Personality Disorder
Integrated Care Pathway

(PD–ICP)

2: General Principles in Treating Personality Disorder
Acknowledgements

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The NHS Highland Personality Disorder Service will coordinate future reviews and updates of this document.

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2.1 Introduction

Personality disorder is an inherently complex condition which presents with difficulties in the cognitive, affective, behavioural and interpersonal domains. Differing degrees of severity, along with varying interpersonal and social contexts means that no two people with the disorder present in the same way. Accordingly, it is widely recognised that a range of treatment and management interventions are necessary to serve this patient group.

This section outlines some of the concepts which have influenced the development, organisation and delivery of services for people with personality disorder in NHS Highland.

These include:

- Recovery
- General treatment strategies
- Stages of change model
- Phase-based treatment
- Matched care

2.2 Recovery

Treatment of personality disorder should follow recovery principles. Recovery is a framework for thinking about mental health which is perhaps particularly applicable to personality disorder. A full discussion of the recovery approach is beyond the scope of this document but the following summary of important recovery principles, drawn from the Scottish Recovery Network website, captures the key factors.

Any treatment for personality disorder should:

- Focus on what people can do, and on their unique attributes and characteristics rather than focus on the things they cannot.
- Take a strengths based approach to the work and emphasise the role of hope and optimism.
- Recognise recovery is a unique and individual experience and that people’s experiences are influenced by their circumstances, background and life events. Opportunities and circumstances also influence outcomes.
- Promote inclusion, equality and involvement.
- Recognise people are experts in their own experience and that empowerment is central to wellness and recovery.
- Work towards goals which are important for the patient and which should be developed collaboratively.
2.3 General Treatment Strategies

These strategies should inform the care and treatment of people with personality disorder in all settings, not only to specific psychological interventions. Current evidence suggests that these general therapeutic strategies are responsible for more of the benefit of any treatment for personality disorder than any specific technique.

Although there is some overlap, the general treatment strategies can usefully be divided between five headings:

- Collaboration
- Consistency
- Motivation
- Validation
- Self-management

2.3.1 Collaboration

2.3.1.1 Collaborative relationship

Building and maintaining a collaborative relationship (also referred to as the therapeutic alliance or therapeutic relationship) is fundamental to the treatment of personality disorder. In contrast to some mental state disorders such as major affective disorders and psychotic disorders, there is little which can be delivered ‘to’ or ‘for’ the patient in terms of effective treatment. Rather, personality disorder is a condition in which effective treatment can only be carried out ‘with’ the person.

While outdated views of personality disorder as essentially untreatable have been overturned, available evidence suggests that personality disorder is only a treatable condition within the context of a collaborative relationship. In other words, if the patient does not wish to engage collaboratively with treatment, then the disorder is untreatable. Shared understanding of this principle is crucial for meaningful work to happen.

An important component of a collaborative relationship is a shared understanding of the roles and responsibilities of both patient and professional. At the most basic level, the clinician is responsible for delivering a reasonable standard of care and, unless there are very clear reasons to assume otherwise (e.g. severe co-occurring major mental illness), each patient is assumed to be a competent adult, responsible for their own choices and the consequences of those choices. Encouraging each patient to take responsibility and engage collaboratively with treatment is necessary to enable valuable positive risk taking to occur. Such an approach can also assist clinicians to avoid assuming responsibility for patients and thereby making clinical decisions that are unhelpful in the longer term, such as providing extended hospital admissions.

A collaborative relationship can help instil a sense of optimism and hope, and provide a basis for a collaborative search for understanding. Furthermore, such a relationship encourages the collaborative setting of realistic treatment targets and effective acquisition of skills and knowledge. In addition, it enables modelling of effective interpersonal functioning and helps maintain motivation in patients and professionals.

