Healthcare Improvement Scotland | ihub

# Personality Disorder Improvement Programme

## The Challenges of Diagnosis

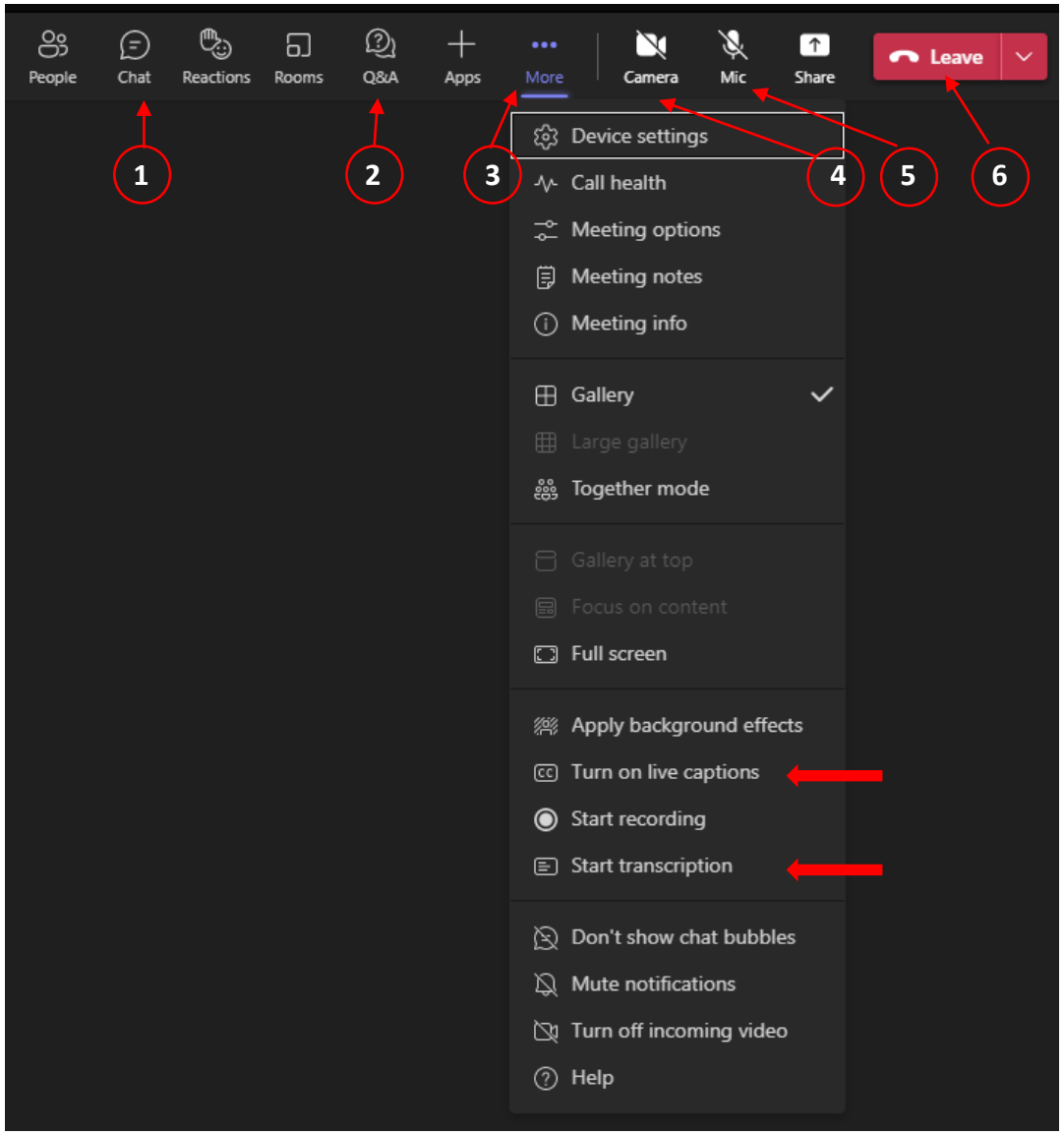
Tuesday 4 October
10:00 – 11:45am

#PDIPscot

Healthcare Improvement Scotland | ihub

# Welcome and introductions

# MS Teams Settings




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. **How to open and close the Q&A function**. This is where we will ask you to feedback from breakout rooms.
3. **Under ‘more’ you can access some accessibility features** such as live captions and also a live transcript of the meeting (highlighted with the arrow).
4. How to **turn your camera** on and off
5. How to **turn your microphone** on and off
6. How to **leave** the meeting

# Parts of this workshop will be recorded.

**The link will be uploaded to our website, so those who are unable to join us today can listen to the speaker session only.**

**Therefore please do not record the session.**

# Agenda for today

| Title | Lead | Duration |
|---|---|---|
| Welcome and introduction | HIS Team | 3 minutes |
| Complex trauma and personality diagnosis | Professor Thanos Karatzias | 25 minutes |
| Discussion session 1 | Breakout rooms | 20 minutes |
| Feedback | HIS Team | 7 minutes |
| Practical experience from implementing ICD-11 from NHS Highland | NHS Highland | 21 minutes |
| Discussion session 2 | Breakout rooms | 20 minutes |
| Feedback | HIS Team | 7 minutes |
| Close | HIS Team | 2 minutes |

