Treatment of personality disorder by generalist mental health clinicians - a good enough treatment?

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Borderline Personality Disorder: An evidence-based guide for generalist mental health professionals

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- Provides an evidence-based intervention for treating people with borderline personality disorder
- Written by two highly experienced clinicians, providing the generalist mental health clinician with a thorough understanding of this disorder
- Includes advice on helping the family of the patient - often neglected in the treatment
- Outlines top 10 interventions that can be given by general mental health clinicians for people with BPD which helps increase their own skills in the area

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Are specialist treatments for personality disorder necessary?
Specialist/Generalist treatments:

- Outcomes across DBT/TFP/SPT were “generally equivalent” (USA)

- GPM ‘v’ DBT shows equal outcomes at end of treatment and at follow-up (Canada)
Specialist/Generalist treatments:

- DBT v. TBE Comparison group lacked key features for NICE recommended treatments (USA)
  
  Linehan MM, Comtois KA, Murray AM, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry. 2006 Jul;63(7):757-66

- DBT v SCM The TAU group showed comparable reductions in all measures and a larger decrease in para-suicidal behaviours and risk. (UK)
  
All treatment conditions resulted in similar improvements

- Frequency of suicide attempts
- severity of suicide attempts
- suicide ideation
- use of crisis services
- reasons for living
Specialist/Generalist treatments:

- Mentalization based treatment (MBT) ‘v’ structured clinical management (SCM) – both were effective treatments. SCM was superior in the initial months at reducing self-harm (UK)


- MBT ‘v’ Supportive Group
  - GAF showed a significantly higher outcome in the MBT group
  - Trend for a higher rate of recovery from BPD in the MBT group
  - Pre-post effect sizes were high for both groups (0.5–2.1)

Specialist/Generalist treatments:

- SFT v TFP but no comparison with structured clinical care (Netherlands)

- TFP v. Community psychotherapists. Comparison treatment was unstructured and heterogeneous (Germany/Austria)
Specialist/Generalist treatments:

- Cognitive analytic therapy ‘v’ Good Clinical Care (GCC) for adolescents with BPD or BPD traits - equally effective with significant improvements across a range of clinical outcome measures (Australia)

Structured Clinical Management
SCM: Key components

- Reliable appointments.
- Detailed crisis plans.
- Clear short term and long term goals.
- Collaborative care plans done together.
- 3 Monthly psychiatric reviews.
- Assertive follow-up if person does not attend an appointment.
- Group psycho-education and skills sessions.
Personality Disorder Care Pathway

Borderline Personality Disorder identified

SCM

DBT or MBT or other

SCM

Generic treatment

Specialist treatment

Engagement focus
SCM pathway

Assessment (socialisation)
- Diagnosis

Setting Frame (attachment)
- Clinical Stance
- Personal Responsibilities
- Identifying Goals
- Crisis plan

Strategies (Foci)
- Problem Solving
- Interpersonal (incl. cognitive distortions)
- Emotional Regulation
- Impulsivity

Planning for life without services
Transition work
Banked Sessions
Assessment (6 - 8 sessions)

- Careful assessment.
- Giving the diagnosis.
- Information sharing/psycho-education.
- Risk.
- Development of hierarchy of therapeutic areas.
Setting the Frame (Up to 3 months)

- Agreement of clinician and patient responsibilities.
- Development of motivation and establishment of therapeutic alliance.
- Risk assessment and risk management.
- Stabilisation of drug misuse and alcohol abuse.
- Development and agreement of comprehensive formulation and goals.
- Involvement of families, relatives, partners and others.
Setting the Frame: Clinical Stance

- Attachment focused.
- Attitude - Be Wise and Mentalize.
- Reliable and consistent.
- Active participation.
- Realistic expectations.
- Team work and communication.
- Hope and optimism.
Giving the diagnosis

- Diminishes sense of uniqueness/alienation
- Establishes realistically hopeful expectations
- Decreases parent blaming and increases parent collaboration
- Increases patient alliance and compliance with treatment
- Prepares the clinician
“She’s a psychopathic, delusional, borderline personality—and I can say that because I’m a psychopathic, delusional, borderline personality myself.”
Attachment Styles

Our attachment to others can be described as:

1. Secure

2. Insecure - Ambivalent (sometimes called anxious)

3. Insecure – Distanced (sometimes called avoidant)

4. Disorganised
Recovery and secure attachment

To enable mental health recovery we need to where possible facilitate a secure attachment with the service user.

Care should be:

- Co-ordinated
- Reliable
- Sensitive to the clients emotional needs
- Consistent (particularly in emotional response)
Facilitating security in SCM

What do you want? What do I want?

- Establishing the contract/agreement/relationship.
- Necessary to reduce the number of ruptures.
- Can lead to immediate reductions in self harming behaviour.
Agreeing what we are going to work on:

- Need to be clear in our focus
- Develop common focus – what is the agreed goal?
- Emphasis on autonomy.
- Treatment is community based.
- Hospitalisation limited.

