

# PERSONALITY DISORDERS

# Personality Disorders

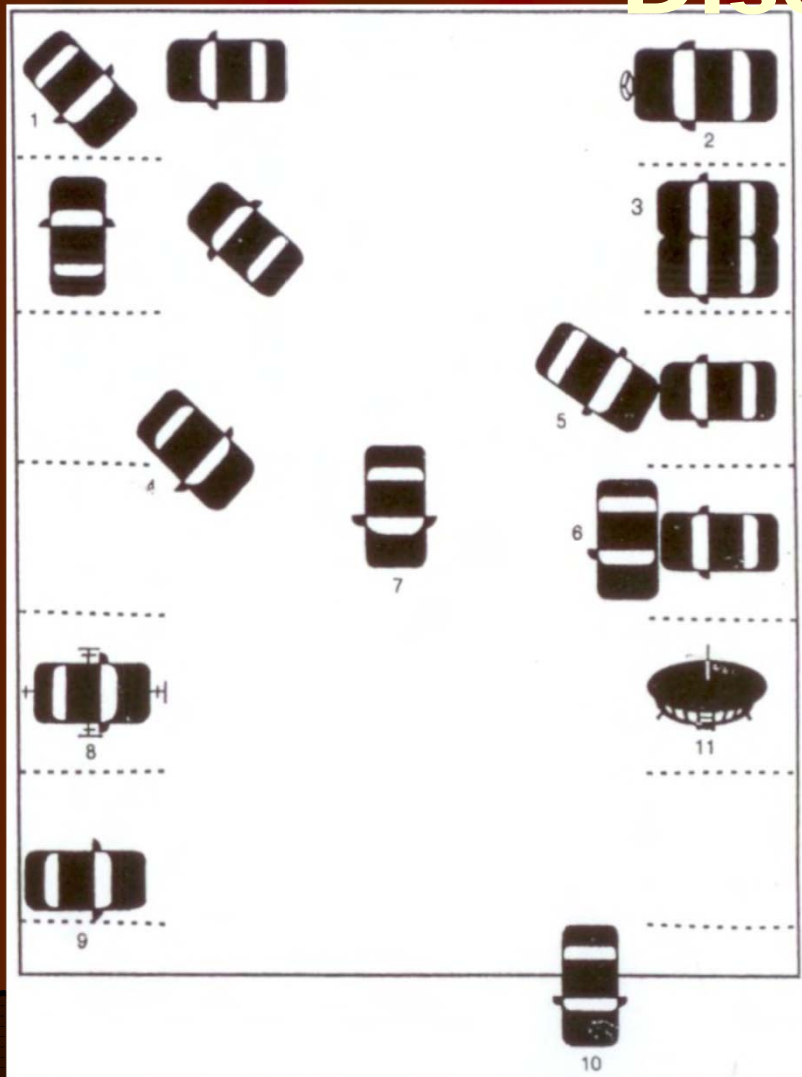
**Personality:** An enduring pattern of thinking, feeling and behaving that persists across time and circumstances.

For some people, elements of their personality (traits) can manifest in intense emotional difficulties & unhelpful behaviours impacting negatively on life roles, occupations & relationships

# Personality Disorder Types

- **Odd/ Eccentric – Cluster A**
  - Paranoid
  - Schizotypal
  - Schizoid
- **Dramatic/ Erratic - Cluster B**
  - Borderline
  - Narcissistic
  - Antisocial
  - Histrionic
- **Anxious/ Avoidant – Cluster C**
  - Dependant
  - Obsessive-Compulsive
  - Avoidant

# Parking Lot of the Personality Disordered



1. **Paranoid:** cornered again!
2. **Narcissist:** Largest car, Prominent hood ornament
3. **Dependent:** Needs other cars to feel sheltered
4. **Passive-Aggressive:** Angles car to take two spaces
5. **Borderline:** Rams into car of ex-lover
6. **Anti-social:** obstructs other cars
7. **Histrionic:** Parks in centre of lot for dramatic effect
8. **Obsessive:** Perfect alignment in parking spot
9. **Avoidant:** Hides in corner
10. **Schizoid:** can't tolerate closeness to other cars
11. **Schizotypal:** intergalactic parking

