Personality Disorder and how they become barriers to effective medical care

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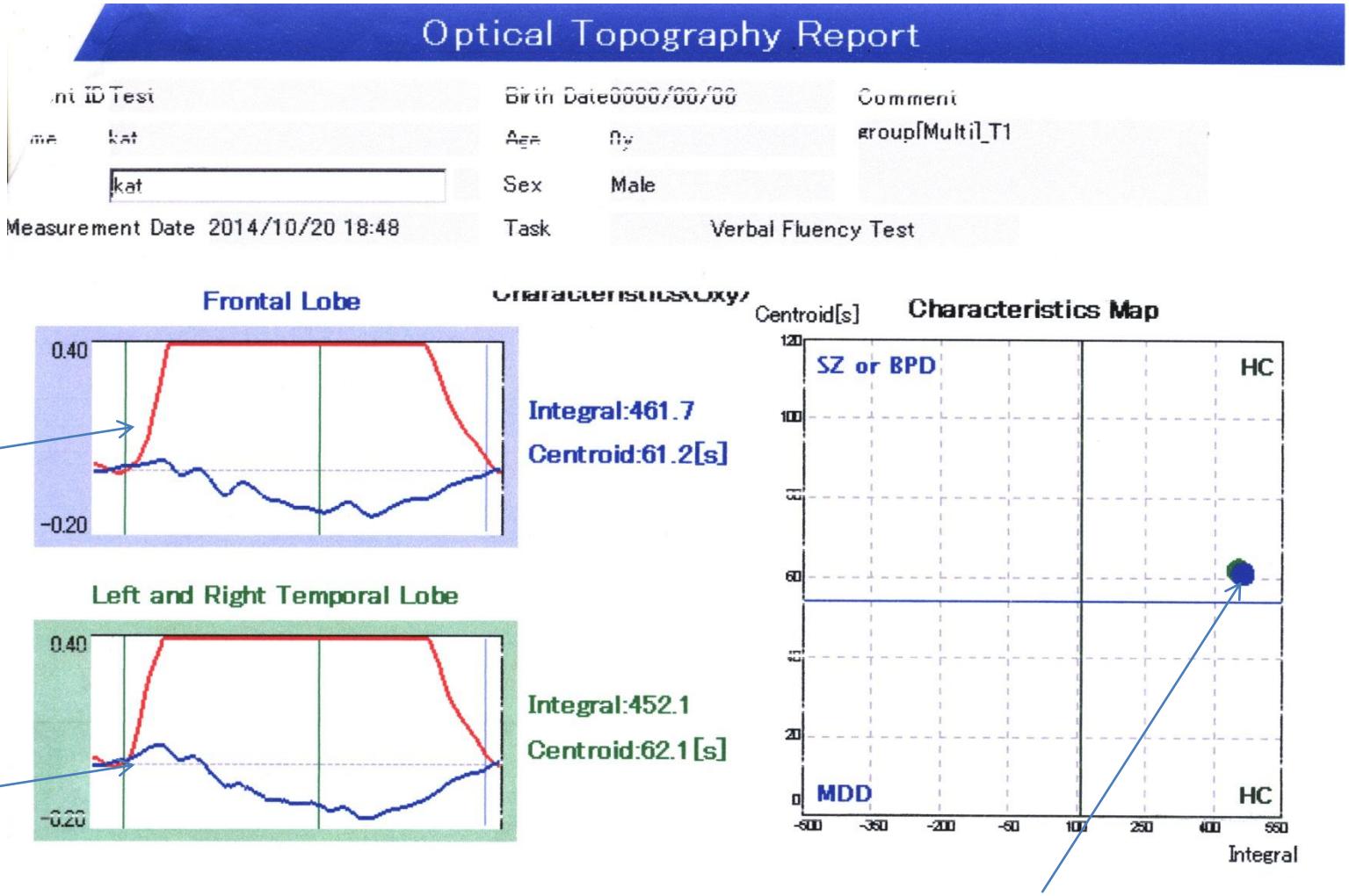
Why do we need to talk about personality disorder today?

- Today we mainly focus on borderline personality disorder and narcissistic personality disorder
- Borderline personality disorder can be seriously disabling and often takes a huge toll on the individual.
- It is characterised by a pattern of instability of interpersonal relationships, self-image and affects, and by marked impulsivity.
- A common factor is a history of traumatic events during childhood and adolescence.
- People with borderline personality disorder are amongst the most likely to use mental health services or medical services.

