MANAGING PERSONALITY DISORDERS on Women's PICU

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Easy!

- **Don’t admit** patients with Personality Disorder (PD), it isn’t the right treatment (Nice guidelines – National guidance on PICUs)

Not so easy!

- Personality Disorder (PD) is a frequent **co-morbidity** in Mood Disorders and Thought Disorders
- Patients **admitted** to PICU because at high risk for themselves or others
- Patients **transferred** to PICU because unmanageable in open wards
- PD complicates other concomitant diagnosis
- PD complicates the management of other disturbed patients

Manuela (I/III)

- Attractive young woman
- Late 20's
- Insuline dependent diabetic
- Misuse of drugs and alcohol (not dependent)
- Recurrent psychotic symptoms (pseudo hallucinations, grandiose and paranoid ideation)
- Dramatic mood fluctuations (rapid, intense, extreme)
- Impulsive risky behaviour (sexual promiscuity – aggressive towards others and objects – self harm)
- Limited insight

Manuela (II/III)

- Lives in a hostel (mixed male and female)
- No trust in neighbours - “they steal from me” “they exploit me” (no next of kin)
- Trashed area of a clothes’s store following altercation with the security guard who was attacked and sustained scratches and superficial cuts
- Police called
- Ambulance called
- Would kill herself rather than going back to hostel
- Admitted to psychiatric hospital

Manuela (III/III)

- History of Depression and Anxity – Bipolar Affective Disorder – Eating Disorder – Personality Disorder (self harm, suicide attempts and harming others)
- Criminal record (GBH /damage to properties)
- Medications: Quetiapine – Mirtazapine – Zopiclone – Diazepam PRN (poor compliance with medications)
- Admitted voluntarily in ward to assess diagnosis and treatment
- Transferred to PICU few days later because of CHAOS with staff and patients: depressed & suicidal - threatens to kill herself with overdose of insuline – increased level of observation - threatens to harm member of staff and patients with needles – volatile – splitting – “manipulative”

Principles of management of patients with Borderline Personality Disorder in in-patient units

- Establish conditions to make the patient and staff safe
- Tolerate intense anger, aggression and hate
- Promote reflection
- Set limits
- Establish and maintain the therapeutic alliance
- Avoid and understand splitting
- Monitor countertransference
- Maintain flexibility

Fagin L. Management of personality disorders in acute in-patients settings. Advances in Psychiatric Treatment Feb. 2004, 10 (2,) 93-99

The main elements of psychiatric intervention in an acute in-patient setting

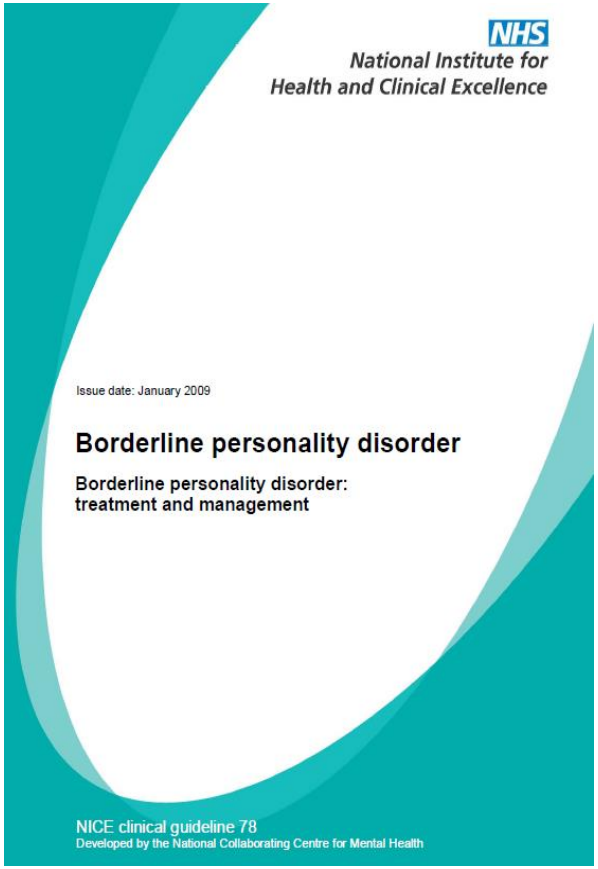
- Careful assessment
- Early care plan (after crisis is overcome)
- Bounderies
- Medications
- Short duration admission (be prepared to discharge even if goals not met)
- Liaise with community services
- Staff support & supervision

