

## Cluster B Assessment @ Halliwick PD Pathway

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ASSESSMENT IS A DIFFICULT INTERVENTION. Patients generally do not like being assessed - as it implies the help may be withheld if “you do not meet our criteria”. Clinicians have not seen the patient previously - thus there is a lot of uncertainty and consequent tendency to procrastinate. Our aim is to create a short document helping the already experienced professional to tell likely Cluster B Personality Disorder patients from those with other major psychiatric disorders. Assessment tends to be shorter if there is good information available on RiO (Notes/Documents-Reports) or in the referral. Assessment is a balance between a very thorough approach (which generates a lot of write-up and can lead to procrastination) and a good-enough approach which is shorter, but nevertheless leads to understanding of the diagnosis and patient’s wish to engage with our service.

### Important traits for EUPD (aka. BPD)

- **Inflexibility from early on** - very hard to shift emotion/behaviour patterns in response to emotional stress. This is not something that would start in mid life or late twenties - traits and problems should start manifesting at least from late teens.
- **Self-harm** - this often is a way to alleviate intolerable emotional distress. It is unusual for mood disorder patients to use self-harm this way. Remember about **Suicidality** - a completed suicide rate for BPD is about 10%.
- **Mood lability** - rapid swings - for BPD high or low mood would not persist for days or weeks and mood shifts are often reactive to interpersonal difficulties.
- **Close relationships** - severe attachment difficulties lead to quickly shifting idealisation and devaluation of relationship partners, often relationships are short lived and marked with fears of abandonment and pleading for the partner not to leave.
- **Impulsivity** - in at least 2 areas that are likely to be self-damaging (e.g. addictions, sex, reckless driving, aggression, bingeing, etc.).
- **“Identity diffusion”** - shifting goals, values, friendships, sexual identity, blurred boundaries between self and others, easily overwhelmed by other people’s projections, tendency to “evacuate emotions”, intrusiveness, very quickly idealising/devaluing in transference relationship.
- **Transient psychotic or dissociative states** - usually in response to emotional distress.



Figure 1: Unstable, intense relationships



Figure 2: Self-harm

If there are good *pre-existing reports* and assessments you do not necessarily need to ask for the same information. It would be wise, though, to check with the patient the items that appear diagnostically salient to you.



Figure 3: Mood swings

If the patient is actively using a significant amount of drugs like cannabis or alcohol, or any amount of “hard drugs” (like cocaine, crack or heroin) - they need to address the drug use prior to considering any psychological interventions.



Figure 4: Identity diffusion



Figure 5: Impulsivity

### *Features of Antisocial Personality Disorder (ASPD)*

ASPD is a pervasive pattern of disregard for and violation of the rights of others. To diagnose there should be evidence of conduct disorder with onset before age 15 and there should be evidence of at least three of the following since the age of 15:

- Repeatedly breaking the law and/or social norms
- Deceitfulness, repeated lying, use of aliases, or conning others for pleasure or personal profit.
- Impulsivity or failure to plan ahead.
- Irritability and aggressiveness, often with physical fights or assaults.
- Reckless disregard for the safety of self or others.
- Being consistently irresponsible (e.g. cannot sustain consistent work behavior, or honor financial obligations)
- Lack of remorse, being indifferent to or rationalising having hurt another person.

### *Diagnostic tools*

SCID PERSONALITY DISORDERS INTERVIEW is long - 132 questions listing all personality disorder symptoms. For each question the clinician has to make up their mind whether the symptom is *definite* (2), *subthreshold* (1) or *not present* (0). All patients receive a preliminary SCID questionnaire to respond to - which is a useful thing to review before your first assessment session. However that self-report questionnaire is not diagnostic in itself. It is best used to identify symptoms (answered with “No”) that may not need further asking about. Full SCID interview is best reserved for particularly complex cases, because presently we cannot afford to do it for everyone - then every assessment would likely take at least 3 to 5 sittings.

### *What interventions to consider*

FOR PEOPLE WHO **do not** MEET THE DIAGNOSTIC CRITERIA. Discharge back to the referrer or locality CMHT - if disorder is severe enough to likely need care coordination. Typically BPAD, psychosis or a primary mood / anxiety disorder. Other sources of therapy - for example **PT** (psychotherapy) pathway which offers psychodynamic or



Figure 6: Anger



Figure 7: Fear of abandonment

Remember - the outline on page 4 is a guide. You probably will be able to write something under each of the headings, or maybe 70% of them. You definitely should have a formulation, a risk summary and a plan.



Figure 8: Risky behaviours



Figure 9: Suicidal threats



Figure 10: Feelings of emptiness



Figure 11: Suspiciousness, derealisation

CAT therapy as well as group therapy. **MAP** pathway (think cluster C, hypoactive personality disorder). **PTSD** pathway for PTSD. CBT therapy is also available. External therapy could be provided by voluntary sector or low fee schemes (look into “Resources” folder on the shared drive). Referrals to other NHS therapy programmes are possible (e.g. Tavistock or Cassel) with good justification and usually obtaining funding from CCG.

FOR PEOPLE WHO **do** MEET THE DIAGNOSTIC CRITERIA. Structured Clinical Management (**SCM**) - either to deal with the problems in short pulses of treatment (with reviews in between), or **CAT informed SCM**. SCM often can prepare people for **MBT**. Full 18 months MBT programme - mostly for BPD. The first step for MBT is **MBTi** - a 10 session psychoeducational group. For people who are primarily presenting with ASPD - pulses of SCM are available and we may be able to organise **ASPD MBT group** once-weekly, if we have sufficient number of patients.

