Project Air Strategy for Schools

Kim Eisler

Psychologist
CHW School-Link Project Officer
The Children's Hospital at Westmead

In 2016 the NSW School-Link Initiative joined in a new strategy **Project Air Strategy for Schools**; which is a collaborative project between NSW Ministry of Health and the NSW Department of Education and the Project Air Strategy for Personality Disorders at University of Wollongong. The program draws on the unique opportunity that schools provide for early intervention and prevention of mental illness among children and young people.

Project Air Strategy for Schools aims to provide education staff with information and tools to work effectively with young people that are experiencing a personality disorder or are presenting with emerging symptoms by offering an evidence –based approach that promotes early intervention within the school environment.

While primarily developed for use in schools **Project Air Strategy for Schools** can provide effective strategies for counsellors, health staff, youth and welfare workers; as well as teachers, teachers' aids, executive staff and school administrators. In recognising that educators' are often well placed to notice changes in students' behaviour it aims to provide those in the education environment with appropriate knowledge and skills to identify and respond to young people with emerging personality disorder symptoms and challenging behaviours including self-harm.

Project Air Strategy for Schools provides a comprehensive set of resources which have been developed to assist schools better recognise and respond to young people with complex mental health problems; it includes Guidelines, fact sheets, train the trainer resources and a short film 'Chloe's story'.

The Guideline (Grenyer et al, 2016) is divided into the following sections:

- Key principles for working with young people
- Understanding complex mental health problems
- Identifying and assessing risk
- Responding to crisis and self-harm situations
- Responding effectively to challenging behaviours
- Working to improve the school and social environment.
- Teacher wellbeing
- Working with parents with a personality disorder

The treatment principles are based on a "relational model" of intervention established by The Project Air Strategy for Personality Disorders and based on the premise that "Relationships are at the core of our mental health, particularly for a person with personality disorder" (Grenyer, 2010: 8). Essentially it concentrates on developing an empathic, non-judgemental, caring and respectful relationship. The aim being to establish trust, open communication and validation of the clients own experience. Thus it emphasises verbal communication.

The approach recognises that psychotherapy needs to be supplemented with brief interventions and structured therapies such as CBT or DBT. Furthermore it promotes collaborative care and planning where families, friends, carers and other professionals work together to offer comprehensive and consistent support (Grenyer, 2010).

Personality Disorder

Personality Disorder (PD) is a mental health disorder recognised by the International Classification of Diseases (ICD), and the Diagnostic and Statistical Guide for Mental Disorders (DSM). PD refers to personality traits that are maladaptive and pervasive in a number of contexts over an extended duration of time, causing significant distress and impairment.

Personality disorders are defined in American Psychiatric Association Diagnostic and Statistical Manual, 5th Edition, (DSM-5) as: An enduring pattern of inner experience and behaviour that deviates markedly from the individual's culture. This pattern is manifested in two (or more) of the following areas:

- Cognition (i.e. ways of perceiving and interpreting self, other people, and events)
- Affectivity (i.e. the range, intensity, lability, and

appropriateness of emotional response)
- Interpersonal functioning
- Impulse control

The fact sheet from **Project Air Strategy for Schools** estimates that PD occurs in around 7-11% of the Australian population (Grenyer et al, 2016). The exact cause of these problems is unknown but it is thought to arise due to a combination of factors including:

⇒ Biological factors – genetic or acquired
⇒ Drug and alcohol use
⇒ Early life experiences – abuse, neglect, death of parents, or other losses and trauma
⇒ Self-esteem and ways of thinking
⇒ Current social circumstances – financial, work, relationship or family stress.

Personality Disorder and Adolescence

Clinicians' attempting to diagnose an adolescent with PD will face multiple issues as clinical presentations are complicated by ongoing developmental changes, hormonal fluctuations, adolescent rebelliousness, peer influences and cognitive development in this age group. For this reason the developers of **Project Air Strategy for Schools** have favoured the term 'emerging personality disorder' as a term that may be applied if a young person does not meet full diagnostic criteria but is presenting with some personality disorder symptoms (Grenyer et al, 2016).

Early warning signs of emerging personality disorder:

Unstable self-image
Frequent mood swings
Self-harming behaviour
Difficulty regulating emotions
Preoccupation with real or imagined abandonment
Excessive self-criticism
Disturbances in attention
Impulsivity or risk-taking
Abuse of drugs or alcohol
Thinking about death or suicide

"Clinicians' attempting to diagnose an adolescent with PD will face multiple issues as clinical presentations are complicated by ongoing developmental changes.."

