Eating disorders, personality disorders & ‘emerging’ personality disorders: Assessment & Management

Jane Morris
Eden Unit, Royal Cornhill Hospital and North of Scotland Managed Clinical Network for Eating Disorders
A clinicians’ view
‘Personality disorders’ in Eden

2009/10

2017.....
2 ‘tribes’

‘STABILITY’ Those who relieve anxiety, anger & guilt by means of avoidance & rituals of sameness (obsessive compulsive). Strong attachment to the disorder – other people seen as obstacles to or protectors of the disorder.

‘INSTABILITY’ Those who relieve anxiety, boredom, anger & shame – by means of ‘acting out’ behaviours, risk-taking (impulsive or borderline). Strong but insecure attachments to other people – disorder communicates perceived needs, albeit maladaptively.
Do you overdiagnose borderline in the presence of an ED?

Do I overdiagnose ASD in the presence of an ED?
Autistic spectrum disorder

DSM5: persistent deficits across multiple contexts, across multiple contexts, in
■ communication and
■ social interaction
■ as well as restricted, repetitive patterns of behavior, interests, or activities
■ Gillberg et al have suggested anorexia nervosa in girls sometimes an autistic equivalent
Starvation and autistic traits

Ancel Keys Minnesota Starvation study (1950) demonstrated

- Increased obsessionality
- Food and eating became a ‘special interest’
- Concrete thinking
- Loss of interpersonal interests and skills

....and also

- Tchanturia et al found some patients no longer demonstrated strong ASD traits when re-nourished
What is the relationship between disorders and personality?

- Personality patterns may make people more vulnerable to a particular range of illnesses – ‘type A’ personality and heart disease.

- Particular disorders may shape personality – people with chronic illnesses often become carers.
What is the relationship between eating disorders and personality?

- Do particular personality patterns predispose a person to develop an ED?
- Do particular personality structures determine the nature of the eating disorder experienced by the sufferer?
- Does the experience of suffering from an ED influence the development of personality?
- Anorexia often found in individuals – and families – who also show OCD, anxiety disorders, ASD
- Bulimia often seen with depression, substance abuse
- Personality disorders also tend to cluster in similar ways – obsessive-compulsive PD with AN, impulsive PD with Bulimic type illnesses
Mean proportion of PDs among patients with any type of eating disorder (ED) was .52 compared to .09 in healthy controls.

No statistically significant differences between AN (.49) and BN (.54) in proportions of any PD or PD clusters

except for obsessive-compulsive PD (.23 vs. .12 in AN and BN, respectively).
How Various Disciplines See Borderline Personality Disorder

Psychoanalyst: "Splitting" Object Relations

Cognitive Therapist: "Faulty Schema"

Dialectical Behavioral Therapist: "Emotional Dysregulation"

Psycho-Pharmacologist: Serotonin and Dopamine Imbalance

Sociologist: "Identity Diffusion"
DSM5: essential features of a personality disorder: impairments in personality (self and interpersonal) functioning and presence of pathological personality traits.

A. Significant impairments in self & interpersonal functioning.

B. One or more pathological personality trait domains or trait facets.

C. The impairments are relatively stable across time and consistent across situations.

D. The impairments are not better understood as normative for the individual’s developmental stage or socio-cultural environment.

E. Impairments in personality functioning and personality trait expression not solely due to the direct physiological effects of a substance (e.g. drug) or a general medical condition (e.g., severe head trauma)
A. Significant impairments in personality functioning

1. Impairments in self functioning (a or b):
   a. **Identity**: impoverished, poorly developed, or unstable self-image, excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
   b. **Self-direction**: Instability in goals, aspirations, values, career plans.

AND

2. Impairments in interpersonal functioning (a or b):
   a. **Empathy**: Compromised ability to recognize the feelings and needs of others, interpersonal hypersensitivity - perceptions of others selectively biased toward negative attributes or vulnerabilities.
   b. **Intimacy**: Intense, unstable, conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; extremes of idealization and devaluation.
B. Pathological personality traits in the following domains:

1. **Negative Affectivity**, characterized by:
   a. **Emotional lability**: emotions easily aroused, intense, out of proportion
   b. **Anxiousness**: nervousness, tenseness, panic; worry about negative effects of past and future possibilities;
   c. **Separation insecurity**: Fears of rejection and/or separation, associated with fears of excessive dependency
   d. **Depressivity**, difficulty recovering from moods; pessimism; pervasive shame; inferior self-worth; thoughts of suicide.

2. **Disinhibition**, characterized by:
   a. **Impulsivity**: sense of urgency, self-harming behavior under emotional distress.
   b. **Risk taking**: Engagement in dangerous, risky, and potentially self-damaging activities, denial of the reality of personal danger.

