Assessment and decision making –paralysis in the family and professional system in parents with personality disorder

While the prevalence of personality disorder (PD) in the population is notoriously hard to assess, it is thought to be between 2% and 10%. Child and family social workers report that around 40% of their caseload involves a parent with PD. Meanwhile some estimates suggest that a much higher proportion of children in care proceedings have a parent with PD.

The families of parents with PD are characterised by long involvement with Social Care services, marked by failed attempts at support and intervention, high anxiety and discord in the professional network, and multiple assessments leading to no change. Typically, despite a staggering number of professional hours devoted to these families and the high level of anxiety within the network, no decision is made until children are removed in an unplanned way, on Emergency Protection Orders, in response to a particular crisis. The impact on children of PD parents will have to be the subject of another paper (see Macfie (2009) for a recent literature review), but suffice it to say that a great deal of harm can be done by leaving children in the care of these parents without effective intervention.

This paper will examine the interplay between parental personality disorder and systemic failure. It will be argued that such failure may most usefully be understood in terms of a bewildered, unthinking and disorganised response to complex parental psychopathology. Having detailed the nature of the challenge faced by professionals in their relationships with PD parents and with each other, I shall set out some principles for managing such cases in order to reduce the unacceptable delay often encountered in decision making around these families.

Personality disorder may most usefully be conceptualised as a disorder of social relationships. Its central characteristics relate to difficulties in interpersonal relationships, and it is defined primarily in terms of behaviour in relation to other people. Clearly, ways of relating have effects on every social context in which the PD parent operates, including any organisation s/he comes into contact with.

Some theorists and practitioners (e.g. Bateman and Fonagy 2004) characterise PD as a disorder whose environmental causes may be related to disorganised attachment relationships in childhood as a result of neglect and/or trauma. Space does not allow for a detailed consideration of this view. Two things are important to note here. First, the profound attachment difficulties experienced by adults with PD are activated in a particularly acute way when they become parents, and have a very significant impact on their relationships with their children. Second, the fact of having a child necessarily involves any parent in a set of relationships with professionals (from health visitors to school staff) who have a dual role: both caring and authoritative. I would contend that, given their attachment difficulties, it is particularly hard for parents with PD to relate in a straightforward way to professionals occupying this dual role, precisely because caring and authority constitute the central components of a parental, or attachment, relationship. These difficulties are particularly acute when PD parents come into contact with Social Workers, but are likely to be apparent in all their relationships with professional organisations.

An assumption being made here is that attachment patterns are played out not only in intimate relationships with children/partners/family members, but in all social relationships. This is in my view a

useful paradigm within which to understand the destructive and confusing patterns of relating experienced by professionals attempting to negotiate with parents with PD.

In delineating the particular patterns of behaviour to which professionals are subject it may be useful to separate them into responses to offers of care on the one hand, and an authoritative structure on the other.

In response to offers of help, professionals are often met with what might be called a 'hostile/dependent' stance on the part of the parent with PD. Immense demands are made on the professional, but at the same time the help and attention offered is denigrated and characterised as 'not what I need'. This 'push-me-pull-you' attitude of overwhelming demand and simultaneous rejection of help is extremely frustrating for professionals.

In response to unboundaried demands on the part of the parent, professionals can find themselves responding in two potential ways. First, they may implicitly accept the responsibility for fulfilling the parent's unmet need by losing their own sense of boundaries and limitations. The net result of this is an exhausting attempt to 'rescue' the PD parent by making superhuman efforts to provide everything the parent insists they need. Professionals may find themselves fielding telephone calls at all hours of the day, chasing after allegations of unprofessional behaviour on the part of other agencies, and in essence buying into the implicit idea that it is the responsibility of the professional network to fill the yawning gaps felt by the PD parent. In psychological terms, what is apparent is the central fact of the PD parent's experience of unmet need associated with past relationships, but enacted in the present. This means that there is by definition no way that any professional can possibly satisfy the need expressed by the PD parent.

