Personality Disorder pathways and interventions

Dr Steve Pearce

Oxfordshire and Buckinghamshire Complex Needs Service

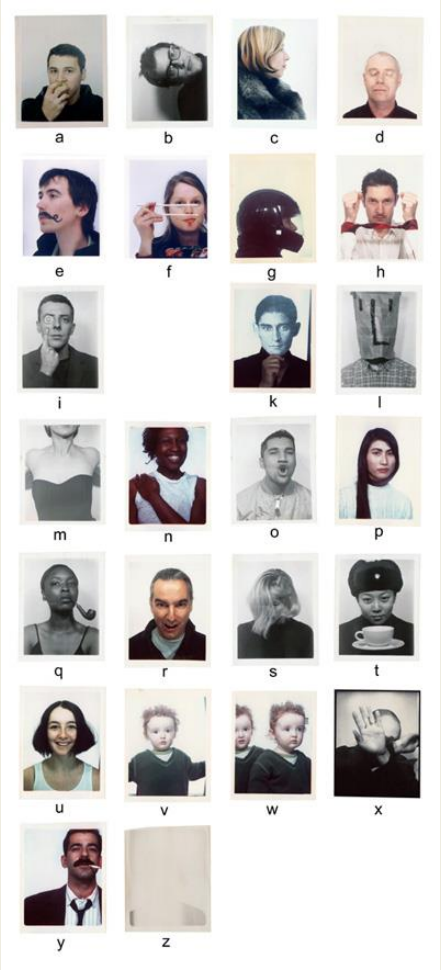
‘It has been said that each generation of mental health professionals has to discover for itself the importance of personality disorder.

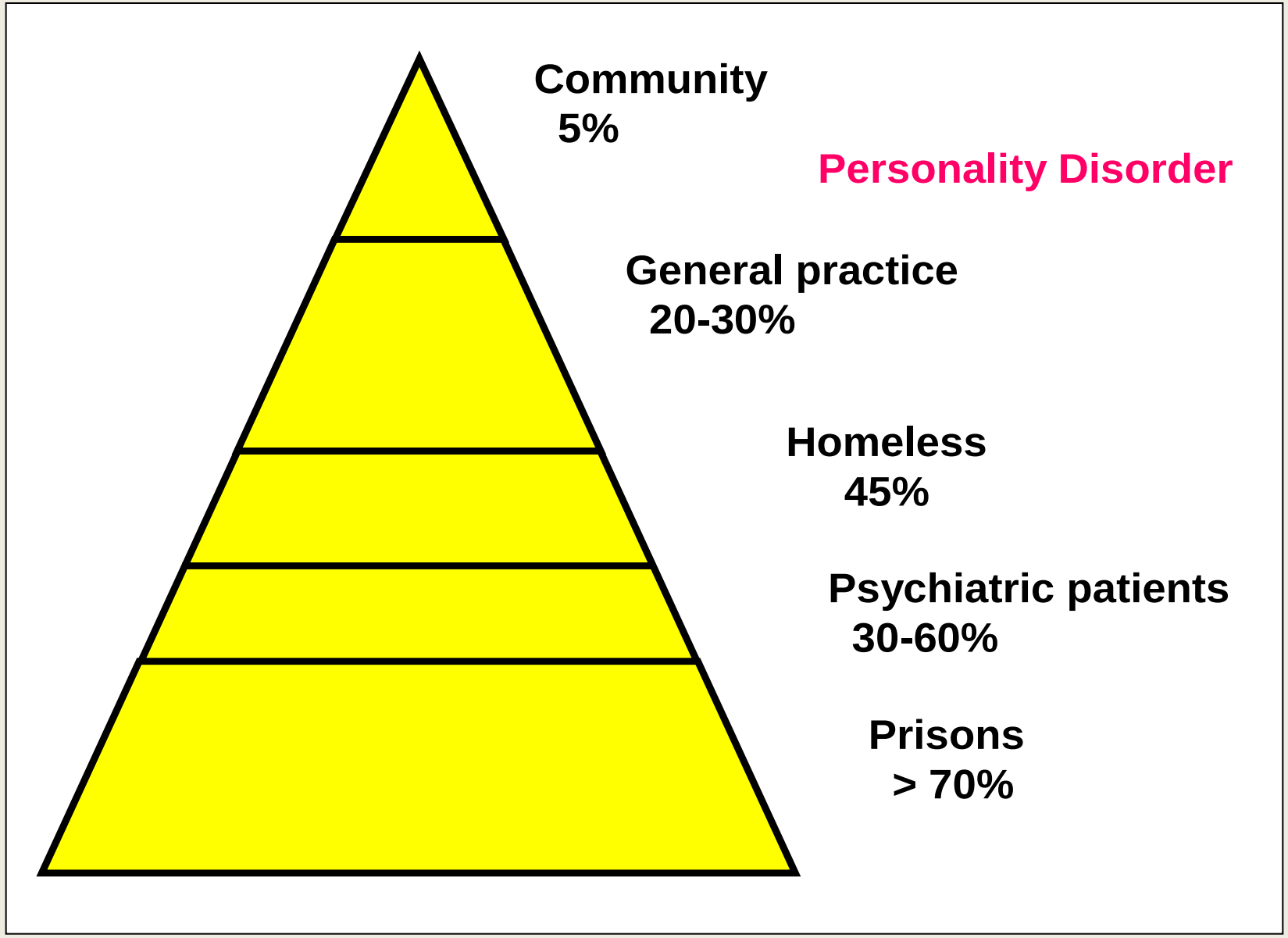
Although personality disorder often seems elusive, and to defy systematisation, the diagnosis appears to be indispensable’.

