Healthcare Improvement Scotland | ihub

Personality Disorder Improvement Programme

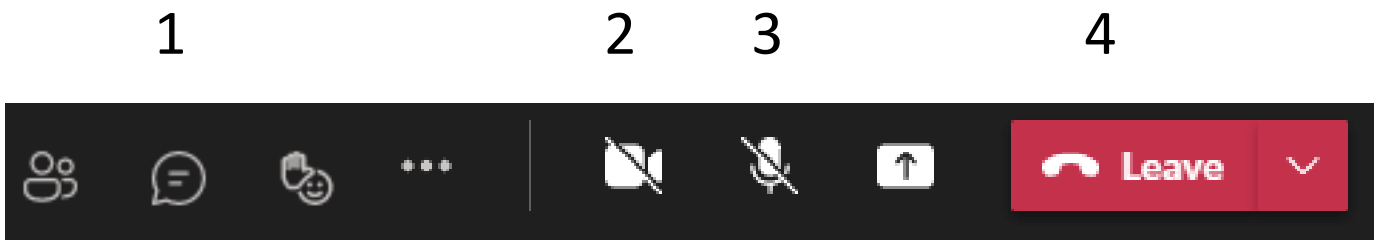
Diagnosis and formulation (including ICD-11)

Monday 5 September
14:00 – 15:30

Welcome and introductions

Gordon Hay
Senior Improvement Advisor
Healthcare Improvement Scotland

Housekeeping



1. **How to open and close the chat panel –** use the chat panel to introduce yourself, raise any questions you may have for the speakers and also post comments.
2. **Cameras are automatically muted**
3. **Microphones are automatically muted.**
4. **Leave the meeting**

This Webinar will be recorded.

The link will be shared, so those who are unable to join us today can listen to the session.

Please do not record the session.

Agenda for today

Item No.	Title	Lead	Duration
1.	**Welcome and introduction**	Gordon Hay	5 minutes
2.	**Implementation of ICD-11 in Scotland; lived experience aspects of the diagnosis**	Dr John Mitchell	30 minutes
3.	**Introduction to ICD-11, including similarities/differences between BPD and CPTSD; role of formulation**	Prof. Michaela Swales	40 minutes
6.	**Question and answer session**	Gordon Hay	15 minutes
7.	**Close**	Gordon Hay	5 minutes

ICD 11 Mental, Behavioural and Neurodevelopmental Disorders implementation in Scotland

Dr John Mitchell CBE
Mental Health Directorate
Scottish Government

The Scottish Government

Conflicts of interest

- Employed part time as mental health advisor Scottish Government and Scottish lead for Implementation of ICD 11 MBND.
- Member of World Health Organisation Advisory Group on ICD 11 MBND implementation.
- Retired Consultant Psychiatrist and Principal Medical Officer Scottish Government.

The Scottish Government

Scottish Government - Coronavirus (COVID-19): mental health - transition and recovery plan

- Commitment 16.9 *“We will implement and promote the use of the International Classification of Diseases 11th edition (ICD-11) from Spring 2021 across all mental health services in Scotland. This will ensure that our approach to mental health services is based on the most up to date international understanding of mental illness”.*
- NHS devolved from United Kingdom. ICD 10 was implemented in England earlier than Scotland.

The Scottish Government

International Classification of Diseases 11th edition

- 30 years since ICD 10 – evolution of concepts of disease.
- Global application through development by World Health Organisation (WHO) and United Nations. https://icd.who.int/en/ Free, open resource. Multidisciplinary and multilingual.
- Covers all disease – physical , mental with additional codes for special purposes.
- 26 chapters of codes and diagnostic guidelines.
- Chapter 6 = mental, behavioural and neurodevelopmental disorders

Why is ICD 11 important?

- Global agreed diagnostic standards allows consistent, valid, comparable, international
  - Quantification of health needs, delivery and costs, Morbidity and mortality.
  - Clinical utility.
  - Research.
  - Teaching and education.

Historical timeline until ICD 10

- 1860 Florence Nightingale proposed a model of systematic collection of hospital data.
- 1893 Jacques Bertillon introduced the Classification of Causes of Death.
- 1900 first international classification of causes of death.
- 1948 WHO assumed responsibility for preparing and publishing every 10 years.
- 1990 ICD 10 endorsed.

Creation, Testing and Implementation Timeline of ICD 11

- 2007 appointment of advisory groups for ICD 11
- 2010-11 formative international field studies in 13 countries
- 2011 creation of Global Clinical Practice Network (GCPN) = 15,500 members from 159 countries collaborating with WHO Dept of mental health and substance misuse in relation to ICD 11 utility and applicability.
- 2012 first draft of proposals
- 2012-2013 international field trials in 14 countries
- June 2018 pre-final version released by WHO
- May 2019 approval by World Health Assembly
- September 2020 phased creation of on line training modules – generic and disorder type specific.
- 2022 publication of Clinical Descriptions and Diagnostic Requirements CDDR intended for general clinical , educational and service use.

Differences between ICD 10 and 11

- ICD 10 groupings based primarily on common presenting symptom / ICD 11 on common underlying aetiological factors.
- ICD 11 guidelines with 3 aspects:
  - Essential features
  - Explicit threshold with normality
  - Differentiation between conditions
- ICD 11 takes lifespan approach eliminating disorders occurring in children and adolescents.
- ICD 11 includes cultural considerations.

06 Mental, behavioural or neurodevelopmental disorders (MBND)

- Syndromes with clinically significant disturbance in cognition, emotional regulation or behaviour that reflects psychological, biological or developmental dysfunction. Usually associated with distress or impairment.
- Excludes *acute stress reaction* (QE84) and *Uncomplicated bereavement* (*QE62*)
- Coded elsewhere *sleep disorders* (7A00-7B2Z); *sexual dysfunctions* (HA00 – HA0Z) and *gender incongruence* (HA60-HA6Z).

Summary paper

file:///C:/Users/z608731/Downloads/Reedetal.2019InnovationsandchangesintheICD-11classification.pdf

SPECIAL ARTICLE

Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders

Geoffrey M. Reed[1,2], Michael B. First[2,3], Cary S. Kogan[4], Steven E. Hyman[5], Oye Gureje[6], Wolfgang Gaebel[7], Mario Maj[8], Dan J. Stein[9], Andreas Maercker[10], Peter Tyrer[11], Angelica Claudino[12], Elena Garralda[11], Luis Salvador-Carulla[13], Rajat Ray[14], John B. Saunders[15], Tarun Dua[1], Vladimir Poznyak[1], María Elena Medina-Mora[16], Kathleen M. Pike[2], José L. Ayuso-Mateos[17], Shigenobu Kanba[18], Jared W. Keeley[19], Brigitte Khoury[20], Valery N. Krasnov[21], Maya Kulygina[21], Anne M. Lovell[22], Jair de Jesus Mari[12], Toshimasa Maruta[23], Chihiro Matsumoto[24], Tahilia J. Rebello[2,3], Michael C. Roberts[25], Rebeca Robles[16], Pratap Sharan[26], Min Zhao[27], Assen Jablensky[28], Pichet Udomratn[29], Afarin Rahimi-Movaghar[30], Per-Anders Rydelius[31], Sabine Bährer-Kohler[32], Ann D. Watts[33], Shekhar Saxena[34]