# Dramatic / Erratic - Presentation

- Difficulty controlling/ regulating emotional reactions
- Difficulty identifying & expressing emotions
- Expression of emotions via aggressive outbursts or impulsive behaviour
- Regular situational crises
- Regular interpersonal conflicts
- Ongoing suicidal feelings or feeling unsafe
- Engaging in self destructive behaviour
- Difficulty maintaining healthy boundaries in personal & professional relationships
- Behaviour results in others feeling manipulated
- Test the limits of relationships

# Dramatic / Erratic - Strategies

- Acknowledge emotions but set limits on behaviour
- Provide choices on how to respond/ deal with the situation
- Do not assume responsibility for the person's problems – assist them to solve their own problems
- Reinforce use of distraction strategies to cope with distress
- Ensure personal/ professional boundaries & expectations are clear from the start
- If boundaries are overstepped address in a timely & non-judgemental manner
- Set firm limits by calmly reinforcing your expectations and potential consequences of the unhelpful behaviour
- Positively reinforce benefits of taking responsibility & any steps taken in this direction

# Treatment of personality disorders

- Requires the person to recognise that they have a problem and to want to do something about it – at least part of the time.
- Involuntary treatment is rarely used. It may be used for short periods to manage crises or if a major mental illness develops.
- Treat symptoms including substance abuse, eating disorder etc.
- Long term venture, needs patience, consistency and skill.

# MHS capacity to engage with Individuals with PD

## Will Do:

- Management Plans
  - Consistency, containment, limit the number of clinicians involved, work out what does and doesn't work for each individual, problem solve trigger
- Symptom Management / Treatment
  - If the client is interested in remediating their skills deficit, then we can assist with that (DBT, CBT etc)
  - Motivational Interviewing / Commitment strategies

## Will not do:

- Force treatment
- Taxi service
- Take abuse
- Rescue people from the consequences of their own actions.



# Common Assumptions

- MANIPULATIVE

- Definition: Able to handle skillfully; control cleverly or deviously (Collins)
- Reality: Borderlines are more often direct, forceful and careless.

- ATTENTION-SEEKING, SPLITTING, LYING:

- Emotional pain → self-harm or suicide → invalidated and misunderstood → new ways to seek help.
- Not intentional.
- Effective treatment requires therapists to conceptualize Borderline Personality Disorder in a more empathic and adaptive way.

# Borderline Personality Disorder

(diagnostic criteria)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and a marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Frantic efforts to avoid real or imagined abandonment
- (2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
- (3) Identity disturbance: markedly and persistently unstable self-image or sense of self
- (4) Impulsivity in at least two areas that are potentially self-damaging (eg. Spending, sex, substance abuse, reckless driving, binge eating)

# Borderline Personality Disorder

(diagnostic criteria cont'd)

- (5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
- (6) Affective instability due to a marked reactivity of mood (eg. Intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- (7) Chronic feelings of emptiness
- (8) Inappropriate intense anger or difficulty controlling anger (eg. Frequent displays of temper, constant anger, recurrent physical fights)
- (9) Transient, stress related paranoid ideation or severe dissociative symptoms

# Remember...

...A person suffering with this illness has almost always been abused at an early age

...Borderline Personality Disorder is an illness

...The individuals perception often distorted

# Borderline Personality Disorder

- Borderline Personality Disorder is difficult to treat and to date has been a drain on mental health services.
- Usual treatment:
  - Reactive
  - Crisis Management
  - Attempts at problem solving
  - Attempts at behavioral change
  - Inability to take a preventative approach

# Effects of BPD on:

- MENTAL HEALTH SERVICE
  - Financial Burden – Emergency services
    - Admissions
  - Ongoing suicide risk
  - No-one wants to work with them
- INDIVIDUAL CLINICIANS
  - Crisis Management
  - Inadequate, overwhelmed, anxious
  - Negative responses
  - Don't want to work with them
- CLIENTS
  - History of abuse or neglect
  - Dysfunctional “patterns”
  - Maladaptive & high risk coping strategies
  - Ongoing struggle
  - All they know

# Behavioural Reinforcement

- It is the nature of people to seek pleasure and to avoid pain. This means that people as a general rule will seek that which is easiest.
- Hospital is generally easiest because:
  - The person is removed from the situation which has triggered the distress
  - The person has another person take responsibility for meeting their daily life needs eg food, housing, clothing
  - The person effectively “takes a holiday” from life and the stressors that go with it.
  - The person can give in to their impulses because the social consequences are lower.
  - The person can get instant relief through medication
- Hospital is ineffective because:
  - It reinforces behaviour that we don't want eg DSH, regression, admission / medication seeking
  - It doesn't teach the skills necessary to make hospital unnecessary.

