Managing Personality Disorder Alongside Advanced Disease

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What to expect from today's talk

Myth busting personality disorders

What is personality and how does it become 'disordered'

An overview of classifications

Core features

Prevalence within palliative care services

Problems specific to this patient group

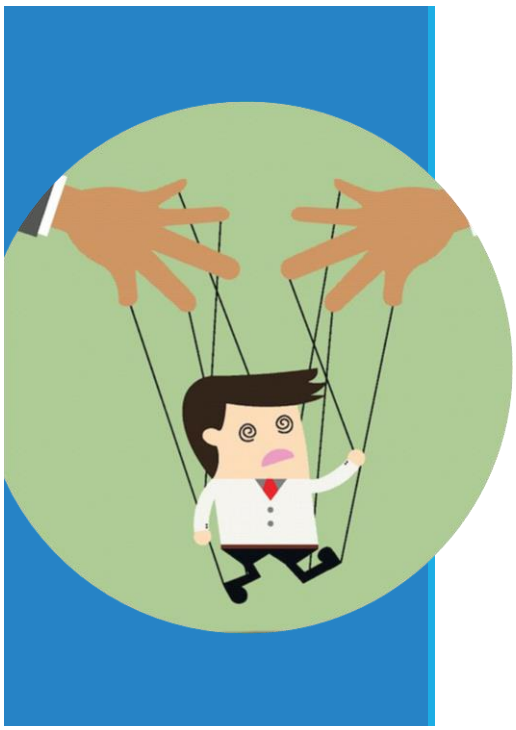
Treatment approaches within psychiatry

Case discussion

Translation of management options to palliative population

What we think we know…

People with personality disorders are dangerous



All people with personality disorders are manipulative

Up to 90% of those diagnosed with a personality disorder suffered early trauma

Personality disorders improve with age

What is personality?

Inherited characteristics, changing with maturation and environmental factors until adulthood

A collection of traits which make us individual and influence how we think, feel and behave.

Although the work of William James in the 80s suggested personality sets 'like plaster' by the age of 30, meta-analytic data from 2000's onwards shows rate of change slows over time.[1]

Personality traits become consistent through exposure to a consistent environment, genetic effects, psychological make-up, the goodness of fit between individuals and their environment, and a strong sense of identity.[2]

Where does it all go wrong?

When personality traits are extreme, and personality development is arrested, delayed, or derailed.

Characterised by adaptive and maladaptive personality trait dimensions.

Personality disorder usually becomes clinically apparent during the transition between childhood and adulthood and has the potential to disrupt the complex developmental tasks associated with this phase of life and the achievement of adult role functioning.

Pervasive effect – often overlooked in clinical practice.[3]

Recognition of this disorder has the potential to deepen understanding of individual patients and to enhance the ability to help them manage their lives.

The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits.

Classification of personality disorder [4]

Cluster A: 'odd/eccentric/socially averse'

Paranoid, Schizoid, Schizotypal

Cluster B: 'dramatic/emotional/impulsive'

Antisocial, Borderline, Histrionic, Narcissistic

Cluster C: 'anxious/fearful'

Avoidant, Dependent, Obsessive-Compulsive

Personality Disorder otherwise not specified

Cluster A

PARANOID PERSONALITY DISORDER:

- excessive sensitivity to setbacks
- unforgiveness of insults
- suspiciousness/tendency to distort experience by misconstruing the neutral or friendly actions of others
- tenacious sense of personal rights
- there is often excessive self-reference.

SCHIZOID PERSONALITY DISORDER

- withdrawal from affectional, social and other contacts
- preference for fantasy, solitary activities, and introspection
- there is a limited capacity to express feelings and to experience pleasure

Cluster B

ANTISOCIAL PERSONALITY DISORDER:

- disregard for social obligations
- callous unconcern for the feelings of others
- manipulative/deceitfulness
- there is gross disparity between behaviour and the prevailing social norms
- not readily modifiable by adverse experience, including punishment
- there is a low tolerance to frustration and a low threshold for discharge of aggression, including violence
- there is a tendency to blame others

BORDERLINE PERSONALITY DISORDER:

- Unstable self-image with chronic feelings of emptiness
- Instability of goals and internal preferences
- Compromised empathy and interpersonal hypersensitivity leading to intense/unstable relationships
- Fear of abandonment/mistrust
- Emotional lability/depressivity
- Impulsive/self- destructive behavior including self-harm and suicide attempts

Cluster B

NARCISSISTIC PERSONALITY DISORDER:

- Goal-setting is based on gaining approval from others
- personal standards are unreasonably high in order to see oneself as exceptional
- Excessive reference to others for self-definition and self-esteem regulation
- Lack of empathy
- excessively attuned to reactions of others; if relevant to self
- Relationships largely superficial
- Grandiosity/attention seeking

HISTRIONIC PERSONALITY DISORDER:

- shallow and labile affectivity
- self-dramatization, theatricality
- exaggerated expression of emotions, suggestibility, egocentricity, self-indulgence
- lack of consideration for others but easily hurt feelings
- continuous seeking for appreciation, excitement and attention

Cluster C

OBSESSIVE-COMPULSIVE PD:

- feelings of doubt, perfectionism, excessive conscientiousness
- checking and preoccupation with details
- stubbornness, caution, and rigidity
- There may be insistent and unwelcome thoughts or impulses that do not attain the severity of an obsessive-compulsive disorder.

