

Personality disorders

Management and Treatment.

Key principles of treatment for all patients

- What we would expect for any patient
- Respect
- Accurate and active treatment
- Accurate assessment and management of risk
- Informed consent
- Consistent and coherent management.

Respect

- Patients with personality disorders are often not treated with respect but instead experience contempt and hostility from staff. This is unacceptable. Maintaining respect for patients involves the presumption that however disordered their communication it represents the truth as they see it and needs to be taken seriously.

Accurate and active treatment

- Patients with personality disorders are often not offered treatment because they are seen as “not ill” or not treatable.
- They may drift away from care in a state of disappointment or anger but this does not mean they have recovered
- The advent of better developed treatment plans for the underlying condition and the value of treating Axis 1 conditions independently of the personality disorder make a passive approach unacceptable.

Accurate assessment and management of risk

- Patients with personality disorders who say they feel at risk of self harm or suicide are often not treated seriously.
- It is true that such patients do make many more statements of intention to self harm seriously than they do actual attempts.
- However their actual risk of self harm resulting in serious damage to themselves or death is massively elevated over the general population.
- Furthermore their level of risk varies between occasions.
- Risk needs accurate and skilled assessment and regular reassessment.

Consent.

- A striking number of patients with personality disorder are never told their diagnosis.
- Their cooperation is not sought in relation to treatment plans
- They are not given accurate information about the risks and benefits of treatment and the availability or restriction of some treatments (rationing).
- Failure to gain adequate informed consent is deception and is unacceptable.
- Patients should be offered appropriate helpful and truthful information about their condition and about the treatments available for it.

Consistency

- Many patients with personality disorder experience their treatment as inconsistent and disunited.
- In a condition where consistency and unity of the self are strikingly lacking this is hardly helpful.
- Vital - a single unified treatment plan
 - on which all are agreed (including the patient)
 - which is carried through concertedly
 - and which, being realistic, is not subject to repeated breakdown

Aetiology.

- Disorder of disgust system
 - Primary
 - Evidence for primary disorder.
 - Acquired
 - Sexual abuse and incest taboo

Consequences of disgust problem

- Failure of soothing
 - Irritability and affective dysregulation.
(executive dysfunction)
- Interpersonal dislocation.
 - Failures of interpersonal learning.
- Intersubjective failure
 - leading to cognitive deficits

What it feels like Primary condition.

- Affect storms
- Agitation
- Mental knitting
- Internal disgust
- Disphoria.

What it feels like secondary effects

- Desperate interpersonal strategies misreading interpersonal situations.
 - Clinging/demanding support
 - Paranoid hostility.
- Desperate intrapersonal strategies
 - Self stimulation
 - Withdrawal and retreat

Personality disorder is a chronic relapsing and remitting condition

- Management over the long term is important
- Management can be as important as treatment
- Patients present in a variety of settings often without a coherent treatment plan
- They get hunt and peck treatment but even these situations are poorly managed.

Management of common clinical situations.

- Not rocket science
- Only work if actually done.
- Plans are only good intentions unless they immediately degenerate into hard work

Mild to moderate personality disorder referred for outpatient help

- Patients with mild to moderate personality disorder experience some difficulties in self management and life adaptation but can live stably and without undue recourse to mental health services.
- They tend to present when
 - They suffer an axis 1 condition
 - They have a life crisis such as a loss
 - They are reviewed by a keen new health professional who identifies chronic ill health.

Mild to moderate personality disorder referred for outpatient help

- Managing these patients in general involves.
 - diagnosing the personality disorder and any axis 1 condition
 - Assessing risk to self and others.
 - Explaining the diagnosis and its consequences and giving the patient access to literature about it.
 - Instituting active treatment for any axis 1 condition and ensuring follow up because this group of patients are less responsive to or compliant with treatment than patients without personality disorder.
 - Cautioning against psychological treatments for the underlying personality disorder without expert advice and evaluation because of the risk of potentially serious side effects from treatment.
 - Advising carers and other health professionals about management.

Brief structured intervention for managing personality disorders in primary care.

- Six sessions.
 - Each session structured with aims and strategies.
 - Session 1 hearing the story giving the diagnosis
 - Session 2 Explaining the condition and exploring the symptoms
 - Session 3 discussing risk and managing self harm
 - Session 4 leading an ordered life
 - Session 5 constructing a crisis plan
 - Session 6 Going “solo”
 - Sessions 7-12 monthly follow up sessions reinforcing lessons learned.