# Treatment- HHOT/MHS Role

## Will Do

- Management Plans
- Symptom Management / Treatment

## Will not do

- Force treatment
- Taxi service
- Take abuse
- Rescue people from the consequences of their own actions.



# Treatment- Management Plans

- Management Plans co-ordinate treatment and response to individuals with PD providing them with consistency and containment.
- Facilitate interagency collaboration maintaining consistency in response across organisations.
- Include a treatment plan
- Provide a plan for Crisis Response
- Involve the individual in their treatment and encourage responsibility and autonomy
- Risk management tool

# Rescuer Vs Punisher

- **Rescuer** – Understandable as these clients are often easy to sympathise with. They often have appalling histories and their distress is tangible. Unfortunately, removing the consequences of their own behaviour or doing things for them, rather than helping them to learn those skills, does help them to remedy the skills deficit.
- **Punisher** – Understandable as these clients create chaos unnecessarily, over –react to the same life stressors that we often have deal with, demand more of your energy than you have to spare. Unfortunately refusing to assist at all, whilst successfully avoiding reinforcing certain behaviours, also doesn't remedy the skills deficits.
- **Middle Ground** – Decline certain requests whilst validating their distress, explaining why your declining and suggesting / offering alternative distress tolerance techniques.

# Treatment- Your Role

- Ensure from the start that personal/professional boundaries are clear  
(this is what I can do for you, & this is what I can't do)
- Never to offer or promise something you cannot deliver (they have been let down too many times before)
- If you make an appointment with them **KEEP IT!** Cancelling reinforces expectation of abandonment. Also appointments are often seen as something to look forward to

# Treatment- Your Role

- Be familiar with the individuals management plan and utilise its recommendations
- Always remain calm, in the face of anxiety, rage or manipulation
- Encourage adaptive coping strategies (breathing, imagery, problem solving, activity etc.)
- Try not to react emotionally to outbursts, remain calm in tone and manner – reinforce you view/position on the situation

# Treatment- Your Role

- Acknowledge the person's current emotions, but set limits on behaviour
- Monitor cues indicating escalating emotions (ie. Tension, raised voice) and if appropriate gently point these out in a non-judgemental manner
- Set firm limits by calmly reinforcing your expectations and potential consequence of a specific behaviour
- Check and validate information before reacting to it

# Treatment- Your Role

- Suicidal/self-harming behaviour is a cry for help, often the person has no other way of expressing their distress/ emotions
- Do not assume responsibility for the person's problem, assist them to solve their own problems
- Reinforce the use of diversion/distraction strategies to cope

# What is DBT

- Dialectical Behaviour Therapy is an evidence based intervention for the treatment of Borderline Personality Disorder
- DBT is a structured, time-limited, cognitive-behavioural treatment designed specifically for Borderline Personality Disorder.
- Developed by Marsha Linehan in the absence of an existing structured and effective treatment for Borderline Personality Disorder.
- Specifically focuses on suicidal and “parasuicidal” behaviour (referring to suicide attempts and self-harm).
- DBT is the first psychotherapy shown to be effective for BPD, evidenced by randomised controlled trials.

- DBT is based on a dialectical world view
- Dialectics is a system of argument in which synthesis is sought between two opposing forces or extremes (thesis and antithesis).
- Synthesis discovers what is valuable in both

And

- Seeks to resolve contradictions between the two
- 3. Examples of Dialectical Tension:
  - Acceptance versus change
  - Nurturing versus challenge
  - Focus on capabilities versus focus on deficits
  - Willfulness versus Willingness



# Biosocial Theory of BPD

- Borderline Personality Disorder is primarily a dysfunction of the “emotion regulation” system resulting from an interaction between biological and social factors.
- Biological = emotionally vulnerable individual. An emotionally vulnerable person is one whose autonomic nervous system reacts excessively to relatively low levels of stress and takes longer than normal to return to baseline once the stress is removed.
- Social = invalidating environment. An invalidating environment refers to a situation where the child’s communication of personal experiences are disqualified or met by erratic, inappropriate and extreme responses from significant others.