Despite these best efforts, professionals typically find themselves at the receiving end of hostility and denigration. In response, the professional can in turn become both hostile and defensive. In the face of aggressive onslaughts on the part of a parent one is trying to help, it is easy to feel aggrieved and rejected and to respond by taking words at face value and (for example) closing the case or, with some relief, referring it on to another professional.

What is missing in these responses is an attempt to reflect upon what is going on in the relationship between parent and professional. This is a situation in which the parent, by virtue of their personality difficulties, has a highly impoverished capacity to reflect in this way, particularly in the context of a relationship in which care is being offered, and which as a consequence arouses their attachment system. The onus is therefore on the professional to reflect upon the process on behalf of both the parent and themselves, and to try to help the parent manage this fraught relationship in a less destructive way.

It is worth thinking about why it is so difficult for a professional to maintain this capacity to reflect. I would suggest a number of internal and contextual reasons for this. First, and perhaps most simply, it is difficult to overestimate the overwhelming intensity of arousal in the PD parent, the equally strong counter-response this evokes in oneself, and the impact this has on one's capacity to think. Second, anxiety, in this case about risk to a child or children, in itself militates against clear thinking. Third, there

is an ambiguity inherent in the role of child mental health or social care professional, an ambiguity not removed by or articulated within the phrase 'working in partnership'. John Simmonds (in press) calls attention to the collision between imposing state authority and offering individual support inherent in the role of Social Worker, and it is uncontroversial to suggest that this is applicable to anyone working in a context in which children may be at risk. Put simply, no professional working with parents and children can do so outside the context of the Children Act. Professionals therefore have a dual role: caring/providing, and assessing/judging.

This gives rise to another aspect of relating that PD parents find especially difficult: negotiating with an authority structure. A mature relationship to authority is one that allows the authority to have a competence one may not possess oneself. This is difficult for all of us to negotiate, but for a parent whose early experience is of a corrupt, malignant or simply absent authority structure, this can be particularly problematic.

A common maladaptive response to authority on the part of parents with PD is paranoia. The parent with PD feels deeply mistrustful of those in authority, to the extent that they simply cannot conceive of the possibility that anyone in authority might be benign in intent. This fundamental mistrust impacts on parental responses towards any organisation that tries to set standards or boundaries of any kind. Parents may act variously in ways that are controlling, withdrawn, openly hostile, oppositional, passive-aggressive, falsely compliant, and/or dishonest. In response, one can feel bullied, rejected, and patronised.

Another response to authority is delinquency. Again, any attempt to impose boundaries will lead the parent overtly or covertly to attack or subvert whatever structure the professional attempts to put in place. Delinquency can be seen as an oppositional response to perceived neglect – the message is something like 'you don't care about me, so why should I do what you say?' Issues of importance are disregarded, and rules flouted. Again, at a personal level, it is hard to underestimate the level of frustration and anger engendered by such dismissive behaviour.

There are a number of problematic responses in the professional network to this delinquent and oppositional stance on the part of the PD parent. First, the professional may become rigid and punitive in an attempt to make the parent comply. Second, the professional may become delinquent themselves, joining with the parent against authority. Third, professionals may 'turn a blind eye', pretending essentially that there has not been a breach of rules. Often in cases involving PD parents one will see different stances taken by different professionals within the network, or by the same agency (say a Social Services department) over time. Again, what is lacking on both sides is reflection about relational processes; the parent reacts in an unthinking way, and the professional response involves a kind of 'reciprocal mindlessness'. The net result is paralysis and delay in decision making.

It is perhaps self-evident that splits in the network occur very frequently in cases involving parents with PD. The term 'splitting' is often cheerily referred to but left at that, as if stating it as a fact will be sufficient to avoid its pitfalls. 'Splitting', referring to the idealisation of one person or part of an organisation and the denigration of another, may be most usefully thought about in terms of the

parent's search for a safe relationship. Professionals working with PD parents will be familiar with the experience of being appealed to by the parent to be the 'good' person in contrast to another professional in the network who is denigrated. In psychological terms one may understand this as a reflection of the parent's profound difficulty in tolerating the idea that a relationship may contain positive and negative elements; a relationship that contains both feels unbearably risky and unsafe.

