The myth of the "Manipulative Personality Disorder": taking the blame out of the illness

UBC Faculty of Medicine. This Changed My Practice (UBC CPD)
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What I did before

Training in the days of the DSM-IV (first published in 1994), we learnt to distinguish symptoms arising from Axis I disorders (e.g. mood, anxiety, and psychotic disorders) from Axis II disorders (i.e. the personality disorders) with fervour. I remember my early implicit assumptions attached to "Axis II" or "PD"— associations of the patient being manipulative or other labels that carried insinuations of "bad". I prided myself in my acumen in stamping a diagnosis of PD to the chart to show that I was not being deceived into thinking that this was Axis I, the conditions for which I reserved my compassion and empathy. In fact, the associations I had in conceiving these patients as "bad" were explicitly handed down in our medical school study guides, with mnemonics for the three clusters of personality disorders labelled as 'mad', 'bad', and 'sad', branding the 'bad' label on the vilified cluster B disorders, which includes the borderline and narcissistic personality disorders that beset those we so frequently see in our practices (Picard, 2011).

While personality disorders no longer carried the therapeutic nihilism of generations past—with effective psychotherapeutic interventions, such a **dialectical behavioural therapy (DBT)** and **psychodynamic therapies** widely accepted and implemented, we still had (and continue to have) a long way to go in terms of addressing the burden of the stigma that these diagnoses carry. Patients frequently describe the stigma of having a mental health condition as more debilitating than the symptoms of the illness itself (Kirby and Keon, 2006). Equally worrisome, is the extent to which stigma diminishes **our capacity and efficacy** in treating those living with personality disorders.

What changed my practice

In the newest edition of the DSM-5 in 2013, the DSM's definition of personality disorder did not change from that of the DSM-IV, despite many heated debates for revision. Personality disorders continue to be defined as enduring patterns of inner experience and behaviours that are dysfunctional in two or more of the following areas: cognition (e.g. distorted ways of perceiving self, others, and the world), emotion regulation, interpersonal functioning, and impulse control (APA, 2013). However, the DSM-5 did abandon the multiaxial system that differentiated personality disorders from other psychiatric disorders, as research challenged our previous assumptions that personality disorders were qualitatively different or more persistent than the Axis I disorders. In fact, many studies highlighted how personality disorders are much less "enduring" than Axis I disorders. Zanarini et al., for example, showed that 55% of patients with borderline personality disorder no longer met diagnostic criteria at 4 years, and 78-99% (and 97-99% for other personality disorders) remitted at a 16 year follow-up (2010, 2012).

While the DSM-IV and 5 defined psychiatric disorders without discussing etiological factors (with the exception of post-traumatic disorders), as I continued my training with an interest in psychotherapy, I learnt that our work as clinicians cannot similarly stop at simply describing symptoms and diagnosing a personality disorder without understanding the context and causative factors that led to this disorder.

Like other mental health conditions, personality disorders have both genetic and environmental causes. While anti-stigma campaigns initially hoped that a focus on the biological causes of mental illness would reduce stigma, a large body of research on mental health stigma has consistently shown the opposite. Framing a person's symptoms in the context of their psychosocial adversity normalizes symptoms, improving empathy and reducing stigma, while more biologically-framed discussions (i.e. "a chemical imbalance in my brain") can dehumanize an individual as different and fundamentally flawed (Lebowitz and Ahn, 2014; Walker & Read, 2002; Read & Harre, 2001; Read & Law, 1999; Mehta and Farina, 1997). A good example of this in practice is how the Canadian Forces frame depression and post-traumatic stress disorder in their soldiers as mental "wounds" and operational stress injuries (National Defense and the Canadian Forces, 2009). In a similar way, **we as clinicians can be curious about the psychosocial "wounds" that led up to the development of a patient's personality disorder**. As author Mary Lou Kownacki states, "There isn't anyone you couldn't love once you've heard their story".

Attachment researcher Louis Cozolino reminds us that **it's not survival of the fittest, but survival of the nurtured** (2007). This is why **psychodynamic theory** explores an individual's history to discover how he or she adapted to psychosocial wounds or deficits in the past (such as difficulties in relationships with caregivers or others—whether from a poor fit, other's deficiencies of emotional and interpersonal skills, or overt neglect and abuse, for example). Similar research quantifying adverse childhood experiences (ACEs) echoes the psychodynamic and attachment research emphasis on the immense consequences of psychosocial "wounds" on health and well-being (e.g. Felitti et al., 1998). In this way, we can explore how these adaptations or defenses were necessary to cope with the adversity of the past, but no longer serve the patient in the present. We also may look at developmental deficits, such as **never having the opportunity to learn to mentalize (to understand the mental state of oneself and others), regulate emotions, or relate healthily to others**, which are all central features of personality disorders (Bateman and Fonagy, 2016).

In DBT, Marsha Linehan addresses the myth that people living with borderline personality disorder (BPD) are manipulative. She quotes the Oxford dictionary's definition of manipulative as being both subtle and skilful, certainly not the qualities we associate with the problematic behaviors of BPD, such as outbursts of rage, suicide attempts, or self-harm (Linehan, 2009). Rather, these behaviors are typically desperate, unskilful attempts to get one's emotional needs met. As such, Linehan views symptoms of **BPD as deficits in the skills of emotion regulation, distress tolerance, and interpersonal effectiveness**, orienting **treatment around becoming more skilful at getting one's emotional needs met**. Central to Linehan's work is the dialect that people with BPD are doing the best they can with the skills they have, and at the same time, they need to **learn more skilful behaviors** (Linehan, 2015).