Young people who have an emerging PD can face a host of difficulties as they are most likely more emotional, less able to regulate their feelings, less resilient and more likely to engage in unhelpful behaviours. As such they can be misdiagnosed, for instance with a conduct disorder, especially as "the message that they are trying to send through their behaviour is often misinterpreted as manipulative, attention seeking or simply "bad" behaviour" (Grenyer et al, 2016).

"Young people who have an emerging PD can face a host of difficulties as they are most likely more emotional, less able to regulate their feelings, less resilient and more likely to engage in unhelpful behaviours."

Project Air Strategy for Schools cautions against over diagnosing young people but also insists that clinicians be wary of "misattributing severe and debilitating distress as a "normal" part of adolescence". They suggest the young person's "whole style of functioning" be examined and that problems need to be severe and have endured for at least one year before warranting a diagnosis. There is mention that while it is common for young people to experience difficulties and take risks, attention should be paid to the frequency, duration and severity of these behaviours (Grenyer et al, 2016).

Personality Disorder and Intellectual Disability

Establishing a co-morbid diagnosis of PD for individuals with ID is exceptionally problematic and there is little research in this area. Most studies which directly tackle this topic focus on adult populations and "Questions remain regarding the etiology, as well as the prevalence and diagnostic validity, in intellectual disabled population" (Wink, 2010: 278). The research suggests that not only is there a lack of valid and reliable diagnostic criteria, but that the difficulties encountered when conducting assessments, due to cognitive and communication issues, could severely compromise outcome measures (Moreland et al 2008; Pridding & Proctor 2008; Wink 2010).

As Pridding and Proctor (2008) report "A review of literature on the diagnosis of PD by Alexander and Cooray (2003, p. 31) found 14 papers reporting prevalence rates from 1–91% in community settings and 22–92% in hospital. The authors comment that this difference is too great to be explained by real differences and question the clinical usefulness of the diagnosis. They conclude that: no accurate prevalence figures for PD in ID are available." (Pridding & Procter, 2008: 2813).

Difficulties in establishing psychiatric diagnoses in individuals with an ID is not limited to PD. It is a field where there is still much work to do and this is particularly relevant for children and young people (Dossetor, 2011). In making a diagnosis the type and severity of an individual's disability can also be a factor, as Tsiouris (2011)found with psychosis and depression which was over-diagnosed in persons with mild to moderate ID and under-diagnosed in persons with severe and profound ID (Tsiouris, 2011). Other studies simply do not include PD, concentrating instead on psychiatric disorders such as anxiety, depression, psychosis, bipolar and impulse control disorders (Dykens et al, 2015).

Difficulties with relationships and experiences of past trauma frequently underlie the development of PD (Grenyer et al, 2016). People with intellectual disability may be more frequently subject to such experiences but it is yet to be determined whether this then causes higher rates of PD. What is important is that these "... experiences of rejection, failure experiences and social deprivation as they grow up," can lead to the development of unhelpful personality traits (Roya, 2014:36).

"Difficulties with relationships and experiences of past trauma frequently underlie the development of PD ..... People with intellectual disability may be more frequently subject to such experiences but it is yet to be determined whether this then causes higher rates of PD"

The authors of **Project Air Strategy for Schools** suggest that a co-occurring personality disorder should only be considered when a person with intellectual disability has mild to moderate cognitive and verbal impairments. They propose that the difficulties students with a moderate or severe ID have with communicating and describing internal experiences makes diagnosis unreliable (Grenyer et al, 2016).

Furthermore the Projects developers' point out that adolescents with a PD and those with ID often present with similar problems - including difficulties with communication, relationships, regulating emotions, coping with distress and engaging in challenging behaviours. As such it can be extremely difficult to determine if these behaviours are due to a person's intellectual disability or a co-occurring personality disorder.

Project Air Strategy for Schools and Intellectual Disability

Project Air Strategy for Schools ultimately leaves it to the discretion of individual schools to decide what materials are appropriate for whom. A fact sheet "Intellectual Disability & Personality Disorder" offers some suggestion to assist staff working with students who have an Intellectual Disability (ID). These include presenting information in a visual format, using frequent repetition and simple language.

The program has some good resources and helpful advice for working with adolescents with complex mental health issues. The limitations of its effectiveness for students who have an ID will be partly determined by the type and degree of the disability individual students present with and the competency of the practitioner in working with these students.

