A Brief Psycho-educational Intervention for Cluster B personality disorder

Clinic Record Sheet

These structured recording sheets are a resource to help you structure and plan each session, and also to record the outcome and plan for the next session. The contents are not meant to be restrictive so much as a guide and a support.

Please do not use this intervention without appropriate training, support and supervision from the Complex Cases Service, CPFT

This workbook for clinicians has been produced by the Complex Cases Service: the specialist, tertiary service (within the Cambridgeshire and Peterborough NHS Foundation Trust) for people with personality disorder. As such, it provides consultation and advice to primary and secondary care services, and oversees the implementation of NICE guidance: "Borderline personality disorder: treatment and management", NICE clinical guideline 78, January 2009.

This workbook is intended to be helpful to clinicians who have been trained to deliver a brief psycho-educational intervention to patients with Cluster B personality disorder for whom the, in compliance with Nice guidance, such support would be appropriate.

If you have any queries, or suggestions as to how the workbook could be improved, do please contact the authors; you can do so by e-mailing us on:

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Introduction

The object of the intervention is to increase the patient's knowledge about personality difficulties and to help them take simple steps that may improve their level of functioning. Each session is prescribed in some detail. The therapist should attempt as best as possible to adhere to the agenda for each session while also allowing the patient to air their own issues to a certain extent.

Principles of management

In all the sessions four principles of management apply:

I. In advance, having a plan for a crisis.

Make sure that you and the patient both know what to do in the event of a crisis or sudden disaster. Likewise, ensure that the person responsible for taking action and 'picking up the bits' also knows that that is their role.

II. Active management of strong feeling

Actively manage strong feeling in sessions. Express sympathy and support and allow a certain amount of ventilation, but also use gentle methods of moving the patient back to a calmer frame of mind. During expressions of very strong feeling (affect storms) stay calm yourself and wait, doing very little other than reflecting and sympathising with the difficulties. Note if the patient is becoming more or less vehement. If the patient is calming down slowly then wait until this has happened before starting any new part of the session. If the patient is becoming more distressed then suggest various things e.g. time out from the session (for example for a cigarette) or offer a token of support such as a glass of water or a cup of tea. If the patient still becomes more distressed, end the session gently and if necessary call for help.

III. Flexible but persistent pursuit of objectives.

Patients with Cluster B personality disorders have very variable moods and attitudes. They find task persistence difficult and may present very differently from session to session. In this brief intervention the therapist needs to be responsive to the different states that the patient presents from session to session or within sessions. Nevertheless, the therapist needs to keep the session's objectives in mind and deliver them as best as possible.

IV. Boundaries and Supervision

Patients with personality disorder have a tendency over time to enact unhelpful patterns of behaviour with others with whom they are in close contact. Even in this brief psycho-educational intervention this may begin to happen. Note particularly any strong positive or negative feelings that the patient evokes or violations (sometimes quite subtle) of therapeutic boundaries, and take these to you supervision for discussion. Keep notes of each session, recording the content of the session and behaviour of the patient.

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Patient details: ……d.o.b. ……..

Clinician name: …….…….

(designation:) ……

Supervisor: …….…….

Start Date[1]: …….

Instructions: this document will necessarily become part of the patient's clinical notes. Please sign and date the bottoms of each page in the space provided.

Your supervisor signs the relevant pages to confirm this document as a record also of your supervision.

[1] i.e. date of first face-to-face contact with respect to this intervention.

Session 1: Hearing the story.

Recording a history should be like telling a story. Write a narrative account of the patient's life and current troubles.

Signed and dated: …….

(Session 1: Hearing the story.)

Signed and dated: …….

(Session 1: Hearing the story.)

Now try to think about some of the following questions if they are not already covered:

I. Why and how was the patient referred for treatment on this occasion?

II. What is the patient's view of their problems and what do they think might be wrong with them.

III. Has the patient had treatment in the past and if so what did they think of it - was it effective?

IV. What sort of treatment (if any) does the patient think would be most helpful and why?

Signed and dated: …….

(Session 1: Hearing the story.)

SUPERVISION: General points to record in collaboration with your supervisor.

1) My current plan for a crisis during the intervention is:

2) In this session I had to manage strong feelings by:

3) In this session it was hard to pursue the session objectives because:

4) I will need to revisit the following issues with my supervisor:

5) My plan for the following session is:

Signed and dated by supervisor: ……

Signed and dated: …….

Session 2: Explaining the condition.

It is often helpful to systematically go through the diagnostic criteria and features with the patient and to work out how each feature manifests itself in the patient's life and how relevant each feature is to them.
Below the key features are listed:

If a feature is relevant to your patient explore with the patient and then record how it has affected them and what problems it has caused.

I. *Fear of Abandonment*. When it seems as though important people might go away the patient feels frantic and tries everything they can think of to get the person back.
If relevant, then explore. Record how affected and problems caused.