# Invalidating Environment

## Examples:

- Constant not occasional invalidation
- Abuse is invalidation
- Indiscriminately rejects communication of private experiences and/or self-generated behaviors
- Punishes emotional displays and intermittently reinforces emotional escalation
- Over-simplifies ease of problem solving and meeting goals

# DBT Assumptions re: clients

- They are doing the best they can.
- They want to improve.
- They must learn new behaviors in all relevant contexts.
- They cannot fail in DBT.
- They may not have caused all of their own problems, but they have to solve them anyway.
- They need to do better, try harder, and/or be more motivated to change.
- The lives of suicidal, borderline individuals are unbearable as they are currently being lived.

# Stages and Targets of Treatment

- **Pre-commitment Stage** – Commitment Targets:
- **Stage I Targets:** (stage I = 1year)
  - Decreasing suicidal & parasuicidal behaviours
  - Decreasing therapy interfering behaviours
  - Decreasing quality-of-life interfering behaviours
- **Stage II Targets:**
  - Decreasing posttraumatic stress
- **Stage III Targets:**
  - Increasing respect for self
  - Achieving individual goals

# Pre-commitment

- **Pre-commitment Stage**
  - Commitment Strategies:
    - Pros and Cons
    - Devil's Advocate
    - Foot in the Door / Door in the Face
    - Connecting Present Commitments to Past Commitments
    - Highlighting Freedom to Choose and Absence of Alternatives
  - Orientation to treatment
  - Agreement on DBT goals

# Stage 1: Active Therapy (12 month DBT program)

- Individual Therapy
- Group Skills Training
- Phone Coaching
- Consult Group

# Modes and Functions of Therapy

MODE	FUNCTION
Individual Psychotherapy	Improve motivation
Group Skills Training	Enhance Capabilities
Phone Coaching	Generalisation of capabilities to all relevant contexts
Consult Group	Capabilities and motivation of therapist

# Stage I: Targets and Strategies

1. Decreasing suicidal & parasuicidal behaviours
2. Decreasing therapy interfering behaviours
  - Behaviour that interferes with client receiving or benefiting from therapy or behaviours that burn-out the therapist
3. Decreasing quality-of-life interfering behaviours
  - Substance abuse, Financial difficulties, Criminal behaviours, High risk sexual behaviours, Serious dysfunctional interpersonal behaviours/employment behaviours
  - Increasing behavioural skills
    - Core mindfulness skills
    - Interpersonal effectiveness
    - Emotion regulation
    - Distress tolerance
    - Self-management



# Stages and Targets Cont/d...

Emotion Dysregulation	Emotion Regulation – primary and secondary emotions, vulnerability factors
Behavioural Dysregulation	Distress Tolerance skills – tolerating negative emotions without engaging in impulsive, desperate behaviours eg DSH, substance abuse, aggression
Interpersonal Dysregulation	Interpersonal Effectiveness – balancing priorities eg objective relationship, self-respect effectiveness and choosing and implementing the appropriate skill.
Self Dysregulation	Mindfulness
Cognitive Dysregulation	Mindfulness

# Individual Psychotherapy

- Individual therapist is the primary therapist. All other therapists that the client is involved with outside of DBT are to be withdrawn.
- All other modes of therapy revolve around individual therapy.
- Helps the client inhibit maladaptive, borderline behaviours and replace them with adaptive skillful responses.
- Close attention is paid to motivational issues, including personal and environmental factors.
- Sessions are usually once weekly for one hour but can vary according to level of crisis.
- Client expected to keep a diary card which is reviewed in session.
- Chain analysis of events leading to particular incident ie self-harm.
- Solution analysis to identify more adaptive & skillful responses.

