Post-traumatic stress disorder and borderline personality disorder traits in the child welfare population

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This article focuses on two conditions – post-traumatic stress disorder (PTSD) and traits of borderline personality disorder (BPD) – that are often associated with exposure to abuse and neglect (e.g. Katerndahl, Burge & Kellogg, 2005), one of which (PTSD) is more prevalent in child welfare and juvenile justice populations (CYF, 2002). Composite case examples are used to illustrate the ways in which youth with these problems may present to Child, Youth & Family (CYF). The article reviews the diagnostic criteria for each condition, briefly discusses some of the issues professionals encounter when working with young people presenting with these conditions, and provides recommendations for obtaining treatment.

Borderline personality disorder traits

Jessica is a 14-year-old Pākehā girl whose arms (particularly her left) and legs have extensive and varied scarring. Her file reports that she has made four suicide attempts; three by panadol overdose and one by asphyxiation. She speaks quietly in a flat tone about the events that led to her involvement with CYF, describing how her mother (later diagnosed with schizophrenia) used to beat her regularly when she was little for soiling, as well as recounting the sexual abuse she experienced from male relatives.

Jessica has had multiple placement breakdowns. Typically, she has formed rapid and close attachments with her caregivers in the first few days. Caregivers have initially been impressed by her level of maturity, her fortitude, and her resilience, and have been keen to help her solve the life problems that have led to her placement with them. Caregivers have often disclosed personal details of their own lives to her. A honeymoon period follows which lasts between six and eight weeks, in which the caregiver remains supportive of Jessica despite problems cropping up at school, with peers, or with members of the public.

The history in her file describes Jessica's life as a series of seemingly "unrelenting crises" (Linehan, 1993). In her last placement, Jessica was assaulted while waiting to be picked up from the movies after getting into an argument with another group of young people. The following week, she absconded from the placement to attend a party one night, slept with her best

friend's boyfriend, and was distraught and overcome with guilt and remorse when the friend cut off all contact with her. She bombarded the friend with desperate apologies in the form of multiple texts, phone calls, bebo postings and cards. When the friend relented and agreed to meet her for coffee (after Jessica threatened suicide), Jessica didn't show up, and subsequently seemed disinterested in repairing the friendship.

Notes describe Jessica as having unpredictable bursts of rage, in which she has assaulted residence staff, community caregivers, and other young people. Frequently staff have noted that there has been no obvious reason for the angry outbursts, and Jessica herself reports finding her emotions confusing and overwhelming. She notes that "I can be feeling fine one minute, and then someone says something and I'm so f.....d off I want to kill them". She has said that she'd rather not have any feelings, is afraid of them, and doesn't see any good in them. Jessica reports feeling numb a lot of the time, which she typically prefers. However, she reports that she will occasionally cut in order to "feel something", at points when she is experiencing numbness and emptiness and finding the experience intolerable.

Definition and criteria

Jessica presents with many of the symptoms of BPD. This is a condition that is characterised by emotional instability. By definition, a personality disorder is an enduring pattern of behaviour, thinking and feeling over an extended period of time, and therefore diagnosing young people with this condition is controversial. In addition, many of its traits are similar to the features of adolescence in general. However, even if a constellation of behaviour might be common or normal in certain groups of people, it is arguably still reasonable to identify it as problematic or pathological if it creates significant problems for the person or people around them. Furthermore, when working with young people who present with BPD traits, it can be useful to consider the theory and principles of effective treatments for adults with this condition. Even if it would be premature to diagnose the young person with BPD, considering what has worked for adults and theories about the emergence of such problems can help professionals find empathy for the young person and guide decisions about management of their behaviour.

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The diagnostic criteria of this condition (APA, 2000) are:

- frantic efforts to avoid real or imagined abandonment
- a pattern of unstable and intense relationships where the person ricochets between admiring and despising the other person
- identity disturbance, lack of a stable sense of self
- impulsivity in at least two areas (e.g. unprotected promiscuous sex, bingeing, alcohol and other drug abuse)
- recurrent suicidal behaviour, threats, or self-harm
- intense and rapid fluctuations in emotions
- chronic feelings of emptiness
- intense and inappropriate anger/difficulty controlling anger
- transient paranoia that is stress-related, extreme dissociation.

Management

This amalgam of problems poses a management challenge to most systems of care. If a young person is presenting with self-harm or suicidal behaviour (i.e. threats, reports of thoughts about suicide or attempts) or serious symptoms of emotional disturbance, a referral to their local child and adolescent mental health services is recommended. It is typically useful to copy any written referral to the GP that the person is currently registered with (even if they have not seen their doctor for a long time or have only seen their doctor once). The reason for this is that the GP is (ideally) the point of continuity and initial contact regarding any health problems that the young person is experiencing.

