Beyond RCTs - synthesizing what works in personality disorders in the context of the development of clinical guidelines

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Thank you for visiting the Project Air Strategy for Personality Disorders. We are enthusiastic mental health workers, consumers and carers looking to improve the lives of people living with a personality disorder. For us, AIR symbolises life and hope, and is something light yet powerful. The gong on our team means "Affect Integration and Recovery". We just hope it is helpful.

**Personal Journeys**

- **Sarah's Story**: My problems started from about the age of 18, when I began feeling extremely depressed. A girl in the year below me at school committed suicide around that time. I don’t know why, but I started having thoughts of suicide myself... Read more

**Latest Research**

- **Diagnosis of Personality Disorders soon to be updated**: There are two widely recognised classification systems for mental health problems. These are the World Health Organisation’s International Classification of Diseases and the American Psychiatric Association’s Diagnostic and Statistical Manual. These classification systems are under review... Read more
Good Clinical Care: Treatment Guidelines

APA American Psychiatric Association Guidelines 2001

BORDERLINE PERSONALITY DISORDER

PART A: Treatment Recommendations for Patients With Borderline Personality Disorder

1. Executive Summary of Recommendations

A. Coding System

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

(I) Recommended with substantial clinical confidence.
(II) Recommended with moderate clinical confidence.
(III) May be recommended on the basis of individual circumstances.

B. General Considerations

Borderline personality disorder is the most common personality disorder in clinical settings. It is characterized by marked distress and functional impairment, and it is associated with high rates of self-destructive behavior (e.g., suicide attempts and completed suicide). The care of patients with borderline personality disorder involves a throughout the course of treatment. The components of psychiatric management for patients with borderline personality disorder include responding to crises and monitoring the patient's safety, establishing and maintaining a therapeutic framework and alliance, providing education about borderline personality disorder and its treatment, coordinating treatment provided by multiple clinicians, monitoring the patient's progress, and reassessing the effectiveness of the treatment plan. The psychiatrist must also be aware of and manage potential problems involving splitting (see section II.B.6.a [p. 9]) and boundaries (see section II.B.6.b [p. 9]).

3. Principles of treatment selection

a) Type. Certain types of psychotherapy (as well as other psychosocial modalities) and certain psychotropic medications are effective in the treatment of borderline personality disorder [1]. Although it has not been empirically established that our approach is more effective than an
CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF BORDERLINE PERSONALITY DISORDER
NHMRC Treatment Guideline for BPD

- Expected to be released 30 November
- Grenyer and Chanen on guidelines development committee
- Draft of Guideline released in public domain – outlines method and major recommendations
- Guidelines funded by Department of Health and Ageing, expected to be released by Minister Butler
Rationale

- BPD is under-recognised, and poorly treated
- Admissions to secure inpatient units are not therapeutic and can contribute to the cycle of admission, self-destructive and other maladaptive behaviours and readmission
- Consumers and carers have commonly reported discrimination by mental health professionals against people with BPD
Background Messages

• Need for National and State approaches
• Need for greater specialist services
• Need for greater training and service development
• Need for consumer / carer / family centred care approaches
• Need to focus on young people and better services for trauma, abuse and neglect
• Build on Spectrum, HYPE, Project Air Strategy
Audience of the guideline:

Aboriginal health workers
Clinical psychologists
General practitioners
Mental Health Occupational Therapists
Mental health nurses
Mental health social workers
Psychiatrists
Psychologists
Registered nurses and midwives
Other health professionals
Method

• ADAPTE – A method for adapting an existing clinical guideline to produce a new clinical guideline (e.g. to update or improve local relevance)

• NICE UK guideline is major source and foundation, only research since 2008 searched and analysed to update or modify NICE recommendations
Highlight message

The Guideline highlights the need for structured and time-limited psychological care with minimal use of medicines, and stresses the need for care to occur in the community (out-patient) settings.
Highlight messages

• BPD is a legitimate diagnosis in mental health services
• Health staff need appropriate training and skills
• Families, carers and partners should get proper support and psychoeducation services
• Medications should not be used as a primary treatment, or added to psychological therapy
• Diagnosis in young people should lead to appropriate treatment
Highlight messages

• DBT should be used for self-harming women
• Manage co-occurring psychological problems concurrently
• Inpatient stays if needed should be brief and goal-directed and long-term stays should be avoided
• More intensive, specialised BPD treatments should be made available
• Care should be coordinated by an identified clinician
Highlight messages

- Parents with BPD should be offered support to ensure welfare of children
- Parents with BPD with infants should be offered interventions to support parenting skills and attachment relationships
Challenges

- **Misdiagnosis** – bipolar disorder, PTSD, substance dependence, psychosis, depression
- **Pharmacotherapy** not recommended as primary treatment – but often over-medicated
- **Relationship deficits** – swing between interpersonal neediness, idealisation, devaluation, hypersensitivity, anger, avoidance
- **Health service deficits** – reactive, limited, punitive, inconsistent, overwhelmed & under resourced
- **Stigma** – amongst health professionals (not wanting to use the term “personality disorder” - increases stigma)
Treatment Guidelines for Personality Disorders
<table>
<thead>
<tr>
<th>Key Principles for Working with People with Personality Disorder</th>
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<tbody>
<tr>
<td>- Demonstrate empathy</td>
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<tr>
<td>- Listen to their current experience</td>
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<tr>
<td>- Validate their current emotional state</td>
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<tr>
<td>- Take their experience seriously, including verbal and non-verbal communications</td>
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<tr>
<td>- Maintain a non-judgemental approach</td>
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<tr>
<td>- Stay calm</td>
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<tr>
<td>- Remain respectful</td>
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<tr>
<td>- Remain caring</td>
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<tr>
<td>- Engage in open communication</td>
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<tr>
<td>- Be clear, consistent, and reliable</td>
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<tr>
<td>- Remember aspects of challenging behaviours have survival value given past experiences</td>
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<tr>
<td>- Convey encouragement and hope about their capacity for change</td>
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How does this translate into practice?

• Consider treatment needs
  – Brief vs. long-term interventions
    • Start with a brief intervention (e.g. focus on problem solving, care planning)
    • Review what’s possible and helpful?

• Use Care Plan
  – Develop crisis management skills and set treatment goals in emergency, inpatient, community settings
Final points on practice…

• Refer to guidelines, principles of practice
• Focus on engagement, working alliance, approach, framework, best treatment option
• Collaborate with the family
  – Issues of past trauma, MI in family – does not preclude engagement. Families want to be involved!
• Adopt a team approach
  – Access to diverse skills, expertise, problem-solving, support