Borderline personality disorder

The pattern of a 4th year medical student



The frontal lobe function is important for cognitive flexibility.

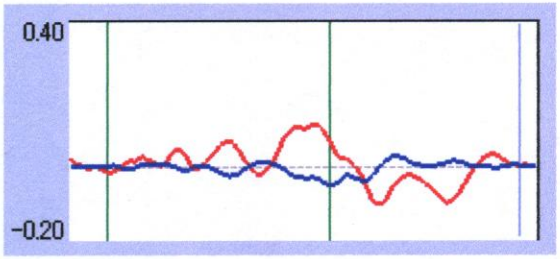
The verbal fluency test requires intact temporal lobe function (e.g. memory).

Observation: The blue dot (frontal lobe) and green dot (temporal lobe) coincides with each other.

Optical Topography Report

Patient ID	VFT	Birth Date	0000/00/00	Comment	MDD. Borderline, Pre ECT
Name	MT	Age	19y		
	MT	Sex	Female		
Measurement Date	2014/10/23 11:19	Task	Verbal Fluency Test		

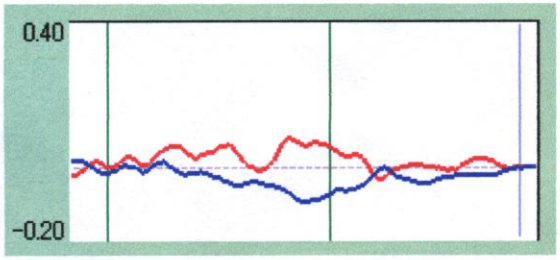
Frontal Lobe



Integral:22.1

Centroid:57.4[s]

Left and Right Temporal Lobe

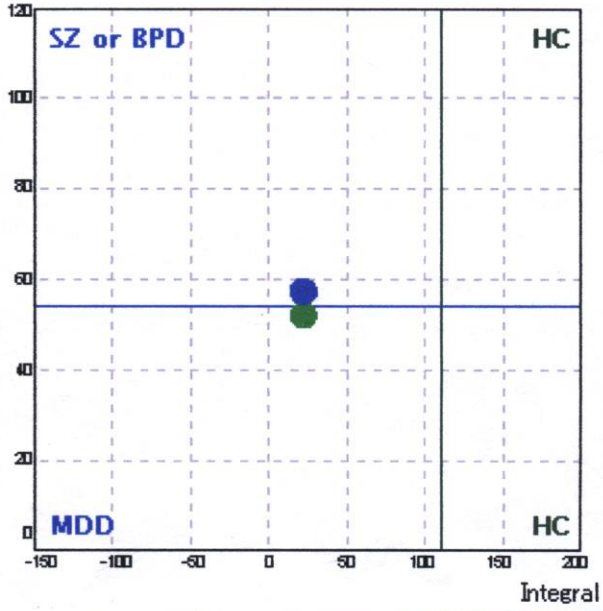


Integral:22.0

Centroid:52.1[s]

Characteristics(Oxy)

Characteristics Map



*These figures are NOT diagnosis result

Mnemonics

I RAISED A PAIN

- **I**dentity disturbance
- **R**elationships are unstable
- **A**bandonment: frantically avoided
- **I**mpulsive
- **S**uicidal gestures, attempts, threats, self harm
- **E**mptiness
- **D**issociative symptoms
- **A**ffective instability
- **P**aranoid ideation
- **A**nger poorly controlled
- **I**dealization followed by devaluation
- **N**egativistic- undermine the efforts of self and others

Comorbidity

- Mood disorders: depression 50%, dysthymia 70%,
- Anxiety: 50% (Post traumatic stress disorder symptoms (e.g. nightmare, hypervigilance, avoidance and flashbacks)
- Eating Disorder: 25%
- Substance abuse disorder: 35-50 %,
- 4 times in alcohol, 8 times in substance abuse disorder vs other personality disorders

Source: Zanarini 2004

Suicide and BPD (1)

- Suicide risk: 5-10%
- 60-78% have suicide behaviours
- 5-10% suicide with peaks during early adolescence to 30's (Yen 2004,Pompili 2005)
- Level of risk (chronic) can be estimated from history of patient's most serious suicide attempt
- Risk remains elevated for years
- Early all cause early mortality (18%)