[1]Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland; [2]Department of Psychiatry, Columbia University Medical Center, New York, NY, USA; [3]New York State Psychiatric Institute, New York, NY, USA; [4]School of Psychology, University of Ottawa, Ottawa, ON, Canada; [5]Stanley Center for Psychiatric Research, Broad Institute of Harvard and Massachusetts Institute of Technology, Cambridge, MA, USA; [6]Department of Psychiatry, University of Ibadan, Ibadan, Nigeria; [7]Department of Psychiatry and Psychotherapy, Medical Faculty, Heinrich-Heine University, Düsseldorf, Germany; [8]Department of Psychiatry, University of Campania "L. Vanvitelli", Naples, Italy; [9]Department of Psychiatry, University of Cape Town, and South African Medical Research Council Unit on Risk and Resilience in Mental Disorders, Cape Town, South Africa; [10]Department of Psychology, University of Zurich, Zurich, Switzerland; [11]Centre for Mental Health, Imperial College, London, UK; [12]Department of Psychiatry, Universidade Federal de São Paulo (UNIFESP/EPM), São Paulo, Brazil; [13]Research School of Population Health, Australian National University, Canberra, ACT, Australia; [14]National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi, India; [15]Centre for Youth Substance Abuse Research, University of Queensland, Brisbane, QLD, Australia; [16]National Institute of Psychiatry Ramón de la Fuente Muñiz, Mexico City, Mexico; [17]Department of Psychiatry, Universidad Autonoma de Madrid; Instituto de Salud Carlos III, Centro de Investigación Biomédica en Red de Salud Mental (CIBERSAM); Instituto de Investigación Sanitaria La Princesa, Madrid, Spain; [18]Department of Neuropsychiatry, Kyushu University, Fukuoka, Japan; [19]Department of Psychology, Virginia Commonwealth University, Richmond, VA, USA; [20]Department of Psychiatry, American University of Beirut Medical Center, Beirut, Lebanon; [21]Moscow Research Institute of Psychiatry, National Medical Research Centre for Psychiatry and Narcology, Moscow, Russian Federation; [22]Institut National de la Santé et de la Recherche Médicale U988, Paris, France; [23]Health Management Center, Seitoku University, Matsudo, Japan; [24]Japanese Society of Psychiatry and Neurology, Tokyo, Japan; [25]Office of Graduate Studies and Clinical Child Psychology Program, University of Kansas, Lawrence, KS, USA; [26]Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India; [27]Shanghai Mental Health Center and Department of Psychiatry, Shanghai Jiao Tong University School of Medicine, Shanghai, People's Republic of China; [28]Centre for Clinical Research in Neuropsychiatry, University of Western Australia, Perth, WA, Australia; [29]Department of Psychiatry, Prince of Songkla University, Hat Yai, Thailand; [30]Iranian National Center for Addiction Studies, Tehran University of Medical Sciences, Tehran, Iran; [31]Department of Child and Adolescent Psychiatry, Karolinska Institute, Stockholm, Sweden; [32]International Federation of Social Workers, Basel, Switzerland; [33]Entabeni Hospital, Durban, South Africa; [34]Harvard T.H. Chan School of Public Health, Boston, MA, USA

Following approval of the ICD-11 by the World Health Assembly in May 2019, World Health Organization (WHO) member states will transition from the ICD-10 to the ICD-11, with reporting of health statistics based on the new system to begin on January 1, 2022. The WHO Department of Mental Health and Substance Abuse will publish Clinical Descriptions and Diagnostic Guidelines (CDDG) for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders following ICD-11's approval. The development of the ICD-11 CDDG over the past decade, based on the principles of clinical utility and global applicability, has been the most broadly international, multilingual, multidisciplinary and participative revision process ever implemented for a classification of mental disorders. Innovations in the ICD-11 include the provision of consistent and systematically characterized information, the adoption of a lifespan approach, and culture-related guidance for each disorder. Dimensional approaches have been incorporated into the classification, particularly for personality disorders and primary psychotic disorders, in ways that are consistent with current evidence, are more compatible with recovery-based approaches, eliminate artificial comorbidity, and more effectively capture changes over time. Here we describe major changes to the structure of the ICD-11 classification of mental disorders as compared to the ICD-10, and the development of two new ICD-11 chapters relevant to mental health practice. We illustrate a set of new categories that have been added to the ICD-11 and present the rationale for their inclusion. Finally, we provide a description of the important changes that have been made in each ICD-11 disorder grouping. This information is intended to be useful for both clinicians and researchers in orienting themselves to the ICD-11 and in preparing for implementation in their own professional contexts.

Key words: International Classification of Diseases, ICD-11, diagnosis, mental disorders, clinical utility, dimensional approaches, culture-related guidance

(World Psychiatry 2019;18:3–19)

In June 2018, the World Health Organization (WHO) released a pre-final version of the 11th revision of the International Clas-

The WHO Department of Mental Health and Substance Abuse has been responsible for coordinating the development

The Scottish Government

Scottish ICD 11 MBND implementation practicalities

- Scottish Implementation Group with relevant stakeholders established and connected to WHO.
- SG Minister of Mental Wellbeing and Social Care
  - Clinical transition 1st November 2022.
  - Opportunity to improve diagnostic experience.
  - Opportunity to improve mental health data.

The Scottish Government

Awareness and Training

– different needs for different people

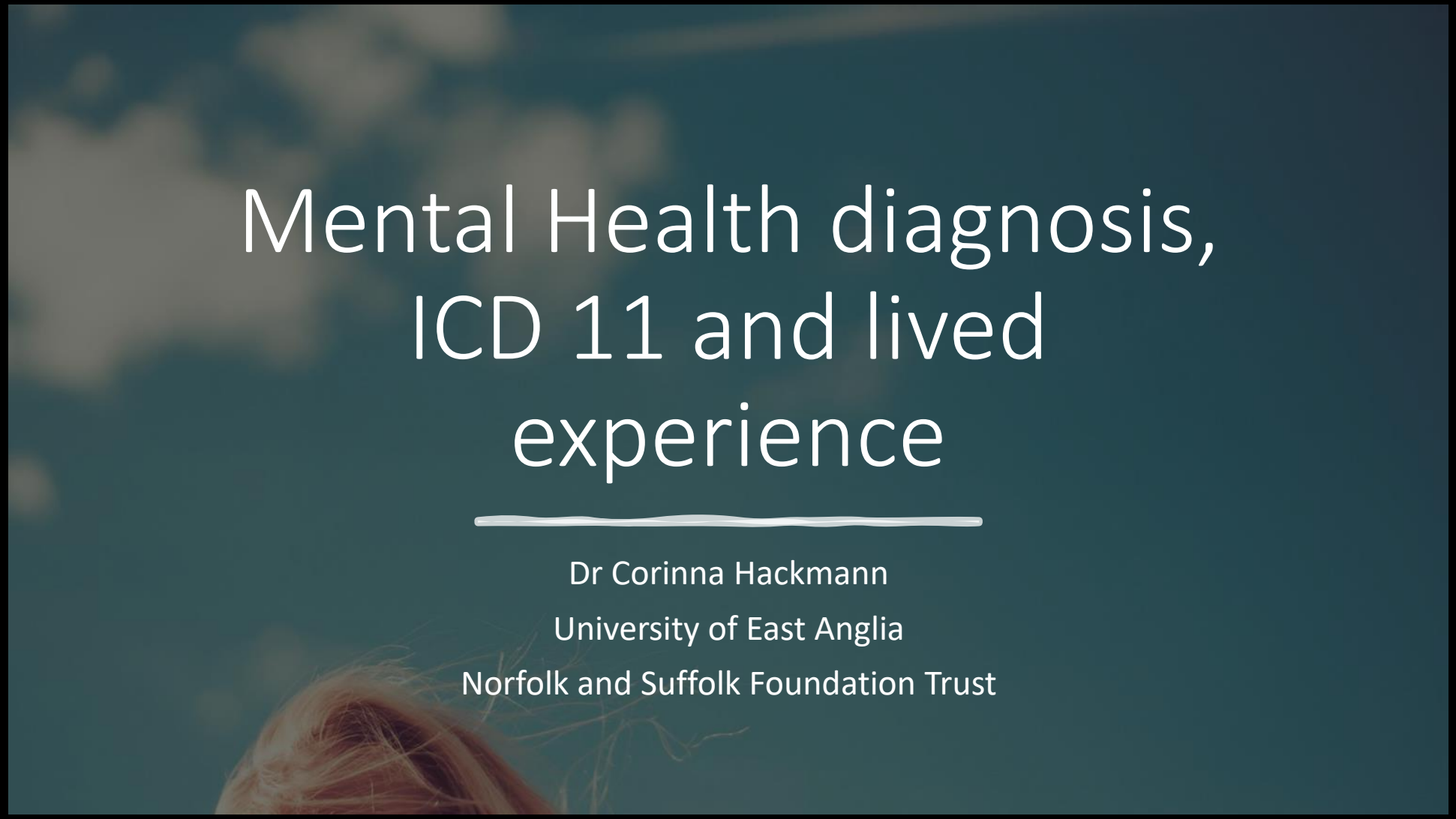
- NHS Education Scotland (NES) general awareness video for public.
- Mental Welfare Commission Scotland leaflet for public.
- NES online training module for MDT clinicians
  - Part of CPD.
  - Not mandatory.
  - Expectation of experiential learning like ICD 9 to 10.
- WHO online modules for specialists.
- New research tools.

