CASE REPORT

The Impact of Borderline Personality Traits on Challenging Behaviour: Implications for Learning Disabilities Services

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Borderline Personality Traits in Learning Disability

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Abstract

This case study describes how threats to stab in a client with learning disabilities (LD) may have been inadvertently reinforced during his detention in a medium secure unit by over-looking borderline personality traits. Formulating the case from the biopsychosocial model of borderline personality disorder (BPD; Linehan, 1993), it is illustrated how an invalidating environment provided by LD services may have interacted with underlying difficulties in emotion regulation to reinforce challenging behaviour. The tendency to explain threats to stab purely in terms of LD may have accidentally invalidated the clients' emotional distress, meaning the only way he could convey how he was feeling was by escalating his challenging behaviour. Risk management procedures may also have strengthened the clients' belief that he was a dangerous person and reinforced the challenging behaviour by gaining interpersonal attention. Further, staff splitting meant that he received variable and unpredictable responses to challenging behaviour. The need for LD services to be aware of how personality features may contribute to presentations of clients with LD and to formulate from an interactive perspective is highlighted.

Introduction

It is now conventional wisdom in clinical settings that the challenging behaviour often seen in borderline personality disorder (BPD) results from an interaction of the vulnerable individual with an environment that does not meet their needs (Linehan, 1993). A key difficulty in service provision is adequately managing the risk posed by clients with BPD without reinforcing their problematic, and ultimately self-damaging, behaviours. For example, parasuicide often results in a gain in emotional and physical care via a hospital admission (Kreitman, 1977), thus potentially reinforcing the likelihood of further self-harming in the future.

This case report will discuss the dilemmas of managing the severely challenging behaviour associated with borderline personality traits in a medium secure unit for people with learning difficulties (LD). It will be considered how initially focusing on the clients' LD to explain his challenging behaviour may have over-shadowed the recognition of his borderline personality traits and inadvertently reinforced his challenging behaviour. The way in which psychological management, informed by a dialectical behaviour therapy perspective on client-environment interactions (DBT; Linehan, 1993), contributed towards the development of an environment that better met the clients' needs will then be described.

The biopsychosocial model underlying DBT argues that borderline pathology is primarily a result of dysfunction of an underlying emotion regulation system, which develops from a biological deficit in inhibitory control and exposure to an invalidating environment in childhood (Linehan, 1993). An invalidating environment is characterised by incompatibility between the needs of the child and environmental provisions, including abuse of different types (Thomas & Chess, 1985). The child learns to think that s/he is wrong in how the sense they make of their feelings,

specifically their relationship to the external world. As a result, they learn to rely on external agencies for understanding rather than developing a sense of personal and judgement agency.

According to Linehan, an invalidating environment also prevents the child learning to label and modulate internal emotional experience (Linehan, 1993). Often the only means by which the child may provoke a helpful environmental response to his/her internal distress us to produce an extreme reaction, thus reinforcing dramatic or exaggerated modes of self-presentation. For example, a child may learn that crying will not elicit sympathy from the family but a threat to self-harm may do so. The patterns of behaviour that are learned from early exposure to an invalidating environment tend to be repeated in later life, often drawing out an invalidating response from subsequent situations and leading to the establishment of a vicious cycle between person and environment.

The following case illustrates the ease with which a service can inadvertently create an invalidating environment that maintains borderline traits and challenging behaviour.

Client history

Dave was a man in his early thirties with a mild learning disability who was admitted to a medium secure unit for people with LD following an escalating pattern of carrying a knife and threatening to kill people in the community[1]. Dave's early history revealed he was fostered at birth, as his natural parents were too young to care for him (in their early teens). He lived with an elderly foster mother until he was two, and then settled long term with a different foster family.

Dave was identified as having mild LD and subsequently attended special schools, where he did reasonably well educationally, but reported feeling unhappy and being bullied. On leaving school, he lived for a number of years in supported accommodation for people with LD. This relatively settled existence was punctuated by difficulties in establishing lasting friendships, feeling lonely, and being unable to hold down regular work or hobbies. He described finding it hard to manage his feelings, often feeling 'miserable' or 'angry', and his moods being very changeable. He was admitted to hospital twice for episodes of depression.

Dave's challenging behaviour developed during his late twenties. He began to shoplift small items from a local newsagent, threatened to set fire to his accommodation, and became increasingly difficult for care staff to manage. He started to carry a knife around with him in a locked briefcase, stating it was for his own protection, and began to threaten to stab people with it. He was charged with carrying an offensive weapon following a threat to a ticket inspector who wanted to check his ticket for a second time. Dave then became depressed again and was admitted to psychiatric hospital for several months, where his challenging behaviour continued. His repeated threats to stab others, the suspicion of an underlying psychotic illness, and an assault on a member of staff who tried to prevent him leaving the ward led to his transfer to a medium secure unit for people with LD.

