Structured Clinical Management

An evidence based approach for generalist mental health clinicians

Professor Anthony Bateman
Third International Congress on Borderline Personality Disorder and Allied Disorders
Tailoring treatments to different developmental pathways and phenomenologies

16 – 18 October 2014
Sheraton Roma Hotel & Conference Center // Rome, Italy

Plenary Speakers
- Martin Bohus, Germany
- Catherine Cohen-Kadosh, UK
- Patrick Luyten, UK
- Lars Mehlum, Norway
- Antonia New, USA
- Alexandra Philipsen, Germany

Special Session
- Peter Fonagy, UK
- Marsha Linehan, USA

www.borderline-congress.org
Borderline Personality Disorder:
An evidence-based guide for generalist mental health professionals

Anthony W. Bateman, Consultant Psychiatrist and Psychotherapist, UK and Roy Krawitz, Consultant Psychiatrist and DBT therapist, Waikato District Health Board, New Zealand

- 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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Aims Realistic Expectations

- This training will provide you with the foundations of SCM.
- Introduction and opportunity to practice delivering core skills in SCM.
- You will be set up in supervision groups with support to build on these foundations in ongoing supervision.
Are specialist treatments for personality disorder necessary?
Specialist/Generalist treatments: the evidence base

- 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: the evidence base

- 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)
  
Specialist/Generalist treatments: the evidence base

- Mentalization based treatment (MBT) ‘v’ structured clinical management (SCM) – both were effective treatments. SCM was superior in the intial 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: the evidence base

- 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: the evidence base

- 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)

Outcomes?

- Zanarini, in a 16 year prospective follow-up study, found that whilst substantial reduction in symptom severity is achievable, good social and vocational function is more difficult to attain with or without treatment.

- McMain et al: at two year follow-up patients with BPD still show marked functional impairment despite well-organised treatment.

- Bateman and Fonagy found that, 8 years after randomisation, patients still had functional impairment.

- Davidson and colleagues found at 6 year follow-up that only one fifth of patients had showed improvement in affective disturbance and their quality of life remained poor.
Who specifically benefits from MBT-BPD?
Moderating effect of Narcissistic PD

Group x Time interaction: \( \beta = 0.20, 95\% \text{CI}: 0.08 - 0.50, z = -3.43, p < 0.001 \)

3-way interaction: \( \beta = 4.9, 95\% \text{CI}: 0.93 - 37.2, z = 1.7, p < 0.07 \)
Antisocial problems and clinical outcome

Group x Time interaction: Beta=0.16, 95%CI: 0.06 - 0.48, z=-3.31, p<0.001
3-way interaction: Beta=3.7, 95%CI: .93 - 17.59, z=1.74, p<0.07
Moderating Effects of Age on GSI

3-way interaction: $\beta = -0.027$, 95% CI $-0.05$ to $-0.001$, $z = 2.1$, $p < 0.04$
Coefficient of difference between slopes = -0.14 (-0.21, -0.08), p<.000

Moderating effect of age on BDI scores

3-way interaction: Beta=-0.027, 95%CI -0.05 - -0.001, z=2.1, p<0.04
MBT patients who remained with clinical problems: SCL-90 subscale scores

Mean SCL-90 scores

No clinical change (n=19)  Significant change (n=52)
Nineteen patients were not free of self-harm, suicide or hospitalization after 18-months of MBT. Who were they?
Does Severity Moderate MBT? Indicators of Severity in IOP-Study

**Severity of Axis I Disorder**

- Number of Axis I Diagnoses
- Severity of Axis I Disorder

**Severity of BPD**

- Number of Descriptive Criteria Met for BPD
- Severity of BPD

**Severity of Axis II Disorder**

- Number of Axis II Diagnoses (inc. BPD)
- Severity of Axis II Disorder

**Severity of Symptomatic Distress**

- SCL-90 General Severity Index
- Severity of Symptomatic Distress
Which, if any, do you think moderates outcome?
Predictive Recovery by Axis II Pathology

One Axis II Diagnosis

Two Axis II Diagnoses

Three Axis II Diagnoses

Four Axis II Diagnoses

Assessment Periods:
- Baseline
- 6 months
- 12 months
- 18 months

Linear Prediction of Recovery
- SCM
- MBT

Comparison of recovery trends over time for different numbers of Axis II diagnoses.
Predicted BDI Scores by Axis II Diagnoses