# Differentiating ICD-11 Complex PTSD from Borderline Personality Disorder: Implications for Assessment and Treatment


## Prof. Thanos Karatzias

Clinical & Health Psychologist

## Edinburgh Napier University &

NHS Lothian Rivers Centre for Traumatic Stress

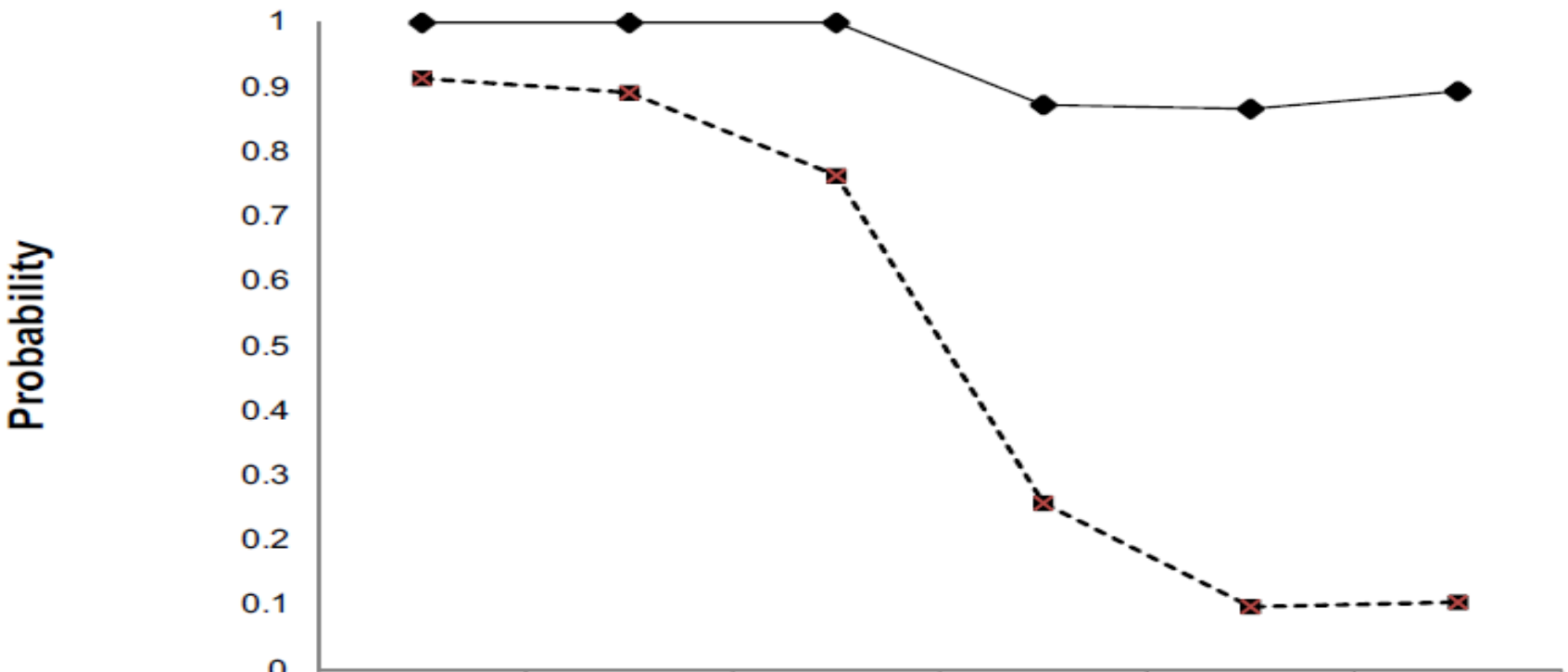
# ICD-11 PTSD and Complex PTSD

World Health Organization


| "Gate" Criterion: Traumatic Stressor | |
|---|---|
| **PTSD** | **CPTSD** |
| Re-experiencing | Re-experiencing |
| Avoidance | Avoidance |
| Sense of Threat | Sense of Threat |
| | Affect Dysregulation |
| | Negative Self Concept |
| | Disturbed Relationships |
| Functional Impairment | Functional Impairment |

Diagnosis is either PTSD *or* CPTSD: If PTSD and DSO criteria met = CPTSD
Type of trauma is a risk factor not a requirement for a diagnosis

# Evidence for ICD-11 CPTSD




| | Re | Av | Threat | ER | NSC | DR |
|---|---|---|---|---|---|---|
| Class 1 (76%) | 1 | 1 | 1 | 0.873 | 0.867 | 0.894 |
| Class 2 (24%) | 0.914 | 0.892 | 0.764 | 0.258 | 0.098 | 0.105 |

Karatzias et al. (2017) Journal of Affective Disorders

# ICD-11 CPTSD – Factorial validity results from treatment seeking samples

| | $\chi^2$ | CFI | TLI | RMSEA (90% CI) |
|---|---|---|---|---|
| **UK mixed clinical group (N = 615)** | 116* | .974 | .964 | .052 (.040, .064) |
| **Lithuanian clinical outpatients (N = 280)** | 340* | .978 | .975 | .043 (.030, .059) |
| **Syrian refugees in Lebanon (N = 112)** | 271* | .946 | .938 | .056 (.037, .072) |
| **Filipino soldiers (N = 450)** | 807* | .978 | .975 | .076 (.071, .082) |
| **Ukrainian internally displaced persons (N = 2,203)** | 390* | .963 | .949 | .058 (.052, .063) |
| **Mixed refugees in Switzerland (N = 134)** | 57 | .981 | .974 | .040 (.010, .070) |

Radican, Nolan, Hyland, Cloitre, McBride, Karatzias et al. (2021) Journal of Anxiety Disorders

# ICD-11 CPTSD – Factorial validity results from general population samples

| | $\chi^2$ | CFI | TLI | RMSEA (90% CI) |
|---|---|---|---|---|
| **USA general population (N = 1,893)** | 214* | .995 | .993 | .044 (.038, .050) |
| **UK general population (N = 1,051)** | 104* | .998 | .997 | .034 (.025, .043) |
| **Irish general population (N = 1,020)** | 128* | .990 | .986 | .041 (.033, .050) |
| **Israeli general population (N = 1,003)** | 118* | .982 | .975 | .053 (.041, .065) |
| **Ghana/Kenya/Nigeria general population (N = 2,524)** | 419* | .992 | .989 | .056 (.051, .061) |
| **China/Japan/Taiwan/Hong Kong students (N = 1,344)** | 481* | .981 | .968 | .063 (.057, .068) |

Radican, Nolan, Hyland, Cloitre, McBride, Karatzias et al. (2021) Journal of Anxiety Disorders

# Prevalence rates: General population samples

| | USA | Israel | Ireland | UK^** | Germany* | Ghana | Kenya | Nigeria |
|---|---|---|---|---|---|---|---|---|
| **PTSD diagnosis** | 3.4% | 6.7% | 5.0% | 5.3% | 1.5% | 17.6% | 20.3% | 17.4% |
| **CPTSD diagnosis** | 3.8% | 4.9% | 7.7% | 12.9% | 0.5% | 13.0% | 13.7% | 19.6% |
| **Total** | 7.2% | 11.6% | 12.7% | 18.2% | 2.0% | 30.6% | 34.0% | 37.0% |

^Trauma exposure was a criterion for inclusion.

*Very narrow definition of trauma exposure applied.

**Karatzias et al. (2019) Depression and Anxiety

# Prevalence rates: Treatment seeking samples

| | Welsh patients | Scottish patients* | Syrian refugees | Mixed refugees in Switzerland |
|---|---|---|---|---|
| **PTSD diagnosis** | 10.9% | 37.0% | 25.2% | 19.7% |
| **CPTSD diagnosis** | 53.6% | 53.1% | 36.1% | 32.8% |
| **Total** | 64.5% | 90.1% | 61.3% | 52.5% |

*Karatzias et al. (2017) Journal of Affective Disorders

# Types of Trauma, ICD-11 PTSD and CPTSD

| **Trauma Type** | | |
|---|---|---|
| | **PTSD** | **CPTSD** |
| Interpersonal Trauma | 91.0% | 97.1% |
| Childhood Trauma | 85.0% | 93.2% |
| Adulthood Trauma Only | 13.5% | 6.8% |
| Both Childhood and Adulthood Trauma | 85.0% | 93.2% |

Karatzias et al. (2016) Journal of Anxiety Disorders

# PTSD vs. CPTSD (n = 106)

| | ICD-11 PTSD | | ICD-11 CPTSD | | | | |
|---|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | t | df | d |
| **Depression** | 9.73 | 3.71 | 12.43 | 4.76 | 2.05 | 78 | .63* |
| **Anxiety** | 14.20 | 3.23 | 16.14 | 4.55 | 1.56 | 78 | .49 |
| **Borderline Personality Disorder** | 9.69 | 3.01 | 11.09 | 1.94 | 2.10 | 68 | .55* |
| **Self-harm** | .80 | .78 | 1.13 | 1.01 | 1.19 | 74 | .37 |
| **Dissociation** | 9.00 | 3.36 | 14.37 | 6.76 | 2.98 | 73 | 1.01** |

Hyland …. Karatzias (2018) Journal of Traumatic Stress

# CPTSD: Service Utilisation (contact with a MH professional the last 12 months)

| | % | χ2 | OR (95% CI) |
|---|---|---|---|
| **ICD-11 PTSD or CPTSD** | 48.6% | 111.47, p < .001 | 6.75 (4.58, 9.95) |
| **ICD-11 PTSD** | 41.2% | 21.52, p < .001 | 3.68 (2.05, 6.59) |
| **ICD-11 CPTSD** | 58.2% | 100.69, p < .001 | 8.70 (5.36, 14.11) |

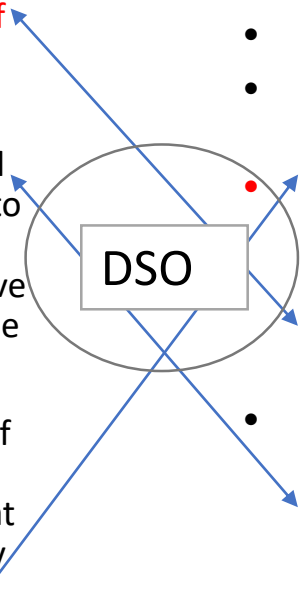
Note: χ2 = chi-square test; OR (95% CI) = Odds ratio (95% confidence intervals).

