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Review Article

At the Sharp End. The Controversial Questions Raised

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Abstract

An unexpected phone call triggered a chain of events, which led to challenges of work as a family therapist on a monumental scale. The outcome was a new model of working with patients who had referred themselves. If they had been referred along the normal channels they would have been diagnosed as personality disorders. The service which resulted was a 'bottoms up service' driven by the patients and their identified needs.

On reflection the successful intervention called into question the whole diagnostic criteria of 'personality disorder' with the implication that it is untreatable, a belief held by some. The patients were resilient, motivated, and innovative: pure gold for a therapist.

As first a therapist and then a manager the result of this experience has led me to propose a paradigm shift possible and achievable by the example described in this article: A move away from the expectations engendered by the National Health Service in the U.K. whereby health is dependent on the welfare system; to one where health is the responsibility of the individual. The position I take is that I do not feel that welfare necessarily equates with health and that The National Health Service can undermine personal responsibility. Attitudes towards maintaining health and the resilience to achieve health should be central goals perpetuated from childhood through to maturity.

The service described demonstrates that from its inception through to successful discharge the patient's personal characteristics are available to tap and employ to bring about change in the most challenging cases.

Managers will always want money to fund such initiatives, but I hope I can convince that this isn't the main need. What's at the heart of this initiative is tapping the motivation of the individual: both patients and therapist.

***Keywords:** Personality Disorders; A New Model; Personal Resilience; Assessment a Two-Way Process; Trust; Empowering Personal Resources and Motivation*

Introduction

I received a call from a medical consultant who explained that she wanted funding for her research on unintended pregnancies. One of the requirements on the application form was a named person who would take care of matters of a social or psychological nature, which might require help. She was making light of her request by saying "There's probable nothing likely to occur, I just need your name". The second requirement was that she needed statistical help with the research.

At the time I was working full time as a family therapist with a large caseload, I was also a wife and mother. I felt I needed her to understand that any undertaking on my part had to be weighed up with my capacity to cope with any additional workload.

My first task was to disavow her belief that my involvement would be in name only, and to explain that in my experience an unintended pregnancy could be symptomatic of a variety of difficulties. I needed to explain to her further that in family therapy the focus is not just on the individual referred but to view and assess the problem within the familial context even seeing the whole family as sick? In other words, the interactions within the whole family becomes the focus and the aim is to try to get to the very root of the problem: The unintended pregnancy maybe just a part and symptomatic of wider psychopathology and social implications.

The statistical analysis was much easier to manage.

I eventually agreed to what was a voluntary arrangement and that I would help with both her requirements as best I could. I could never have realised just what would happen and the consequences! Not long after the consultant had obtained her funding and she was busy beginning her research I got a phone call. It wasn't via the usual channels, but it came from a telephone box - furthermore it wasn't associated with an unintended pregnancy. The caller was a young man in trouble who wanted help to withdraw from drugs. He had to keep putting money into the telephone booth, so our conversation was disjointed. Sensing that the caller was frightened and perhaps to terrified to use a telephone in the usual manner I quickly suggested we met in a church: somewhere private, safe and also a centralised local landmark. I suggested a time when I was free, and he readily agreed. This was the first of many clandestine meetings with patients who in preference to the established provision wanted to choose who they wanted to help them and where. I learnt a valuable lesson that there is a need for treatment/help call it what you will, to be tailored to the needs of the individual. It needs to be flexible and that sometimes by just providing blanket approaches and services does nothing to reach and meet the needs of some patients. Not responding and meeting their needs means a lost opportunity to turn lives around.

The first patient

In the meantime returning to the meeting I found the young man waiting nervously sitting in a pew in a darkened part of the church. I never knew how he got my telephone number, but I presumed it was associated with a flyer which was offering confidential help to pregnant girls.

