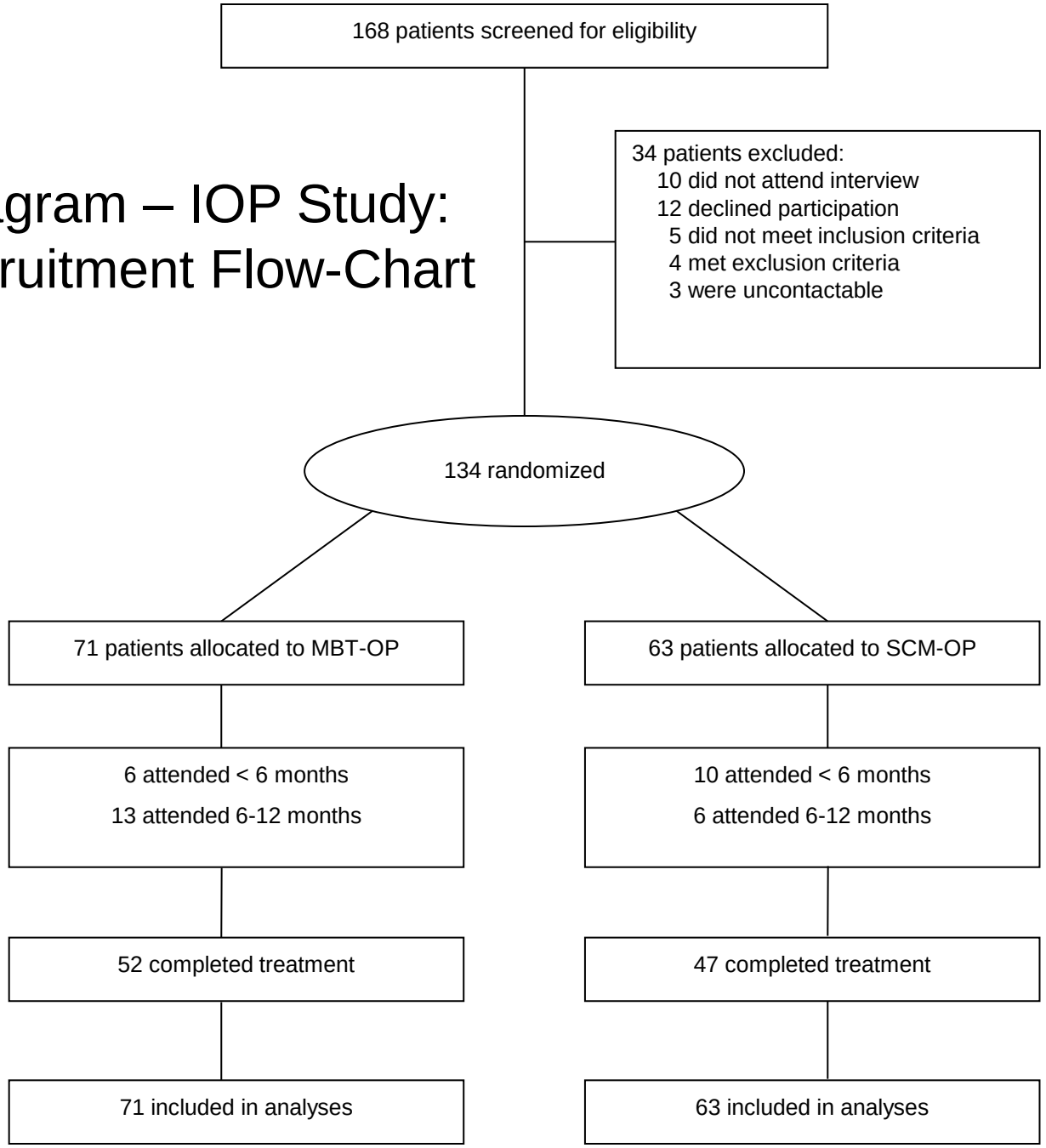
Mentalizing, structured clinical management, and antisocial personality disorder

Prof Anthony Bateman

4th Bergen Conference on Forensic Psychiatry: Personality Disorder

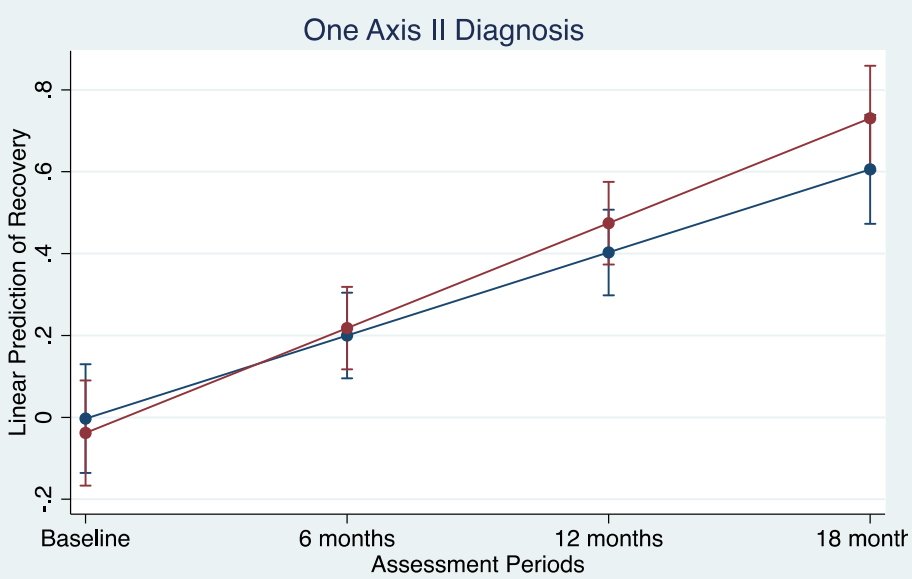
Consort Diagram – IOP Study: Patient Recruitment Flow-Chart

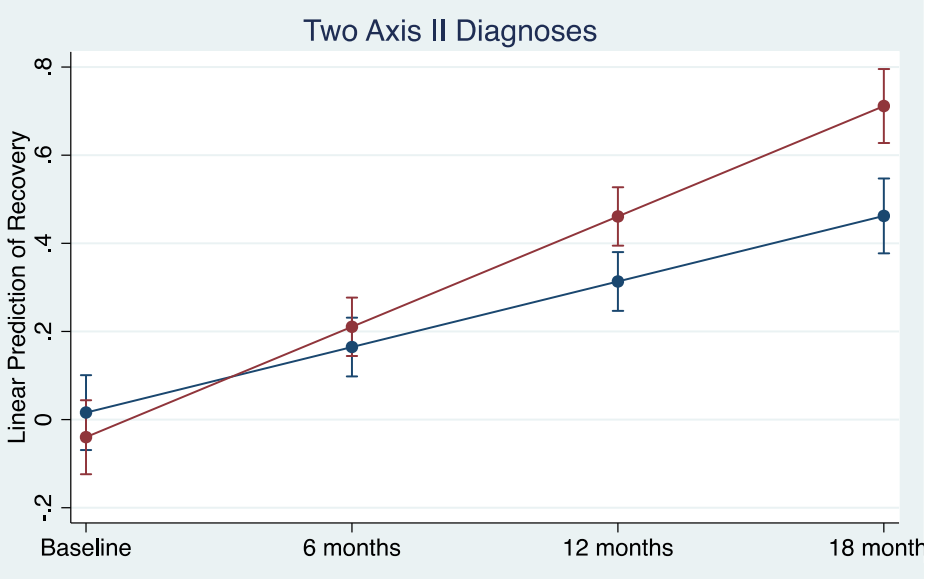


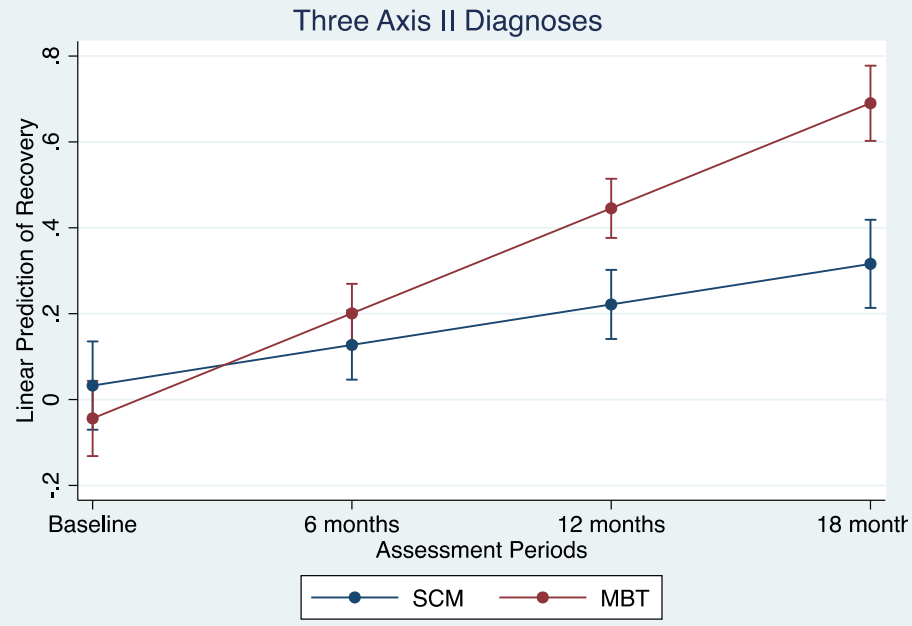
Moderators of outcome?

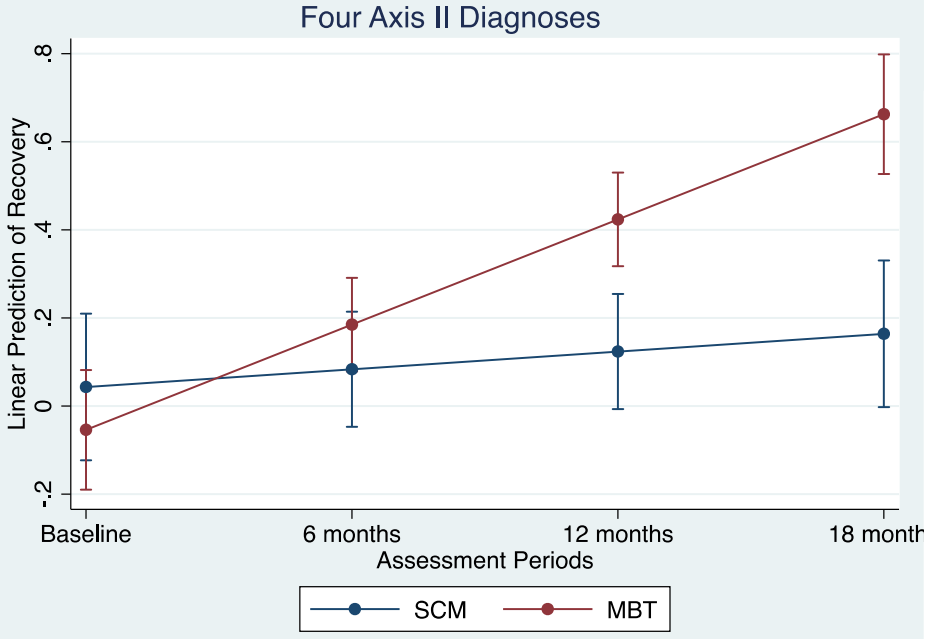
Bateman, A., & Fonagy, P. (2013). Impact of clinical severity on outcomes of mentalisation-based treatment for borderline personality disorder. *British Journal of Psychiatry, 203*, 221-227.