Ruptures within the relationship between patient and professional are to be expected. When this occurs, the focus should be on early identification of markers of rupture, exploration of the
reasons for the rupture, and exploration and validation of the patient’s thoughts and feelings about the rupture. Rapid repair to the relationship is the aim. This may require finding solutions to prevent the rupture recurring.

2.3.1.2 Collaboration within and across teams

Collaboration is not only important between patients and professionals but also between different professionals, teams and agencies. Good communication and joined-up working helps ensure consistency. A shared care model will often be valuable in working with this patient group, in which different clinicians and services work together to implement different parts of a treatment plan.

2.3.1.3 Social network involvement

Members of the patient’s social network should be involved in the treatment plan where appropriate. Education about the condition, along with a shared understanding of the formulation and the treatment plan (and their role within it) can improve collaboration and outcomes.

2.3.1.4 Mental Health Act and Compulsory Treatment

Compulsory treatment should be avoided except in exceptional circumstances and voluntary treatment should resume as soon as possible. The potential harm of removing responsibility from the patient and associated loss of collaborative working should be carefully considered. Any benefit of detention is likely to occur at the safety and containment phases of treatment only. Self-regulation and control are unlikely to occur while the patient’s responsibility for themselves is removed and thus meaningful stabilisation is unlikely. Furthermore, there is no good evidence for the effectiveness of compulsory treatment and some specialist psychological interventions (e.g. Dialectical Behaviour Therapy or DBT) specifically state that patients should engage with the treatment voluntarily. Similar cautions apply to patients who have been instructed to attend a treatment program by the courts or other agencies.

2.3.1.5 Patient involvement

Patient involvement and collaboration is important not only within the treatment of individual patients but also for the development and delivery of services for people with personality disorder.

Patient involvement in services can be conceptualised as a continuum with increasing levels of input:

- **Information**: Patients are given information about services. Examples include provision of leaflets and open days.

- **Consultation**: Information, views and feedback about services are sought from patients. Examples include feedback forms for specific interventions and focus groups.

- **Participation**: Patients influence the development of the service. Examples include the Personality Disorder Service Steering Group, which includes NHS staff, patients and other stakeholders.

- **Inclusion**: Patients are involved in the delivery of the service. Examples include the Volunteer Post in the CAS Day Service and co-delivery of education sessions.
• **Partnership:** Patients are involved in sharing decisions and responsibility. Examples include patients sitting on interview panels for staff and volunteer appointments to the Personality Disorder Service.

2.3.2 Consistency

Consistency can be taken to mean adherence to the treatment frame. Consistency within care and treatment is particularly important as many patients will have limited previous experience of consistent relationships. Often personality disorder pathology can make consistency difficult and there will frequently be attempts to change the treatment frame by the patient or clinician. Supportive limit setting is a vital component of therapy but can occasionally be met by negative responses from the patient which should also be highlighted and addressed immediately.

Similarly, strong emotional responses on the part of the clinician must be managed in order to maintain consistency. These reactions can be useful in helping the clinician understand the reactions of other people to the patient. However, a clinician's emotional responses to the patient should only be explicitly revealed to the patient after significant reflection on whether the revelation is likely to be therapeutic or not. Often, it is more useful to support the patient to reflect on their own behaviour and the behaviour of other people in the context of the thoughts and emotions which might lie behind the behaviours.

It may be necessary for the clinician to seek supervision to accept, examine, understand and contain especially strong emotional responses. Regular supervision and consultation, and working to a clear formulation can help maintain consistency of approach for an individual therapist. Good communication and collaborative inter-professional working can help maintain consistency across teams.

2.3.2.1 Treatment frame

Appropriate treatment frame management for anyone treating people with personality disorder is a key therapeutic skill. Treatment frame refers to the agreed structure and “ground rules” which are sometimes called the “limits” or “boundaries” of any therapeutic intervention. These include limits of:

- **Time:** Including the timing (time and day) of sessions, the length of sessions, the length of the contract and frequency of sessions, and arrangements for cancellations, missed sessions etc.