Assessment

Our contact with Dave began soon after his admission, to asses and offer suggestions for managing his challenging behaviour from a psychological perspective. Over time, it became apparent that Dave was not as clearly learning disabled as was previously believed and that his challenging behaviour could be more usefully

explained by reference to a number of borderline personality traits he displayed. Detailed investigation using the WAIS-III (Psychological Corporation, 1997) revealed he had a full scale IQ of 72 (performance IQ 69; verbal IQ 79) and his scores on the Adaptive Behaviour Scale (Nihira et al., 1993) showed no deficit in adaptive functioning. This meant that Dave did not meet full diagnostic for LD and fell in the more 'borderline' range of intellectual functioning.

Observation of Dave in the unit and application of functional analysis revealed that threats to stab often occurred when he experienced emotions he could not control (anxiety, anger, or sadness), when he was not the centre of attention, and when he did not know how to manage interpersonal situations. His threats were usually made verbally, where he would politely ask if he could kill the person he was talking to or say he wanted to kill someone else. Dave said he did not know why he made threats to stab, but said that it gave him a 'buzz' and made him feel strong. Staff response to his threats was to minimise risk by not allowing him near knives, to observe him closely, and talk through his desire to stab other people. This usually led to a short-term reduction in the intensity of threats and his experience of negative emotions.

Use of the structured clinical interview for diagnosis of personality disorder (SCID-II; Spitzer et al., 1990) and clinical observation of him in the unit indicated he had a number of traits of BPD. He showed identity disturbance, fluctuating between a rigidly positive, powerful sense of sense and a globally negative, hopeless view of self. He had little sense of who he was or what he wanted in the future and reported feeling 'empty' inside. His mood was very volatile, switching from anxiety to sadness to happiness. In addition, he showed intense, inappropriate anger, often leading to his threats to kill. He was impulsive in self-damaging ways, manifested by shoplifting and threats to stab or burn for no apparent reason. He also made recurrent threats to

kill himself, although there was no sign he intended to carry these out. His initial 'psychotic' presentation in hindsight could also be seen as a form of transient stress related paranoid ideation[2].

Psychological Formulation

A formulation of Dave's challenging behaviour as a function of both his learning disability and his borderline traits is shown in Figure 1. Two key features that maintained his challenging behaviour were his detention in a medium secure unit and recognition of his borderline personality traits being over-shadowed by LD.

INSERT FIGURE 1 ABOUT HERE

Reinforcing Effects of Forensic Environment

Detention in a medium secure may have maintained Dave's challenging behaviour in a number of ways. First, he saw himself as a 'bad, dangerous' person, rather than someone with mental health difficulties. He described wishing to go to prison so that he would be taken seriously and be left alone. This almost delusional view of himself served to bolster his fragile self-esteem when faced with rejection in the environment (Roberts, 1992). Dave's detention in a forensic service further reinforced the image he held of himself as a dangerous man.

Second, the way in which the unit responded to Dave's threats may also have maintained them. Dave described making threats to 'get a buzz', to get rid of 'nasty feelings' inside him, to feel powerful, and to gain attention. When clients made threats the standard response of the unit was to suspend leave, revoke kitchen access, and spend time with them one to one. In the short term, this response reinforced Dave's

'dangerous' self-image, at the same time supporting his self-esteem and making him anxious that the system could not contain him. Further, Dave reported often feeling lonely and using threats as a way to gain attention. The staff response was then a powerful positive reinforcer. The long term consequences of Dave's threats, however, challenged his fragile self-image. He made threats in a polite fashion, often asking 'can I kill you please'. This, coupled with never acting on his threats, meant people did not take him seriously and led to him feeling powerless. Additionally, the restriction of Dave's freedom frustrated him and his relationships suffered as a result of his threats. His only response to the growing distress was to escalate his threats, thus forming a vicious cycle.

Third, Dave's borderline traits also led to some degree of staff splitting. The projection of different parts of the self at different times can mean that disparate views of the client with BPD can be formed across staff members, making it difficult to agree on the best treatment strategies. In Dave's case, there was a split between staff who viewed his threats as an expression of his anxiety and thought he needed nurturing from those who saw his threats as a serious intention to kill and thought he should be 'punished' for this. This meant that he received variable and unpredictable responses from different parts of the system, another feature of invalidating environments.

On a more general level, it is possible to construe Dave's detention in medium security when he had shown little concrete evidence of dangerousness as a form of extreme invalidation. The biopsychosocial model of BPD refers to the interaction between the client and the environment, such that both act in an increasingly extreme fashion and challenging behaviour escalates (Linehan, 1993). In this way, Dave

recreated an environment in which he was invalidated by systems as well as individuals.

Reinforcing Effects of a Focus on Learning Disability

Focusing on Dave's LD may have diagnostically over-shadowed the recognition of his borderline traits. Mental health problems (in particular, personality issues) are often over looked in people with LD, since their emotional responses and behaviours tend to be linked to external rather than internal factors (see Jopp & Keys, 2001 for a review). In LD services, nurses are typically not trained in mental health, which adds to the likelihood of these issues not being recognised.