Treatment

- **Physical** – Medications
- **Psychological** – Talking treatment

NICE – Borderline PD (2009)

- Treat comorbid conditions
- **Do not use drug treatment** specifically for borderline personality disorder or individual symptoms associated with it
- **Antipsychotic** drugs should not be used for medium and long term
- Short term use (one week) of *sedative medication* may be considered



Antipsychotic medication

- Prescribers report benefits among inpatients with severe BPD not see in the community. Including benefits associated with Clozapine among those who have not responded to others antipsychotic drugs
- No clinical trails
- Case series (Frogley et al/. 2013) 22 women treated in specialist IP services. Improvements in mental health global functioning and reduced observation over 18 months follow-up
- Proposal for randomised trail of Clozapine with placebo or alternative antipsychotic: if so, which comparator(s) would you support?

TALKING TREATMENT

- **MBT - mentalization based therapy**
- DBT – dialectical behaviour therapy
- CBT – cognitive behavioural therapy
- Schema Focused Therapy
- Transference Focused Therapy
- Dynamic Psychotherapy
- Cognitive Analytical Therapy
- Therapeutic Community

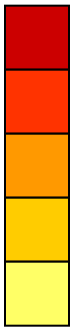
MBT key features

- To promote mentalizing by getting to know **own** and **others mental states**
- The **effects of mental states** on emotions and behaviour (’acting out’)
- Separating ones **thoughts** from **feelings**
- Understanding one’s **impact on others**

Delivering MBT: therapist's stance

- **Not knowing**
- Ask questions to promote exploration
- Ask about patient's understanding of motives
- Highlight alternative perspectives
- Avoid presenting complex mental states
- Avoid simplified explanations
- Model honesty and courage via acknowledgement of your own mistakes

Basic principles of mentalizing



Most aroused

Least aroused

Supportive/empathic

Clarification and elaboration

Basic mentalizing

- Mentalizing the transference

Non-mentalizing states

- **Psychic equivalence**: what exists in the mind must exist in the external world
- **Pretend mode/pseudomentalizing**: excessive detail but no real understanding is experienced
- **Teleological stance**: physical world is the only way to understand interactions with others.

Case scenario

- Manuela attends her final ward round; due to be discharged to her LMHT as diagnosis clarified (BPD) and stable mental state and behaviour on the ward.
- She appears very reluctant to be discharged.
- She threatens DSH.

How to manage Manuela (1)?

- *Keep calm*
- *Listen, look and “stop”*
- *Involve patient*

How to manage Manuela (2)?

- Avoid being dismissive of her feelings '*You'll be OK*'
- Acknowledge her feelings (*anxiety or anger*)
- Explore why she was feeling this way (abandonment) and validate/normalise
- Remind her of the agreed plan '*We have been discussing this for several weeks*'
- '*Not knowing*' – neither you know or she knows whether she would deteriorate following D/C
- Opportunity to do something different this time

How to manage Manuela (3)?

- Emphasise positive things done prior to the planned D/C (college, voluntary work, sorted benefits or accommodation problems)
- Remind her of support/services available to her if there is a crisis (SPA, A&E, GP, Samaritans)
- What was helpful in the past (if discharged before)
- Supervision and support (supervision with consultants, reflective practice)

General principles in management of PD patients

- Consistent, responsive and reliable
- Explicit about limitations and boundaries
- Combine psychological and social
- Actively involvement in all aspects of treatment
- Manage expectations: short and long-term goals
- Anticipate crises and help people develop plans to manage these
- Comprehensive communication within teams