- **Place:** Including the location and setting of sessions. Sessions should be private and without interruption.

- **Administration:** Including explicit management structure, confidentiality and its limits, communication with other professionals, and supervision arrangements.

- **Task of therapy:** Including treatment targets informed by the phase-based model and specific short and long term goals which have been collaboratively agreed upon.

- **Roles:** Including the roles, responsibilities and interpersonal boundaries of therapist and patient and agreement on how treatment goals will be attained.

Key aspects of the frame such as those outlined above should be made explicit and agreed at the start of treatment. Some aspects may remain implicit but may need to be made explicit when necessary—for example, in a situation where a patient offers the therapist a gift.

Once treatment has begun, it is the therapist’s responsibility to maintain a secure treatment
frame. A secure frame is one which is firm but not rigid, and which marries clarity, consistency and reliability with sensitivity of response to the patient’s needs. An insecure frame lacks consistency, reliability and predictability and often leads to a deterioration of the patient’s condition.

At times there may be pressure to modify a limit or boundary within treatment. It is important to recognise when such a modification would help maintain the treatment frame and when the modification would threaten the frame. Any threat to the frame should be openly discussed within treatment with a view to repair. This includes acknowledgement of errors of frame management on the therapist’s part or unavoidable interruptions to the frame. In these situations, the aim should be re-establishment of a secure treatment frame at the earliest opportunity.

However, on rare occasions, such severe pressure will be put on the treatment frame by some patients that it may be necessary to terminate the treatment contract. This should be considered when it is likely to represent a less harmful option compared with continuing treatment within an insecure frame. It is important to remain aware that resisting pressure to inappropriately modify the frame will not make the patient worse, whereas giving in to pressure to inappropriately modify the frame will not be helpful to the patient.

2.3.2.2 Splitting

In situations where several professionals have contact with a patient, the treatment frame should be clearly shared and agreed by all involved. This helps reduce the risk of “splitting”.

Patients with personality disorder frequently experience the world in a polarised way which is sometimes described as experiencing the world “in black and white”. This can mean that one team member is experienced as “all good”, while another is experienced as “all bad”. This can affect the behaviour of the practitioners involved. For example, the team member experienced as “all good” may be more likely to want to offer the patient an overly nurturing care plan at the expense of the patient taking responsibility for their own safety and recovery, whereas the team member experienced as “all bad” may begin to think that the patient is not being helped by the team and should be discharged. Dynamics such as this can contribute to team conflict, especially if there are pre-existing professional or personal differences, can lead to the creation of insecure treatment frames which are harmful for patients, and can leave professionals feeling unsupported and uncontained. This process is sometimes known as “splitting”.

Splitting can also occur between different teams involved with a patient’s care, leading to a potentially destabilising inconsistency of approach. This form of splitting is especially likely if conflicting theoretical and attitudinal positions are held by different teams, particularly in situations where communication between teams is sub-optimal and the ability to consider alternative perspectives is reduced.

Therefore, good communication between everyone involved, regular self-observation and reflection, and a consistent treatment frame are necessary not only for the benefit of the patient, but also for the benefit of the professionals and services involved. In particularly complex cases, consideration should be given to use of the Care Programme Approach which helps ensure regular meetings, good communication and the provision of a clear written care plan (incorporating the treatment frame) for all involved, thus optimising consistency. Appropriate supervision also has an important role to play in helping professionals recognise and manage splitting processes.
2.3.2.3 Endings and transitions

Clinicians should recognise that withdrawal or ending of treatments, and transition from one service to another, may evoke strong emotional responses in some patients. Such changes should be highlighted and discussed as far ahead in time as possible and a crisis self-management plan should be in place. Changes should be managed in a structured way which is made explicit within the treatment frame. Collaboration between services and patients is crucial at times of transition from one service to another to ensure as little inconsistency as possible. When a patient is referred for assessment or treatment to another service, consideration should be given as to whether support arrangements would be appropriate in the interim.

