BPD GUIDANCE

Assessment, Diagnosis and Formulation

CCC PRINCIPLES:

- **Empathic service response and development of a good treatment alliance**
- **Collaborative and meaningful goal-setting**
- **Psycho-education for patients, families and friends**

BACKGROUND:

Borderline personality disorder (BPD), also known as Emotionally Unstable personality disorder, is a condition that has historically been under-diagnosed for a number of reasons, including concern about stigma, staff not feeling confident about making this diagnosis and negative views about the course and treatability of the disorder. It could be considered discriminatory not to make a diagnosis, as this may prevent the individual from accessing appropriate information, accessing evidence-based care and treatment, and it leads to under-representation of this diagnosis in healthcare planning and policy. **Accurate diagnosis, formulation and treatment planning maximises the chance of recovery** from this condition, which is associated with so much distress, poor functioning and resource uptake.

BPD should be considered as a diagnostic possibility from an early point in the assessment process, rather than only receiving consideration later in the process when other diagnoses have been excluded. Early consideration of the diagnosis helps to avoid situations where people receive inappropriate, unnecessary and sometimes harmful treatments. Diagnostic review should also be considered for people who are already engaged in services, where this seems a better fit for that person's presentation than their current diagnosis.

A comprehensive and careful diagnosis and formulation is essential, because treatment for people with BPD is significantly different from treatment for people with substance misuse, depression, post-traumatic stress disorder, bipolar disorder or psychotic symptoms who do not have BPD.

A careful diagnosis and formulation has a number of additional benefits:

- engaging the person in treatment, including their role in self-management
- clarifying the level of risk,
- creating a sense of hope for the future
- identifying pathways to effective therapies.
- establishing rapport
- identification of psychosocial problems which may interfere with treatment
- facilitating a multi-disciplinary approach to care and recovery

Personality disorders are by their very nature complex, and therefore often require relatively more time to assess than many other disorders. Three to four sessions to assess and formulate is not untypical.

It is important for the clinician to remain:

- empathic and validating
- respectful
- non-judgemental
- encouraging
- hopeful about the person's capacity for change, whilst validating their situation and current state.

Ref: CCC3 Tips on Empathy and Validation

STEP by STEP GUIDANCE:

1) Does the person meet the diagnostic criteria for BPD?
2) Embedding the diagnosis within a multi-disciplinary formulation
3) Developing a collaborative plan for moving towards recovery
4) Plan for ongoing review, and re-formulation

1) Does the person meet the diagnostic criteria for BPD?

Reaching a diagnosis might be relatively straightforward, or may only become clear over the course of several assessment appointments in the community or during periods of observation in an in-patient setting. A diagnosis of BPD should be considered if the person is presenting with any of the following:

- Frequent suicidal, self-harming behaviour or risky behaviour
- Marked emotional instability
- Multiple co-occurring psychiatric conditions
- Non-response to established treatments for current psychiatric symptoms
- A high level of functional impairment

Current diagnostic criteria are found in ICD-10 and DSM-V (Appendix 1)
ICD-11 is due to be implemented in Scotland from Nov 2022 (Appendix 2)

If the person presents with complex difficulties and/or it is difficult to distinguish between possible co-morbid disorders, then:

- Consider the use of the multi disciplinary team, e.g.
  - complex case discussion
  - assessment by medical staff with expertise in diagnosis
  - assessment / consultation with psychology staff to help develop a comprehensive formulation
- Consider use of a diagnostic or screening tool **(Appendix 3)**

Making a diagnosis of BPD can be challenging for less experienced health professionals. The symptoms of BPD overlap with those of other psychiatric disorders (e.g. depression, substance use disorders, eating disorders, post-traumatic stress disorder, bipolar disorder, psychosis) *and* other personality disorders, and these conditions may co-occur in a person with BPD. Support and supervision from experienced staff and the wider team will help ensure all staff develop the confidence to participate in the process of diagnosis.

Diagnosis should be seen as the start of a process which allows for review and change over time. It is important to remember that the course of a personality disorder is likely to include remission of affective and impulsive symptoms over time, although social and functional impairments may be more resistant to treatment.

Once the diagnosis is clear, this should be recorded on EMIS If someone no longer meets diagnostic criteria, the diagnosis should be amended on EMIS

People in a state of crisis may struggle to engage collaboratively in the process of diagnosis and formulation. Interpersonal difficulties are a core feature of BPD, and the person may attend sporadically, or drop out of contact. In such situations a working diagnosis can be held by the care team, which is built upon gradually, if and when they re-present to the service. It is sometimes this pattern of poor engagement which can trigger the diagnostic process, or help confirm it.

2) <u>Embedding the diagnosis within a formulation</u>

How to develop a shared formulation

Making the diagnosis establishes the symptom profile of the person's current presentation, combined with an overview of the onset, development, and severity of the difficulties. It is important to embed this information within an individualised formulation that brings a sense of context and understanding about how the difficulties have developed, what the maintaining factors are, and what the implications might be for the person moving forward.