One Axis II Diagnosis

Two Axis II Diagnoses

Three Axis II Diagnoses

Four Axis II Diagnoses

Baseline 6 months 12 months 18 months
Assessment Period

Baseline 6 months 12 months 18 months
Assessment Period

Baseline 6 months 12 months 18 months
Assessment Period

Baseline 6 months 12 months 18 months
Assessment Period

Linear Prediction of BDI Scores

SCM MBT
Predicted Interpersonal Problems by Axis II Diagnoses

One Axis II Diagnosis

Two Axis II Diagnoses

Three Axis II Diagnoses

Four Axis II Diagnoses

Linear Prediction of IIP Scores

Baseline 6 months 12 months 18 months
Assessment Period

SCM MBT

Baseline 6 months 12 months 18 months
Assessment Period

SCM MBT
Predicted Self-Harm By Axis II Diagnoses

- One Axis II Diagnosis
- Two Axis II Diagnoses
- Three Axis II Diagnoses
- Four or More Axis II Diagnoses
The Impact of Therapists on Treatment Outcome
Variance due to Tx and Therapists in NIMH study of Depression (CBT & IPT)

Kim et al., 2006, *Psychother Res*, 16:161

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>0%</td>
<td>5% to 11%</td>
</tr>
<tr>
<td>HRSD</td>
<td>0%</td>
<td>1% to 12%</td>
</tr>
<tr>
<td>HSCL-90</td>
<td>0%</td>
<td>3% to 10%</td>
</tr>
<tr>
<td>GAS</td>
<td>0%</td>
<td>8% to 12%</td>
</tr>
</tbody>
</table>
Variance due to therapists in practice
Wampold & Brown, JCCP, 2006

• 581 Therapists, 6146 heterogeneous patients
• Diagnosis, degree, experience: 0% variance
• Medication: 1% (but also dependent on psychotherapist)
• Provider: 5%
• Top quartile produced twice the effect of the lowest quartile in subsequent year
Impact of individual therapists in routine practice
Okiishi et al. 2006 (J Clin Psychol 62:9, 1157)

- 6,499 patients seen by 71 therapists

- therapists had to see at least 15 clients
  - on average saw 92

- number of sessions: range 1-203; mean 8.7

- therapists saw equivalent range of clients in terms of disturbance & presentation

- HLM used to compare ‘trajectories’ (recovery curves) of patients using OQ45
Clients of Some Therapists Improve Faster or Slower Than Others
Slope of Improvement Across Therapists Unaffected by:

- therapist experience
- gender
- type of training
  - counselling psychology, clinical psychology, social work, marital/family therapist
  - orientation
  - CBT, humanistic, psychodynamic
# Outcomes for Best and Worst Performing Therapists

<table>
<thead>
<tr>
<th></th>
<th>recovered</th>
<th>improved</th>
<th>deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td>top 10% therapists</td>
<td>22.4%</td>
<td>21.5%</td>
<td>5.2%</td>
</tr>
<tr>
<td>bottom 10% therapists</td>
<td>10.6%</td>
<td>17.4%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>
Incidence of Harmful Effects

- estimates are that 5-10% of therapy clients deteriorate
  - across all orientations, client groups, modalities
  - in RCTs of ‘empirically supported treatments’

- rates higher than in control groups
  - e.g. NIMH reanalysis (Ogles et al. 1995)
  - 13/162 (8%) deteriorated, all in active treatments

- in Lambert’s work therapists tend to be poor at:
  - predicting who will do badly
  - recognising failing therapies
Reducing the Harmful Effects of Psychotherapy: The work of Lambert (2009)

- Across studies the rate of observed deterioration in psychotherapy was 10-25% with young people.
- Some therapists have rates of deterioration of around 50% and their treatment is NEVER associated with recovery.

Introduction of *outcome tracking* (session by session monitoring)
- Early warning when patient goes off trajectory.

Therapists randomized to feedback vs no-feedback
- Deterioration reduced by 50%.
- Recovery improves by 50%.
- Average therapy is shorter.
- Patients who show early negative response receive longer and more effective treatment.
Do no harm... outcomes informed care

- Most therapists see themselves as better than average:
  - Dew & Riemer (2003, 16th Annual Research Conference, University of South Florida)

  - 143 counselors asked to grade their job performance on scale from A+ to F
    - 66% rate themselves as A or better
    - None rated themselves as below average

- Outcomes informed care may be a critical way of linking the EBP approach and practice based evidence
Percentage of patients, by site, who achieve clinically meaningful improvement within median treatment length


