PERSONALITY DISORDERS

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SESSION TOPICS:

- Steps for diagnosis
- Primary Health Care role in Management
- Referral options
- What to look out for

WHAT IS A PERSONALITY DISORDER?

DSM-V Diagnostic Criteria

The essential features of a personality disorder are impairments in:

- Personality
  - self functioning (identity or self-direction)
  - Interpersonal functioning (empathy or intimacy), and
- One or more pathological personality traits.

TO DIAGNOSE A PERSONALITY DISORDER, THE FOLLOWING CRITERIA MUST BE MET:

- The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
- The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or sociocultural environment.
- The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication)

THE PERSONALITY DISORDERS

Cluster A (odd/eccentric)	Cluster B (emotional/erratic)	Cluster C (fearful)
- Paranoid - Schizoid - Schizotypal	- Antisocial - Borderline - Histrionic - Narcissistic	- Avoidant - Dependent - Obsessive-Compulsive

BORDERLINE PERSONALITY DISORDER CRITERIA

Five of the nine criteria:

- abandonment
- unstable and intense interpersonal relationships
- unstable self-image
- impulsivity
- recurrent suicidal behaviour (or) self-mutilating behaviour
- affective instability due to a marked reactivity of mood
- emptiness
- anger
- paranoid ideation or severe dissociative symptoms

BIPOLAR AFFECTIVE DISORDER

- Family history of BPAD
- Episodic
- Rapid onset and offset of depressive episodes of short duration (<3 months)
- Recurrent depression (more than five episodes)
- Depression with marked psychomotor retardation
- Seasonality
- Hyperthymic temperament
- Hypomania associated with antidepressants
- Psychotic features

BORDERLINE PD

- Reactivity of mood (interpersonal sensitivity)
- Non-episodic, high frequency of "swings"
- Self-harm/parasuicidal behaviour
- Impulsive/risky behaviour is driven by distress and/or manipulation (rather than grandiosity in mania)
- Less marked physiological shift symptoms when mood low (as compared to in major depressive episode)
- Quasi/pseudo-psychotic phenomena
- Invalidating childhood experiences (trauma, abuse, neglect)
- Abandonment/engulfment/annihilation concerns
- Demandingness/entitlement
- History of personality disorder in childhood caregivers

BORDERLINE PD VS PTSD/TRAUMA

Recent study found that 4 main symptoms were present in those with BPD, and not indicative of PTSD/Complex PTSD:

1. frantic efforts to avoid real or imagined abandonment,
2. unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation,
3. markedly and persistently unstable self-image or sense of self,
4. impulsiveness.

(Cloitre et. al 2014)

HOW IT DEVELOPS: BIO-SOCIAL MODEL

Biological: born with a tendency for emotions to switch on quickly, be intense, hard to moderate, and hang around.

PLUS +

Invalidating Environment during childhood & teen years: personal experiences and responses are dismissed, punished or 'invalidated' by significant others in child's life.

High risk environments:

- Physical, Emotional and Sexual Abuse
- Mismatched personalities
- Loss of attention from a caregiver
- Parental psychiatric hx

EMOTION DYSREGULATION

Biological vulnerability

+

Invalidating Environment

Difficulties regulating emotions

= Can't soothe

= Unable to inhibit inappropriate behaviours

PRESENTATION/ PATTERNS

- Dramatic /unusual presentations of distress
- Emotional extremes with rapid cycling
- ‘Frequent Flyers’
- Interpersonal style
- Risk issues: Suicidal ideation; self-harm behaviours
- Self- destructive behaviours: Substance use, disordered eating, gambling etc

BASIC PRINCIPLES OF ASSESSMENT

Clinical Interview:

- History of problem (onset, course, features, impact, previous psych contacts)
- Mental Status Examination (appearance, attitude, behaviour, mood and affect, speech, thought process and content, perceptions, cognition, insight, judgement)
- Risk (to self, to others)
- Interpersonal style
- Life history (childhood, relationships, occupational, recreational)
- Family's mental health history
- Physical health and substance use
- Existing coping strategies

ASSESSMENT CONT.

- Assess over multiple consultations
- Collateral information/hx from others can be useful
- Psychometric Assessment
  - Minnesota Multiphasic Personality Inventory (MMPI-2)
  - Millon Clinical Multiaxial Inventory (MCMI-III)
  -Structured Clinical Interview for DSM-V Axis II disorders (SCID)

PRIMARY HEALTH CARE CLINICIAN'S ROLES IN MANAGEMENT

- Assess for diagnosis
- Give diagnosis/ information/psychoeducation
- Develop management plan, including risk/crisis
- Stabilization
- Facilitate referral to specialist services (as needed)
- Medications
  - Not usually primary therapy for BPD
  - May be useful to manage other Axis I disorders (e.g. depression. anxiety)

BPD: INFORMING CLIENTS ABOUT THE DIAGNOSIS

- Three steps:
  - Collaborative
  - Provide Validation & Linking
  - The Good News Diagnosis

- Additional information: Enhanced Clinical Pathway: The Acute Inpatient Care of patients with Emotionally Unstable Personality Disorder- Clinicians Handbook pg 64-69

COLLABORATIVE

- “ I think I am starting to get a good sense of what things have been like for you and some of the difficulties you have been experiencing, but I would like to talk some more, to help me better understand you and clarify a diagnosis for your current experience. A diagnosis is a label we give to groups or clusters of symptoms that people typically experience together; we do this because people tend to find it useful to understand their diagnosis and it helps us to decide on the most appropriate and effective treatment for you.”

