Severe personality disorder:
What not to do

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NICE guidelines (2009)

- Drug treatments should not be used for borderline or antisocial personality disorder or for individual symptoms
- The role of mood stabilisers for borderline personality should be tested in placebo controlled trials

- Consider offering group-based CBT for people with antisocial personality disorder
- Do not use brief psychological interventions for people with borderline personality disorder of less than three months
- Consider twice weekly sessions
- Consider DBT for women with repeated self harm
Overview

• Drug treatments
• Psychological treatments
• Low-intensity interventions
• What not to do

• Assessment and diagnosis
Problems with ICD-10/DSM IV

• General criteria and 9 (ICD), 10 (DSM) ‘types’
• Binary nature of prototypes fails to account for the continuous nature of personality dysfunction
• Marked heterogeneity among people with the same diagnosis
• Most people in contact with mental health services meet criteria for several personality disorders
• Prototypes (dependent, histrionic etc) don’t exist! Unstable/neurotic, rigid, detached, antisocial (Mulder et al. 2011)
ICD-11 (DSM 5 alternative model)

- Mild, moderate and severe personality disorder
- Personality difficulty
- Five trait domains (detachment, dissociality, anankastia, disinhibition, negative affectivity)
- Borderline specifier
- *Classification is as reliable and appears to have greater clinical utility* (Bach et al. 2018)
- *Brief questionnaires can support assessment in clinical practice* SASPD (Olajide et al. 2018)
- *Reduced stigma?*
Severe personality disorder ICD-11

• Severe disturbances in **functioning of the self** (e.g. not having a stable sense of who they are)

• Problems in **interpersonal** functioning seriously affect virtually all relationships, inability or unwillingness to perform social and occupational roles

• Severe **harm to self or others** that has caused long-term damage or has endangered life

• Negative affectivity, disinhibition +/- antisociality
Drug treatments
Antidepressants

- 7 trials, poor methodological quality
- 6 no evidence of benefit (one - Amitriptyline reported reduction in depressive symptoms)

- Comorbid personality disorder is single best predictor of poor response to antidepressant medication among people with major depression best predictor of poor response (Goorwood et al, 2010)

- But, 30% of people in contact with services meet criteria for depression. Treatment of depression among those with coexisting personality disorder.......
Why?

• Symptoms do not have same neurobiological correlates as in depression
• Compliance
• Coexisting drug and alcohol use
• Alexithymia - ‘No words for self’ – reduced ability to identify and describe one’s emotions
• Qualitative exploration of patient’s experience of self ascribed to ‘depression’ among borderline PD and major depression (Westen et al. 1992)

*diffuse negative feelings.....emptiness, loneliness, shame*
Antipsychotics

- 13 trials: (2) Haloperidol, (4) Olanzapine, (1) Aripiprazole, (1) Thiothixene, (1) Ziprasidone
- Some evidence of reductions in hostility, anger and impulsivity

**BUT**

- Short term: 1-3 months
- No clear on primary outcome
- High attrition rate (up to 50% not followed up)
- Best quality trial conducted to date did not find a significant change in mental health (Schulz et al. 2008)
  - Additional 2.5kg weight at 12 weeks
Mood stabilisers

- 9 trials: (1) Carbamazepine, (3) Valproate, (3) Topiramate, (2) Lamotrigine.
- Findings – evidence that they lead to reductions in anger, depression and impulsivity.

**BUT**

- Small (<50)
- Poor methodological quality (primary outcome not always stated, arrangements for masking assessors unclear)
- Short-term follow-up
LABILE trial (2018)