Predictive Recovery by Axis II Pathology

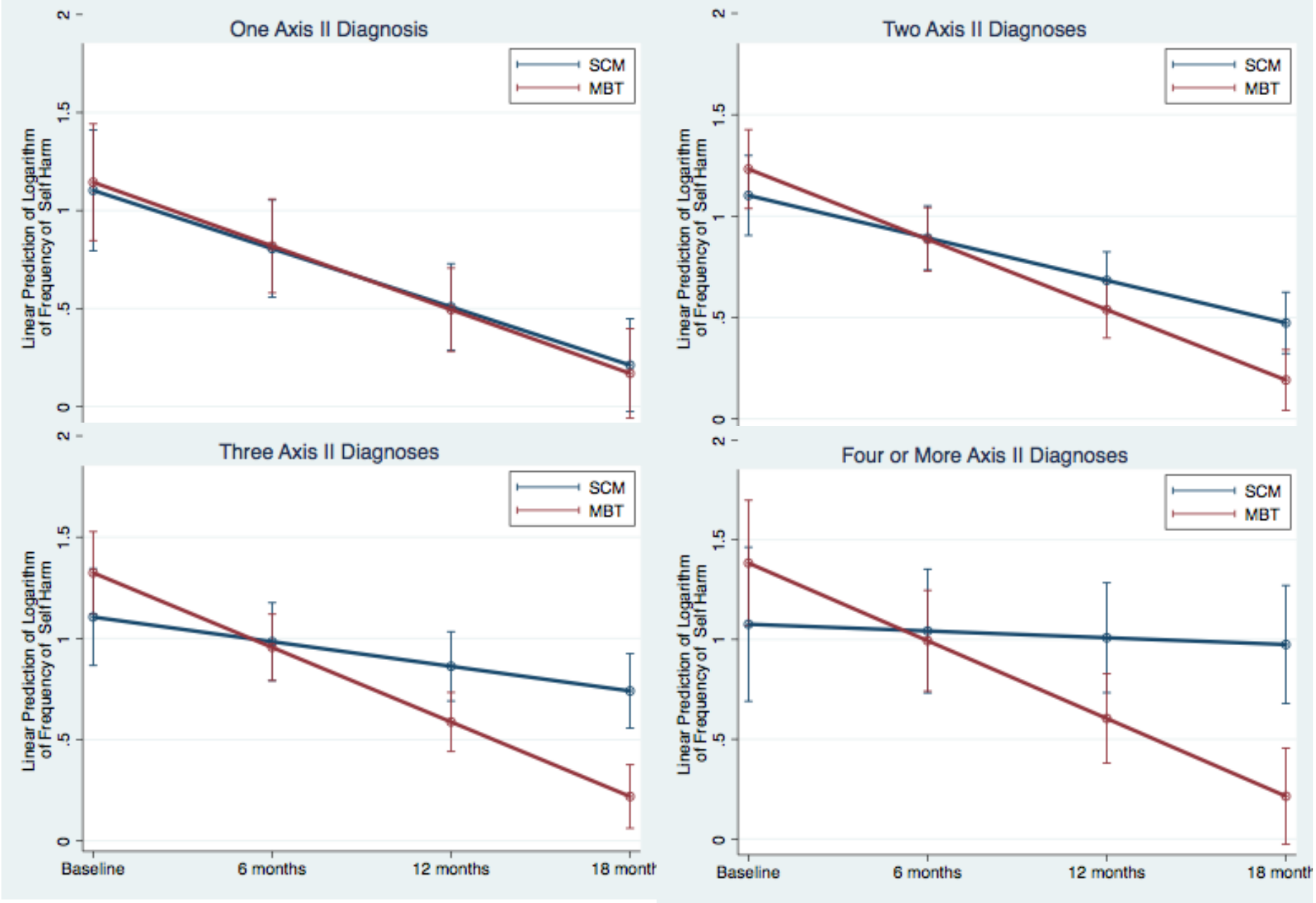








Predicted Self-Harm By Axis II Diagnoses



Two programmes of study:

MBT-ASPD – randomised controlled trial (MOAM)

SCM – *training and implementation*

Antisocial Personality Disorder

Bateman, A., & Fonagy, P. (2011). Antisocial Personality Disorder. In A. Bateman & P. Fonagy (Eds.), *Mentalizing in Mental Health Practice* (pp. 357-378). Washington: APPI

Bateman, A., & Fonagy, P. (2016). *Mentalization based treatment for personality disorders: a practical guide*. Oxford: Oxford University Press

Bateman, A., O'Connell, J., Lorenzini, N., Gardner, T., & Fonagy, P. (2016). A randomised controlled trial of Mentalization-Based Treatment versus Structured Clinical Management for patients with comorbid borderline personality disorder and antisocial personality disorder. *BMC Psychiatry, 304*, 304-311.

ASPD characteristics

- Failure to conform to social norms with respect to lawful behaviours
- Deceitfulness
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness
- Reckless disregard for safety of self or other
- Consistent irresponsibility
- Lack of remorse

None of these features is endearing to others. The self-serving attitude of people with ASPD and unpredictability makes people wary of them.

Why consider ASPD?

ASPD

Highly prevalent amongst UK offending population and is associated with increase likelihood of committing violent behaviours, future reconvictions and recidivism severity.

Societal costs

Physical and emotional damage to victims, criminal justice system involvement, increase of health care, lost employment opportunities, relationship breakdown; family disruption and substance misuse.

Major public health implications

Associations with psychiatric co-morbidity, substance abuse, suicide, family violence and early death.

Why Consider ASPD - Recommendations and Implementation of NICE Guidance

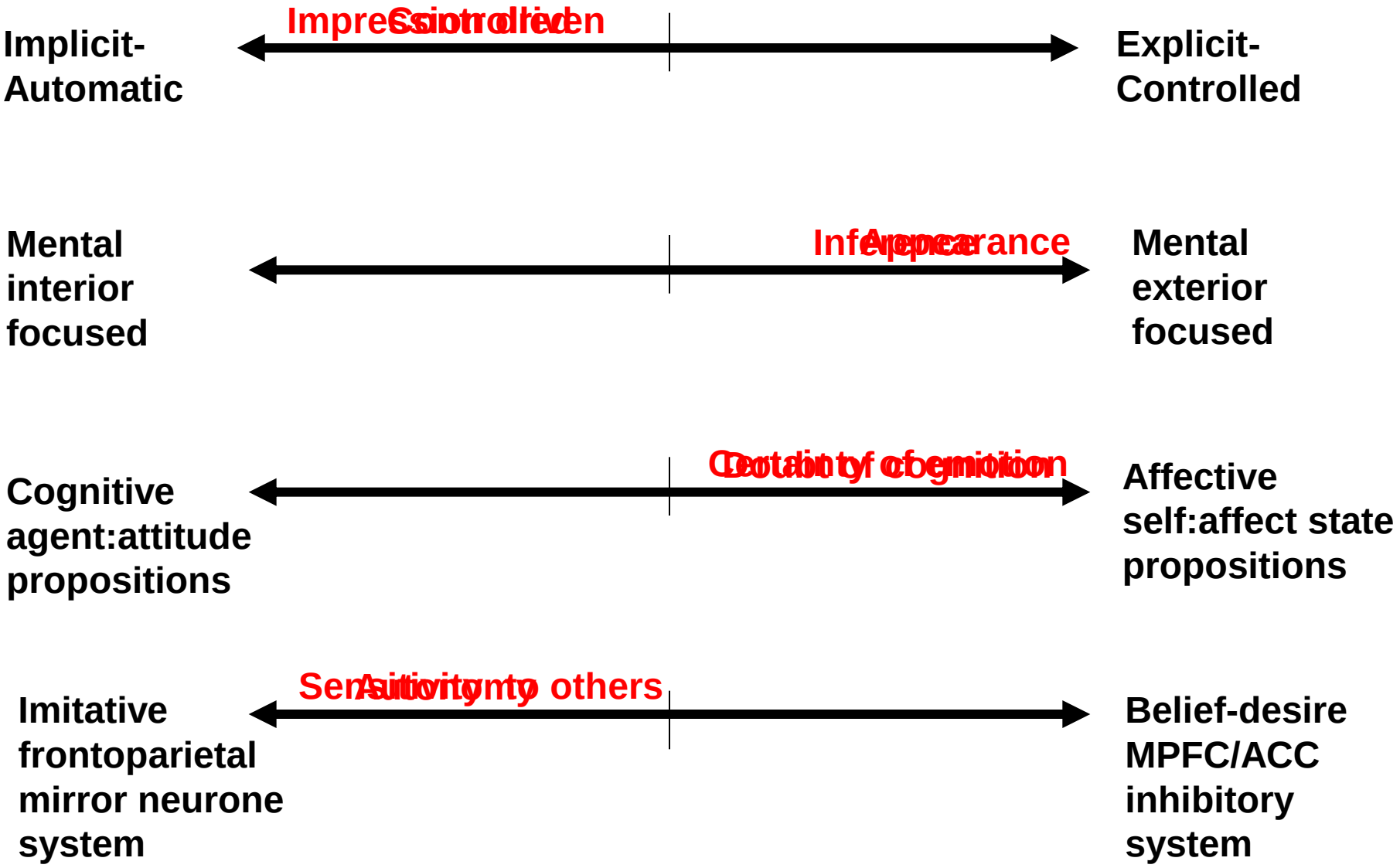
Crawford et al (2009) Service provision for men with antisocial personality disorder who make contact with mental health services services. Personality and Mental Health 3: 165–171

- ASPD who had had contact with mental health services
  - Nearly all participants met criteria for ‘probable anxiety disorder’
  - >50% were misusing alcohol and other drugs.
- 12 months following recruitment
  - 40% of the sample attended emergency medical services
  - 20% had at least one period of inpatient treatment.
- Only 21% participants received follow-up care during the 12 months following recruitment.

What is mentalizing?

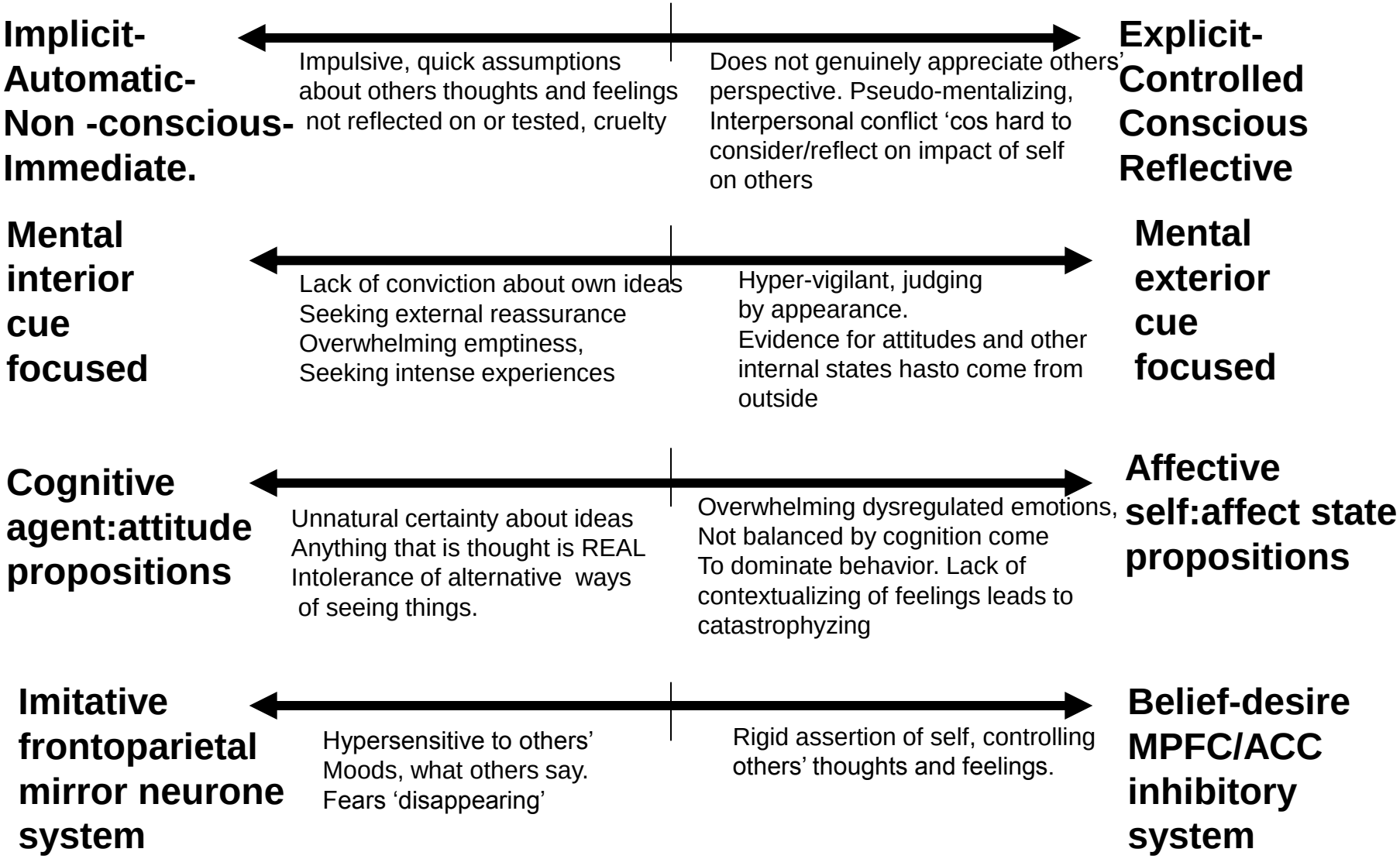
Mentalizing is a form of ***imaginative*** mental activity about others or oneself, namely, perceiving and interpreting human behaviour in terms of ***intentional*** mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).