Data

- WHO seeking data from 194 member countries from 1 January 2022.
- Public Health Scotland working with NHS Digital.

Lived Experience

- Sensitivity of language.
- Want good diagnostic experience.

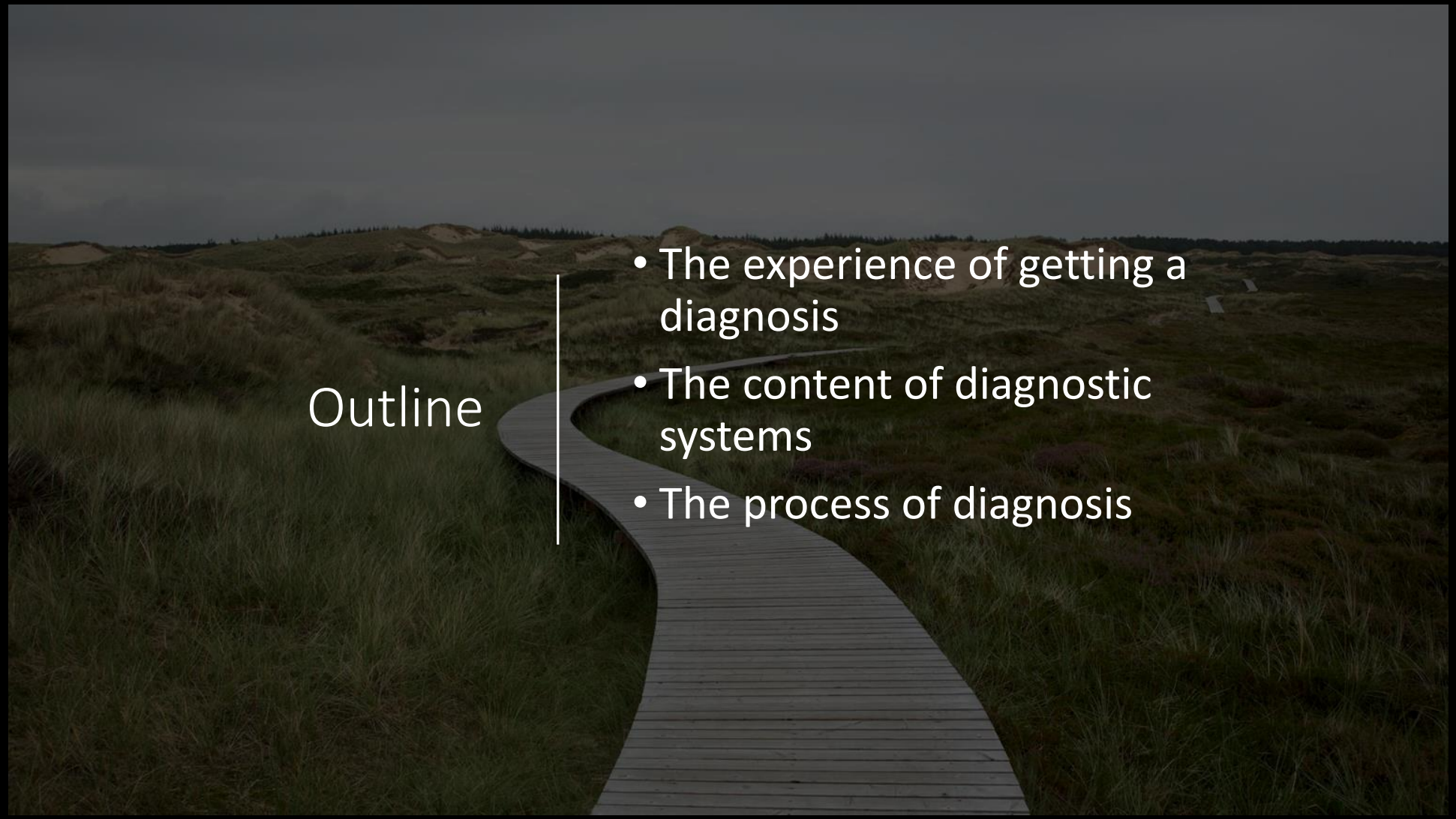


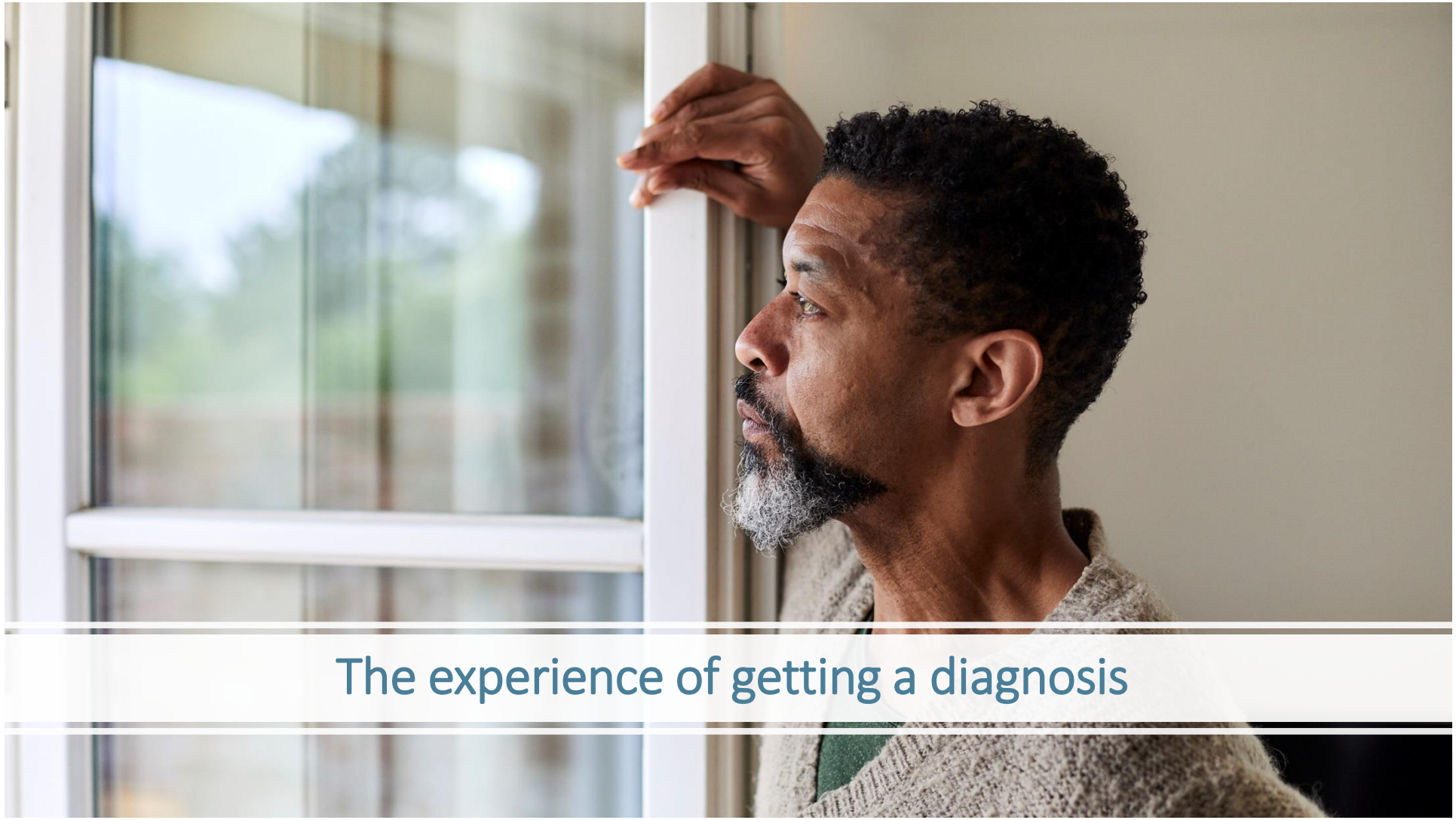
Mental Health diagnosis, ICD 11 and lived experience

Dr Corinna Hackmann

University of East Anglia

Norfolk and Suffolk Foundation Trust


Outline
• The experience of getting a diagnosis
• The content of diagnostic systems
• The process of diagnosis



The experience of getting a diagnosis

Whose diagnosis is it anyway?

