Disordered Personality and Dysfunctional Parenting

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Personality as a function of Self

• The organising principle of dispositions, capacities and traits
• The narrative thread of experience
• The boundary between yourself and others: social regulator; interpreter of intentions; communicative
• The regulator of affect and arousal in response to stimuli (especially threat)
McAdams’ levels of personality

- Cultural and social
- Narrative
- Cognitions
- Genes
Personality disorder

- Disorders of affect regulation e.g. dysthymia, poor anger control
- Disorders of arousal regulation e.g. hyperarousal to threat
- Disorders of self-integration
- Interpersonal dysfunction
- Commonly co-morbid with other disorders and substance misuse
The capacity to be distressed

‘She spoke as one, *incapable* of her own distress’
How common is it?

• About 4% of the general population; but higher in clinical groups
• Different degrees of severity: only 1% is severe in terms of dysfunction and disability
• Different forms: avoidant, anxious, antagonistic
• DSM 5 and ICD 11
• Antisocial, Borderline, Narcissistic
Personality disorder: a relational disorder?

• Relationships of care giving and care eliciting at times of need
• Associated with risky behaviours that result in social alienation and exclusion
• Risk to self: Substance misuse, eating disorders, deliberate self harm, somatising
• Direct risk to others (rare): violence associated with BPD and ASPD: (paranoia)
• Indirect to others: hostility, neglect, emotional abuse, failure to care
Caregiving capacity

• How do we learn to provide good enough care?
• Caregiving and care eliciting systems are both aspects of attachment system
• Carers learn to be carers by being cared for
• Especially at times of distress/threat and perceived vulnerability
Personality capacities necessary for Caregiving

• Recognition and monitoring of other’s distress/needs
• Appropriate regulation of arousal and distress response to others’ distress
• Appropriate care-eliciting and care-giving behaviour
• Tolerating negative affects in the self
Personality structure and attachment

- Sroufe et al Minnesota study
- Studied attachment in high risk mother-baby dyads
- Insecure attachment in childhood tended to persist into adolescence and adulthood
- Associated with later diagnosis of personality disorder
- Relevance for affect and arousal regulation;
  *mentalising*
Hostile helpless states of mind

• Lyons Ruth et al
• Studies of maternal attachment in mums who have experienced DV; high risk mums
• Mums with children who had disorganised attachment oscillated between hostility and helplessness
• A kind of adult disorganisation of mind
From a nursery observer

Mum seemed vacant...she did not seem to have the capacity to think about what her child might be thinking... so she didn’t have the basis for a true connection....
Sonia’s story

Sonia was 19. When she was younger, her stepfather sexually abused her; but her mother did nothing when Sonia told her and Sonia began to develop self-harming behaviours. She dropped out of school; fell pregnant unexpectedly, and had a little boy called Joel. Sonia fractured his femur when he was 18 months old. When I asked Sonia about her relationship with her mother, she said:

‘There’s something between us that isn’t there’
Personality disorder: association with childhood adversity

- Childhood adversity significantly increases the risk of being diagnosed with a pd in adolescence and adulthood (Afifi et al 2011;)
- Most true for neglect & CPA (Taillieu et al 2016)
- Dose response effect: the worse the abuse/neglect, the worse the pd?
- Important relationship with attachment behaviours and parental sensitivity
Degrees of personality disorder

- Dimensions, (not categories) describe pd best
- Personalities may become *disorganised*
- Or dysfunctional traits may be expressed at times of stress
- Internal: mood disturbance
- External factors: trauma, relationships with attachment figures: people you care for
Severity of dysfunction

• How does the dysfunction get expressed in the external world?

• What life domains are affected?
  • Work and employment
  • Peer relationships
  • Social rule breaking
  • Care giving and care eliciting relationships: health, emotional relationships, parenting
PD affects parental sensitivity

• Ability to respond contingently with appropriate affective response
• Mums with BPD show less or disorganised response as early as 6 weeks (Hobson et al)
• PD related to maternal insecurity of attachment
• The way a mother responds to a child’s distress
Parental personality affects child development

- Equal GxE contribution; where E is parental behaviour and attachment to/with child
- The epigenome: maternal stress and social status affects children’s genetic expression
- Parental personality affects relationship with child: communications, stress management
- Parental personality dysfunction can lead to abnormal parental behaviour: hostility, harshness, fear
Pd in parents affects mental health of children

- Wolff & Acton (1968) 89% parents of CAMHs referrals had pd; 51% moderate or severe
- Parental ASPD associated with CD/aggressiveness in children
- Maternal BPD impacts on personality development in daughters
- Maternal somatising disorder and somatising in children
Personality and illness behaviour

- Your personality affects how you seek help from others when stressed
- Strong association between PD and somatising disorders and other forms of abnormal illness behaviour: medically unexplained symptoms, frequent presentations
- May extend to abnormal care eliciting for others e.g dependent children
- Health anxiety as response to stress
Magda’s story

Magda migrated to England with her husband and 2 children. The marriage broke up soon after, amid domestic violence between Magda and her husband. Magda started to drink heavily and took 2 overdoses. She got pregnant by a new partner and had another baby. She started to starve and torment her 5 year old son; and falsely claimed he had a medical condition that required a special diet.
Pd and child maltreatment

