GPs at the Deep End

Pioneer Scheme Day-release programme

Wednesday 5th July 2017

Horselethill Road, Glasgow

Personality disorder

With Dr Andrea Williams, Consultant Psychiatrist in Psychotherapy

Background

Dr Williams works in the PD and Homelessness Team, based at Hunter Street Homeless Health Centre. This is currently the only service for PD within NHS Greater Glasgow and Clyde. NHS Highland has had a Personality Disorder Integrated care pathway since 2009 (1) and there are other Health boards across Scotland with pockets of resources.

Patients with PD can be a challenge for practitioners:

- Changeable presentation
- Can evoke a strong emotional response – including 'manipulative', 'at it', etc
- Not easily helped or treated
- No integrated care pathway in Glasgow
- Controversies over classification
- Stigma for patients
- Patient can 'Split staff' – an unconscious process
- Attachment Behaviour to staff , particularly institutional patients

How does PD develop?

Genetics →Temperament→ Attachment and childhood experiences →Adult experience and relationships → Adult Personality

Personality can change throughout adult life, hence the use of psychotherapy.

Genetics – Hereditary rates

- normal personality traits 30-60%
- Antisocial personality disorder 40%
- Borderline Personality Disorder 35-45%
- Paranoid 29%
- Schizoid 29%

A secure attachment between baby and parent/guardian allows the development of more synapses in the brain. As the child develops this can affect how they are able to manage threat by the fight or flight reaction. The pre-frontal cortex responsible for reasoning often switches off at a lower threshold.

Classification

DSM V has recently been reviewed and ICD 11 is currently being reviewed, likely out in 2019. DSM V now categorises PD in Axis 1 alongside other psychiatric disorders. There is a debate in psychiatry about PD as often patients don't fit neatly into the categories and can meet criteria for multiple personality disorders.

ICD 11 is proposing a more radical move to a dimensional system, rating on severity of personality disturbance then on trait dimensions. This may provide a less stigmatising description but will mean the diagnosis will be a large description and it will be harder to group patients together for trials.

Prevalence

4% of the General population have a PD (Coid 2006), 33% of patients in CMHT, 40-50% of inpatient psychiatry patients (Herzog 1992) and 70% of prisoners (Singleton 1998). Dr Williams was not sure of the figures for primary care.

Diagnosing BPD (spectrum of traits)

- Emotionally instability
- Self-image unclear
- Intense, unstable relationships
- Extreme efforts to avoid abandonment
- Self harm/suicidal threats
- Lack of impulse control

Pharmacotherapy in PD is not recommended in the 2008 NICE guidelines except to treat co-morbidities. There was guidance in Australia to suggest use of time limited treatments – atypical antipsychotics for impulsive/aggressive behaviour, mood stabilisers for labile mood and AD for depressive symptoms.

There have been several small studies and overall they support the role of psychotherapy but there is a need for replicating studies. A cross-section of ~2600 patients within CMHT in GGC showed 92% were prescribed psychotropic medication. These patients had a singular diagnosis of PD.

Mentalising

Mentalising is the ability as humans to attend to the mental state in ourselves and others, as we attempt to understand our own actions and those of others on the basis of intentional mental state.

The focus of MBT is to help the person develop better capacity to mentalise – and to restore this more quickly when lost. Patients may present with the ability to control or understand their

own and others emotional states, unwilling to listen/attune, gross distortions and misunderstanding when they have stopped mentalising.

Strategies for managing in consultation

- Attune, empathise
- Try to shock them out of the non-mentalising state – curiosity without assumptions "I can't see what you mean..."
- Try asking them to put themselves in other mindsets
- Don't pretend to understand if you don't
- Keep it brief, notice when losing their interest
- Don't offer solutions until fully clarifying the problem
- Try to match the intervention to the level of emotional arousal
- Perhaps not having these patients last in the day – transferring their own 'bad feeling' to the practitioner, good housekeeping

Glasgow bases for Psychotherapy

North – Anvil centre

South – Leverndale

Resources

1 http://www.nhshighland.scot.nhs.uk/Services/Pages/Personalitydisorderservice.aspx

Further Reading

- Meeting the challenge – making a difference. Working effectively to support people with personality disorder in the community. http://www.crisiscareconcordat.org.uk/inspiration/meeting-the-challenge-making-a-difference/ (*a good document for non-specialist practitioners about personality disorder, especially the practical guidance in section 4, p.38)*

- The Ailment by Tom F. Main (1957) http://onlinelibrary.wiley.com/doi/10.1111/j.2044-8341.1957.tb01193.x/abstract *(Main studied the feelings aroused in a team of nurses caring for a group of psychiatric patients who had little potential for recovery. He found that a sedative would be used in the management of a patient "only at the moment when the nurse had reached the limit of her human resources and was no longer able to stand the patient's problems without anxiety, impatience, guilt, anger or despair".)*

- NICE guidelines for borderline personality disorder: https://www.nice.org.uk/guidance/cg78 and antisocial personality disorder: https://www.nice.org.uk/guidance/cg77