Hyland, Vallières, Cloitre, Ben-Ezra, Karatzias et al. (2020). Social Psychiatry and Psychiatric Epidemiology

# Differentiating CPTSD and BPD

# ICD-11 PD

- problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction)
- and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) that have persisted over an extended period of time (e.g., 2 years or more).
- The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles)..




# ICD-11 CPTSD

- exposure to an event or series of events.
- PTSD symptoms
- severe and pervasive problems in affect regulation
- persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event
- persistent difficulties in sustaining relationships and in feeling close to others.

# LCA Analysis on a sample of multiply traumatised individuals

Four distinct classes of individuals:

✓A CPTSD/High BPD (43.1%)

✓A CPTSD/Moderate BPD class (40%)

✓A PTSD/Low BPD class (16.9%)

- The two CPTSD classes were associated with greater exposure to multiple, interpersonal traumas earlier in life and exhibited higher functional impairment.

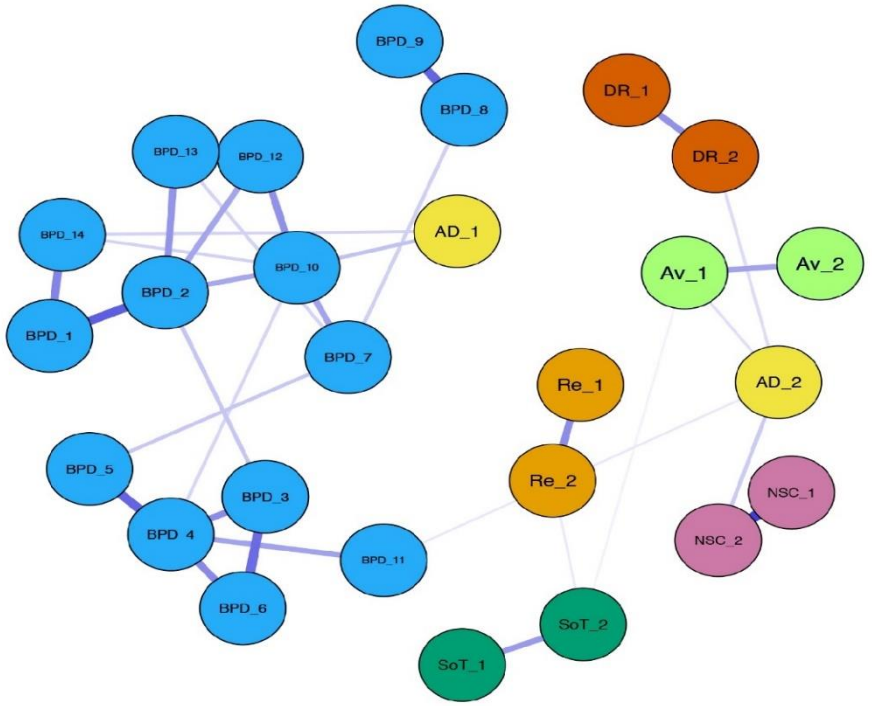
Jowett, Karatzias, Shevlin, Albert (2020). *Personality Disorders: Theory, Research, and Treatment*

# Exploratory structural equation modelling (ESEM) on a traumatised sample from the UK general population

- A three-factor model with latent variables reflective of ‘PTSD’, ‘DSO’, and ‘BPD’ symptomatology provided the best fit of the data.
- The PTSD, DSO, and BPD factors were all positively associated childhood interpersonal trauma.

Hyland, Karatzias Cloitre, Shevlin (2019) Journal of Traumatic Stress

# A network analysis in a highly traumatized sample




**Re−experiencing**
- Re_1: Having upsetting dreams that replay part of the experience or are clearly related to the experience?
- Re_2: Having powerful images or memories that sometimes come into your mind in which you feel the

**Avoidance**
- Av_1: Avoiding internal reminders of the experience
- Av_2: Avoiding external reminders of the experience (for example, people, places, conversations, objects,

**Sense of Threat**
- SoT_1: Being "super−alert", watchful, or on guard?
- SoT_2: Feeling jumpy or easily startled?

**Affective disregulation**
- AD_1: When I am upset, it takes me a long time to calm down.
- AD_2: I feel numb or emotionally shut down.

**Negative self−concept**
- NSC_1: I feel like a failure.
- NSC_2: I feel worthless.

**Disturbed relationships**
- DR_1: I feel distant or cut off from people.
- DR_2: I find it hard to stay emotionally close to people.

**Borderline Personality Disorder**
- BPD_1: Have you often become frantic when you thought that …. was going to leave you?
- BPD_2: Do your relationships with people you really care about have lots of extreme ups and downs?
- BPD_3: Have you suddenly changed your sense of who you are and where you are headed?
- BPD_4: Does your sense of who you are often change dramatically?
- BPD_5: Are you different with different people or ….hat sometimes you don't know who you really are?
- BPD_6: Have there been lots of sudden changes in your goals, career plans, religious beliefs, and so on?
- BPD_7: Have you often done things impulsively?
- BPD_8: Have you tried to hurt or kill yourself or threatened to do so?
- BPD_9: Have you ever cut, burned, or scratched yourself on purpose?
- BPD_10: Do you have a lot of sudden mood changes?
- BPD_11: Do you often feel empty inside?
- BPD_12: Do you often have temper outbursts or get so angry that you lose control?
- BPD_13: Do you hit people or throw things when you get angry?
- BPD_14: When you are under a lot of stress, do you get …people or feel especially spaced out?

Owczarek, Karatzias et al. (2022) Journal of Personality Disorders

# 2 key findings

- BPD and CPTSD are largely separated.
- Affective Dysregulation items were the only items related to BPD.

Owczarek, Karatzias et al. (2022) Journal of Personality Disorders

| CPTSD | BPD |
| --- | --- |
| **Emotional Regulation** | |
| reactive anger and substance misuse | self-injurious behaviours and suicidality |
| **Disrupted Sense of self** | |
| sense of self is defined as a stable, deeply negative self-perception | highly unstable and alternating between polarised positive and negative self-perception |
| **Disturbed Relationships** | |
| difficulties stem from mistrust, associated with being hurt, and are kept at a distance more consistently | volatile and oscillating between intensely idealised and disparaging |

# Treating overlapping CPTSD and BPD

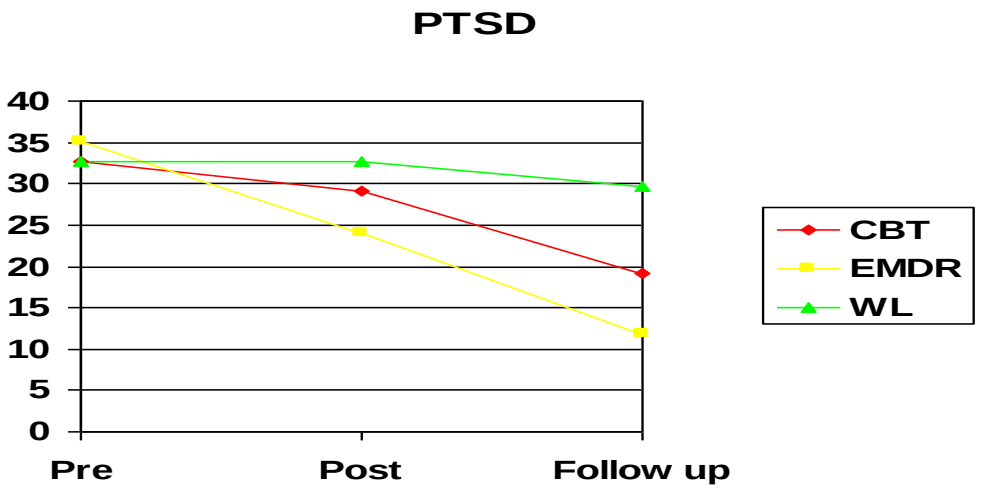
- Targeting CPTSD?
- Targeting BPD?
- Targeting Affect Dysregulation?