- Multicentre, double-blind, placebo-controlled randomized trial
- 276 people aged 18 or over, who met diagnostic criteria for BPD (excluded those with co-existing bipolar affective disorder or psychosis, those already taking a mood stabiliser, and women at risk of pregnancy)
- 1:1 ratio to up to 400mg of lamotrigine per day or an inert placebo
- Zanarini Rating scale for Borderline Personality Disorder (ZAN-BPD) at 52 weeks.
- 70% FU at one year, primary outcome ZANBPD
- Adherence = 69% at 12 weeks, 39% at 12 months
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Treatment group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lamotrigine ((N = 137))</td>
</tr>
<tr>
<td><strong>Was the IMP received as per protocol? ([n (%)])^a</strong></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>93 (68)</td>
</tr>
<tr>
<td>Yes</td>
<td>44 (32)</td>
</tr>
<tr>
<td><strong>Percentage of the 52-week period that the participant was taking (\geq 100 \text{ mg})</strong></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>60 (35)</td>
</tr>
<tr>
<td>Range</td>
<td>2–94</td>
</tr>
<tr>
<td><strong>Number of weeks that the participant received IMP</strong></td>
<td></td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>32 (9–52)</td>
</tr>
<tr>
<td>Minimum, maximum</td>
<td>0, 52</td>
</tr>
<tr>
<td><strong>Number (%) of participants taking IMP</strong></td>
<td></td>
</tr>
<tr>
<td>At 12 weeks</td>
<td>95 (69)</td>
</tr>
<tr>
<td>At 52 weeks</td>
<td>49 (36)</td>
</tr>
<tr>
<td><strong>Dose (mg) of IMP taken</strong></td>
<td></td>
</tr>
<tr>
<td>At 12 weeks</td>
<td></td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>200 (200–200)</td>
</tr>
<tr>
<td>Range</td>
<td>25–400</td>
</tr>
<tr>
<td>At 52 weeks</td>
<td></td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>200 (200–200)</td>
</tr>
<tr>
<td>Range</td>
<td>100–400</td>
</tr>
<tr>
<td>Treatment group</td>
<td>Adjusted difference in means(^a)</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>0.0</td>
</tr>
<tr>
<td>Placebo</td>
<td>−</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>0.0</td>
</tr>
<tr>
<td>Placebo</td>
<td>−</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>−0.1</td>
</tr>
<tr>
<td>Placebo</td>
<td>−</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>0.3</td>
</tr>
<tr>
<td>Placebo</td>
<td>−</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>0.0</td>
</tr>
<tr>
<td>Placebo</td>
<td>−</td>
</tr>
</tbody>
</table>
Side effects of medication

- Weight gain, Stephens-Johnson Syndrome
- **Valproate:** *Children exposed to valproate in utero are at a high risk of serious developmental disorders (30-40% of cases)*
- Congenital malformations (in 10% of cases)
- 6 unplanned pregnancies among people in LABILE trial
Prescribing in practice

- Audits in UK and USA – 80-95% prescribed psychotropic medication. 1 in 12 on four or more (Baker Glen et al. 2010; Bender et al. 2001, Crawford et al, 2010)

- 2/3rds taking antidepressants – half of these have no record of being depressed

- 40% on antipsychotics (and 40% of these have been prescribed for more than three years)

- Monitoring of side effects is lower than among those with mental illness (POMH, 2013)

• Survey of 116 psychiatrists working on inpatient forensic services

• Psychotropic medication seen as effective by prescribers

  ‘I don't think it applies to the most severely disordered individuals.’

  ‘The NICE Guidelines on PD are useful only to the extent that they demonstrate there is no robust evidence for therapeutic interventions. For practising clinicians they are practically useless.’

  ‘Many patients can only undergo psychological therapies if adjunct medication is used’.

  ‘Every day I see evidence that drug treatment is beneficial for severely borderline individuals.’
Use of clozapine (Dickens et al. 2016)

20 women in secure care
“My thoughts are calmer.... Before they were pretty much all over the place and they were a bit strange. Yeah, I was a bit mad and all over the place before, Clozaril calmed them down.”

“My relationships are better now than they have ever been, with staff and the patients...because I’m stable and they aren’t worried about what I’m going to say next.”