What I do now

1. **Target specific symptoms:**

I now view personality disorder symptoms as important treatment targets in themselves, rather than devaluing the symptoms as only frustrating obstacles in the way of treating other, more 'valid' conditions. Making a formal personality disorder diagnosis takes experience and expertise, especially given the overlapping symptoms with other disorders. While experts in the field recommend making this diagnosis to accurately capture a wide

constellation of troubling symptoms and appropriately guide treatment, such as favouring psychotherapy over medications (e.g. Paris, 2007), clinicians less experienced in this area can refer to mental health professionals or target specific symptoms (e.g. emotional dysregulation or “difficulties with anger”) for treatment.

2. **Explore the patient’s psychosocial story:**

Be **curious about each patient’s story** to understand the context of adversity that (in combination with biological vulnerability) created their symptoms of impaired cognitions, affectivity, interpersonal functioning, and impulse control. To do this, do not reduce the mental health inquiry to simply ticking off symptom checklists or questionnaires, but rather explore a psychosocial history to put symptoms into context of how and why they developed.

3. **Validate personality disorder symptoms:**

Explore with the patient how these symptoms make sense given the adaptations that were necessary to cope with the circumstances of their life, even though they may not be serving the person in the present.

Marsha Linehan discusses 6 levels of validation (2015):

1. Pay attention.
2. Accurately reflect their thoughts, assumptions, feelings, behaviors (e.g. “You must be really frustrated that I had to cancel our last appointment”). Note that the act of acknowledging and naming thoughts and feelings, especially when they are unpleasant, activates the prefrontal cortex while reducing limbic system activity, which helps regulate emotions (e.g. Lieberman, 2007).
3. Articulate the unspoken (e.g. “I also wonder if you feel somewhat rejected…”).
4. Validate reaction in terms of past experiences (e.g. “It makes sense that you feel rejected as it seems like I’m just another person on the list of people in your life who haven’t been there for you”).
5. Validate reaction in terms of current experience (e.g. “This must be extra frustrating when you’re already so stressed as a single parent with so little support and time to yourself”).
6. Radical genuineness (i.e. treating the person as an equal, a real human; e.g. “I wish I hadn’t had to cancel when you really needed the appointment. Anyone would be upset at being cancelled on like this.”)

4. **Focus on collaborative problem solving** rather than unilaterally providing solutions (which may feel minimizing and invalidating of the complexity of the challenge). For example, “In terms of your goal to lose weight, what do imagine could make a difference? What are some of the obstacles? What is one small step you could take?”

5. **Seek to understand your own emotional reaction:**

Work to refrain from blaming the patient for their symptoms, as challenging as they are to manage at times. Individuals do not choose to have the symptoms of their personality disorder any more than they chose the psychosocial adversity and biological vulnerability that caused them. People living with personality disorder

symptoms live in immense emotional pain and frequently project (often unconsciously) some of their difficult emotions onto others, such as making the doctor feel what they are feeling, whether helpless, anxious, or incompetent. Rather than identifying with these feelings and taking them personally, becoming reactive or defensive, **seek to understand your emotional reaction** to the patient as patient's less skilful ways of trying to communicate their emotional experiences and trying to get their needs met. For example, when patient's communications are making you feel powerless as a doctor, try to gently give back the projection to the patient ("I imagine you feel so powerless with all this going on").Researcher Dr. Brene Brown echoes Marsha Linehan in her assertion that everyone is doing the best they can (Brown, 2015). Not only is **compassion and empathy central to providing effective care for the patient** (Gilbert, 2010), it is also **central to the well-being of the doctor**. Brown's research correlates believing that everyone is doing the best they can with resilience (Brown, 2015). She concludes that our own sense of unworthiness or feeling 'not enough' can impair our ability to be generous in our assumptions with others, leading us to offload our vulnerability with judgment, blame, or self-righteousness. This approach is similar to the core feature of mindfulness, which cultivates nonjudgment and compassion as a tool to promote one's own wellness (e.g. Neff, 2003). **Formal training in mindfulness practice for clinicians** can often be helpful in this.

6. **Set healthy boundaries:**

You cannot be compassionate and empathic without healthy boundaries, such as **addressing inappropriate behaviors**. Boundaries clearly state to patients what behaviour is okay and what is not okay. In this way we can acknowledge our patients are doing the best they can, AND that the consequences of their behaviour are not okay (e.g. "I really want to help you manage your symptoms AND missing appointments/yelling at my staff/repeatedly calling our office etc. prevents me from being able to help you… so for us to continue to work together, these behaviors are not okay and need to stop. What would need to happen so this behaviour doesn't occur again? If it does happen again, [insert appropriate consequence]"). Rather than blaming, which leads to stigma, shame, and shutting down, we hope to encourage responsibility of actions, self-compassion and change (Picard, 2011).

7. **Schedule proactive regular visits:**

Most patients with personality disorders have insecure attachment styles, so if they are visiting their physician frequently, they can benefit from proactive regularly scheduled visits to help provide a dependable relationship with their provider.

Psychiatrist and interpersonal theorist Dr. Harry Stack Sullivan was known for stating, 'It takes people to make people sick, and it takes people to make people well again' (Sullivan, 1953). We as physicians have the opportunity to aggravate and reinforce patient's disorder with invalidation and blame, or we can work towards supporting their recovery with compassion, empathy, and healthy boundaries.

http://thischangedmypractice.com/personality-disorders-taking-the-blame-out-of-the-illness/

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