# CPTSD Treatment: Where are we?

- ICD-11 Complex PTSD (CPTSD) is a **new condition** and there are as yet no clinical trials for its treatment.

- There is a substantial evidence base on the treatment of PTSD.

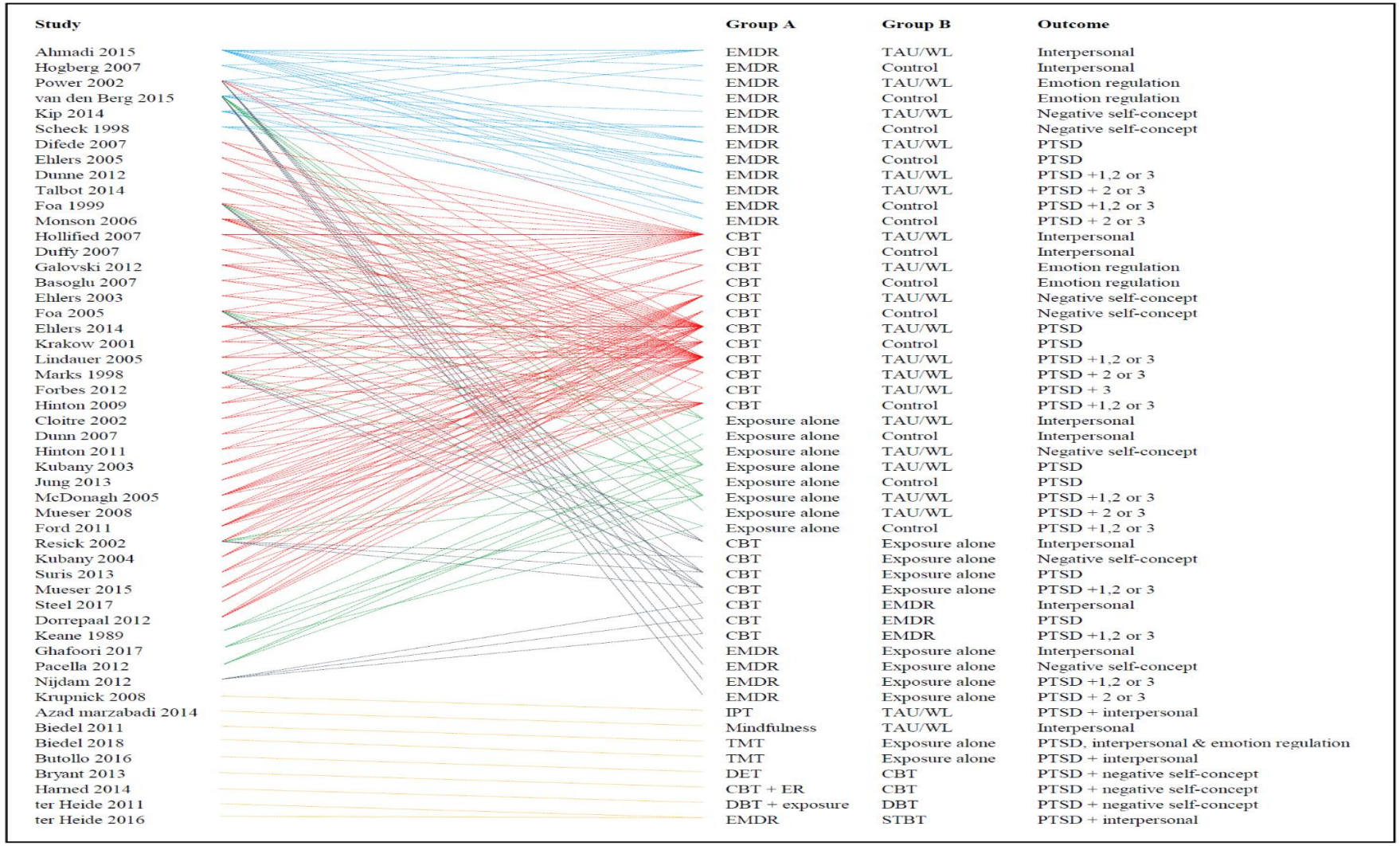
# PTSD treatment
# EMDR vs. TfCBT vs. WL




Power et al… Karatzias, 2002 Clinical Psychology and Psychotherapy
Karatzias et al., 2007 European Archives of Psychiatry and Clinical Neuroscience
Karatzias et al., 2011 Journal of Nervous and Mental Disease

# Are existing therapies effective for CPTSD?

# Metanalysis of existing therapies for CPTSD



| Study | Group A | Group B | Outcome |
|---|---|---|---|
| Ahmadi 2015 | EMDR | TAU/WL | Interpersonal |
| Hogberg 2007 | EMDR | Control | Interpersonal |
| Power 2002 | EMDR | TAU/WL | Emotion regulation |
| van den Berg 2015 | EMDR | Control | Emotion regulation |
| Kip 2014 | EMDR | TAU/WL | Negative self-concept |
| Scheck 1998 | EMDR | Control | Negative self-concept |
| Difede 2007 | EMDR | TAU/WL | PTSD |
| Ehlers 2005 | EMDR | Control | PTSD |
| Dunne 2012 | EMDR | TAU/WL | PTSD +1,2 or 3 |
| Talbot 2014 | EMDR | TAU/WL | PTSD + 2 or 3 |
| Foa 1999 | EMDR | Control | PTSD +1,2 or 3 |
| Monson 2006 | EMDR | Control | PTSD + 2 or 3 |
| Hollified 2007 | CBT | TAU/WL | Interpersonal |
| Duffy 2007 | CBT | Control | Interpersonal |
| Galovski 2012 | CBT | TAU/WL | Emotion regulation |
| Basoglu 2007 | CBT | Control | Emotion regulation |
| Ehlers 2003 | CBT | TAU/WL | Negative self-concept |
| Foa 2005 | CBT | Control | Negative self-concept |
| Ehlers 2014 | CBT | TAU/WL | PTSD |
| Krakow 2001 | CBT | Control | PTSD |
| Lindauer 2005 | CBT | TAU/WL | PTSD +1,2 or 3 |
| Marks 1998 | CBT | TAU/WL | PTSD + 2 or 3 |
| Forbes 2012 | CBT | TAU/WL | PTSD + 3 |
| Hinton 2009 | CBT | Control | PTSD +1,2 or 3 |
| Cloitre 2002 | Exposure alone | TAU/WL | Interpersonal |
| Dunn 2007 | Exposure alone | Control | Interpersonal |
| Hinton 2011 | Exposure alone | TAU/WL | Negative self-concept |
| Kubany 2003 | Exposure alone | TAU/WL | PTSD |
| Jung 2013 | Exposure alone | Control | PTSD |
| McDonagh 2005 | Exposure alone | TAU/WL | PTSD +1,2 or 3 |
| Mueser 2008 | Exposure alone | TAU/WL | PTSD + 2 or 3 |
| Ford 2011 | Exposure alone | Control | PTSD +1,2 or 3 |
| Resick 2002 | CBT | Exposure alone | Interpersonal |
| Kubany 2004 | CBT | Exposure alone | Negative self-concept |
| Suris 2013 | CBT | Exposure alone | PTSD |
| Mueser 2015 | CBT | Exposure alone | PTSD +1,2 or 3 |
| Steel 2017 | CBT | EMDR | Interpersonal |
| Dorrepaal 2012 | CBT | EMDR | PTSD |
| Keane 1989 | CBT | EMDR | PTSD +1,2 or 3 |
| Ghafoori 2017 | EMDR | Exposure alone | Interpersonal |
| Pacella 2012 | EMDR | Exposure alone | Negative self-concept |
| Nijdam 2012 | EMDR | Exposure alone | PTSD +1,2 or 3 |
| Krupnick 2008 | EMDR | Exposure alone | PTSD + 2 or 3 |
| Azad marzabadi 2014 | IPT | TAU/WL | PTSD + interpersonal |
| Biedel 2011 | Mindfulness | TAU/WL | Interpersonal |
| Biedel 2018 | TMT | Exposure alone | PTSD, interpersonal & emotion regulation |
| Butollo 2016 | TMT | Exposure alone | PTSD + interpersonal |
| Bryant 2013 | DET | CBT | PTSD + negative self-concept |
| Harned 2014 | CBT + ER | CBT | PTSD + negative self-concept |
| ter Heide 2011 | DBT + exposure | DBT | PTSD + negative self-concept |
| ter Heide 2016 | EMDR | STBT | PTSD + interpersonal |

