

West Lothian Health and Social Care Partnership Personas for Emotionally Unstable Personality Disorder and Complex Post- Traumatic Stress Disorder Pathway

How these personas were developed

- These are needs-based, clinical practice personas
- They were developed by drawing on **existing literature around matched care models** (West Lothian Integrated Care Pathway for EUPD and cPTSD) and combining this with **clinicians' extensive experience** of supporting and treating people with EUPD and Complex PTSD.
- The personas were put together by identifying **common patterns** seen in clinical practice across groups of individuals. Hence, they are **archetypes, not stereotypes or caricatures**. These common patterns include:
 - common challenges faced by people and their needs
 - severity and complexity of presentation and/or diagnosis
 - the level of risk associated
 - the type and intensity of support they may need
 - common treatment goals that individuals may have

Why use personas and how to use them?

- These personas provide realistic examples that help staff think through and have a structured conversation around:

What is the person's need, which phase of intervention should they start with to meet that need, and how does that phase match their needs?

- The personas can be used in several ways, including staff training and development, education and awareness, and pathway discussions with staff, agencies and services involved.
- Frontline staff can use personas to facilitate a conversation around types of coordinated actions required for people with similar needs and challenges
- They can be used **alongside the pathway visualisation** or on its own during team-based assessment, formulation and treatment interventions through active self-reflection.

Personas



Alex

Alex's has asked for treatment for flashbacks and nightmares. She has a history of repeated relational trauma in childhood. She is working but has had to take some days off following panic attacks. **She has previously had two previous presentations to unscheduled care following self-harm** around the time of disclosure **but no subsequent crisis presentations over the last 18 months.**

What Alex finds difficult

- Flashbacks and nightmares
- Feeling unsafe and high levels of current anxiety
- Panic attacks triggered by re-experiencing
- Difficulty being around men alone
- Historic self-harm to manage flashbacks

Alex's Goals

- To reduce flashbacks and nightmares
- To reduce anxiety and feel safe day to day
- To make sense of and process traumatic memories
- To get back to hobbies and interests and be able to go into town with friends without feeling scared

Safety and Stability

Alex describes fleeting thoughts of suicide when highly distressed but no current or previous intent. There is no current self-harm. Her friends are significant protective factors, and she states she would never act on thoughts of suicide.

Right now:

Risk: Alex does not feel at risk of harming herself

Alcohol & Substances: No current concerns

Functioning: No concerns regarding adaptive functioning and currently working .



Phase 2: Trauma Re-processing

Interventions

Alex wants support to help make sense of her traumatic experiences and their impact

She has done some reading on complex PTSD, is able to manage the distress of discussing her experiences and has some pre-existing coping strategies that she finds helpful

Psychological Therapies
Service: Trauma-Reprocessing Therapy



Ben

Ben is 19 and has a history of repeated interpersonal trauma in childhood. He began to experience flashbacks and nightmares during his first serious relationship. He describes intense shame regarding his experiences and becomes highly distressed when talking about the past. He has stopped working and is drinking more than usual because of how he is feeling

What Ben finds difficult

- Flashbacks and nightmares
- Feeling unsafe and high levels of current anxiety
- Severe shame and self-blame
- Intermittent binge drinking (x1 per month) when out with friends to manage feelings and 'appear normal'.

Ben's Goals

- For nightmares and flashbacks to stop
- To feel less guilty and ashamed
- To learn how to manage emotions.
- To feel safe and comfortable around friends without alcohol

Safety and Stability

Ben denies any current thoughts or plans of suicide. He states he would never do this due to his strong faith beliefs. He **struggles to talk about his feelings without being highly distressed, anxious and ashamed**

He is **using alcohol more than he would** like at the weekends to help him feel normal and less anxious while socialising with friends.

Risk: Ben does not feel at risk of harming himself

Alcohol & Substances: Intermittent binge drinking. Not dependent. Recognises this as an unhelpful coping strategy

Functioning: No concerns regarding self-care, not currently working, recognises unhelpful alcohol use .



Phase 1:

Safety & Stabilisation
Emotion Regulation
(Mild Need)



Phase 2:

Trauma Re-processing

Service & Intervention

- Ben needs some help managing his emotions before he will be able to manage Phase 2 interventions.
- He'd benefit from learning more about trauma to normalise and validate his experiences and reduce shame.

Psychological Therapies Service:

Men's Survive & Thrive Group then
Phase 2 Trauma-Reprocessing
Therapy



Jen

Jen is 40 and recently experienced the breakdown of her marriage. Following an overdose, Jen was admitted to medicine and then transferred to Ward 17. During this admission, Jen received a diagnosis of Emotionally Unstable Personality Disorder (EUPD), although clinicians had previously queried this diagnosis during earlier mental health assessments at unscheduled care. Jen has a history of previous overdose and has attended crisis services.



