National Comorbidity Guidelines

Face-to-Face Training Program

Module 5: Personality Disorders

Participant Workbook

Funded by

Australian Government
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Delivered by

THE UNIVERSITY OF SYDNEY
Matilda Centre

360edge.

The training development team

Paula Ross, 360Edge

Nicole Lee, 360Edge

Christina Marel, the University of Sydney's Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

Erin Madden, the University of Sydney's Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

Katherine Mills, the University of Sydney's Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

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W: comorbidityguidelines.org.au

E: enquiries@comorbidityguidelines.org.au

The University of Sydney's Matilda Centre for Research in Mental Health and Substance Use

Personality Disorders

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Personality disorders

Agenda

Understanding personality disorders

Helping clients with AOD use and personality disorders to manage symptoms

What treatments work for clients with AOD use and personality disorders

Clients in AOD treatment

Borderline Personality Disorder (BPD)
37–66%
more commonly women

Antisocial Personality Disorder (ASPD)
61–72%
more commonly men

NOTES

Guiding principles

Guiding principles

First, do no harm

Work within your capacity

Engage in ongoing professional development

Recognise that the management of comorbidity is part of AOD workers' core business

Provide equity of access to care

Adopt a 'no wrong door' policy

Guiding principles

Recognise that comorbidity is common and that all clients should be routinely screened for comorbid conditions

Conduct ongoing monitoring of symptoms and assessment of client outcomes

Adopt a holistic approach

Adopt a client-centred approach

Emphasise the collaborative nature of treatment

Have realistic expectations

Guiding principles

Express confidence in the effectiveness of the treatment program

Adopt a non-judgemental attitude

Adopt a non-confrontational approach to treatment

Involve families and carers in treatment

Consult and collaborate with other health care providers

Ensure continuity of care

Understanding personality disorders

NOTES

How do people with personality disorders present in AOD treatment?

- Impulsivity
- Challenges in social relationships including suspiciousness
- Difficulty forming positive therapeutic alliance
- Difficulty accepting or utilising feedback
- Emotional detachment or excessive attachment and dependence
- Emotional instability
- Pervasive and persistent anger
- Inflexibility

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DSM-5 diagnoses of personality disorder

Enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture

Pervasive and inflexible

Onset in adolescence or early adulthood

Stable over time

Leads to distress or impairment

NOTES

Clusters

Cluster A	Cluster B	Cluster C
Odd or eccentric	Dramatic, emotional, erratic	Anxious or fearful
Paranoid	Antisocial	Obsessive-compulsive
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Avoidant
	Narcissistic	

There are ICD-10 codes to match these DSM-5 diagnoses found in Appendix D of the Comorbidity Guidelines

NOTES

Module 5 Activity 1: Personality Disorder match up

Match the description with the personality disorder.

Description	Personality disorder
Need to be taken care of, submissive, fearful of separation	Paranoid personality disorder
Detachment from social relationships, restricted range of expression of emotion	Schizoid personality disorder
Excessive emotionality and attention seeking	Schizotypal personality disorder
Social and interpersonal deficits, discomfort with close relationships, cognitive and perceptual distortions, behavioural eccentricities	Antisocial personality disorder
Social inhibition, inadequacy, hypersensitive to negative evaluation	Borderline personality disorder
Impulsivity and unstable interpersonal relationships, self-image and affect	Histrionic personality disorder
Preoccupation with order, perfection, mental and interpersonal control	Narcissistic personality disorder
Disregard for, and violation of, rights of others	Avoidant personality disorder
Distrusting and suspicious of others	Dependent personality disorder
Grandiose, need for admiration, lack of empathy	Obsessive-compulsive personality disorder

Do's and don'ts of managing a client with symptoms of personality disorders

- ✓ Place strong emphasis on engagement to develop a good client-worker relationship and build strong rapport
- ✓ Set clear boundaries and expectations regarding the client's role and behaviour. Some clients may seek to test these boundaries
- ✓ Establish and maintain a constant approach to clients and reinforce boundaries
- ✓ Anticipate compliance problems and remain patient and persistent
- ✓ Plan clear and mutual goals and stick to them; give clear and specific instructions
- ✓ Help with the current problems the client presents with rather than trying to establish causes or exploring past problems

Do’s and don’ts of managing a client with symptoms of personality disorders

- ✓ Assist the client to develop skills to manage negative emotions (e.g., breathing retraining, progressive muscle relaxation, cognitive restructuring)
- ✓ Take careful notes and monitor the risk of suicide and self-harm
- ✓ Avoid judgement and seek assistance for personal reactions (including frustration, anger, dislike) and poor attitudes towards the client
- ✓ Listen to and evaluate the client’s concerns
- ✓ Accept but do not confirm the client’s beliefs

Do’s and don’ts of managing a client with symptoms of personality disorders

- ✗ Reward inappropriate behaviour (such as demanding, aggressive, suicidal, chaotic or seductive behaviour)
- ✗ Get frustrated and angry with the client. Remain firm, calm and in control
- ✗ Assume a difficult client has a personality disorder; many do not, and many clients with these disorders are not difficult