Again, what the professional experiences at point-blank range are unexamined, raw, infantile feelings of fear and helplessness on the part of the parent, and at an emotional level the temptation to react in a similarly unthinking way can be extremely strong. In terms of the family one is there to help, the temptation is to collude with the parent's dismissal of issues of importance in relation to the child's needs in order to preserve the relationship with the parent. In terms of the network, the professional may get into a situation in which s/he feels s/he is the only one who truly understands this person, while others in the network are overly harsh and unforgiving. Again, what is most difficult for any professional involved in these relationships, whether they find themselves idealised or denigrated, is to hold a position of thoughtfulness, both in relation to the parent and to the network, which militates against the split and the conflict and paralysis that ensue.

Case management

The main principles here for any professional working with parents with a diagnosis of PD are:

- To maintain a sense of the relational aspects of the parent's functioning, rather than simply its phenomenology
- In doing so, to maintain a position of thoughtfulness in relation to both parent and other professionals, in the face of unthinking 'acting out'.

These principles apply both to individuals and to systems. What do they mean in practice? I would suggest the following:

Individual

1. As suggested, it is useful to see any relationship between parent and professional as being in some sense an attachment relationship. It is therefore unhelpful to act in a way which denies this, i.e. by changing personnel working with a parent without acknowledging the potential difficulty of this for the parent. Such unthinking behaviour on the part of professionals will arouse the parent's sense of abandonment and consequent aggression. More to the point, it makes no sense at all, when attempting to focus the parent's mind on attachment issues in relation to their own children, to act in a way that implies such issues are unimportant in one's own relationship with the parent.
2. Awareness of the impact of one's relationships with PD parents requires supervision which takes seriously relational aspects of behaviour, and supports one in managing one's own emotional counter-responses, e.g. frustration, despair, indifference, hostility.

System

1. The management of cases involving PD parents is likely to involve a hierarchy of interventions: these may overlap, and it is crucial to develop a structure to avoid chaos and conflict.
2. The importance of well-integrated, coherent, stable and well-supervised services cannot be overestimated.
3. Gathering information is vital. This requires the network to:
    a) Maintain awareness of gaps in information
    b) Use all sources/informants
    c) Build a picture of:
        i) Adult functioning
        ii) Parental functioning
        iii) Relationships
        iv) Child functioning
    d) Information must be well documented, detailed, and specific
4. Establishing and maintaining a network is equally vital. This will require:
    a) multi-professional/agency meetings
    b) Inclusion of non-professionals in network
    c) Agreed means of contact and communication
    d) Agreed roles and boundaries between agencies
5. Engagement is an important issue and requires collective thought. Efforts should be made by all involved, and the network itself, to do the following:
    a) Maintain a positive and accepting attitude to help-seeking
    b) Be accessible
    c) Do outreach work where possible to minimise missed meetings and consequent delay/frustration
    d) Form an authoritative structure that is clear and well-understood by all, including the parent
    e) Make sure limits are set in a clearly explained and non-punitive manner

6. To have any hope of success, assessments/ interventions need to be comprehensive. This means:

    a) The case should have an agreed case manager

    b) The family's physical environment needs to be addressed: finances, housing, schooling, health

    c) The family's social/emotional environment likewise: safety, attachments, friends, activities

    d) Short-term aims need to be established (crisis planning)

    f) Long-term aims need addressing only after the situation has been stabilised

The overall aim of these practical steps is to create a system around the family which has a clear structure and a capacity to think. I have argued that without such a structure, systems tend to become 'personality disordered' in response to PD parents and to flip backwards and forwards between over- and under-involvement, over-controlling and neglectful behaviour.

Minna Daum 11.7.09

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