Phase 1:

Safety & Stabilisation
Emotion Regulation
(Moderate Need)



Phase 2:

Trauma Re-processing

What Jen finds difficult

- Fear of rejection and abandonment
- Managing overwhelming emotional distress
- Coping with the impact of her marriage breakdown
- Frequent superficial self-harm (scratching), particularly during times of distress

Jen's Goals

- To feel more in control of her emotions
- To reduce impulsive self-harm

Safety and Stability

Jen does not experience chronic suicidal thoughts, but there are times when she becomes overwhelmed by distress and self-harms. Jen has had previous contact with crisis services, including **four crisis presentations over the past three years and one inpatient admission. Jen's diagnosis was based on her history and previous clinical notes**

Risk: Frequent superficial self-harm (scratching) when distressed. Previous overdose and crisis presentations.

Alcohol & Substances: No concerns

Functioning: Jen is currently at work, even though she had to take a few days off due to her mental health, no concerns about adaptive functioning

Intervention

Does not need MDT support but would benefit from additional emotional regulation support before engaging in longer-term psychological therapy.

West Lothian
CPN team

Psychological
therapies



James

James is 25 and has a diagnosis of Complex PTSD and EUPD. He has longstanding difficulties with emotional regulation, relationships and chronic suicidal thoughts, with frequent presentations to A&E, crisis services with previous inpatient admissions. James often expects to be let down by services, which can make engagement difficult.



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Phase 1: Safety & Stabilisation
Emotion Regulation
(Significant Need)



Phase 2:
Trauma Re-processing

What James finds difficult

- Managing overwhelming emotions and periods of intense distress
- Living with chronic suicidal thoughts that can quickly escalate to an acute risk when distressed
- Maintaining relationships with other people
- Trusting clinicians and services, often expecting to be let down and under threat of being banned from his GP and 3rd sector due to aggressive outbursts. (shows remorse quickly but no behaviour change)
- Feeling angry and frustrated when talking about previous experiences of seeking support
- Seeing clinicians as either very helpful or very unhelpful, with these views changing quickly
- Working with male clinicians due to the impact of previous trauma

Jame's Goals: James wants help with managing anger and distress and help with his relationships. Also wants help managing his substance use

Safety and Stability

James has **frequent contact with the police following suicide attempts (not always intoxicated).**

He **frequently presents to A&E and crisis services** and has a history of inpatient admissions. At the A&E James often presents highly dysregulated, demanding admission and alleging overdose. Although he frequently settles following assessment interview with ACAST, he continues to experience repeated crises.

Risk: Chronic suicidal ideation with multiple episodes of acute risk, recurrent suicide attempts and **self-harm through burning** with a recent presentation to A&E after burning himself

Alcohol & Substances: Has **co-morbid substance** use with infrequent amphetamine use.

Functioning: Difficulties across multiple areas of life including relationships, emotional regulation and engagement with support services

Interventions

- GP referred for assessment of possible bipolar affective disorder.
- Reviewed by a consultant psychiatrist for 6 monthly review.
- Working diagnosis was Complex PTSD, with EUPD under further assessment. Since the locum consultant moved on, James' risk has escalated.
- Diagnostic understanding should be developed through review of the person's history and repeated presentations.
- Aggression may suggest antisocial PD, rather than male presentation of EUPD - consider clinical judgment

CMHT: James was initially referred by GP for bipolar disorder, but assessment suggested complex PTSD and EUPD. Similar stories may not always referred with a confirmed diagnosis. ACAST more likely involved in crisis presentations and as a bridge to existing community care



Jane

Jane is a 48-year-old mother of two with a diagnosis of EUPD. Jane's children are moving out due to work and college, which has had a significant impact on her. Jane finds feelings of rejection and abandonment particularly difficult and frequently seeks support when distressed. When she feels unsupported or unable to access help quickly enough, her distress can escalate and increase the likelihood of overdose and presentation to A&E.



Phase 1: Containment



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Phase 1: Safety & Stabilisation
(Significant Need)



Phase 2:
Trauma Re-processing

What Jane finds difficult

- Feeling "fed-up" is a trigger and can lead to crisis
- Adjusting to significant life changes, including her children becoming more independent
- Feeling unsupported or dismissed by those around her
- Tolerating delays in support when distressed

Jane's Goals

- To have additional support through a difficult period
- To feel more supported when distress increases
- To manage crises without needing hospital admission where possible

Safety and Stability

Jane has a history of overdose and alleged overdose, with presentations to A&E

increasing during periods of heightened distress. Recent changes in family circumstances have led to an escalation in risk.