Suicide and BPD (2)

Increased suicidal behaviour when:

- Worsening of Major Depressive Episode
- Worsening substance abuse
- Recent discharge (weeks) from psychiatric hospital
- Recent negative life events: usually involving the breakdown of an important relationship

Frequencies (My clinical experience)

- 10% outpatients, 20 % inpatients (NUH Depression Clinic/psychiatric ward)
- 30- 60% of personality disorder in clinical population
- A trend with decreasing in the age of onset
- The prevalence is increasing

Aetiologies

- Due to inability to deal with separateness of caregivers (Modell 1963)
- Fears of abandonment secondary to traumatic childhood separations (Masterson 1978)
- Family environments marked by high conflict and unpredictability (Gunderson 1989)
- Lacking emotionally available mother during rapprochement (Kernberg)
- emotionally vulnerable temperament transacting with an invalidating environment (Linehan 1993)

Aetiologies

Childhood Trauma (Western figures)

– Abuse (all types) , neglect

– Physical abuse: 10-73%

– Increased reports of family dysfunction, separation/

- loss, parental alcohol abuse, criminality

– Childhood sexual: 16-71 %

– Sexual abuse in 60-70% of severe BPD

– Childhood sexual abuse by male non-caretaker increase the risk adult diagnosis of BPD

In Singapore, emotional abuse is very common.

Source: Battle 2004

What are the main barrier in looking after BPD?

Splitting

- Splitting: patient sees one clinician as all good, another as all bad
- Management
  - Recognize this is a feature of the disorder, not the person. Ie patient is doing this because it is a feature of the disorder to idealize and devalue
  - Communication between team members is key – talk about this when it arises
  - Listen to the patient, do not take sides, coach patient on how to speak with the team member

Management – hospitalisation

Admission criteria for BPD

- Life threatening suicide attempt or imminent
- danger to others
- Psychosis or severe symptoms interfering with functioning that are unresponsive to outpatient treatment
- Aim for admissions which are brief, structured

and with clear achievable goals

- Patients need to know that improvement will take time and not likely to occur as an inpatient.

Source: Paris 2002

How to communicate with BPD on admission

- Encourage patient to talk about how they feel, (emotion, event that prompted the emotion)
- Encourage patient to become an active partner in problem solving
- Ask patient to be explicit about wanting help
- Ask patient to be explicit about what help they hope you can offer
- Ask patient what they have tried, have tried in the past or have thought about trying that might help

A challenging case of BPD at the National University Hospital, Singapore

Case presentation: Miss L

Admissions in 2014:

- 1.Ward 33 (NUH): 28-Jan-2014 to 04-Feb-2014 (Reason of admission panic attacks; no discharge medication)
- 2.Ward 33 (NUH): 21-Apr-2014 to 25 – April 2014 (Reason for admission: paracetamol overdose; no discharge medication)
- 3. Ward 33 (NUH): 16-May-2014 to 20-May-2014 (Reason for admission; Multiple drug overdose, transfer to IMH)
- 4. 1 July 2014: NUH AED: overdose and transfer to IMH directly
- 5. 7 July 2014: overdose and absconded from TTSH AED.
- 6. Ward 33 (NUH): 09-Jul-2014 to 12-Aug-2014 (Reason for admission: drug overdose;
- 7. Ward 33 (NUH): 14-Aug-2014 to 22-Sep-2014 (Reason for admission: unstable emotion; shoplifting; dishcarge with psychiatric medications)
- 8. Sept 2014 to now: Outpatient appointments (3 times a week)
- Seen by: 6 consultant psychiatrists in our department; 1 consultant psychiatrist at the IMH; 3 private psychiatrists

History of Miss L
28-Jan-2014 to 04-Feb-2014

- **Demographics**: 17 year old female, studying biochemistry in a private school
- **Present complaint:** 1.Suicidal Ideation, 2.Panic attack
  3. Auditory hallucinations
- **History of present complaint:**

- She had been feeling depressed x 2 months
  - She had been skipping school
  - Her parents separated
  - She stayed with her mother (along with aunt & younger sister)
  - She felt depressed because unable to talk to them
  - She spoke to school counsellor - unable to cope with school
  - She stopped going to school.
- She was seen at NUH as out pt on 13.1.2014
  - She was advised to be on fluoxetine since 24th Jan, which she defaulted

