COOLAROO CLINIC MANAGEMENT

SGL 21/12/17

PERSONALITY DISORDER (PD)

Dr John Hodgson presented, out-lining his approach to patients with PD: how to identify, taking a more relevant history, and the pit-falls of management.

In our catchment area there are many patients with PD, and because of our Clinic's culture of trying to help, we attract a lot of them!

Points:

1. **Emotional Control**: (How to recognize the problem). Patients with PD basically have poor emotional control. Their emotions **DRIVE** their actions, so they exhibit poor judgement and behavior. This in turn leads them to drug taking (attempts at self-management), bad driving and infringements, stress and anger (and all the societal problems associated with anger). This creates a **BURDEN** that can become intolerable, leading to self-harming. (The physical pain brings them back to reality: it is easier to deal with physical pain rather than emotional pain).
2. They do not see themselves or their behavior as part of the problem. It is always someone else's fault. Solutions to their problems are expected to be actioned by someone else.
3. Self Esteem: measures of self-esteem have been rising. There are 2 sorts of self-esteem:
    a. Those who work hard, are empathic and knowledgeable, so their lives are fulfilling and rewarding.
    b. Those who strut. They are opinionated, loud, brash and don't care. They report a lot of self-confidence, but their behavior is often not socially acceptable and it is often a large contributing factor in domestic violence. They show no shame.
4. **History:** One is looking for their ability to cope, their ability to express and be aware of the emotional content in scenarios or past experiences. Because they can't cope, they tend to avoid situations and may run away or stand and fight (These are unhelpful behaviors). I feel this is one of the causes for anxiety. (I think anxiety is more common than depression). One gets the feeling that they did not "fit-in" during their life. I find it is best to judge this by asking about their life. Split it up into time periods:
    a. Birth to primary school:
        i. This is the period where emotional control begins: eg: temper tantrums. Good parenting directs the child to "go over there (remove yourself from the situation) and calm down" (let the emotion dissipate and regain emotional control).
        ii. Did they have a happy childhood?
        iii. How do they get on with parents? Were there any major emotional traumas (mother not available, parent's separation, family deaths or major rivalries, etc.)? Parents are supposed to provide us with a warm, fuzzy early life: we have fairy stories where "everybody lived happily ever after". They protect us from the real world. If the real world intrudes into life, they sweep us up and protect us. If this time of our life is unsupported and hence fearful, our brains get "hard-wired" differently to those of us who felt loved and protected.

iv. Fear is the greatest driver of change; the antidote is *genuine* love. Fearful people become hypervigilant, constantly on edge, and can't relax (the "fight or flight response"). We relax and our vigilance settles when we feel wanted and loved.

b. Primary school:
   i. Was it enjoyable?
   ii. Did you learn anything?
   iii. Look out for them "being the class clown": gains attention and is then viewed by the child as peer acceptance.
   iv. If they are always in trouble, is this because they are frightened?
   v. If a child plays up in class and spend a lot of time outside the principal's office, what do they learn?
   vi. Primary School is the time when children need to learn more about relationships with non-family, so friendships are important. Look for signs of loneliness, awkwardness and of being ostracized. Be particularly aware of the child who **survived their childhood** rather than enjoyed it.

c. Secondary school: PUBERTY and our becoming aware of ourselves starts. The two stages:
   i. "Am I normal"? Body shape and characteristics. Pimples. Spend time in front of the mirror. Clothes.
   ii. This is followed by "who am I'? Exploring relationships with others, dealing with "the outside world" and periods of intense emotional turmoil. Who did you trust? Who could you talk to? Often it's a grandparent, uncle or aunt, a good family friend or neighbor (good role models). Beware the person who says "no-one", because, why not? Beware when the major support dies, moves away, or abuses. Did they seek solace in alcohol or other drugs (escapism)? The majority of us had to "tough-it-out" so huge self-learning curve about who you are and your place in the world.

d. Post school:
   i. What age did they leave school? Year 11 and 12 you have to develop opinions and self-reflect, but up until then it was largely "write down what the teacher says", so not a lot of independent thinking development.
   ii. **History on quality and length of time of** employment, relationships, accommodation and financial management helps assess coping. (If poor, do you think they have been "running away" from issues?)
   iii. What age were they when their problems started. The later the age the problem started, the longer they had to learn early life-coping skills. Did they learn resilience?
   iv. If their early life had emotional turmoil, and they survived this, they often don't understand how they managed this. Hence, they don't recognize this emotional problems arising, but rather blame their problems on: partner left; started drugs; got in trouble with the law; lost my job, etc. In such cases you may need to help them to "join-the-dots". Point out your suspicion that their past skills relate to the present problem