Karatzias et al. (2019) Psychological Medicine

# Life events in a community treatment seeking sample

| N= 195 | | | |
|---|---|---|---|
| **Childhood Trauma (CTQ)** | | **Adulthood Trauma (LEC)** | |
| Emotional Abuse | 70.3% | Physical assault | 80.5% |
| Emotional neglect | 63.1% | Sexual Assault | 58.5% |
| Sexual abuse | 55.9% | Weapon Assault | 51.6% |
| Physical abuse | 54.9% | Transport Accident | 50.3% |
| Physical neglect | 52.8% | Other Unwanted Sexual Experience | 48.7% |
| Any Childhood Trauma | 82.1% | **Multiple Life Events (2-12)** | **94.6%** |
| **Multiple abuses** | **70.8%** | **Adulthood Trauma only** | **16.4%** |
| **Interpersonal Trauma (Childhood or Adulthood)** | **93.7%** | | |
| Interpersonal trauma only (Childhood or adulthood) | 10.3% | | |
| **Childhood Trauma only** | **0.0 %** | | |
| **Childhood and Adulthood Trauma** | **82.1%** | | |

Karatzias et al. (2016) Journal of Affective Disorders

# Life events in a prison population

| N= 112 | | | |
|---|---|---|---|
| **Childhood Trauma (CTQ)** | | **Adulthood Trauma (LEC)** | |
| Emotional Abuse | 77.5 | Physical assault | 75.3 |
| Emotional neglect | 78.7 | Sexual Assault | 55.1 |
| Sexual abuse | 50.6 | Weapon Assault | 51.7 |
| Physical abuse | 59.6 | Serious harm caused to someone else | 49.4 |
| Physical neglect | 65.2 | Other Unwanted Sexual Experience | 53.9 |
| **Multiple abuses** | **55.1** | **Any Life Event** | **84.2** |

Howard, Karatzias et al. (2016), Clinical Psychology and Psychotherapy
Howard, Karatzias et al. (2016), Social Psychiatry & Psychiatric Epidemiology
Facer-Irwin, Karatzias et al. (2020), Psychological Medicine

# Adverse Childhood Events
# Population Based Studies (2018 -19)

| Adverse childhood event | UK* % | Ireland % | USA % | Israel % |
|---|---|---|---|---|
| Verbal abuse by a parent or caregiver | 36% | 36% | 21% | 27% |
| Physical abuse by a parent or caregiver | 34% | 28% | 16% | 23% |
| Sexual abuse by a parent or caregiver | 16% | 16% | 18% | 19% |
| Emotional neglect by a parent or caregiver | 36% | 30% | 17% | 23% |
| Physical neglect by a parent or caregiver | 10% | 10% | 5% | 5% |
| Parents separated or divorced | 31% | 20% | 34% | 16% |
| Witnessing physical violence between parents or caregivers | 16% | 13% | 12% | 9% |
| Alcohol or drug use in the family home | 18% | 26% | 25% | 8% |
| Mental illness in the family home | 25% | 23% | 16% | 15% |
| Household member went to prison | 7% | 7% | 8% | 3% |

*Karatzias et al. (2019), Depression & Anxiety

# What do we know about the treatment of CPTSD?

# Metanalysis of Group Therapies for Complex Interpersonal Trauma

- Phased 1 interventions can be useful for symptoms of general distress (e.g. anxiety and depression).
- Phased 2 (Trauma Focused) interventions are required for traumatic stress.

Mahoney, Karatzias, Hutton (2019). Journal of Affective Disorders

# Pilot RCT of Phase 1 Interventions

- N = 86 female prisoners with interpersonal trauma.
- 10 sessions of Phase 1 (group psychoeducation) vs. standard care.
- Group psychoeducation achieved only **small effect sizes** in comparison to usual care across all outcomes including behavioural problems, emotional regulation and psychopathology.

Mahoney, Karatzias et al. (2020). Clinical Psychology & Psychotherapy

# Metanalysis of psychological and pharmacological interventions for PTSD following complex trauma

- Multicomponent interventions that included skills-based strategies along with trauma-focused strategies are the most promising interventions for emotional dysregulation and interpersonal problems in people with complex trauma.
- Multicomponent interventions that included cognitive restructuring and imaginal exposure were the most effective for reducing PTSD symptoms.

Coventry, Meader, Melton, Temple, Dale, Wright, Cloitre, Karatzias et al. (2020). **PLOS Medicine**

# What about acceptability of therapies?

- Patients with complex trauma have high attrition rates compared to those with PTSD.
- Patient centred approaches can be helpful in reducing attrition rates in psychological therapies.

Coventry, Meader, Melton, Temple, Dale, Wright, Cloitre, Karatzias et al. (2020). PLOS Medicine

# Person centered care

4 core principles:

- ✓Affording people dignity
- ✓Compassion and respect
- ✓Offering coordinated and personalised care, support or treatment
- ✓Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

In this framework, the role of the health care professional is to enable the individual to make decisions about their own care and treatment on the basis of their needs (Health Foundation, 2014)

# Modular therapy for CPTSD: A person centered approach

1. A thorough assessment of the patient's presenting problems resulting in a case formulation about the underlying causes.
2. Therapist and patient decide on specific CPTSD clusters to target based on preference, readiness and severity using appropriate evidence based interventions.
3. At the end of delivery of this module, an assessment is conducted and the next therapeutic target is selected.

Karatzias & Cloitre (2020). Journal of Traumatic Stress

# A new modular treatment protocol for CPTSD

- **Enhanced STAIR (ESTAIR) Narrative Therapy for CPTSD** (Cloitre, Karatzias, McGlanachy, 2019)
- Based on STAIR model (Cloitre et al., 2002, 2010)
- 25 sessions: 6 sessions per cluster (Self-concept, affect regulation, interpersonal relationships, PTSD) + a formulation session prior to start of treatment.

# Treating overlapping CPTSD and BPD

- New area of enquiry
    - Understanding the role of childhood polytraumatisation.
- There is a need for further clinical research in this area…
    - Targeting CPTSD (Modular therapies)
    - Targeting BPD (DBT)
    - New models addressing specific overlapping symptoms (affective dysregulation)

# Conclusions

- CPTSD and BPD are distinct conditions but can co-occur in a small percentage of individuals.
- Emotional dysregulation seems to be responsible for the overlap between CPTSD and BPD in relevant research.
- There is a need for more clinical research in addressing the comorbidity between CPTSD and BPD.