<table>
<thead>
<tr>
<th>Site</th>
<th>Sample Size</th>
<th>Median sessions</th>
<th>% Recovered</th>
<th>% Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Assistance</td>
<td>3,269</td>
<td>3</td>
<td>7.4</td>
<td>18.3</td>
</tr>
<tr>
<td>University Counseling</td>
<td>1,188</td>
<td>4</td>
<td>5.9</td>
<td>15.2</td>
</tr>
<tr>
<td>Local HMO</td>
<td>595</td>
<td>2</td>
<td>5.7%</td>
<td>14.3</td>
</tr>
<tr>
<td>National HMO</td>
<td>536</td>
<td>4</td>
<td>9.1</td>
<td>24.4</td>
</tr>
<tr>
<td>Training CMH</td>
<td>123</td>
<td>8</td>
<td>6.5</td>
<td>20.3</td>
</tr>
<tr>
<td>State CMH</td>
<td>361</td>
<td>4</td>
<td>5.8</td>
<td>17.7</td>
</tr>
<tr>
<td>Total 6,072</td>
<td>6072</td>
<td>3</td>
<td>6.5</td>
<td>16.6</td>
</tr>
</tbody>
</table>
Therapist predicted treatment success compared to actual treatment outcomes after psychotherapy

Odds of a clinical episode in MBT by therapist
Flow of the Training

- Review Personality Disorder
- Introducing SCM
- Clinical Stance Assessment

Morning of Day 2

- Clinical Interventions Core Strategies
- Treatment Planning

NEXT STEPS Supervision
What is Personality Disorder?
Personality Disorder
What is it?

- Personality Disorder is a medical label
- It is when somebody has long standing difficulties coping

However:
- Is it different from a mental illness?
Personality Disorder

What is a Personality Disorder?

Personality Disorders first emerged in DSM III when they utilized a multi-axial diagnostic system-

Multi-axial Assessment

- Axis I Clinical Disorders
- Axis II Personality Disorders
- Axis III General Medical Conditions
- Axis IV Psychosocial and Environmental Problems
- Axis V Global Assessment of Functioning

DSM V is no-longer using the multi-axis system
Medical definition of a PERSONALITY DISORDER

Within the DSM IV definition of PD traits, areas identified:

- how the individual perceives and relates to others,
- their belief about the environment and their position within it,
- resulting behaviours in a wide range of social and personal context.

It also states that PD is an:

“enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”
Personality Disorder – three main areas of difficulty.

- **Affect Regulation**
  - Modulation/Tolerance

- **Identity**
  - Fragile self esteem

- **Relationships**
  - How they relate to themselves and others
Clinical Features of Borderline Personality Disorder (DSM-IV: 5 of 9)

- a pattern of unstable intense relationships,
- inappropriate, intense anger
- frantic efforts to avoid abandonment
- affective instability,
- impulsive actions
- recurrent self-harm & suicidality,
- chronic feelings of emptiness or boredom (dysphoria),
- transient, stress-related paranoid thoughts
- identity disturbance severe dissociative symptoms

unstable relationships
affective dysregulation
impulsivity
aggression
Attachment theory

- SEPARATION ANXIETY
- ANNIHILATION
- PARANOID ANXIETY
- PROTEST
- DESPAIR
- DETACHMENT

- AUTONOMOUS
- DISMISSIVE/DETACHED
- PRE-OCCUPIED
- ENMESHED
- INCOHERENT
Bowlby’s Attachment Theory

- Need of human infant to seek protection and security through physical contact with the caregiver

- Attachment system
- Attachment behaviours

- Caregiving system
- Caregiving behaviours

  - proximity seeking
  - clinging
  - smiling

  - touching
  - holding
  - soothing

- Affectional bond: expectation of being offered care
Attachment Classification: Secure

- Parenting behaviour
  - co-ordinated
  - sensitive
  - stabilised emotional response

- Developmental impact
  - organised in stress
  - negative emotions feel less frightening (meaningful, communicative)
Attachment Classification: Anxious-avoidant

- Parenting behaviour
  - emotional arousal not re-established
  - over-aroused through intrusive parenting
  - caregiver unresponsive or intolerant

- Developmental impact
  - over-regulate affect
  - avoid distressing situations
  - seeking proximity is futile
  - avoid disclosing dependence
  - attachment behaviours are deactivated
Attachment Classification: Anxious-resistant