2.3.3 Motivation

Up to 75% of people with personality disorder will be treatment-resisting, in other words they will neither seek, nor wish to undertake treatment. Of the 25% who do seek treatment, levels of motivation to change will vary from patient to patient and over time. Treatment is invariably challenging and frequently requires intense sustained effort. For this reason, it is important to build and maintain motivation for change. In fact, this is frequently the major focus of treatment for people at the pre-contemplation, contemplation and preparation stages of change. Strategies for increasing motivation include:

- **Using discontent with the current situation** to build motivation
- **Instilling hope and an optimistic stance**. This can involve education about the disorder, effective treatments, and the relatively positive prognosis.
- **Creating other alternatives**. This often involves time spent teaching problem and solution analysis.
- **Identifying incentives** for making changes and incentives for not making changes. This often involves pros and cons of changing versus not changing.
- **Managing ambivalence**. This involves exploring the tension between fear of change versus desire for change, highlighting and amplifying the discrepancy between current and desired experience, encouraging consideration of the benefits of change, and attending to the fear of change and associated concerns.
- **Encouraging patience and persistence** including highlighting that longstanding patterns of experience and behaviour take a long time to change.
- **Identifying internal and external obstacles** to motivation and change.

In aiming to build and maintain motivation, professionals should avoid taking responsibility for the patient or engaging in confrontational and coercive interventions. This is often difficult because professionals frequently feel a sense of responsibility when progress is slow. Occasionally, clinicians may find themselves pressuring the patient or giving advice. While this may not be unwelcome for the patient, it undermines the necessary position of the patient accepting responsibility for change. The only option open to the patient when professionals adopt these overly-directive behaviours is to behave in a dependent manner.

Maintaining clinician motivation during what can often be slow, challenging work is also important. A collaborative relationship with the patient, recognition that progress can sometimes be slow but that significant recovery is possible, setting realistic treatment goals, maintaining self-observation and reflection, and regular supervision all contribute to the maintenance of
 Validation is a key strategy in the treatment of personality disorder and can be defined as acknowledgement of the legitimacy of a person’s behaviour and experience. Invalidation is a related concept, considered to be of significant importance in the development and maintenance of personality disorder. Invalidation occurs when a person’s behaviour and internal experiences are discounted or not regarded as legitimate. Invalidation occurs on a continuum, ranging from having one’s opinion dismissed as “stupid” to severe neglect and physical or sexual abuse. Invalidation, in transaction with an emotionally sensitive temperament, may play a particular role in the development of borderline personality disorder.

The establishment of a validating treatment process strengthens the working relationship, provides new and validating experiences to help counter previous invalidating experiences, promotes self-validation and encourages the development of a more adaptive sense of self. Validation can and should occur in almost every interaction with patients. However, it is important to recognise that validation does not necessarily imply approval.

Validation involves active listening and observation, accurate reflection of the patient’s emotions, thoughts and behaviours, and direct validation (the explicit acknowledgement of a thought, emotion or behaviour as valid and legitimate for that person, both understandable in the current context and in the context of previous experiences).

It is useful to help a patient distinguish between their experience, the reasons given for the experience, the conclusions drawn from the experience, and the action based upon the experience. While beliefs and emotions should be accepted and acknowledged, their origin and implications should be questioned and explored.

It is important to recognise that unhelpful behaviours, for example self-harm or substance misuse, may be the only way the person has had to cope with their experiences and that there is always some validity to any behaviour in its own context.

Relentless self-invalidation is often present in people with personality disorder and usually serves to maintain the disorder. Therefore, negative self-judgements should be identified and highlighted and areas of competence should be recognised and acknowledged. This promotes self-observation and reflection and can help to reduce self-invalidation over time.

