Encouraging Outcomes: Piloting individual psychodynamically Informed therapy for patients with moderate to severe PD and complex co-morbidities

Dr Henry Allberry (Locum SHO), Dr Justyna Szczupak (ST4 in General Psychiatry),
Dr Angeliki Zoumpouli (Consultant Psychiatrist and Medical Psychotherapist)
Croydon Personality Disorder Service
Touchstone Bethlem Royal Hospital

South London and Maudsley NHS Foundation Trust

Aims and Hypothesis:

Individual psychodynamically-informed therapy is often not seen as a potential effective treatment for patients with complex co-morbidities. Our hypothesis is that attachment based individual therapies can make a difference in the lives and functioning of complex patients, as well as their use of emergency and inpatient services,

Background:

Good clinical practice suggests evidence-based therapy for Borderline Personality Disorder patients, such as Mentalisation Based Therapy (MBT) programmes[1]. Historically, on the basis of co-morbid diagnoses, some patients are excluded: dissocial personality disorder issues, autistic traits, psychotic illness, physical illness, and Post-traumatic stress Disorder (PTSD) features. Furthermore, in recent years there has been more interest in dimensional approaches in psychiatry, as it is felt that the diagnosis of Borderline Personality Disorder or Emotionally Unstable Personality Disorder fails to capture the complexity of many of the patients given this label[2]. Given the diagnostic and therapeutic gap in the services, we are piloting individual psychotherapeutic intervention for patients with complex needs. This is a psychodynamically informed attachment-based intervention provided by senior therapists and it presupposes a formulation-based dimensional approach to diagnosis of complex patients.

Methods:

We offered individual psychodynamic therapy for 6-12 months to 8 patients. The therapists were either a Consultant psychiatrist and Medical Psychotherapist (6 patients) or senior therapists supervised by a Consultant (2 patients). Most of the data was extracted from electronic records/ reports. Apart from the clinical data provided by therapists, we asked an independent psychiatrist to assess GAF pre and after 6 months of therapy based on clinical notes. The results we accepted were the lowest. We also asked the independent psychiatrist to look into inpatient admission rates 1 year before and 6 months after start of therapy, as well as A&E attendance.

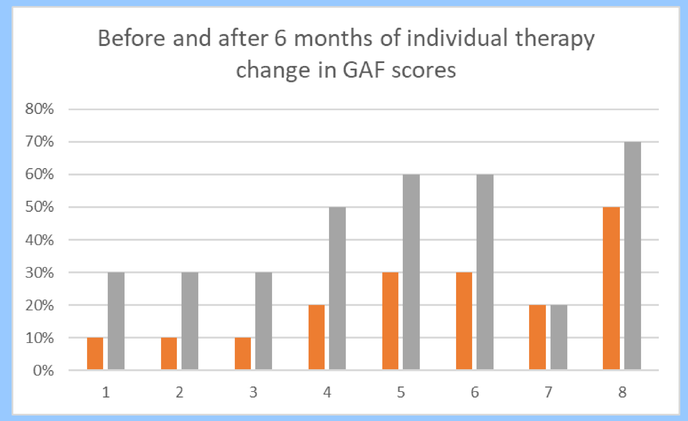
References:
[1] Services for people diagnosable with personality disorder; Royal College of Psychiatrists; 2020; https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2
2 Bach B, First MB. Application of the ICD-11 classification of personality disorders. BMC Psychiatry. 2018 Oct 29;18(1):351. doi: 10.1186/s12888-018-1908-3. PMID: 30373564; PMCID: PMC6206910.

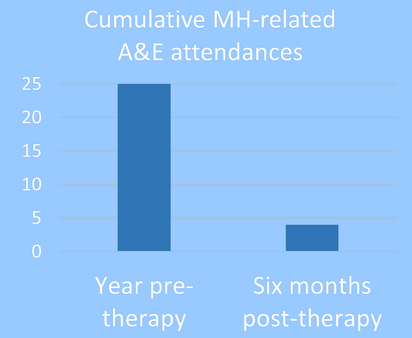
Diagnoses/ Demographics:

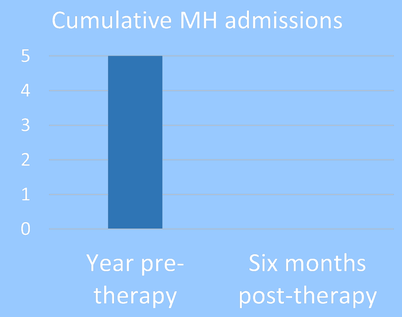
- 5/8 identified as female, 3/8 male
- 3/8 Black British, 1/8 mixed Indian- White British, 1/8 British Sr lankan, 3/8 White British
- ICD-11 diagnoses inc.: Moderate-Severe personality disorder (6D10—11) with signifiers; detachment (11.1), disinhibition (11.2) and dissociality (11.2) , Borderline pattern (11.5);
- 5/8 identified as female, 3/8 male
- 3/8 Black British, 1/8 mixed Indian- White British, 1/8 British Sr lankan, 3/8 White British
- 3/8 also co-morbid diagnosis of ASD/ ADHD, 1/8 schizioaffective disorder, 3/8 Complex PTSD
- Age ranged from 20-61 (median age = 45).
- Sessions offered ranged from 9-25 (at point of data extraction); proportion of sessions attended ranged from 44% (2 s.f. - 4 out of 9), to 100%
- 3/8 identified as gay, 3/8 straight and 2/8 as non-binary
- 6/8 on combination of antidepressant, mood-stabiliser and antipsychotic medications, 2/8 on no psychotropic medications
- 2/8 had some changes of psychotropic medications during therapy
- 6/8 never had therapy, 2/8 had some therapy before (DBT or counselling)
- 3/8 were unable to leave the house at the start of therapy and were offered therapy online to begin with (which then changed to face to face during the course of therapy)

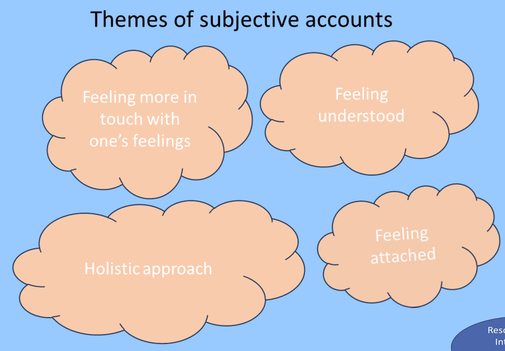
Results:

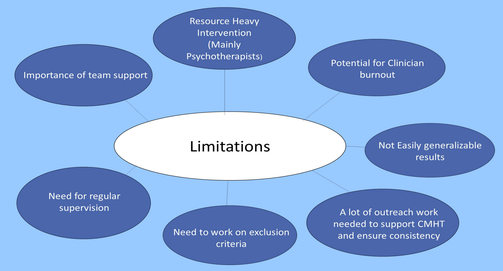
7/8 patients successfully engaged with weekly/two-weekly psychotherapy. Significant improvements were noted in Global Functioning Scale (GFS) scores.











Discussion:

The changes noted in GAF, admission rates and A&E attendance rates are remarkable 6 months post start of therapy are remarkable and indicate a trend of improvement. The changes in some of the outcomes including GAF scale on some occasions could have been affected by medication changes during therapy. More thought is needed in sustainability of model including resources and supervision needed.

Conclusions:

Individualised psychodynamic work for complex patients with co-morbidities including dissocial traits, autism, psychosis, PTSD provided by experienced clinicians and regular supervision can provide encouraging results. More thought needs to be had about providing flexible individualised treatments for people with complex co-morbidities.