Treatment vectors in re-establishing mentalizing



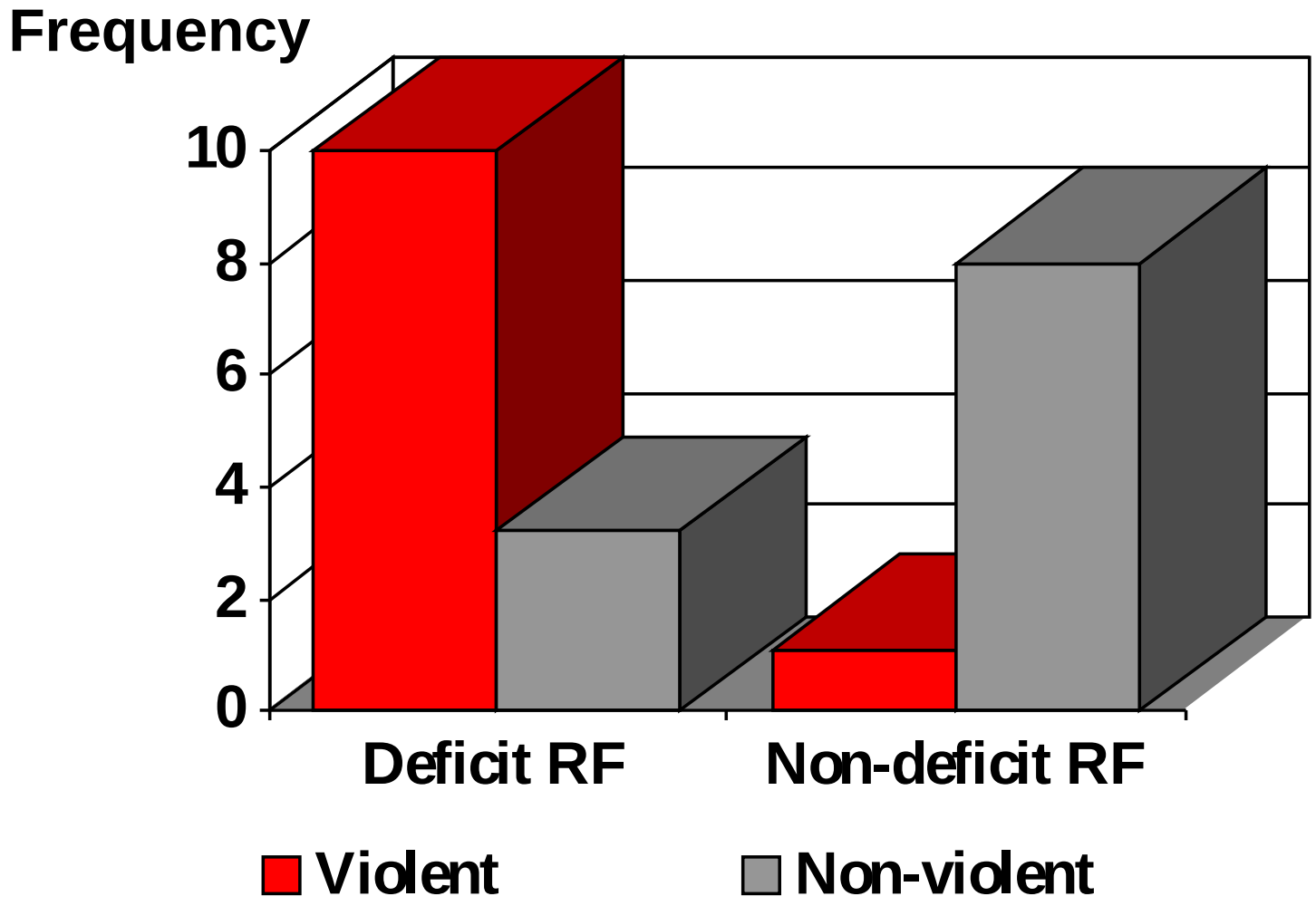
Imbalance of mentalization generates problems

Fonagy, P., & Luyten, P. (2009). *Development and Psychopathology, 21*, 1355-1381.



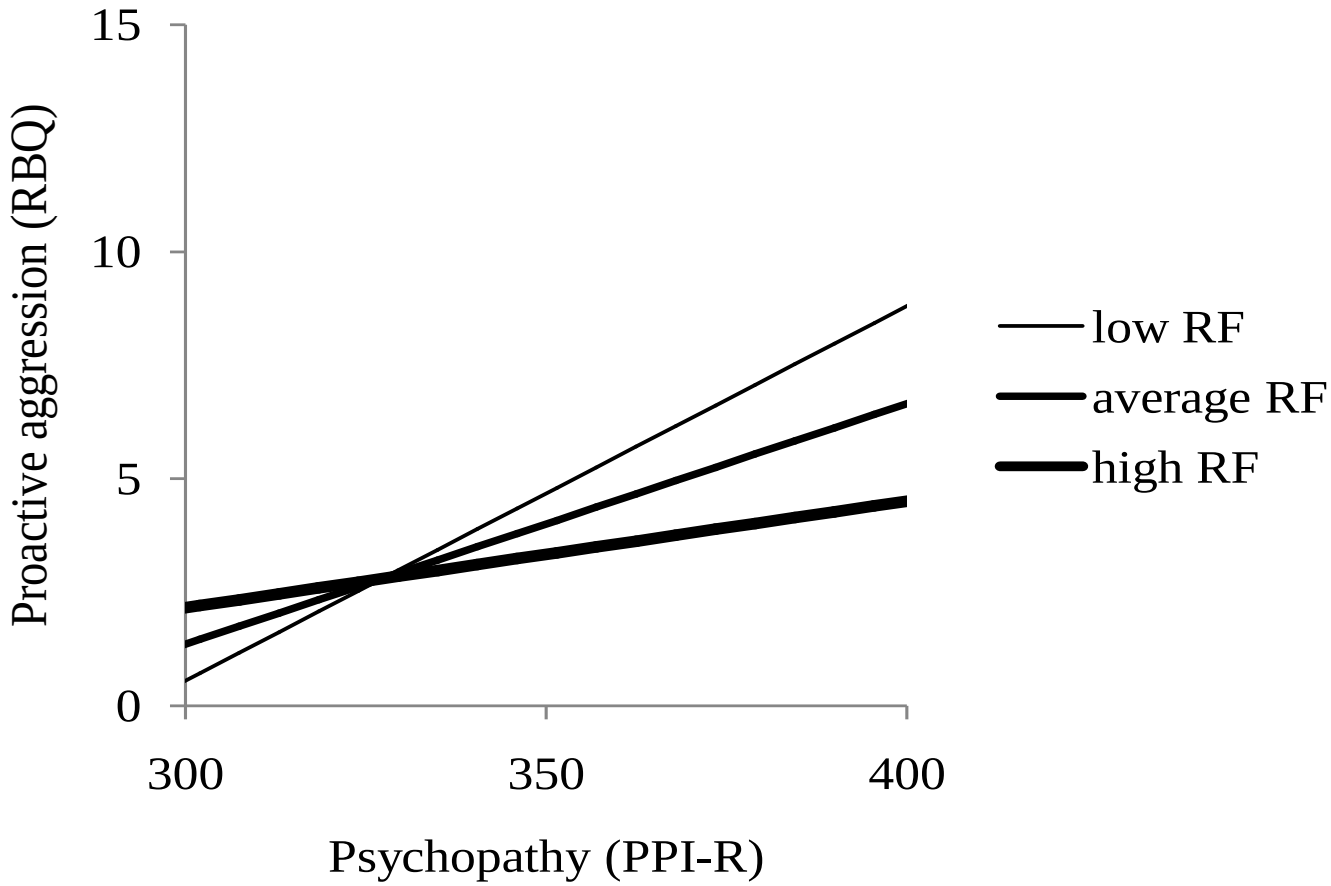
Deficit of Reflective Function in Violent and Non-violent Prisoners with PD

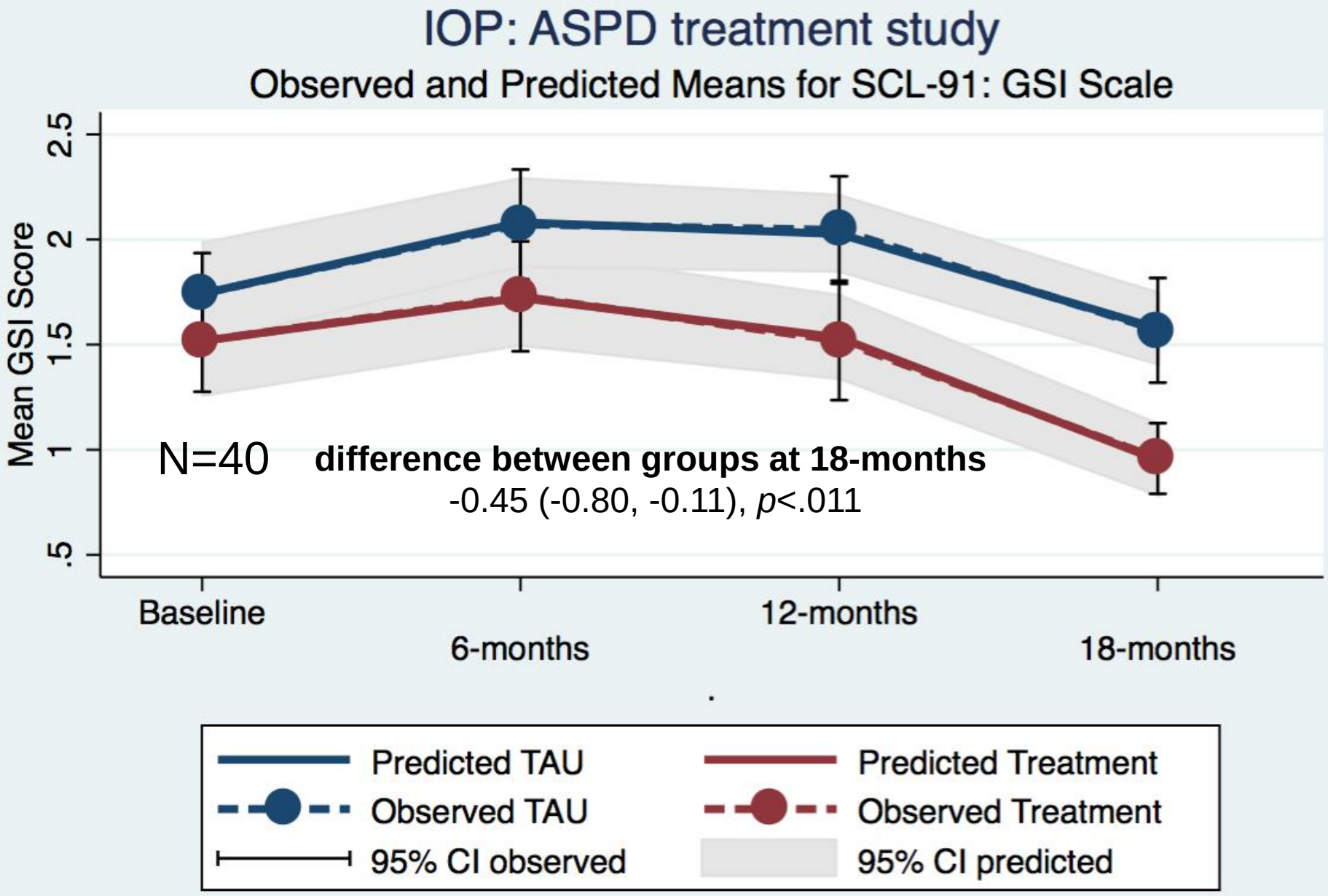
Levinson and Fonagy (2004)