- Livesley 2001

Defining features

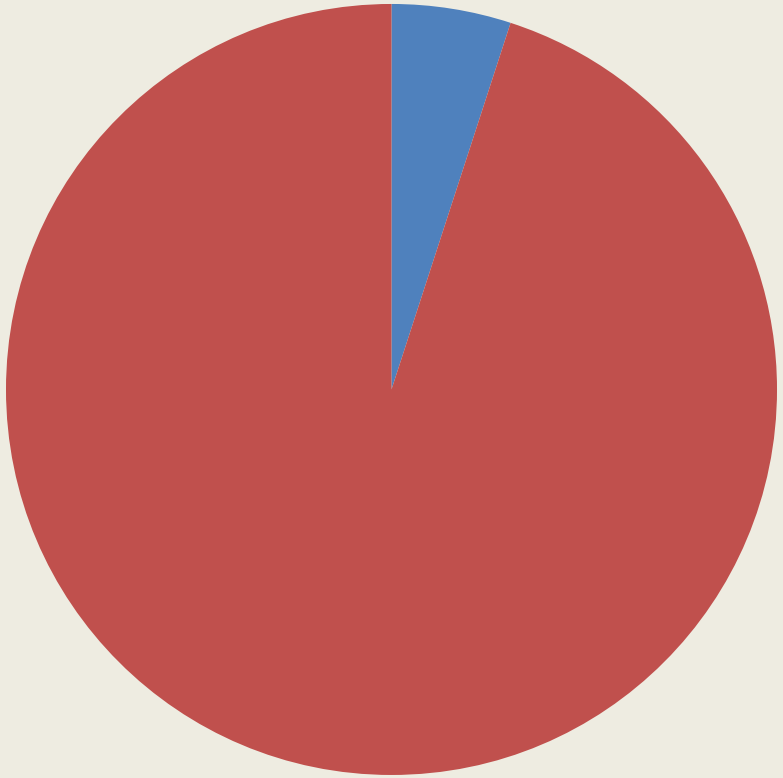
- Enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individuals culture
- Inflexible and pervasive
- Leading to clinically significant distress or impairment in social, occupational, or other important areas