“...before, because my mood was unstable, I ended up being out of therapy because I wasn’t achieving or working towards goals.... I’m really stable and I’ve started applying the skills that we learn in DBT.”
Increasing use of clozapine

- No randomised trials. 12 case series and reports
- Frogley et al. 2014: 22 female inpatients. 6 monthly measures plus patient experience (increased weight 90 to 101kg)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Baseline (0)</th>
<th>6 months (6)</th>
<th>12 months (12)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean (CI)</td>
<td>N</td>
</tr>
<tr>
<td>BPRS score</td>
<td>21</td>
<td>29.4 (21.5 to 37.3)</td>
<td>21</td>
</tr>
<tr>
<td>GAF score</td>
<td>18</td>
<td>21 (14 to 28)</td>
<td>17</td>
</tr>
<tr>
<td>Observations (days enhanced)</td>
<td>22</td>
<td>10.9 (6.3 to 15.4)</td>
<td>22</td>
</tr>
<tr>
<td>Sessions (number attended)</td>
<td>21</td>
<td>34 (25 to 42)</td>
<td>21</td>
</tr>
<tr>
<td>Sessions (% attended)</td>
<td>21</td>
<td>57.3 (44.4 to 70.2)</td>
<td>21</td>
</tr>
<tr>
<td>MOAS score</td>
<td>22</td>
<td>12.2 (5.0 to 18.4)</td>
<td>22</td>
</tr>
<tr>
<td>MOAS weighted score</td>
<td>22</td>
<td>65.3 (31.4 to 99.5)</td>
<td>22</td>
</tr>
<tr>
<td>MOAS self-harm score</td>
<td>22</td>
<td>4 (1.4 to 6.6)</td>
<td>22</td>
</tr>
<tr>
<td>MOAS self-harm weighted score</td>
<td>22</td>
<td>33.8 (8.9 to 58.7)</td>
<td>22</td>
</tr>
</tbody>
</table>
CALMED Trial

• **Design:** A two-arm, parallel group, double-blind, placebo-controlled randomised trial with an integrated pilot study.

• **Setting:** General adult mental health wards, PICU, low, medium and high secure units delivered by eight Trusts and third sector providers.

• **Target population:** Inpatients aged 18 years or over, meet diagnostic criteria for BPD, failed to make an adequate clinical response to other antipsychotic medication. **Excluding:** Coexisting schizophrenia or bipolar I, on clozapine, due to be discharged within two weeks, contraindication to clozapine (unwilling to have monitoring), lack capacity.

• **Interventions:** Capsules containing clozapine titrated up to 300mg (400mg allowed) over a two to three weeks or an inert placebo.
**CALMED Trial**

- **Primary outcome**: total score on the Zanarini rating scale for Borderline Personality Disorder (ZANBPD) over six months.

- **Secondary outcomes**: three and six months, mental health (BPRS), violence to self or others (M-OAS), deliberate self-harm, health-related quality of life (EQ-5D-5L), side effects of treatment, adherence and adverse reactions. Resource use and costs.

- **Sample size**: 166 participants (83 prescribed clozapine and 83 prescribed placebo) to have 90% power to detect a four point difference in ZAN-BPD score at six months (0.05 level of statistical significance). To take account of 25% loss to follow-up we will recruit 222 subjects.
1. North West (Ashworth)  
   Lancashire, Merseyside, Manchester

2. East Midlands (Rampton)  
   Nottinghamshire, Leicestershire

3. Northamptonshire (St Andrew’s, Elysium)

4. West London (Broadmoor)  
   CNWL, WLMHT
Psychological treatments
Sub-group analysis of data from 12 trials of active treatment versus TAU n = 1029 (Omar et al. 2014)

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Does NOT include group SMD (95% CI) p value</th>
<th>Includes group SMD (95% CI) p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>General mental health</td>
<td>-0.05 (0.33 to 0.23) 0.72</td>
<td>-0.425 (-0.80 to 0.04) 0.03</td>
</tr>
<tr>
<td>Depression</td>
<td>-0.17 (-0.431 to 0.10) 0.22</td>
<td>-0.269 (-0.45 to -0.10) &lt;0.005</td>
</tr>
<tr>
<td>Deliberate self-harm</td>
<td>-0.035 (-0.345 to 0.275) 0.83</td>
<td>-0.558 (-0.847 to -0.270) &lt;0.001</td>
</tr>
<tr>
<td>Social functioning</td>
<td>-0.137 (-0.402 to 0.128) 0.31</td>
<td>-1.527 (-2.669 to 0.355) 0.01</td>
</tr>
</tbody>
</table>
PEPS study (McMurrnan et al. 2018)