For many notification issues, the role of CYF is often seen to be discrete, time-limited, and task-focused. While there are costs and benefits to this approach, and there are a range of views on whether a young person requires a longer period of monitoring by a statutory agency, if CYF cannot undertake an extended monitoring role, ensuring that the person's primary health care provider has enough information to monitor effectively is essential. This also means that when there is a transfer of health care, the new practitioner will receive a record of the earlier concerns, and therefore be better placed to monitor this and broker ongoing treatment.

Frequently, working with young people with these problems can be confusing, burdensome, and very stressful for the professionals involved. A prominent theory regarding the emergence of BPD highlights the interplay between the person and their social environment in the development of this disorder (Linehan, 1993). This theory (the biosocial model of BPD) states that BPD is caused by the transaction over time between an emotionally sensitive and reactive child, and an environment that (intentionally or otherwise) invalidates that child's experiences.

Invalidation in this context refers to any action or communication in response to the child's behaviour that indicates to the child that their feelings, actions, wants, needs, thoughts, or sensations are unimportant, non-existent, inappropriate or wrong. From this perspective, abuse and neglect constitute extreme forms of invalidation. Frequently removal from abusive or neglectful situations doesn't completely solve the problems of these young people. Furthermore, invalidation exists on a continuum and the majority of people experience frequent invalidation without developing BPD.

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The biosocial theory provides a possible explanation for why problems can persist after a young person has been placed in a safe environment. The theory states that the repeated interactions between an *emotionally vulnerable* young person and invalidating responses by people in their immediate environment are what set the scene for the development of BPD. Furthermore, the theory emphasises the bi-directionality of these influences; the young person's extreme emotional responses, unpredictability and impulsivity can exhaust the resources of the people around them. This makes their caregivers less responsive to emotional expression, and raises the risk of further invalidation, more emotional arousal and less resilience.

The environment becomes relatively immune to low-level emotional outbursts, which leads to an escalating pattern of increasing emotional explosions in order to obtain any type of helpful or caring response from the people around them. People are increasingly likely to feel manipulated, angry and tired of such responses, and therefore more likely to respond selectively to outbursts that are so intense and frightening that they are seen to require some effort to contain or manage them. With such problems, it is often useful to bear in mind that all human actions are shaped by their context (an example is a fortnightly pay packet; few people would continue to go to work if they were not getting paid), and that often we are not fully aware of the factors that are influencing our behaviour.

Accordingly, there is every likelihood that young people who are confused and afraid of the strength of their feelings are largely unaware of how much their emotional behaviour is influenced by other people's responses. If the biosocial theory applies to the experience of such young people, then two very helpful things that professionals can do are (1) to validate the person's experience in any way that is accurate and respectful of both the person and the professional, and (2) to pay very careful and precise attention to the factors in the environment that may be shaping or supporting problematic behaviour, and to selectively shape up and reinforce more skilful behaviour. For caregivers and social workers to have any chance of maintaining such a dual-pronged approach, support and acknowledgement of the difficulties and burnout risks associated with working with emotionally reactive young people is essential.

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Post-traumatic stress disorder

Jaydon is a nine-year-old boy of Māori, Pākehā/New Zealand European, and Cook Island Māori ethnicity. He is currently placed with his aunt and her female partner after he was uplifted from his mother's house at the age of six years following concerns regarding physical abuse and neglect, along with exposure to family violence between his mother and her partner. The notification to CYF was made by police following a call out which led to the partner's arrest for assault, and Jaydon's mother's admission to hospital for surgery following multiple skull and facial fractures and a closed head injury.

Jaydon is a quiet boy who often seems somewhat dazed and disconnected from his surroundings. However he is also very watchful, and becomes extremely anxious at any sign of disagreement or raised voices between his aunt and her partner. Previously, if they ended up arguing in his presence he would retreat to a corner of the room and become 'frozen'; his gaze would become unfocused, he would look terrified, and his body would be tense and rigid. In the first 18 months after he came to live with them, he suffered frequent night terrors. His play tended to be solitary, and characterised by repetitious and violent scripts. These would involve taking two (sometimes three) figurines from an action set he had been given and enacting an argument between two of them. This would culminate in a fight in which the larger action doll would beat up the other one who was then put in the back of an 'ambulance' (a dump truck) and put to bed. Occasionally the third action doll would intervene and vanquish the larger doll.

His initial year at his new school was tumultuous; he hit another pupil twice, hit his teacher once, and was stood down on three occasions following these incidents. These outbursts were very unpredictable and it was difficult to identify in retrospect what had prompted them. In his first year Jaydon also became extremely distressed when he saw men dressed in fluorescent high-visibility safety vests, although he is now much calmer in the presence of these cues. His caregivers have been very gentle with him, while remaining unwavering in their insistence that he refrain from violent behaviour. They have encouraged him to take his own pace at putting himself in situations which he finds frightening but which are objectively safe.