3. **Antagonism**, Anger, irritability in response to minor slights
DSM–IV (APA, 1994)

Diagnostic criteria for borderline personality disorder At least five of:

- Intense and unstable personal relationships
- Frantic efforts to avoid real or imagined abandonment
- Identity disturbance or problems with sense of self
- Impulsivity that is potentially self-damaging
- Recurrent suicidal or parasuicidal behaviour
- Affective instability
- Chronic feelings of emptiness
- Inappropriate intense or uncontrollable anger
- Transient stress-related paranoid ideation or severe dissociative symptoms
ICD criteria

**F60.3 Emotionally unstable personality disorder**

Marked tendency to act impulsively without consideration of the consequences, together with affective instability. Outbursts of intense anger may lead to "behavioural explosions"; especially when impulsive acts are criticized or thwarted by others.

**F60.30 Impulsive type**

The predominant characteristics are emotional instability and lack of impulse control.

**F60.31 Borderline type**

Several of the characteristics of emotional instability are present. The patient's self-image, aims, and internal preferences (including sexual) are often unclear or disturbed.

Chronic feelings of emptiness.

A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm.
MULTI-IMPULSIVE BULIMIA
(Lacey, 1993)

Bulimia nervosa + at least 3 of the following:
- Heroin, LSD, amphetamines, street tranquillisers
- Abuse of alcohol
- Stealing/ shop lifting
- self harm – Overdoses, self-cutting or burning

And frequently ‘promiscuous sexual behaviours’, inability to be truthful
Complex trauma
(Judith Herman 1993)

- Affective dysregulation, esp anger and self-destructiveness,
- Alterations in attention/ consciousness, dissociative episodes & depersonalization,
- Chronic guilt & shame,
- Incorporation of perpetrators’ belief system
- Problems with trust and intimacy
- Somatization of medical problems, and
- Hopelessness & negative predictions.
Common features

- Emotional instability, rapid emotional shifts, emotional hypersensitivity
- Interpersonal difficulties – idealisation/denigration
- History of trauma and sensitivity to perceived trauma
- Identity struggles
- Maladaptive coping mechanisms eg DSH
How might eating disorder symptoms mimic personality disorder symptoms?
Eating disorders and self harm

- **DSH as primary?** For some patients self-starving is a form of self-harm and may replace the ‘need’ for cutting, overdosing etc. Body image gratification may then ensue and become a perpetuating factor.

- **ED as primary?** Others resort to these other forms of self-harm for the first time if their anorexia is ‘taken away from them’ or if they ‘break the rules’ themselves. For some patients this is ‘neutralising’ behaviour, whilst for others it is a communication of protest.

- Some patients remain natural restrictors all their lives, unable to achieve any peace of mind unless they take constant control. But for the majority, with age, treatment, and the passage of time, ‘graduation’ is from restricting anorexia to bulimic type anorexia, perhaps even to normal weight bulimia.
Effects of eating disorders on the brain

- Hypoglycemia – chronic ‘restrictors’ show adaptation – not so for those who binge-purge, where rapid swings in glu levels act like drug highs and withdrawal

- Hypoglycemia mimics symptoms of anxiety, and loss of K+ and Mg++ makes people even more nervous and twitchy

- Starvation makes us aggressive – difference between hunger and anger often hard to discriminate – and utterly preoccupied with food
Eating disorders AS trauma

- There is usually ‘war’ – or at least conflict
- There is famine
- Sufferers may experience ‘incarceration’ & ‘torture’ for months and years
- The brain responds to this trauma with stress steroids and other acute and chronic adjustments
Personality Disorders as developmental delay

- Paradoxically, whilst attempts to control weight are attempts at control and stability, they may lead to increasing amplifications of instability
- and make it harder and harder for people to learn ordinary skills for coping with life or attracting help from other people
Where is the ‘borderlineness’?

- In the age of the patients - ‘emerging’ borderline as a variant of normal development? Eden patients now a decade younger than before
Age of the patients - ‘emerging’ borderline as a variant of normal adolescent development?

- Emotional instability, rapid emotional shifts, emotional hypersensitivity
- Interpersonal difficulties – idealisation/denigration
- Exposure to of trauma and sensitivity to perceived trauma
- Identity struggles
- Maladaptive coping mechanisms
‘..the distinctions between personality disorders outlined in DSM-5 may not adequately reflect the true distribution of these presentations in adolescence.

‘…the categorical stability of BPD in adolescents is relatively low”. Estimates of stability vary widely from study to study.’
- **Mattanah et al**
  Semistructured diagnostic interview
  Only 23 % adolescent patients still met diagnostic criteria for BPD 2 years later

- **Greenfield et al**
  Self-report questionnaire
  hospital-presenting suicidal adolescents
  76 % still met criteria for BPD 4 years later

- **Adult studies**: 44 % patients continued to meet criteria for BPD after 2 years and 15 % after 10 years.
‘Data suggest considerable flexibility and malleability of BPD traits in youth, making this a key developmental period during which to intervene, and adolescent BPD features have been shown to respond to intervention’.