- Parenting behaviour
  - inconsistent responsiveness

- Developmental impact
  - under-regulate, heightening expression of distress in order to elicit caregiving responses
  - low threshold for threat
  - preoccupied with contact with caregiver
  - vigilant for presence or loss of caregiver
  - proximity not soothing but results in persistent anxiety
Attachment Classification: Disorganised

- Parenting behaviour
  - attachment figure simultaneously source of reassurance and fear
  - prolonged separation
  - intense marital conflict
  - neglect
  - physical or sexual abuse

- Developmental impact
  - capacity to respond to stress most compromised
  - disorganisation
  - disorientation
  - dissociation
  - bizarre repetitive movements
  - self-harm, self-mutilation
  - extreme controlling behaviour
Infant Attachment and Adult Relationships

- IWM has origin infancy, profoundly influenced by experiences with primary caregiver
- Not all adult relationships affected by attachment system
- IWM guides emotional and behavioural response when threat is perceived
- Continuity of attachment across life-cycle
The child’s distress is a signal to the attachment person to do something to comfort the child – and adult.

We are programmed to respond in these ways (all mammals are). It is instinctive.
Attachment Styles

Our attachment to others can be described as:

1. Secure

2. Insecure - Ambivalent/Overinvolved (sometimes called anxious)

3. Insecure – Distanced (sometimes called avoidant)
Insecure Attachment - Ambivalent/Overinvolved

They have learnt that they can not trust that people will reliably be there for them (in terms of presence and response). This can lead them to hold tightly onto people for fear they will leave or stop caring.

<table>
<thead>
<tr>
<th>Characteristics of Ambivalent Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>As Children:</strong></td>
</tr>
<tr>
<td>1. May be wary of strangers.</td>
</tr>
<tr>
<td>2. Become greatly distressed when the parent leaves.</td>
</tr>
<tr>
<td>3. Do not appear to be comforted by the return of the parent.</td>
</tr>
<tr>
<td><strong>As Adults:</strong></td>
</tr>
<tr>
<td>1. Reluctant to become close to others.</td>
</tr>
<tr>
<td>2. Worry that their partner does not love them.</td>
</tr>
<tr>
<td>3. Become very distraught when a relationship ends.</td>
</tr>
</tbody>
</table>
Insecure Attachment - Distanced

They have learnt their feelings are often overlooked, misunderstood or they have been tormented for what they were feeling, or experienced other negative consequences.

### Characteristics of Avoidant Attachment

<table>
<thead>
<tr>
<th>As Children:</th>
<th>As Adults:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. May avoid parents.</td>
<td>1. May have problems with intimacy.</td>
</tr>
<tr>
<td>2. Does not seek much comfort or contact from parents.</td>
<td>2. Invest little emotion in social and romantic relationships.</td>
</tr>
<tr>
<td>3. Shows little or no preference between parent and stranger.</td>
<td>3. Unable or unwilling to share thoughts and feelings with others.</td>
</tr>
</tbody>
</table>
Secure Attachment

Having a secure attachment seen as good/healthy and essential to facilitate recovery
## Secure Attachment

### Characteristics of Secure Attachment

<table>
<thead>
<tr>
<th>As Children:</th>
<th>As Adults:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Able to separate from parent.</td>
<td>1. Have trusting, lasting relationships.</td>
</tr>
<tr>
<td>2. Seek comfort from parents when frightened.</td>
<td>2. Tend to have good self-esteem.</td>
</tr>
<tr>
<td>3. Return of parents is met with positive emotions.</td>
<td>3. Comfortable sharing feelings with friends and partners.</td>
</tr>
<tr>
<td>4. Prefers parents to strangers.</td>
<td>4. Seek out social support.</td>
</tr>
</tbody>
</table>
Attachment Classification: Secure

- Parenting behaviour
  - co-ordinated
  - sensitive
  - stabilised emotional response

- Developmental impact
  - organised in stress
  - negative emotions feel less frightening (meaningful, communicative)
Recovery Requires 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)
Emergence Video
Commonalities between treatments

An evidence base for a generalist mental health approach
Structured Clinical Management

Organised Case Management specific to personality disorder
Structured Clinical Management

- Evidence based approach to working with people with personality disorder.