# Thank you for attending

# Breakout room

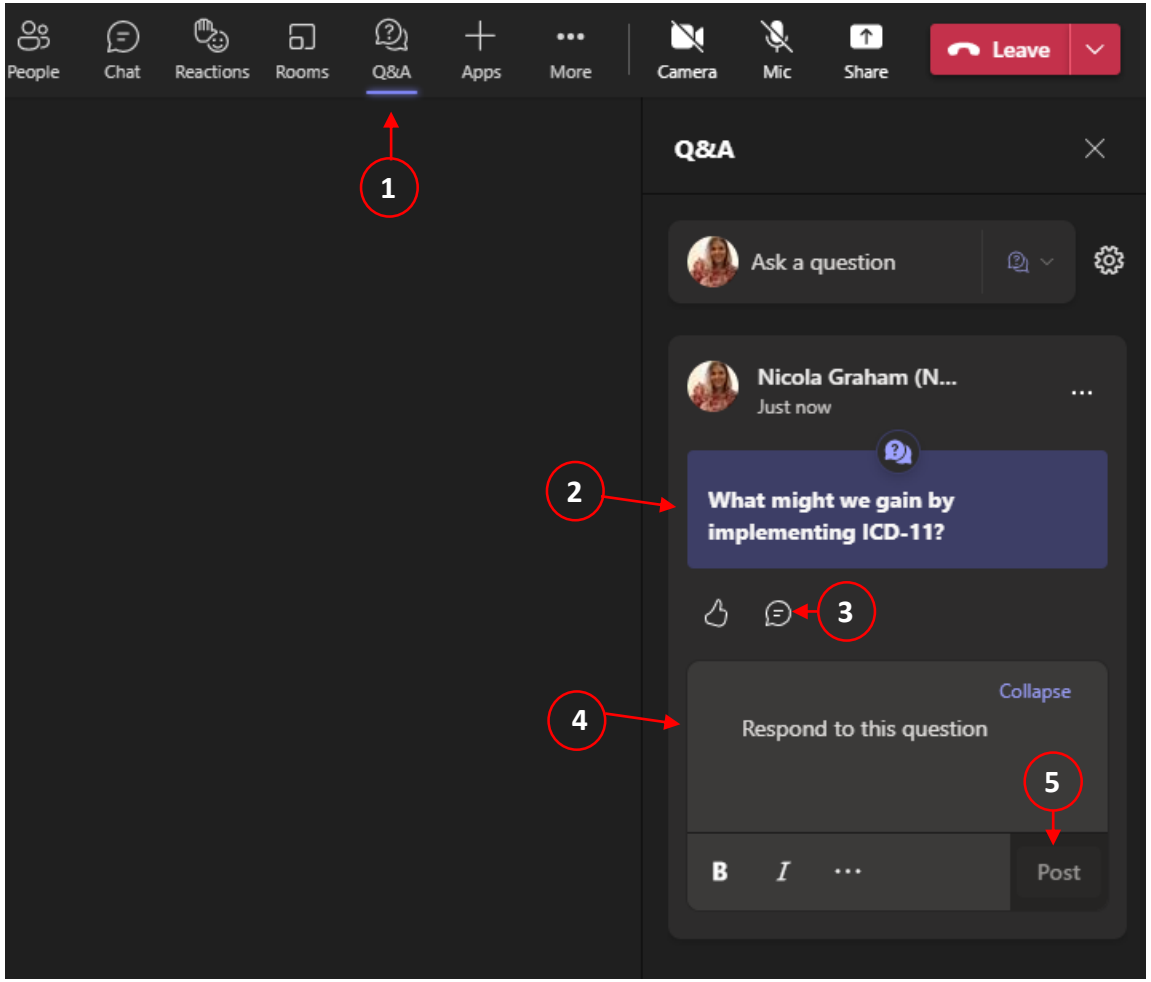
Think of the questions below:

1. **How can we distinguish between the two diagnoses in clinical practice and how does that impact on the individual?**
2. **What are the implications for these two diagnoses in terms of treatment?**

In order for us to have successful break out rooms, we've popped some guidance below:

1. Be respectful to others whilst they are speaking
2. Be thoughtful about language and mindful of other peoples experience
3. Allow others to contribute

# Breakout room feedback




Instructions on how to feedback your discussions from the breakout room

1. Find ‘Q&A’ on the top bar and click on it
2. You will see the questions that were asked in the sessions
3. Find the question you want to feedback on and click the speech bubble underneath the comment
4. Respond to the question
5. Press post

# Using ICD-11 in practice

Dr Tim Agnew, Consultant Psychiatrist and Psychotherapist, Clinical Lead NHS Highland Personality Disorder Service

# Overview

- Background
- Rationale
- Practicalities
- Benefits and costs

# NHS Highland PDS

- Multidisciplinary specialist service
- Draws referrals from secondary care mental health services in “North Highland”
- For patients who care cannot be effectively provided solely in secondary care services due to reasons of severity, complexity or lack of treatment response
- Assessment, formulation and treatment recommendations is the first and most fundamental step in the treatment pathway

# Assessment, formulation and treatment recommendations

- Co-authored multimodal assessment of person's history and current situation
- Individualised formulation of problems and goals drawn from multisource assessment information
- Formulation includes ICD psychiatric diagnoses

# Psychiatric diagnosis

- Sets of criteria agreed by committees of experts
- Necessarily reductive
- Impersonal
- Imperfect
- …but important
  - can be useful shorthand to aid communication (if one remembers that the diagnosis is not the same as the individual and forms just one aspect of the picture)
  - supports development and application of effective treatments
  - application of diagnosis to guide treatment is an accepted standard in psychiatric practice and variance from this standard may be difficult to justify

# Timeline

- 2016: using severity and trait domains of ICD-11 within formulation and diagnosis but using ICD-10 as diagnosis coding tool
- 2020 -2021: using ICD-11 diagnoses alongside ICD-10
- 2022: using ICD-11 only

# Rationale for moving to ICD-11

- ICD-10/DSM-3 categories have little scientific validity (and areas of significant disagreement)
- Marked co-occurrence/consanguinity
- ICD-10 has no severity dimension
- Dimensional model more scientifically sound and clinically useful than categorical model
  - Extensive literature on “normal” personality trait dimensions
  - Emerging literature on “disordered” personality trait dimensions

# Applying the diagnosis: General Criteria

- An enduring disturbance characterized by problems in functioning of aspects of the self and/or interpersonal dysfunction
- The disturbance has persisted for 2 years or more.
- The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated).
- The disturbance is manifest across a range of personal and social situations.
- The symptoms are not due to a medication or substance, including withdrawal effects, and are not better accounted for by another mental disorder, a Disease of the Nervous System, or another medical condition.
- The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- Personality Disorder should not be diagnosed if the patterns of behaviour characterizing the personality disturbance are developmentally appropriate (e.g., problems related to establishing an independent self-identity during adolescence) or can be explained primarily by social or cultural factors, including socio-political conflict.