# Group Skills Training

- Distress Tolerance Skills
  - Observing you Breath, Half-smiling, Acceptance Strategies, Wilful Vs Willing
- Emotion Regulation
  - Identifying Emotions, Identifying the function of Emotions, PLEASE Factors, Build Positive Experiences, Opposite to Emotion Action,
- Interpersonal Effectiveness
  - Identifying Priorities eg Objective Vs Relationship Vs Self Respect
  - Identifying factors which reduce effectiveness eg skill deficit, worry thoughts, emotions, indecision
  - Identifying intensity of asking / saying no
  - DEAR MAN, GIVE, FAST
- Core Mindfulness
  - States of Mind
  - What and How Skills

# Phone Coaching

- Phone contact with individual therapist - working hours.
- After hours, clients call PEC
- DBT information folders kept with PEC, Acute Care Team, and Wards G, H, and I. Folders contain information on:
  - active clients
  - acute presentation plans
  - procedure for phone coaching
  - overview of skills taught

# Phone Coaching cont/d...

## Purpose of Telephone Coaching

- Decrease suicide crisis behaviours – opportunity to intervene prior to self-harm
- Increase generalisation of DBT behavioural skills to outside environment
- Decrease sense of conflict, alienation, distance with the therapist
- Increase client's ability to ask for help effectively

**NOTE: Phone coaching not available for 24 hours if self-harm has occurred**

# Crisis Survival Skills

- Mindfulness
- Distract with Wise Mind ACCEPTS
- Self Soothe
- Improve the Moment
- Pros and Cons

# Mindfulness

## “WHAT” SKILLS

- Observing
  - noticing the experience without reacting.
  - stay in control and remain alert.
  - watch your thoughts coming and going.
  - notice what comes through your senses.
- Describing
  - use words to describe your experiences.
- Participating
  - become involved in the moment.
  - actively practice the skills.

## “HOW” SKILLS

- Non-judgmentally
  - do not evaluate.
  - acceptance of the moment.
- One-mindfully
  - one thing at a time.
  - let go of distractions.
- Effectively
  - focus on what works.

# Distract with Wise Mind ACCEPTS

- Activities
  - Go for a walk, talk to someone, watch a video
- Comparisons
  - To someone less fortunate, to when they were doing better
- Contribution
  - Make someone a cup of tea, volunteer work
- Emotions
  - Do something that will create a different emotion – watch a funny video
- Pushing Away
  - Decide not to think about that now, mindfulness
- Thoughts
  - Imagery techniques
- Sensations
  - Squeeze Ice, run cold water over the back of your neck / head



# Self Soothe

## - the Five Senses:

- Sight – Look at beautiful soothing things eg paintings in a museum, the trees / flowers outside, make your environment pretty
- Hearing – Listen to soothing things eg music, birds, water
- Taste – make yourself a treat, have your favourite lollies on hand, cup of decaf tea
- Smell – burn incense or scented oil, bake bread, try a perfume tester
- Touch – play with a pet, get a cuddle from a safe person, snuggle in a blanket, try on fur coats in a clothes shop

# IMPROVE the Moment

- Imagery
- Meaning
  - Lemonade out of Lemons
- Prayer
- Relaxation
  - Breathing, progressive muscle
- One thing at a time
  - Mindfulness
- Vacation
  - Stay in bed, ask someone to make you a cup of tea, clean up later (remember other people, reciprocity)
- Encouragement
  - Cheerleading

# Pros and Cons

- Pros of doing something (eg DSH, drinking, violence)
- Cons of doing that
- Pros of not doing that
- Cons of not doing that
- Can only do this activity in "Wise Mind"
- Once completed, it can be used as a wallet prompt in time where they can't find Wise Mind.

# Referral Process

- All referrals are internal (within INBMHS)
- Referrals are made directly to DBT Coordinator
- Steps to referral:
  - \* Read referral guidelines
  - \* Discuss referral with the client
  - \* Discuss referral with DBT Coordinator
  - \* Complete generic referral form, specify DBT
- Client will then be assessed for suitability
- If suitable, individual therapist assigned
- Pre-commitment commenced (approx. 4 sessions)
- Referring party remains principal contact until client has entered active treatment (Group skills training)