- Based Bateman/Fonagy model: supportive approach with case management + integration of other techniques
  
  - Involves helping the person to:
    - Problem solve
    - Manage a crisis
    - Develop skills to manage emotions/impulses/interpersonal interaction
    - Use medication and services appropriately
Aims of SCM

Aims of the intervention are to help the person to:

- Use services more effectively (starting with yourself).
- Develop a better understanding of their own internal states of mind (internal states).
- Learn and practice skills to manage emotions/impulses/relationships more effectively.
- Develop activities outside of services (vocational).
"We're encouraging people to become involved in their own rescue."
The Spine of SCM

- 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 psychoeducation and skills sessions – managing emotions/impulses/interpersonal problems.
Clinician stance
Clinical stance for SCM

- Attitude - Be Wise and Mentalize
- Reliable and consistent
- Active participation
- Realistic expectations
- Team work and communication
- Hope and optimism
- Ability to implement basic skills training
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
Why Wise? Why Mentalize?

- We work better with people if we understand ourselves and them better
  - **Wise mind** – being aware of one’s own state of mind (emotional/reasonable)
  - **Mentalization** – is also about being aware of our own state of mind and also how we perceive the state of mind of somebody else
  - **Holding mind in mind**
  - Aware that often our own internal beliefs affect how we assume others are thinking
States of Mind

Reasonable Mind

Equally non-mentalizing
Cut off cold
Dismissing
Non understanding

Wise Mind

Emotional Mind

Egocentric
Non-mentalizing
Be Wise and Mentalize is about:

- being more psychologically aware
- It is about being aware of your own mental states (own mind) and also being able to make informed independent judgements about the mental states of others
Clinician attitudes and stigma

- Reaction to anger and negative emotional states (feelings in the clinician)
- Perception of willful treatment resistance
- Frequent flyers
- Misinformation about heritability and prognosis
- Slow progress
Validating mental state

- It is easy to be drawn into discussing a person’s behaviour and miss validating how they feel.
  - For instance, if a person informs you they are working hard to go out but finding it really difficult it can be easy to reinforce the effort and miss the ‘finding it difficult’ this may leave them feeling not heard/listened too.
Illustrating stance

- Video Clip (Anthony from conference)
  - Highlighting clinical stance e.g.
    - Validating mental state
    - Active, responsive, curious
    - Challenging passivity
    - Focusing on current situations
  - Introducing workbook
Practising clinical stance in role play (scenario A)

- Illustrate the model for role playing in Trio’s – set people up in teams as per Borough

Diagram:
- Observer/s
- Practitioner
- Colleague
Practising clinical stance in role play (scenario A)

- Anne whom you are working with tells you (with anger tone) that she feels you are not interested in her and can tell by your facial expression that you don’t care about her. She wants to change worker.

- You have only worked with her for two months after she requested a change of co-coordinator previously.

  - In teams practice managing this scenario, and write down some notes (on the following page of the workbook):
Practising clinical stance in role play (scenario B)

- Tracey has a long history of serious suicidal behaviour and frequent admissions to hospital. Once admitted the length of stay can be several months as suicidal behaviour often continues. She is frequently on special observations. You are aware that staff on the inpatient unit do not feel an admission is helpful.

- In session Tracey looks really low – she tells you she feels suicidal and can’t keep herself safe anymore. On questioning she expresses a need to go into hospital.

- In teams practice managing this scenario, and write down some notes in the workbook:
Structured Clinical Management

Assessment and diagnosis
SCM: strategic processes

- Careful assessment
- Giving the diagnosis
- Information
- Crisis planning
- Risk assessment and risk management
- Development of a hierarchy of therapeutic areas
Talking to the person to make a diagnosis

- What makes you you?
- Does your sense of who you are change?
- Do you know who and what you like and dislike?
- Do you tend to become what others want you to be?
- Are you easily influenced by others?
- Can you tell what other people are thinking?
- Do you seek out sensation and risky pursuits?
Talking to the person to make a diagnosis

- Are you a careful planner?
- Do you think about the consequences of your decisions before you make a final decision?
- Do the intensity of your emotions lead to actions that you later regret?
- How would you describe the quality of your relationships?
- Are you always on the alert when with other people?
- Are you concerned with what others think about you?
- Can you be oversensitive?
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.”
RESPONSES TO DIAGNOSIS OF BPD

(N = 30)

- Shame
- Likability
- Hope
- Overall

Rubovszky et al. unpublished
Structured Clinical Management

Treatment planning
In Crisis Video

- Play in crisis video – illustrating how service and service user are not working together.
What do you want? : What do I want?

- Establishing the contract/agreement (aims nature of the relationship).
- Necessary to reduce the number of ruptures.
- Can lead to immediate reductions in self harming behaviour.