> NOTE: primary aim of SCM is to reduce unnecessary hospital admissions:
“We’re encouraging people to become involved in their own rescue.”
Crisis Planning

Managing safety: seven principles

1. Assess risk – differentiate non-lethal and true suicide intent
2. Don’t ignore or derogate – express concern
3. Ask what the patient thinks will help – foster sense of self agency
4. Clarify precipitants – chain analysis and seek interpersonal events
5. Be clear about your limits – under or over valuing your importance
6. Explore the effect on treatment
7. Discuss with colleagues
Crisis Planning

- Crisis Plans one of the most important things you can do.

- Key pointers to an effective crisis plan
  - Not adequate to have to attend A & E
  - Need to work with the patient to collaboratively come up with the plan
  - Use previous examples (three) that led to self destructive behaviour/or contact to services. Looking to establish early warning signs.
Prescribing Guidance

- When medication is used it should be considered in the context of the longer-term treatment plan.
- Prescribing should be integrated into the overall management of the patient.
- Crisis prescribing
  - Inevitable but sometimes better to offer follow-up review next day rather than prescribe.
Prescriber Guidance

- Try and avoid adding medication to current medication regimes during a crisis.
- Prescribing using the neutral stance.
- Keep in therapeutic range -avoid higher doses of medication (no evidence for this).
- Take interest in how the person responds to medication (2 to 4 weeks adherence).
- Avoid changing until 2 – 4 week period is completed.
SCM Strategies

Problem Solving and Foci
SCM: interventions

Non-specific interventions
- Interviewing skills
- Attitude
- Empathy
- Validation
- Positive regard
- Advocacy

Specific interventions
- Tolerating emotions
- Mood regulation
- Impulse control
- Self-harm
- Sensitivity and Interpersonal problems
Clinician Stance

- Active, responsive, curious
- Expect patients to be active in controlling their life (agency, accountability)
- Challenge passivity, avoidance, silences, diversions
- Support via listening, interest, selective validation
- Focus on life situations; relationships and vocations
- Work > love
- Change is expected
Problem Solving

Specific Interventions
SCM: Core treatment strategies

- Problem Solving underpins core treatment strategies:
  - Emotion management
  - Mood regulation
  - Impulse control
  - Interpersonal sensitivity
  - Interpersonal problems
  - Suicidality and self-harm and management of risk
How to Solve a Problem

- There are 4 steps in problem solving:
  - Defining the problem.
  - Generating potential solutions
  - Selecting and planning the solution.
  - Implementing and monitoring the solution.
Emotions

Tolerance of Emotions and Mood Regulation
Key Strategies

- Psycho-education
- Labelling
- Normalising
- Contextualising
- Relaxation
Impulsivity
Impulsivity and impulse control

- **Not attending**: decreased attention – easily getting bored, inability to concentrate on a task, difficulty keeping to topic when something else comes into the mind

- **Not planning**: lack of premeditation; limited consideration about or concern for consequences; excitement about risky activities that precludes considering negative consequences

- **Action**: action without reflection – going into action rapidly, acting rashly sometimes related to pleasing as well as displeasing emotions
## Impulsivity

<table>
<thead>
<tr>
<th>Category</th>
<th>Emotion name</th>
<th>Urge</th>
<th>Indicators</th>
<th>Helpful response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not attending</td>
<td>Boredom</td>
<td>Do something exciting</td>
<td>Awareness of inability to concentrate</td>
<td>Skilful action with others</td>
</tr>
<tr>
<td>Not planning</td>
<td>Anticipated satisfaction</td>
<td>Opportunistic theft</td>
<td>Awareness of thoughts of entitlement</td>
<td>Stop, think</td>
</tr>
<tr>
<td>Action</td>
<td>Loneliness</td>
<td>Find boyfriend, Get drunk</td>
<td>Noticing action urge</td>
<td>Meet friends</td>
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Interpersonal Relationships and Sensitivity
Strategy: Interpersonal Skills

- Ask questions – ‘Why are you folding your arms’? ‘Why do you look at me like that?’ ‘What are you thinking?’
- State a tentative conclusion and ask for confirmation – I suppose that you feel that …. Is that what you do feel/think at the moment or are you feeling/thinking something else’?
- Explain how when someone says something or looks at you in a particular way that this results in certain emotions in oneself - ‘When you say that, I feel… Is that what you mean me to feel?’
- Explain your point of view – if it is not in line with what the other person means ask them to correct you.
- Consider the context of the interaction.
9. SCM extras

Top 10 Strategies, Group work, Family and Supervision.
Top Ten Strategies for clinicians

- Mentalizing and mindfulness
- Valued action irrespective of emotions
  - including identification of emotion
  - acceptance of emotions
- Self-acceptance
- Accepting thoughts and valued action
- Changing thoughts
- Decreasing hyperarousal
- Chain analysis
- Structure
  - Joint crisis plans
  - Problem solving
  - Psychoeducation
- Skills
  - Distress tolerance skills
  - Interpersonal effectiveness skills
- Clinical feedback of treatment outcomes
Thank you!

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