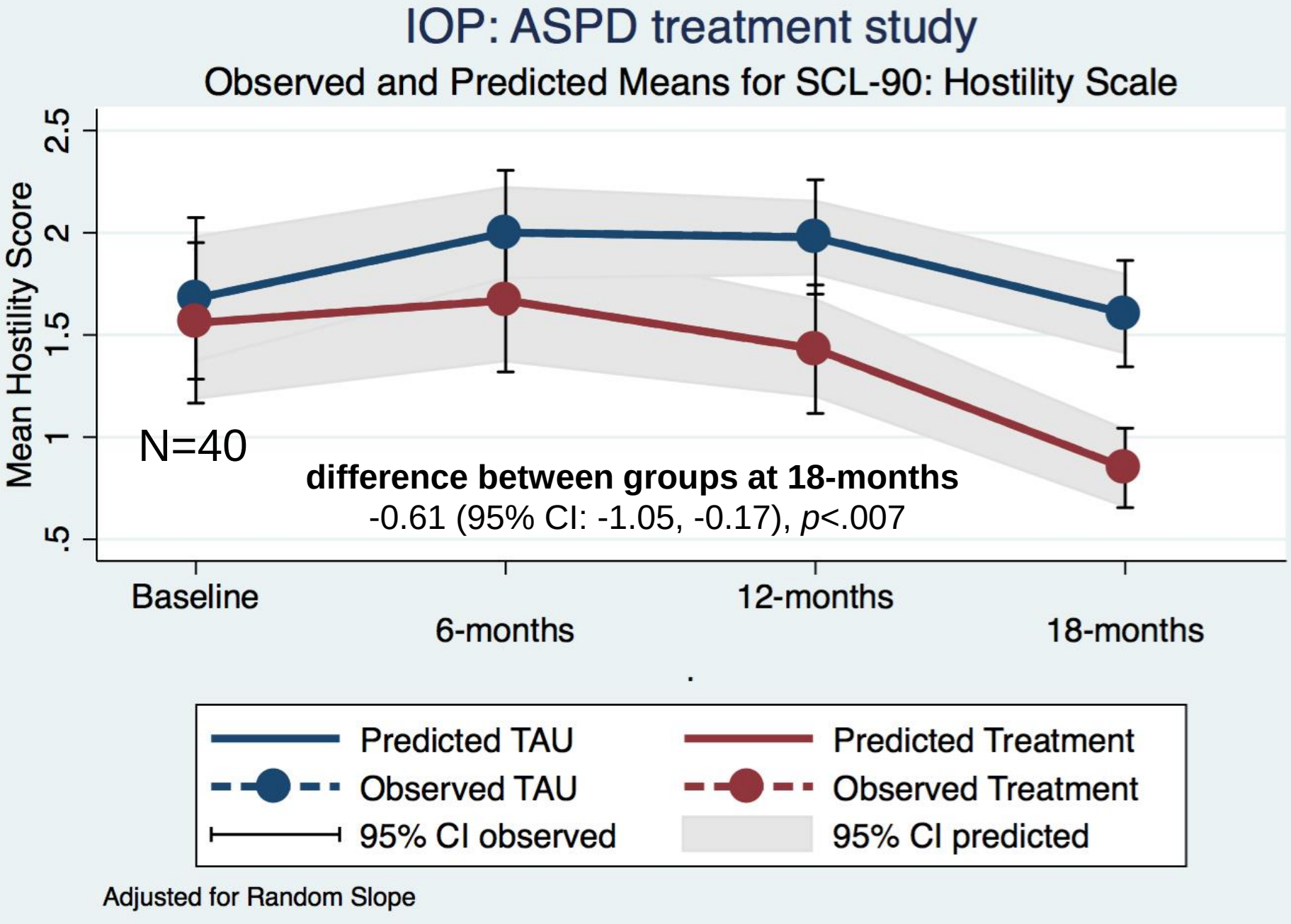


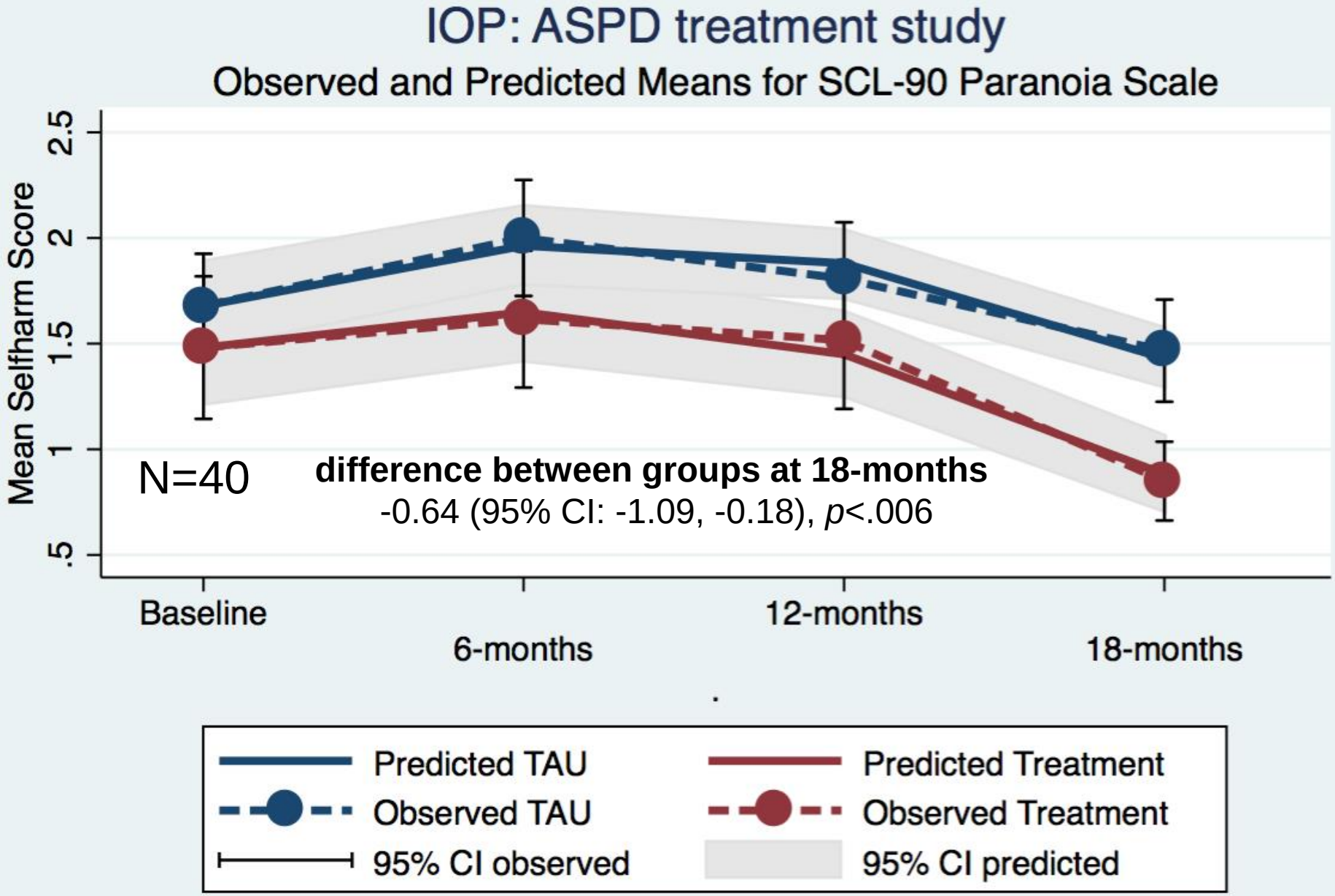
RF moderates the relationship between psychopathy and proactive aggressive behaviour

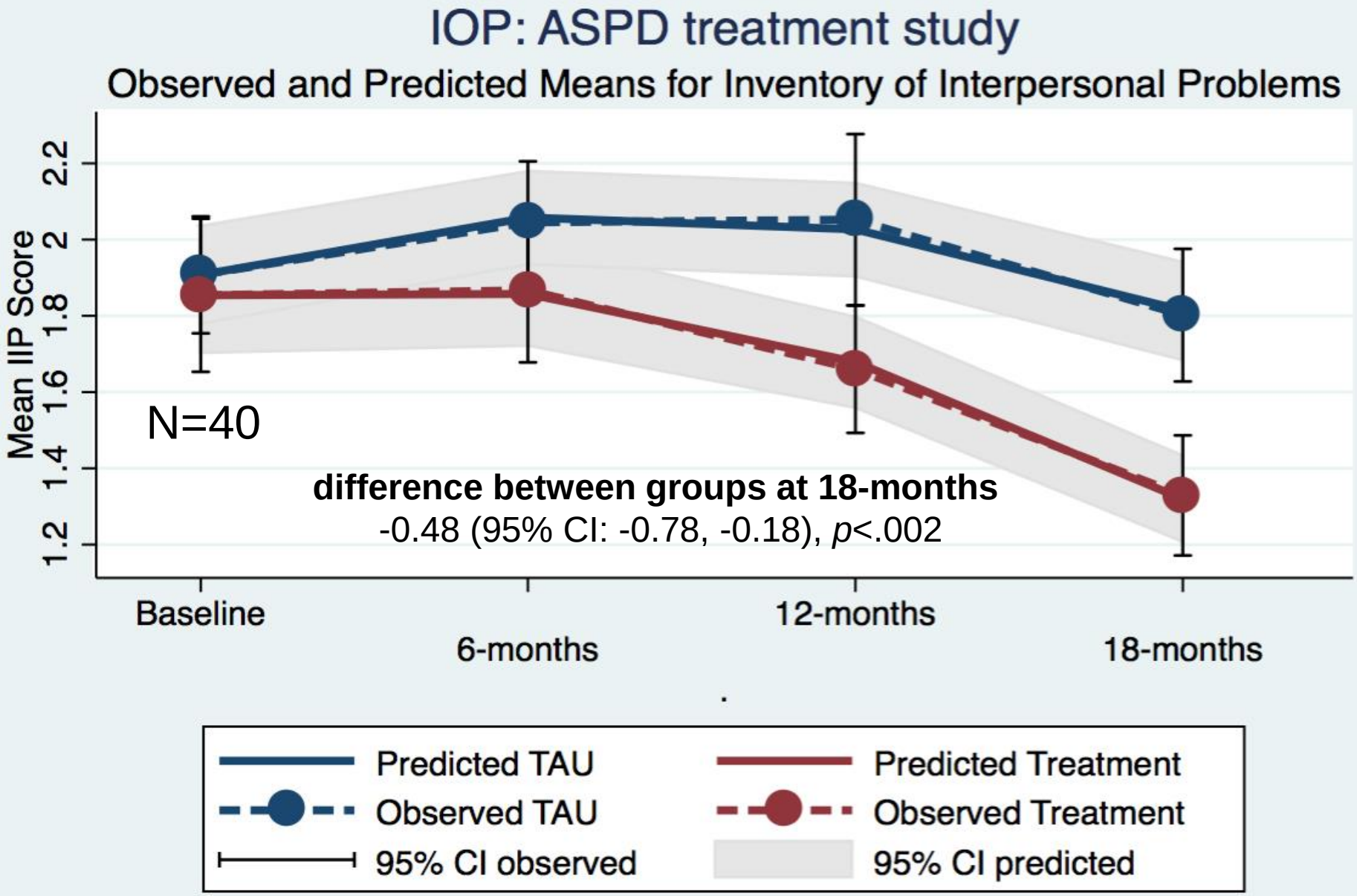
Taubner, White, Zimmermann, Fonagy & Nolte, 2013, JACP)