What would the agreement be here?
Agreeing what we are going to work on:

- We need to be clear in our focus
- We then need to develop a common goal focus – what is your agreed goal?
- Emphasis on autonomy.
- Treatment is community based.
- Hospitalization limited.
SCM: strategic processes

- Agreement of clinician and patient responsibilities
- Development of motivation and establishment of therapeutic alliance
- Stabilisation of drug misuse and alcohol abuse
- Development and agreement of comprehensive formulation and goals
- Involvement of families, relatives, partners and others.
Clinician agreements

- Formulate action plans with the patient which are designed to meet problems
- Agree timing of subsequent review arrangements
- Provide specific information about treatment and its rationale
- Engage the patient in the agreed treatment programme
- Fulfil clinician aspects of an agreed crisis plan
- Provide the treatment sessions professionally
- Ensure the patient has full information about any medication
Clinician agreements

- Complete and maintain a full risk assessment and treatment plan which includes the crisis plan
- Integrate different components of the patient’s involvement with services
- Involve patients, carers (family, friends, or care staff from residential homes), an independent advocate (if requested), mental health professionals and others e.g. police
- Document patients' and carers' views on their involvement with the treatment programme
- Engage other mental health services, housing and social care when appropriate
- Facilitate admission to hospital if necessary
Patient agreements

- Attending treatment sessions on time
- Being open and honest in treatment
- Engaging in addressing the agreed target areas
- Attempting to stay alive and avoiding acts of self-harm
- Fulfilling patient aspects of the crisis plan and revisiting it with the clinician when necessary
Setting the Frame Exercise

- Discuss with the patient the frame of treatment
- Outline treatment programme
- Discuss their concerns about treatment
- Define a goal
- Establish the contract
Managing safety: seven principles

- Assess risk – differentiate non-lethal and true suicide intent
- Don’t ignore or derogate – express concern
- Ask what the patient thinks will help – foster sense of self agency
- Clarify precipitants – chain analysis and seek interpersonal events
- Be clear about your limits – no omniscience and omnipotence
- Explore the effect on treatment
- Discuss with colleagues
Algorithm for Intersession Availability

**Crisis Calls**

- **No calls**
  - ~ 30%
  - OK
  - Crisis
    - “Why not call?”
    - Alternative plan developed

- **OK**
  - ~ 55%

- **Repeated Calls (non-crisis)**
  - ~ 15%
  - In next session:
    - was it useful? If so, why? (aloneness, care, etc.)
    - How might it be managed otherwise?
    - Revisit crisis plan

**Change content of calls**
- a) abbreviate
- b) problem solve
- c) email

**Change agreement**
- a) only for crises
- b) call before, not after
- c) use ER or emails

**Set your limit**
MOE'S FIX-IT SHOP

NO HEROIC MEASURES
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.
Information for me:

Positive things I can do when I am in a crisis:

Things which have not been helpful when I have been faced with crises in the past:

Staying up all night; admitted to hospital; increasing the dosage of my medication as this prolongs my stay in hospital; health professionals concentrating on my past history instead of current problems

Specific refusals regarding treatment during a crisis:

I do not want to be hospitalised unless it is absolutely necessary; please don’t make decisions about my treatment without including me in the discussion first

Information for healthcare professionals:

My difficulties as I see them now:

I am addicted to cannabis, I often go out of my way to get it (which puts me in danger); I have several worries about family and thinking about them can make me feel very depressed; attempting to deal with the problems in my life can lead to thoughts of suicide

Details of any current treatment / support from health professionals:

Physical illnesses & medication:

Situations which can lead to a crisis:

Things I would like professionals to do which may help me when I am in a crisis:

Things which professionals have said or done which have not been helpful in the past:

Practical Help in a Crisis:

Agencies or people that I would like to have copies of this Joint Crisis Plan:

√ Myself
√ My GP, Dr. X
√ My Community Drug Project worker
√ My CPN
√ My partner
Role Play

- In Groups discuss the frame of SCM
  - Give the diagnosis
  - How often would you see the person?
  - Where would you see the person?
  - How long will your appts last?
  - Would you offer an follow up?
  - Develop some goals
Practice

- In groups we want you to practice giving a diagnosis of BPD to a colleague.