ANXIOUS/AVOIDANT PD:

- feelings of tension and apprehension
- insecurity and inferiority
- There is a continuous yearning to be liked and accepted
- a hypersensitivity to rejection and criticism
- restricted personal attachments
- a tendency to avoid certain activities by habitual exaggeration of the potential dangers or risks in everyday situations.

Cluster C

DEPENDENT PERSONALITY DISORDER:

- pervasive passive reliance on other people to make one's major and minor life decisions
- great fear of abandonment
- feelings of helplessness and incompetence
- passive compliance with the wishes of elders and others
- tendency to transfer responsibility to others

Prevalence

General population:

- Large 2006 epidemiological [5] study showed prevalence of approx. 5% in UK
- Recent SR +MA (113,998 individuals) [6] showed prevalence of any PD ~12% (1.9% borderline, 3% antisocial, 1.2% narcissistic)
- In clinical populations, borderline personality disorder is the most common personality disorder, with a prevalence of 10% of all psychiatric outpatients and between 15% and 25% of inpatients.[3]

Palliative care population:

- Little evidence – most literature quote figures in general population as range.
- Pall Med study from hospice setting (2003) showed 2.2% with formal PD diagnosis and further 5% with 'life-long personality difficulties' with no formal diagnosis. [7]

Problems specific to this patient cohort within the palliative care population

- Normal coping mechanisms not present
- Arouse intense emotions in health care staff – transference/countertransference.
- Can cause splitting amongst team.[8]
- Consume large amounts of clinical time to potentially disengage with plan. [9]
- Quick to change views/wishes leaving team to adapt care.
- Suicide risk/self-harm – potentially lethal medication.
- Difficult interpersonal relationships with family members complicating care planning.
- High prevalence of early +/- adult life trauma. [10]

Why is it important to identify and support

- Suffering from PD and additionally trying to make sense of advanced disease and own mortality.
- Likely to be a large psychosocial component to pain. [8]
- Establishing a 'normal' relationship with clinical team likely to be difficult for patient – early efforts can prevent future breakdown.
- May have had lots of psychotherapeutic input in the past; learnings of which may be able to be accessed through psychiatry team.
- 20% of your customers take up 80% of your time – demanding on the clinical team so early identification means measures can be put in place to best support team.
- Evidence to show personality disorder in cancer risk factor for lower quality of life.[11]

Treatment approaches within psychiatry

Psychosocial treatment – broad range of psychotherapeutic modalities have been developed which focus on different aspects of a persons difficulties; reducing life-threatening symptoms + distressing mental state symptoms, improving interpersonal interactions, developing personal identity or problem solving for practical problems.[12]

Can be individual or group approaches.

Pharmacotherapy – focusses on specific pathological aspects of personality disorder such as affective instability, cognitive-perceptual disturbance or impulsivity.

Exploration and treatment of comorbidity – many meet criteria for diagnosis of more than 1 PD and there is a high proportion with depression, anxiety or substance dependence.

CLUSTER A

Thought to be least adaptive and treatable

No well organised RCTs exist

- **Psychosocial:** CBT suggested as preferred based on limited evidence. [13]
- **Pharmacotherapy:** few, small open-label studies showed some overall benefit – no robust evidence on risk-benefit. [14]

CLUSTER C

Thought to have best outlook and treatability.

- **Psychosocial:** Meta-analytical data specific to cluster C disorders found CBT + psychodynamic therapy led to medium to large treatment effects. [15,16,17]
- **Pharmacotherapy:** No RCTS but suggested as social phobia has evidence for SSRI management, this evidence could be used to inform management.

CLUSTER B – ANTISOCIAL PD

Few high quality studies in this patient group and no pooled data due to different conceptualisations of psychopathy and antisocial PD.

Much of data from incarcerated patients

Primary measure often recidivism

Psychosocial: CBT and social skill training evidence in juveniles and young adults. [18]

Pharmacotherapy: NICE advise no routine use.[19]

Borderline Personality Disorder

Majority of research interest focused on BPD, with a now well-established evidence base out of which have been born general principles for managing BPD.

Psychosocial: Changed dramatically over past 40 years ago, where psychoanalytic approaches were the mainstay. Creative adaptations of therapies for BPD developed and subjected to RCT with most leading to improved outcomes for life-threatening symptoms.[12]

Modalities with evidence base: Dialectical Behaviour Therapy, specific CBT, Transference-focused therapy and Psychodynamic psychotherapy.

Pharmacotherapy: NICE guidance based on Cochrane Review – not used as primary therapy, time limited for acute crisis. [20,21]

If used: Aripiprazole/olanzapine and mood stabilisers (lamotrigine, valproate) can improve symptoms in short term.