IOP: ASPD treatment study
Observed and Predicted Means for SCL-91: GSI Scale
Mean GSI Score
.5
1
1.5
2
2.5
Baseline
6-months
12-months
18-months
N=40
difference between groups at 18-months
-0.45 (-0.80, -0.11), p<.011
Predicted TAU
Observed TAU
95% CI observed
Predicted Treatment
Observed Treatment
95% CI predicted
Adjusted for Random Slope

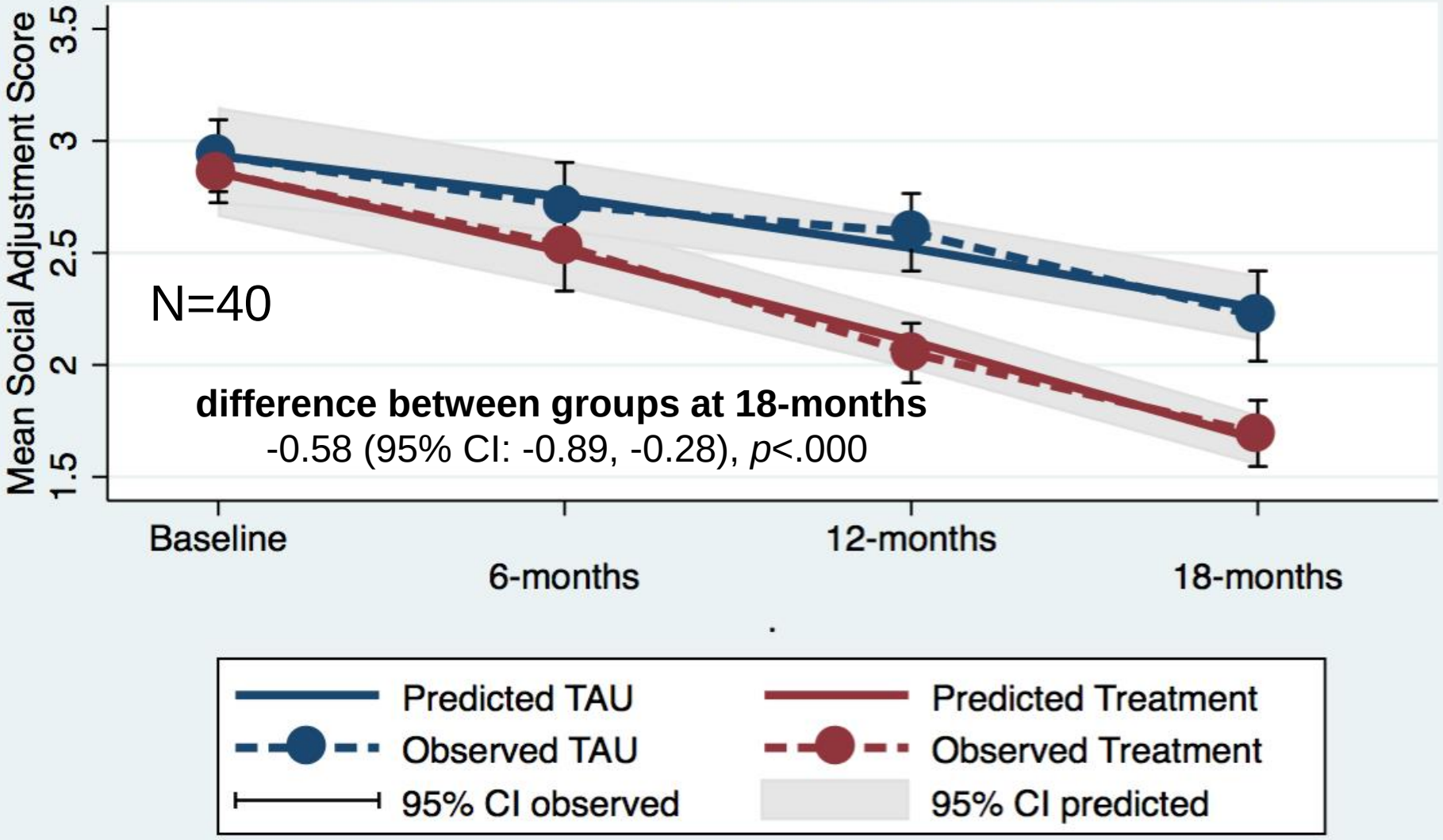

IOP: ASPD treatment study
Observed and Predicted Means for SCL-90: Hostility Scale
Mean Hostility Score
.5
1
1.5
2
2.5
N=40
difference between groups at 18-months
-0.61 (95% CI: -1.05, -0.17), p<.007
Baseline
6-months
12-months
18-months
Predicted TAU
Observed TAU
95% CI observed
Predicted Treatment
Observed Treatment
95% CI predicted
Adjusted for Random Slope


IOP: ASPD treatment study
Observed and Predicted Means for SCL-90 Paranoia Scale
Mean Selfharm Score
.5
1
1.5
2
2.5
N=40
difference between groups at 18-months
-0.64 (95% CI: -1.09, -0.18), p<.006
Baseline
6-months
12-months
18-months
Predicted TAU
Observed TAU
95% CI observed
Predicted Treatment
Observed Treatment
95% CI predicted
Adjusted for Random Intercept and Slope

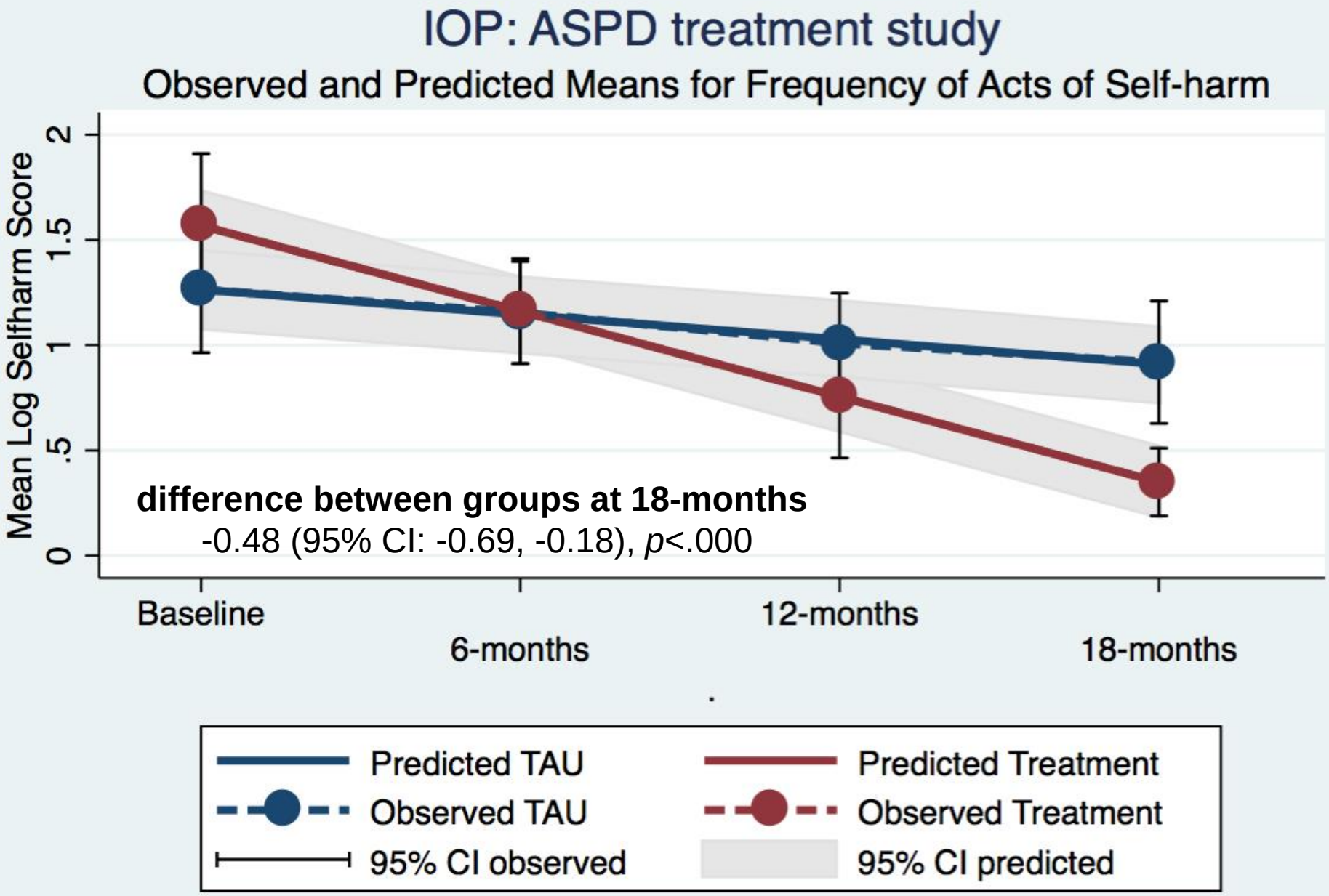

IOP: ASPD treatment study
Observed and Predicted Means for Inventory of Interpersonal Problems
Mean IIP Score
1.2
1.4
1.6
1.8
2
2.2
N=40
difference between groups at 18-months
-0.48 (95% CI: -0.78, -0.18), p<.002
Baseline
6-months
12-months
18-months
Predicted TAU
Observed TAU
95% CI observed
Predicted Treatment
Observed Treatment
95% CI predicted
Adjusted for Random Slope