Diagram:

- Observer
- Practitioner
- Colleague
The four foci of SCM

- Interpersonal
  - Engagement in therapy by developing a therapeutic alliance despite the alliance being challenged by the interpersonal problems of the patient

- Impulsivity
  - Reduction of self-damaging, threatening, or suicidal behaviour
  - Rash decision making

- Emotional dysregulation
  - Emotional storms
  - Crisis demand

- Cognitive distortions
  - Interpersonal sensitivity especially to health service personnel
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
## SCM: interventions

<table>
<thead>
<tr>
<th>Non-specific interventions</th>
<th>Specific interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Interviewing skills</td>
<td>- Tolerating emotions</td>
</tr>
<tr>
<td>- Attitude</td>
<td>- Mood regulation</td>
</tr>
<tr>
<td>- Empathy</td>
<td>- Impulse control</td>
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<tr>
<td>- Validation</td>
<td>- Self-harm</td>
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<tr>
<td>- Positive regard</td>
<td>- Sensitivity and</td>
</tr>
<tr>
<td></td>
<td>Interpersonal problems</td>
</tr>
</tbody>
</table>
Problem Solving
Advocacy

- Helping the patient plan about how to deal with life problems in an effective way
- Providing information about rights and about structures of organisations that the patient is negotiating with (e.g. housing, probation)
- Helping the patient write letters to or arrange appointments with any person, organisation or authority who can offer support
- Preparing the patient for meetings with, for example, social workers, psychiatrists, landlords, the police, probation
- Making links with family and carers, community mental health teams, legal representatives and so on.
Praise, Criticism & Feedback

- Differences between praise, criticism & feedback:
  - **Praise**: an expression of approval
  - **Criticism**: an expression of disapproval based on perceived mistakes or faults
  - **Feedback**: info about performance of a task, as basis for improvement

- Don’t forget that these activities are done for you and for others if you are mentalizing – e.g. give yourself some praise/criticism as well as others!

- **Questions**:
  - How does it make you feel when you receive approval?
  - How does it make you feel when others criticize what you do?
  - Are you able to respond to feedback differently?
  - Think about a time when you criticized someone else. What happened? How did that situation ultimately make you feel?
When to Solve a Problem

- We all solve problems. This should be when calm & can take an unemotional view. DON’T try to solve problems when emotional.

- Top Tips:
  - Try to be calm & logical
  - You might need to discuss it with someone you trust first
  - Attitude is key. Embrace problems. The more you solve, the greater your experience
  - If you’re too emotional, take a break. Every problem has a solution
  - Stop thinking about what you can't do & think about what you can do
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.
The 4 Steps

- **Defining the problem:**
  - The problem may not be obvious. Beware of thinking that the problem is the behavior itself. Use ‘mentalising of other’ technique – what is going on in her mind to make her do this?’

- Now the problem’s defined, analyze it i.e. gather information

- **Generate Potential Solutions:**
  - Begin to develop possible solutions. This is creative & practical; every possible solution is identified

- There aren’t wrong answers & judgments shouldn’t be made

- **Select and Plan the Solution:**
  - Select the best solution to fix the problem. This is a process of elimination
  - Come to consensus on solution best for all & compromise

- **Implement the solution:**
  - Write down clear, measurable steps to reach goal
  - Check on progress and evaluate the outcome. Don’t blame each other for lack of success. This is a joint responsibility
Pathway of problem solving discussion

- Identify the problem – discuss this in the group and/or individual sessions and generate a hierarchy of problems
- Agree on the first problem to be solved if there are a number
- Discuss steps towards achieving a solution to the problem – brainstorm solutions
- Share your own possible solutions to the problem but remain neutral about whether the patient uses them or not
- Assess advantages and disadvantages of all the solutions suggested
- Ask the patients to report back the following week on the results
- Re-visit the solutions to see if they can be improved
Problem Solving Role Play

- Revisiting the scenario with Anne whereby she has asked you to change care co-ordinator. Following on from validating how she is feeling (mental state) now work with Anne to problem solve this situation (using the criteria as a guide in your booklet).
In groups we want you to practice problem solving – you can use either scenario A or B.

The emphasis for these role plays is problem solving.
Core Treatment Strategies
Problem areas – a reminder

- Tolerance of emotions
- Mood regulation
- Impulse control
- Sensitivity and interpersonal problems
- Self harm
Emotions
Emotions

Basic
- Interest and curiosity, exploratory behaviour
- Fear
- Anger
- Sexual
- Separation anxiety/sadness
- Love/caring
- Play/joy

Social
- Guilt
- Shame
- Self-critical
- Embarrassment
- Pride

Require representation of others (overlap with secondary emotions)
Primary and Secondary Emotions

- Primary Emotions are what we experience first for instance fear.
- Secondary emotions are what we feel after e.g. fear can turn to anger – people may not always be consciously aware of the primary emotion.
Key Strategies