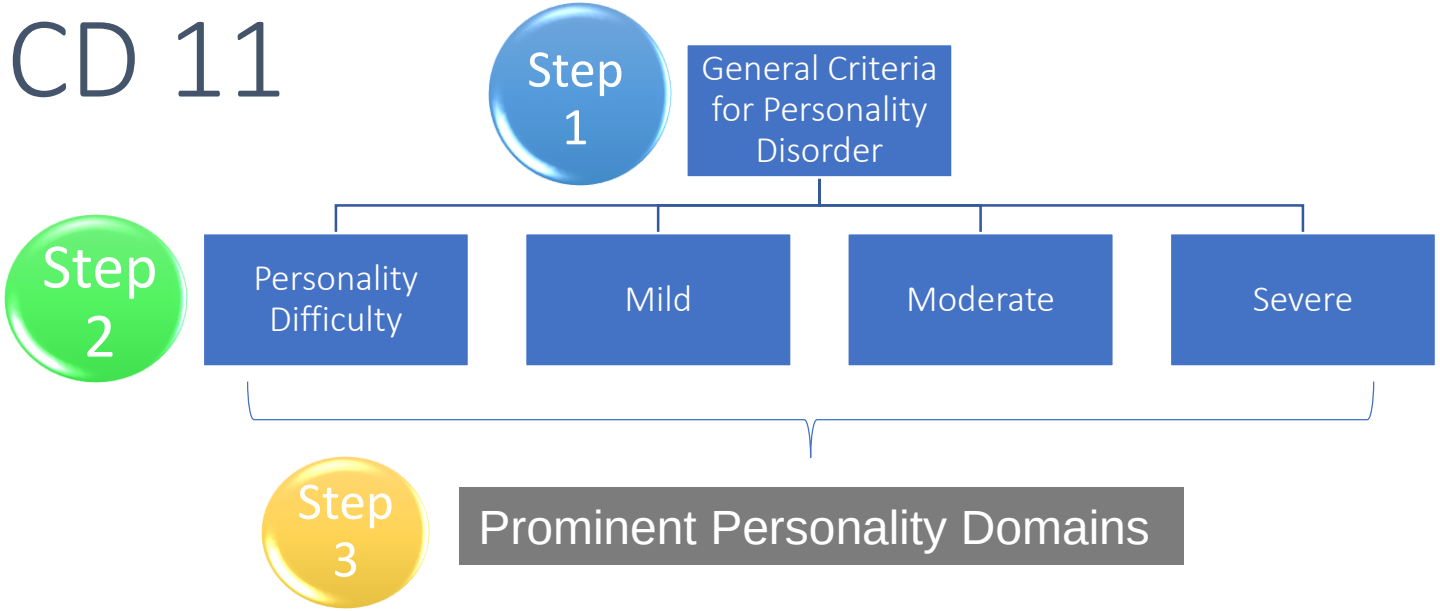
# Severity

| Problem Area | MILD Personality Disorder | MODERATE Personality Disorder | SEVERE Personality Disorder |
|---|---|---|---|
| Areas of personality functioning affected | Some | Many | All |
| Relationships affected | Many | Most | All (or almost all) |
| Specific manifestations of personality disorder | Mild | Moderate | Severe |
| Level of associated harm to self or others | None | Some | Often |

# “Personality difficulty”

- Personality difficulty refers to pronounced personality characteristics that may affect merit a diagnosis of Personality Disorder.
- Personality difficulty is characterised by 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. In contrast to Personality disorders, these difficulties are manifested in cognitive and emotional experience and expression only intermittently (e.g., during times of stress) or at low intensity. The difficulties are associated with some problems in functioning but these are insufficiently severe to cause notable disruption in social, occupational, and interpersonal relationships and may be limited to specific relationships or situations.

# ICD 11




**Negative Affectivity**

Tendency to experience a broad range of negative emotions

**Detachment**

Tendency to maintain social distance and emotional distance

**Dissociality**

Tendency to disregard the rights and feelings of others, encompassing self-centredness and lack of empathy

**Disinhibition**

Tendency to act rashly based on immediate external or internal stimuli

**Anankastia**

Tendency for a narrow focus on one's rigid standards of perfection and right and wrong and on controlling oneself, others and situations to ensure these standards are met

Borderline pattern

# Borderline pattern (5 of 9)

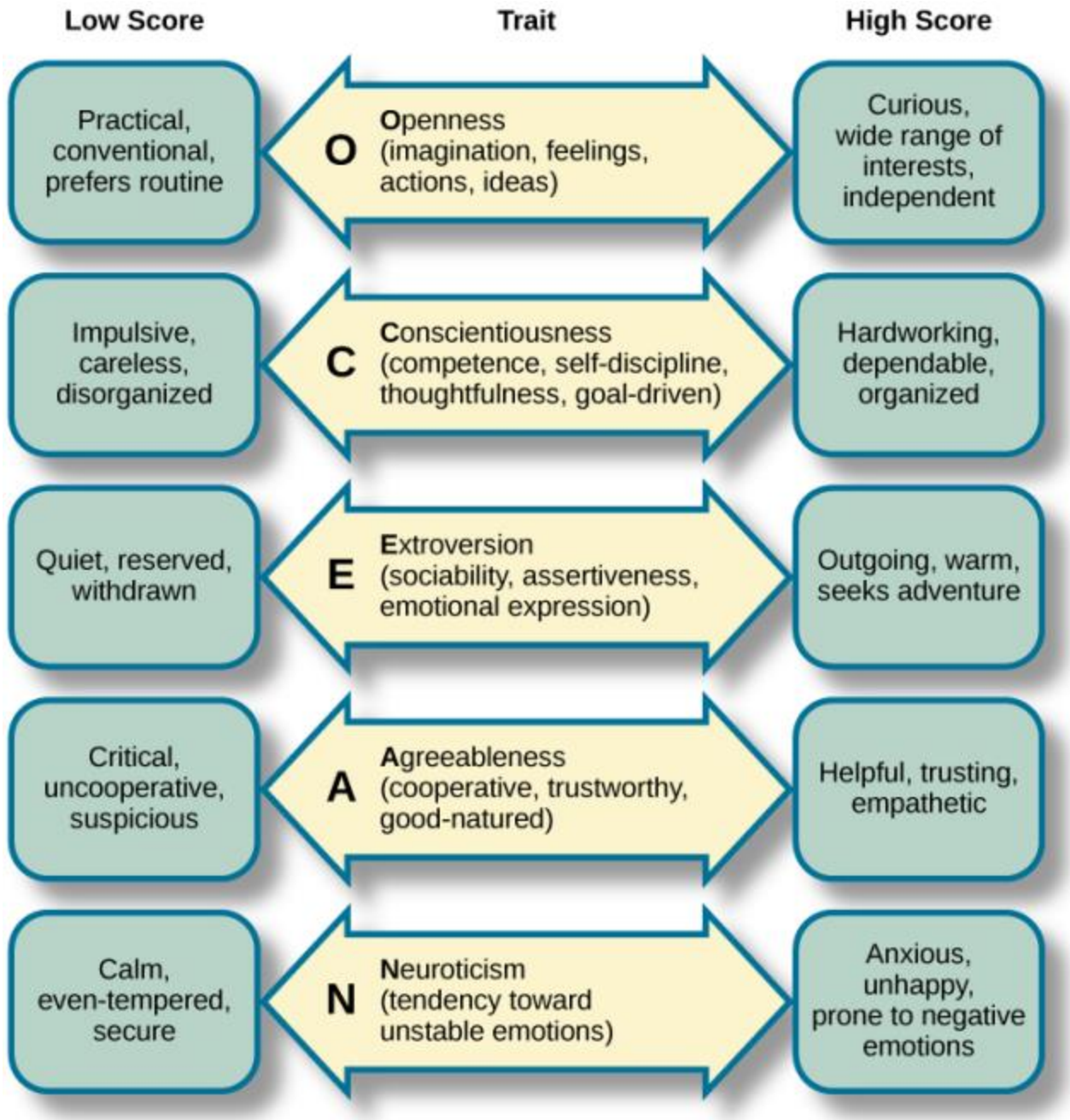
- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships
- Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self.
- A tendency to act rashly in states of high negative affect, leading to potentially self-damaging Recurrent episodes of self-harm (e.g., suicide attempts or gestures, self-mutilation).
- Emotional instability due to marked reactivity of mood.
- Chronic feelings of emptiness.
- Inappropriate intense anger or difficulty controlling anger manifested in frequent displays of temper
- Transient dissociative symptoms or psychotic-like features in situations of high affective arousal.

# …also

- Other manifestations of Borderline pattern, not all of which may be present in a given individual at a given time, include the following:
  - A view of the self as inadequate, bad, guilty, disgusting, and contemptible.
  - An experience of the self as profoundly different and isolated from other people; a painful sense of alienation and pervasive loneliness.
  - Proneness to rejection hypersensitivity; problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships; frequent misinterpretation of social signals.