History of Miss L
28-Jan-2014 to 04-Feb-2014

- **HPC**: -Today morning, while going to polyclinic, she had another panic attack
  - She **heard someone's foot steps but she could find no one around.**
  - She felt extremely cold with the breeze which **made her perceive something abnormal**
  - She said she did not like any polyclinic doctor.
  - She felt that she got diverted to other hospitals every time she went there and it made her feel more depressed.
  -She was unhappy with a few staff in NUH ED, felt they were staring at her and speaking about her, made her feel bad.
- - Denied manic symptoms. Denied any persecutory delusions while inpatient; however, reported that she was scared of a fellow patient in the ward (claims pt glared at her), was also unhappy with a particular ward staff but unable to elaborate. Denied perceptual disturbances but mentioned presence of **"red lights"** outside room window

Background history (1)

- **Psychiatric history**: Emotional dysregulation of adolescence, with borderline personality traits, complex PTSD, Major depressive disorder with psychotic features, panic disorder
- **Medical history:** very severe acne, MRI Brain: normal
- **Premorbid personality**: chronic feeling of emptiness, unstable emotion, impulsive and poor anger control, prefer to speak in British ascent, when asked why, said she wanted to set herself apart from her peers, to be better than them. Made unpleasant remarks about certain doctors who had seen her previously. seems to prefer some doctors over others, exhibits splitting behaviour.

Background history (2)

- **Substance abuse**: Admitted to trying "Speed" (amphetamine) a year ago, no illicit drug ingestion recently. Drug screen negative.
- **Social history**: Lives with aunt (primary caregiver), mother and younger sister 15yrs old. Does not feel close to family. Parent divorced when she was 8-year-old. Dad is remarried and has his own family, lives separately. Not in close contact. Last spoke to father 3-4 months ago. Denies physical or sexual abuse (Father claims pt's mother used to beat her when young)

Background history (3)

- **Education**: “O” level education, claimed she passed the exam. But father/aunt did not witness her results; non-smoker; non-drinker.
- **Forensic history**: involved in shoplifting.
- **Occupational history**: temporary job in Starhub
- **Psychosexual history**: multiple romantic relationships in the past, sexually active.

Mental state examination (1)

- **MSE on transfer**: initially extremely rude and guarded, rolling eyes and refusing to talk. Angry that she is being admitted against her will. Later opened up: very angry, expressed frustration with the world, can't stand normality. Claims to have no friends, implies she doesn't need any. Not close to anybody including family. Alludes to interpersonal conflicts with both parents (they are divorced) and aunt who lives with her.
- - Recounted panic attack at Sun 4am: not sure about trigger (earlier mentioned a **black presence** in her room that scared her), had chest pain/SOB/impending sense of doom. Had fleeting urge to jump then. resolved spontaneously. Claims she had a second episode at polyclinic (went there to get meds for panic attack) but was brought to NUH A&E instead. Claimed that she had a 3rd such episode in NUH A&E.

  All three episodes were not witnessed.

Mental state examination (2)

- **After admission to ward:**. Euthymic, affect appropriate. Coherent, Relevant, not thought disordered. Denies perceptual disturbances. No suicidal ideation (rapid change in mental state).
- **Physical examination**: multiple laceration marks on the forearm.

Access to services (Miss L)

- September 2014 to end of 2014: After discharge, her follow-up appointment with psychiatrist is Tuesday pm clinic), Thursday pm (clinic) and Saturday am (ward 33).
- Psychiatrist-in-charge or case manager will call her if she does not appear in the clinic.
- On discharge (Sept, 2014), she was told that re-admission is not seen as a failure (e.g. using re-admission of diabetes patient as an example).

Autonomy and choice (Miss L)

- August 2014: healthy means of weight management (exercising instead of purging)
- August 2014: discussion about education: consideration is that pt will return to MDIS and cont studies there instead of repeating "O" levels
- September 2014: involvement of Miss L in 3 family meetings with her father and her aunt to discuss discharge plan.

Developing an optimistic and trusting relationship (Miss L)

- **April 2014:** She said when she took the medication she did not care if it would end her life or not. Half of her did not want to end her life as liver failure from drug overdose would be one of the 'worst ways to go' but then again if her liver fails then she 'cant be **blamed** for it' says that currently she has no regrets about what she did.
- **April 2014:** Discussed with patient about not being adherent to appointments. Patient was afraid of being judged.