- Psycho-education
- Labelling
- Normalising
- Contextualising
- Relaxation
Strategies: Emotion/Mood Management

- Identifying and labelling
- Reflecting but not necessarily reacting
- Opposite action/Countervalent expression
  - Example of acting opposite
    - Ask groups to come up with examples of acting opposite – what would be the example here?
Strategy: Emotion/Mood Management

- Identifying contexts in which individual group members find the intensity of their emotions leads to actions that they regret.
- The clinician asks the group to outline ways in which they have been able to act skilfully despite the intense experience of emotion?
Strategy: Emotion/Mood Management

- Relaxation Techniques
  - Progressive muscle relaxation
  - Breathing skills
  - Silence and meditation stance
  - Yoga and holding postures
Strategy: Emotion/Mood Management

- Distraction by engaging in other activities – Clinicians teach that distraction by definition avoids emotion experiencing and so should be used as little as possible, however used as much as necessary to prevent a destructive downward spiral.

- Recognising that anxiety can arise from automatic thoughts – if an emotion occurs the patients are asked to consider the associated feeling as a stimulus to thinking about what they are feeling – ‘What am I thinking right now or just before I had this feeling?’

- Provide the patients with a daily thought record sheet if you think this will be helpful.
Strategy: Emotion/Mood Management

- Awareness of emotions as signals
- Validation of experience of background mood
- Exploration of past experience (limit)
- Explore continuation of effect in present
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
<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</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>
</tr>
</tbody>
</table>
Strategies: Impulsivity

- Name the impulse
- Become aware of the indicators of likely action
- Self-monitor
- Finding a solution
Strategy: name the impulse

- The clinician asks the patients to describe an episode related to one of the aspects of impulsivity outlined earlier. Identify the action urge. Have there been any occasions when one of them has managed not to take action and, if so, how this was done.

- Discuss what an impulse is and explore ways in which each patient manages not to take action immediately. Go around the group asking each patient in turn. Write the answers down in the box on the template.
Strategy: Identify indicators of possible action

- The clinician asks the patients to identify what tells them they are likely to take action
  - Consider bodily experiences – e.g. heart rate, breathing, flushing, stomach butterflies
  - Identify feelings – e.g. anger, upset, excitement, preparedness, vigilance

- Slow down thoughts by observing and identifying each thought to generate a ‘long fuse’
Strategy: self-monitor

- The clinician asks the patients to now self-reflect. Are they acting on assumptions without checking out the facts? If a friend acted as they had done based on the assumption without checking out the facts what advice would they give?

- Do they notice that they are reacting rather than reflecting. If they discover that they would give alternative advice to a friend, the clinician can promote a wider discussion about the different advice that the group members identify

- ‘Can you heed your own advice?’ If not what stops you taking your own advice?”
Strategy: find a solution

- The clinician ends the task by asking the patients now to focus on different responses
  - What happens if I make this response?
  - How does the outcome differ if I make an alternative response?
  - Can I practise that response?
  - Do I need to consider other problems such as how I manage my feelings?
Interpersonal Sensitivity
Interpersonal Sensitivity

- Emergency Department video
Interpersonal Sensitivity

- The clinician outlines the internal and external cues that we use to understand others.
- The clinician asks the group to give examples of when they have misunderstood the motive of someone close to them or when they have relied mostly on external cues.
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.
Role plays – Questioning

- In groups we want you to practice interpersonal questioning– you can use either scenario A or B.
- The emphasis for these role plays is questioning – see workbook.
Revisit the Video

Watching the video again – see if you can spot any of the core strategies

- Validating mental state
- Active response, curiosity
- Challenging passivity
- Focusing on current situation
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
Group Work

- Principles of Group work
- Clear ground rules
- Consistency
- Managing Process
  - Parking
  - Siding
  - Triangulation
Content of Group

- Psycho-education
- Incorporating mentalization principles about self and others.
- Here in 5bp would involve co-facilitating a managing emotions group: Training will be available if you are interested.
  - Mindfulness
  - Emotional Regulation
  - Distress Tolerance
  - Interpersonal Effectiveness
Skill consolidation:

- Weekly Peer Supervision to be facilitated by experienced practitioner in DBT or MBT.

Supervision in two main parts

- Skill development
  - Role playing
  - Could include once a month consultation with expert by experience (for other perspective)

- Self awareness
  - Working with countertransferance
  - How to minimise projection