II. *Interpersonal instability.* Relationships with other people are always very strong. It seems as though everyone is either a really important good person who the patient wants to get close to or a rotten bad person who is threatening. Sometimes the same person can seem good and bad in the same day even.
If relevant, then explore. Record how affected and problems caused

III. *Unstable sense of self.* It is terribly hard for the patient to know what they want to do, who they really are and what their true wishes and feelings are.
If relevant, then explore. Record how affected and problems caused.

Signed and dated: …….

IV. *Mood instability.* It seems as though the patient can never tell what mood they will be in. They can be up one minute and then miserable the next.
If relevant, then explore. Record how affected and problems caused.

V. *Waves of feeling awful*. A particularly nasty feeling is a wave of misery, self disgust and agitation that just comes out of nowhere and lasts a few hours or a day or so. At such times it is hard to function and the patient feels they cannot bare it and would do anything to end the state.
If relevant, then explore. Record how affected and problems caused.

VI. *Self as "bad", "evil" or "disgusting"*. The patient reports a strong inner feeling that they are bad or wicked or disgusting in some way. Even if other people say that this is not so the patient feels that this is just because other people have not realized it yet.
If relevant, then explore. Record how affected and problems caused.

VII. *Problems with anger.* Sometimes the patient gets incredibly angry and even has outbursts of fury which may lead to them suffering from the reactions of others.
If relevant, then explore. Record how affected and problems caused.

VIII. *Impulsivity.* Lots of times the patient suddenly gets it into their head to do things that they later regret and which seem in retrospect to be quite dangerous or damaging.
If relevant, then explore. Record how affected and problems caused.

Signed and dated: …….

IX. *Suicidal behaviour*. The patient has made previous efforts to end their life or behaved in such a way as to put their life at risk with the thought that it might end.
If relevant, then explore. Record how affected and problems caused.

X. *Self-harm.* The patient uses self harm to end bad feelings or to punish themselves.
If relevant, then explore. Record how affected and problems caused.

XI. *Unhelpful mood-altering behaviours.* The patient uses drink or drugs or sex or risky behavior to block out bad feeling and for a thrill because life feels so difficult and hard to cope with.
If relevant, then explore. Record how affected and problems caused.

XII. *"Emptiness".* The patient experiences a feeling of being empty on the inside.
If relevant, then explore. Record how affected and problems caused.

XIII. *Transient(?) psychotic symptoms.* On occasion things have been so bad that the patient has felt that people were threatening them or plotting against them and might even have heard voices or thought people were talking about them or to them in circumstances where this was not likely.
If relevant, then explore. Record how affected and problems caused.

Signed and dated: …….

(Session 2: Explaining the condition.)

SUPERVISION: General points to record in collaboration with your supervisor.

1) My current plan for a crisis during the intervention is:

2) In this session I had to manage strong feelings by:

3) In this session it was hard to pursue the session objectives because:

4) I will need to revisit the following issues with my supervisor:

5) My plan for the following session is:

Signed and dated by supervisor: ……
Signed and dated: …….

Session 3: Awareness of risk and self-harm

Make persistent, systematic but gentle enquiry into all areas of risk, self neglect and self harm.

If you have immediate concerns about the safety of your patient or others then gently end the session and seek help

I. Seriously risky behaviours.

Deliberate suicide attempts, overdoses (of any kind), other seriously risky behaviours.

- What have they done?

- What was the reason for these behaviours? Did they have some benefit to the patient at the time? Did they seem like the only option?

- How did things turn out? How was the patient affected, how were other people affected?

- Did the patient ever have a go at changing the behaviour or the situation that produced it? If so what happened as a result?

Signed and dated: …….

- Does anything make the behaviour definitely worse?

II. Self harming behaviors

Cutting, burning, hitting oneself, other self harm.

- What have they done?

- What was the reason for these behaviours? Did they have some benefit to the patient at the time? Did they seem like the only option?

- How did things turn out? How was the patient affected, how were other people affected?

- Did the patient ever have a go at changing the behaviour or the situation that produced it? If so what happened as a result?

- Does anything make the behaviour definitely worse?

Signed and dated: …….

III. Risky behaviors

Reckless driving, unsafe sex, unsafe use of drink or drugs to deal with feelings, other.

- What have they done?

- What was the reason for these behaviours,? Did they have some benefit to the patient at the time? Did they seem like the only option?

- How did things turn out? How was the patient affected, how were other people affected

- Did the patient ever have a go at changing the behaviour or the situation that produced it? If so what happened as a result?

- Does anything make the behaviour definitely worse?

Signed and dated: …….

IV. Plans for change

- Is the patient able to identify any behaviors that they might be able to change?

- What would be the benefits of change?

- What would be the problems with changing?

- What plan could the patient have for changing?