Definition and criteria

PTSD is a condition that is characterised by avoidance, increased physiological arousal, and re-experiencing following exposure to an event which involved the threat or occurrence of death or serious injury or physical integrity (APA, 2000). The traumatised person does not have to have directly experienced the event; it is possible to present with PTSD as a result of witnessing an event involving the above characteristics. The person's response has to have involved intense fear, helplessness or horror (APA, 2000). In children, this may manifest as agitation or disorganised behaviour. According to the *Diagnostic and statistical manual of mental disorders* (DPA, 2000), re-experiencing emerges in one or more of the following five ways:

- recurrent and distressing memories of the event (in children this may emerge as repetitive play involving themes associated with the trauma)
- recurrent nightmares
- acting or feeling as if the trauma were recurring/reliving the experience
- intense subjective distress when exposed to reminders/cues associated with the trauma
- intense physiological reactivity when exposed to reminders/cues associated with the trauma.

Avoidance and numbing is evidenced by three or more of the following:

- efforts to avoid thoughts, feelings or talking about the trauma
- efforts to avoid traumatic cues, i.e. people, places or activities that might prompt memories of the trauma
- inability to recall a significant aspect of the trauma
- diminished interest or participation in important activities
- feeling detached or cut off from other people
- restricted emotional range, i.e. blunting/ numbing – "emotional anaesthesia" (APA, 2000, p. 464)
- sense of foreshortened future.

Symptoms of increased arousal are outlined below and must be greater than baseline levels of physiological arousal before exposure to trauma:

- difficulty sleeping, i.e. interrupted sleep, difficulties getting to sleep
- irritability/angry outbursts
- reduced concentration
- hyper-vigilance, i.e. unusually responsive to any indication of threat in the environment
- exaggerated startle response.

These symptoms must have occurred for longer than a month and be significantly interfering with the person's life in order to meet criteria for PTSD. A file review of children and young people within CYF indicated that approximately 6% met criteria for PTSD (CYF, 2002).

Management

The two best-evidenced treatments for adults with PTSD are prolonged exposure and eye-movement desensitisation and reprocessing (EMDR). Prolonged exposure is a cognitive-behavioural therapy that includes a very systematic and paced/graduated series of exercises designed to get the person to experience all the thoughts, contexts, feelings and sensations associated with the trauma they have been avoiding. The treatment seems to work by allowing the person's body and mind to gradually habituate or accustom itself to the cues associated with activation of the traumatic response so they no longer experience intense distress when faced with reminders of the trauma.

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It takes between 12 and 16 weeks for treatment to occur and it has a relatively good success rate. Between 40% and 90% of people no longer meet criteria for PTSD after nine to 12 sessions (SAMHSA, 2003; Schnurr et al, 2007). After completing cognitive-behavioural therapy incorporating prolonged exposure modified for children and adolescents, 92% of young participants no longer met criteria for PTSD. This compared with the wait list control participants, of whom 58% still suffered from PTSD (Smith et al, 2007).

In terms of readiness to undertake treatment for PTSD, it is important to ensure that the person has enough skills in dealing with and experiencing painful emotions to be able to tolerate the treatment. If they are engaging in self-harm or suicidal behaviour, there is little evidence to suggest that they have enough resilience and behavioural control to be able to participate in treatment that will involve exposure to further emotional arousal. Accordingly, any treatment for PTSD with such individuals will have to focus on providing them with skills to manage their emotions and stop suicidal and self-harm behaviour first.

The second consideration relates to willingness to see the treatment through, as stopping treatment before the person experiences an improvement in their distress may give them an experience of failure, and sensitise them to the traumatic cues further, i.e. make the problem worse rather than better. For this, informed consent and therapeutic engagement is extremely important.

When referring children and young people to counsellors registered by ACC to provide treatment for abuse or trauma, it is helpful for social workers to assist family members or caregivers in determining (1) whether the practitioner adheres to a treatment that has evidence of working, (2) how the practitioner monitors progress and assesses outcome, and (3) what the practitioner's initial treatment goals will be for a traumatised person who is actively self-harming or suicidal. PTSD often co-occurs with other mental disorders, such as depression, and substance abuse. When the co-morbidity contributes to a more complex presentation, it may be more appropriate for the young person to be seen within a multi-disciplinary team rather than by an individual clinician.

Conclusion

Young people within the CYF environment are likely to have experienced elevated levels of exposure to the risk factors associated with

developing PTSD or BPD traits. Therefore it is important that social workers are aware of these conditions and how best to seek appropriate treatment for them. The provision of support for social workers in the recognition, management and accessing of services for these complex conditions is also essential.

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