Guideline Based Treatment at the Trimbos-institute, Utrecht
by Ad Kaasenbrood

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Background

In 2008 the Trimbos-institute in Utrecht, The Netherlands, edited the Multidisciplinary Guideline (MDG) on Diagnosis and Treatment of Personality Disorders. This was perceived as a major achievement. The treatment of personality disorders until then had been surrounded by a dark and negative aura: having a personality disorder was equated to being untreatable. Now there was optimism: four psychotherapeutic treatments had proven to be effective; psychotherapy is the main treatment for people with personality disorder and it brought together schools of very different theoretical orientations. Despite this optimism there were still doubts in the following areas: doubts on how firm the evidence on these four psychotherapies really was … and still is; doubts regarding the patients that weren't included in the guideline but needed care in daily practice and doubts that the Dutch MDG paid almost no attention to psychiatric management (for instance). Probably the most troubling doubt arose from a survey: researchers found that only 23% of all the people in treatment for a personality disorder actually had psychotherapy (Hermens et al. 2011).[1] One of the explanations was that most of the mental health institutions lacked the necessary psychotherapeutic expertise to put the guideline into practice.

The problem and a solution

Though the treatment of people with a personality disorder seemed to be well established, apparently there was too selective a focus on specialist psychotherapy. A lot of clients do not get specialist psychotherapy but Treatment as usual (TAU). We know TAU is of a variable nature and quality and that TAU has a considerable drop-out rate. So what we (Expertise Center Personality Disorders, ECPD, in The Netherlands) looked for was a program that integrated the following: all kinds of care that are needed to treat people with a personality disorder—psychotherapy, psychiatric management, crisis management, pharmacotherapy, vocational therapy etc and generally accepted common characteristics of effective treatments. That has become what we now call the Guideline Based Treatment (GBT). The ECPD developed it in close cooperation with representatives of twelve general mental health institutes and representatives of clients and families. The GBT is very much in line with (and is partly based on) Anthony Bateman's Structured Clinical Management (SCM) and John Gunderson's Good Psychiatric Management (GPM) – both these treatments are shown to be effective – and the ideas of Andrew Chanen and John Clarkin on effective treatment for personality disorders in general.

Guideline Based Treatment

A selection of the recommendations of the GBT will be presented in this newsletter. The GBT is broken down into four elements: General Principles for Treatment, Basic Attitude, General Treatment Strategies and Specific Treatment Strategies. The first three elements apply to all clinicians working in the personality disorder program in general mental health settings. Given the importance of an appropriate treatment environment and therapeutic frame for a successful treatment, the majority of the recommendations concern the creation of a consistent and comprehensive treatment environment with continuity of care. Next to these basic elements of care, specific interventions are added to specifically address the complaints of the patient.

[1] Hermens ML, van Splunteren PT, van den Bosch A, Verheul R. (2011). Barriers to implementing the clinical guideline on borderline personality disorder in the Netherlands. Psychiatr. Serv. 2011 Nov; 62

General principles for treatment

Most of these principles have been established as factors that are linked to treatment success:

- The treatment is structured (setting, appointments, availability of therapist, agreement on who is doing what, etcetera)
- The treatment is integrated (integration of necessary services and common factors)
- The treatment is consistent (general vision, handling of incidents, team members share vision on every treatment)
- Basic attitude of willingness to cooperate with the client
- Individually tailored treatment
- Treatment is goal oriented
- Treatment is active and if necessary outreaching
- Treatment focuses on motivation
- Treatment has an active focus on crisis management
- Treatment focuses on the therapeutic relationship
- Treatment focuses on reflection
- Treatment involves family and friends in the treatment
- Continuity of care (coordination of elements in the treatment, continuity of clinicians)
- Treatment mostly takes place in a team with clear leadership and mutual support and reflection of its members
- The organization shares the vision of the team and the clinicians and offers support to and reflection of the team.

Clinicians working with people with a personality disorder should display the following basic attitudes:

- Welcoming, enthusiastic and optimistic
- Organizations and clinicians should be mutually supportive
- Motivated to work with these clients
- Not knowing, curious, respectful, warm, authentic, flexible, willing to find the balance between validation and confrontation and supportive
- Engaging the client in an active role
- Monitoring the quality of the therapeutic alliance, display sensitivity to problems in the relationship and willing to repair break ups. Being able to maintain a positive attitude even when disliking the client
- Active, not remotely observing and reflecting
- Focusing on the consequences of the disorder for client's daily activities
- Plan therapy sessions on fixed moments
- Monitoring comments of the client on the treatment and the therapeutic alliance

General treatment strategies

Treatment strategies should be fixed elements of every treatment of a client with a personality disorder. These strategies represent steps in the process of care, which might overlap.

STEP 1: Entry

In the Netherlands most patients enter mental health institutions through the 'front door': a generalist intake setting. There is a substantial drop out of treatment during the intake. Basic attitude principles should be implemented in this 'front door'. Changes of therapist should be prevented and general principles maintained.

STEP 2: Comprehensive assessment

Not only classification of the disorder but also assessment of severity, functional deficits, risk,

social environment, status of work, course of the disorder, treatment history and biographical data

STEP 3: Diagnose and psycho-education

Clinician, client and relatives collate the complaints of the client and relatives as well as the symptoms of the disorder, so all parties understand how symptoms lead to problems in daily living. The clinician explains what treatment can do. He has an optimistic attitude

STEP 4: Treatment plan with hierarchy of treatment goals

Treatment goals are formulated SMART. Symptoms are coupled to repetitive patterns of disadaptive behaviors. In the treatment plan goals are prioritized, the interventions are described, there is a description of 'who is doing what' and of the evaluation of the treatment (moments, measures etc). All on basis of mutual agreement

STEP 5: Crisisplan and enduring monitoring and managing risks

The plan is put in explicit, operational terms (phases of crisis, signs, intervention, who is doing what, assessment of results). After every crisis the plan is evaluated and if necessary adjusted. Implications for the treatment plan are monitored. Risks are monitored permanently and addressed if necessary

STEP 6: Engaging and motivating client

Key concepts are: cooperation, validation, being involved, being available, giving actual support (e.g. help to write letters to official agencies), generating hope, involving relatives from the start, starting with small accessible goals, not trying to convince or confront prematurely, outreach in case of drop out. All on basis of mutual agreement

STEP 7: Evaluate and adjust treatment plan with all who are involved

Standard measures to monitor treatment progress are recommended. In case of treatment stagnations, reasons are analyzed. If necessary the treatment plan is adjusted

STEP 8: Monitoring therapeutic relationship and repairing

There is a constant focus on the quality of the therapeutic relationship. Ruptures in the bond are repaired before continuing therapy. In fact, repairing is therapy

STEP 9: End treatment/referral/goodbye/reductions in sessions

Take time to introduce changes in the therapeutic contact. Explain it, discuss it, and give the client time to adjust to it

Specific treatment strategies

The fourth element is a specific strategy to treat the complaints and symptoms of the patient. In fact it does not matter too much which one to choose as long as it is a well described intervention that is generally accepted as being appropriate and as long as it is executed systematically with fixed points of evaluation. In the IGT we gave the example of a problem solving module as the specific treatment strategy.

To conclude:

The GBT is not meant to replace the 'Big 4', as was suggested and feared by many psychotherapists in the Netherlands. With the GBT and a program for implementing audits in contributing institutions, we hope to improve TAU in general mental health settings in the Netherlands, to diminish drop out of treatment and to make the "Big 4" more accessible.

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