- Four psychoeducation sessions and 12 weekly groups exploring options for solving problems
- 18 month follow-up
- Safety concerns led the DMEC to halt recruitment prematurely
- 154 received PEPS and 152 usual treatment.
- Median attendance at psycho-education was 88% and for problem solving group sessions was 48%
## Results

### SFQ score

<table>
<thead>
<tr>
<th>SFQ score</th>
<th>Treatment arm</th>
<th>Adjusted(^a) difference in means(^b)</th>
<th>95% CI</th>
<th>(p)-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Usual treatment ((n = 152))</td>
<td>PEPS ((n = 154))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline, mean(^c) (SE)</td>
<td>14.3 (0.4)</td>
<td>15.0 (0.6)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>24 weeks, mean (SE)</td>
<td>13.9 (0.4)</td>
<td>13.7 (0.4)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>72 weeks, mean (SE)</td>
<td>13.8 (0.5)</td>
<td>13.5 (0.4)</td>
<td>-0.73</td>
<td>-1.83 to 0.38</td>
</tr>
</tbody>
</table>

### Adverse event report categories

<table>
<thead>
<tr>
<th>Adverse event report categories</th>
<th>Treatment arm</th>
<th>Usual treatment ((N = 152))</th>
<th>PEPS ((N = 154))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants with any adverse event, (n) (%)</td>
<td>39 (26)</td>
<td>60 (39)</td>
<td></td>
</tr>
<tr>
<td>All adverse event reports, (^a) (n) events ((n) individuals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalisation</td>
<td>62 (33)</td>
<td>100 (51)</td>
<td></td>
</tr>
<tr>
<td>Death(^b)</td>
<td>0</td>
<td>4 (4)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>14 (12)</td>
<td>13 (12)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>76 (39)</td>
<td>117 (60)</td>
<td></td>
</tr>
</tbody>
</table>
General features of programmes

- Assessment: agreed treatment plan
- Boundaries and flexibility
- Validation (doing the best at this time)
- Crisis planning
- Access to group-based treatment, peer support
- Co-ordinated care - ability to help patients in crisis via the programme
- Team work and communication
- Supervision (to manage counter-transference)
Therapeutic community (Pearce et al. 2018)

- Collaborative approach to staff–patient interaction, emphasis on empowerment, personal responsibility, shared decision-making and participation in communal activity

- Observational evidence of benefit, regression to the mean (Lees et al. 2004)

- 70 people randomised to day-TC or crisis planning plus TAU. In-patient days, mental health, self-harm and satisfaction 24 months later

- Non-statistically significant reduction in inpatient days (-11.4%, 95% CI -31.6 to 10.1), significant reductions in self harm and higher satisfaction with care
MBT vs DBT  (Barnicot et al. 2018)

- Quasi-experimental comparison of 90 patients with BPD treated at three MBT and three DBT services in UK

- Drop-out, self harm emotional dysregulation (DERS - Difficulties in Emotion Regulation Scale) over 12 months

- After adjusting for potential confounding factors fewer participants allocated to DBT than MBT completed 12 months of treatment (42% vs 72%, p =0.06)