Therapists should make every effort to avoid invalidating the patient. However, mistakes are inevitable and therapists should openly acknowledge any errors they have made as soon as possible. Minimising problems, prematurely focusing on the positive, providing inappropriate reassurance, interpreting normal experiences as pathological and interpreting all problems as stemming from personality disorder are frequently experienced as particularly invalidating by patients. If a rupture does occur in the therapeutic relationship, it is important to identify this quickly, to explore possible reasons, and to explore and validate the patient’s reaction to the rupture.
2.3.4.1 Case example

Bill felt let down and angry when his friend did not telephone as promised. He decided that his friend no longer liked him and that the only way that he could reduce his intense anger was to cut himself, a behaviour which he had been trying to reduce.

In this situation, it was valid that Bill felt rejected and angry in light of his assumption that his friend had rejected him (even though that assumption may have been incorrect). In the past, people failing to telephone as arranged had signalled the rupture of friendships. Bill’s judgement that only self-harm could reduce the intensity of his anger was also valid (also probably incorrect), given that this had been the only strategy that had worked to reduce his anger in the past. The act of self-harm was valid as the only solution Bill could see to change an intolerable emotional state.

The therapist, after actively listening to Bill explain the situation, reflected her understanding of the situation and Bill’s associated emotions, thoughts and behaviours back to him and checked out that she had understood correctly without missing any important information. She then directly validated Bill’s experience while helping him explore and question the antecedents and consequences:

**Therapist:** So, Bill, if I have understood you correctly, your friend didn’t phone you as agreed, and you took this to mean that he no longer liked you. You felt let down and angry and cut yourself to reduce your anger to a tolerable level. You then thought you were a failure and felt ashamed. Is that about right? [accurate reflection following active listening]

**Bill:** Yes, that’s about right.

**Therapist:** I can see why you felt angry and let down, anyone would if they thought their friend had snubbed them and didn’t like them any more [direct validation]. . . but how did you know for sure that your friend had deliberately let you down [exploring antecedent]?

**Bill:** Well, he didn’t phone, what else could it mean?

**Therapist:** What other alternative explanations might there be? [exploring antecedent]

**Bill:** I don’t know. . . well, I suppose he may have run out of credit or lost his phone.

**Therapist:** Possibly—I suppose we don’t know for sure until we have more information, but I remember you said that a lot of people have let you down in the past, so I can see why you made that judgement [direct validation; distinguishing judgement from fact]. I can also see why you cut yourself—your anger was intolerable and you needed to do whatever it took to feel differently, cutting yourself was the only thing you knew had worked in the past [direct validation].

**Bill:** Yes, I had no other option.

**Therapist:** I recognise that’s how it seemed for you at the time, and I get that something had to be done [direct validation] but you’ve identified before that cutting yourself causes you to feel very ashamed and you’re left with a scar. Do you think it may have been worth trying out any of the emotion regulation skills you have learned over the past few weeks first? [exploring alternatives]
2.3.5 Self-management

Promoting and supporting self-management represents the overall aim of the treatment of personality disorder. Self-management is such a broad topic that it has been given its own section in this ICP. Please see the Self-management Section for further details.

2.4 Stages of Change Model (Trans-theoretical Model of Intentional Change)

The Stages of Change Model or Trans-theoretical Model of Intentional Change (TTM) (Prochaska, 2010) has been applied to many different patient groups with various health conditions, and describes how people modify unhelpful behaviours, or increase or acquire helpful behaviours.

Essentially the TTM is conceptualised as comprising 5 stages (see Figure 2.1) which are progressed through sequentially (or sometimes as a cycle). Occasionally, there may be a return from a particular stage to an earlier stage but population studies show that in personality disorder sustained recovery is more likely than relapse. A relapse can be defined as return from the Action or Maintenance stage to an earlier stage. This may occur due to significant ongoing stressors or because subsequent and necessary phases of treatment have not been undertaken at an appropriate time. For example, if trauma work is not made available to an individual with post-traumatic features in a reasonable time after stabilisation, a recurrence of previous unhelpful behaviours often occurs. This is usually as an ineffective attempt to deal with overwhelming post traumatic symptoms.