- Studies of detected child abusers find high rates of pd (60-70%)
- Parental ASPD is significant predictor of neglect and abuse by parents
- PD present in 33%-50% of abnormal illness behaviour cases
- Link with defence style: projection of agency on to child
Lyra’s story

Lyra was physically abused and neglected as a child; and was taken into care. She left care at 16 and married soon after. She had 4 children in quick succession; and then her marriage broke up. She made a new partnership immediately and had a baby boy, Peter. She failed to act when her partner and his brother abused Peter.
PD and poor care-giving

- Failure to monitor or react to distress
- Indifference to need for care
- Reacting to need for care with hostility, anxiety, panic, distress,
- Helplessness and confusion
- Frightened or frightening carers
- Failure to relate to other carers: controlling care giving
Relevance for parenting assessment

• Parents with pd are likely to have had histories of abuse and neglect themselves
• Insecure attachment common
• Poor mentalising and negative affect management
• Hostility when stressed
• Can’t ask for help effectively from professionals
Manifestations of poor care by parents with pd

• Hostility towards children who are distressed; can’t contain distress
• Hostility towards those who care for children
• Failure to notice or monitor children’s needs (Neglect)
• May see child as peer/competitor/adult
• Abuse: physical, emotional
How to improve services?

- Better and early identification and assessment of parents and failures of care
- Consultation to LA and CAMHS
- Provision of evidence based therapies and psycho-education
- Training and support for staff
- Cross-agency work
- Example from NOMS services for offenders with PD
Medico-legal problems

• Experts in separate domains: Paediatricians, CAMHS and Adult Psychiatry don’t ‘see’ each others’ work
• Resistance leads to lack of services for treatment of parents with PD: especially mothers
• Concerns re risk and evidence base
• Problems with abnormal illness behaviour: must follow paediatric review
Caution when abnormal illness behaviour suspected

- The facts of any alleged behaviour **must** be decided by a court
- No link between psychiatric diagnosis and behaviours
- Psychiatric expert testimony cannot proceed until the paediatric facts have been established
- Need to advise all parties at instruction
Therapy (1) Parents with BPD traits

- Emotional regulation skills (from DBT)
- Mentalisation based therapies: learning about other people’s intentions
- Judicious use of medication
- Psycho-education about attachment
- Video work with children and work on awareness of children’s minds e.g. Circle of security
Therapy (2): Parents with antisocial traits

- Assessing motivation and degree of antisociality
- Careful assessment of risk and attitudes to vulnerability
- Check for co-morbid substance misuse
- May well have both antisocial and BPD traits
- Check criminal record: crime is not the same as ASPD
Treatability of moderate to severe pd: best guesses

• Some types of pd are more treatment resistant than others
• Interpersonal profile with deceit, high denigration of others is not a good sign
• Spread of pathology into >1 domain
• Co-morbidity
• Availability of treatment and therapists
General comments

• Mild to moderate degrees of pd are treatable
• Evidence for efficacy of group approaches, especially MBT, DBT and group approaches
• Medication has a role
• Improving affect and arousal regulation
• Supporting pro-social stance
Problems

• When the Pd is confined to relationships with dependent children: absence of other markers
• Behavioural dysfunction only on one domain: e.g. illness behaviour
• Not seen as ‘severe’ enough for CMHTs: but how to get help?
• Lack of services and joined up thinking: parents may be identified through CAMHS, liaison, perinatal or Child protection but can’t get help
• Absence of services in which to test therapies
• Reluctance to identify parents as having personality pathology

• “We are at a pivotal moment in UK child health, when recent gains are likely to be lost. The Unicef report strikes right to the heart of a defining question for our times: what is the duty of the State in protecting and providing the best conditions for nurturing our children? Government policy can foster or hinder children’s health, development and well-being.”
Mr Justice Hedley 2007

“It matters not whether the parent is wise or foolish, rich or poor, educated or illiterate, provided the child's moral and physical health are not in danger. ...It follows that we must be willing to tolerate very diverse standards of parenting, including the eccentric, the barely adequate and the inconsistent... it is not the provenance of the state to spare children all the consequence of defective parenting....”
**Resource allocation as an ethical issue: justice**

- Money for health is being reduced
- Mental health services especially vulnerable
- Perinatal services are getting new resources
- Limited by (a) duration of 12 months post-delivery and (b) diagnosis
- Do non-psychiatric services have to do this?
“We’re not funded...”

• Imagine a cardiac care service
• We’re not funded to care for heart failure, only MIs
• We’re not funded to provide aftercare
• We don’t admit people who have an MI due to a long term condition
• Or whose MI is due to high levels of ACEs
Conclusion

• The NOMS service now gets about £67M to run services for offenders whose personality disorders make them high risk to others.

• If there are 15 M women of child bearing age (ONS 2012); and 2% have BPD: that is 300,000 potentially problematic parents

• *If 1% get into care proceedings, that is 3000 cases, each costing £25 000 per child*

• Could we spend the money better?

• Health Commissioners/Family Justice/ LAs Let’s talk......
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