Risk:

- Jane's chronic risk is linked to feelings of rejection and abandonment and is reflected in repeated presentations to A&E following paracetamol overdose.
- Since her children began moving out, there has been an escalation in distress and risk.
- When Jane feels unable to access support quickly enough from her CPN, she is more likely to attempt paracetamol overdose, requiring urgent treatment with NAC and admission to A&E.

Alcohol & Substances: No concerns identified.

Functioning: Current family changes have increased Jane's emotional distress and reliance on crisis support.

Intervention

- **Previous joint working between CMHT and ACAST has worked well for Jane**, helping to manage periods of crisis and prevent hospital admission. Staff who know Jane well recognise that coordinated support across services is particularly effective for her.
- **ACAST involvement would usually occur following a crisis presentation**, rather than through a direct CMHT request. However, CMHT can alert ACAST if there are concerns that Jane may present in crisis or attend A&E out of hours. This helps ensure that ACAST are aware of the situation and can support joint working if needed.
- **The severity of Jane's self-harm would be a concern to psychiatrist and would like input from a multidisciplinary team.** Jane's difficulties have previously been discussed in the context of EUPD and CPTSD.

ACAST usually after crisis presentation, +/- joint working with CMHT

CMHT: Do both safety and trauma processing



Emily

Emily is 35 and has been working with the West Lothian CPN Team for the past three years. She has a diagnosis of Complex PTSD and recurrent depression.

Emily recently took an overdose. The trigger is unclear, although she describes feeling "fed up" with feeling this way. She continues to experience ongoing suicidal thoughts and feels that her current support has not fully met her needs.

What Emily finds difficult

- Explaining her needs or describing her emotions
- Putting into practice previous distress tolerance and decider skills, doesn't have faith in them

Emily's Goals

- To "feel normal"
- To not feel like she has different personalities
- To feel more stable and predictable
- To understand herself and better articulate her needs.

Safety and Stability

- **Emily doesn't feel depressed just doesn't want to be here anymore.** Depressive disorder is recurrent
- Feels at risk of harming herself and ending her life, reflects that she feels like this all the time
- previous admissions have been therapeutic, resulted in improved mood and have been beneficial in the treatment of comorbid depression – no evidence of escalating risk in inpatient setting

Risk: Recent overdose and ongoing suicidal ideation.

Alcohol and Substances: No concerns identified.

Functioning: Ongoing emotional distress is affecting Emily's wellbeing and sense of hope



Phase 1: Safety



Phase 1: Containment



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Phase 1: Safety & Stabilisation
(Significant Need)



Phase 2:
Trauma Re-processing

Intervention

- Ongoing support from the WL CPN Team but not sure how CPN support has been helpful.
- The CPN has requested a consultant review of Emily's antidepressant medication.
- MDT intervention is increasingly indicated and more appropriate to Emily's needs, transfer from West Lothian CPN team to CMHT
- Emily is willing to accept additional support, including home treatment.
- Emily would also consider hospital admission if required.

Ward:
Admission may be beneficial

ACAST: periods of intensive home treatment as an alternative to admission

CMHT: Do both safety and trauma processing



Fiona

Fiona is 42 and has a diagnosis of EUPD and Complex PTSD, with a history of childhood sexual abuse, serious self-harm, and a recent overdose requiring medical treatment on a ward.

What Fiona finds difficult

- Changes in nursing staff
- Putting previous distress tolerance skills into practice
- Putting previous decider skills into practice
- Describing her emotions
- She has been stable for a while and has been destabilised by a life event

Fiona's goals

- To be able to use previous distress tolerance when emotions are heightened
- To be able to maintain a relationship and be involved in her daughter's life

Safety and Stability

- Her difficulties with mood instability have deteriorated with the upcoming court case of the person who sexually abused her when she was a child.
- Escalating self-harm to be contained and prevented from further escalation
- Previous self harm required plastics intervention
- Staff feel her self-harm can escalate when admitted to the ward
- Need to balance the management of acute and chronic risk. Short admissions may be needed, but should be brief enough to avoid becoming counter-therapeutic

Risk: Ongoing suicidal thoughts, recent overdose and serious self harm . **Fiona has expressed that she is not regretful about the overdose and continues to report feeling that she does not want to be here.** Risk for Fiona increases in inpatient setting due to Fiona's feelings of subjective rejection and abandonment

Alcohol and Substances: No concerns identified.

Functioning: Self-harm can signal significant distress and a need for care. Indicator for an ACP