Patients presenting in any setting who pose a risk of suicide or self harm.

- Things we know about risk in personality disorder
 - Patients with this diagnosis are at serious risk
 - Patients are more at risk of suicide and deliberate self harm if they
 - a. Have a history of previous suicide attempts or self harm (the more the more serious, the more recently the more serious)
 - b. Have a history of impulsive behaviour or antisocial behaviour
 - c. Have a concurrent drug or alcohol problem.

Key actions in relation to risk

- An assessment of risk should be done **WITH A FRESH MIND** on every occasion that the patient presents.
 - Patients should be asked explicitly about risky behaviours and thoughts.
 - The patient's own assessment of risk or stated intent should guide but not determine the risk assessment.
- Risk should be classified as acute or chronic.
 - Chronic risk – persistent suicidal ideas or fantasies and persistent risky behaviours.
 - Acute risk – recent exacerbations in suicidal risk as a result of psychosocial stress or depressive illness is signalled by acute increases in risky behaviour or thinking

Acute risk should be managed by

- Awareness of events signals which mark the onset of increased risk
- Active treatment with increased contact, access to support and if necessary admission/home treatment.
- Every effort should be made to avoid detaining patients under the mental health act but if necessary this step should be used.
- Brief admissions can be extremely helpful and should not be regarded as a failure.

Chronic risk should be managed by

- Strategies to reduce the risk of impulsive actions
 - limiting doses of medication, taking control of all sources of prescribing.
 - Psychoeducation about self harm.
 - Active treatment of axis 1 conditions
 - Instituting active treatment for borderline personality disorder

Amongst patients who present a risk of suicide or self harm there are two special groups.

The patient presenting in accident and emergency

- Patients with borderline personality disorder who present in A and E should be treated with courtesy and respect.
- They should all be offered a psychosocial assessment by an appropriately qualified individual.
- Both past behaviour and stated intents should guide risk assessment but not predetermine it.
- Patients who wish to leave casualty before they have been assessed may lack the capacity to appreciate how to act in their best interests as a result of intoxication, agitation or psychotic phenomena.
- Patients who lack capacity should be detained and expert advice sought.

The multiple attender

- Patients who present repeatedly in a range of settings or the same setting pose particular problems.
- This behaviour represents an indication for referral to and advice from the specialist personality disorder service.
- The mainstay of management is a flexible and practically deliverable crisis plan negotiated between all parties.
- The most common treatment failure is due to an impractical treatment plan because of
 - Unachievable demands on the service
 - Unachievable demands on the patient

Personality disordered patients who abuse substances.

- Personality disordered patients who abuse alcohol or drugs are often denied services.
- alcohol and drug use increases the risk of completed suicide very substantially
- There are differences between this group and either patients with personality disorder alone or substance abuse alone.
- The pattern of drug and alcohol use is often characteristic.
- The of alcohol use tends to be in binges with abstinent periods.
- The pattern of drug use tends to one of be multiple drug use.
- This group of patients often have axis 1 conditions as well including depression, psychosis and organic brain damage.
- This group of patients warrant specialist treatment deciding between using a drug and alcohol service based approach or specialist treatment for personality disorder should depend on patient preference and pragmatic considerations (eg service availability)



Disturbed behaviour.

- In very great measure personality disordered Patients become acutely disturbed on inpatient units and generally (for example in A&E) for one of three reasons
 - Perceived rejection
 - Rage
 - Agitation.

Disturbed behaviour

- Rejection
 - Patients experience refusals to engage in contact as rejecting.
 - They have little capacity to appreciate stresses or other demands on staff.
 - They often have little capacity to tolerate delay.
 - The resulting disturbance is not a manipulative attempt to gain contact but a distressed response to acute anxiety.
- Rage
 - Rage responses develop in relation to thwarting and also experiences of being really or apparently disrespected.
 - In men rage responses may result in violence in women they may result in self harm.

For disturbed behaviour driven by rage or rejection responses the appropriate response is normally.