- Diagnosis has an impact on those who receive it
- It can be viewed almost as a complex intervention with intended and unintended outcomes

- Diagnosis can:
  - Aid understanding of complex and distressing psychiatric symptoms/lived experience
  - Offer a shared language with clinicians, family, friends and others (e.g. employers)
  - Validate distress and difficulties
  - Support access and shared decision-making regarding care and treatment
  - Guides thinking and discussion about prognosis and recovery

"For me it actually meant something and explained something when I had the diagnosis… although I was horrified, I was almost relieved and now I embrace the fact because I understand myself and my history a lot better"

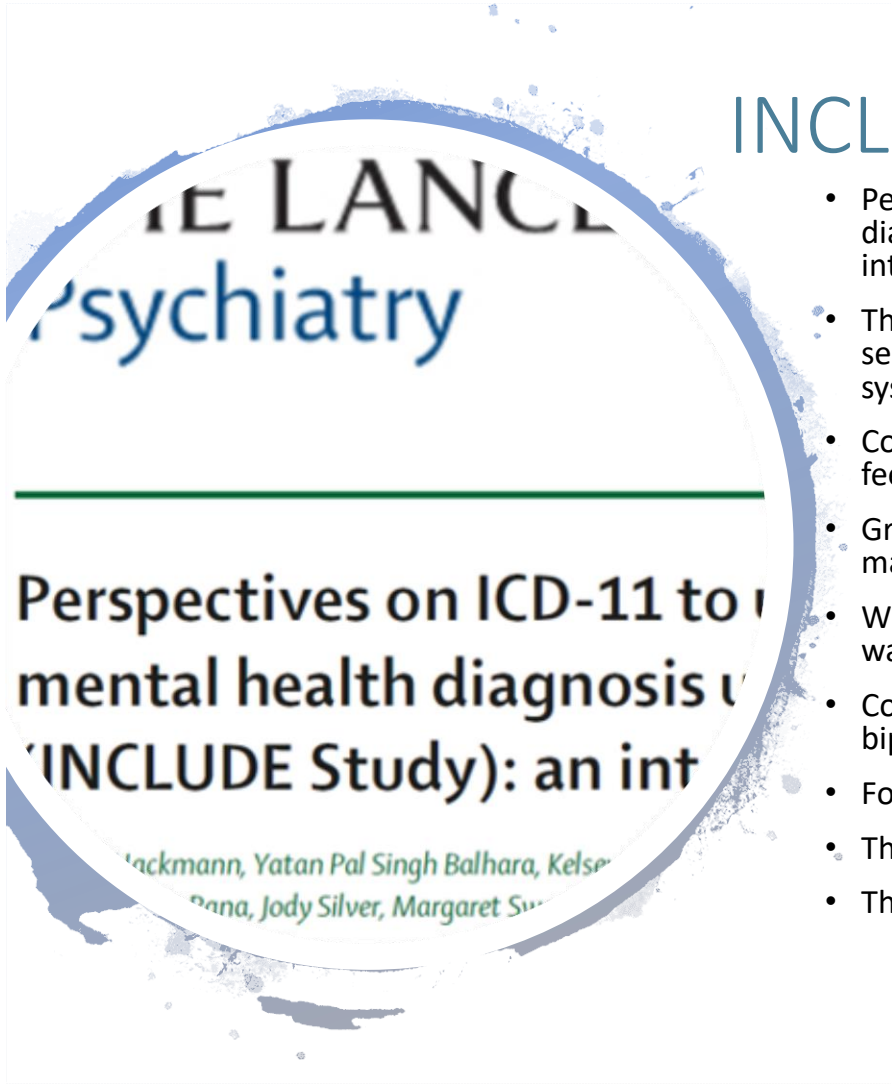
Whose diagnosis is it anyway?

- However, diagnosis can also
  - Feel reductive, labelling, stigmatising and/or meaningless
  - Come to dominate an individual's sense of identity
  - Exacerbate MH difficulties and disengagement from services

> *"When I was diagnosed at the age of 26 I was told not to tell anyone, never to tell anyone that I had this really severe mental illness, that I would never get work, that I would have real trouble with relationships and it was something to very much keep quiet about, so the stigma was immense"*

- Both the content of diagnostic systems and the way that diagnosis is decided and communicated (the diagnostic process) benefit from the lived experience perspective to maximise benefits and minimise potential harms

The content of diagnostic systems



INCLUDE study

- Perspectives on ICD-11 to understand and improve mental health diagnosis using expertise by experience (INCLUDE Study): an international qualitative study
- The INCLUDE study was the first to systematically collate and feedback service user perspectives into the development of a major diagnostic system (ICD)
- Collaborated with the WHO and Columbia University to collate feedback from service users in the UK, US and India
- Growing recognition of the critical importance of lived-experience to major developments
- WHO recognition that people tend to 'google' their diagnosis so the way that people respond to the direct content is important
- Collected feedback on 5 diagnoses: depressive episode, schizophrenia, bipolar 1, personality disorder and generalised anxiety disorder
- Focus-groups to elicit feedback – included accessible language version
- Thematic analysis to develop themes
- Themes used as basis for co-produced recommendations for the WHO

Hackmann et al, 2019a

INCLUDE study findings

- Missing and additional features
- Participants identified **additional features** that were common and important to lived-experience but not included in the ICD system
- E.g. **interpersonal difficulties** in schizophrenia – this included difficulties communicating

“I […] used to be like what’s happened to me? But […] I couldn’t outwardly express myself because I was just sort of in a shell” (UK Focus Group)

“They’re not able to discuss or come across to other people with a within a standard sort of behavioural pattern” (India Focus Group)

Resonance with lived-experience

- Participants identified features that reflected outward appearance but did not resonate with lived-experience
- The proposed ICD-11 features for bipolar disorder type 1 include “decreased need for sleep”, as distinct from insomnia

“I didn’t sleep because I was thinking about other things, but I didn’t necessarily feel less need for sleep” (US Focus Group)

- Participants in the schizophrenia focus groups reacted to the word “disorganised” (relating to thinking and behaviour)

“I feel really mentally clear, and I write letters and I use words, and you know, and go really over the top, but my mind is really clear” (UK Focus Group)

“What appears meaningless or disorganised to you may not be so for me... it can have a very clear meaning for me” (India Focus Group)

Objectionable and technical language

- Personality disorder group responded to the feature: “maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour”