Asking about personality disorders

It is important for clinicians to develop comfort and familiarity asking about symptoms. This is not to conduct a full mental health assessment or diagnose but to be able to:

- Understand a client's experience
- Understand the relationship between symptoms and AOD use
- Monitor symptoms throughout treatment
- Consider what impact personality disorder symptoms might have on treatment engagement and participation

NOTES

Navigating working with clients with AOD disorders and symptoms of personality disorders

Take a non-judgemental stance

Many traits are malleable, assisted by good treatment and corrective life experiences

Monitor your evaluation of the client. Pay attention to negative cognitions

Separate your own experience from the client's intention ("I feel X but this was not the client's intention")

Think carefully about why the client is engaging in the behaviours you find challenging

Beck Institute (2019)

NOTES

Module 5 Activity 2: Case study Sophia. Comorbid substance use and symptoms of personality disorder

- Sophia, 40 year-old female.
- Completed intake and assessment with your agency four months ago. Has engaged extremely well with the intake worker and reception staff who express concern for her. Initial few sessions seemed to go well. Has attended six times, but cancelled and failed to attend many appointments. Continues to engage and request appointments. Often attends with a crisis to talk about in detail.
- Sophia has a 20-year history of problematic alcohol use.
- History of childhood trauma and unstable relationships.
- One daughter (22 years). Sophia has limited contact with her daughter who lives independently and has her own mental health and severe AOD use problems. Sophia's granddaughter (18 months) has been removed from her mother and is living with her paternal grandmother. Sophia is very distressed about her daughter's situation and that the baby was not placed with her.
- Repeatedly tells you that her goal is to work with you on her mood and drinking. When you attempt to discuss these goals with her she becomes distressed that these things have not improved, or becomes angry with you that you are not listening and helping her with her current crisis.

Activity continued over page

Module 5 Activity 2: Self-reflection worksheet

(adapted from www.beckinstitute.org/working-with-borderline-personality-disorder)

What negative cognitions might I have about Sophia?	______________________________
What is the precise behaviour Sophia is engaging in?	______________________________
What does her behaviour mean to me?	______________________________
What is a more neutral or compassionate explanation for why she is behaving in this way?	______________________________
What would I like to see her do instead?	______________________________
Are there any conversations I could have with her that might be helpful for our work together?	______________________________

Borderline personality disorder

A diagnosis of BPD is associated with a more severe profile and reduced retention in residential AOD treatment

Recent research indicates BPD may be associated with a history of trauma

Some propose that terms such as ‘complex developmental trauma’ may be more useful

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Domains

Frantic efforts to avoid real or imagined abandonment	A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation	Identity disturbance: markedly and persistently unstable self-image or sense of self
Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)	Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour	Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
Chronic feelings of emptiness	Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)	Transient, stress-related paranoid ideation or severe dissociative symptoms

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Module 5 Activity 3: Relationship between Borderline Personality Disorder and substance use

How might substance use help someone with these symptoms? How might it make these symptoms worse?

Emotional dysregulation	
Interpersonal difficulties	
Behavioural issues	
Cognitive issues	
Sense of self	

Helping clients with AOD use and BPD - what works?

Dialectical Behaviour Therapy (DBT) and DBT-S (skills based)

Dual Focus Schema Therapy (DFST)

Dynamic Deconstructive Psychotherapy (DPP)

Little research for comorbid PD / substance use together. Psychotherapy as first line intervention, more research needed before pharmacotherapy is recommended

Alternative treatments: omega-3, physical activity

Further information:

Comorbidity Guidelines (Chapter B6)

Project Air Webinar https://www.mhpn.org.au/WebinarRecording/105/Personality-Disorders-and-Substance-Use-Tips-on-Effective-Treatment-Approaches#.XYc1kZMzbOS

NOTES

What can an AOD clinician do?

Recommended stages of treatment for BPD are

1. Develop alliance
2. Symptom reduction
3. Deal with personality disturbance

Focus on 1. and 2.

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Develop alliance

- See things from client perspective and tell this to the client
- Collaborative style that checks with the client “have I got this right?”
- If client presents as easily overwhelmed keep questions and feedback cognitive “what do you think about…”
- Provide a formulation and treatment plan that makes sense to the client and invite feedback

NOTES

Symptom reduction

Ensure agreement on what to focus on first

Obtain agreement on goals and tasks

Examples of treatment for symptom reduction

Suicidality/self harm – DBT

Emotional dysregulation - DBT

Anxiety – CBT, Mindfulness

Depressive symptoms - CBT

AOD use – MI

NOTES

Module 5 Activity 4: Skills practice formulation and treatment planning

1. Work in pairs, with one person role playing the clinician and one person role playing Sophia (refer to case study in Activity 2).
2. The clinician reflects on their formulation and treatment plan to Sophia and invites feedback.
3. The clinician then discusses with Sophia what symptoms to focus on as a priority and has a brief discussion on the therapeutic tasks and strategies that might be involved.
4. The facilitator will then ask you to reverse roles, and repeat steps 2-3.
5. The new person role playing Sophia chooses a different symptom reduction priority for treatment to ensure a different discussion.

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