Translating this evidence base to propose a generalist approach

Specialist treatments have similar effects despite distinct theory allowing core features to be drawn which are required for all effective treatment.

Five common characteristics of evidence-based treatments for borderline personality disorder [12]
1 Structured (manual directed) approaches to prototypic borderline personality disorder problems
2 Patients are encouraged to assume control of themselves (i.e. sense of agency)
3 Therapists help connections of feelings to events and actions
4 Therapists are active, responsive, and validating
5 Therapists discuss cases, including personal reactions, with others

Case description taken from piece by Feeley et al in Journal of pain and symptom management. [13]

'A 44-year old-woman with a five-month history of metastatic pancreatic cancer presented with intractable abdominal pain. Despite escalating a multimodal pain regimen, she did not receive adequate relief and required admission to an inpatient hospice unit for symptom management.

She carried a diagnosis of BPD and chemical dependency, had previous psychiatric hospitalizations and suicide attempts, and failed to respond to extensive psychopharmacologic and psychotherapeutic interventions. She had a history of unstable relationships although was able to maintain her marriage in the previous two years, and she maintained sobriety for four years before her cancer diagnosis. Adjustment to the inpatient hospice unit was challenging for the patient and staff alike. Her complaints of abdominal pain waxed and waned. At times she was pleasant, engaged, and joking with staff, but sometimes, she was demanding, socially inappropriate, and dramatic. Her mood vacillated widely between neediness and rage. She was very demanding of the nurses' time and presented herself to the nurses' station up to 20 times an hour. Failure to meet her requests to her immediate satisfaction resulted in tantrums, causing significant disruption to the staff, other patients, and visitors.

Given concerns that pain or anxiety was driving her behaviour, her medication regimen was up-titrated with little observed improvement in her pain or behaviour. Somnolence and lethargy developed, leading to a subsequent decrease in her medications. A pattern evolved of medication up- and down-titration with fluctuation between behavioural dyscontrol and sedation. Chaplaincy and social services were involved, but individual counselling seemed to provide no relief of her suffering. The behavioural cycle continued to escalate, as did the staff's frustration and distress.'

Assess the needs of the patient AND the resources available

Does the patient have a known diagnosis of BPD? Is there a mental health team involved?

Thorough assessment for comorbidity – substantial proportion of those with BPD have comorbid anxiety, depression and alcohol and drug misuse.

Establish goals of management within the palliative care setting (managing emotional lability, demand on staff, splitting, suicide risk etc)

What therapeutic options do you have available to you?

Where is the patient in their physical disease trajectory?

During ALL interactions

- Supportive demeanour – this is crucial to reinforce non-abandonment.
- Acknowledge the patients distress and focus on specific problems knowing the treatment plan; positive reinforcement for patient assuming control.
- Remind yourself that any emotional outbursts or hostile behaviour comes from a place of suffering and remain composed and emotionally neutral. This is containing for the patient.
- Be aware of any known history of trauma and adjust care giving appropriately.
- Monitor your own feelings throughout and debrief afterwards if needed.
- Where splitting is occurring, don't be drawn into any idealisation or devaluation; ensure the message is that of a unified team.

Early containment of behaviours that disrupt or interfere with the therapeutic relationship with team

Increase the patient's sense of control

- Consistency of care providers
- Boundary setting
- Concrete rules and consequences
- Apply consistently – awareness of splitting
- Enforce calmly with neutral emotionality
- Provide positive reinforcement during positive interactions

Psychotherapy

- Are formal psychotherapeutic options available? Evidence suggests length of treatment not related to outcomes; improved outcomes could be achieved in shorter term.
- Treatment providers should have previous experience with borderline personality disorder or input from psychiatric services
- Focus on managing life situations – positive reinforcement where indicated.
- Non-intensive psychotherapy space (i.e once per week, with additional sessions as needed).

Pharmacotherapy

Involve the psychiatry team if it is felt that medication may be helpful.

As per NICE recommendations; this should be symptom focussed and short-term.

If used: Aripiprazole/olanzapine and mood stabilisers (lamotrigine, valproate) can improve symptoms in short term. [20,21]

Up to 70% of patients with established BPD diagnosis will be taking or have been taking medication, often inappropriately. [12]

Support the MDT

- Education and support for all staff involved in care – critical that the mental health clinicians educate medical caregivers about the fact that borderline pathology is a psychiatric disorder.
- Clear handover at every shift swap and regular debrief.
- Organise a meeting, ideally attended by all who treat the patient, including therapists, nurses, and consultants – discussion of feelings brought about by patient.
- Limits and consistency of care should be decided through unanimous agreement.
- Minimise changes in nursing coverage, as well as number of doctors and nurses providing feedback to the patient on a daily basis.

Take home messages

- This patient group present a unique set of difficulties within a palliative care setting; utilise the support of available mental health services.
- Very limited evidence for this population within PC setting and so translation of evidence from psychiatric setting required.
- Early identification and proactive behavioural management approaches.
- Remember the suffering patient throughout all challenges encountered.
- Support all staff involved in the care.

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