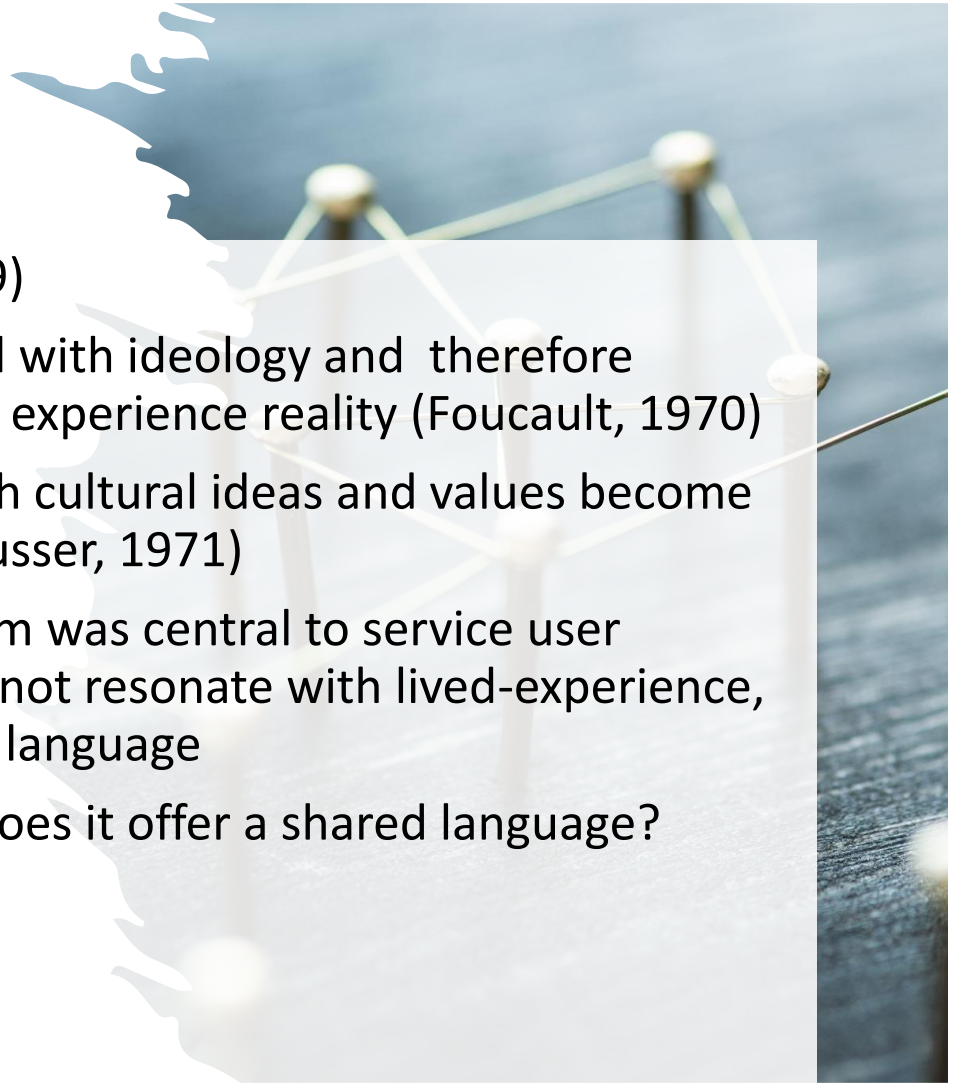
“I absolutely hate the word maladaptive… It’s somebody else’s judgement if it’s a bad adaption or not, but it’s an adaptation that somebody has had to make to survive their circumstances, so therefore it’s actually a very valid adaption for that person in the situation.” (UK Focus Group)

- Depressive episode features of “retardation” and “neurovegetative”

“When you say ‘retardation’ it gives the idea that we can’t actually halfway defend ourselves or we’re helpless or we need to actually– someone needs to be watching us every 5 seconds” (US Focus Group)

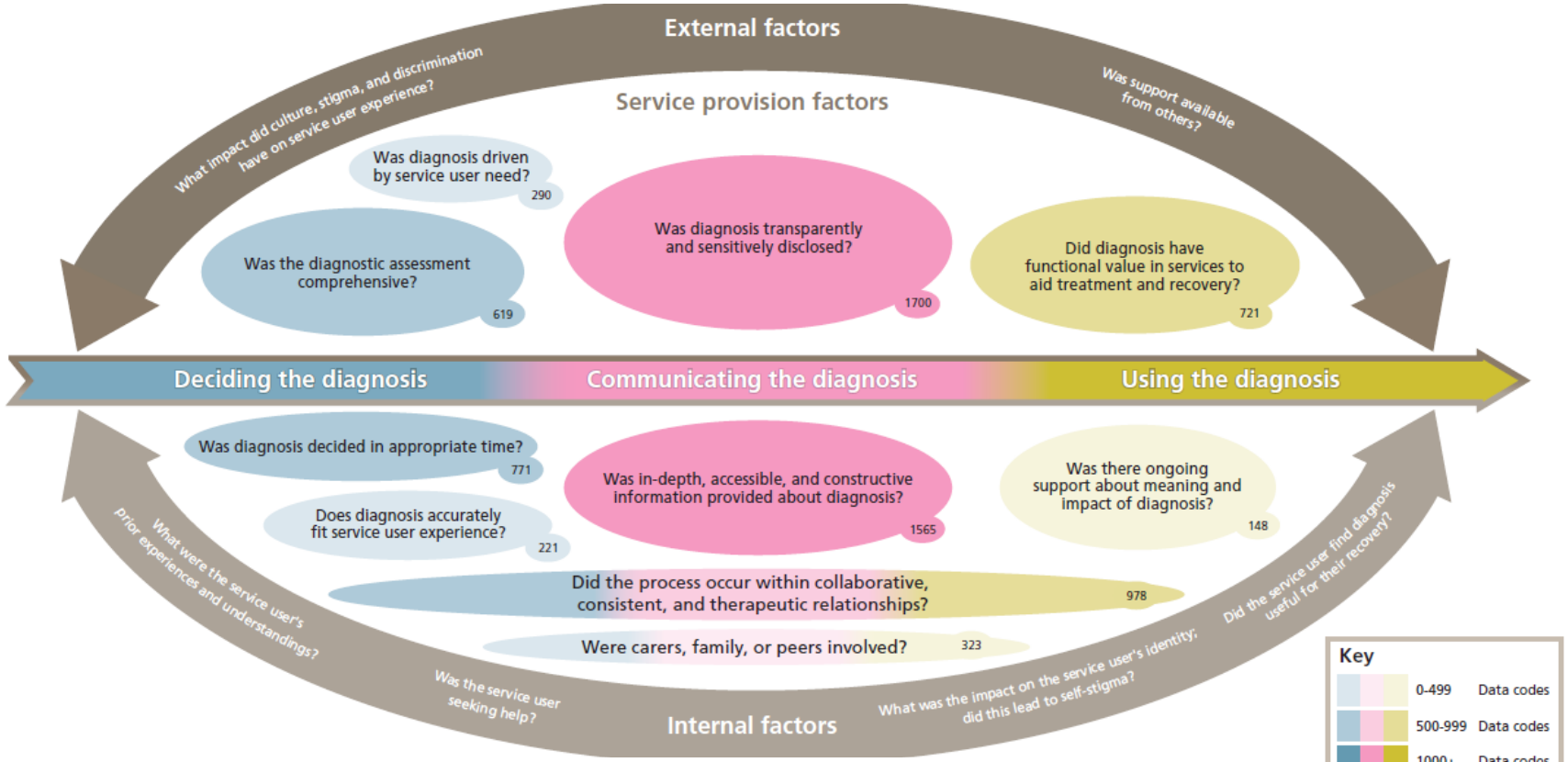
Language

- “Language is everything” (Filer, 2019)
- Language is a social process, imbued with ideology and therefore determines how we understand and experience reality (Foucault, 1970)
- Interpellation is the process by which cultural ideas and values become internalised through language (Althusser, 1971)
- The use of language in the ICD system was central to service user feedback – including words that did not resonate with lived-experience, confusing, technical and objectional language
- It offers a common language – but does it offer a shared language?