Managing discharge
Miss L

- Discharge is the end of care and treatment
- There is no discrete phases between inpatient treatment and recovery. Miss L is scared of recovery and feels loss as she has no plan after discharge.
- Frequent and regular out-patient follow-ups are available.

Risk management and crisis (2)
Miss L

- Sept 2014: noted to be self-harming in the ward (trigger: a discharged pt texting her that she has overdosed), also got very affected when other patients were discharged (crying, feelings of abandonment)
- Sept 2014: hiding plastic knives in the ward, multiple episodes of self-cutting in the ward.
- Sept 2014: however, on day before planned discharge, pt noted to start cutting behaviour/become tearful - discharge postponed once as a result

Pharmacological treatment

SSRIs

- Effective in treating co-morbid depressive disorder
- Effective in treating anger/impulse dyscontrol
- Relatively well tolerated
- Low lethality for overdose

MANAGEMENT OF IMPULSIVITY / AFFECTIVE INSTABILITY

- Antidepressants
  - Selective serotonin reuptake inhibitors (fluoxetine, fluvoxamine)

- Mood stabilizers
  - Sodium valproate
  - Topiramate
  - Lamotrigine

BORDERLINE PERSONALITY DISORDER
Atypical Antipsychotic Medications

- Improve:
  1) Anxiety
  2) Affective symptoms
  3) Anger/aggression
  4) Cognitive disorganization
  5) Self-injurious behavior

BORDERLINE PERSONALITY DISORDER
Atypical Antipsychotic Medications
(open and double-blind studies)

1) Olanzapine
2) Aripiprazole
3) Quetiapine
4) Risperidone

Opiate Antagonists

- Numerous case reports and trials of naloxone and naltrexone for self-injurious behaviors and dissociative symptoms in personality and developmental disorders (Bohus et al, 1999; Roth et al, 1996; Saper, 2000; Sonne et al, 1996; Symons er al, 2001)

Prognosis

- Prospective, longitudinal studies: remission rates up to 50% at 2 years, up to 90% at 10 years
- All symptoms decreased
- – Impulsive symptoms ↓ the most i.e. SIB 81% to
- 25%
- – Affective symptoms↓ least i.e. depression
- 99% to 70%
- – Cognitive and Interpersonal symptoms in between impulsive and affective symptoms