IOP: ASPD treatment study

Observed and Predicted Means for Social Adjustment Scale

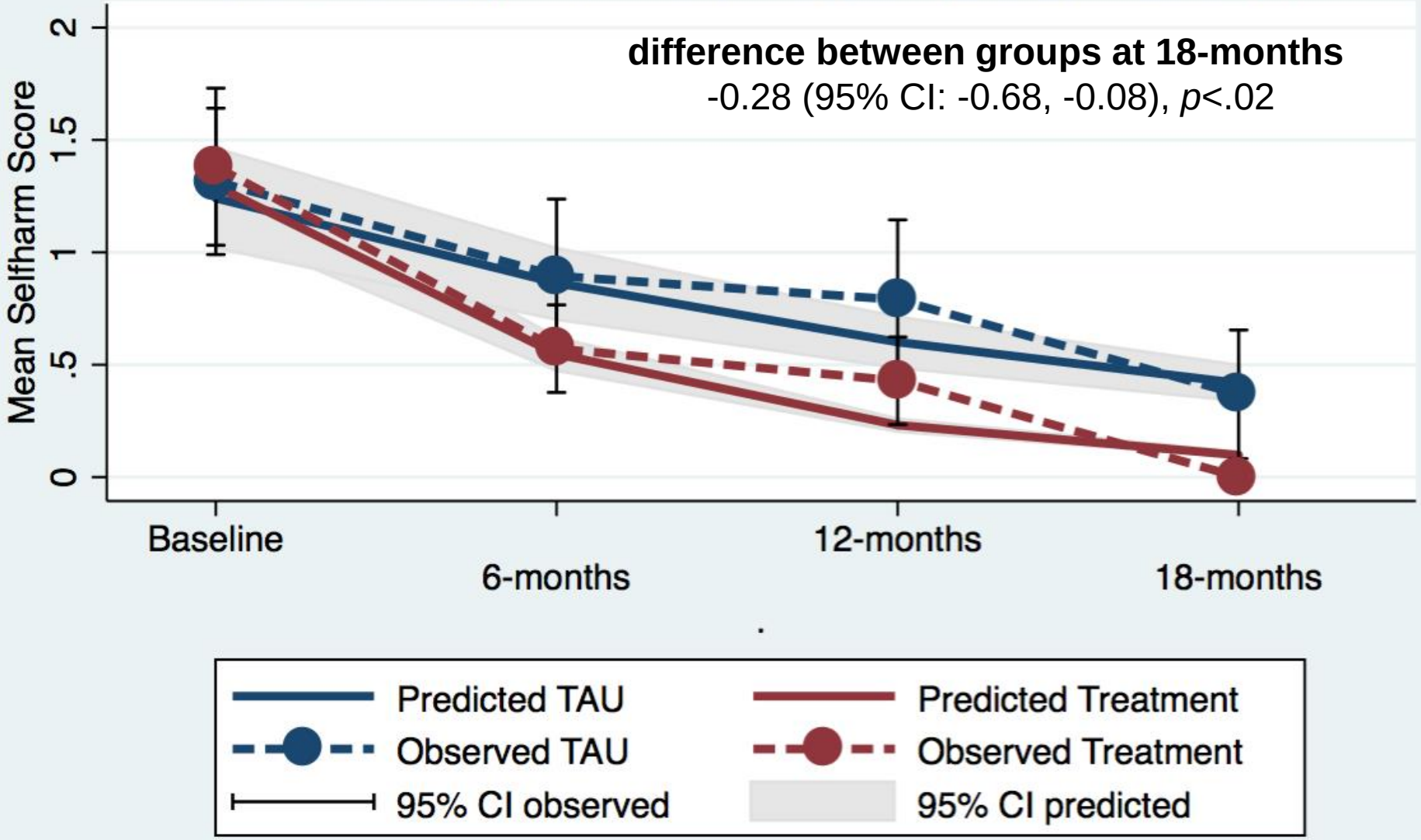


Adjusted for Random Slope

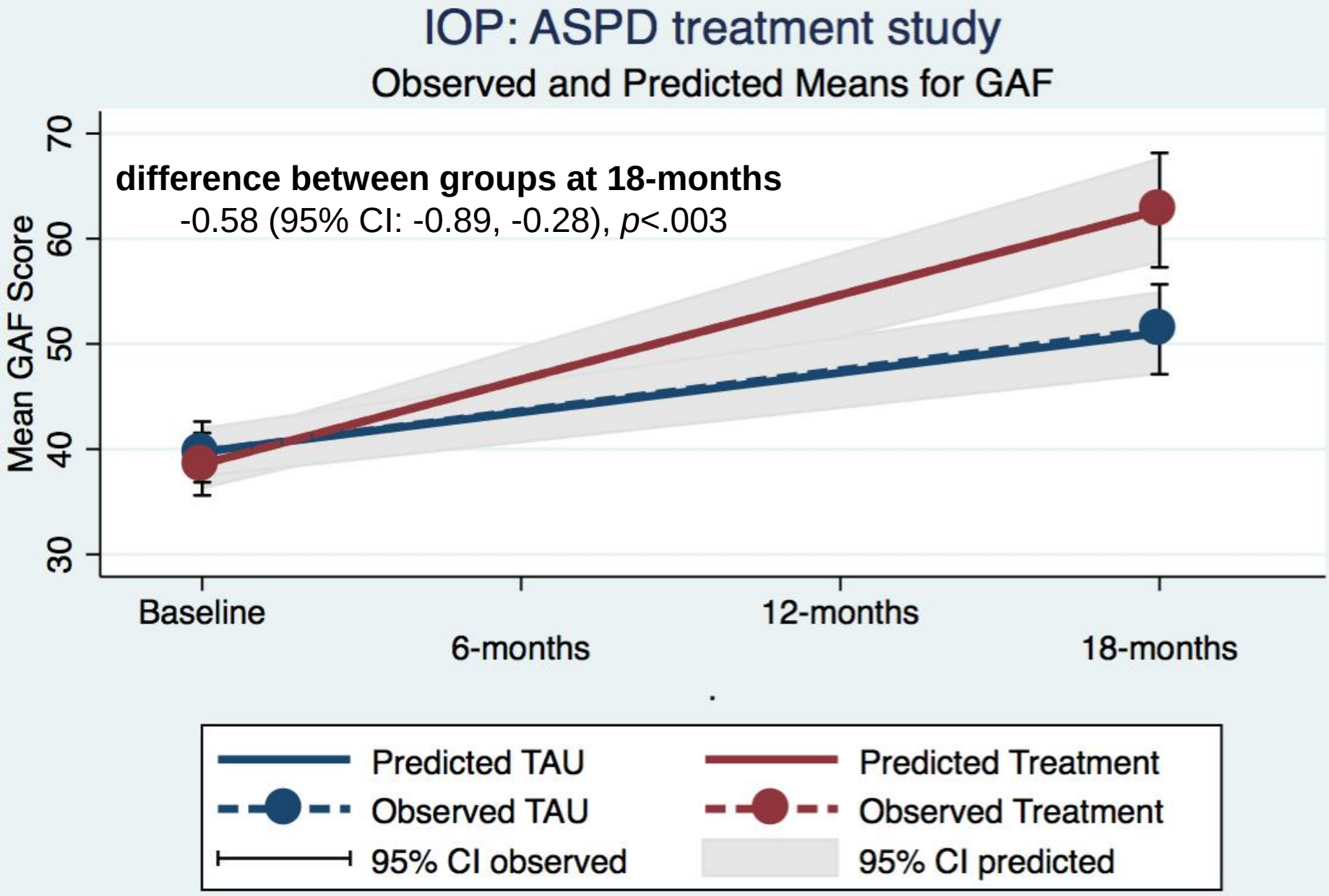

IOP: ASPD treatment study
Observed and Predicted Means for Frequency of Acts of Self-harm
Mean Log Selfharm Score
0
.5
1
1.5
2
difference between groups at 18-months
-0.48 (95% CI: -0.69, -0.18), p<.000
Baseline
6-months
12-months
18-months
Predicted TAU
Observed TAU
95% CI observed
Predicted Treatment
Observed Treatment
95% CI predicted
Adjusted for random intercept and initial values

IOP: ASPD treatment study

Observed and predicted mean frequency of suicide attempts



Poisson random effects regressions adjusted for random intercept


IOP: ASPD treatment study
Observed and Predicted Means for GAF
difference between groups at 18-months
-0.58 (95% CI: -0.89, -0.28), p<.003
Mean GAF Score
30
40
50
60
70
Baseline
6-months
12-months
18-months
Predicted TAU
Observed TAU
95% CI observed
Predicted Treatment
Observed Treatment
95% CI predicted
Adjusted for Random Intercept

MOAM

Mentalization for Offending Adult Males

ISRCTN32309003 DOI 10.1186/ISRCTN32309003

Evidence:

Currently no treatment with a robust evidence base for alleviating ASPD

Research:

Paucity of high quality studies is notable

Preliminary support for MBT:

Pilot of MBT for ASPD at two UK centers suggests that treatment can be learned and reliably applied

Next logical step: RCT comparing MBT to Usual Services to determine its clinical and cost-effectiveness

Outcomes

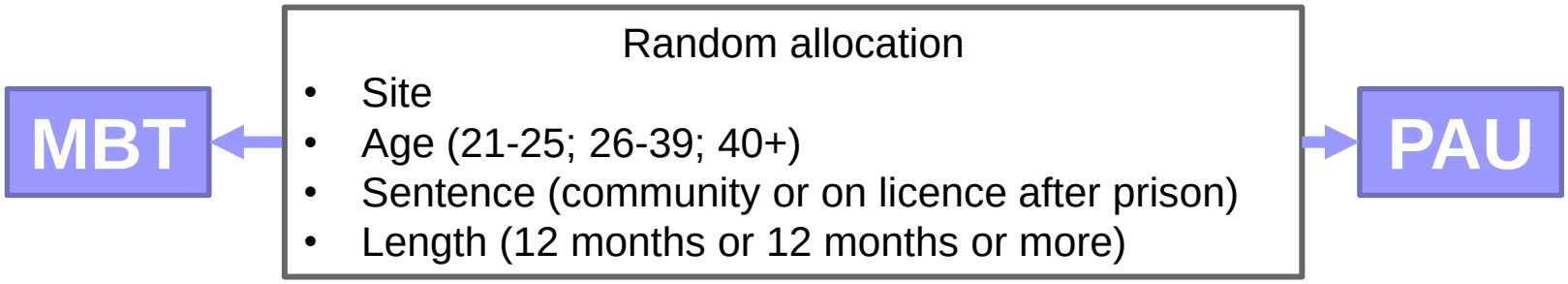
Primary Outcome	**Reduction in the frequency of aggressive acts**
Secondary Outcomes:	**Criminal: other (re)offending behaviour**
	Mental Health : anxiety and depression, drug and alcohol use, self-harm and suicidal behaviour, impulsivity, and beliefs
	Health: quality of life, health and functioning
	Service use: services including A & E and use of social services during the treatment and follow-up period.
	Cost-benefit analysis to determine the actual cost of service delivery in both treatment conditions and whether MBT-ASPD leads to reduction in costs compared to PAU.

Research Design

- Multi-site randomized control trial in a real life NHS setting.
- Recruitment target 302 participants across 14 sites
- Participants randomly allocated to MBT or Probation as Usual (PAU)
- User Voice Peer Researchers collecting data alongside traditional Research Assistants
- Participants are followed up every 3 months for 24 months post randomisation.

-Primary outcome measures and offending records obtained every 3 months post randomisation

-Secondary outcomes collected every 6 months



Overview of structured clinical management (SCM)

NICE Quality Standards for BPD and ASPD

1. Mental health professionals use a structured clinical assessment to diagnose borderline or antisocial personality disorder.
2. People with borderline personality disorder are offered psychological therapies and are involved in choosing the type, duration and intensity of therapy.
3. People with antisocial personality disorder are offered group-based cognitive and behavioural therapies and are involved in choosing the duration and intensity of the interventions.
4. People with borderline or antisocial personality disorders are prescribed antipsychotic or sedative medication only for short-term crisis management or treatment of comorbid conditions.

NICE Quality Statements

5

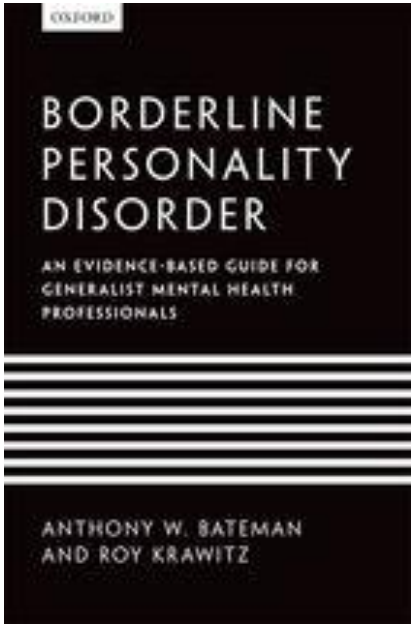
- People with borderline or antisocial personality disorder agree a structured and phased plan with their care provider before their services change or are withdrawn.

6

- Mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision.