- **Pre-contemplation (Not ready)**
  People at this stage are not intending to take action in the next six months and are often unaware of the unhelpful nature of their behaviour. Sometimes people at this stage may have tried to change a number of times with limited success and may feel demoralised and discouraged from trying again.

- **Contemplation (Getting ready)**
  People are starting to recognise that their behaviour is unhelpful and begin to look more closely at the pros and cons of their continued actions. They are usually increasingly aware of the possible benefits of changing but remain significantly influenced by the benefits of the current behaviour and apprehensive about change. This balance between the pros and cons of changing can lead to people remaining at this stage for long periods of time.

- **Preparation (Ready)**
  People are intending to take action in the next month or so and may begin to make small steps towards behaviour change.

- **Action**
  People have made specific overt modifications in reducing unhelpful behaviour and/or acquiring or increasing helpful behaviour.

- **Maintenance** People have maintained action for some time and are working to prevent a return to previous behavioural patterns. In this stage, change strategies are not employed as often as in the Action stage and people are typically increasingly confident
that they can maintain change.

The TTM can be applied to each phase of treatment within the overall treatment pathway. For example, an individual may be in the maintenance phase with regard to stabilisation (phase 1) but in the contemplation or preparation stage with regard to trauma work (phase 2). In such a case, the TTM could help identify that the focus of the treatment should be on maintaining stabilisation and increasing motivation for trauma work.

Motivational interventions to increase intention to change can be especially useful in the pre-contemplation, contemplation and preparation stages by assisting patients to reach the stage where meaningful behavioural change can occur. Examples of motivational interventions are described under Motivation in the General Treatment Strategies section.

Figure 2.1: Stages of change model

2.5 Phases of Treatment

The overall goal in the treatment of personality disorder is to improve adaptation to the environment rather than effect personality change. However, given the complexity of personality disorder, at times it can be difficult to develop a specific treatment plan in the service of this goal, and a structured approach can be of real value. There is expert consensus that phase-based models are important in informing the sequence of interventions in the care and treatment of complex mental disorders such as personality disorder.

The particular model used in this document adapts the work of Livesley (2003) and, like most other phase-based models, comprises 3 main phases. However, Phase 1 (stabilisation) is broken down into a further 3 sub-phases. This finer-grained model is more clinically useful. For example, it can help explain why lengthy hospital admission usually fails to produce stabilisation: while hospital admission has value in the safety phase and to some degree the
containment phase, it seldom has a positive effect (and often exerts a negative effect) on promoting self-regulation and control. This is related to the removal of responsibility for self-management from the patient.

Any treatment for personality disorder should be based upon an individual formulation with clarity about the goals and purpose of the intervention for the person at that time. Each phase should be worked through sequentially. The phases of treatment comprise:

1. **Stabilisation (or MAKING STABLE). The focus is on the present:**
   a) **Safety**: Interventions to ensure the safety of the patient and others.
   b) **Containment**: Interventions based primarily on general treatment strategies such as validation and stabilising the environment in order to contain behavioural and affective instability. May be supplemented with medication if appropriate in the short term.
   c) **Regulation and control**: Behavioural, cognitive and occasionally pharmacological interventions to reduce symptoms and improve self-regulation of affects and impulses

2. **Exploration and change (or MAKING SENSE). The focus is on the past:**
   Interventions to change the cognitive, affective, interpersonal and situational factors contributing to the patient’s difficulties. This phase may include specific trauma work but may be a more general exploration of long standing patterns of thinking and behaviour.

3. **Integration and synthesis (or MAKING CONNECTIONS). The focus is on the future**: Interventions designed to promote a more integrated sense of self along with more integrated and adaptive interpersonal systems

A single treatment approach can have a focus in more than one phase area, although usually the focus would be on only one phase at any given time, with sequential working through of the phases. **Table 2.1**, compares the primary focus areas of several interventions.