His story was as follows: He was twenty, slightly built with dark unkempt greasy hair, pale, unshaven and timid. He had left school and went to university where he found the change from home to university difficult – He was offered cannabis and he immediately felt uplifted. He progressed and belonged to a drug taking peer group. He then recognised he was in a dangerous downward spiral, and that his habit was becoming unsustainable. His studies were deteriorating, and he was finally asked to leave.

He returned home from university ashamed. He then lived with his elderly parents but could not afford the cannabis to which he was addicted. After several clandestine meetings I eventually asked him if I could visit his parents and surprisingly he agreed. They were a sad old couple quite ancient and very worried about their only son. They had no idea of their sons predicament. Previously they were proud of him doing well academically and feeling that he was assured of a future that they had never had. He had started threatening them for money, which clearly, they couldn't afford. Although I got the impression that if they had the money they would have given it to him. Clearly the patients parents needed protection? I remember the old mother showing me her son's bedroom pleased to show me that her son was taking an interest in biology – it was cannabis growing profusely!

The outcome was good he eventually resumed university and did well.

I continued to get referrals, so much so that I couldn't manage them all. Clearly the anonymity of the clandestine meetings and the confidentiality indicated an important and compelling alternative to the established National Health Service and Social Services, provided via doctors, clinics and voluntary bodies. Although most of the patients I saw at that time were wanting to get off addictions; drugs, drink, gaming etc there were also many other problems which covered the whole spectrum of the so-called personality disorders and deviant behaviour, such as bestiality, together with some neurotic obsessions phobias etc.

There appeared to be an information web working beneath the norms of society reaching those who wanted to abstain and to get them the help they needed but on their terms. I found this intriguing because each patient was very wary and untrusting - it seemed unlikely that they were informing each other. I could only assume they were searching and their antennae were acutely active and picking up the part of the flyer (for unintended pregnancy) which assured anonymity?

This was a different way of working for me I was learning. I never knew how the patients had found me but they did. They knew, recognised, and appreciated they were deviant. However, they appeared to want to have the sort of help, which gave them control without becoming patients in the normal manner. One factor I learnt was that the assessment process was a two - way affair. I needed to assess them, but the stakes were so high for them that they needed to assess me. They were assessing my ability to help them: my strength to withstand their problems, my wisdom and expertise to bring about change but also if they could trust me. Testing me out was a feature in each initial meeting. I've mentioned this in a previous case study but it's worth repeating here: One patient started by saying "I've fractured a man's skull, I've broken arms! as if to intimidate me - implying the question 'Can you cope with me?" The age range was wide – the youngest self -referral was eight the oldest a senior citizen. It was risky for me and for them; some were in trouble with the law, drug pushers, debt repayments etc.

What happened next?

Need and demand dictated that things could not go on as they were - it was unsustainable. The meetings were in: churches, car parks, doss houses (Usually Hotels no longer viable) cafes, anywhere for that first meeting which was so crucial to gain a chance to help them turn their lives around. I can't emphasise how important that first meeting was, I knew that if I did not add up in their assessment of me there would be no second chance to help them.

A base with facilities was indicated where someone could man the telephone. Consequently in short, a new service was born driven by and centred on the needs of these particular patients. At the time the government was very worried about HIV and Aids so any initiative making a provision for the treatment and prevention of drug addiction with its link to the use of needles was encouraged with the availability of alarmist money. A case was made, and funding became available - a house was purchased, and a base was established. I continued to see patients initially wherever it was safest but then gradually as a trust was built up between us they would venture to the house/clinic and I would see them in my room.

How did it work?

This was a new way of working with psychopathology; with the patients making the running; they weren't referred with the usual case notes, history, symptoms, and suggested diagnosis and medication. Furthermore there was no resources: no beds for cold turkey, no prescription pad, no social workers, no back up team. It was to put it mildly clandestine; we the patient and I had nothing but our combine resources. The fear was omnipresent at every new encounter. It was risky for us both: for them in case they were recognised particularly so for the drug users. If the pushers found out they would take their revenge by shooting in the kneecap, which was the current reprisal for breaking rank. Sometimes the patients continued buying drugs just to keep the drug pushers at bay. For me it was also risky I was venturing into underworlds I had never encountered before. Nobody knew where I was – or what I was doing - I had no supervision.