5. **Examination:** Note their facial expression, their body posture, and in particular whether these are *congruous with the emotion* you would expect: if the story sounds terrible, do they seem appropriately upset? Note their tone of voice, use of words and their overall expression. Are they angry, fearful, paranoid, manic, or tangential? What were they talking

about when their *voice wavered or the tear appeared in their eye*? Do you think they are selfish and don't really care about anyone else? Those with PD often do not appear to have the appropriate emotion you would expect. The world centers around them. A lot of language around: "they should"; "the boss has to listen to me"; "my partner or kids must". **"Why do "they", the boss or partners "Have to"?** Where is the law that says so? They do not see themselves as part of the problem: they want everything to work the way they want to; **they expect the doctor to fix it!**

6. **Medication:** beware!! Medication is not going to fix any of the above. It may settle the emotion, but the risk is dependence, because ultimately we have to learn to live with our emotions. They eventually dissipate and become less poignant and painful. Time allows them to settle.
7. **Counselling:** (I prefer to call this teaching) This is based upon CBT that has now morphed into:
    a. ACT (acceptance commitment therapy): one accepts that life throws problems your way, and you're committed to finding solutions.
    b. Mindfulness: one is aware of one's emotions and what is going on around one. However, if I stop, take a deep breath, and focus on the sounds, wind, sunlight, hunger, clothes against my skin, the seat I'm sitting in, etc for 30 seconds. This allows one to consider: "I'm OK. Calm down. Things will be OK. **I** can do……"

Counselling teaches us ways to cope. Somehow we are expected to learn this as we get older. Who teaches us? **If we missed learning about how to control our emotions, how to get our point of view across without getting angry, how to deal with frustration, boredom, or worry, counselling is the solution. In fact, *it's the only solution*, so frequently the doctor's management needs to be directed at *starting* the patient's learning about how to cope.**

Remember the DBT approach, the steps:

STOP

WHAT IS THE PROBLEM?

THINK OF 3 POSSIBLE SOLUTIONS

PICK THE BEST SOLUTION AND PUT IT INTO ACTION

REVIEW PROGRESS: IF IT'S NOT WORKING, GO BACK TO THE FIRST STEP **(people have a tendency to keep trying to make a solution work instead of attempting a different solution: talking about possible solutions is very helpful!)**

8. **Worry:** Problems can either be solved or not solved. If they can't be solved, they have to be lived with. Worrying about them leads no-where except to make us stressed. Often the most stressed are those who are trying to cope with too many problems.
9. **Triggers:** when we remember past events, we also have a return of the emotions we felt at the time. This is what happens in PTSD. Significant anniversaries do this, deaths, trauma, etc. Beware the parent who was traumatized at a certain age, and their children are approaching the same age.

There are lots of on-line resources and helpful websites. Good starting points are:

"headtohealth.gov.au"

"beyondblue.org.au"

I still use the SPHERE booklets that go through structured problem solving, because, when I have complex and difficult patients, I find using this approach is non-threatening to the patient, they can engage in the process without getting distressed, and it shows them the way I want them to think.

I no longer do counselling. I prepare patients to go to counselling by explaining to them how it works. This may take some sessions, and I just talk to them about their life in general, their happiness, and that we all need some time to stop thinking, planning and worrying!

SUICIDE RISK

When a person presents in crisis with elevated suicide risk, treatment is aimed at reducing the emotional turmoil.

Explore the emotions by asking them about them. Answering questions gets them to think about their answer, and they have to stop thinking about how bad the burden is. This may take some time.

The aim is to settle them, but not teach, explore or counsel, because they are not in the right frame of mind to learn. Give them simple strategies to follow if their emotions return. These are

RING TRIAGE, LIFELINE, ETC. Give the phone numbers, and make sure they put these in a place where they are easily found.

EXPLORE THEIR INTENT AND IMMIDIATE SUPPORTS: Often people say "but I wouldn't because of ….." (Often children or family). Have their photo or a reminder of them close at hand. If method is OD, put a photo of them beside the drugs; if method is outside, put photo on the exit door; if it involves a car, put photo on steering wheel. Discussing this makes it seem you care, and it helps relieve the emotional burden.

REVIEW THEM BY PHONE OR IN PERSON WITHIN A FEW HOURS, OR NEXT COUPLE OF DAYS DEPENDING ON YOUR CONCERNS AROUND RISK.

At the review, just ask how they are and whether your suggestions were helpful. Ask if they wish to prevent this in the future? If they don't want to, this is a problem and future management is aimed at getting them to change their mind. If they do, offer them a mental health plan and explain the counselling process that occurs when they see a psychologist. If they don't, future management is aimed at changing this view. If they do like the idea, get them back for a long appointment and complete the Mental Health Plan and referral.

Hence, the process is:

Review the management crisis and offer more help. Prescribing medication can be considered. This is usually a level B or C consult. Judge their readiness for change.

Get them back to start change by doing the Mental Health Plan. Usually a 40 to 60 min consultation (2717)