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

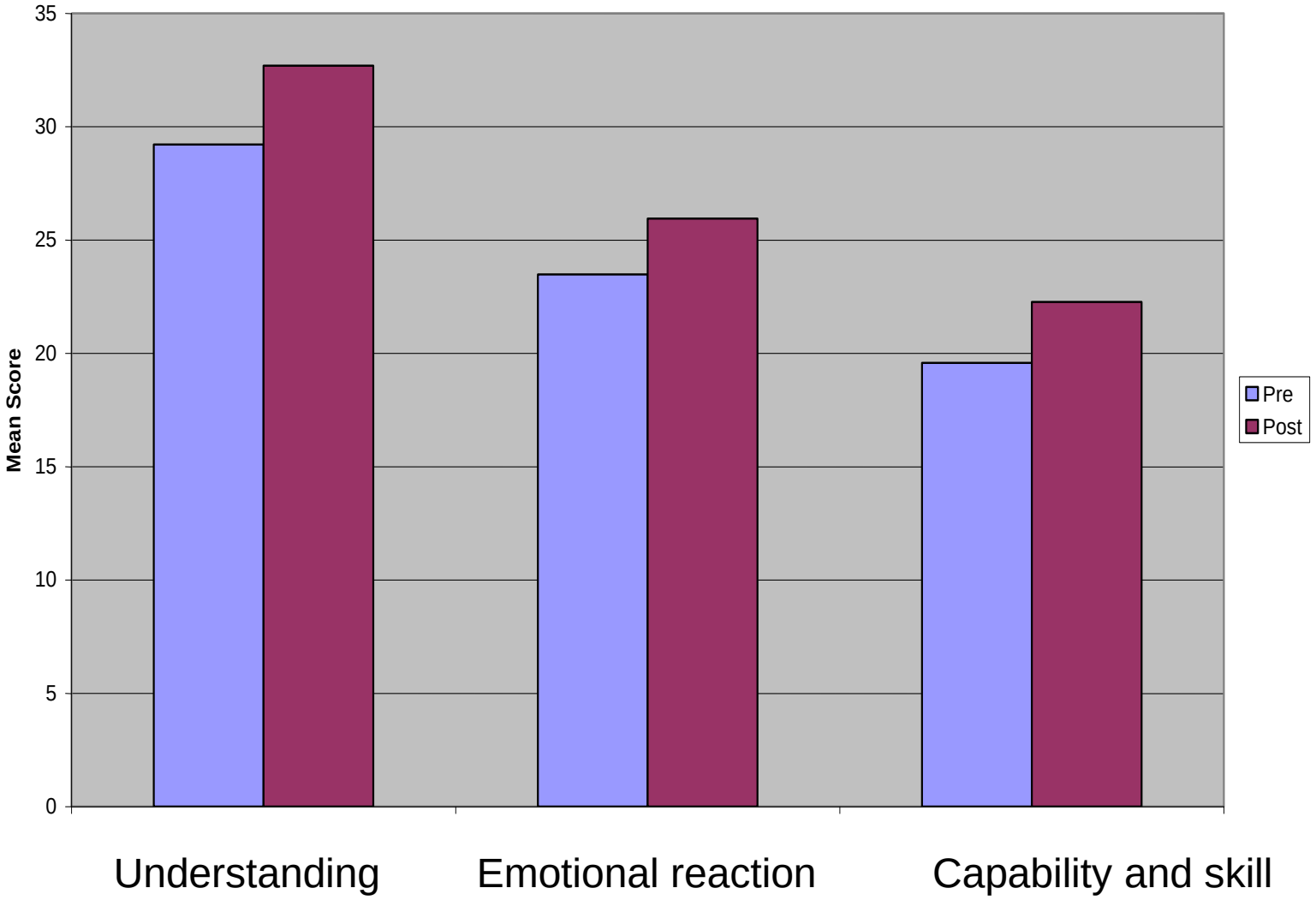
- **Provides an evidence-based intervention for treating people with borderline personality disorder**
- **Written by two highly experienced clinicians, providing the generalist mental health clinician with a thorough understanding of this disorder**
- **Includes advice on helping the family of the patient - 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**

978-0-19-964420-9 Paperback | May 2013 £24.99

SCM: Key components – principle driven

- Structure
  - Reliable appointments.
  - Detailed crisis plans.
  - Assertive follow-up if person does not attend an appointment.
- Agreements
  - Clear short term and long term goals.
  - Collaborative care plans done together.
- Interventions
  - Group psycho-education and skills sessions
  - Organised around core areas of personality disorder

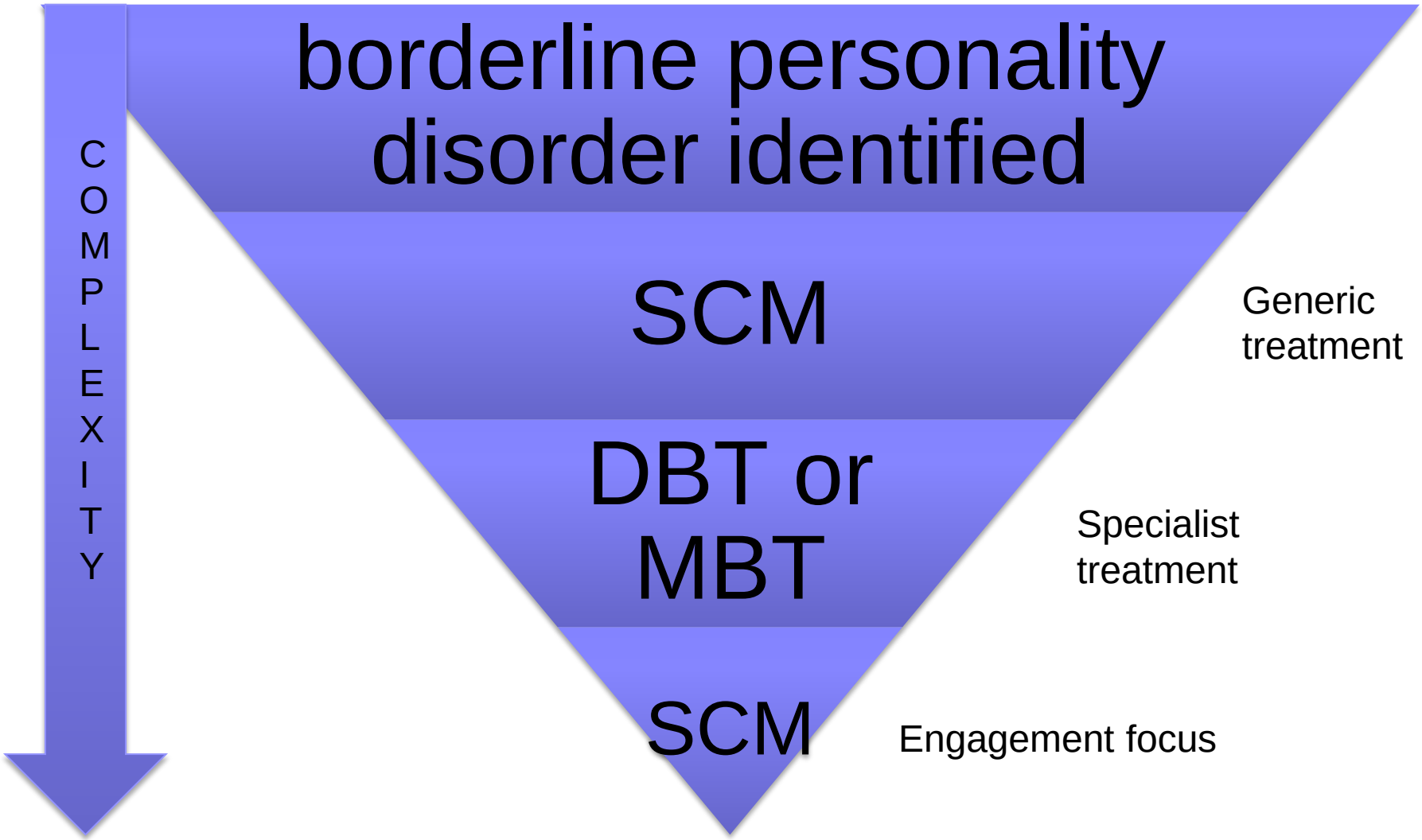
Training Outcomes (N=146)



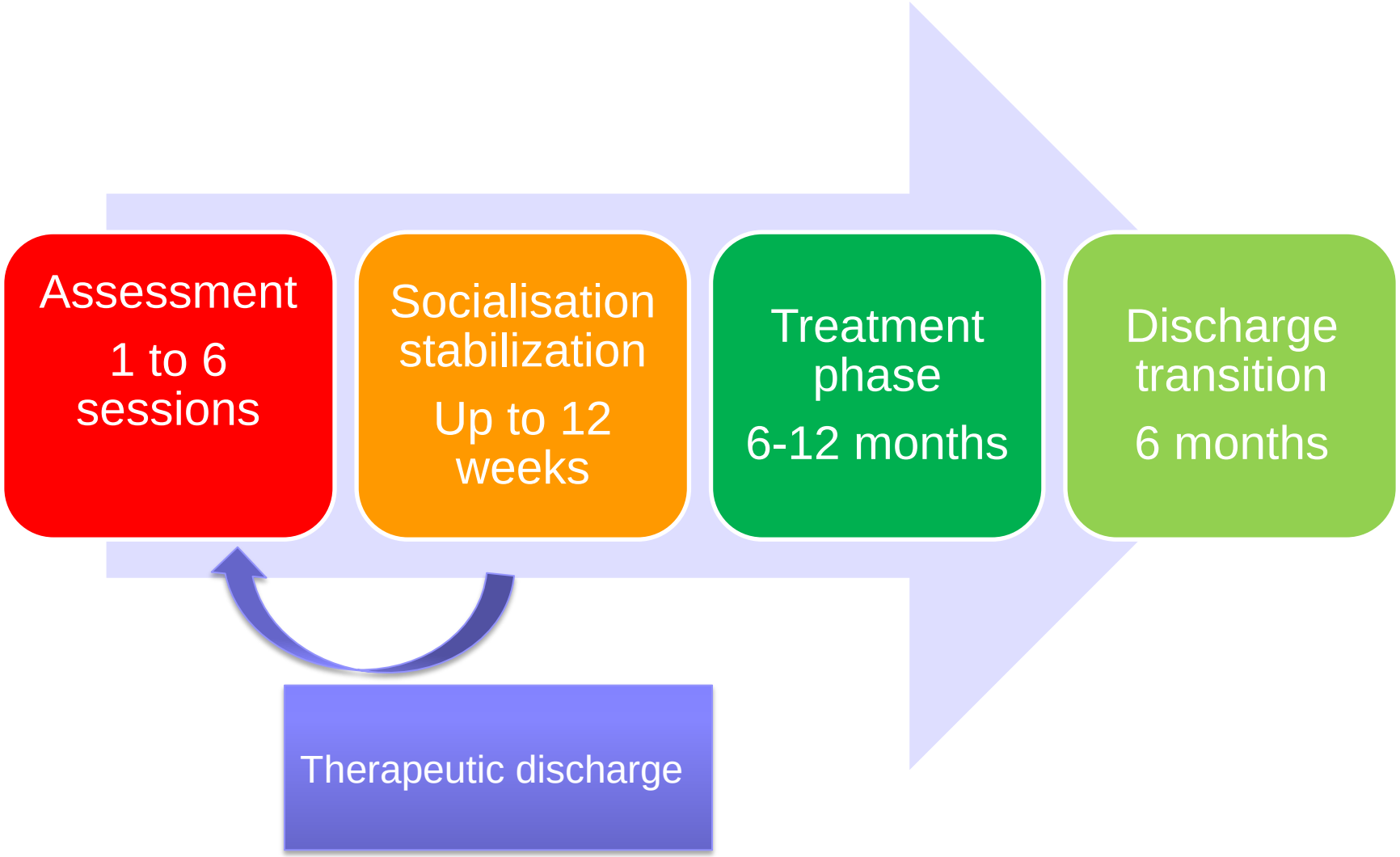
Contact with services % (n=138)

Services/Team	Pre-contact 6 months %	During treatment 6 months %	6 months post-treatment %
Rapid assessment and discharge	74	32	20
Home Treatment	85	28	12
Assessment	80	50	10
Criminal Justice	36	10	3
Hospital admission	100	35	8

Personality Disorder Care Pathway



Pathway


Assessment
1 to 6 sessions
Socialisation stabilization
Up to 12 weeks
Treatment phase
6-12 months
Discharge transition
6 months
Therapeutic discharge

Assessment (Up to 6 sessions)

- Careful assessment.
- Giving the diagnosis.
- Information sharing/psycho-education.
- Risk.
- Development of hierarchy of therapeutic areas.

