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# Introduction to the special issue on National Institute for Health and Clinical Excellence guidelines

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This issue of *Personality and Mental Health* is devoted in its entirety to comments on the National Institute of Clinical Excellence's Guidelines for the Treatment of Antisocial Personality Disorder and Borderline Personality Disorder. Both are products of the UK's National Institute for Health and Clinical Excellence (NICE), and were issued in January 2009. These guidelines can be found at http://guidance.nice.org.uk/CG77 for antisocial personality disorder, and at http://guidance.nice.org.uk/CG78 for borderline personality disorder. Each guideline has a complete version, a shortened version (that can be thought of as a detailed executive summary) and a handy 'quick reference guide'.

What is key in the approach in these guidelines is the emphasis on both treatment and management. Anyone who has worked with these two groups of patients appreciates fully that management of the patient and of the treatment of the patient may be as important as the actual treatment choices themselves. These are cohorts of patients that have legendary, even if not always accurate, reputations for being very difficult if not impossible to treat. While the view of the resistance of these patient groups to treatment may have been modified somewhat by the recent follow-along studies of borderline personality disorder (Skodol et al., 2005; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005), as well as the development of a number of successful evidence-based treatments for borderline personality disorder (Bateman & Fonagy, 1999; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Davidson et al., 2006; Giesen-Bloo et al., 2006; Linehan et al., 2006), the problems in developing and implementing successful treatment for those with antisocial personality disorder remain mostly elusive despite the thorough and helpful work of the NICE guideline.

The guidelines are unique and valuable in that not only do they provide us a set of 'dos' and 'do nots' in the treatment of these disorders, but they also address issues such as clinician expertise, training of providers, coordination of care and organization of healthcare services that can optimize the provision of care for these patients. This is particularly relevant in the current debate about healthcare in the United States where I practice and where the fragmentation of cost coverage for healthcare can only add to a lack of coordination of services for people who above all need structure and a consistent and informed multi-disciplinary approach to their care. A national health programme, such as exists in the UK, can allow and foster the development and implementation of

coordinated services that we can only wish for in the United States.

There has often been a discussion as to whether borderline personality disorder and antisocial personality disorder are merely two sides of the same coin. For example, while borderline patients appear extremely sensitive to interpersonal interactions (even though they may not be very good at interpreting or planning for them and ultimately end up straining these relationships), antisocial personality patients are typically viewed as immune to these interactions while many of them may at the same time be astute in their ability to charm others. For antisocial personality patients, this may be a stereotype and simplistic, but we need further research here. Borderline patients appear at times to act out against and harm themselves when distressed or overwhelmed, while antisocial patients appear to act out against society (even though they might rarely acknowledge the awareness of their own distress). These guidelines, however, at least in their conclusions about management and treatment, would suggest that these two groups are at times quite different populations, and approaches that work for one may not work for the other.

What appears to be similar in the recommendations for each of the patient groups is that treatment be planned, structured, coordinated and manualized to be able to provide true guidance when sailing the complex, chaotic and countertransferential-laden waters of trying to provide good care for these individuals.

One additional point deserves mentioning. The NICE guidance suggests that with both of these patient populations, treatment will not only be complex, but will have to take place over a substantial period of time. Treatment that lasts only a couple of months does not appear to suffice with these complicated patients. But a sustained, organized, informed and collaborative endeavor can provide successes where in the past we could only believe that the idea of success was an illusion (Bateman & Zanarini, 2008).

## References

Bateman, A., & Fonagy, P. (1999). The effectiveness of partial hospitalization in the treatment of borderline personality disorder—A randomized controlled trial. *American Journal of Psychiatry*, *156*, 1563–1569.

Bateman, A., & Zanarini, M. C. (2008). Personality disorder. In P. Tyrer, & K. R. Silk (Eds.), *Cambridge textbook of effective treatments in psychiatry* (pp. 659–681). New York, NY: Cambridge University Press.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry*, *164*, 922–928.

Davidson, K., Norrie, J., Tyrer, P., Gumley, A., Tata, P., Murray, H., & Palmer, S. (2006). The effectiveness of cognitive behavior therapy for borderline personality disorder: Results from the borderline personality disorder study of cognitive therapy (BOSCOT) trial. *Journal of Personality Disorders*, *20*, 450–465.

Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., Kremers, I., Nadort, M., & Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder. Randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry*, *63*, 649–658.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., Korslund, K. E., Tutek, D. A., Reynolds, S. K., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, *63*, 757–766.

Skodol, A. E., Gunderson, J. G., Shea, M. T., McGlashan, T. H., Morey, L. C., Sanislow, C. A., Bender, D. S., Grilo, C. M., Zanarini, M. C., Yen, S., Pagano, M. E., & Stout, R. L. (2005). The Collaborative Longitudinal Personality Disorders Study (CLPS): Overview and implications. *Journal of Personality Disorders*, *19*, 487–504.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2005). The McLean Study of Adult Development (MSAD): Overview and implications of the first six years of prospective follow-up. *Journal of Personality Disorders*, *19*, 505–523.

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