FORMULATION: THE 5Ps

Presenting Problems:	BPD symptoms and the impact of these on the person's functioning; risk
Predisposing Factors:	Trauma informed history taking (consider inclusion of significant others)
Precipitating Factors:	What has triggered presentation to services / need for diagnosis at this time?
Perpetuating Factors:	Consider coping mechanisms, relationships, environmental and social factors that are helping to maintain the person's distress and difficulty
Protective Factors:	Consider existing personal strengths, coping mechanisms, relationships, environmental and social factors that might be available to support recovery

Ref: CCC 5, 6, 7 Formulation Templates and Examples

In most cases, a formulation can be developed within CMHT and / or ward settings. This is best done in discussion with the multidisciplinary team over more than one appointment. A comprehensive history, ideally including a history from another source (family, support worker, friend etc.), forms the basis of formulation. This must include a sensitive and trauma informed exploration of early life experiences and attachment relationships, including experiences of abuse or neglect. It is important to establish a pattern of personality traits and functioning over time and in different circumstances.

The process of diagnosis and developing a formulation can be a helpful intervention in itself. There may be cases where this is the end point of contact

Communicating the Diagnosis and Formulation

The diagnosis should be discussed with the person (and their family, partner or carer, if appropriate). Health professionals should only do this when they are reasonably confident that the diagnosis is correct.
Health professionals should take care to maintain a balance between validating the person's problems and experiences, and promoting a view that change is possible, through a shared effort.
A formulation driven approach will help the person understand the context in which their difficulties have arisen, and thus develop a more compassionate understanding of their experience of BPD and to become involved in their own recovery. This should include a realistic but hopeful view of the likely course of the disorder, ie that this is not necessarily a diagnosis for life.

After a thorough assessment process, the clinician should:

- confirm the diagnosis of BPD, and explain what this condition means
- draw on the formulation to help the person understand the context in which these symptoms have arisen
- give a hopeful message about the natural course of the disorder and therapeutic approaches that might be available
- give the person information (e.g. fact sheets, reliable websites) **(Appendix 4)**

- advise the person that some of the information about BPD that they may find on the internet is misleading
- invite the person to ask any questions about the diagnosis
- discuss whether the person would like to inform their family, partner or carers of their diagnosis.

Sometimes people experience relief when given a diagnosis that makes sense to them and their difficulties. Some people may experience distress if they are told the diagnosis at an inappropriate time or context. The diagnosis must be explained carefully, using non-technical language. The term 'borderline' is often confusing to people with BPD and their families and friends and, for some people it may have associations with blame and stigma. People can also struggle with the term "personality disorder", as it can seem like something about them as a person is "wrong" or "flawed". Therefore, the clinician should explain the condition in a sensitive, non-judgemental way that conveys that it is not the person's own fault, but a condition that is thought to develop from a mix of genetic and environmental risk factors.

Consider offering post-assessment support
Post-assessment support is particularly important when sensitive or traumatic material has been discussed. This can include out-of hours or Crisis Team phone numbers.

Discuss the involvement of family/ friends
Discuss whether the person would like to inform family members or close friends of their diagnosis. If so, discuss how you can best support the person in this process. For example, would it be beneficial to set up a meeting between the clinician, the person, and their carer/s, or would the person prefer to inform them on their own? It may be useful to provide the carer with Fact Sheets about diagnosis, treatment, and how the family can best support the person. (**Appendix 4)**

3. Developing a collaborative plan for moving towards recovery

As part of the diagnosis and formulation it is important to conceptualise where in the recovery journey the person might be, and what the most appropriate intervention might be at this point in time.

The Plan might include:

- A discussion about whether support from the CMHT is required at this time.
- Consideration of third sector support (emotional, practical, or activity based)
- A treatment plan within the care team (CMHT or inpatient ward) utilising CCC (Co-ordinated Clinical Care) principles
- Establishing a crisis management plan including management of risk (See separate Guidance Document on Crisis Management)
- Review of readiness for change
- Consideration for referral to evidence based therapy for treatment of BPD
- Consider referral for other psychological therapies
- Consider role of Occupational Therapy in supporting occupational and social engagement, function and reasonable adaptations in relation to employability

needs. Inclusion of the wider network (family, friends, social services, crisis teams) in the development of crisis / staying well plans or goals for therapy and support required to facilitate this

APPENDIX 1:

ICD-10 Diagnostic Criteria

Box 1: General Criteria for Personality Disorder - F60

1.	A personality disorder is an enduring pattern of inner experience and behaviour. This pattern manifests in two or more of the following areas: a Thinking b Feeling c Interpersonal relationships d Impulse control
2.	This pattern deviates markedly from cultural norms and expectations.
3.	This pattern is pervasive and inflexible.
4.	It is stable over time.
5.	It leads to distress or impairment

F60.3 Emotionally Unstable Personality Disorder

	Impulsive Type F60.30	**Borderline Type F60.31**
A	**General Criteria for PD (F60) must be met**	
B	**At least three of the following** must be present, one of which must be (2):	**At least three of the following** must be present:
	1) Marked tendency to act unexpectedly and without consideration of the consequences	1) Marked tendency to act unexpectedly and without consideration of the consequences
	2) Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized;	2) Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized;
	3) Liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions;	3) Liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions;
	4) Difficulty in maintaining any course of action that offers no immediate reward;	4) Difficulty in maintaining any course of action that offers no immediate reward;
	5) Unstable and capricious mood.	5) Unstable and capricious mood.