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**Table 2.1**: Comparison of primary areas of focus for a variety of interventions.
2.5.1 Phase 1

People with personality disorder often present to services with emotional and behavioural dysregulation, requiring stabilisation interventions. These can be effectively provided across many settings and may range from supporting the problem-solving of a distressing interpersonal situation, to treatment of an Axis 1 or physical comorbidity, to a specialist psychological therapy targeting parasuicidal behaviour. Stabilisation may require support from several different services or agencies. An overall formulation with clarity about the phase of treatment and including explicit short and longer term goals is valuable in optimising consistency and may mean the difference between repeated management of symptoms and treatment of the underlying disorder.

2.5.1.1 Case example

Jane, a 25 year old lady with severe borderline personality disorder, presented with multiple difficulties including poorly managed diabetes mellitus, alcohol dependence, housing difficulties, marked emotional dysregulation, self-harming behaviours and multiple suicide attempts. Stabilisation involved input from her psychiatrist who made the diagnosis and stopped the antidepressant tablet which appeared to be contributing to increased emotional dysregulation, her GP who helped her stabilise her diabetes, the Addictions Service which helped her stabilise her alcohol dependence, the Housing Officer who helped her to find appropriate accommodation, the DBT therapist who provided specific psychological therapy with a beneficial effect on parasuicidal behaviours, and her CPN who monitored her overall mental health, helped maintain motivation and consistency, and co-ordinated the overall treatment plan under the Care Program Approach.

2.5.2 Phases 2 and 3

Historically, less attention has been paid to the second and third phase within mainstream mental health services, which remain more involved with stabilisation than any other phase of treatment. However, it is often the case that patients are unlikely to progress in their recovery once stabilisation occurs if the later phases are not addressed in some manner. Failing to address Phases 2 and 3 can result in relapse and a return to previous unhelpful behaviours, repeated presentations and a sense of frustration and helplessness in patients and professionals.

For the most part, each of the three phases should be worked through in order, but it is important to note that the phases of treatment may overlap slightly and that some interventions will allow for work in more than one phase of treatment. For example, although standard DBT is primarily focused on stabilisation, the emphasis can shift to exploration and change (and even integration and synthesis) once stabilisation occurs. While some patients will require the input of services during all phases of treatment, many will not. For example, someone who has been supported to stabilise by services may then be able to meet the goals of Phase 2 and 3 themselves, or with minimal support.

Attaining stabilisation enables some patients to reflect on longstanding patterns of behaviour and
thinking and the skills they have acquired during Phase 1 allow them to make effective changes to these patterns (exploration/change). They may not require specific input from services to complete this Phase 2 work. These changes, as time goes on, may allow for involvement in new opportunities, such as new employment, recreational activities and friendships, leading to a more integrated sense of self within a new, healthier interpersonal context. Others may not require support with Phase 2, but may benefit from Phase 3 input. Occasionally, people may present without requiring specific stabilisation work, but would benefit from work targeted at Phase 2 or Phase 3. The chances of meaningful recovery are increased when the tasks of all the phases are addressed.

2.5.2.1 Case example

Bob was helped to stabilise by the input of his CPN and the STEPPS program. He did not require any specific trauma work and, from his new position of emotional and behavioural stability, he felt confident in being discharged from services. He was then able to work through Phase 2 himself, exploring and making changes to long-standing patterns of thinking and behaviour using the skills of self-observation and reflection which he had learned in Phase 1 of treatment. He started some new recreational activities locally and eventually he decided to re-enter the work-place. He obtained a part-time job which, together with the recreational activities he was involved with, helped him achieve many of the objectives of Phase 3 work including the development of new roles, responsibilities, activities and relationships, all of which contributed to a more integrated sense of self and a firmer sense of his place within his community.