COLLABORATIVE CONT.

- “From what we have discussed so far, I think your experiences fit with a diagnosis called Emotionally Unstable Personality Disorder, which is also known as Borderline Personality Disorder. Is that something you have heard of before?”

COLLABORATIVE CONT.

- " BPD is a label we give to a pattern of coping skills and tendencies in relationships that develop over time in response to unstable, unpredictable environments. Because you know you the best, I would like for us to work together to decide if this diagnosis fits for you. I am going to ask you some questions and the more these questions and the more these questions describe things that you experience, the more likely it is that this diagnosis is what fits for you right now. Are you willing to do that with me?"

- Go through each criteria- can use SCID for BPD

PROVIDING VALIDATION & LINKING

- Validate the patient's current symptoms (thinking style, belief or behavioural pattern) in the context of their past experiences.
- Label these symptoms as adaptive in past environment (helped them survive), however don't fit in the current environment.

THE GOOD NEWS DIAGNOSIS

Explain not the person's fault- condition of the brain & mind hat is associated with genetic an environmental risk factors

Convey Optimism- diagnosis is good news as very good treatments are available, and they can completely recover

Can be useful to give them information to take away and read

www.sane.org

www.bpdfoundation.org.au

www.bpdaustralia.com

MANAGEMENT PLAN & CRISIS PLAN

Develop as soon as possible

Develop crisis plan collaboratively when client not in crisis

Consistency- when crisis occurs stick to plan

MANAGING RISK

Standard protocols for risk management apply

Differentiate chronic risk and acute risk

Check with a colleague
Document

Suicidal and self-harm behaviours are an attempt at problem solving

Find out what the problem is and give alternatives to manage the distress

Validate the emotional pain prior to suggesting change

Only brief (72 hrs) hospitalisations are supported

Weekly dispensing to remove means for risk

GENERAL PRINCIPLES OF CARE

Balance validation & change (teach skills)

Self-care & supervision

Consistency & clear boundaries

Plan early for crisis

Nurture & Limit Set (limited re-parenting)

COMMON PROBLEMS

Enmeshed relationship	•Rescue/Save
Withholding relationship	•Punitive

SPECIALIST SERVICES REFERRAL OPTIONS: EVIDENCE-BASED COMMUNITY TREATMENT

- Dialectical Behaviour Therapy (DBT)
- Schema Mode Therapy
- Mentalization-based Therapy (MBT)
- https://www.psychology.org.au/for-members/publications/inpsych/2018/april/Treating-borderline-personality-disorder

DBT PROGRAMS

Public:

Fremantle MHS

Rockingham Peel MHS

North Metro MHS DBT – based at Osborne MHS

NGOs

Lifeline's DBTeen

360 Health

Private:

Perth Clinic (also Adolescent Program)

The Hollywood Clinic

The Marian Centre

MENTALIZATION BASED THERAPY (MBT)

- CAMHS
- Touchstone- 6 month day patient program to teens with emerging BPD and includes families
- Pregnancy 2 Parenthood clinic in Joondalup- infant, child, and family mental health practice (low fee/ bulk-bill service)
- Individual practitioners: contact Matt Ruggiero for practitioners who are accredited in MBT

m.ruggiero@scienceofself.com.au

SCHEMA MODE

- Available from trained therapists as an individual therapy
  - Can be accessed via a Better Outcomes referral to a Clinical Psychologist in Private Practice
  - Accredited therapists: Find a therapist

https://www.schematherapysociety.org/

SUPPORT FOR FAMILY & CARERS

- Family Connections group- 12 weeks DBT skills based
- Held regularly across the state & via Teleconnections
- Open to all family members/carers of individuals with BPD
- Sign up online via www.bpdaustralia.com

8 KEY RECOMMENDATIONS (PROJECT AIR)

1. BPD is legitimate diagnosis for healthcare services
2. Structured psychological therapies should be provided
3. Medicines should not be used as primary therapy
4. Treatment should occur mostly in the community
5. Adolescents should get structure psychological therapies
6. Consumers should be offered a choice of psychological therapies
7. Families and carers should be offered support
8. Young people with emerging symptoms should be assessed for BPD.

CONCLUSIONS

- Managing patients with Borderline PD can be challenging and rewarding- supervision and self-care help
- Evidence based treatment is available for BPD- instill hope in your patients
- Validation of emotional distress is key

PASSIONATE ABOUT PDS

- Register as a member of the Mental Health Network and ensure you select the Personality Disorders Sub Network.
  - https://www.surveymonkey.com/r/SFRS3KM
  - Current project: State-wide Model of Service for PDs
- MHPN- BPD; DBT Perth
- Training in DBT and Schema Therapy
  - www.psychology-training.com.au

MORE INFORMATION

- WAPHA pathways- BPD
- http://bpdfoundation.org.au/for-gps.php
- https://www.racgp.org.au/afp/2011/june/managing-borderline-personality-disorder-and-substance-use/
- Beatson, J. Rao, S & Watson, C (2010). *BPD Towards Effective Treatment*. Australian Postgraduate Medicine. Fitzroy: VIC (available to order from www.spectrumbpd.com.au
- *EUPD Clinical Pathway* developed at Royal Perth Hospital