Not taking into account the personality issues influencing Dave's presentation may have led to services responding to his distress in an invalidating fashion. He reported that any behavioural problems he had showed were attributed to his LD. In his early life, however, Dave was separated from his natural mother and first foster mother, which is likely to have disturbed his attachment pattern (Bowlby, 1969) and acquisition of theory of mind (Fonagy et al., 2000). Explaining emotional and behavioural disturbances as a consequence of LD rather than to a difficulty in grieving and establishing new relationships probably prevented Dave from making sense of his internal experience and feeling any ownership of his actions. Further, Dave may have felt that his emotional experience was not being taken seriously, so extreme antisocial behaviour may have been his only way of communicating the extent of his distress. His history reveals a pattern of escalating threats to shoplift, commit arson, self harm, and injure other people. This is typical of BPD where the environment is not meeting the clients need for external emotion regulation (Linehan, 1993).

Intervention

A combination of behavioural management and individual therapy was applied to attempt to reduce Dave's challenging behaviour. When Dave made threats, staff were asked to control the risk this posed while giving him the minimum interpersonal attention. When Dave expressed his difficulties in a more acceptable fashion, staff were encouraged to give him interpersonal attention to help him manage the situation more adaptively, thus reinforcing an alternative behaviour. Individual therapy focused on identifying the functions Dave's threats served and their short and long term consequences. After establishing some insight into the behaviour, other ways were considered that allowed him to feel powerful, gain attention, and manage internal experiences without incurring any of the costs. This involved some cognitive restructuring and relaxation training. We also worked to develop his capacity to reflect on his own emotional experience and ways to manage this.

Outcome

The outcome of this intervention was positive. There was an initial extinction burst (Lerman & Iwata, 1995), where Dave's threats to kill increased. At this time, he also threatened to self-harm and to rape female staff. Lack of a staff reaction to this behaviour led to a gradual reduction in the frequency and intensity of his threats. At the end of six months of individual treatment, Dave had not made a threat to kill for over a month, his relationships had improved in the unit, and he was being prepared for discharge.

Discussion

The major implication of this case is the ease with which challenging behaviour is inadvertently reinforced if personality features that are contributing to the presentation are not identified. This suggests it is important for LD services, perhaps particularly those with a forensic component, to be vigilant for the possibility of the presence of a personality disorder in such clients. One way to minimise diagnostic shadowing of mental-health issues may be to further encourage staff working in LD settings to have additional mental health training. In many ways this conclusion echoes recommendations in the challenging behaviour literature to use person-centred interventions that keep the client as the focus of the intervention process (Emerson, 1995). In this instance, Dave's LD over-shadowed recognition that he had an ongoing pattern of difficulty in managing emotions, relationships, and his sense of identity.

An additional implication is that management of challenging behaviour in such clients often benefits from taking an interactive perspective. Challenging behaviour intensifies following repeating exchanges between a vulnerable individual and an invalidating environment. People in the environment may invalidate the client inadvertently, partially as a result of projective identification by the client with BPD of negative parts of the self onto significant others (Fonagy et al., 2000).

The danger of an interactional approach is that the focus shifts to 'blaming the environment' rather than 'blaming the client'. This is equally counter-productive since the person with BPD will continue to delegate responsibility for their internal world to significant others. Careful behavioural management to prevent inadvertent reinforcement of challenging behaviour and individual work with clients to encourage them to be able to reflect on their internal world and develop more adaptive ways of

managing it themselves are both required. While a symptom-based, environmental intervention is likely to lead to short term improvement in functioning in BPD, ongoing individual therapy is required to build a coherent sense of self, to facilitate self-management of emotional experience, and to better cope with the demands of relationships. A combination of these interventions is a key feature of the DBT approach to BPD and it is increasingly realised that challenging behaviour in LD can be managed by both shaping the environment and teaching the client self-control techniques (Emerson, 1998).

Although this case report has focused on the deleterious effects of Dave's contact with services, it is possible that detention may have been of positive benefit to him in the long term. His relatively high level of intellectual functioning was identified and he was offered the opportunity to gain insight into his own behaviour. It is intriguing to speculate whether his current borderline traits reflect a true diagnosis of BPD or whether they represent a developmental phase as he breaks away from an image of himself as a learning disabled man. If the latter is the case, the borderline features may remit as he builds a more coherent sense of self.

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Footnotes

[1] - Details of the case have been altered or omitted to preserve client confidentiality.

[2] - In some ways, however, Dave did not present as a typical case of BPD. He did not show a pattern of intense, unstable relationships or any frantic attempts to avoid abandonment. Additionally, records show he had some relatively settled periods of functioning early in his adult life, which is not consistent with a diagnosis of BPD. It may be the case that living in supported accommodation allowed him to maintain a high level of functioning, since in this setting his challenging behaviours were explained away as a function of LD and staff provided stable, but not overly intimate, relationships, to some extent regardless of his actions. Dave's LD and the presence of these atypical features encouraged us to avoid making a formal diagnosis of BPD. Instead, we explored whether reformulating the case in terms of his borderline personality traits could productively inform his management.

Figure 1

Formulation of Dave's Challenging Behaviour