On one occasion a drug user wanted to prevent drugs being shipped and asked me if I would notify the police confidentially. I agreed and made the call. I was subsequently contacted by the drug squad leader. The conversation started amicably enough with me passing on the date and location of the shipment. He then asked to speak to me again and asked where I had got this information? I told him I couldn't divulge the source. Things then turned nasty and he threatened to subpoena me! Quite naturally this was uncomfortable since confidentiality was at the root of the success. So, I just said well you may try but I'll never divulge the source – he didn't try again.

Developing a method fit for purpose

It became incumbent upon me to develop a method which very broadly involved three defining modalities: the past the present and the future. I'd listen to the patient's immediate situation during the first meeting and then I would explain to them how I worked and what was required of them. They were then sent to think of the commitment they needed to make. So this was a real departure from the usual expectation of patients. Patients usually can expect the entire service to kick in and to provide all the support and resources they need in every aspect of their lives.

Initially these patients needed to make a decision of his/her readiness to make a commitment to work towards established goals. Success of reaching the goal was based on the combined commitment of the patient and myself; our only resource was our united effort. I felt it very important to start this way nurturing them and exploring what my expectation of them could be? How far could I go? The contract went like this. "If you want help with your problem I will give you 100% but I'll expect a 100% from you. The journey will be a journey of discovery the hardest and the most difficult but also the most exciting journey and rewarding you'll ever take! I further explain that they would at times rebel, become defensive and test me out. That I accepted but I would make sanctions such as cancelling an appointment, but that they could always resume. But because I had to be efficient to be effective I was strict. If they agreed to this contract, we would start together aiming to start a journey weather the ups and downs until finally the patient could manage alone and could be discharged: Not just limping along on the fringes of society but ready to use the huge power they had generated by overcoming the initial problem to benefit themselves and society.

Malnourishment and adversity

On some occasions the patients with addiction would be undernourished so I would recognise that they needed to understand what powered the body apart from drugs and alcohol. I would explain that they needed to become healthy by living and respecting their bodies. This harks of mothering, which it was. Some of them had never been mothered!

I used the same so-called 'model' whatever the situation because it worked! Why did it work? It worked I feel sure because I was looking to mobilise the very latent power which caused them to self-treat, turn to drugs, and to depart into deviance in the first place. These patients were different: independent and resourceful. My conviction was that so often they turned to mind altering substances or so called deviant behaviour in an effort to feel better. A child who is trying to cope against a background of marital instability who is suddenly offered magic mushrooms feels immediately transformed. Most of the patients were then victims of this effort to self - treat. Very importantly they still had belief in themselves and it was my job to reinforce that belief and desire.

Personality Disorder?

Against this background I've often felt uncomfortable with the diagnosis personality disorder because there is a belief by some that patients so labelled in this category cannot be treated. While nearly all the patients who referred themselves to this service could be diagnosed as personality disorder I found them motivated, responsive, innovative, and very exciting to work with. I am reminded of Jung's gold to be found amongst the trash of the unconscious? Yes they probably were untreatable if their own resources weren't mobilised and given a chance an olive branch! But if they were they were gold for any therapist.

Psychotherapy the importance of narrative

Initially an important ingredient of this joint approach was undoubtedly the confidentiality that was the trigger for their gamble to disclose to me the nature of their difficulties. So confidentiality had to be observed. In practice this meant never taking notes, never going behind their backs. Another necessary ingredient was the respect we as therapists owe to our patients, never taking a telephone call during 'their' time, never keeping them waiting, reinforcing the value of our respect for them.