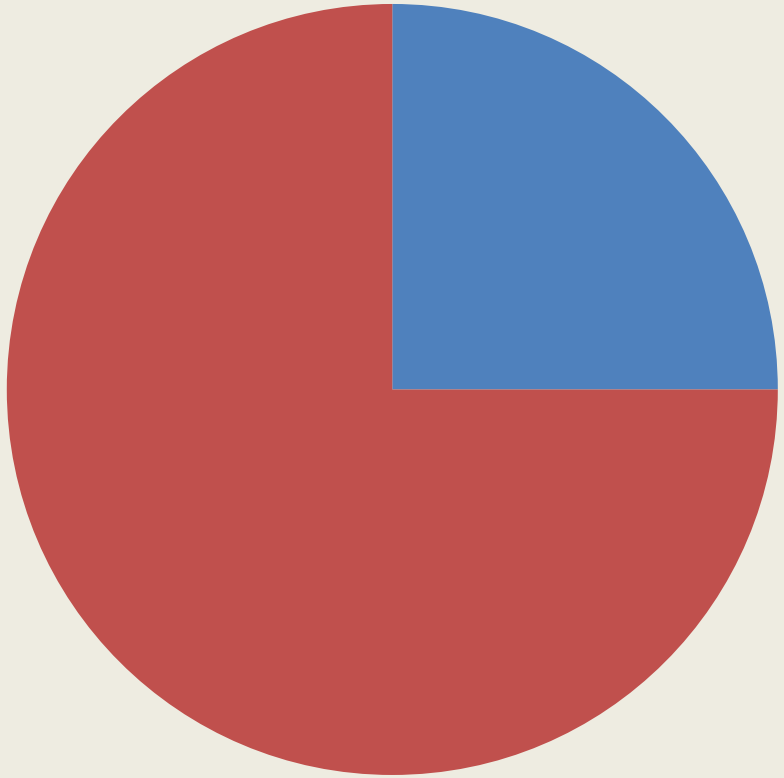

Community
5%
Personality Disorder
General practice
20-30%
Homeless
45%
Psychiatric patients
30-60%
Prisons
> 70%

20% of GP attenders meet the criteria for PD, and these attenders are often frequent re-attenders and on average 3x more expensive to manage than those without PD (Moran et al, 2014)

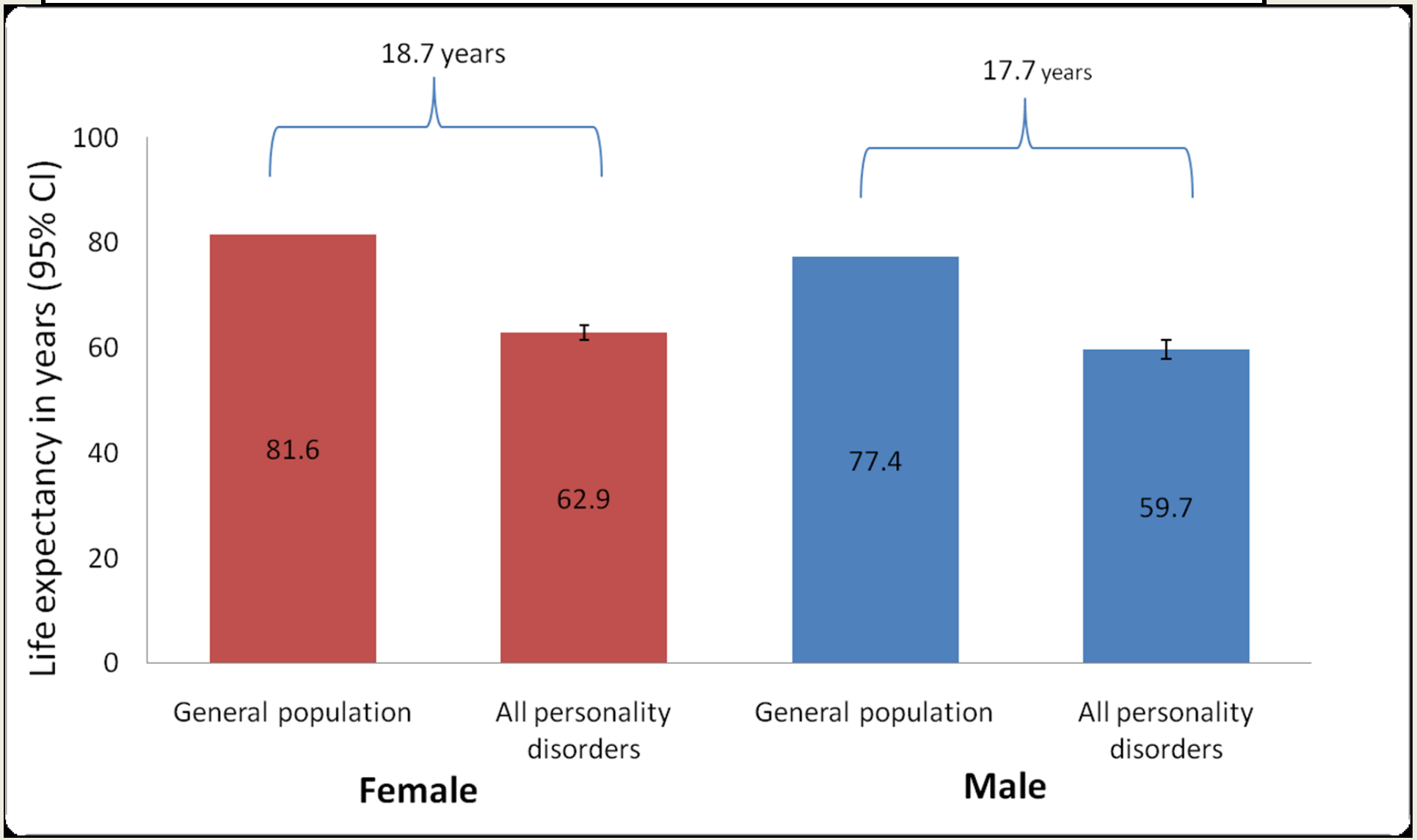
5% of population (Coid 2006)