IN THE INTERIM - during waiting times it is important to explain availability of *crisis services* - calling 999, samaritans, going to A&E, referral to the local Crisis Team. During the day the assessing clinician (this applies for assessment period and treatment waiting period) can be contacted through calling Halliwick reception, although we may not be able to respond on the same day.

### *Mentalizing and Attachment*

Mentalizing is the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes. Nevertheless, human beings can temporarily lose awareness that others have minds, and can even at times treat one another as physical objects.

Mentalization is not a static, unitary capacity, but a dynamic, multifaceted ability that has particular salience in the context of *attachment relationships*. Temporary lapses in mentalization are part and parcel of normal functioning, but the ability to continue to mentalize even under stressful circumstances, and a relatively fast recovery from lapses in mentalization, are the hallmark of robust mentalization. Robust mentalization is strongly related to secure attachment.

**Hyperactivation Strategies.** To manage their internal states and interactions with others, people with BPD tend to use attachment hyperactivation strategies in which the anxious BPD attaches to others easily and quickly. This often results in disappointment for two reasons: first, attachment hyperactivation causes individuals to form inappropriately intense attachments to others; second, it inhibits neural systems associated with judging the trustworthiness of others. Thus, BPD patients rapidly idealize their treatment and therapist, become overtrusting, and tend to overstep normal social boundaries. However, when their needs are not met, BPD patients may quickly reverse their strategies by becoming dismissive, hostile, and critical. With such patients, it is not recommended to offer treatment in an environment overstimulating of attachment (for example, an in-patient unit or a therapy that intensifies the patient-therapist relationship too early).

**Deactivation Strategies.** By contrast, BPD individuals who primarily use attachment deactivation strategies, such as emotional distance, are able to keep mentalization longer on-line. In the face of interpersonal stress, they emotionally distance themselves. Under increasing levels of stress, these deactivating strategies tend to fail, leading to a strong reactivation of feelings of insecurity, heightened activation of negative self-representations, and increased levels of internal distress.

## Assessment Interview

- **Presenting Complaint.** What brings the patient to the assessment and reason for referral.
- **Current psychiatric symptoms (Axis I)** and level of functioning. Check symptoms associated with the presenting complaint as well as the ones important to make a differential diagnosis.
- **Personal History** (development and life events). Ask for developmental history and main object relations. Check for developmental delays and difficult life events (i.e. history of abuse and neglect, bullying, trauma)
- **History of Axis II symptoms**
  - See on the first page: diffusion of self, self-harm, impulsivity, unstable emotions and relationships, etc.
  - Reflective Function. Think about the patient’s capacity to *mentalize* and make use of interpretations.
  - Defences/Coping Mechanisms. Think about the defence mechanisms used by the patient in assessment as well as defences employed during difficult periods of their life.
- **Risk Assessment** (historical and current)
  - To self (self harm, suicide)
  - To others
  - From others
  - Non-compliance, self-neglect, etc.
- **Drugs and alcohol**
- **Psychiatric History**
  - Include previous hospitalisations, psychotherapy, medication, other treatments, etc.
- **Family Psychiatric History**
- **Medical History** (include *current medications, allergies*)
- **Forensic History**
- **Social History** (Patient’s main relationships, social network, housing, financial situation and employment)
- **Formulation** Integrate the findings obtained in the assessment and write your diagnostic impression, including your formulation (summary) of risk and ability of the patient to make use of therapy.
- **Care Plan** Provide a care plan that integrates biopsychosocial interventions.
- **Crisis Plan** Agree with the patient on a plan as to how to deal with a crisis. This will usually involve contacting the responsible clinician during working hours, and contacting the crisis team or attending A&E out of hours.

If the presentation includes psychotic or dissociative symptoms, their short length and emergence during periods of emotional stress may suggest EUPD instead of a primary psychotic disorder.

In BPAD symptoms of depression / mania / hypomania tend to last for days or weeks, are not reactive to interpersonal difficulties and do not get resolved by changes in the environment.

During manic episodes there is heightened energy, reduced need for sleep, thought disorder, often persistent psychotic symptoms and disinhibition - which are not characteristic of EUPD.

EUPD patients quickly idealise or devalue their clinicians. They mostly see others as “good or bad”, not being able to tolerate ambivalence and mixed feelings towards others.

Be attentive to the patient’s risk, in particular with patients that avoid speaking, conveying “that nothing is wrong” while appearing detached from their emotions.

Check what patients think of previous psychotherapy as this gives an indication whether they would be able to make use of a new episode of treatment.

Think whether motivation to seek treatment is genuine and personal or if it is to comply with someone else’s wishes or demands.

If you have doubts or questions regarding your assessment, you can present the case at the weekly **assessments workshop on Tuesdays** at 14:00. Try to be focused and specific with your queries.

This assessment guidance has been compiled by Dr Klotins and Dr Ventura-Wurman. It is, however, is a collective piece of work and if you notice some bits that would be especially helpful to pay attention to when assessing patients, you should use below link to submit your thoughts. What you say will be anonymous, unless you type in your name alongside your observation. Click on [is.gd/pdbassmt](https://is.gd/pdbassmt) or type it in your phone’s browser (e.g. Chrome).