Source: Grilo 1998, Zanarini 2003

Reasons for improvement

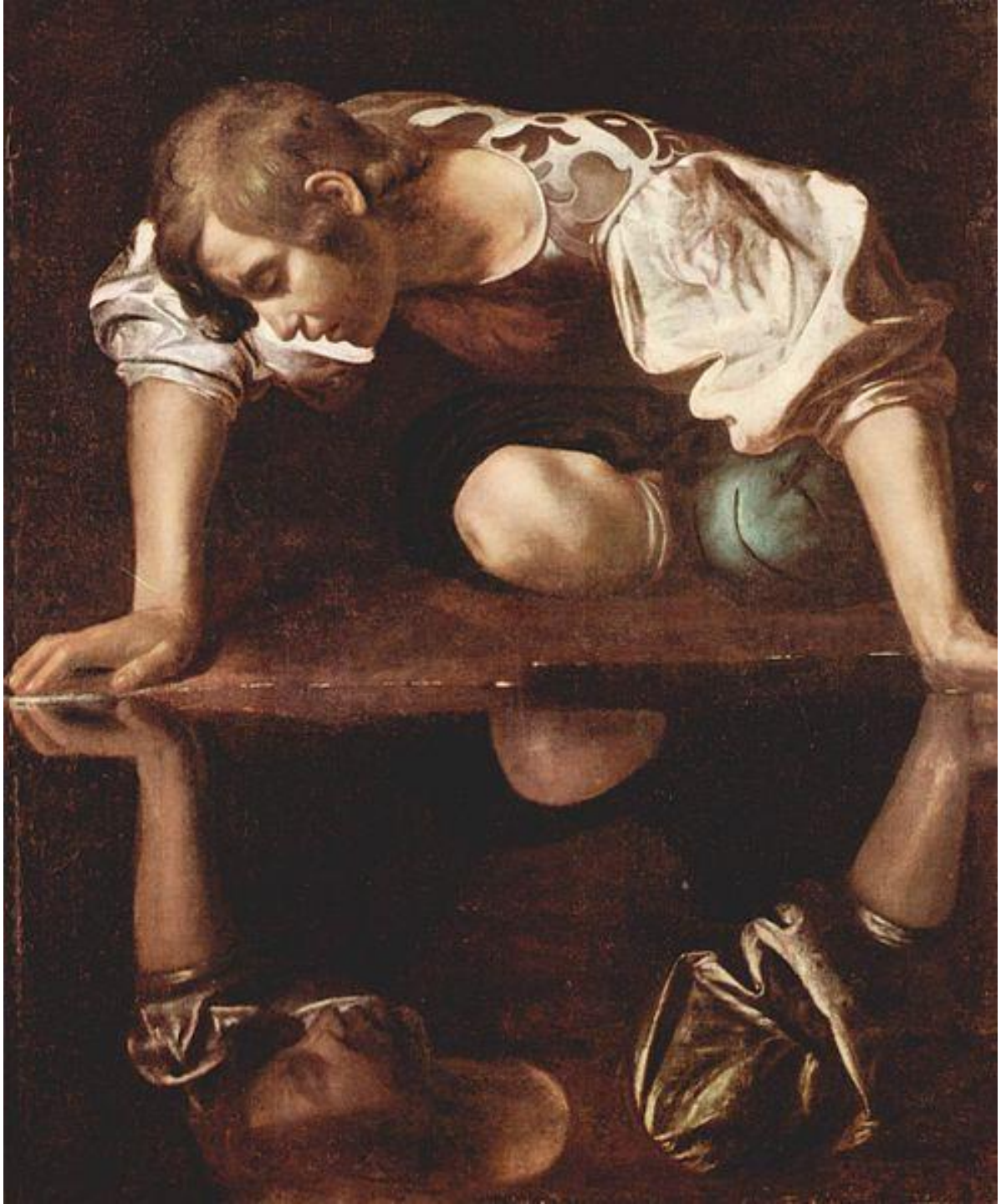
- Maturation- impulsivity decreases with age
- Social learning- increase skills over time
- Avoidance of conflictual intimacy – most develop employment, social network but have troubles with intimacy

Source: Gunderson and Links 2008

Poor prognostic factors

- Early childhood sexual abuse
- Early first psychiatric contact
- Chronicity of symptoms,
- Higher affective instability, aggression,
- Substance use disorder,
- Greater number/severity of BPD pathology
- Ongoing substance use

Source: Skodol 2002, Zanarini 2004



Narcissistic personality disorder

Disordered Personalities Mnemonic

- **A FAME GAME**

- **A**ttention required in excessive amounts

- **F**antasies: unlimited success, beauty, brilliance
- **A**rrogant
- **M**anipulative
- **E**nvious of others

- **G**randiose sense of self importance
- **A**ssociates with special people
- **M**e-first attitude
- **E**mpathy for others is lacking

Two types of Narcissistic personality disorder patients
Psychodynamic Psychiatry in Practice (Gabbard)

The Oblivious Narcissist	The Hypervigiliant Narcissist
1. No awareness of reactions of others	1 Highly sensitive to reactions of others
2. Arrogant and aggressive	2. Inhibited and shy
3 Self – absorbed	3. Direct attention more towards others than toward self.
4 Needs to be centre of attention	4. Shuns being the centre of attention
5 Has a sender but no receiver (e.g. broadcasting lengthy messages about oneself on facebook)	5. Listens to others carefully for evidence of slights or criticisms
6. Is apparently impervious to having feelings hurt by others	6. Has easily hurt feelings; is prone to feeling ashamed or humuliated.

A patient can alternate between the oblivious and hypervigilant state.

Approach for NPD

- NPD patients usually present as medical or surgical patients.
- Respect their entitlement: “A” class patient.
- Be supportive and praise positive aspects of their lives.
- Patients with NPD have very high expectations. Need to ensure one’s clinical competency in a condition when looking after NPD. They may be right in their complaints.
- They are more prone to take medico-legal actions. The best way to avoid legal issue is to build trust with patients.
- Frequent update and explanation about management plan.
- Involve patients with NPD in decision making.
- Avoid narcissistic injury (NI): criticism of non-compliance, humiliation (e.g. Physical exam in front of a lot of medical students), avoid rejection in appointment.
- Be flexible with NPD patients in appointments.

Further discussion