The process of diagnosis

Factors influencing service user experience of mental health diagnosis



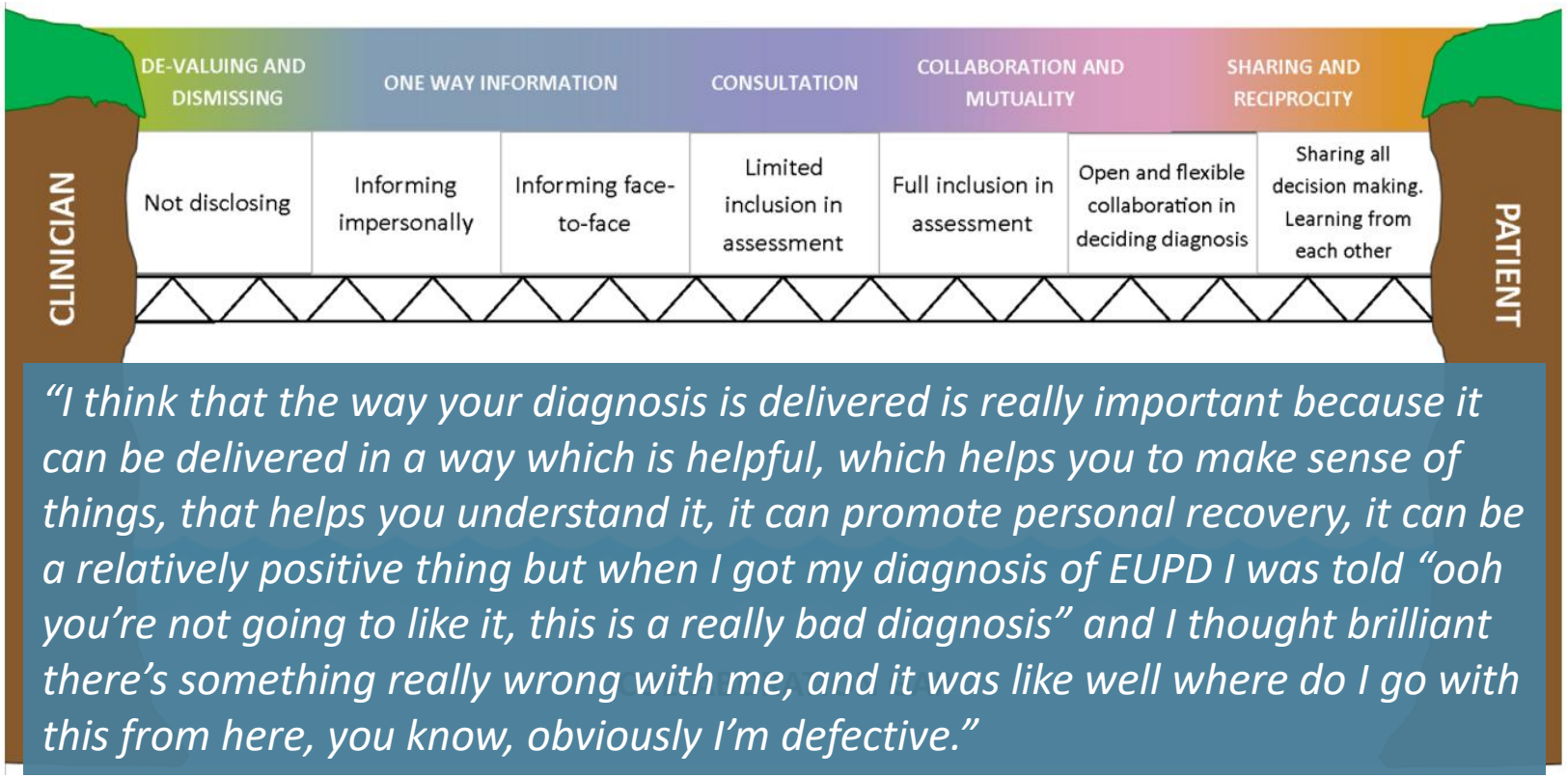
Perkins A, Ridler J, Browes D, Peryer G, Notley C, Hackmann C. Experiencing mental health diagnosis: a systematic review of service user, clinician, and carer perspectives across clinical settings. *The Lancet Psychiatry.* 2018;5(9):747-764.

Diagnosis is a process

- The way that diagnosis is decided, shared/communicated and applied to care and treatment decisions is important

Hackmann et al, 2019b

Improving the experience of diagnosis



"I think that the way your diagnosis is delivered is really important because it can be delivered in a way which is helpful, which helps you to make sense of things, that helps you understand it, it can promote personal recovery, it can be a relatively positive thing but when I got my diagnosis of EUPD I was told "ooh you're not going to like it, this is a really bad diagnosis" and I thought brilliant there's something really wrong with me, and it was like well where do I go with this from here, you know, obviously I'm defective."

Source, Hackmann et al, 2019b

References

1. Althusser L. (1971) "Ideology and Ideological State Apparatuses (Notes towards an Investigation)". Lenin and Philosophy and Other Essays
2. Filer, N. (2019). The Heartland: Finding and Losing Schizophrenia. London, Faber & Faber.
3. Foucault, M. (1970) The Order of Discourse chpt 3 pp.48- 79 in Young, R. (ed) Untying the Text: A post Structuralist Reader. London: Routledge
4. **Hackmann, C., Balhara, Y., Clayman, K., Nemec, P. B., Notley, C., Pike, K., ... & Shakespeare, T. (2019a). Perspectives on ICD-11 to understand and improve mental health diagnosis using expertise by experience (INCLUDE Study): an international qualitative study. The Lancet Psychiatry, 6(9), 778-785.**
5. **Hackmann C, Wilson J, Perkins A, Zeilig H. (2019b) Collaborative diagnosis between clinician and patient: why to do it and what to consider. British Journal of Psychiatric Advances 2019;25(4):214 22.doi.org/10.1192/bja.2019.6**
6. **Perkins, A., Ridler, J., Browes, D., Peryer, G., Notley, C., & Hackmann, C. (2018). Experiencing mental health diagnosis: a systematic review of service user, clinician, and carer perspectives across clinical settings. The Lancet Psychiatry, 5(9), 747-764.**
7. **Zeilig, Hackmann and Plant. The language of diagnosis in mental illness. Submitted to Palgrave Encyclopaedia of the Health Humanities**

Thank you

johnmitchell4@gov.scot

The Scottish Government

PERSONALITY DISORDER DIAGNOSIS IN ICD-11

Michaela Swales PhD

Department of Human & Behavioural Sciences
Bangor University, Wales, UK

Conflicts of interest

- I receive income from:
  - Trainings in DBT
  - Consultation and supervision in DBT
  - Royalties from books on DBT
- My husband is the managing director and principal shareholder of British Isles DBT training
- I was a member of the ICD-11 Working Group for Personality Disorder Diagnoses

Context of Personality Disorder diagnosis

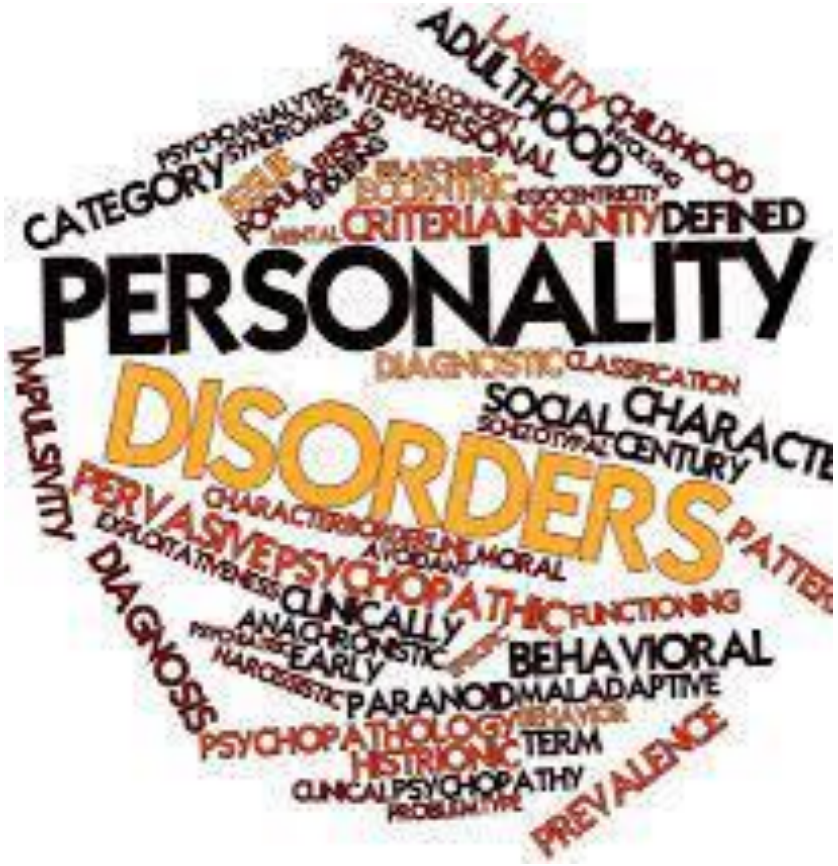
- We all have a personality
- Central often to how we describe ourselves
- Risk of harm from the diagnosis
- Proceed with caution
- There are now effective treatments for PD
- PD diagnosis impacts on effectiveness of treatment for other conditions
- Consider costs and benefits