Signed and dated: …….

(Session 3: Awareness of risk and self-harm))

SUPERVISION: General points to record in collaboration with your supervisor.

1) My current plan for a crisis during the intervention is:

2) In this session I had to manage strong feelings by:

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Signed and dated by supervisor: ……

Signed and dated: …….

Session 4: Leading an ordered life.

Take the patient systematically through their daily life identifying whether their lifestyle choices are beneficial to them

I. Sleep

How does the patient sleep? Is the pattern normal? Do they go to bed and wake at regular and usual times of the day and night? Does the patient sleep during the day? Does the patient use sedatives (alcohol or pills)? Does this pattern of sleep work well for the patient or does it debilitate them?

II. Eating

How does the patient eat? Do they eat regular meals and usual foods? Are they too fat or too thin? Is there evidence of an eating disorder? Does this pattern of eating work well for the patient or does it debilitate them?

III. Exercise

Does the patient take regular physical exercise? If they do is it excessive or appropriate? If the patient does not exercise have they ever considered it? Does this pattern of exercise work well for the patient or does it debilitate them?

Signed and dated: …….

IV. Occupation.

How does the patient fill their day? Do they have a job or an occupation? If they do is it satisfying or is it something they dread? If the patient has no regular occupation what do they do with themselves during the day? Does this pattern of activity work well for the patient or does it debilitate them?

V. Routine.

How is the pattern of life structured? Does the patient have a regular routine and plan how they will spend their time? If they do is it rigid and demanding or appropriate? If the patient has no plans is their life chaotic and unstructured? Does this way of managing routines and plans work well for the patient or does it debilitate them?

Signed and dated: …….

VI. Plans for change

- Is the patient able to identify any aspects of their daily routine that they might be able to change in ways that would be helpful to them?

- What would be the benefits of change?

- What would be the problems with changing?

- What plan could the patient have for changing?

Signed and dated: …….

(Session 4: Leading an ordered life)

SUPERVISION: General points to record in collaboration with your supervisor.

1) My current plan for a crisis during the intervention is:

2) In this session I had to manage strong feelings by:

3) In this session it was hard to pursue the session objectives because:

4) I will need to revisit the following issues with my supervisor:

5) My plan for the following session is:

Signed and dated by supervisor: ……

Signed and dated: …….

Session 5: Developing a crisis plan.

A. Crisis Timeline

- What are the main crises that the patient experiences?

- Typically, how do they start?
  - What provokes them - situations, feelings, actions of others, actions by the patient?

- What happens as they evolve?

- How do they usually end?

- When they end badly what are the bad things that happen for the patient? for others?

- When they end more OK what causes this better outcome?

Signed and dated: …….

B. Coping with crisis.

I. Prevention

- Are there any provoking situations the patient could avoid?

- Are there any ways in which other people could help the patient prevent a crisis?

- How will the patient ask them to help?

II. Coping if a crisis evolves

- Are there things that the patient could do to cope better during a crisis?

- Are there people who could help the patient during a crisis?

Signed and dated: …….

- How will they be asked to help?

- Are there any things that should definitely be avoided?

- How will they be avoided?

III. Calling in help from services

- When might the patient or a relative need to call in help from services?

- How will this be done?

Signed and dated: …….

- Who will be available?

- What should they do?

IV. What should the patient and other people do if the crisis plan breaks down for some reason or doesn't work?

Signed and dated: …….

(Session 5: Developing a crisis plan))

SUPERVISION: General points to record in collaboration with your supervisor.

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Signed and dated by supervisor: ……

Signed and dated: …….

Session 6 – Saying goodbye

I. **Write the patient a short letter summarizing the main points that arose out of the treatment.**

Signed and dated: …….

(Session 6: Saying goodbye)

Signed and dated: …….

II. Take time to review the sessions with the patient.

- From the patient's point of view what were the main good things in the therapy?

- From the patient's point of view what were the main things that they will try to use in the future that seem helpful?

- From the patient's point of view were there any big outstanding problems/issues that the sessions could not address?

- How does the patient see the future?

- What are the main positive/hopeful features?

- What are the main worries or fears?

Signed and dated: …….

- What was your view of the sessions?

III. If another worker needs to see this patient in the future what important things should they know which would help them?

Signed and dated: …….

(Session 6: Saying goodbye)

SUPERVISION: General points to record in collaboration with your supervisor.

Signed and dated by supervisor: ……

Signed and dated: …….

Overview of Objectives and Strategies for each session

Session 1: Hearing the story.

Objectives

1) Induct patient into the treatment plan.
2) To gain a narrative understanding of the patient's story and difficulties, getting as good as possible a sense of the way the patient sees them.
3) To give the patient feedback on their story showing them how aspects of the story are consistent with their personality difficulties, and floating the diagnosis of personality disorder.
4) To begin to detoxify the diagnostic label by showing acceptance that the patient's difficulties are real and troubling. Expect and acknowledge that such acceptance may not always have been the patient's past experience of interactions with staff.