Another ingredient was to hear their story - their narrative. Perhaps it was the first time anyone had listened to them. This was sacred and intense. I was looking for milestones to help me understand what had brought them to the point where they were desperate enough to see me. For them it was to make sense of their life so far. This dialogue would begin not with why are you drinking, drug taking, etc and how many pints or how much, but instead: What are your earliest memories? "Right then what happened next "probing into the past, delving, reaching agreeable conclusions, explaining perhaps hurts, from a mother or fathers point of view.

The need to recognise deficits

Generally I was dealing with developmental deficits in that these patients had experienced skewed upbringings. Like William; Thomson (2017) [1] they belonged to peer groups where the pressure and need to belong meant they needed to became involved in deviance, theft, and anti-social behaviour. Therapy had to deal not only with the recognition that leaving the peer group would create a vacuum which had to be filled, but also that with possessing educational and social deficits they had to be fit and prepared to enter another social group with needs to conform within society? So each session would hop back and forth from the past the present and the future.

Another final factor was that they had to do homework there were sanction if they didn't attend the next appointment having done their homework to my satisfaction. The homework gave them a bridge linking each session. Homework started simply but would become progressively more demanding and more involved as they progressed. Beginning with a simple task such as keep a note of what you have eaten (paper and pencil provided) and we'll discuss it next time. Finally, homework would involve something like; agreeing to contact the college and arrange to see the head of this or that course or to go for a job interview. I always started a session with have you done your homework?

When I realised what was necessary for the patients to integrate into the society from which they had been marginalised I started a group. The purpose of the group was to take them out and do something enjoyable but also learning and behaving respectfully while in the company of others. It sounds unimportant but just something simple like gathering up the cups after coffee and getting the appreciation of the café owner was demonstrating that society is responsive to acts of thoughtfulness. Something they would have spurned in their previous peer group of nonconformists where deviance was the ticket to belong. However, I was aware that bringing together my patients in a group had its real dangers and I risked them forming a splinter group. But it never happened.

The future and preparing them for the next leap was exciting on the one hand but daunting on the other. They often had had no schooling to speak of so the future had to be confronted on all sides. There were issues related to everyday living, every conceivable hurdle had to be confronted. Earning a living and a future career were the ultimate aim tempered naturally by the aptitudes and abilities and resilience of each individual. Evening classes and night school were options but so were applying for jobs. Being interviewed and making suggestions about appropriate clothing and appearance had to be discussed. Sometimes giving them dummy interviews was appropriate.

But this is where the particular gold of the patients shone through. Given that their appearance began to improve, they felt better, they were living healthily, and they were innovative. They did not expect care, so they would embrace the challenges with solutions. Their past had made them street wise and resilient these skills they mobilised and used to best effect to further their future's.

Inevitably the day would come when I knew I should broach the subject of discharge. This was difficult for me and for them, but it was akin to the fledgling that needs to make their first flight and move away from the nest, a necessary event. It was the culmination of the contract between us returning to them the power and expectation that if they could come this far on this very difficult journey they could reach for the sky and some of them did. I was very moved when they returned to tell me how far they had gone. One patient tracked me down and placed £250 on the table saying, "That's for you to help someone like me".

Comparative services

On a more reflective note I was asked to meet on a monthly basis with other therapists who were employed to cope with dependency at a regional level. It took a day out of my month and I didn't know how justifiable it would be. Time was always at a premium.

We who were intended to provide therapy and to prevent the proliferation of drugs and H.I.V were asked by the experts in the county responsible for monitoring services to give them the numbers of referrals each month. They needed to justify funds by collecting statistics i.e. numbers of treatments. “We” the so-called therapists would sit in a circle of approximately 18 and each would report on the number of new patients and the number of treatments given. The striking factor for me was that I was the only member of the group who could report new patients on a regular basis. The other therapists had to use their time in prevention.

Conclusion

My hope is that by sharing my experience with so called personality disorders will be considered differently. That services which are starting up, failing, or just unable to ever discharge patients will reconsider strategies to bring about change. I’ve treated many patients but these are the patients I most enjoyed - from that first encounter through the journey and then the final farewell though sad was wonderful and a privilege.

Bibliography

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