Personality Development

- Genetics
- Temperament
- Early development
- Trauma
- Adverse Childhood Experiences
- Learned patterns of behaviour to cope and respond

Main changes from ICD-10

- ICD-10
  - Categorical approach
  - Ten different PD e.g. EUPD
  - Artificial ‘co-morbidity’
- ICD-11
  - Single category
  - Severity
  - Trait domains



Steps in diagnosing Personality Disorder

- Assessment of general PD diagnostic requirements; **IF MET, THEN**:
- Assessment of **severity** AND
- Assessment of **personality trait domains** relevant to individuals' personality disturbance

IF APPLICABLE, assignment of **Borderline Qualifier**

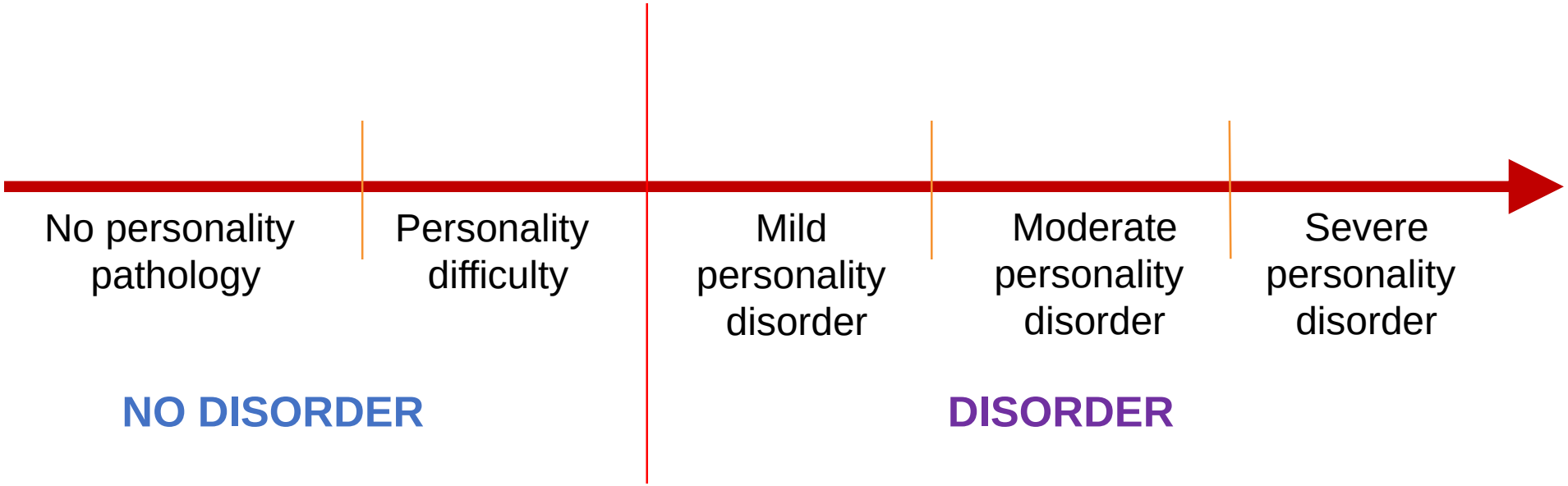
General PD Diagnostic Guidelines: Essential Features - I

- **Enduring** disturbance (> 2 years) characterized by:
  - **Problems in functioning of aspects of the self and/or**
  - **Interpersonal dysfunction** across various contexts and relationships
- Manifested in **maladaptive *patterns*** of **cognition, emotional experience, emotional expression,** and **behaviour** …

General PD Diagnostic Guidelines: Essential Features - II

- Disturbance is:
- Manifest **across a range of personal and social situations**
- **Not developmentally appropriate**
- **Not explained** primarily **by social or cultural factors**, including socio-political conflict.
- **Not due to** the direct effects of a **medication or substance**, including withdrawal effects
- Associated with **substantial distress** or **significant impairment** in personal, family, social, educational, occupational or other important areas of functioning

Imposing a categorical classification on a dimensional construct



Determining PD Severity

- Severity of personality disturbance is determined by the following:
  - The degree and pervasiveness of disturbance in the **person's relationships and their sense of self**.
  - The intensity and breadth of the **emotional, cognitive and behavioural manifestations** of personality dysfunction
  - The extent to which these patterns and problems cause **distress or psychosocial impairment**
  - The **level of risk of harm** to self and others

Mild Personality Disorder

- Not all areas of personality are affected
    - Some relationships are maintained and/or some roles carried out.
- Problems in emotions, cognitions and behaviours are generally of mild severity
- Not associated with substantial harm to self or others
- May still cause substantial distress and impairment
    - the distress and impairment is limited to a narrower range of functioning OR
    - if the difficulties are across many areas of functioning the difficulties are less intense.

Moderate Personality Disorder

- Multiple areas of personality functioning are affected
    - Marked problems in most interpersonal relationships
    - Expected social and occupational roles impaired to a degree.
    - Relationships characterized by conflict, avoidance, withdrawal, and/or extreme dependency
- Emotions, cognitions and behaviours are generally of moderate severity
- Sometimes associated with harm to self or others
- Associated with marked impairment in important areas of functioning, although functioning in circumscribed areas may be maintained

Severe Personality Disorder

- Severe disturbances in functioning of the self
- Virtually all relationships affected
- Ability and willingness to perform expected social and occupational roles is absent or severely compromised
- Emotions, behaviours and cognitions are extreme
- Often associated with harm to self or others
- Associated with severe impairment in all or nearly all areas of life

Personality Difficulty

- Not considered a mental disorder
- Refers to pronounced personality characteristics that may affect treatment or health services
- Long-standing difficulties (e.g., at least 2 years), in the individual's way of experiencing and thinking about the self, others and the world
- Manifested in cognitive and emotional experience and expression only intermittently (e.g., during times of stress) or at low intensity
- Typically associated with some problems in functioning

Intended advantages of simplified diagnosis

- Greater simplicity and clinical utility
- Utility of severity classification in non-specialist settings
- Improves identification of risk
- Improves differentiation of need for complex vs. simpler treatments
- Helps to track change in personality status over time

