td>
<td>Over-react to this</td>
<td>Monitor the service-user.</td>
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<td>Co-operate with emergency services.</td>
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<td>Discuss the situation and begin to plan for future care with the multi-disciplinary team and the service-user as soon as is possible once the initial emergency has passed.</td>
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**References**