# Five Factor Model

- Openness to experience
- Conscientiousness
- Extraversion
- Agreeableness
- Neuroticism


Low Score
Trait
High Score
Practical, conventional, prefers routine
O
Openness (imagination, feelings, actions, ideas)
Curious, wide range of interests, independent
Impulsive, careless, disorganized
C
Conscientiousness (competence, self-discipline, thoughtfulness, goal-driven)
Hardworking, dependable, organized
Quiet, reserved, withdrawn
E
Extroversion (sociability, assertiveness, emotional expression)
Outgoing, warm, seeks adventure
Critical, uncooperative, suspicious
A
Agreeableness (cooperative, trustworthy, good-natured)
Helpful, trusting, empathetic
Calm, even-tempered, secure
N
Neuroticism (tendency toward unstable emotions)
Anxious, unhappy, prone to negative emotions

# OCEAN to ICD-11 crosswalk

| | Negative Affectivity | Detachment | Dissociality | Disinhibition | Anankastia |
|---|---|---|---|---|---|
| Openness | | | | | - |
| Conscientiousness | | | - | - | + |
| Extraversion | | - | | | |
| Agreeableness | | | - | | |
| Neuroticism | + | - | | | |

| Trait domain | Five factor model and aspects |
| --- | --- |
| Negative affectivity | High **NEUROTICISM**<br>(High WITHDRAWAL)<br>(High VOLATILITY) |
| Detachment | High WITHDRAWAL<br>Low ENTHUSIASM |
| Dissociality | Low **AGREEABLENESS**<br>(Low COMPASSION)<br>(Low POLITENESS) |
| Disinhibition | Low ORDERLINESS<br>High VOLATILITY<br>High ENTHUSIASM |
| Anakastia | High **CONSCIENTIOUSNESS**<br>(High INDUSTRIOUSNESS)<br>(High ORDERLINESS) |

# Summary of changes

- Severity dimension
- Trait descriptors
- Borderline Pattern descriptor
- Age criterion
- Persistence criterion
- Stability descriptor
- Personality difficulty (as factor influencing health)
- CPTSD

# In practice…

- NHS Highland MH Services fully moved to ICD-11 in 2022
- What about historical diagnoses?
  - Principle of parsimony
  - Any PDS assessments for past 7 years will have severity descriptor
  - BPD/EUPD = Borderline Pattern
  - No longer diagnose PTSD in someone who meets criteria for borderline pattern, diagnose CPTSD instead
- “Personality Difficulties” to replace previous less helpful diagnostic labels?

# ICD-10 to ICD-11 crosswalk

| | Negative Affectivity | Detachment | Dissociality | Disinhibition | Anankastia |
|---|---|---|---|---|---|
| Paranoid | + | + | | | |
| Schizoid | - | + | | | |
| Dissocial | +/- | | + | + | |
| EUPD | + | | +/- | + | |
| Histrionic | + | - | + | + | |
| Anankastic | +/- | | | - | + |
| Anxious | + | + | - | | |
| Dependent | + | | - | | |
| (Narcissistic) | + | | + | | |

# Thank you

# Breakout room

Think of the questions below:

**1. What might be the challenges of implementing ICD-11 from your experience or in your area of practice?**

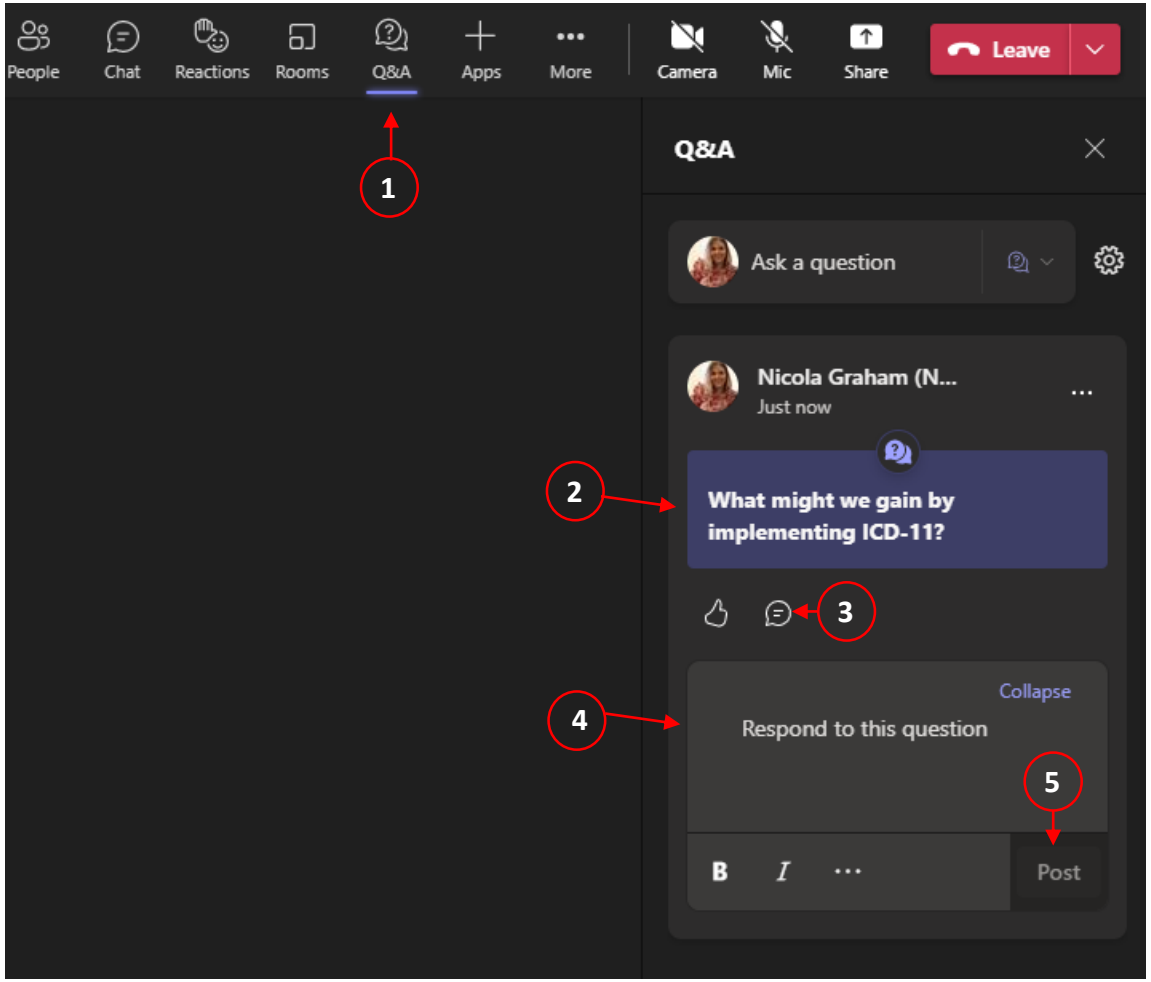
**2. What might be the potential gains of using ICD-11 and what might be lost by losing the categories of ICD-10?**

**3. What do we do about historical diagnosis?**

In order for us to have successful break out rooms, we've popped some guidance below:

1. Be respectful to others whilst they are speaking
2. Be thoughtful about language and mindful of other peoples experience
3. Allow others to contribute

# Breakout room feedback




Instructions on how to feedback your discussions from the breakout room

1. Find ‘Q&A’ on the top bar and click on it
2. You will see the questions that were asked in the sessions
3. Find the question you want to feedback on and click the speech bubble underneath the comment
4. Respond to the question
5. Press post

# Polls

# Next steps

Follow up email circulated soon. Slides and recording will be uploaded to website which can be accessed here

Next webinar will take place 7 November and will focus on the work between NHS Lanarkshire and Scottish Recovery Network

Get in touch with the team on his.mhportfolio@nhs.scot or on twitter by visiting @SPSP_MH