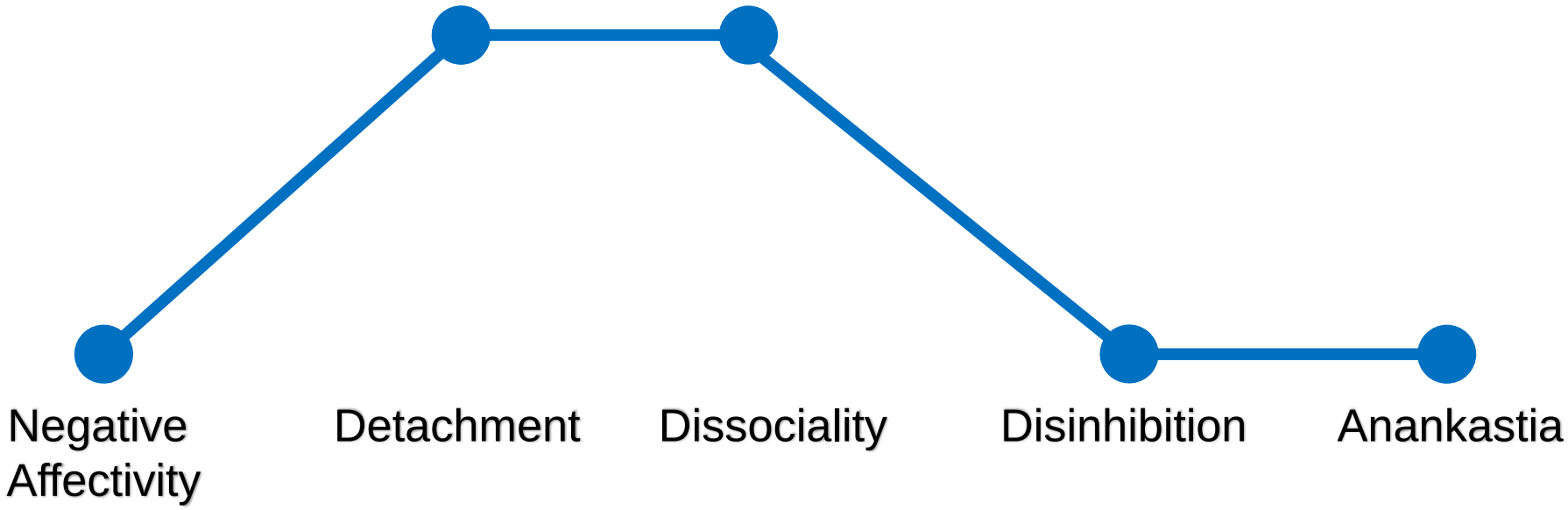
Trait Domains in ICD-11

- Continuous with personality characteristics in individuals who do not have Personality Disorder or Personality Difficulty
- Not diagnostic categories; represent a set of dimensions that correspond to underlying structure of personality
- As many trait domain qualifiers may be applied as necessary to describe personality functioning
- Individuals with more severe personality disturbance tend to have a greater number of prominent trait domains
- But, a person may have a Severe Personality Disorder and manifest only one prominent trait domain (e.g., Detachment)

Trait Domain Qualifiers

- Negative Affectivity
- Detachment
- Dissociality
- Disinhibition
- Anankastia
- Psychoticism/ Schizotypy *not* included (as it is in *DSM*-5 Section III) because Schizotypal Disorder is in ICD-11 section of Schizophrenia and Other Primary Psychotic Disorders

Trait domain qualifiers describe a profile of personality (disorder)



Negative Affectivity

CORE FEATURE:
experiencing a broad range of negative emotions

Detachment

CORE FEATURE:
Maintaining interpersonal distance (social detachment), and emotional distance (emotional detachment).

Dissociality

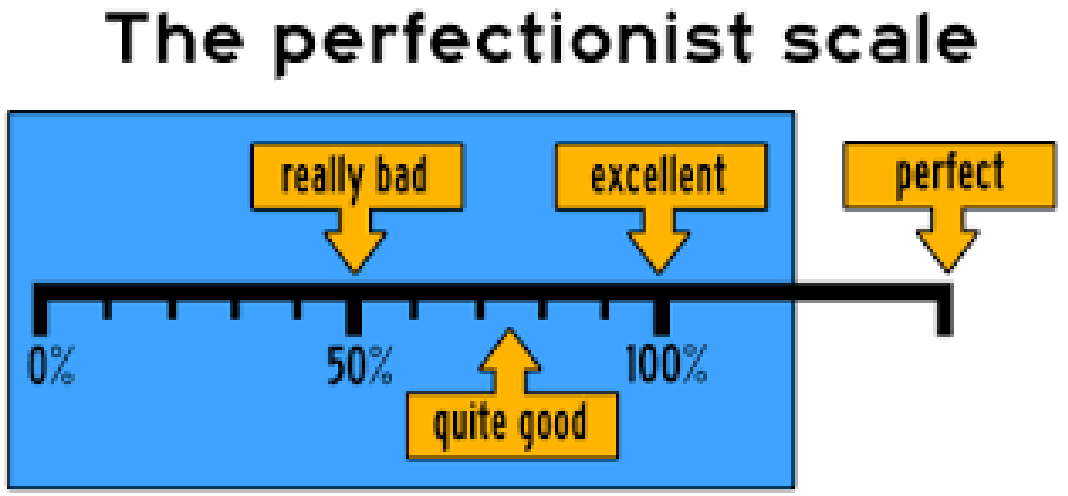
CORE FEATURE: Disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy
Disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy

Disinhibition

CORE FEATURE: Persistent tendency for impulsive action in response to immediate internal or environmental stimuli without consideration of longer-term consequences

Anankastia

CORE FEATURE: Narrow focus on rigid standard of perfection, of right and wrong, on controlling one's own and others' behaviour and situations to ensure conformity to these standards



Borderline Pattern Qualifier - I

- Included to enhance clinical utility and continuity
- Considerable overlap with information contained in the trait domain qualifiers
- ‘BPD’ does not ‘fall out’ of a factor analysis. It represents moderate to severe general personality dysfunction
- Helps identify people who might benefit from certain treatments
- Pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity

Borderline Pattern Qualifier - II

Five (or more) of the following:

- Frantic efforts to avoid real or imagined abandonment
- Pattern of unstable and intense interpersonal relationships
- Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self
- Tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours
- Recurrent episodes of self-harm
- Emotional instability due to marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate intense anger or difficulty controlling anger
- Transient dissociative symptoms or psychotic-like features in situations of high affective arousal

PD diagnosis: summary

- Understand where personality disorders come from
- Be awake to social and cultural contextual factors
- Consider costs and benefits of the diagnosis
  - Assess for general PD diagnostic requirements;
    IF MET, THEN:
  - Assess for **severity** AND THEN
  - Assess for **personality trait domains** relevant to individuals' personality disturbance

    IF APPLICABLE, assign the **Borderline Qualifier**

Complex-PTSD

- Develops following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse).
- All diagnostic requirements for PTSD are met (Re-experiencing; avoidance of thoughts memories of the event; Perceptions of heightened current threat).
- In addition, Complex PTSD is characterised by severe and persistent Disturbances in Self-Organisation (DSO)
  - 1) problems in affect regulation;
  - 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and
  - 3) difficulties in sustaining relationships and in feeling close to others.
- These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- Clearly overlap with elements of the old 'BPD' pattern

Differences between CPTSD and PD (BPQ). Felding, Mikkelsen & Bach (2021)

Symptom duration	Self-functioning	Interpersonal functioning:
• C-PTSD presence of symptoms for more than a few weeks • PD more than 2 years • Onset of C-PTSD closely related to the traumatic exposure	• Narrower definition for C-PTSD (beliefs and emotions more specifically related to the stressor). PD stability and coherence of sense of self / capacity for self-direction	• C-PTSD – persistent difficulties in sustaining relationships and feeling close to others • PD – ability to understand and appreciate others' perspectives

Handling the diagnostic overlap Felding, Mikkelsen & Bach (2021)

- "Boundary" section of the ICD-11
- C-PTSD allows for allocation of a PD diagnosis in addition if it provides clinical utility e.g. access to a specific treatment
- PD guidelines explicitly state:
  - Only diagnose PD if the person's problems are not better described by another diagnosis
  - IE rule out C-PTSD first.

Clinical implications

- Early childhood experiences shape our personality
- Persistent early childhood adversity may result in C-PTSD, PD or 'both'
- Not everyone with problems that are labelled as PD has a trauma history
- Describing and understanding these patterns with the people who come to us for help is the starting point
- Choosing treatments with an evidence base that accounts for personality functioning important
- For people with both PD and PTSD / C-PTSD there are evidence-based treatments that tackle both issues (DBT+Prolonged Exposure; DBT for complex PTSD).

Polls

Q&A Session

Next steps

Evaluation survey – link in the chat box

Follow up email circulated soon

Workshop 2 – Tuesday 4th October

Keep in touch

his.mhportfolio@nhs.scot

@SPSP_MH

To find out more visit https://ihub.scot/improvement-programmes/mental-health-portfolio/personality-disorder-improvement-programme/