(Chanen et al)
‘Indeed, BPD might be better considered as a disorder of younger people, with a rise in prevalence from puberty and a steady decline with each decade from young adulthood…BPD occurs in up to 22% of adolescents and young adults receiving out-patient treatment’.
A distinct diagnosable condition manageable with prevention or early intervention?

- Australian Helping Young People Early (HYPE) based on CAT with systemic involvement and integrated team support
- Dutch Emotion Regulation Training (ERT) treatment programme based on STEPPS groups – no better than TAU
Increased borderline traits in society?

My mother’s generation

My daughter’s peers

Are successive generations giving and receiving care in different ways?
A case of anorexia nervosa, Addenbrookes Hospital, late 1970s
Hilde Bruch:

- ‘The Golden Cage’ 1978
- ‘Me too anorexics’
Bulimia nervosa: an ominous variant of anorexia nervosa.

ABSTRACT Thirty patients were selected for a prospective study according to two criteria: (i) an irresistible urge to overeat (bulimia nervosa), followed by self-induced vomiting or purging; (ii) a morbid fear of becoming fat. The majority of the patients had a previous…..
My daughter’s peers – the internet age

- Sexuality – more liberal – and beyond
- Fashion industry & celebrity culture
- Greatly increased substance misuse
- Cutting and deliberate self harm
- Identity concerns – especially gender
- Social media use? (NHSG wifi on wards)
In the establishment/service setting – a borderline NHS?

- Emotional instability, rapid emotional shifts, emotional hypersensitivity
- Interpersonal difficulties – ‘splitting’ idealisation/denigration
- History of trauma and sensitivity to perceived trauma
- Identity struggles
- Maladaptive coping mechanisms
...or an autistic response to stress?

- Rigidity
- Concrete thinking
- Difficulties in communication and managing interpersonal relationships
- Desire for order and sameness – struggle with change
- Focus on the fine detail at the expense of the bigger picture
Do the differences matter?

- Attempts to work therapeutically with people with EDs depend crucially on development of a respectful therapeutic relationship.
- Understanding attachment styles and personality profiles is helpful in formulating helpful expectations of people in treatment.
- Even in the presence of personality disorders we need to be aware of the effects of starvation and other eating disordered behaviours on the capacity to learn.
But in fact, so much in common, that if you can manage one you can probably manage the other

- Sense of being attacked and complained against by patient and patient’s carers
- High risk for patients – of death and physical injury, so that mental health professionals are very afraid
- Inability to commit to treatment without help

‘If young people with BPD lack self-management skills, how can they be expected to manage the process of therapy?’ Chanen
.....so much in common, that if you can manage one you can probably manage the other

- And those of us who are quite borderline may find ASD an exhilarating challenge
- Whilst those of us who are ASD can often tolerate risk in borderlines with greater equanimity –
- As in marriage!
- Indeed, very strong partnership/team support is ESSENTIAL
Family and carer interventions

- Living with AN-BN puts greatest caring burden on carers – even > schizophrenia
- Patients re-enact with staff the same patterns experienced by lay carers
- Working with carers can repair splitting, restore perspective and share skills
- Maudsley-type family work still best evidenced treatment for AN in young
Carers, clinicians, families & teams

- Tolerate being hated without hating back
- Constantly communicate – share splitting rather than be split by it
- Enjoy the jokes – even when they are on you
- Be sorry when you are wrong
- But not paralyzingly sorry – we don’t let it stop us going back (and getting it wrong again, differently)
What might be helpful?

- **CBT?** Vicious cycle of restraint > binge > purge + further restraint > bigger binge > purge etc etc
- **IPT-BN?** Disorders as failure to cope with interpersonal incidents
- **DBT?** Disorders as failure of emotional regulation and distress tolerance. Insists on integrated professional teamwork
- **MBT?** Failure of mentalising capacity
- **CAT?** Reciprocal roles and procedural sequencing
- **FBT?** Primary attachments as basis for restabilising physiology & healthier behaviour

Clinical psychology review, vol. 57, pp. 141-163

‘…regardless of the intervention or disorder, both maladaptive emotion regulation strategy use and overall emotion dysregulation were found to significantly decrease following treatment’

‘Parallel decreases were also found in symptoms of anxiety, depression, substance use, eating pathology and borderline personality disorder. ‘
Importance of

- Tailor-made formulations for each individual patient, shared by all the team as well as with patient and family
- Physiological stability
- Emotional regulation skills
- Interpersonal skills
- All within strong and well-supervised
THANK YOU