Strategies.

- Tell patient the treatment plan and give leaflet.
- Ask open-ended questions.
- Non-judgemental curiosity.
- Following affective threads.
- Pacing feedback to the patient's reaction.
- Giving direct information/explanation about Cluster B personality disorders.
- Acknowledging and accepting previous experiences of poor care.

Session 2: Explaining the condition.

Objectives

1) To give the patient basic information about the condition and to explore the ways in which the condition manifests in the patient's life and story.
2) To help the patient understand repetitive patterns in their life and their current difficulties as related to the diagnosis of personality disorder.

3) To give the patient access to appropriate sources of further information about the condition. The choice of such information will depend upon the patient's level of educational attainment, their access to information sources, and their wish for information.

Strategies.

- Providing verbal and written information about personality disorder.
- Fitting or 'personalising' this information to the patient's particular experience.
- Pointing out repeating patterns in the patient's life and asking the patient if they can give examples of other patterns.
- Linking repeated difficulty to the features of personality disorder.

Session 3: Awareness of risk and self-harm

Objectives

1) To explore with the patient any and all risky or self-harming/self-destructive behaviours they may use to help them cope.
2) To help the patient see that these activities might be helpful in the short term but may also have long-term ill effects.
3) Selecting only one or two behaviours and using a 'minimax' strategy (minimum effort to change for maximum gain if change is achieved) to explore possible ways of changing behaviour.

Strategies

- Persistent systematic (but gentle) enquiry into all areas of risk, self-neglect and self-harm.
- Exploration of the reason for these behaviours, including acknowledgement of their utility in managing mood states.
- Exploration with the patient of the consequences of these behaviours on themselves, their relationships and other people.
- Identification of the most harmful and worrying behaviours, and of previous effective efforts the patient has made to change behaviour.
- Identify things that worked and things that didn't work to change the behaviours.
- Exploration of one or two strategies for behaviour change in areas where the patient would get a lot out of achieving the change.

Session 4: Leading an ordered life.

Objectives

1) To give the patient an awareness of basic mental health promoting activities which may benefit them in coping with the condition.
2) Helping the patient to appreciate that their condition makes certain kinds of lifestyle particularly likely to be both tempting and risky.
3) Selecting only one or two new activities, and using a minimax strategy (minimum effort to change for maximum gain if change is achieved) to explore possible ways of changing behaviour.

Strategies

- Giving information about the way in which borderline personality disorder imposes a need to lead a consciously well-ordered life.
- Careful delineation of current lifestyle: sleep, eating, exercise, leisure, work.
- Exploration of how lifestyle choices interact with illness to improve or worsen it.
- Selection of one or two changes in lifestyle that might be particularly beneficial and reasonably easy to make.

Session 5: When it all goes pear-shaped

Objectives

1) Helping the patient take a compassionate (but accurate) view of major illness driven disasters in life, and helping the patient acknowledge that these may occur again.
2) Identifying risk factors for major disaster, and warning signs of impending catastrophe
3) Exploring a range of strategies for dealing with catastrophic situations, and creating a personal crisis plan.

Strategies.

- Review of bad times and sudden crises.
- Search for early warning signs and moments when alternative strategies could be used.
- Exploration of the aftermath of crises: helpful and unhelpful things the patient did then or others did to the patient

- Realistic exploration of barriers to implementing strategies for self help and getting help from others.
- Explanation of the "Odysseus strategy" (Odysseus tied himself to the mast so he could hear the song of the sirens. The idea, therefore, of identifying situations where retreat from life and self imposed brief withdrawal might be the only option)
- Joint construction of a tentative personal crisis plan

After Session 5, in preparation for Session 6, write a "Goodbye" letter that summarises what has been achieved - brief formulation, coping strategies, crisis management plan – and what the patient might profitably do in the future.

Session 6: Saying goodbye

Objectives.

1) Acknowledging that the intervention has been minimal and that the patient will need to do much more work on his or her own. Allowing and accepting the strong feelings that this solitary task may evoke.
2) Reviewing significant strengths that the therapy has revealed in the patient which may be helpful in the future
3) Reviewing the crisis plan and exploring how it might be used in the future.
4) Delivery of a caring but clear-sighted "Goodbye" letter.

Strategies.

- Exploration of feelings about this being the last session.
- Acknowledging the lifelong nature of the difficulties.
- Discussion of any new learning, ideas, behaviours that the therapy has provoked
- Exploration of ways to continue these when encouragement from the therapist is not present
- Linking with User groups encouraged.
- Review of crisis plan and anticipation of how it might be used.
- A "goodbye" letter addressed to the patient that is also copied to the GP.