- 1 attend to safety issues for the patient and others.
- 2 De escalation techniques. (offering a cup of tea, taking the patient outside for a walk/cigarette)
- 3 Make sustained, tolerant and unhurried enquiry as to the reasons for the behaviour.
- 4 Acknowledge the patient's perspective on disputes and experienced slights.
- 5 Explain the limits of what can be offered as limits to treatment rather than as appropriate treatment.

Agitation

- Agitation with severe suicidal ideation is a common experience.
- It may be unprovoked or in response to interpersonal blows.
- Unlike continuous low mood or agitation in depressed patients it may resolve rapidly in minutes only to flare up again unpredictably.

For disturbed behaviour driven by agitation the appropriate response is normally.

- 1 sympathy.
- 2 offers of distraction or exploration of other coping strategies.
- 3 Consideration of the use of medication.
- 4 Increased vigilance for suicide risk and consideration of a period of more intensive nursing observations.
- 5 Acknowledgement that the mood state may return unpredictably and willingness to offer further contact at that time.

Intensive nursing observations (specializing) in personality disordered patients

- This is appropriate for the management of some cases of agitation and suicidal ideation.
- It can be experienced by some patients as profoundly reassuring and by others as intrusive and distressing.
 - 1 its use should be explicitly discussed with the patient
 - 2 increases and decreases in the level of observation should be assessed very regularly (two or three times a day) In contrast with psychotic or depressed patients where the pattern of observations is, in general a steady progress from intensive to minimal in borderline patients who require it the level of observation should be expected to fluctuate.
 - 3 Observations should be as “natural” and as integrated into the life of the ward as possible.
 - 4 With selected patients consideration should be given to allowing them to set their own level of nursing observation.



Disturbed behaviour and contracts.

- Patients with serious borderline personality disorder do not have the capacity to make and keep promises or, when aroused to envisage the future consequences of their actions. They do not, when aroused respond well to offers of delayed gratification because these are not real to them. These features limit the value of contracts.

The patient who wants to leave or to discharge themselves from the ward or unit.

- Leaving after a short admission may be appropriate.
- If the patient is well enough to go home and not a risk to themselves or others it is appropriate to:
 - 1 Congratulate the patient on feeling better.
 - 2 For a new patient with a personality disorder take time to offer psychoeducation about the condition with access to literature and user groups.
 - 3 Offer follow up and support.
- Some patients wish to leave because they have suicidal plans:
 - 1 All patients should be asked directly about suicide and self harm plans
 - 2 Risk should be carefully assessed.
 - 3 If the patient is not detainable risks should be explicitly discussed with the patient and their carer and patients encouraged to remain on the ward.
 - 4 High acute risk patients who are adamant they wish to leave should be detained.

Substantive treatment for the personality disorder

- None.
- The best we can do is make up for deficits
- Help patients cope.
- **HOWEVER**
 - This best is really quite good.

Drug treatment

- None!

Psychological treatment

Task 1

Establish a sustainable setting.

Task 2

Focus on health promotion as much as deficit reduction.

- Compassionate self observation
- Social obligation
- Creative imagination.

Establish a sustainable setting

- Develop and maintain mental closeness.
- Managing risk
- Establishing a sustainable attachment relationship
- Zero tolerance policy
- Playing the long game.

Compassionate self observation

Mental robustness and flexibility

Coherent experience of consciousness

Honest assessment of moral standing

Realistic assessment of strengths and weaknesses

Compassionate self observation

- Enhance mental robustness by stopping self harm and other escape behaviours (zero tolerance policy)
- Promote conscious coherence by introduction of the concept of an “ordered life” and use of CAT tools.
- Generate self and other tolerance by group experience and therapeutic modelling.
- Promote self knowledge and accurate appraisal in psychotherapy.
- Truth speaking service

Social obligation

Understanding the emotional life of others

Developing obligations and commitment to them

Commitment to “society” and political development

Social obligation

- Psychoeducaton about social exclusion and the social contract.
- Group contacts in a safe setting to promote obligations and commitment to others.
- Work for others.

Creative imagination.

- Understanding the self - memory and desire
- Developing a view of the self as creative
- Freedom from anxiety in solving problems.
- Tolerance of disappointment and tragedy.

Creative imagination.

- Mourning.
- Work on that which has been spoiled.
- Creative therapies.
- Problem solving approach to making something of life.
- Tolerance of idiosyncratic solutions.