24% of Primary care consultations (Moran 1999)



Life Expectancy for People with a diagnosis of PD



Source: Fok et al. (2012)

Costs

- More expensive than depression
  - Medication
  - Inpatient costs
  - Day patient costs
  - Outpatient costs
  - Therapy costs

(Bender 2001)

Associations

- Housing, employment, substance misuse
- Difficult consulting behaviour (Hahn 1996)
  - 1/3 of difficult patients have PD, mostly dependent (Schafer 1998)
- More likely to experience pain, more likely to rate pain as severe (Biskin 2014, BPD)
- Long term somatisation (Bornstein 2008)

Impact on other disorders

- Makes depression and anxiety harder to treat

Tyrer 1993

- Makes patients harder to help (less likely to be referred to secondary care)

Moran 2001

- Increases cardiovascular risks

Moran 2007

Cluster system

- Cluster A: ‘odd, eccentric’
  - Schizoid
  - Paranoid
- Cluster B ‘emotional, erratic’
  - Emotionally unstable (Borderline)
  - Histrionic
  - Dissocial/antisocial
  - Narcissistic
- Cluster C ‘anxious, fearful’
  - Obsessive-compulsive
  - Dependent
  - Avoidant

BPD

- Frantic efforts to avoid real or imagined abandonment
- Pattern of **unstable and intense relationships** alternating between idealisation and devaluation

- Identity disturbance: unstable sense of self or self-image

- Self damaging impulsivity (spending, sex, substance misuse, driving, eating)
- Recurrent **suicidal behaviour**, gestures or threats or self mutilating behaviour

- Affective instability due to marked reactivity of mood
- Inappropriate intense anger or **difficulties controlling anger**
- Chronic feelings of emptiness

- Transient stress related paranoid ideation or severe dissociative symptoms

Can be difficult to diagnose

- Correspondence between GP and standardised ratings of PD low
  - GP ratings associated with less likeable, less compliant, vague complaints, more stressful to deal with
  - None of these were true of standardised rated PD patients

(Moran 2001)

Standardised assessment of personality – assessment screen (SAPAS)

1. ***In general*, do you have difficulty making and keeping friends?**
2. **Would you *normally* describe yourself as a loner?**
3. ***In general*, do you trust other people?**
4. **Do you *normally* lose your temper easily?**
5. **Are you *normally* an impulsive sort of person?**

(If need clarification: Do you rush into most things without thinking about the consequences?)

6. **Are you *normally* a worrier?**
7. ***In general*, do you depend on others a lot?**
8. ***In general*, are you a perfectionist?**

(Check that this applies to most tasks – not just isolated areas of their life)

Moran 2003

Causes and course of PD

- Associations
  - Adverse childhood experiences
  - Family history
  - Later adversity
- Course
  - BPD gradually improves – peak suicide is 30s (3-8% Pompili 2005)
  - ASPD and OCPD probably don't
  - Dependent and avoidant may worsen

Treatment pathways

Traditional PD provision

- Psychological therapies: weekly outpatient model
- CMHTs
- Inpatient units

Modern PD provision

- AMHTs
- CNS – 94% PD
- Psychological services – probably 50% PD
- IAPT?

- Single point of access
- PD pathway

Psychological and other treatment

What?	Where?
• Medication	• AMHT
• CBT and emotional skills (incl. DBT skills), mostly group based	
• Mentalising skills • ?Social skills training	• SCM, CNS, PS
• Comprehensive multimodal programmes	• CNS, OSCA for under 25s
• Structured clinical management (SCM)	• AMHT treatment teams