		PLUS At least two of the following in addition: 1) Disturbances in an uncertainty about self-image, aims and internal preferences (including sexual);
		2) Liability to become involved in intense and unstable relationships, often leading to emotional crisis;
		3) Excessive efforts to avoid abandonment;
		4) Recurrent threats or acts of self-harm;
		5) Chronic feelings of emptiness.

DSM-5 diagnostic criteria for BPD

Borderline Personality Disorder	
A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) or the following:	
1.	Frantic efforts to avoid real or imagined abandonment (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5)
2.	A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
3.	Identity disturbance: markedly and persistently unstable self-image or sense of self
4.	Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating) (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5)
5.	Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
6.	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)
7.	Chronic feelings of emptiness
8.	Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9.	Transient, stress-related paranoid ideation or severe dissociative symptoms

APPENDIX 2

ICD-11 (To be Implemented in Scotland from Nov 2022)

ICD-11– Personality Disorder – F6 D10 – Diagnostic Requirements

Step 1 - Essential Features

- An enduring disturbance characterized by problems in functioning of aspects of the self and/or interpersonal dysfunction
- The disturbance has persisted over an extended period of time (e.g., lasting 2 years or more).
- The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive
- The disturbance is manifest across a range of personal and social situations
- The symptoms are not due to the direct effects of 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

Step 2 - Severity Determination

Once the diagnosis of a Personality Disorder has been established, it should be described in terms of its level of severity:

- Degree and pervasiveness of disturbances in functioning of aspects of the self
- Degree and pervasiveness of interpersonal dysfunction across various contexts and relationships
- Pervasiveness, severity, and chronicity of emotional, cognitive, and behavioural manifestations of the personality dysfunction
- The extent to which the dysfunctions in the above areas are associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

Severity Levels:

- 6D10.0 Mild Personality Disorder
- 6D10.1 Moderate Personality Disorder
- 6D10.2 Severe Personality Disorder

There is also a sub-threshold category in ICD-11:

- QE50.7 Personality Difficulty

Personality Difficulty is not classified as a mental disorder, but rather is listed in the grouping of Problems Associated with Interpersonal Interactions in the chapter on Factors Influencing Health Status or Contact with Health Services. Personality Difficulty refers to pronounced personality characteristics that may affect treatment or health services but do not rise to the level of severity to merit a diagnosis of Personality Disorder.

Step 3 – Trait Domains

Personality Disorder and Personality Difficulty can be further described using five trait domain specifiers. These trait domains describe the characteristics of the individual's personality that are most prominent and that contribute to personality disturbance. As many as necessary to describe personality functioning should be applied.

Trait domain specifiers that may be recorded include the following:

- 6D11.0 Negative Affectivity
- 6D11.1 Detachment
- 6D11.2 Dissociality
- 6D11.3 Disinhibition
- 6D11.4 Anankastia

Step 4 - Borderline Pattern Qualifier

Clinicians may also wish to add an additional specifier for 'Borderline pattern':

- 6D11.5 Borderline pattern

The Borderline pattern specifier has been included to enhance the clinical utility of the classification of Personality Disorder. Specifically, use of this specifier may facilitate the identification of individuals who may respond to certain psychotherapeutic treatments.

Borderline pattern

The Borderline pattern specifier may be applied to individuals whose pattern of personality disturbance is characterised by:

- Affective instability
- Recurrent suicidal behaviour, gestures or threats or self-mutilating behaviour
- Difficulty in maintaining any course of action that offers no immediate reward
- Frantic efforts to avoid real or imagined abandonment
- Pattern of unstable and intense interpersonal relationships
- Identity disturbance
- Chronic feelings of emptiness
- Impulsivity and/or inappropriate intense anger or difficulty controlling anger
- Transient stress-related paranoid ideas or severe dissociative symptoms

Coding Note: This category should ONLY be used in combination with a Personality disorder category (Mild, Moderate, or Severe) or Personality difficulty.

APPENDIX 3

Suggested Rating Scales/ Screening Tools for BPD

- **PDQ-4**
- **BSL-23**

These tools have been suggested as at the time of writing these are free to use in NHS GGC

Check that you have permission to use any rating scales or instruments: Please check the library's QUEST site, as this contains a list of instruments which have been previously checked by the library.

APPENDIX 4

MIND "Understanding borderline personality disorder" MIND information leaflet

RETHINK MENTAL ILLNESS "Borderline personality Disorder" RETHINK information leaflet

PROJECT AIR Fact Sheets for families and carers available at www.projectairstrategy.org