2.5.3 Timing and sequencing

There is general agreement that patients should receive the right input at the right time and that the different phases of treatment should be as joined-up as possible, although input for each phase may be provided by different services. For example, the available evidence appears to indicate that after a period of 2 months of stability, specific trauma work can usefully be started. Experience suggests that waiting for longer does not provide any particular clinical benefit and a hard-won window of opportunity may be lost. It is therefore of particular importance to strive for a joined-up approach to working through the phases of treatment in a patient-centred way.

It is important to note that psychological interventions are not inert and have the potential to cause harm. For example, undertaking emotionally intense trauma work in an individual who has not been supported to appropriately stabilise first and has not learnt skills of self-regulation and control has the potential to cause harm. The patient is likely to become emotionally dysregulated and use unhelpful and potentially dangerous behaviours in an attempt to re-regulate. Use of the phase-based model can reduce the potential for a psychological intervention to cause harm.

Movement through phases of treatment is not always one way. Occasionally, people will have a recurrence of emotional and behavioural dysregulation after a period of stability. In cases like this, the focus of treatment should return to the stabilisation phase. Almost invariably, the time required to re-stabilise is shorter than the time taken for the initial stabilization work and usually requires a focus on increasing motivation to use pre-existing skills or a brief revision of skills rather than a fresh re-learning of skills.

2.6 Matched Care
The concept of matched (or stepped) care is based on the understanding that for most health conditions, there will be a larger number of people with less severe forms of the disorder, with numbers of those affected by the disorder becoming progressively smaller as severity increases. Treatment is organised in tiers to best match intensity of service with complexity and severity of need. This has benefits for patients and services but does require appropriate assessment and signposting of patients to the most appropriate intervention for them at that time. For example, STEPPS is the most appropriate stabilisation intervention for moderate severity borderline personality difficulties but DBT is more appropriate for treating patients with more severe forms of the disorder, given its more intensive approach.

The concept of matched care is sometimes represented as a pyramid, as in Figure 2.2.

In NHS Highland, services fall within the first 3 tiers of this model. Primary care, social care, third sector and specialist outreach from the PDS (primarily in terms of education/awareness interventions) comprise the first tier. Tier 2 includes inpatient and community mental health services (including STEPPS), and PDS outreach interventions to these services. These outreach interventions include education/awareness, and consultation/liaison interventions. The PDS represents the third tier of service in NHS Highland incorporating DBT and the CAS Day Service.

Table 2.2 shows some examples of interventions for each phase of treatment available within the different tiers of service provision. This table is illustrative only and is by no means exhaustive.
Table 2.2 Examples of available interventions by phase of treatment within each tier of service provision.

<table>
<thead>
<tr>
<th>Tier 1 (Primary care, social care, third sector)</th>
<th>Phase 1 (stabilisation)</th>
<th>Phase 2 (exploration and change)</th>
<th>Phase 3 (integration and synthesis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care: treatment of co-morbid physical illness</td>
<td>All agencies: model non-specific work supporting self-reflection and identification and change of unhelpful patterns of behaviour</td>
<td>Employment services: Employability Officer support</td>
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<tr>
<td>Housing: assistance with appropriate accommodation</td>
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</tbody>
</table>

| Tier 2 (Mainstream mental health) | | |
|----------------------------------|-------------------------|---------------------------------|-----------------------------------|
| Addictions services: treatment of substance dependence | CMHT: STEPPS, treatment of co-occurring mental illness | CMHT: Occupational therapy support to engage in mainstream community activities, Vocational Support Team |
| | CMHT: STEPPS, treatment of co-occurring mental illness | |
| | Psychology department: trauma work | |

<table>
<thead>
<tr>
<th>Tier 3 (Local specialist services)</th>
<th>PDS: DBT</th>
<th>PDS: DBT, DBT-PE</th>
<th>PDS: CAS Day Service</th>
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