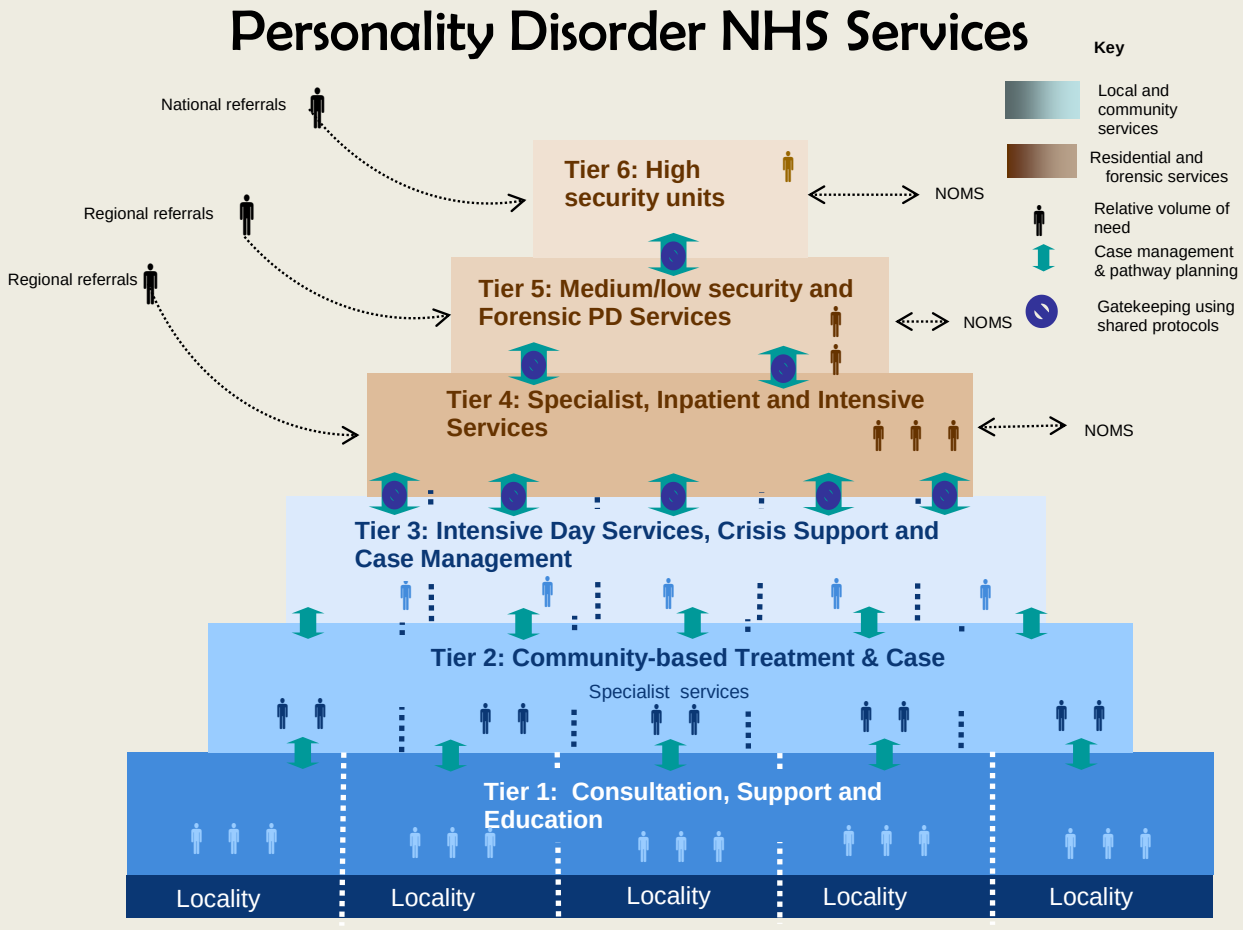
‘Thank you for your referral of the above detailed patient…for consider[illegible] of individ[illegible]herapy.

CNS is the pathway c[illegible]xfordshire for people with pe[illegible]rder…

We will not be [illegible]g you[illegible]l at this time’.