Conclusion

Considering the high rates of mental health issues facing students with an ID (between 30 -50%) and the frequent placement of these students in mainstream schools it would appear that specialist resources to aid clinicians working with this population would be in high demand. Challenging behaviours and emotional dysregulation are often significant issues for this population of young people and thus they could be considered 'core business' for counsellors working in educational settings.

Modifying treatment approaches and providing appropriate resources can potentially address some of the problems clinicians will face when using **Project Air Strategy for Schools** with ID students but may need further adjustments for adolescents who have a moderate or severe disability.

References

American Psychiatric Association, 2013. *Diagnostic and statistical manual of mental disorders* (DSM-5®). American Psychiatric Pub.

Dossetor, D. (2011). Mental Illness and intellectual disability: The concepts, the evidence, and the clinical skills. In D. Dossetor, D. White and L. Whatson (Eds.), *Mental Health of Children and Adolescents with Intellectual and Developmental Disabilities: A Framework for Professional Practice.* Melbourne: IP Communications.

Dykens, E.M., Shah, B., Davis, B., Baker, C., Fife, T. and Fitzpatrick, J. (2015) Psychiatric disorders in adolescents and young adults with Down syndrome and other intellectual disabilities, *Journal of Neurodevelopmental Disorders* 7:9 DOI 10.1186/s11689-015-9101-1

Grenyer, B.F.S. (2010) *An Integrative Relational Step-Down Model of Care: The Project Air Strategy for Personality Disorder.* The ACPARIAN, 9,8-13.

Grenyer, B.F.S., Gray, A.S. and Townsend M.L. (2016) *Project Air Strategy Working with young people with complex mental health issues. Understanding and responding to emerging personality disorder, trauma history, self-harm and suicidal behaviour and difficulties with identity, emotions and relationships.* Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute. 2016 http://www.projectairstrategy.org/index.html

Moreland, J., Steve Hendy, S. and Brown, F. (2008) The Validity of a Personality Disorder Diagnosis for People with an Intellectual Disability *Journal of Applied Research in Intellectual Disabilities* 21, 219–226

Roya, M., Retzerb, A. and Sikaboforic T. (2015) Personality development and intellectual disability. *Current Opinion in Psychiatry 28(1):35-39.*

Tsiouris, J. A., Kim, S. Y., Brown, W. T. and Cohen, I. L. (2011), Association of aggressive behaviours with psychiatric disorders, age, sex and degree of intellectual disability: a large-scale survey. *Journal of Intellectual Disability* Research, 55: 636–649. doi:10.1111/j.1365-2788.2011.01418.x

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines.* Geneva, World Health Organization.

Pridding, A. and Procter, N.G. (2008) A systematic review of personality disorder amongst people with intellectual disability with implications for the mental health nurse practitioner. *Journal of Clinical Nursing* 17, 2811–2819

Wink, L.K., Erickson, C.A., Chambers, J.E. and McDougle, C.J. (2010) Co-Morbid Intellectual Disability and Borderline Personality Disorder: A Case Series, *Psychiatry 73*(3) 277 -287;

http://www.projectairstrategy.org/content/groups/public/@web/@ihmri/documents/doc/uow225736.pdf

Tips for Supporting a Person with Intellectual Disability and Emotional Difficulties

- People with intellectual disabilities sometimes use impulsive and challenging behaviours in an attempt to cope with overwhelming emotions. These behaviours can include aggression, self-harm and substance use. Therefore, it is important to develop a plan to ensure every-one's safety in the event of a crisis.
- All information needs to be simplified and presented at a level the person can understand. Try presenting information in visual (for instance pictures or charts) and practical ways, such as role-playing social skills or practicing coping strategies together when the person is calm.
- It is important for everyone in the person's support network to communicate and develop consistent boundaries and goals. This creates a predictable environment and helps the person feel safe.
- People with intellectual disability need opportunities to consolidate learning. Repeating skills and concepts over time can help the person remember the information and put it into practice.
- Providing tangible rewards for behavioural improvements can help to reinforce gains. A chart outlining progress towards goals and rewards can increase motivation and help keep everyone on-track.
- People with intellectual disabilities often find it difficult to understand abstract concepts. Therefore, try to focus on simple skills, such as reinforcing or role-playing how to ask for something and how to tell someone how I feel.
- Psychological therapy takes time. It is important to be patient and expect set-backs.
- Working with and supporting a person's strengths increases their confidence and sense of wellbeing. Activities that incorporate these strengths maintain interest and persistence. The use of humour and playful activities can also reinforce appropriate social skills.

http://www.projectairstrategy.org/content/groups/public/@web/@ihmri/documents/doc/uow184577.pdf