Setting the Frame (Up to 3 months)

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

SCM Strategies: Foci

- **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

Attachment Styles

Our attachment to others can be described as:

1. Secure

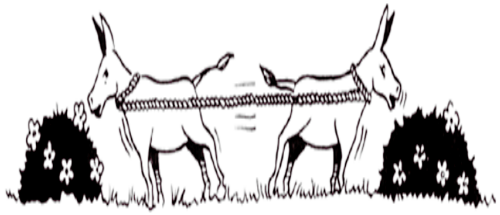
2. Insecure -Ambivalent
   (sometimes called anxious)

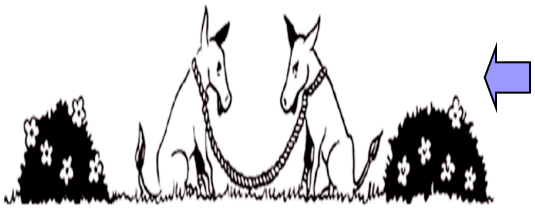
3. Insecure – Distanced
   (sometimes called avoidant)

4. Disorganised

Facilitating security in SCM

What do you want? What do I want?





What would the agreement be here?

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

Agreeing what we are going to work on:

- Need to be clear in our focus
- Develop common focus – what is the agreed goal?
- Emphasis on autonomy.
- Treatment is community based.
- Hospitalisation limited.
  - NOTE: primary aim of SCM is to reduce unnecessary hospital admissions:

Crisis Planning

Crisis Plans, Admissions and Prescribing.

Managing safety: seven principles

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

Crisis Planning

- Crisis Plans one of the most important things you can do.
- Key pointers to an effective crisis plan
  - Not adequate to have to attend A & E
  - Need to work with the patient to collaboratively come up with the plan
  - Use previous examples (three) that led to self destructive behaviour/or contact to services. Looking to establish early warning signs.

SCM Strategies

Problem Solving and Foci

SCM: interventions

Non-specific interventions

- Interviewing skills
- Attitude
- Empathy
- Validation
- Positive regard
- Advocacy

Specific interventions

- Tolerating emotions
- Mood regulation
- Impulse control
- Self-harm
- Sensitivity and Interpersonal problems

Clinician Stance

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

Problem Solving

Specific Interventions

SCM: Core treatment strategies

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

How to Solve a Problem

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

Emotions

Tolerance of Emotions and Mood Regulation

Key Strategies

- Psycho-education
- Labelling
- Normalising
- Contextualising
- Relaxation

Impulsivity

Impulsivity and impulse control

- **Not attending**: decreased attention – easily getting bored, inability to concentrate on a task, difficulty keeping to topic when something else comes into the mind
- **Not planning:** lack of premeditation; limited consideration about or concern for consequences; excitement about risky activities that precludes considering negative consequences
- **Action:** action without reflection – going into action rapidly, acting rashly sometimes related to pleasing as well as displeasing emotions

Impulsivity

Category	Emotion name	Urge	Indicators	Helpful response
Not attending	Boredom	Do something exciting	Awareness of inability to concentrate	Skilful action with others
Not planning	Anticipated satisfaction	Opportunistic theft	Awareness of thoughts of entitlement	Stop, think
Action	Loneliness	Find boyfriend, Get drunk	Noticing action urge	Meet friends

Interpersonal

Relationships and Sensitivity

Strategy: Interpersonal Skills

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

9. SCM extras

Top 10 Strategies, Group work, Family and Supervision.

Top Ten Strategies for clinicians

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

Thank you!

For further information:

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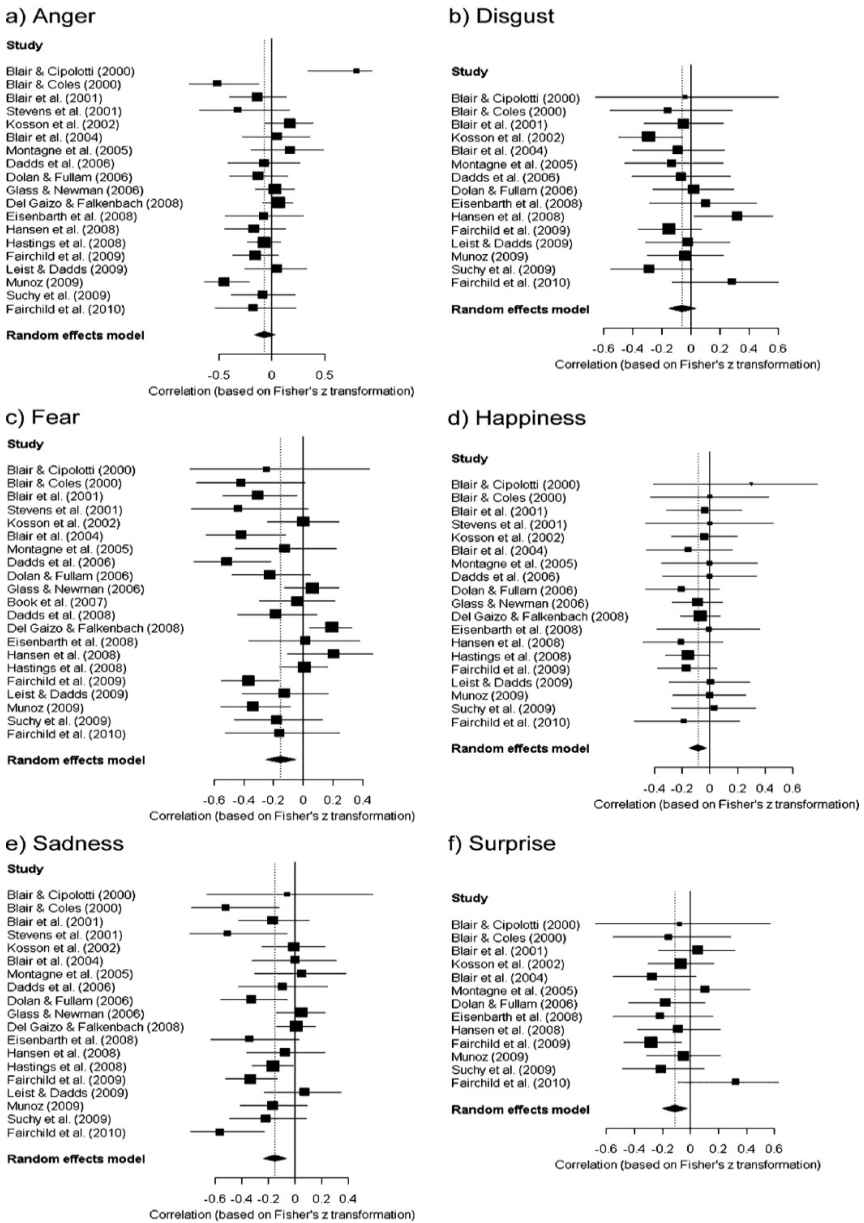
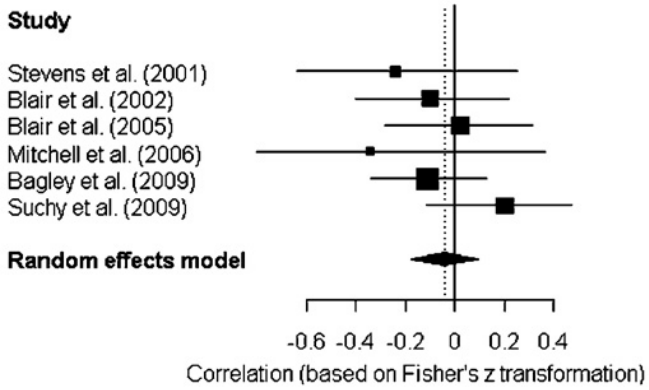
Emotional recognition

Forest plots for **facial cues** for the six emotions. Dawel et al 2012

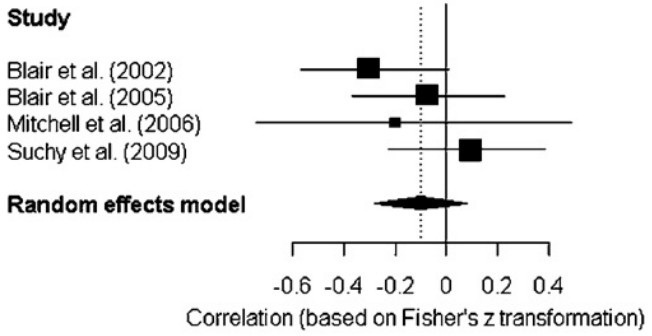


Forest plots mean effect sizes **vocal cues** for the six emotions. Dawel et al 2012.

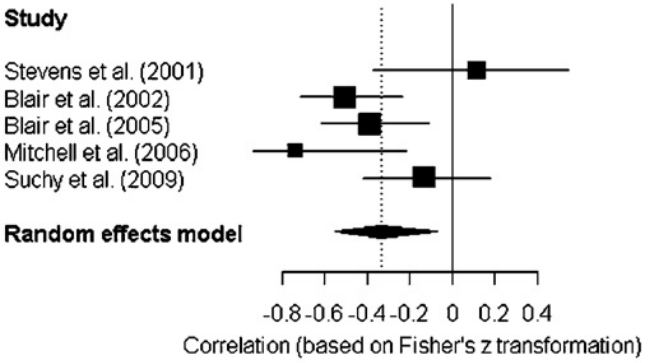
a) Anger



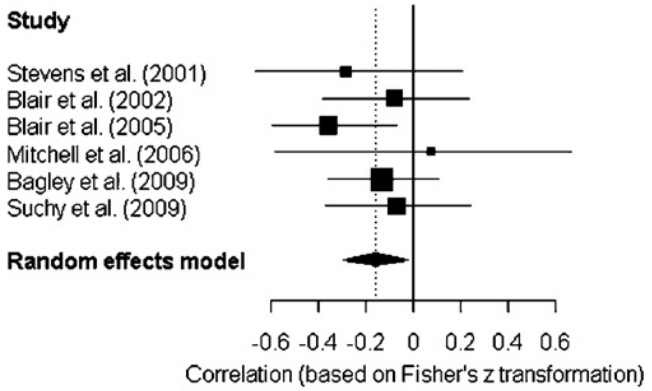
b) Disgust



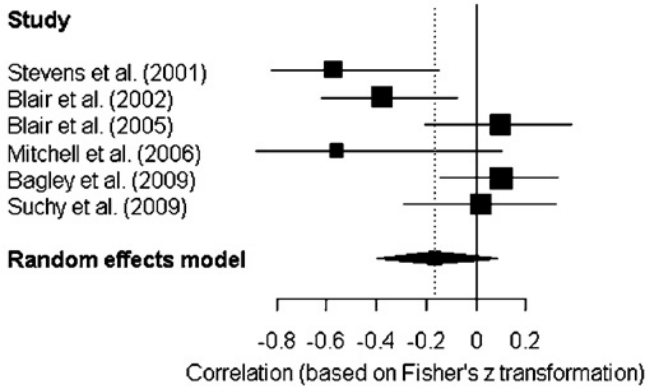
c) Fear



d) Happiness



e) Sadness



f) Surprise