Complex Needs Service

- Tier 3 PD service
- All PDs
  - 94% PD
  - Average of 3 PDs per patient
  - Max 5 PDs
  - 90% BPD
- Interventions
  - Mentalisation based therapy (MBT),
  - Emotional skills groups,
  - Democratic therapeutic communities
  - Structured clinical management
  - Family and friends groups
  - STARS (expert patient) programme
  - Training



End

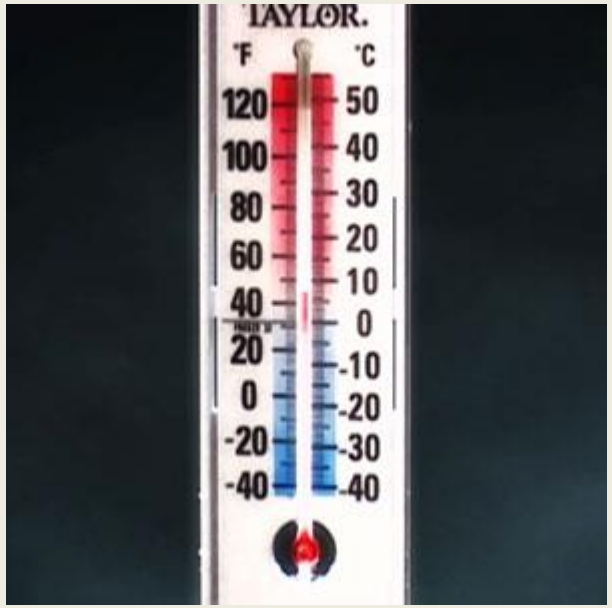
Steve.pearce@oxfordhealth.nhs.uk

Consultation skills

- Expectations (incl reception staff)
- Boundaries
- Interpersonal focus
- Arousal and mentalisation -
- Agency and self efficacy
- Experience of being the subject of reliable, coherent and rational thinking
- Discussion and supervision

Difficult to know what is in own and others minds (Mentalisation)

As emotional temp rises



em·pa·thy (ĕm'pə-thē) n.

Identification with and understanding of another's situation, feelings, and motives.

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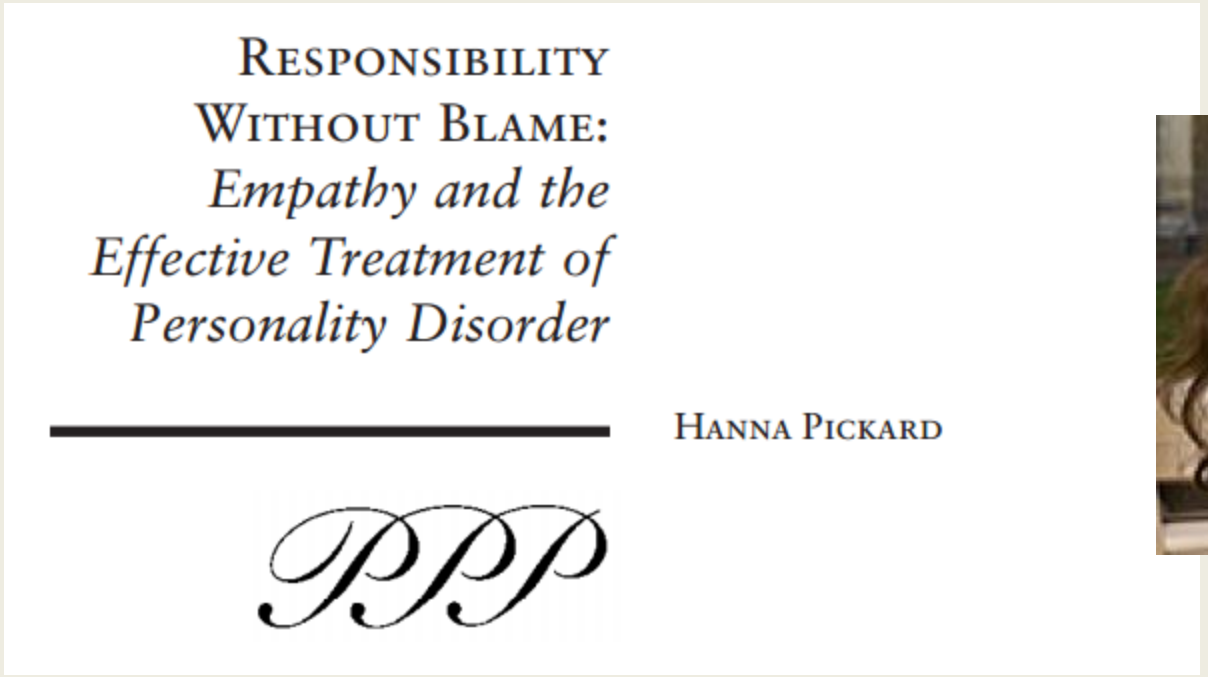

Pickard 2011

Consultation skills

- Expectations
- Boundaries
- Interpersonal focus
- Arousal and mentalisation
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- Discussion and supervision

- Feeling that worker is indestructible and engaged