- After adjusting for confounding and drop-out, participants allocated to DBT had a steeper decline in incidents of self-harm (IRR = 0.93, p = 0.03) and in emotional dysregulation (β = -1.79, p = 0.01).
Low intensity interventions
<table>
<thead>
<tr>
<th>Mentalization Based Treatment</th>
<th>Dialectical Behaviour Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with borderline personality disorder</td>
<td>Adults with borderline personality disorder</td>
</tr>
<tr>
<td>Group and individual sessions plus telephone support</td>
<td>Group and individual sessions plus telephone support</td>
</tr>
<tr>
<td>Methods for promoting mentalizing and improving a person’s mental health and interpersonal functioning</td>
<td>Behavioural skills coaching in areas including mindfulness, emotion regulation and distress tolerance</td>
</tr>
<tr>
<td>Clinical staff who have received a minimum of three days training and receive regular supervision</td>
<td>Mental health professionals who have been trained to deliver DBT and receive regular supervision</td>
</tr>
<tr>
<td>Weekly individual sessions and weekly groups</td>
<td>Weekly individual sessions and weekly groups. Telephone consultations as required.</td>
</tr>
<tr>
<td>Groups last 75 to 90 minutes</td>
<td>60 minute individual sessions 150 minute groups</td>
</tr>
<tr>
<td>18 months</td>
<td>12 to 18 months</td>
</tr>
<tr>
<td>100 to 150 sessions*</td>
<td>100 sessions*</td>
</tr>
</tbody>
</table>
Low-intensity interventions

- 84% of Trusts in England now offer some evidence based high intensity treatment (Dale et al. 2018)
- But very few people receive them (Coid et al. 2009)
- As many as half of those who are referred do not engage with high intensity services (McMurran et al. 2010)
- Usual care for people with personality disorder is often inconsistent and many service users report negative experiences of the care they receive
Treatment as usual

*Crawford et al. 2017*
Complete case analysis of people referred to CMHTs in a London borough over an 18 month period
Low-intensity interventions

• Some evidence that Structured Clinical Management (Bateman & Krawitz, 2012) and Good Psychiatric Management (Gunderson, 2009) may be of benefit but are high intensity (lasting for many months)

• Web-base psychoeducation is promising (Zanarini et al. 2018)

• Peer-support groups are valued by service users – and attendance is associated with reduced use of emergency medical services (Miller & Crawford, 2010)

• Short forms of MBT and DBT are being evaluated and tested (including those delivered by Experts by Experience)
Psychological Support for Personality

6 to 10 individual sessions delivered over three to six months:

- **Information about personality, PD and role of health services**
- **Validation aimed at reducing self-blame, increasing motivation**
- **Focus on problem area(s) and offer psychological skill(s) for managing them**
- **Consider role of relationships and structured activities**
- **Use a ‘mentalising stance’ to highlight the importance of mental states**
- **Delivery by someone who has experience, relevant competencies and receives regular supervision**
What not to do
• Misdiagnose (give treatments that are unlikely to help)

• Ignore (fail to offer evidence based treatments where these are available)

• Over medicate

• Deliver stand-alone psychological treatments

• Playing out disturbed relationships
Playing out disturbed relationships

• Extremes, no ‘middle ground’
  (victim OR aggressor others as idealised OR denigrated)

• Fear of abandonment, frantic efforts to avoid endings
  (and how staff respond to this)

• Interaction with aptitudes, beliefs and personality of healthcare staff

• More likely the longer contact continues, when uncertainty/no treatment plan and when ending is discussed/implemented
Common scenarios

- Identifying with the victim (injustice / the patients distress)
  Giving more - succeeding where others have failed. Encourages dependency, leads to frustration and withdrawal of care. Even if one person can maintain it, others can’t....complaints

- Identifying with the aggressor (intolerance of their behaviour)
  - unwilling to make adjustments, respond to minor violations, lack of adherence to a plan leads to punitive measures, compulsory treatment or discharge from care

- Colluding with fear of abandonment
  Implementing planned endings associated with poorer adherence, self-harm or hostility. Prolonging treatment leads to short term improvements but increases likelihood of future adverse reactions
Avoiding the pitfalls

- Better awareness and assessment of personality disorder: SASPD, SAP-AS
- Avoid over-use of medication: short term use (review and stop), promethazine.
- Facilitate access to evidence-based psychological therapies
- Avoiding extremes
- Keeping patients actively involved in their own management
- Keep thinking (the ability to understand the mental state, of oneself or others, that underlies overt behaviour)